County of San Mateo

Inter-Departmental Correspondence

Department: HEALTH
File #: 19-867

Board Meeting Date: 9/17/2019

Special Notice / Hearing: None
Vote Required: Majority

To: Honorable Board of Supervisors

From: Louise F. Rogers, Chief, San Mateo County Health
Scott Gilman, Director, Behavioral Health and Recovery Services

Subject: San Mateo County Mental Health Services Act Annual Update

RECOMMENDATION:

Adopt a resolution authorizing the approval and submission of San Mateo County's Mental Health Services Act (MHSA) FY 2018-2019 Annual Update for MHSA Programs and Expenditures to the State Mental Health Services Oversight and Accountability Commission.

BACKGROUND:

In 2004, California voters passed Proposition 63, known as the MHSA, which made additional state funds available to expand and transform mental health services. Since 2006, MHSA resources and expenditures have been approved by your Board as part of the larger County Health budget. State legislation requires that the MHSA Three-Year Program and Expenditure Plans and subsequent Annual Updates be approved by the County's Boards of Supervisors. The Mental Health and Substance Abuse Recovery Commission (MHSARC) has reviewed the FY 2018-19 MHSA Annual Update, following a public hearing and 30-day public comment, and is recommending approval by the Board of Supervisors.

DISCUSSION:

On August 7, 2018, your Board approved the MHSA Three-Year Program and Expenditure Plan for FY 2017-18 through FY 2019-20. The three-year plan has completed two years of implementation in which BHRS continues to engage with diverse stakeholders through the MHSARC and the MHSA Steering Committee.

Key updates to the MHSA Plan from last year's submission include:

1) State approval of a two-year innovation funding extension for the San Mateo County Pride Center and a one-year, no additional cost, extension of the Health Ambassador Program for Youth (HAP-Y) and the Neurosequential Model of Therapeutics (NMT) in an adult system of care.

2) State approval of San Mateo County's Assembly Bill 114 Plan to participate on the statewide Technology Suite Collaborative Innovation project.

3) Guidelines for an MHSA Prudent Reserve were established by the State Department of Health Care Services, at an amount of 33 percent of the average Community Services and Supports revenue received from MHSA. The MHSA Steering Committee reviewed and approved a recommended Total Reserve, including the Prudent Reserve, of 50 percent of the highest annual MHSA revenue. Excess unspent funds in reserve will be used to advance MHSA program priorities identified in the MHSA Three-Year Plan.

Full Service Partnerships (FSPs)

Every year a status report on the impact of FSPs is provided to your Board. The FSP service model provides intensive "whatever it takes" mental health services and supports to eligible youth and transition-aged youth (TAY), adult and medically fragile older-adult clients. FSPs continue to demonstrate positive health outcomes for clients, particularly for reducing arrests, decreasing mental and physical health emergencies, increasing employment, and lowering school suspensions for youth. These positive outcomes are maintained when viewed across four to five years of continued participation. This year we included a substance use outcome and found that fewer adult and older adult clients had an active substance use problem and are receiving treatment from a substance use provider, after a year in FSP services.

Specific outcomes for youth (school attendance, grades, and suspensions) demonstrated some variability across years of participation, although this observation entails a small number of clients and it involves the highest risk youth. Thus, conclusions should not be over-interpreted. The complete FSP outcome report is enclosed as part of the MHSA Annual Update; a chart summarizing improvements is detailed below.

Improvement in Outcomes by Age Group, Year before FSP Compared with First Year in FSP (through June 30, 2018)

FSP Outcomes *Self-reported Outcomes*	**Adult (25 to 59 years) N = 346**			**Older adult (60 years & older) N = 59**		
	Yr prior	*Year 1*	*% change*	*Yr prior*	*Year 1*	*% chang*
Homelessness	91	58	36.3%	3	8	N/A**
Detention or Incarceration	61	43	29.5%	3	5	N/A**
Employment	35	44	25.7%	4	2	N/A**
Arrests	52	6	88.5%	3	0	N/A**
Mental Health Emergency	151	57	62.3%	13	7	46.2%
Physical Health Emergency	83	26	68.7%	18	12	33.3%
Active S.A. Problem	268	171	36.2%	44	18	59.1%
S.A. Treatment	184	62	66.3%	39	6	84.6%

FSP Outcomes *Self-reported Outcomes*	Child (16 years and younger) N = 148			TAY (17 to 25 years) N = 202		
	Yr prior	*Year 1*	*% change*	*Yr prior*	*Year 1*	*% chang*
Homelessness	8	6	25%	24	26	8%
Detention or Incarceration	22	26	18%	31	29	6%
Arrests	24	9	63%	54	19	65%
Mental Health Emergency	57	7	88%	84	23	73%
Physical Health Emergency	13	0	100%	51	5	90%
Suspension	38	19	50%	21	5	76%
Grade*	3.28	2.95	10%	3.17	3.11	2%
Attendance*	2.25	1.85	18%	2.26	2.39	5%

* School attendance and grades are ratings on a 1-5 scale (higher is better).
** Not Applicable

The MHSARC reviewed and recommended that your Board approve the MHSA Annual Update on March 6, 2019, and subsequently reviewed and approved the MHSA Innovation extensions for the HAP-Y and NMT-Adults on June 5, 2019.

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

The MHSA Annual Update for FY 2018-19 contributes to the Shared Vision 2025 outcome of a Healthy Community by expanding recovery-based mental health programs for people with serious mental illness, reducing the long-term negative impact from untreated mental illness, and preventing mental illness from becoming severe and disabling.

A client is considered "maintained at the current or lower level of care" if, during the fiscal year, they did not have a new admission to a higher level of care, or had one or more new admissions to a program with the same or lower level of care. It is projected that 75 percent of FSP clients shall be maintained at a current or lower level of care.

PERFORMANCE MEASURE:

Measure	FY 2018-19 Actual	FY 2019-20 Projected
Percentage of FSP clients maintained at current or lower level of care	74% 406 of 551 clients	75% 413 of 551 clients

FISCAL IMPACT:

There is no Net County Cost associated with this plan. BHRS received $32.9 million in MHSA funding in FY 2017-18 and $33.5 million in FY 2018-19. We anticipate a reduction in MHSA revenue for FY 2019-20 because of the state implementation of “No Place Like Home” legislation. Funds that are not yet allocated through our internal planning process or RFP to the community are held in a Trust Account. This Trust Account is also used to manage the fluctuations in funding that occur from year to year, as well as to support maintenance of effort and cost increases for current programs.

RESOLUTION NO. 076905

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

* * * * * *

RESOLUTION AUTHORIZING THE APPROVAL AND SUBMISSION OF SAN MATEO COUNTY'S MENTAL HEALTH SERVICES ACT (MHSA) FY 2018-2019 ANNUAL UPDATE FOR MHSA PROGRAMS AND EXPENDITURES TO THE STATE MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

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

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

WHEREAS, State legislation requires counties to seek approval of their MHSA Three-Year Program and Expenditure Plans and Annual Updates from their Board of Supervisors; and

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

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

NOW THEREFORE, IT IS HEREBY DETERMINED AND ORDERED that this Board of Supervisors accepts the MHSA Annual Update for Fiscal Year 2018-19 and approves its submission to the State Department of Health Care Services.

* * * * * *

RESOLUTION NUMBER: 076905

Regularly passed and adopted this 17th day of September, 2019

AYES and in favor of said resolution:

Supervisors: *DAVE PINE*

CAROLE GROOM

DON HORSLEY

WARREN SLOCUM

DAVID J. CANEPA

NOES and against said resolution:

Supervisors: *NONE*

Carole Groom

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

Certificate of Delivery

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

Assistant Clerk of the Board of Supervisors

SAN MATEO COUNTY HEALTH

BEHAVIORAL HEALTH & RECOVERY SERVICES

San Mateo County Mental Health Services Act

Annual Update for Programs & Expenditures, FY 18-19

(Program highlights and data from FY 2016-2017 services)

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MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: County of San Mateo

☐ Three-Year Program and Expenditure Plan
☒ Annual Update

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

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

This Three-Year Program and Expenditure Plan or Annual Update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Three-Year Program and Expenditure Plan or Annual Update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on September 17, 2019.

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

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

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

Scott Gilman 10/8/19
Signature Date

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: County of San Mateo

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

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Scott Gilman, MSA	Name: Juan Raigoza
Telephone Number: (650) 573-2748	Telephone Number: (650) 363-4777
E-mail: sgilman@smcgov.org	E-mail: controller@smcgov.org

Local Mental Health Mailing Address:

San Mateo County, Behavioral Health and Recovery Services (BHRS)
2000 Alameda de las Pulgas, Ste 235
San Mateo, CA 94403

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

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

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

Scott Gilman 10/8/19
Signature Date

I hereby certify that for the fiscal year ended June 30, 2018, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated _____ for the fiscal year ended June 30, 2018. I further certify that for the fiscal year ended June 30, 2018, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

Juan Raigoza
County Auditor Controller / City Financial Officer (PRINT)

by Kim Mah Li 10/15/19
Signature Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)

INTRODUCTION

INTRODUCTION TO SAN MATEO COUNTY

Located on the San Francisco Peninsula, San Mateo County is bordered by the Pacific Ocean to the west and San Francisco Bay to the east. The County was formed in April 1856 out of the southern portion of then-San Francisco County. Within its 455 square miles, the County is known for a mild climate and scenic vistas. It is home to some of the most spectacular and varied geography in the United States that includes redwood forests, rolling hills, farmland, tidal marshes, creeks and beaches.

The County is committed to building a healthy community. In collaboration with community-based partners, the County provides access to health care services, especially to the underserved and unserved as well as creating a safe and convenient opportunities for physical activities. Much of the shoreline along the San Francisco Bay is part of the San Francisco Bay Trail. This trail provides residents and visitors alike with miles of biking and walking in the numerous park and recreation areas, and trails.

The County has long been a center for innovation. It is home to numerous colleges and research parks and is within the "golden triangle" of three of the top research institutions in the world: Stanford University, the University of California at San Francisco and the University of California at Berkeley. Today, San Mateo County's bioscience, computer software, green technology, hospitality, financial management, health care and transportation companies are industry leaders.

Situated in San Mateo County is San Francisco International Airport, the second largest and busiest airport in California, and the Port of Redwood City, which is the only deep water port in the Southern part of the San Francisco Bay. These economic hubs have added to the rapidly growing vitality of the County.

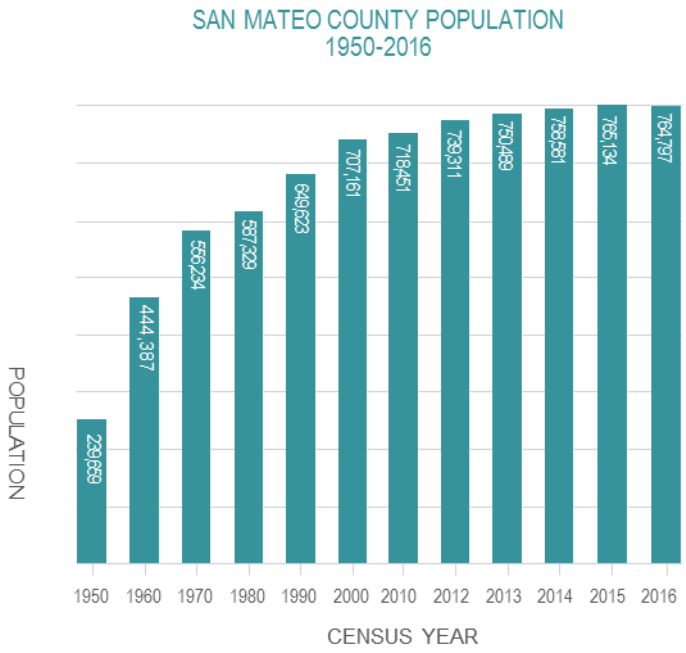
COUNTY OF SAN MATEO MISSION

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

We are committed to:

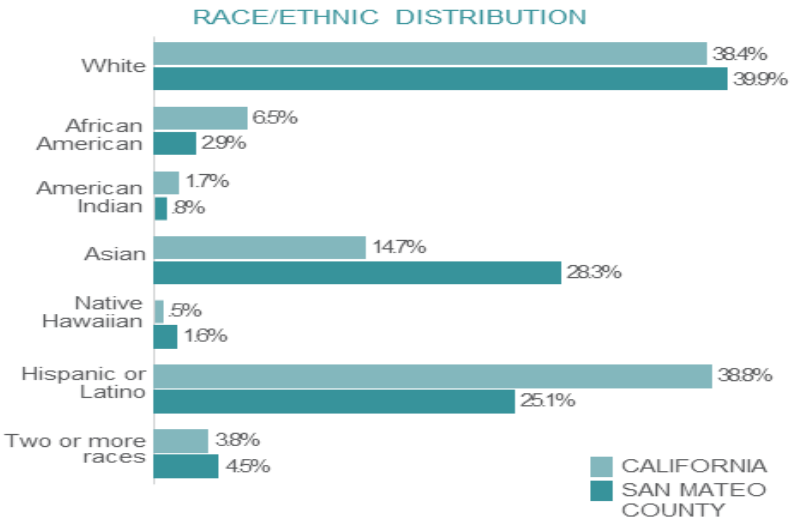
- The highest standards of public service;
- A common vision of responsiveness;
- The highest standards of ethical conduct;
- Treating people with respect and dignity.

The 2016 population estimated by the U.S. Census Bureau was 764,797 — a 6.4 percent jump over the 2010 Census. Daly City remains the most populous city followed by San Mateo and Redwood City.



The median age of San Mateo County residents was 39.3 years compared to the state's median age of 35.2 years, according to the 2010 Census. Projections indicate future decades will see a significant spike in the county's population 65 years and older. In 2015, the Census estimated 6 percent of the population was under 5 years old, 21.2 percent were under 18 and 15 percent were 65 or older.

As the County's population continues to shift, the racial and ethnic composition continues to diversify. 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), Tagalog and Russian (as identified by Health Plan of San Mateo). The Health System identified Tongan, Samoan as priority languages based on a growing number of clients served and emerging languages as Arabic, Burmese, Hindi, and Portuguese.



MHSA BACKGROUND

Proposition 63, the Mental Health Services Act (MHSA), was approved by California voters in November 2004 and provided dedicated funding for mental health services by imposing a 1% tax on personal income over $1 million dollars translating to about $27 million annual average for San Mateo County in the last five years through Fiscal Year 2017-18.

PRINCIPLES AND FUNDING BOUNDARIES

MHSA emphasizes transformation of the mental health system while improving the quality of life for individuals living with mental illness. Core values include:

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

MHSA programming is grouped into Components each with funding allocation and guidelines.

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

One Time Funding:

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

** Up to 20% of the avg. 5-year total of MHSA funds can be allocated from CSS to WET, CF/IT and Prudent Reserve*

In San Mateo County, MHSA dollars are integrated throughout the BHRS system and highly leveraged. MHSA-funded activities further BHRS' vision, mission and strategic initiatives.

COMMUNITY PROGRAM PLANNING

COMMUNITY PROGRAM PLANNING

The San Mateo County Behavioral Health and Recovery Services (BHRS) promotes a vision of collaboration and integration by embedding MHSA programs and services within existing infrastructures. San Mateo County does not separate MHSA planning from its other continuous planning processes. Given this, stakeholder input from system-wide planning activities is taken into account in MHSA planning. In 2005, BHRS devised a local planning process and structure to seek input from the broad San Mateo County stakeholder community. The Mental Health and Substance Abuse Recovery Commission (MHSARC), formerly the Mental Health Board, is involved in all MHSA planning activities providing input, receiving regular updates as a standing agenda item on the monthly MHSARC meetings, and making final recommendations to the San Mateo County Board of Supervisors (BoS) on all MHSA plans and updates. The MHSARC meetings are open to the public, and attendance is encouraged through various means: notice of meetings (flyers, emails) are sent to a broad and increasing network of contacts including community partners and County agencies, as well as consumer and advocacy organizations, and the general public. MHSARC commissioners are all members of the MHSA Steering Committee.

MHSA STEERING COMMITTEE

The MHSA Steering Committee was also created in 2005 and continues to play a critical role in the development of MHSA program and expenditure plans. In 2016, the MHSA Steering Committee was restructured to strengthen the representation of diverse stakeholders. The MHSA Steering Committee makes recommendations to the planning and services development process and as a group, assures that MHSA planning reflects local diverse needs and priorities, contains the appropriate balance of services within available resources and meets the criteria and goals established. The Steering Committee meetings are open to the public and include time for public comment as well as means for submission of written comments.

The MHSA Steering Committee is co-chaired by a member of the San Mateo County BoS and by the Chair of the MHSARC. Comprised of over 40 community leaders representing the diverse San Mateo community including behavioral health constituencies (clients, advocates, family members, community partners, County and CBO staff), and non-behavioral health constituencies (County leadership, Education, Healthcare, Criminal Justice, Probation, Courts, among others). Additionally, all members of the MHSARC are members of the MHSA Steering Committee.

MHSA Steering Committee Members

Stakeholder Group	Name(s)	Title (if applicable)	Organization Affiliation (if applicable)
Family Member	Patricia Way**	Chair, MHSARC	
SMC District 1	David Pine**	Supervisor, District 1	Board of Supervisors
Client/Consumer	Aisha Williams		Lived Experience Academy
Client/Consumer Client/Consumer - Adults	Alan Cochran Jairo Wilches	 Liaison and BHRS Wellness Champion	Lived Experience Academy BHRS, Office of Family and Consumer Affairs
Client/Consumer - Adults	Michael Lim		
Client/Consumer - Adults	Michael S. Horgan	Program Coordinator	Heart & Soul, Inc.
Client/Consumer - Adults	Patrick Field		
Client/Consumer - SA	Jose Solano		BHRS, Pathways Program
Diversity & Equity	Maria Lorente-Foresti	Director	Office of Diversity & Equity
Education	Mary McGrath	Administrator	SMCOE, Safe and Supportive Schools
Family Member	Judith Schutzman		
Family Member	Juliana Fuerbringer		California Clubhouse
Family Member	Yolanda Novello	Family Partner	BHRS
Other - Advocate	Randall Fox	Health, Law and Policy Advocate	Former MHSARC Chairman
Other - Aging and Adult	Anna Sawamura	Program Services Mgr	SMC Aging & Adult Services
Other - Peer Support	Ray Mills	Executive Director	Voices of Recovery
Provider of MH/SU Svcs	Adriana Furuzawa	Division Director	Felton Institute - PREP
Provider of MH/SU Svcs	Cardum Harmon	Executive Director	Heart & Soul, Inc.
Provider of MH/SU Svcs	Clarise Blanchard	Interim Executive Director	Pyramid Alternatives
Provider of MH/SU Svcs	Gloria Gutierrez	MH Counselor	BHRS
Provider of MH/SU Svcs	Joann Watkins	Clinical Director	Puente de la Costa Sur
Provider of MH/SU Svcs	Melissa Platte	Executive Director	Mental Health Association
Provider of Social Svcs	Kava Tulua		East Palo Alto Partnership for Mental Healt Outreach
Provider of Social Svcs	Mary Bier		North County Outreach Collaborative
Provider of Social Svcs	Rev. William Chester McCall		Multicultural Counselling & Educational Services of the Bay Area
Provider of Social Svcs	Sheri Broussard		HIP Housing

**Membership as of January 2019*

*** MHSA Steering Committee Chairs*

MHSARC Commission Members*

Stakeholder Group	Name(s)	Title (if applicable)
Family Member	Patricia Way	Chair
Public	Donald Mattei	Vice- Chair
SMC District 1	David Pine	Supervisor, District 1
SMC District 1	Randy Torrijos	Staff to David Pine
Client	Wanda Thompson	Member at Large
Client	Patrisha Ragins	Member
Client	Rodney Roddewig	Member
Client	Carol Marble	Member
Client	Kate Pfaff	Member
Family Member	Bill Nash	Member
Law Enforcement	Mark Duri	Member
Public	Sheila Brat	Member
Public	Leticia Bido	Member
Public	Yoko Ng	Member
Public	Isabel Uibel	Member
Public	Betty Savin	Member
Public	Cherry Leung	Member
Public	Catherine Koss	Member

** MHSARC members are MHSA Steering Committee members (membership as of January 2019)*

30-DAY PUBLIC COMMENT AND PUBLIC HEARING

MHSA legislation requires counties to prepare and circulate MHSA plans and updates for at least a 30-day public comment period for stakeholders and any interested party to review and comment. Additionally, the MHSARC, San Mateo County's local mental health board, conducts a public hearing at the close of the 30-day comment period. The Annual Update FY 2017-18 (covering data from FY 2016-17) was presented at an MHSA Steering Committee meeting on January 30, 2019 and the MHSARC voted to open the public comment on February 6, 2019 and consequently voted to close it on March 8, 2019 after a Public Hearing and reviewing public comments and necessary updates made to the plan.

Please see Appendix 1 for MHSA Steering Committee meeting materials and all public comments received during the 30-day public comment period for the FY 18/19 Annual Update. The complete Annual Update is submitted to the San Mateo County local Board of Supervisors for adoption and to the County of San Mateo Controller's Office to certify expenditures before final submission to the State of California Mental Health Services Oversight and Accountability Commission (MHSOAC).

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

- Flyers created and sent to/placed at County facilities, as well as other venues like family resource centers and community-based organizations;
- Announcements at numerous internal and external community meetings;
- Announcements at program activities engaging diverse families and communities (Parent Project, Health Ambassador Program, Lived Experience Academy, etc.);
- E-mails disseminating information to over 1,500 community members and partners;
- Word of mouth on the part of committed staff and active stakeholders,
- Postings on a dedicated MHSA webpage smchealth.org/bhrs/mhsa, the BHRS Wellness Matters bi-monthly e-journal and the BHRS Blog www.smcbhrsblog.org

INNOVATION EXTENSION PLANNING

The Pride Center

On September 24, 2018 the Pride Center accomplishments, evaluation outcomes and need for a two-year MHSA Innovation extension were presented to the MHSA Steering Committee. While initial findings indicate that the Pride Center is improving access to behavioral health services for the LGBTQ community, an additional two years of funding would allow the Pride Center to extend their work with improving access to services and to accomplish the following goals:

1) Strengthen internal and external collaboration efforts to further evaluate whether the coordinated service approach improves service delivery (Learning Goal #1).
2) Measure clinical outcomes of clients with severe mental illness, specifically the improvement of mental health indicators for individuals who might not otherwise have accessed clinical services and/or received culturally responsive care (Learning Goal #1).
3) Develop a replicable best practice model to share statewide and nationally, as the evaluation continues to demonstrate that the coordinated service approach improves health outcomes and access for LGBTQ.

Members of the MHSA Steering Committee unanimously agreed to request a 2-year extension. On October 3, 2018, The MHSARC voted to open a 30-day public comment period and held a public hearing at the closing of the public comment period on November 7, 2018. The MHSARC unanimously voted to move forward with the extension request for the Pride Center. The extension request was reviewed and approved by the San Mateo County Board of Supervisors on February 2, 2019 and by the Mental Health Oversight and Accountability Commission (MHSOAC) at the State on March 28, 2019. Please see Appendix 2 for the Pride Center Innovation Extension Requests and approvals, including all public comments received and the MHSA Steering Committee Meeting Materials.

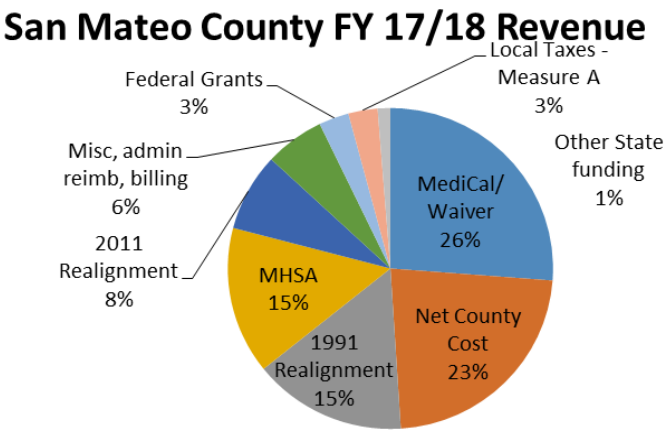
Health Ambassador Program for Youth (HAP-Y) and Neurosequential Model of Therapeutics in an Adult System of Care (NMT - Adults)

On May 1, 2019, members of the MHSA Steering Committee reviewed the need for a 1- year extension, at no additional cost, of both the HAP-Y and NMT-Adults Innovation projects. The MHSARC reviewed and approved the extension following a 30-day public comment process and public hearing on June 5, 2019. The request has been submitted to the MHSAOAC for final consideration. See Appendix 3 for the HAP-Y and NMT- Adults Innovation Extension Requests and MHSA Steering Committee Materials.

FUNDING SUMMARY

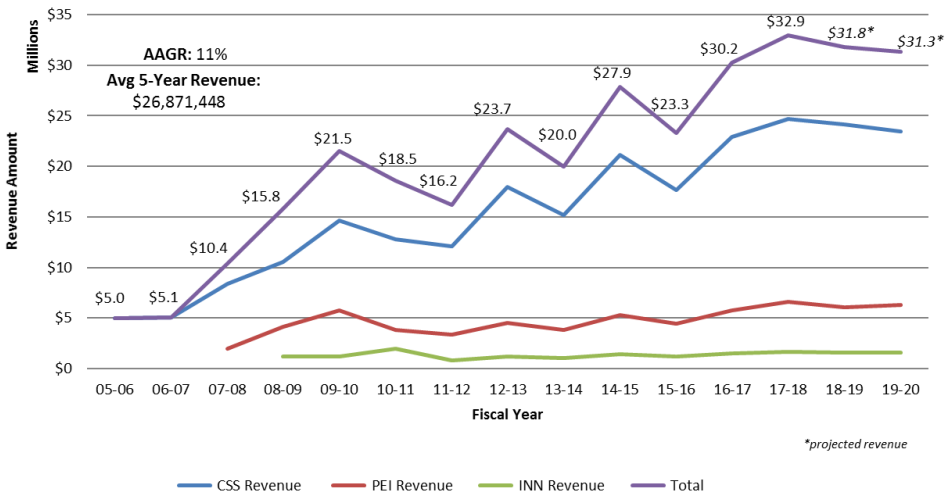
FUNDING SUMMARY

Statewide, MHSA represents a little under a third of community mental health funding. In San Mateo County, MHSA represents about 15% of the behavioral health revenue, translating to $27 million annual average in the last five years through Fiscal Year (FY) 2017-18.



The annual revenue distributions are difficult to estimate and volatile. MHSA funding is based on various projections that take into account information produced by the State Department of Finance, analyses provided by the California Behavioral Health Director's Association (CBHDA), and ongoing internal analyses of the State's fiscal situation. MHSA revenue is driven by the economy with only one tenth of 1% of tax payers are subject to the MHSA tax. The following chart shows annual revenue allocation for San Mateo County since inception. Initially, in FY 04-05 and FY 05-06, funding was received for Community Services and Supports (CSS) only. Prevention and Early Intervention (PEI) and Innovations (INN) dollars were released in FY 07-08 and FY 08-09, respectively. Commencing July 1, 2012, the County began receiving monthly MHSA allocations based on actual accrual of tax revenue (AB100), resulting in a "one time" allocation that fiscal year. Additionally, changes in the tax law that took effect on January 1, 2013, led to many taxpayers filing in December 2012 resulting in an additional increase in funding in FY 14-15.

Revenue Growth



FUNDING CONSIDERATIONS

Reversion (Assembly Bill 114)

MHSA legislation requires that MHSA funding under the key components (CSS, PEI and INN) be spent within a 3-year time or must be returned to the State for reallocation to other mental health agencies. Up until July 2017, the Department of Health Care Services (DHCS), who has fiscal authority over MHSA, had no process for recovering unspent funds subject to reversion.

A one-time legislation, Assembly Bill (AB) 114, was enacted allowing Counties to submit a plan by July 1, 2018 for expending their respective reversion funds by June 30, 2020. Information Notice 18-033 was released by DHCS in August 2018 to further clarify implementation of a process to calculate and recover reverted funds. San Mateo County annual spending in CSS and PEI targets the 5-year average revenue, which keeps us in the clear of reversion risk. INN requires project approval by the Mental Health Services Oversight Accountability Commission (MHSOAC) before funds can be expended. AB 114 established that the 3-year reversion time frame for INN funds will now commence upon approval of the project plans; this will minimize the reversion risk for funds accrued while awaiting approval.

Allocation to MHSA Components and Prudent Reserve

Information Notice 18-033 has further specified the required allocation of revenue to the three key components (CSS, PEI and INN) and prudent reserve levels. The following represent the guidelines for expenditure planning:

- 76% of total annual revenue must be allocated to CSS.
    - At least 51% of CSS must be spent on FSPs.
- 19% of total annual revenue must be allocated to PEI.
    - At least 51% of PEI must be spent on programs serving ages 0-25.
- 5% of total annual revenue must be allocated to INN.
- Up to 20% of the average of previous 5-year revenue may be transferred annually from CSS to Prudent Reserve, Capital Facilities and Technology (CF/TN) and/or Workforce Education and Training (WET) components.
- A maximum of 33% of the largest annual revenue may fund the Prudent Reserve. A Prudent Reserve ensures that unforeseen decreases in the revenue would not cause programs to cease.
- Up to 5% of total annual revenue may be spent on administration and planning.

A WET 10-Year Impact and Sustainability Report was developed with stakeholder input on February 7, 2018. The WET Report was submitted with the recent MHSA Three-Year Plan. The recommendation was to transfer $500,000 from CSS to WET annually to fund ongoing WET activities.

Target Reserve and Funds Available to Spend

Information Notice 18-033 released in August 1, 2018 and Information Notice 19-017 on March 20, 2019 establishing a Prudent Reserve guideline that does not exceed 33% of the average Community Services and Supports (CSS) revenue received in the preceding five years. For San Mateo County that would be $10.8 million. Currently, San Mateo County's Prudent Reserve remains at $600,000 and we have opted to leave additional unspent funds in an MHSA Trust Fund instead of the Prudent Reserve, given the current guidelines associated with accessing the Prudent Reserve. San Mateo County is recommending a Total Reserve Goal of 50% (Prudent Reserve and additional operating reserve), of the highest annual revenue. This would allow the flexibility in budgeting for short-term fluctuations in funding without having to go through the State's administrative process to access the Prudent Reserve, if the revenue decline is less than the State's threshold or funding is needed in a timely manner.

The San Mateo County MHSA Trust Fund balance as of end of fiscal year 2017-18 totals about $36 million. The MHSA Steering Committee reviewed and approved the recommended Reserve Goal on January 31, 2019. Available funds will be used to advance MHSA program priorities identified in the MHSA Three-Year Plan Community Program Planning process.

50% of Highest Annual Revenue	
Unspent*	$35.7M
Reserve Goal	-$16.5M
Obligated (INN)	-$6.7M
Available to Spend	**$12.5M**

**as of 7/1/18*

No Place Like Home - Local Impact

The "No Place Like Home" legislation relies on MHSA funds to securitize a $2 billion bond for chronically homeless individuals with serious mental illness. San Mateo County estimated cost would be $1.3 million, taken "off the top" of MHSA revenues, which means decreased expansion monies for MHSA programming is expected starting in FY 2019-20.

MHSA FUNDING PRINCIPLES

MHSA Funding Principles were developed to guide annual funding allocations and expansions; they also build from the County's and Health division budget balancing principles to guide MHSA reduction and allocation decisions when needed. Decisions regarding MHSA funding are based on the most current MHSA Three-Year Plan. Any funding priorities being considered outside of the MHSA Three-Year Plan priorities require MHSA Steering Committee approval and

stakeholder engagement, which will include a 30-day public comment period and public hearing as required by the MHSA legislation.

The MHSA Funding Principles where presented to the MHSA Steering Committee in September 2018 for input and comment given a budget reduction planning throughout our County that was expected to have implications for MHSA funding.

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

PRIORITY EXPANSIONS

A summary of MHSA expenditures by component for FY 18/19 is enclosed, see Appendix 4. We were expecting a $2 million-dollar impact due to No Place Like Home legislation on MHSA revenues to begin FY 18/19. Expenditure maintenance coupled with increased revenue allowed for new program implementation as shown below.

Progress on MHSA Three-Year Plan Priority Expansions

Component	Updated Priority Expansions	Estimated Cost Per Fiscal Year	Implemented
CSS General Systems Development	Expansion of supports for older adults *	$130,000	**YES – Partial** Senior Peer Counseling; OASIS expansion expected FY 18/19
	Field-based mental health and wellness services to expand access to Coastside	$450,000	**In Progress**
CSS Outreach & Engagement	Expansion of culturally responsive outreach strategies to link high-risk, isolated and emerging cultural and ethnic groups to svcs	$50,000	**YES – Partial** Chinese community outreach in North County
	TOTAL CSS	**$630,000**	

Component	Updated Priority Expansions **	Estimated Cost Per Fiscal Year	Implemented
Prevention & Early Intervention	Expansion of Stigma Free San Mateo, Suicide Prevention and Student Mental Health efforts*	$50,000	**Yes – Partial** Suicide Prev Week mini-grants
	Youth mental health crisis support and prevention	$600,000	**In Progress**
	Trauma-Informed Services training for 0-5 providers*	$150,000	**In Progress** First 5 of SMC MOU
	After-care services for early psychosis treatment for reengagement, maintenance and family navigator support	$230,000	**YES** (re)MIND/BEAM Aftercare Services
	TOTAL PEI	**$1,030,000**	

* Reprioritized from Previous Expansion Plan

* Added based on the PEI Taskforce recommendations in Three-Year Plan, approved by the MHSARC on February 6, 2018

UPDATE TO THE THREE-YEAR PLAN FY 17/18 – FY 19/20

Under direction of our County Managers Office and our Board of Supervisors, all San Mateo County departments have been planning for budget reductions starting with the upcoming fiscal year 2019-20. BHRS leadership has been working on a budget reduction plan that maximizes billing and fiscal practices to draw down every possible dollar from Medi-Cal and other revenue sources, including MHSA. An MHSA fiscal analysis was conducted and identified $2 million ongoing, unallocated funds that will be allocated to the following core services for clients with serious mental illness (SMI).

- Full Service Partnerships for Laura's Law eligible clients - $890,639
- Augmented Board and Care for SMI - $1.1 million

County operated clinics verify that a client is SMI and refers to FSP level services when appropriate. Housing, including augmented board and care, is brought in to play when needed and available.

As referenced earlier, available funds will be used to advance MHSA program priorities identified in the MHSA Three-Year Plan Community Program Planning process. The following categories will be considered for one-time funding strategies using the $12.5 million unspent, pending stakeholder input, a 30-day public comment and hearing and approval by the MHSARC.

- System Improvements
- Technology-related system improvements
- Capital Facilities improvements –if County owned and needed for MHSA services
- Workforce Education and Training needs
- Stop Gaps for current Innovation programs and other budget reduction impacts
    - The Pride Center – post 2-year extension request through June 30, 2021
    - Health Ambassador Program for Youth – slated to end June 30, 2020
    - Neurosequential Model of Therapeutics for adults – slated to end June 30, 2020
    - Tech Suite – slated to end June 30, 2020

The funding priorities were presented to the MHSA Steering Committee on January 30, 2019 (Appendix 1) as an update to the MHSA Three-Year Plan. A draft Plan to Spend was presented to the MHSA Steering Committee on April 22, 2019 (Appendix 3). Given the feedback received, the 30-day public comment for the Plan to Spend will be postponed. Additional analysis and input will be conducted including targeted input sessions to further involve stakeholders and clients/family members and incorporating budget reduction impacts in the plan.

ANNUAL UPDATE

FY 2018-2019

(Program highlights and data from FY 2016-2017 services)

ANNUAL UPDATE FY 2018-19

Welfare and Institutions Code Section (WIC) § 5847 states that county mental health programs shall prepare and submit an Annual Updates for Mental Health Service Act (MHSA) programs and expenditures. The Annual Update includes any changes to the Plan and expenditures.

Given that data for a full fiscal year is not readily available by the time plans need to be submitted to the State, this Annual Update discusses program highlights and data from FY 2016-17.

COMMUNITY SERVICES AND SUPPORTS

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

- **Full Service Partnership (FSP)** plans for and provides the full spectrum of services, which include mental health and non-mental health services and supports to advance the client's goals and support the client's recovery, wellness and resilience.

- **General Systems Development (GSD)** improves the County's mental health service delivery system. GSS may only be used for; mental health treatment, including alternative and culturally specific treatments; peer support; supportive services to assist the client, and when appropriate the client's family, in obtaining employment, housing, and/or education; wellness centers; personal service coordination/case management/personal service coordination to assist the client, and when appropriate the client's family, to access needed medical, educational, social, vocational rehabilitative or other community services; needs assessment; individual Services and Supports Plan development; crisis intervention/stabilization services; family education services; improve the county mental health service delivery system; develop and implement strategies for reducing ethnic/racial disparities.

- **Outreach and Engagement (O&E)** is to reach, identify, and engage unserved individuals and communities in the mental health system and reduce disparities identified by the County. O&E funds may be used to pay for strategies to reduce ethnic/racial disparities; food, clothing, and shelter, but only when the purpose is to engage unserved individuals, and when appropriate their families, in the mental health system; and general outreach activities to entities and individuals.

COMMUNITY SERVICES & SUPPORTS (CSS)

FULL SERVICE PARTNERSHIPS (FSP)

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

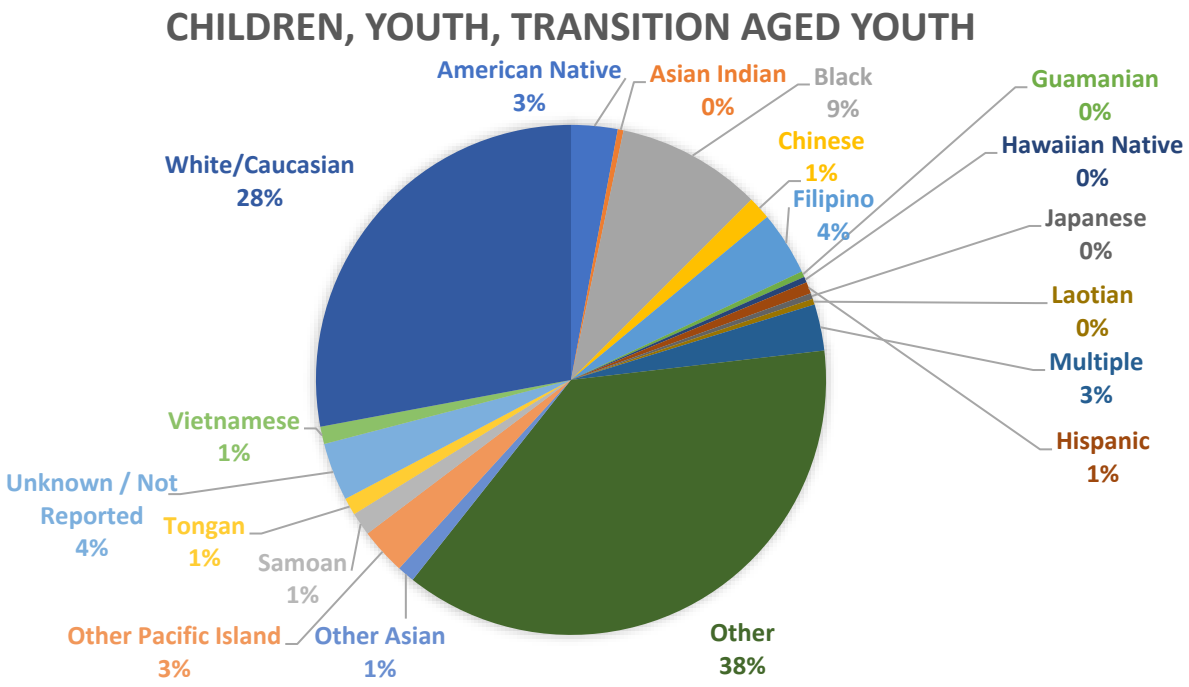
Based on currently contracted amounts and slots, the average FSP cost per person is $26,650 with age breakdowns in the table below. Clients enter and discontinue participation throughout the year. Cost per person figures do not speak to the span or quality of services available to clients either through BHRS or through contracted providers and may overlook important local issues such as the cost of housing, supported services provided, etc.

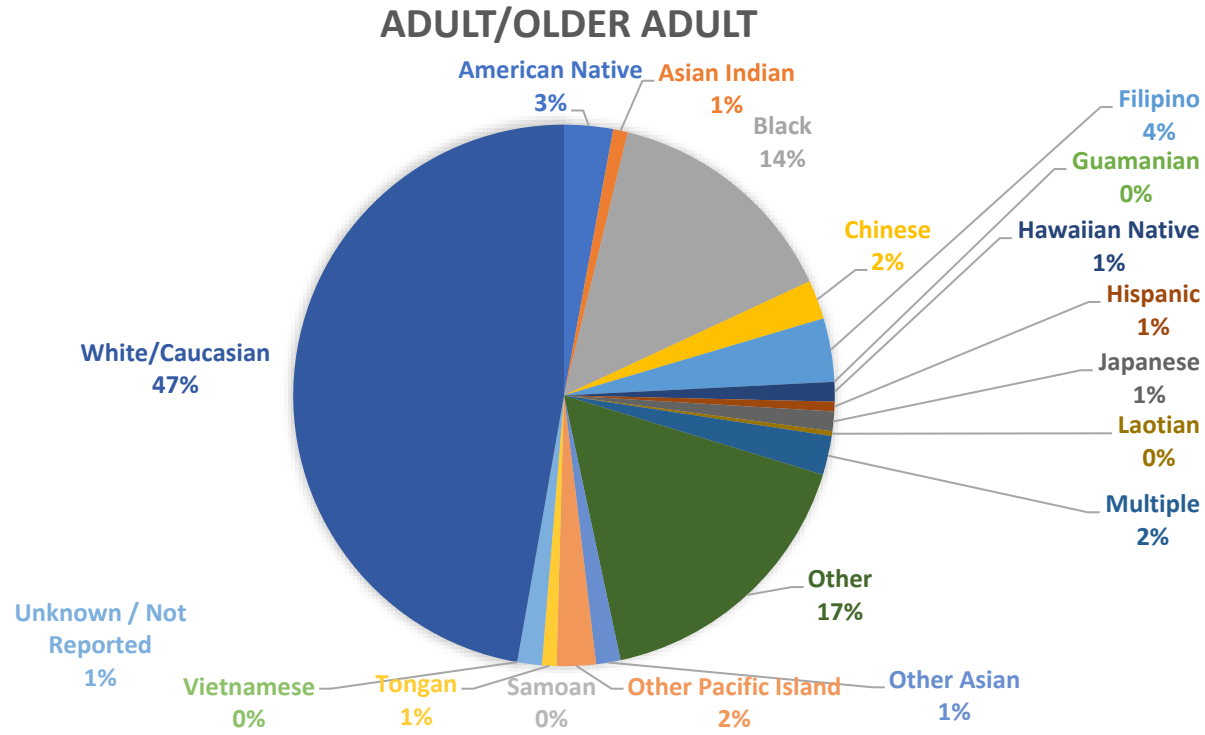
Program	FY 16-17 Clients served	FSP slots	Cost per person*
Children/Youth (C/Y) FSP's	**125**	**105**	**$42,388**
C/Y in Out-of-County Foster Care Settings FSP (Fred Finch)	12	20	$27,792
Integrated FSP "SAYFE" (Edgewood)	47	40	$47,052
Comprehensive FSP "Turning Point" (Edgewood)	66	45	$45,022
Transitional Age Youth (TAY) FSP's	**121**	**40**	**$45,022**
Comprehensive FSP "Turning Point" (Edgewood)	64	40	$45,022
Enhanced Supported Education Services (Caminar)	46	40**	$4,236
Supported Housing Services (MHA)	11	20**	$17,166
Adult/Older Adult FSP's	**304**	**252**	**$17,489**
Adult and Older Adult/Medically Fragile FSP (Telecare)	232	207	$15,086
Housing Support (Telecare)	---	90**	$15,723
Comprehensive FSP (Caminar)	36	30	$27,854
Housing Support (Caminar)	---	18**	$9,630
Integrated FSP (Mateo Lodge)	36	15	$7,847

*Calculated based on # of contracted slots; there are reimbursements and other revenues sources associated with FSP's that decrease the final MHSA funding contribution.

** Contracted service goal

FSP RACE/ETHNICITY DEMOGRAPHICS BY AGE GROUP





- *Numbers add up to 98% in both graphs, populations with one to four individuals served are represented with 0% or 1% in the graphs.*

FSP PERFORMANCE OUTCOMES

As part of San Mateo County's evaluation of the FSP programs, American Institutes for Research (AIR) analyzes FSP data to understand how enrollment in the FSP is promoting resiliency and improved health outcomes of participants, see Appendix 5 for the AIR FSP Outcomes Report.

Year-to-year outcomes are tracked for individual clients in FSPs. Information collected for FSPs include data in 10 domains; residential (e.g. homeless, emergency shelter, apartment alone) education (e.g. school enrollment and graduation, completion dates, grades, attendance, special education assistance), employment, financial support, legal issues, emergency interventions, health status, substance abuse, and for older adults, activities of daily living and instrumental activities of daily living. Data from Edgewood, Fred Finch, Caminar, and Telecare FSP participants is collected by providers via self-reported intake assessment, key event tracking and 3-month regular assessments.

FSP PERFORMANCE OUTCOMES BY AGE GROUP

Below is the percent improvement from the year just prior to participating in the FSP and the first year in FSP, by age group. During the first year of FSPs, clients continue to demonstrate positive improvements in all age groups for homelessness, employment arrests, mental and physical health emergencies and school suspensions for youth. These positive outcomes are mostly maintained when looking across four or five years of continued participation. Specific outcomes for youth (school attendance, grades and suspensions) demonstrated some variability across years of participation, although it is a small number of the most high-risk youth and should not be over-interpreted.

FSP Outcomes*	Child (16 years & younger)	TAY (17 to 24 years)	Adult (25 to 59 years)	Older adult (60 years & older)
Self-reported Outcomes (Survey data)				
Homelessness	22%	7%	28%	NR
Detention or Incarceration	(24%)	16%	30%	NR
Arrests	67%	65%	87%	NR
Mental Health Emergencies	89%	67%	57%	42%
Physical Health Emergencies	100%	88%	65%	29%
School Suspensions	47%	72%	NR	NR
Attendance Ratings	10%	(4)%	NR	NR
Grade Ratings	14%	1%	NR	NR
Employment	NR	NR	26%	NR

* Percent change in ratings indicates the change in the average rating for the first year on the program as compared to the year just prior to FSP.

NR = Not Reported

Moreover, the main finding from the hospitalization outcomes (EHR data) is that enrollment in a FSP program is associated with a reduction in hospital and psychiatric emergency service (PES) use for all cohorts. Specifically, compared to the year before joining an FSP, there are reductions in the percent of partners with any hospitalization, mean hospital days per partner, percent of partners using any PES, and mean PES event per partner. These reductions are consistently observed over the years since the inception of the FSP program. The table below shows the percent of clients with any hospitalization decreases after joining FSP for all age groups. Adults experienced the greatest percentage point reduction from 38% of partners with any hospitalization before FSP decreasing to 20% during FSP.

FSP Partners Have Significantly Improved Hospitalization Outcomes (n=623)

	Mean	95% Confidence Interval
Percent of Partners with Any Hospitalization*		
1 Year Before	23%	(20% - 26%)
Year 1 During	13%	(10% - 15%)
Mean Number of Hospital Days, per Partner*		
1 Year Before	6.90	(5.50 - 8.30)
Year 1 During	2.81	(1.91 - 3.70)
Percent of Partners with any PES Event*		
1 Year Before	42%	(38% - 45%)
Year 1 During	28%	(25% - 32%)
Mean PES Events, per Partner*		
1 Year Before	1.11	(0.95 - 1.28)
Year 1 During	0.73	(0.59 - 0.87)

*Results are statistically significant at the 95% level

CHILDREN AND YOUTH (C/Y) PROGRAM HIGHLIGHTS

EDGEWOOD CENTER FOR CHILDREN AND FAMILIES: "TURNING POINT" AND "SAYFE"

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

SAYFE

The Short-term, Adjunctive Youth and Family Engagement (SAYFE) Program serves 40 youth and families at any one time by augmenting and extending the clinical work and existing treatment plan within: (1) the outpatient and Therapeutic Day School (TDS) programs and (2) clients who are currently being served by Behavioral Health and Recovery Services (BHRS) in a Regional county clinic.

Turning Point C/Y

The Turning Point Child and Youth (TPCY) Program is a comprehensive program for 50 of the highest risk children/youth living in San Mateo County. TPCY is designed to help children and youth achieve independence, stability, and wellness within the context of their culture, community, and family.

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

SAYFE and TPCY utilize the Wraparound Model of Care, which engages children, youth and their families through four phases of treatment:

- Phase I (Discovery) - Engagement, assessment, stabilization, and planning
- Phase II (Hope) - Build skills and family connectedness
- Phase III (Renewal) - Strengthening and expanding formal and informal community support systems, affirm and support self-reliance strategies, prevent relapse, and leadership training
- Phase IV (Constancy) - Individualized aftercare planning to promote stability and permanence

For all youth and their families who participate in the SAYFE or TPCY programs, treatment may include any or all of the following modalities: assessment services, psychiatry, case management and intensive case management; family and group psychotherapy; family conferencing; collateral services; rehab services; plan development; family support; Therapeutic Behavioral Services (TBS) and behavior coaching; and substance abuse and co-occurring disorders services.

Identified San Mateo County resident populations to be served by the program are:

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

Additionally, all enrollees in SAYFE:

- Are ages 6-18 years old;
- Must be enrolled in, or at-risk of placement in an intensive school-based program (20 slots); or
- Are currently being served in a Regional County clinic and at-risk of out-of-home placement (20 slots).

Additionally, all enrollees in C/Y:

- Are ages 6-21 years old;
- Are at risk for placement in a level 10-14 residential facility or "stepping down" from a level 10-14 residential facility; and

Must be currently involved in Child and Family Services (Child Welfare) or Probation.

PROGRAM IMPACT

C/Y utilizes the Wraparound model of care, an intensive, holistic, evidence-based method of engaging with individuals with complex needs (most typically children, youth, and their families) so that they can live in their homes and communities and realize their hopes and dreams. The wraparound process provides a structured, creative and individualized team planning process that when compared to traditional treatment planning, results in plans that are more effective and more relevant. Wraparound plans are more holistic than traditional care plans in that they are designed to meet the identified needs of caregivers and siblings and to address a range of life areas. Wraparound also aims to develop the problem-solving skills,

coping skills, and self-efficacy of youth and family members. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network.

Building on several of the wrap principles including, natural supports, collaboration, and family voice and choice, Edgewood is particularly skilled at engaging families and the natural supports in a youth's life. The following success story highlights the of the TPCY and SAYFE teams:

The TPCY Clinical Case Manager has been working with Sheila (the name and some identifying factors have been changed to protect the youth's identity) since October 2016. The youth was referred by her BHRS Youth case manager to the Turning Point CY Program. Throughout her time in the program, Sheila and her family participated in individual and family therapy, collateral support, case management and family conferencing. Sheila also participated in individual and group activities with the TPCY Youth Specialist.

Sheila's family, especially her parents, were very supportive to her throughout treatment. However, the treatment team noticed barriers to the parents' full participation at the beginning of treatment. It had been challenging for the parents to acknowledge Sheila's eating disorder in relation to her mental health challenges. The team did a lot of psychoeducation to support the family. The parents carried a lot of stigma associated with mental health issues and this impacted the youth's recovery as evidence by a lot of denial of symptoms during the beginning of treatment. Due to the family's cultural background this was one of the biggest challenges for the team. Another challenge was that the family wanted treatment for the youth and did not realize that they were a big part of the equation and need to be included. The tense relationship between the parents was impacting the youth and a few months into treatment they realized they also needed to be part of it in order help her in her recovery.

From enrollment to graduation from TPCY, there was significant progress. Sheila gained an understanding about her mental health and was proactive in utilizing coping skills addressed during individual therapy. Sheila was able to manage her depressive symptoms and decrease previous behaviors of isolation.

SUCCESSES

William had a diagnosis of generalized anxiety disorder and major depressive disorder when referred to Edgewood. He presented with agoraphobia-like symptoms, (would rarely leave the home), had not attended school in over four years nor did he participate in any peer social settings when he started with SAYFE in February 2017.

William was initially not engaged in services, and his primary caregiver, his maternal aunt, was anxious that William was unenthused about any of wraparound's supports. His aunt was herself

not willing to take advantage of the full supports, and she and William both regularly turned down further resources or activities intended to assist with Williams's growth (Parenting classes; family partner services; gaming get-togethers; etc.).

William eventually began coming to the San Carlos office for family therapy sessions with his aunt, and slowly engaged with the family clinician. He also began meeting twice a week with a SAYFE behavior coach and was starting to show progress after a few months: leaving the home for behavior coaching meetings in the community, and discussing deep resentments, and his motivations for avoiding school during family sessions.

By the time he graduated from SAYFE in September, William was attending school 4 out of 5 days a week. William was reporting that he was seeing friends and socializing every day while at school and had now begun going for dinner and hanging out with people in the evenings and on weekends. William expressed some ambivalence, but that he felt prepared to graduate from SAYFE, and his team was absolutely confident about his positive, continued trajectory upward as we closed with cake and a small party (to which William had invited his mother with whom he was starting to rebuild his relationship). William's diagnosis at closing was MDD, in partial remission.

David entered the program as a 10-year old boy who was experiencing intense grief and loss, which was affecting his daily functioning, peer and family relationships, and ability to focus in school. He had witnessed his older brother's arrest in their home, due to his brother being charged with child abuse of a relative. As described by his grandmother, David had a very close and loving relationship with his brother, and the sudden removal of his brother in his life, had a very deep impact on him emotionally and behaviorally at school and within all his relationships. David began physically attacking his grandmother and younger brother and continued enacting aggressive behaviors at school. He also began shutting down emotionally, unable to focus on day to day studies and tasks. In addition, he was unable to have healthy peer relationships, leaving him feeling like he was a "problem child," which he reported to our team when we began SAYFE services in August 2016.

A month after SAYFE services opened, the family experienced a sudden housing crisis. Due to a disagreement between his grandmother and the friend they were renting rooms from, the family suddenly found themselves homeless. During this time, SAYFE provided immediate support, with toiletries, food, clothing, help with transportation and school uniforms, so that the family's basic needs were met while David's grandparents were seeking shelter with a local agency.

Throughout this time within SAYFE services, this family has continued to experience challenges, such as David's grandfather losing his job, David switching to a different classroom placement, family members experiencing multiple natural disasters in other parts of the country, and then again losing their home. David, his grandparents and younger brother, engaged fully in SAYFE services, which included participating in our After School Intensive Services and receiving Therapeutic Behavioral Services.

David came a long way while participating in the SAYFE program. David not only increased his ability to communicate his thoughts and feelings in a healthy manner, but he also strengthened his relationship with his family and is now making friends. He recently reported no longer thinking of himself as a "problem child," and that he feels cared about by his teachers, providers, and classmates. He and his family continue to move forward in their journey with the support of the SAYFE program and the network of community resources that we have helped to build around them.

CHALLENGES

There were a handful of challenges during the fiscal year (2016-2017). Most notable is that these challenges that have persisted since the last fiscal year report. Edgewood continues to try new strategies that address the ever-increasing cost of living and lack of qualified candidates to fill open positions. The high cost of living continues to present a challenge for the families and employees who are unable to locate affordable and suitable housing.

- The challenges:
  - Families are frequently living in households with multiple members, impacting quality of life, privacy, and safety.
  - Families are frequently relocating out of county which results in an abrupt termination of services.
  - Staffs are unable to afford living in the county. This has resulted in them moving out of the county, which has negatively impacted their commutes. As a result, many have left to work closer to home and avoid the lengthy commute.
- The strategies:
  - Increase the mileage reimbursement amount to the IRS rate.
  - Participate in community gathers and dialogues around housing challenges to provide support and collaboration with agencies that focus on housing.
  - Partner with the Second Harvest Food Bank and local stores to collect and distribute basic needs items and provide larger donations to families to help offset their housing costs.
  - Deploy more laptops and higher quality cell phones to help employees be more mobile which allows more flexibility in their daily schedules.

Recruiting and retaining qualified employees remains a challenge in an even more competitive job market.

- The challenges:
  - Unfilled positions resulted in leadership and direct line staffs carrying additional work, feeling overwhelmed, and burned out; which in turn created additional vacancies.
  - Families experienced several provider changes, as different members of their treatment team transitioned to/from the team.
  - Salary rates do not match the astronomical cost of living in the county.
- The strategies:
  - Assessing compensation plan and comparing it to other similar agencies.
  - Expanded recruitment efforts and strategies.
  - Hired an agency recruiter in the Human Resources department.
  - Increased the stipend for the Employee Referral Program, an internal incentive for employees who refer applicants that get hired.

DEMOGRAPHIC DATA

A total of 113 unduplicated youths were served in FY16-17. The census was slightly higher (66 youths) in C/Y compared to (47 youths) in SAYFE. While there was a range of ages served, 82% of youths were clustered around adolescence (12-17).

Total Clients Served			
113			
Male	-	Female	-
Race/Ethnicity			
Latino	42%		
White/Caucasian	25%		
Black/African American	11%		
Middle Eastern/North African	3%		
Pacific Islander	1%		
Pilipino/Filipino	2%		
Unknown	13%		
Other	3%		

FRED FINCH YOUTH CENTER: EAST BAY WRAP PROGRAM

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

PROGRAM IMPACT

At discharge, **21% reached their mental health treatment goals** and **57% partially reached their goals.** 21% moved out of the service area. 64% stayed at the same placement and 14% went to a lower level of care (or 78% placement stability) only 7% went to a higher level of care. 86% of the discharges were planned. 2 siblings moved out of the service area before their treatment plan was developed.

SUCCESSES

The Fred Finch agency recently required all programs in Northern California to use the Child and Adolescent Needs and Strengths (CANS) or Adult Needs and Strengths Assessment – Transition to Adulthood Version (ANSA-T). The Fred Finch Youth Center is measuring data in Child Strengths, Behavioral Emotional, Living Situation and overall improvement in at least 1 domain.

Due to the changes in the AB1299 and the FFA requirement issue, an increase was seen in serving 18-21-year-old participants. The program showed a willingness to adapt and serve transition aged youth population.

During this fiscal year, the youth center had a positive experience with one of the teenage male participant. He has numerous behavioral issues but a very committed foster parent. Over this year, he was able to successfully transition back into regular education after spending 1.5 years in a Special Day Class. He received a full array of FSP services including Care Coordination, Youth Partner, Parent Partner and Psychiatry. These services have been helpful for the parent to get strategies and vent her frustrations. The youth is able to see and experience adults who genuinely care for him and want him to succeed.

CHALLENGES

Under enrollment was a challenge during the 2016-2017 fiscal year. The maximum contracted enrollment is 20, however for this fiscal year, the program averaged at 14.5 per month. For the last 6 months of this fiscal quarter, the program was at 12 enrollees. The new legislation bill AB 1299, was rolled out this fiscal year. AB 1299 allows youth who live out of their court county to receive Medi-Cal coverage for mental health. Fred Finch Youth Center is still exploring how AB 1299 will fully impact their services. Additionally, the program previously served youth connected to FFA services and youth who were in the Family Reunification phase of dependency court. Both populations were determined to not be eligible for referral to this program. Fred Finch Youth Center has reduced the number of clinicians to better match the current size of this program and will increase our staffing should we get more referrals.

DEMOGRAPHICS

Total Clients Served			
14.5 clients enrolled per month			
Male	44%	Female	56%
Race/Ethnicity			
Black/African American		20%	
Latino		16%	
White/Caucasian		20%	
Asian Pacific Islander		20%	
Other		24%	

Additional Data: 8 admissions, 14 discharges, 100% home language English

TRANSITION AGE YOUTH (TAY) PROGRAM HIGHLIGHTS

EDGEWOOD CENTER FOR CHILDREN AND FAMILIES: TAY PROGRAM

The TAY-FSP Program provides intensive community-based supports and services to transition age youth identified as having the “highest needs” in San Mateo County. The referral process is restricted to representatives of BHRS or a contractor of BHRS, the Human Service Agency, and the juvenile/adult justice system.

Transitioning from adolescence to adulthood is challenging for any young adult, those referred to the TAY-FSP program present with an array of risk factors and complex mental/physical

health conditions making this transition infinitely more difficult. As the traditional milestones of adulthood continue to be pushed to later years, there is a noticeable extension and slowdown of the transition to adulthood. There is a movement among clinicians, sociologists, researchers, educators, and general practitioners for the term, 'emerging adulthood' it offers a deeper understanding and acceptance of what occurs for anyone between the ages of 17-25. Acknowledging that it is not "just a transition" but in fact a unique period of life when individuals are learning to accept responsibility for themselves, make independent choices, and practice the behaviors and skills needed for managing adulthood, empowers our transition age youth and validates their experience.

The TAY-FSP program relies on a diverse staff and innovative program model to effectively meet the needs of this vulnerable and often marginalized population. Specific supports and services provided by our multi-disciplinary team include: case management, mental health treatment (assessment, therapy, medication management, and psychiatry), family support, crisis prevention and intervention, skill building (independent living, relational, safety, and emotional/behavioral), socialization and recreational activities, peer and family relationship building, academic support and coordination, employment exploration, and housing support.

PROGRAM IMPACT

The Transition Age Youth (TAY) Full Service Partnership (FSP***)*** program provides intensive community-based mental health services to 50 of the highest risk emerging adults (ages 16-25) in San Mateo County. The program relies on a diverse staff and innovative program model to effectively meet the needs of this underserved and often marginalized population. Emerging adults are typically referred when areas of their life are stressed by multiple issues, including symptoms of severe mental illness. The services include comprehensive mental health treatment, care coordination, skills training, career and academic exploration, family support, 24/7 crisis support, housing support, and continuity of care during acute psychiatric episodes and criminal justice contacts.

Building rapport with the aim of creating a genuine partnership with each emerging adult is the initial focus and an ongoing process throughout their engagement with the TAY FSP program. A high value is placed on the time spent with each emerging adult, in the company of those who support them, and in creating environments that are welcoming to emerging adults. Investing time and attention in them, listening and learning, offering unconditional support and respect, using humor, and being creative generally result in a trusting relationship. To paraphrase the comments of one of the newly enrolled emerging adults;

"thank you for calling all the time, and not to make me feel bad about missing appointments or to tell me about why I should be in your program, but to see how I was doing and if I needed anything. I really thought you would just give up or maybe be mad, but you always left nice messages. Thanks for not giving up."

During this reporting period, the TAY FSP program conducted outreach and engagement efforts to **35 new emerging adults.** By the end of the year **18 were discharged**: 7 successfully completed our program and stepped down to a lower level of care, 7 disengaged from services, 3 transitioned to the same level of care, and 1 transitioned to a higher level of care. During this phase of life, transition age youth are exploring and engaging in educational and vocational activities. Many prefer to work or go to school while involved in the program, finding the structure and activities helpful and often meaningful. Some choose to focus on their mental health and forgo traditional educational/vocational pursuits.

EDUCATIONAL ENGAGEMENT	VOCATIONAL ENGAGEMENT
25 received 1:1 educational support	22 engaged in 1:1 vocational support
1 completed and passed their GED	8 engaged in volunteer opportunities
21 were attending high school	12 engaged in supported employment
16 attended at least one semester of community college	23 engaged in paid work (not considered supported employment)

SUCCESSES

Through the years the program has noticed a trend of increased referrals for transition age youth who can best be described as 'neurodiverse.' These emerging adults possess neurological differences which greatly impact who they are, how they behave, and how they understand the world around them. Rather than expecting a cure, including their ability to assimilate into the neurotypical world, the TAY FSP program has recognized their need for help and accommodation and accordingly has adjusted service delivery practices. Examples of these adjustments include: enhancing behavioral approaches, expanding experiential learning opportunities, and engaging natural supports in neurobehavioral surveys. While these adjustments have resulted in earlier identification of neurodiverse emerging adults, more effective interventions and a deeper understanding of neurodiversity for natural supports, there is still more that needs to be understood regarding best practices in treatment of neurodiverse individuals.

CHALLENGES

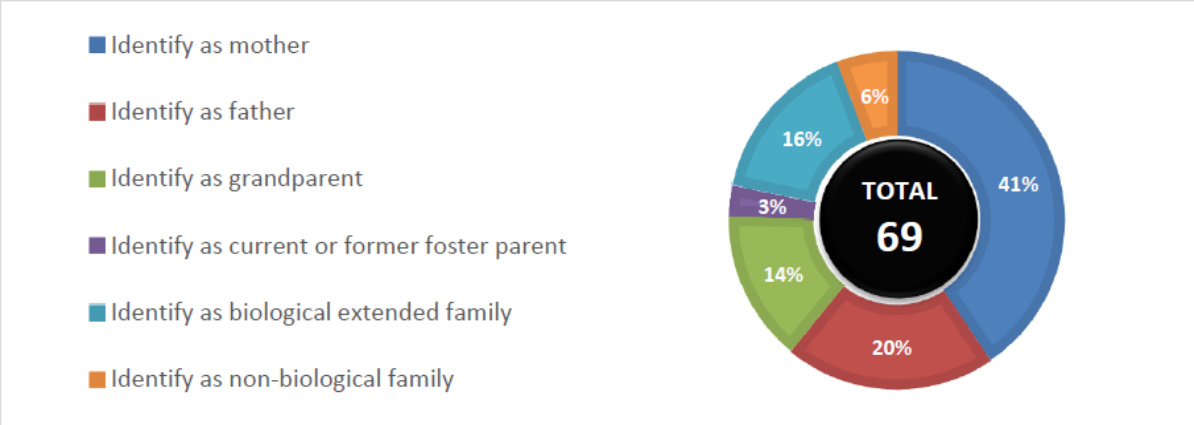
Two of the TAY FSP program's greatest challenges continue to be the cost of living and the housing crisis in the Bay Area. Both have significantly impacted emerging adults and families in all facets of their lives. Finding available and affordable housing in safe neighborhoods is a struggle. Moreover, housing vouchers are limited and landlords who accept them are even more so. Additionally, the cost of living and housing crisis have had a dramatic effect on our staff and our recruiting efforts to fill vacancies. Like those we serve, many staff face tough decisions regarding paying more for rent, taking on additional work, leaving a job to make more money, moving in with others, relocating or leaving the county altogether.

DEMOGRAPHIC DATA

During this reporting period, the TAY FSP program served 64 unduplicated individuals with the ability to serve up to 50 emerging adults (ages 16-25) at any given time.

Total Clients Served			
64			
Male	60%	Female	34%
Race/Ethnicity			
Latino	38%		
White/Caucasian	17%		
Black/African American	5%		
Pacific Islander	9%		
Asian	6%		
Middle Eastern and North African	5%		
Bi- or Multi-racial/ethnic	20%		

The TAY FSP program applies an inclusive understanding of "family," recognizes the need to acknowledge all important people in the life of an emerging adult and explores ways of including them in their treatment and future planning. The TAY FSP program staff work with caregivers, family members, peers, significant others and any other natural supports identified by the emerging adults to increase their positive and healthy relationships now and in the future. This year there was an increased involvement of fathers, and the family partners held monthly lunches at across the county to bring small groups of individuals together to decrease isolation and increase peer support.



Gender Identity:

- 2% Gender Non-Conforming,
- 2% Transgender,
- 2% Prefer Not to List

Sexual Orientation:

- 55% Heterosexual
- 8% Bisexual
- 6% Questioning or Unsure
- 5% Gay or Lesbian
- 2% Queer
- 2% Orientation Not Listed
- 20% Not Reported
- 2% Prefer Not to List

Additional Data

- 23% Former Foster Youth, 21% Receiving Disability Benefits, 11% Adult Probation, 5% Juvenile Probation, 5% LPS Conservatorship
- 78% have a history of trauma
- 75% have a diagnosis of Bipolar, Schizophrenia, Schizoaffective and/or Major Depressive disorders
- 45% have a substance use disorder diagnosis
- 23% have a physical health condition that impacts their daily functioning and/or mental health
- 12.5% have been diagnosed with a cognitive impairment or delay

EDGEWOOD CENTER FOR CHILDREN AND FAMILIES: TAY SUPPORTIVE HOUSING

Addressing the housing needs of San Mateo County's TAY population is an important aspect of the work of the Edgewood TAY-FSP program. Made possible by a joint partnership with the Mental Health Association (MHA) of San Mateo, Edgewood is able to provide housing subsidies and MHSA housing monies to reduce the risk of homelessness and increase the probability of

stable housing as youth transition to adulthood. Teaching daily living skills, medication management, household safety/cleanliness, budgeting, and roommate relationship skills are a part of the treatment and education of the youth accessing housing support and subsidies from the TAY-FSP program.

PROGRAM IMPACT

Through their partnership with the Mental Health Association (MHA) of San Mateo, Edgewood, TAY Supportive Housing can provide housing subsidies and use housing dollars to address current housing needs and reduce the risk of homelessness. The majority of the emerging adults in this program are not ready to live independently for a myriad of reasons, the most common being: (a) the impact of their mental illness on their daily functioning (b) the delayed development of their brain due to the impact of trauma, and (c) lack of independent living skills needed to live safely on their own. Additionally, emerging adults and families are choosing to stay together in the home through their 20s and into their 30s. The unaffordability of housing in the Bay Area has also led families to stay together out of necessity.

As the emerging adults the program serves are not prepared to live independently, treatment team members teach daily living skills, medication management, household safety/cleanliness, budgeting, and roommate relationship skills. Weekly housing meetings are held at our clustered apartment site to bring residents together, identify shared stressors of living independently, and practice new skills. This year, the 11 emerging adults who used housing dollars were housed in the following settings:

- Caminar: Eucalyptus House
- Edgewood/MHA Clustered Apartments
- Ohevet's Board & Care (2 dedicated beds)
- Shelter Network: Maple Street Shelter (1 dedicated male bed)

SUCCESSES

During this reporting period, the Transition Age Youth (TAY) Full Service Partnership (FSP) program **served 64 unduplicated individuals** and had the ability to serve up to 50 emerging adults (ages 16-25) at any given time. During this reporting period, **the program had the highest percentage of emerging adults living in safe and stable housing in recent years, approximately 63.5%.** TAY FSP defines these individuals as 'stably housed'; residing in living situations that are not time-limited nor conditional, pose little risk to personal safety, provide for adequate health and wellbeing, and promote recovery and growth. The vast majority of these individuals were living with a family member. As expected, some of these emerging

adults had PES or and/or acute hospital contacts, and following hospitalization and appropriate stabilization they all returned home.

36.5% of the 64 we served during this reporting period were considered 'precariously housed' in living situations that are time-limited or conditional, have some form of criteria or evaluation that must be met/maintained to access this setting, pose a risk to interpersonal safety or do not offer a locus of control regarding personal safety, and do not consistently promote wellness and recovery. Within this cohort, we used housing dollars to support 11 emerging adults.

CHALLENGES

A 24-year-old female of Pacific Islander descent who had been living in her car and working full-time came to our program due to her significant stressors, recent victimization, and being underserved by her private insurance. A highly motivated young woman, she had many goals but struggled with focus and follow through, especially when her symptoms increased and her car was no longer an option for housing. With the help of her TAY FSP treatment team and housing dollars she accessed living situations for short-term stabilization, personal health and safety, and skill building. In that time she also completed her GED.

Two challenges TAY FSP continues to face are:

1. The lack of an emergency/short-term housing option designed specifically for Transition Age Youth. The shelters and housing programs in this county, while appropriately focused on decreasing homelessness, possess an approach and philosophy for adults, not 18-25 year old's who are adults on paper but not in skills, abilities, interests or practice.
2. Identifying safe and appropriate housing options for our growing neurodiverse population. Families and housing programs alike are struggling to manage the complex behaviors, learning and processing styles, and skills gaps presented by this population. A. What we have found to be helpful are behavioral approaches, OT assessments, and low-stress living settings where expectations are clear and consequences are not punitive.

DEMOGRAPHIC DATA

Total Clients Receiving MHSA Housing Funds	
64	
Race/Ethnicity	
White/Caucasian	28%
Latino	18%
Asian	9%
Black/African American	9%

Native Hawaiian or Other Pacific Islander	9%
Bi-or Multi-racial/ethnic	28%
Gender Identity	
Male	55%
Female	36%
Gender Non-conforming	9%
Sexual Orientation	
Bisexual	18%
Gay/Lesbian	9%
Heterosexual	46%
Queer	9%
Questioning/Unsure	18%

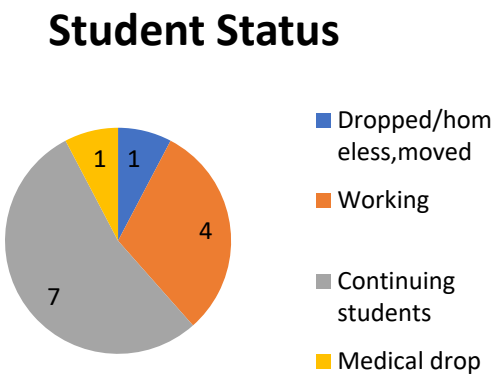
CAMINAR: SUPPORTIVE EDUCATION PROGRAM

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

PROGRAM IMPACT

Caminar's Supported Education Program, in collaboration with the College of San Mateo, provides students with the opportunity to experience a safe beginning or re-entry to college and to acquire skills to be a successful student. Peer Counseling classes, (Introduction and Advanced Peer Counseling) matched with the Counseling Department's skills development classes, are designed to address the needs of students with mental health/emotional needs. Students can receive classroom accommodations, college counseling, priority registration, and individual support for school needs. This study track provides training for students interested in working as a peer mentor in the human services field. Caminar's classes can lead to certificates, degrees and most of all, a life-changing experience.

- 2 classes offered at the College of San Mateo; Fall semester- Introduction to Peer Counseling and Spring semester- Advanced Peer counseling.
- Weekly education check-in at Edgewood Children and Family's youth Drop In Center.
- Quarterly programming collaboration with AUM (Arts Unity Movement) delivering youth-specific activities such as dance, painting, drumming, and group topics.
- Weekly social/connection outings to points of interest in San Mateo county for youth at Caminar's residential programs.
- Annual picnic BBQ and games with Caminar's Yail program and residential programs 8/4.
- School Fair event at the Drop-In center.
- Tabling at the 'Recovery Resource Fair' RWC, 9/12 and picnic on 9/19
- Tabling at 'Careers Fair' College of San Mateo, 10/2
- Educational counseling and support to entering and re-entering students.
- Individualized on and off-campus tutoring.
- Drop-in support and linkage on campus



Supported Education Program 560
Total number of unduplicated clients served:
Goal: 100 Outcome: 139

Minutes of service provided:
Goal: 12,000 Outcome: 22,053

Peer counseling class:
Goal: Teach 2 classes Outcome: 2 classes conducted
Goal: 85% retention rate Outcome: 85% retention rate
Goal: 2.5 GPA Outcome: 3.0
Goal: 90% Satisfaction Outcome: 100% Satisfaction with class
Fall semester: 13 Spring semester: 13

Supported Education TAY Program 563
Clients served:
Goal: 40 clients Outcome: 46

Provide contacts and engagement activities:
Goal: Provide 650 contacts Outcome: Provided 850 contacts
Goal: Provide 240 engagement activities Outcome: Provided 667 activities

Peer counseling class TAY students:
Goal: 80% retention rate Outcome: 100% retention rate
Goal: 90% satisfaction with class Outcome: 100% satisfaction with class

Overall TAY GPA: 3.0
Goal: provide 20 contacts/month at Edgewood's Drop in Center Outcome: 16 contacts
Goal: Provide 4 vocational activities Outcome: 5 vocational activities provided

SUCCESSES

- 3 TAY were able to maintain their educational pursuit throughout the year
- Specialized workshops offered to TAY by a collaboration with the 'Arts Unity Movement' program
- Increase in the variety of Social engagement activities offered
- '**FutureViews**' (**V**ocational **I**ndependence and **E**mpowerment through **W**orkability and **S**cholastics) a Skyline College student support and development program (in collaboration with Caminar's Supported Education, BHRS North County clinic and Skyline's Workability 3 program)

CHALLENGES

- Housing stability- youth are at risk of homelessness and often lack the resources to ensure a stabile living situation
- Foster Youth in particular are at risk of instability which can negatively impact educational and vocational success
- Educational and vocational pursuits are at risk of interruption from frequent personal crisis situations, poor support system, and/or increase in symptoms
- Cost of educational related materials and lack of understanding of student resources
- Poor history of financial aid/academic performance affects academic success
- Inadequate academic preparation prior to post-secondary entry

ADULT/OLDER ADULT PROGRAM HIGHLIGHTS

TELECARE, INC.: ADULT, OLDER ADULT, AND MEDICALLY FRAGILE FSP

The FSP program, overseen by Telecare, Inc., provides services to the highest risk adults, highest risk older adults/medically fragile adults. Additionally, the Outreach and Support Services portion targets potential FSP enrollees through outreach, engagement and support services. These programs assist consumers/members to enroll and once enrolled, to achieve independence, stability and wellness within the context of their cultures and communities.

Program staff are available 24/7 and provide services including: medication support, continuity of care during inpatient episodes and criminal justice contacts, medical treatment support,

crisis response, housing and housing supports, vocational and educational services individualized service plans, transportation, peer services, and money management. Services specific to Older Adult/Medically Fragile include maximizing social and daily living skills and facilitating use of in-home supportive agencies.

PROGRAM IMPACT

Over the past several years, the programs at Telecare's FSP have been evolving to move their members in a more focused manner towards recovery. Telecare utilizes various evidence based and promising practice groups (e.g. WRAP, seeking safety and co-occurring education and engagement). As these groups and practices have taken root in the overall culture, it is encouraging to witness the effects of such practices in the language and behaviors of the members outside of group settings. Currently the program has language capacity in English, Spanish, Russian and Tagalog.

The housing strategy that Telecare FSP uses continues to be highly successful and is being recognized as a model for other programs and agencies. Nevertheless, the extreme cost of living in San Mateo County along with the fact that housing funding has not increased per space since its inception in 2006 are posing serious issues to both existing clients housing as well as the overall system of care's ability to become less impacted.

CHALLENGES

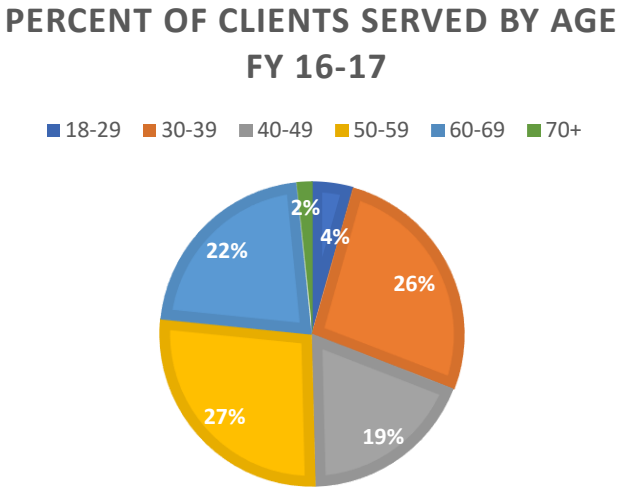
Recruitment of staff (particularly licensed staff) is extremely challenging. Due to the cost of living/affordability of the area, many months can go by with an open position (e.g. Nurse, Team Leads, Psychiatrists or Nurse Practitioners) without any resume's, much less qualified. **The lack of adequate funding for these positions is posing serious issues for coverage and services.**

Over the past several years, the cost of living in the area has increased exponentially, forcing out housing providers and, therefore, having a negative impact on outcomes. While the program still has managed to keep impressive variety and volume of housing options (all things considered), it is, nevertheless, the case that total numbers of housing units have dropped leading to an increase on homelessness for the clients with the most challenging behaviors.

The same issues remain as they have been for several years now, albeit exacerbated: Housing availability for members and staff recruitment (particularly for licensed staff). For the program's members, the radical gentrification through the increase in housing costs has led to the loss of sites where we can do a housing first model. **This has led to the largest homeless population this program has had in it's 17 year history. There were times when this programs homeless population was 1%, now it's over 6%.**

DEMOGRAPHIC DATA

Total Clients Served	
232	
Race/Ethnicity	
African American/Black	15.1%
Asian	5.7%
Caucasian/White	57.3%
Latino	11.5%
Pacific Islander	5.2%
Native American	1.0%
Other	4.1%



- **Gender**
  - 6.1% Male, 35.9% Female
- **Total Unduplicated Census:** 192, **Total Unduplicated Served:** 232
  - Both of the unduplicated figures show a significant reduction from previous years due largely to the fact that the contract monitor prefers that a member go from the referral source (locked MHRC's) to some form of housing.

CAMINAR: FSP FOR ADULTS AND OLDER ADULTS/MEDICALLY FRAGILE

Caminar's FSP program is designed to serve 30 high-risk adults and highest risk older adults / medically fragile. Most adults with SMI served by FSP have histories of hospitalization, institutionalization, substance use, not engaged in medical treatment and have difficulty

participating in structured activities and living independently. Older adults have cognitive impairments and medical comorbidities.

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

FSP has a high staffing ratio of staff to consumers, with a ratio of 10:1. There are frequent team meetings to discuss clients in crisis, hospitalizations, incarcerations, med noncompliance and homelessness. A psychiatrist and/or NP is assigned to the client to provide medication evaluation and psychoeducation. Case managers assist clients with needs related to mental health services, rehabilitation, housing, employment, education, social and recreational activities and health care. Consumer treatment includes a variety of modalities based on consumer needs, including case management, individual, group or family therapy, psychiatric medication prescription, and general medication support and monitoring. Consumer self-help and peer support services include money management, assisting with employment opportunities, social rehab and assistance with referrals and housing. FSP services are delivered by a multidisciplinary team, which provides 24/7, 7 days per week crisis response support, including in-home support services and services at other consumer locations as appropriate. Case managers help to plan for linkage to and coordination with primary care services, with the intent of the strengthening the client's ability to access healthcare services and ensuring follow up with detailed care plans.

PROGRAM IMPACT

Caminar's FSP (Full Service Partnership) program served a total of 36 unique clients for fiscal year 2016-2017.

- **Productivity for the FSP program for the FY 2016-2017 was at 113%.**
- The FSP program successfully moved 1 client to a lower level of care.
- The FSP program provided and managed a housing subsidy through Behavioral Health and Recovery Services dollars for 17 clients this fiscal year to prevent and/or reduce homelessness.
- 73% of FSP clients avoided incarceration.
- 65% of clients enrolled in FSP were not re-hospitalized.
- 87% of clients in the FSP program have permanent housing/shelter.

- Family support groups increased this year from 1x a month to 3x's a month
- 30 family members have received support from the Family Support Partner this year.

SUCCESSES

Supported Education

The Supported Education program had its annual graduation event May 18th on the College of San Mateo campus in the Student Life and Leadership Center. A total of 12 Students who have completed the Peer Counseling class were awarded certificates of completion, and their digital stories, produced in class, were played during the event. One of these student digital stories was also highlighted at the county-wide MHSA (Mental Health Services Act) held April 26th in Redwood City.

Skyline College is also the site for a class offering a first step or returning step for clients of BHRS (county Behavioral Health and Recovery services), Community Gatepath, and Jefferson School District Continuation School students. This class identifies strengths, builds skills, and exposes students to academic and vocational pathways.

- Unduplicated Clients served- 139
- Unduplicated TAY (Transitional Aged Youth) served- 46

TAY program staff were also a part of the annual 'Back to School' event August 9th at Edgewood's Drop-In Center in San Bruno.

Additional highlights included:

- 3 TAY were able to maintain their educational pursuit throughout the year
- Specialized workshops offered to TAY by a collaboration with the 'Arts Unity Movement' program
- Increase in the variety of Social engagement activities offered
- '**FutureViews**' (**V**ocational **I**ndependence and **E**mpowerment through **W**orkability and **S**cholastics) a Skyline College student support and development program (in collaboration with Caminar's Supported Education, BHRS North County clinic and Skyline's Workability 3 program)

FSP clients can directly benefit from the Supported Education program by enrolling in the classes so they can learn new skills and engage with their peers. Furthermore, once they participate in these classes, the hope is that they will apply for positions within other CBO's serving adults with SMI, such as, Peer Support and Assistant Case Manager positions. A goal of the FSP program to assist clients to become involved in paid work and/or education. This includes direct services or referral to vocational assessment, job development, supported employment, competitive employment and other employment services.

CHALLENGES

The limited housing options for our clients given the continued increase in housing costs in the Bay Area along with their low incomes continues to be the biggest challenge for FSP. Landlords can rent to higher paying consumers and are choosing to do so. Along with limited resources for adequate housing, more of our clients are finding themselves utilizing services at our hospitals, and/or engaging in activities around increased substance use and abuse. In addition, our clients reflect an aging population and as such have an increase in medical needs and their medical issues become a dominant component of their lives.

Clients are also continuing to experience major medical concerns in our FSP program. These clients will need long term medical assistance, but are currently being managed in the community or temporarily placed in SNFs in the hopes of returning to the community. All FSP clients are continuing to be seen weekly for at least two hours by their case managers, nurses, psychiatrists, assistant case managers and/or community support workers who provide medication support to them in their home.

DEMOGRAPHICS

Total Clients Served	
36	
Gender	
Male	57%
Female	43%
Race/Ethnicity	
African American/Black	6.7%
Asian/ Asian American	6.7%
Caucasian/White	56.7%
Mixed	6.7%
Hispanic/Latino	13.3%
Other	3.3%

Not Specified	6.7%
Age	
19-30	10%
31-33	10%
33+	80%
Primary Language	
English	93.3%
Spanish	3.3%
Not Specified	3.3%
Cost per client	
$27,854	

MATEO LODGE: SOUTH COUNTY INTEGRATED FSP

During 2016-2017 Mateo Lodge was contracted to provide 50 hours of service per week for 3 different levels of intensity; task-oriented case management supplemental case management, and FSP clinical case management.

PROGRAM IMPACT

Embedded Case Management closed 19 cases during this reporting period. Mateo Lodge also provided evening and weekend coverage on an as needed basis from the mobile support team as part of their agency to further support at risk client needs. Below are the outcomes.

During this reporting cycle, four clients referred with OCD/agoraphobia symptoms successfully met with one case manager that worked diligently at increasing clinical interventions such as exposure and coping skill techniques, enabling client's to continue to obtain outpatient clinic services.

Remarkable outcomes are noted for four clients that moved out of county to seek affordable housing in other counties in California. With the onset of AOT, clients previously considered for FSP referrals were routed to and signed up with AOT. As outcomes indicate a sharp decline in clients' relinking back to team, this may be indicative of barriers encountered in locating and communicating with clients to re-engage in services.

Outcome	# Clients
Stabilized back to team	4
AOT	2

Pathways	1
Higher Level FSP	3
Refused Case Management	1
Moved out of County	3
AWOL	1
Closed to clinic	4

SUCCESSES

One successful intervention with a client with increased medical complications resulted in a board and care placement. Client was housed with MHA for 1 year after being homeless for over 20 years. Given client's chronic homelessness, her MHA placement was under-utilized as they would sleep in apartment 3 nights a week only. The client became psychiatrically unstable, not eating or drinking, requiring high case management to evaluate, collaborate, and ultimately hospitalizing the client from the community who was in renal failure. The client recovered and was placed in a board and care to address both medical and psychiatric symptoms.

Seven clients that have either PSH or HRP vouchers are stable except one who lost voucher for non-payment of rent, who is now on rep payee. One client is being referred to Assisted Outpatient Services to better meet the needs for client engagement and higher level of FSP support.

CHALLENGES

ECM staffing was reduced from 48 to 40 hours weekly effective August 2016 and again to 34 hours weekly effective January 2017 by contractor agency staffing challenges.

The main challenge for the clients served through Embedded Case Management are limited housing, communication by telephone due to homelessness, co-occurring AOD disorders, trust issue stemming from mental health diagnosis and limited resources for undocumented clients.

Most of the referrals for the ECM program are to improve client's engagement with their treatment teams (not making it to appointments) and/or are not stable. The difficult to engage client is typically medication non-compliant and/or homeless with limited family/social support. Use of culturally appropriate community agencies (faith based, Club House,) has helped support recovery when limited financial and family support exists.

Due to the level of impairment of the clients referred, it has been challenging to make connection with the client when they do not show for their appointments. There are clients who are homeless, with no social support, who unless they contact the clinic, or are in hospital

or jail could not be contacted. The Case Manager makes every attempt to meet clients in the community to ensure they have the basic needs of food, access to mental health services/primary care, and to further support their housing needs. Engagement strategies used are home visits (both scheduled and unscheduled), use of natural family support, case conference with outpatient community partners, hospital, jail, and joint home visits with a member of the treatment team. The best outcomes for ECM clients exist when there is a warm handoff from their clinical treatment team.

DEMOGRAPHICS

Total Clients Served	
36	
Age	
18-59	34
60+	2
Race/Ethnicity	
African American/Black	5.5%
Asian	2.8%
Caucasian/White	64%
Filipino	5.5%
Hispanic/Latino	17%
Burmese	2.8%
Other/Not Reported	2.8%
Clients Served 36 + 1 re-referrals	
Carried over from 2015-2016	12
New referrals	16
Closed cases	19
Voucher based clients	7

*Numbers equal more than 37 due to clients qualifying for more than one category

There are currently 10 Embedded Intensive Case Management (ECM) clients, of which 1 is also receiving voucher support effectively increasing the community-based case management for the various voucher programs to 7 clients. The voucher-based clients receive quarterly home visits, monthly phone check in, and assistance with negotiation with landlords, etc. in preparation for annual housing inspections, relocation if needed and redetermination paperwork/appointments. Each client meets with their embedded case manager and completes

a “Needs Assessment” to facilitate client goals to targets case management tasks/activities and updates LOCUS bi-yearly for evaluation of level of care. ECM provides Rep-payee for three clients’ working on budget and providing fiscal education to clients’.

Level of Care for 29 Clients receiving Embedded Intensive Case Management (ECM)

Level of Care	Open	Closed	Total
A	0	4	4
B	10	9	19
C	0	6	6

GENERAL SYSTEM DEVELOPMENT (GSD)

OLDER ADULT SYSTEM OF INTEGRATED SERVICE (OASIS)

OASIS serves a client population that is aging, increasingly fragile and medically complex. OASIS clients come into the program with multiple co-occurring conditions related to physical health, cognitive impairment, substance use, functional limitations and social isolation in addition to their serious mental health conditions. This requires more hands-on case management support and assistance to enable these clients to remain living in a community based-setting. The case management provided also necessitates greater collaboration among the OASIS psychiatrists and primary care providers due to complex medical conditions and comorbid with their serious mental health conditions.

PROGRAM IMPACT AND SUCCESSES

Nina was enrolled in OASIS in 2006 for treatment of Major Depressive Disorder with psychotic features and a paranoid behavior pattern. She had difficulties following instructions and was very stubborn in her fixed paranoid thoughts and suspicions of those around her. She was known by police officers who went to her house due to the multiple complaints she filed on her neighbors and her neighbors filed against her. She also fired many IHSS care givers stating that they were taking away her properties.

During the treatment course, Nina was able to be stabilized with medication and was supported by her psychiatrist and case manager who both working very closely with her and earned her trust. Last year Nina became very ill, losing her weight, becoming physically weaker which impacted her COPD and her need for oxygen. She was eventually referred to hospice.

Nina was at home with Hospice team, IHSS & OASIS support. During a home visit by the OASIS psychiatrist, Nina expressed her desire and longing for the fruit flavor of a peach. The psychiatrist quickly went to the grocery store and brought a peach back to Nina's home. After Nina ate the peach she stated that she had been longing for a peach for so long, and finally had chance to eat one. She expressed her satisfaction and appreciation to the psychiatrist. Two hours after this visit, the OASIS team received notification from the Hospice visiting nurse that Nina passed away. Nina died at age 74.

Although it is not part of the OASIS treatment for the psychiatrist to go out to the store to buy a peach for Nina, the psychiatrist and the team were so glad that Nina had a chance to enjoy a final peach before she died.

The dedicated direct service staff so often go the extra mile to ensure that the clients not only get the essential mental health care they need, but also provide the emotional and concrete support needed to help our clients have the highest quality of life possible.

CHALLENGES

OASIS continually assists clients to maintain their quality of life in the community. Since this population has become increasingly physically fragile with medically complex conditions in addition to their mental illness, the staff has encountered even more difficult challenges than in the past.

A). Lack of staff assistant to escort clients to follow-up medical appointments.

Most OASIS clients need to be escorted to their medical appointments to assist them in managing their anxiety and to help them note down the doctor's instructions for them to be compliant at home. Without this kind of support, the seniors will often avoid going to their doctor. If clients do see the doctor, most of time they are unable to remember the instructions given to them. As a result, they don't correctly follow the medical treatment that is critical for their overall health condition.

B). Lack of resources of placement for the proper level of care that clients need.

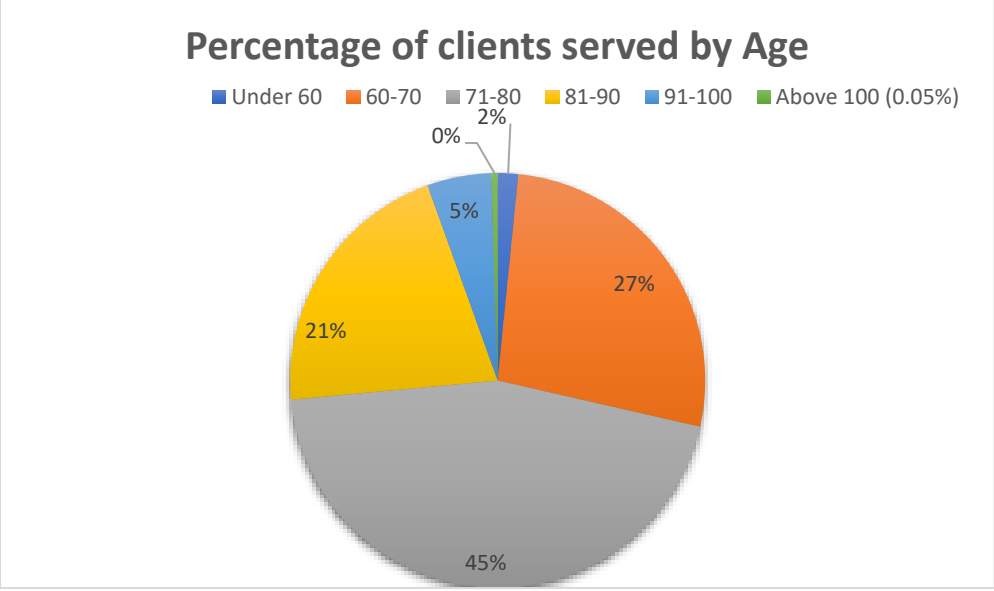
Because of the complex medical issues our elderly face, finding housing or proper placement for them has become another serious challenge. As there is no intermediate care facility in San Mateo County, it has become increasingly challenging to find the appropriate placement for complex clients needing considerable care and supervision, but not meeting criteria for skilled nursing care. This is even further impacted by the extremely limited number of licensed board and care homes willing to accept residents on SSI. Clients may therefore choose to remain at

home or continue to reside in a board and care facility that may have personnel with only limited medical knowledge as the clients' condition declines. OASIS staff has had to deal with more medically at-risk clients over time with a higher rate of client deaths. As the data indicated, the percent of discharges due to death from medical causes is 31.4%. Each time when a staff member loses a client it has significant and building emotional impact on the staff.

DEMOGRAPHIC DATA

OASIS Total Client Served	
248 48 New clients 51 Discharged clients	
Sex	
Male	25%
Female	75%
Languages	
Monolingual Spanish	19%
Monolingual Chinese	14%

Cost per client
$3,050



Reason for discharge	% of discharged cases
Death (medical reason)	31.4%
No mental health symptoms & referral made	23.5%
Stable & back to PCP follow-up	17.6%
Transferred to SNF	7.8%
Declined home visit or no response to outreach	3.9%
Dementia & back to PCP for follow-up care	3.9%
Moved out of SM county	9.8%
Stable & transferred back to county regional clinic	2%
Total	**51 Discharged cases**

PATHWAYS COURT MENTAL HEALTH PROGRAM

Pathways Program is a mental health court developed in collaboration with San Mateo County Courts, Probation, District Attorney, Private Defender Program, Sheriff's Office, Correctional Health, NAMI, Behavioral Health and Recovery Services clinics, specialty teams and its contractors. The Pathways program goal is to avoid incarceration of seriously mentally ill individuals and offer an alternative route through the criminal justice system. Eligible clients must be adults 18 and older, living in San Mateo County, diagnosed with a serious mental illness, has a statutory eligibility for probation, and agrees to fulfill Pathways program requirement. Since the inception of the program, Pathways has graduated 91 clients by providing them with an opportunity to remain in the community with increased treatment support and tailored supervision.

During this fiscal year, the Pathways Mental Health Treatment Court was honored by the Board of Supervisors with a San Mateo County Stars Award for outstanding program performance. They hired a full-time Lead Clinician who completes assessments and reports while also facilitating therapy and Clubhouse groups. They also hired a Case Manager to provide community services and intense case management and were able to operate almost at full capacity. In the year ahead, Pathways will have a fully staffed program with the addition of a mental health clinician that will work towards completing Pathways assessments, reports and treatment plans. They are also expecting to have an intern from Palo Alto University to expand our services for the year.

PROGRAM IMPACT

The Pathways Mental Health Court Program served 46 clients this fiscal year with 14 graduates successfully completing probation. Pathways graduates receive certificates signed by our judge and get their court costs deleted in recognition of their work. Some graduates also receive expungement of their legal charges. Since Pathways began in 2006, 95 participants have graduated. The program invites Pathways Alumni to their picnics and other events as role models for current Pathways participants.

SUCCESSES

Participants shared many successes with us this year:

- 13 obtained employment
- 10 maintained employment
- 5 enrolled in higher education
- 3 started trade schools
- 3 graduated El Centro
- 3 graduated Women's Recovery Association
- 2 graduated Project 90
- 2 reunited with their children
- 2 graduated Women's Enrichment Center
- 2 graduated Asian American Recovery Services
- 2 participated in job internships
- 1 proceeds toward a GED
- 1 made progress toward a GED
- 1 obtained a Real State License
- 1 obtained full VA benefits
- 1 graduated CDPR – Kaiser Permanente

DEMOGRAPHICS

Total Clients Served			
46			
Male	29	Female	13
Race/Ethnicity			
White/Caucasian		33%	
Hispanic/Latino		31%	
Asian		12%	
African-American		7%	
Other		7%	

Pathways excluded 5 participants this year. None went AWOL.

Cost per client
$6,954

STARVISTA: G.I.R.L.S PROGRAM

The initial focus of the GIRLS Program is addressing the trauma and co-occurring issues of the participants of the program by developing a treatment plan and strategies supporting recovery from both mental health and substance use issues introducing Cognitive Behavioral Treatment (CBT) strategies to promote healthy choices and encouraging a clean and sober lifestyle. Equally important is the understanding of the clients' emotional situation by initiating a psychological evaluation which helps identifying relevant mental health issues that are impacting a participant and may be creating challenges and impeding a participant's progress. Additionally, the trauma issues impacting this population are significant and substantial and require specialized training and intervention skills.

Overall, the program has provided intakes, assessments, collaborative treatment planning for each client together with individual therapy (on a weekly basis), group therapy (two groups once a week), family therapy (on a weekly basis), and multi-family groups (twice a month), utilizing educational & psycho-educational & process models as well as case management including extensive collaboration with the multi-disciplinary team (on a weekly basis). The program works interactively and collaboratively with all partners including probation, institutions, Behavioral Health and Recovery Services, Pyramid, The Art of Yoga, and Rape Trauma Services. The program has also provided equine facilitated therapy and Zumba classes. 39 clients were served during the year.

System of Care

This year, to improve access to services for clients who would struggle to get to Camp Kemp for services, StarVista GIRLS program provided individual and family therapy both in the office in San Carlos and at other community locations such as BHRS offices close to a client's home. StarVista GIRLS program has also offered the option of having a therapy group at the San Carlos office for Phase II clients. StarVista GIRLS program collaborated with BHRS to provide families that needed additional support with transportation with taxi vouchers to enable them to reach Camp Kemp. They also referred clients to a range of providers, including Rape Trauma Services, other StarVista programs, such as Your House South, Daybreak, Insights, and the Counseling Center, as well as other nonprofit community agencies, such as Teen Success, Outlet, the Prep team, or to Family Partners or Pre to Three through BHRS.

The StarVista Management Team and the GIRLS Program staff remain fully committed to continuing to provide excellent evidenced based programming and services to the clients they serve.

PROGRAM IMPACT

The primary short-term outcome is a demonstrated increase in engagement for both clients and their families. Additionally, clients are engaged in school and have made academic progress, increase in cooperative family unit, increase in positive peer relationships, and increase in pro-social activities.

Outcomes based on girls completing the 6-12-month GIRLS program indicate:

Increase in positive individual engagement	90%
Increase in positive family unit	64%
Increase in positive academic engagement	92%
Increase in positive peer relationship	67%
Increase in pro-social activities	67%

SUCCESSES

StarVista is proud to support their youth in the Girl's Program at Camp Kemp. This year, 13 clients graduated and completed girls program successfully compared to 10 clients out of 44 in the previous year.

In an exciting development this year, StarVista secured a grant from Kaiser Permanente to enhance trauma-informed care by providing the team with training in family therapy through Live supervision by Pamela Parkinson, Ph.D., LCSW. In an effort to support ongoing training and development of the entire multi-disciplinary team (comprised of Probation, BHRS and other community-based organizations staff), StarVista also utilized this grant to offer the multi-disciplinary team trainings on Vicarious Traumatization by Laura Van Der Noot Lipsky and on Trauma-Informed Tools to use with clients by Kelley Callahan, Ph.D. and Rachel Chapple, Ph.D. The training on vicarious traumatization was particularly well received throughout the MDT and provided some helpful tools to mitigate the effects of working with such a high level of trauma.

In addition to the therapy groups, StarVista's GIRLS staff facilitated Zumba groups, which have been something that many of the girls have very much enjoyed and appreciated. Physical exercise not only improves physical health, but also provides a natural release of hormones that have been proven to improve mood and energy levels. Not to mention, it's fun! Additionally,

StarVista facilitated two equine facilitated therapy outings. These outings offer a unique environment that provides the girls with additional opportunities to explore self-awareness and develop interpersonal skills.

There were multiple changes to the service environment this year with probation selecting an alternate provider, the departure of the Behavioral Health and Recovery Services bilingual clinician in January and the Rape Trauma Services bilingual clinician in March. While change can offer unique challenges, StarVista remained a mainstay of the Camp Kemp program and continued to take on a lead role. At a time when it is hard to recruit and retain staff with the relevant skills, StarVista continued to provide bilingual services through our Program Coordinator, Nubia Barraza, who has been with the program for almost 6 years. StarVista remains committed to serving this youth population and plans to continue provide high level services for these young people in years to come.

As of July 3, 2017, Pyramid Alternatives and StarVista successfully merged. Pyramid is an integral piece of the Camp Kemp multi-disciplinary team, so the merger will offer improved collaboration and will expand the reach for services offered at StarVista.

CHALLENGES

In June 2016, the GIRLS program moved from Camp Kemp to a StarVista office in San Carlos. In response to the result of the Probation RFP, the probation department requested the GIRLS program move out of the offices at Camp Kemp, so StarVista responded by ensuring an appropriate office location in a timely manner to ensure there was no disruption in services. GIRLS program continued to provide all services for all phases of the program at Camp Kemp providing a safe, familiar space for services creating continuity is thought to have positive impact on the clients' ability to feel comfortable. With our new location, we were also able to offer the option of family therapy or individual therapy at an accessible and youth friendly location in San Carlos for clients living in the community.

It has been observed generally by staff that the girls entering the program continue to have more complex issues, including significant substance abuse, mental health issues, sexual trauma/commercial sexual exploitation, histories of running away, attachment issues, and family-of-origin issues that make it challenging for them to complete tasks necessary for release into Phase II of their programming. Additionally, there are significant levels of gang involvement and sexual exploitation which adds a further layer of complexity to this work.

Other Challenges

One of the challenges within the team has been reducing the clinical staff to one Program Coordinator and 3 interns and figuring out how to train interns who are only in the program for

a year to work effectively within the Camp Kemp system with such complex clients. StarVista GIRLS program reviewed and redesigned their intern training in the hope that they can help interns orient more easily to the program requirements. StarVista understands the importance of staff retention. With the merger between StarVista and Pyramid Alternatives finalized, the program will have more staff members and hopes to increase retention within the team to build knowledge and have more support available to new staff or interns. StarVista Management works hard to support the staff and interns by building a supportive team and with organization wide policies such as “self-care days” to support mental health and decrease the chance of burnout.

This year the client numbers were low for the first few months and as this appeared to be a system wide trend, two of our interns secured additional placements elsewhere to ensure they received enough hours working with clients during their internships. Then in January, the BHRS bilingual clinician left and in March an RTS bilingual clinician left and the client numbers rapidly increased. To try to meet the therapy requirements for the clients, everyone took on the maximum number of clients they could, but there still was a shortfall in the number of clinicians available. This meant that there are a number of clients who were not allocated family therapists. The mental health providers came up with creative solutions to draw from external resources to cover as many of the clients as possible, but there is still a waitlist for family therapy. We are currently exploring whether StarVista can share a staff member with another program to help cover the family therapy families.

There has been a recent increase in the number of girls reporting CSEC victimization. This populations presents with unique challenges including, but not limited to, increased levels of trauma, sexually transmitted diseases, pregnancy, domestic violence, mental health concerns and a risk for recruitment of other youth. StarVista has organized a CSEC training which the team is attending. The GIRLS program will continue to explore other CSEC training opportunities for the team to best serve this complex youth population.

Community Needs

The StarVista team regularly work with the client’s Probation Officer to connect clients with a CASA worker and connect clients with local community resources, such as their local BHRS clinic, StarVista residential programs as appropriate such as Daybreak or Your House South. The team regularly referred clients to Rape Trauma Services (RTS) when a client has experienced sexual trauma and work closely with the RTS team to ensure clients receive support as needed, for example if a client wishes to report sexual abuse. Clients are also referred to the BHRS Family Partners when the family could benefit from more support. The team also refers clients to organizations such as Teen Success, Outlet, or the Prep Team when there are specialized needs.

There appears to be an increased need for intensive outpatient (and inpatient) services in San Mateo County. Over the past few years, many youth-oriented programs have closed. Youth shelters, group homes (in response to AB 403), inpatient substance use programs, and youth outpatient therapy/substance use programs appear to be decreasing. For some of the clients where placement with the family or caregivers is challenging there are limited options available to support them. With CSEC youth where clients could benefit from very specialized services, there are limited referral options. Youth appear to be experiencing more mental health issues related to trauma and substance use. With fewer programs to serve this priority population, many youth are finding their needs are not being met. Fortunately, Camp Kemp and GIRLS program provides structured, evidenced based approaches to therapeutic services and utilizes its multi-dimensional team to provide wraparound services to address the specific needs of each participant.

DEMOGRAPHICS

Total Clients Served	
39	
Age	
0-15	8%
16-25	92%
Race/Ethnicity %, (#clients)	
Hispanic/Latino	59% (23)
African-American	8% (3)
Pacific Islander	0% (0)
Filipino	13% (5)
Other	10% (4)
Asian	5% (2)
Native American	0% (0)
Multi-ethnic	5% (2)
Cost per client	
$2,370.50	

LANGUAGE	ENGLISH	SPANISH	CHINESE	TAGALOG	TONGAN	SAMOAN	OTHER	TOTAL
# OF CLIENTS	**38**	**1**	0	0	0	0	0	39

% OF CLIENTS	**97%**	**3%**	0%	0%	0%	0%	0%	100%

PUENTE CLINIC

The Puente Clinic was created in 2007 under the Behavioral Health & Recovery Services (BHRS) of San Mateo County Health System to accommodate the sudden increase of psychiatric service need due to the closure of Agnews Developmental Center and relocation of many intellectually disabled adults to San Mateo County. The word "Puente" means "Bridge" in Spanish, and it implies to help clients bridge what could be a life of dependence and isolation to a life of independence and integration with the whole community.

Clients with intellectual disability have higher comorbid psychiatric disorders, face more stressors and traumatic exposure in life, and experience more stigmatization and discrimination. But limits in communication/cognitive ability and aberrant brain development/function make it challenging for behavioral health providers assess, diagnose, and treat these clients. Clinical staff at the Puente Clinic are trained and experienced in working with adult clients with both intellectual disability and psychiatric conditions. In carrying out this unique function, the Puente Clinic collaborates closely with the San Mateo County Branch of the Golden Gate Region Center (GGRC), which coordinates benefits (daily living, housing, etc.) for County residents who have intellectual disabilities.

The Puente Clinic serves as the lead clinical team in BHRS to receive psychiatric service referrals from GGRC. The team provides assessment, psychotherapy, and medication management, and coordinates case management with GGRC case managers. Currently, the Puente Clinic has 1 Full-Time Marriage & Family Therapist, 2 Half-Time Psychiatrists, and 1 Half-Time Nurse Practitioner (Extra Help). A typical client referred to Puente Clinic is someone having mild or more intellectual disability and significant limits in communication ability, with one or more of the following conditions:

1. Client is returning to the community from a developmental center or a locked or delayed egress facility.
2. Client is at risk for a higher level of care.
3. Client requires in-home services as clinically determined.

4. Client has had multiple psychiatric emergency services contact.
5. Client has complex diagnostic issues or polypharmacy.

PROGRAM IMPACT

Clients with intellectual disability and their family need tremendous amount of help in various aspects of life function since birth or early childhood. In San Mateo County, GGRC administers Federal and State funding and coordinates service needs of intellectually disabled residents. The Puente Clinic is the primary contact for GGRC when adult clients require specialized behavioral health services. In addition to providing direct services, the Puente Clinic also provides consultation to other BHRS clinics/teams and facilitates collaboration between GGRC and other BHRS clinics/teams. The GGRC San Mateo Branch currently has about 2500 adult intellectually disabled clients. Epidemiological data suggest that about one third of these clients (about 800 adult GGRC clients) have significant behavioral or mental health conditions that require psychiatric assessment and treatment intervention. Many of these clients are not covered by a private insurer and hence their care becomes the responsibility of BHRS. Other than the Puente Clinic, which follows about 250 clients, other BHRS clinics/teams carry a small caseload of GGRC clients with milder form of intellectual disability. Therefore, it is reasonable to estimate that there are still about 300 to 400 GGRC clients who are not currently registered with BHRS might need mental health services at any given time.

Also, during this report period, the GGRC San Mateo Branch started developing a new set of group homes to receive intellectually disabled adult clients relocating to this county due to closing of several Development Centers in the State. It is projected that a total of 25 high-acuity level group homes would be established in 2017 and 2018 to house about 100 clients (90% adults) to be relocated to this County from the Sonoma Developmental Center. Of these, about 70 clients are identified to need specialized behavioral group home placement. Many of these Development Center clients have moderate to severe intellectual disability conditions, require intensive behavioral and mental health treatment, and are taking multiple psychiatric medications. They most likely require BHRS' support for a full scope of mental health services. The Puente Clinic is by default the team to receive these referrals and will likely become the main psychiatric service provider for this group of clients.

Beyond providing clinical services, the Puente Clinic also serves as a training location for trainees interested in learning about intellectual disability and the knowledge and skills in assessing and treating these clients with behavioral health conditions. Through these opportunities, the Puente Clinic facilities the development of future work force that will have expertise in working with this unique client population. During this report period, the clinic had

a MFT intern placed from the San Francisco State University for the full year, and several medical students coming from the University of California, San Francisco, for a short-term rotation.

Program Outcomes

The two major diagnoses of Puente Clients were "Unspecified disruptive, impulse-control, and conduct disorder" (27%) and "Intermittent explosive disorder"(17%).

These represented some main reasons for Puente Clinic referrals – disruptive behaviors, including yelling, hitting, biting, self-mutilation, resisting to control, etc. Sometimes, it was possible to identify other underlying major psychiatric condition, such as schizophrenia (15%), major depression (3%), bipolar disorder (1%), obsessive-compulsive disorder (6%), anxiety disorder (10%), etc.

SUCCESSES/CHALLENGES

During the report period Jul 2016-Jun 2017, several newly referred psychotherapy clients gained significant progress in symptom relieve and functional improvement. Clients with intellectual disability are easily challenged by their ability to express fully what has happened to them and what they are experiencing. The experienced psychotherapist and her trainee worked with these clients and used specialized techniques to build rapport, gain trust, assess, and render effective therapeutic intervention.

Client A was a client not only with an intellectual disability, but also with a deaf condition. She had indicated to her GGRC social worker that she would like to become more independent from her parents as she was already in her 30s. She was also pursuing guidance in developing productive and safe romantic relationship with male friends. To work with this client, the Puente Clinic therapists first established reliable sign-language interpretation support provided by BHRS and the County Health System, and then through careful management of communication among the client, the therapist, and the interpreter, to establish a trusting and secure environment for the client to voice her challenges, stressors, symptoms, and wishes. It was reported by the client that this was the first time in her life that she was able to have someone with professional expertise listen to her and give her guidance in relationship problems. The therapy was on going and the client was gaining confidence to pursue partial control of her own guardianship.

Client B was a female client in her young 20s. She was fairly self-dependent and cheerful in life until a sexual assault incident happened at a public pool. When she was referred to the Puente

Clinic, she had become withdrawn in life, avoiding most public places, and ridden with fears and panic attacks. The Puente Clinic therapist worked closely with both the client and the client's most trusted person, the mother, and provided a safe therapeutic space for the client to express her self-doubt, fear, anxiety, and insecurity. While the therapy continued, the client was more and more able to communicate verbally, express positive emotions, and to reflect on how the incident impacted her life. The Puente Clinic therapist also consulted with the GGRC social worker in identifying safe and meaningful activities that could be supported by service providers in the community.

Although there were successes in client treatment, the Puente Clinic was challenged by the limited staffing resource. After 10 years, the Puente Clinic caseload has grown to 250, which is about to saturate the service capacity of the team with one full-time therapist/case manager, two half-time psychiatrists, and one half-time nurse practitioner. And the number continued to grow in recent years. The Puente Clinic team depended on the co-located Central County Clinic to provide administrative and nursing support. Although the nursing staff could help the Central County Clinic psychiatry staff with pharmacy and laboratory functions, they could only have time to help the Puente Clinic psychiatrists with medication injection and clozapine registry. In addition, although ideally the GGRC social worker functioned as the main care coordinator for clients, the Puente Clinic clinician actually had to constantly coordinate care provision and communication among the client, family, caretaker, GGRC social worker, and other health care providers, which took a lot of time and effort. As stated in the "Program Impact" section, there is a greater need of specialized behavioral and mental health services for intellectually disabled adults in the community, and yet the Puente Clinic can't close that gap by itself with its current capacity.

DEMOGRAPHICS

Total Clients Served	
249	
Gender	
Male 61.68%	Female 38.32%
Race/Ethnicity	
Not Hispanic or Latino	57.66%
Unknown/Not Reported	30.66%
Hispanic or Latino	9.12%
No Ethnicity Recorded	2.55%
Age	

10-19	0%
20-29	14.96%
30-39	16.42%
40-49	17.52%
50-59	26.28%
60-69	18.25%
70-79	5.84%
80-89	0.73%

Cost per client
$1,565

Program Activities

Enrollment

Year	Admission	Discharge	Total Caseload
Jul 2015-Jun 2016	29	15	251
Jul 2016-Jun 2017	**29**	**31**	**249**

In the period of July 2016-June 2017, Puente Clinic admitted 29 clients, discharged 31, and reached the total number at 249. Of the 29 new clients, 7 were admitted for psychotherapy, and 22 for medication.

Of the total 249 clients, 26 received psychotherapy, and the rest were mainly for medication. The caseload for our two psychiatrists and one nurse practitioner was fairly even, and they spent a lot of time in case management and communication with family, caretaker, pharmacies, and other providers.

CALIFORNIA CLUBHOUSE

Clubhouse is a membership-based social/vocational community where people living with persistent mental illness come to rebuild their lives. Participation is free. It's a place to go from 9:00-5:00pm weekdays to build upon strengths and abilities and a place to socialize evenings and weekends.

This year started with a relocation from their rented room in San Mateo, to a nearly three times as large facility in San Carlos. California Clubhouse is collocated in the same building as Heart & Soul. This has allowed for a deeper collaboration to develop between the two organizations. The first year in the new space centered around establishing and re-establishing their presence in the greater San Mateo County area, focusing on broad community advocacy through:

- Focus on filling a gap in services/a real need
- Providing a proven model of hope-based recovery
- Rallying many different groups around our mission

Funding and Governance

California Clubhouse is funded approximately 60% by San Mateo County (BHRS) and the remaining 40% through a mix of private donors, foundation grants, fundraising events, earned program revenue, creative fundraising programs, and corporate sponsorships.

Conclusion

California Clubhouse is thriving as a young organization, only 2 years old. But, what our numbers fail to tell is the story behind the numbers. It is the story of people spreading their wings, reclaiming their lives and sustaining their hope through UPWARD MOBILITY! Every day our members are achieving upward mobility for themselves. Whether it is getting out of bed and leaving the house daily or it is enrolling in college or applying for a job. Every day, members are spreading their wings and soaring to new heights!

PROGRAM IMPACT

California Clubhouse Growth For FY 2016 To 2017

Average Daily Attendance:	Total Visits:	Total Hours:	Total Meals:
20	3,999	15,821	2,875

Total Outreach:	Total Mobile Visits:	Total Socials:	Number Of Cities Served:
2,062	171	64	20

Young Adult Program (YAP)

YAP is targeted to young adults (ages 18-35) with psychiatric disabilities (schizophrenia, schizoaffective disorder, bipolar disorder, major depression). Specialized programs that focus on the interests of youth have proven effective in better managing the course of the illness over time.

YAP achieved the following results this year:

- Created community liaison relationships with schools, colleges, community psychiatric clinics and youth organizations to attract young adults.
- Utilized Clubhouse peer mentors to welcome new youth members though tours, orientation and development of a youth-orientated programming.
- Engaged youth in activities and services that meet their needs and interest
    - Young Adult Programming includes Reach out, Social media and increased communication methods, multiple social activities, educational opportunities and vocational skill building

Through strong peer relationships built over time at California Clubhouse, young adults developed self-awareness and confidence to make choices resulting in greater self-sufficiency, independence and belonging.

This year California Clubhouse officially launched their Career Development Program which includes two types of supported employment, Transitional Employment (TE) and Supported Employment (SE).

> *"… a place to be, and a place to grow as a healthy person. From homeless to hospital, to the mental health recovery center, to California Clubhouse, to employment! Truly, I feel like I went from 0 to 60mph and the California Clubhouse is to be thanked. With their encouragement for active participation in Clubhouse activities from the beginning of enrollment at the Clubhouse, and then later to the transitional employment managers introductions. I have made progress in rebuilding my life. Most recently I have been working part-time as a regular employee at Walgreens. I started in June of 2017 with the transition- to-employment program at the Clubhouse. The focus is to help members like me find a placement temporarily with the hope that it will build stamina for working and give a recent employment 'good reference', or maybe even an offer to stay on as a regular employee. Next month, I will become a permanent employee. Thank You California Clubhouse!*" Deborah Ann C.

SUCCESSES/CHALLENGES

Activities

The Social program has also grown in popularity and diversity of activities and has averaged five social activities per month. The programming has included large scale activities such as visiting the Monterey Bay Aquarium, Alcatraz, the Academy of Science, Healing Voices Movie Screening, Pride Celebration, San Mateo County Fair, Downtown San Mateo Festival, picnics, and hikes, and the first ever California Clubhouse Prom Night. Smaller scale events include board games and dinner, bowling, karaoke, and art socials.

California Clubhouse have celebrated every holiday on the actual day. The holiday socials are highly attended averaging 15-20 members in addition to staff, family and board members.

Wellness

California Clubhouse staff and Board understand that mental health is not separate from physical health, and that a healthy lifestyle is a powerful component in improving mental health recovery and its long-lasting effects. Thus, they see strengthening the delivery of our Wellness Works program as key to delivering a strong wellness foundation for our members.

Their goal has been to institute a paradigm shift in the way psychiatric and non-medical rehabilitation programs embrace health and wellness. While preserving the focus of the Clubhouse on life events such as aspiring to work, achieving independence, combating loneliness and managing stress, Wellness Works activities are woven skillfully into day to day operations rather than as stand-alone workshops or sessions offered in the community.

Basic offerings, opportunities and plans for members under Wellness Works' four pillars include:

Nutrition	**Physical Activity**
Multiple opportunities to participate and learn many aspects of nutrition including menu planning, food shopping, meal preparation, budgeting, food safety/storage and healthy snack options.	Promotion of cardiovascular activities and encouragement to increase frequency of activities members may already do. A variety of beneficial exercise options are offered on site including yoga, aerobics and walks, also a pedometer/walking challenge and opportunities to participate in sports and active games. A deliberate effort is made to include physical activities into planned recreational activities
Wellness Education	**Socio-emotional Wellness**
Promotion of wellness through prevention-based education in Lunch and Learn groups and in house forums on health-related topics cardiovascular disease and diabetes prevention.	Promotion of healthy relationship building in the Clubhouse setting by developing support networks and organizing social and recreational activities for bonding. We offer meditation and mindfulness exercises and increase member motivation to participate in wellness activities through social encouragement. Home and hospital visits are frequent when needed, as is continuing outreach to members who may lapse

Outreach & Orientation

California Clubhouse conducts an extensive outreach system which includes daily and weekly calls depending on the need of the member. They call all members regularly to remind them of upcoming events such as social programs and community meetings. Members who are hospitalized or "shut in" receive a visit by a member and staff team. Get well, sympathy,

birthday and congratulation cards are sent out regularly to members. **Their Outreach system has proven very successful.**

California Clubhouse's orientation of new members is conducted at least weekly both in group and individual formats to meet the needs and schedules of new members. During orientation, new members are given a brief overview of the Clubhouse Model and are orientated to the programming and operations of the Clubhouse. They are also advised of their rights as a member of the Clubhouse.

Community Partnerships

The clubhouse is committed to collaborating with mental health initiatives throughout the county. They have a member and staff teams that officially serve on most of the ODE Initiatives including: Pride Initiative, Filipino Initiative, Chinese Health Initiative, Spirituality Initiative, Latino Collaborative, and the Diversity and Equity Council.

California Clubhouse is proud to be one of three San Mateo Peer directed organizations (Voices of Recovery, Heart & Soul, California Clubhouse) that have partnered to launch the Peer Recovery Collaborative in San Mateo County. The Peer Recovery Collaborative (PRC) meets at least monthly to strategize opportunities for partnership. Since forming the Collaborative, the PRC has hosted events such as Healing Voices Movie Screenings in Los Altos and San Mateo, and a facilitated training for mental health providers, "Honoring the Individual Journey." As an agency partner in the PRC (Peer Recovery Collaborative) we worked with BHRS OCFA and ODE offices, as well as NAMI to plan a Peer and Family Recovery Summit for San Mateo County. The summit will take place in the fall of 2017.

This last year, California Clubhouse also grew their partnerships in the greater community with increased visits by Telecare Cordilleras clients; our continued partnership with Caminar Case Management and Residential Services; and our on-going incredibly supportive relationship with Putnam Clubhouse. An exciting community partnership has been in development, the HOPE (Helping Our Peers Emerge) Program which is a joint effort between California Clubhouse, Heart & Soul, NAMI San Mateo County, Voices of Recovery and San Mate County Behavioral Health and Recovery Services to help individuals coming out of psychiatric hospitalization emerge with peer, family and employment support, thus reducing their returns to the hospital.

Facility

California Clubhouse has relocated. One major barrier of participation that they have identified in the new space is the lack of public transportation nearby. The closest bus stop is ½ mile walk. Currently, staff and members are carpooling and ridesharing to get members to and from the clubhouse, however, going forward, they will be working with SamTrans and other providers in

the neighborhood to advocate for additional bus service. Thanks to the generous support of the San Mateo County Board of Supervisors, California Clubhouse was gifted a 12 passenger van this year. However, they are having issues with operation of the van due to DMV rules around such operations. They will continue to problem solve this with our stakeholders, members, staff and board.

DEMOGRAPHICS

Total Enrolled Members Served	
152	
Race/Ethnicity % (# clients)	
Caucasian/White	55% (83)
Hispanic/Latino	12.5% (19)
African-American	8.5% (13)
Asian	8.5% (13)
Pacific Islander	3% (4)
Mixed	11% (17)
Native American	0.7% (1)
Unknown	1% (2)
Age	
20-25	6% (9)
26-30	8% (12)
31-40	20% (30)
41-50	19% (29)
51-60	31% (47)
61-70	14% (22)
>70	2% (3)

City of Residence	
Daly City	5
South San Francisco	5
Millbrae	5
Burlingame	9
San Bruno	10
Redwood City	36
Menlo Park	2
East Palo Alto	7

San Carlos	5
Belmont	7
San Mateo	41
Hillsborough	1
Pacifica	3
Half Moon Bay	1
Foster City	2
San Jose	0
San Francisco	6

Colma	1
Unknown/Homeless (SMC)	4

Out of State	2
	152

Cost per client
$1,974

Enrollment/Membership

New member enrollment is coming from a variety of sources such as:

- BHRS County Clinics (North, South and Central)
- Kaiser
- Pathways
- MHA
- NAMI
- Cordilleras (*both the Suites and the Third Floor*)
- Caminar
- Voices of Recovery
- Heart & Soul
- Center for Independence of individuals with Disabilities
- VRS
- DABS, Inc.
- Telecare
- Edgewood
- Faith Based Organizations
- ODE Initiatives

SENIOR PEER COUNSELING

The Senior Peer Counseling Program, provided by Peninsula Family Service, recruits and trains volunteers to serve homebound seniors with support, information, consultation, peer counseling, and practical assistance with routine tasks such as accompanying seniors to appointments, assisting with transportation, and supporting social activities. The Senior Peer Counseling program has been expanded to include Chinese, Filipino and LGBT volunteers.

PROGRAM IMPACT

The recruitment goal set for this year was to recruit 60 new peer counselors. 72 counselors were recruited to date, **120%.**

The training goal set for this year was to train 36 new peer counselors. **39 peer counselors successfully completed the training this year.**

This third quarter the Senior Peer Counseling Program had 126 senior peer counselors participating in the program year to date, **126 percent of goal.** 18 counselors retired through this quarter, bringing the current total of active peer counselors to 108.

The goal is to serve 425 clients during the program year. Year to date we have served 462, 109%. With 96 cases closed to date, the current active caseload is 366.

In order to serve more people with the current resource of peer counselors, the program offers weekly support groups at various community sites. There are currently **twelve groups** in senior/community centers, senior housing, the new PRIDE Center, other non-profit agencies and even a local bookstore in San Mateo County.

The group sessions have different formats. Some meetings are organized as an open discussion which gives everyone an opportunity to engage and express their sentiments, thoughts, concerns, and feelings. Other meetings are topic-based discussions, and/or presentations from outside speakers. This quarter's specific areas explored include:

- Health and pain issues
- Poetry discussion
- New Year's resolutions
- Are Your Thoughts Helping or Harming your Life?
- Group coloring
- Job Search
- Family issues and how to deal with difficult people
- Housing issues
- Self-awareness
- Simple meditation techniques
- End of Life issues
- Dreaming
- Retirement adjustments
- Suicide among seniors
- The current federal administration and how it affects Latinos
- Memories
- Healthy food and cooking
- Simple meditation techniques
- Hoarding versus Collecting

SUCCESSES/CHALLENGES

The LGBTQ Coordinator and the Program Director, in collaboration with the lead agency Starvista, participated in the development of the first LGBTQ Pride Center in San Mateo County. The Center had a launch party on June 1st and more than 400 people from the community attended. Senior Peer Counseling Program staff worked diligently to support the creation of the

San Mateo Pride Center by participating in regular, ongoing operational partners' meetings, as well as interview panels to help hire staff for the Center. The additional funding provided Ellyn with 8 more hours per week for her to develop and start new activities which were the first ongoing programs to take place at the Center.

The Senior Peer Counseling program continues to have a waiting list for mostly English-speaking individuals requesting peer counseling services. Most of the clients on the waiting list reside in central and south San Mateo County which is where the program is currently targeting outreach. The largest number of referrals come from service providers, followed by healthcare providers and self-referrals.

In addition to various open houses the Senior Peer Counseling program participated in a variety of outreach activities during the quarter. Volunteer recruitment continues to be one of the main focuses of the program and a large user of staff time.

Because of the growth in the program of many activities, new volunteers and clients who are either in the program or on the waiting list the manager of the program needed more than just 22 hours to complete her job. Thanks to some foundation grants, Senior Peer Counseling was are able to offer her a full time position effective july1, 2017.

DEMOGRAPHICS

Total Clients Served	
462	
Race/Ethnicity	
Hispanic/Latino	38%
Filipino	29%
Asian	6%
African American	.6%
Other/ Caucasian	27%
Age	
25-59	3%
60+	97
Language	
English	28%
Spanish	37%
Chinese	6%
Tagalog	29%
Cost per client	

$ 306

Please note 6 LGBTQ clients were served. They are listed above under Caucasian and English-speaking.

CO-OCCURING CONTRACTS WITH ALCOHOL & OTHER DRUG PROVIDERS

BHRS contracts with nine AOD providers for either additional residential treatment bed days, additional non-residential treatment service hours, or to enhance services provided to clients already in residential or non-residential treatment.

UNITS OF SERVICE (UOS) DELIVERED

Total Contracted Providers			
9			
Provider	**UOS Delivered**	**Contracted Amount**	**% Fulfilled**
El Centro de Libertad	266	265	100%
HR360 – Women's Recovery Assoc	102	262	39%
Our Common Ground	127	803	632%
Pyramid Alternatives	912	701	130%
Service League of San Mateo	840	840	100%
Free At Last	330	327	101%
Project 90	304	463	66%

PEER SUPPORT WORKERS & FAMILY PARTNERS

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

PEER SUPPORT WORKERS

There are 17 Peer Support Worker positions in the BHRS adult system. These are permanent, benefited civil service positions, most of which are full-time; currently all positions are filled. They are distributed throughout the system in a variety of clinical program teams, such as Adult Resource Management, Service Connect, YTAC, Total Wellness, OASIS and the regional clinics.

The Peer Support Workers are a very culturally, racially, ethnically and linguistically diverse group which includes Chinese, Pacific Islander, Latino, Caucasian and African American staff, several of whom are immigrant bilingual and bi-cultural.

Peer Support Workers facilitate groups such as WRAP, WRAP for housing, Dual Diagnosis Group, Welcome Registration/Orientation for new clients, Mindfulness, Healthy Eating, Arts and Crafts, Healthy Living, Ash Thinkers, Ash Kickers, Chinese Family Support Group, Cooking with Ease and Stress Management groups. Peer Support Workers also help clients with some case management activities such as finding housing, connecting to vocational resources, applying for benefits and providing transportation.

Peer Support Workers bring their lived experience to the broader community by participating on community groups and initiatives such as the African American Initiative, the Lived Experience Speakers Academy, the Lived Experience Education Workgroup, the Housing Operations and Policy Committee, the Community Service Area planning, and the Latino Collaborative, among others.

FAMILY PARTNERS

There are 11 Family Partners working in San Mateo County Behavioral Health and Recovery Services, representing diverse cultural and linguistic experiences including bicultural and bilingual Spanish and Tongan, as well as English speaking African American.

- 7 Family Partners are embedded on the youth clinical services teams. (full time civil service positions)
- 1 Family Partner on the Youth to Adult Program (3 year grant funded position)
- 1 Family Partner on the Office of Diversity and Equity (3 year grant funded position)
- 1 Family Partner is on the Adult Pathways Mental Health court team (full time civil service position)
- 1 Family Partner on the Pre-3 Program (part time civil service position)

BHRS Family Partners can be referred to provide support for families who are not receiving services on the teams that they are embedded on. Cultural and linguistic matches are a key factor in making these assignments.

Family Partners provide:

- Individual support to parents of youth and young adults, sharing their lived experience with the families they serve
- Case management
- Group support to parents/caregivers by providing educational activities around children and their mental health

Groups co-facilitated by Family Partners include:

- Wellness Recovery Action Planning (WRAP) – English and Spanish
- Equip Educate and Support (EES - UACF) – English and Spanish
- Nami Basics - English and Spanish
- Parent Café's – Spanish
- Parent Support Groups at clinics- Spanish

Family Partners also bring their lived experience to the broader community by participating on the following community groups and initiatives: African American Initiative, Latino Collaborative, Pacific Islander Initiative, North county Outreach Committee, Community Service Area Meetings, and Pacific Islander Task Force.

Testimonials

My experience working with Family Partners has been wonderful because they supported me when I needed a guidance or vent about my frustrations with someone. They helped me have more confidence in myself and feel supported. Having someone to share my doubts about my child's treatment and learn what community resources I can use is very important. Cynthia – Redwood City

The support I have received from my family has been excellent. She has supported me in so many ways over the years by giving me skills and tools to be a better person and mother for my children. Going to the classes and programs she recommends have helped me become a more understanding and supportive parent for my children. Francisca – Half Moon Bay

As a mother of a young adult the help I receive from my Family Partner has been HUGE! She is always checking in to see how things are going. I know I can call her anytime if I have any concerns or doubts regarding his treatment. She always returns my calls. When I'm desperate I can talk with her and things are better. She has been great in helping me understand my son. Mercedes– San Mateo

EVIDENCED-BASED PRACTICE (EBP)

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

Total Youth Clients Served	Cost per Client
258	**$2,185**
Total Adult Clients Served	**Cost per Client**
686	**$1,190**

CHILD WELFARE PARTNERS

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

Total Clients Served	Cost per Client
105	**$3,901**

OUTREACH AND ENGAGEMENT (O&E)

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

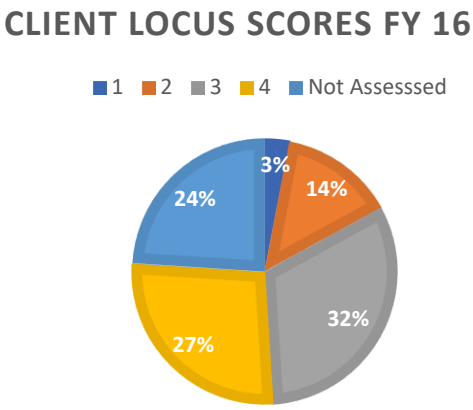
PRE-CRISIS RESPONSE

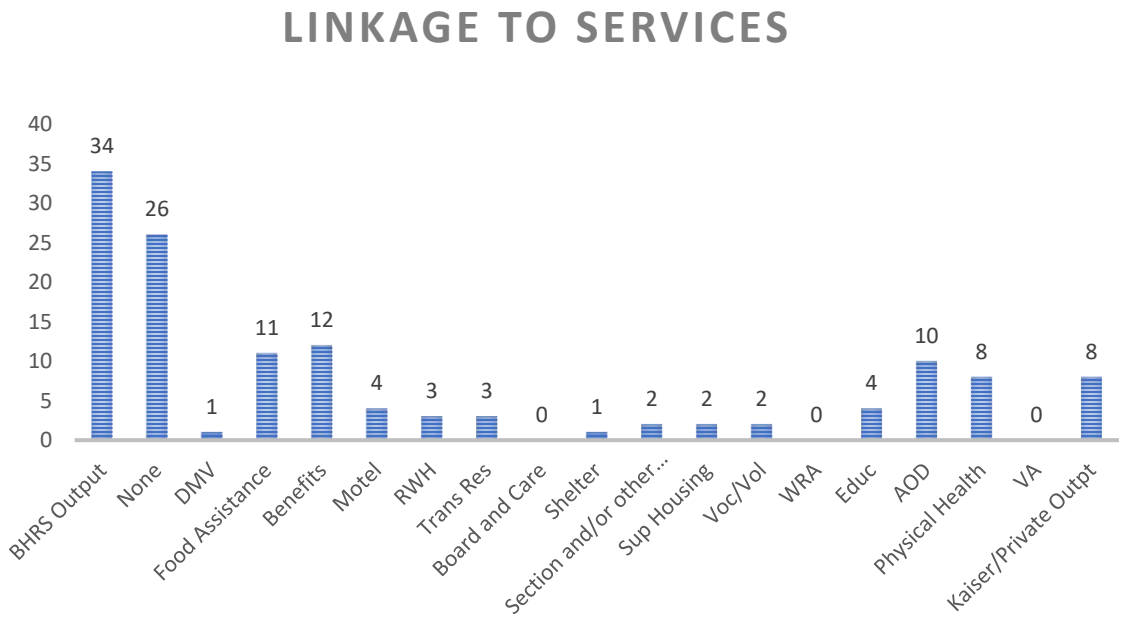
MATEO LODGE: FAMILY ASSERTIVE SUPPORT TEAM (FAST)

MHSA funding for pre-crisis response began in May 2013. Mateo Lodge was contracted to provide in-home outreach services that offer engagement, assessment, crisis intervention, case management and support services to individuals, family and caretakers. FAST provides early intervention and assessment and works with the family over a 2-3-month period. Services include behavioral health and community resource education, linkages to outpatient mental health care and rehabilitation and recovery services, and short-term counseling, support, and case management. The FAST team consists of clinical case managers, peer and family partners, and a psychiatrist.

PROGRAM IMPACT

Clients are given a score based on their LOCUS (Level of Care Utilization System) on a scale from 1-4. This tool is used to help determine the resource intensity needs of individuals who receive adult mental health services. A low LOCUS score means a lower level of care while a high score means a higher level of care. The following represents the level of resource intensity of the total clients served:



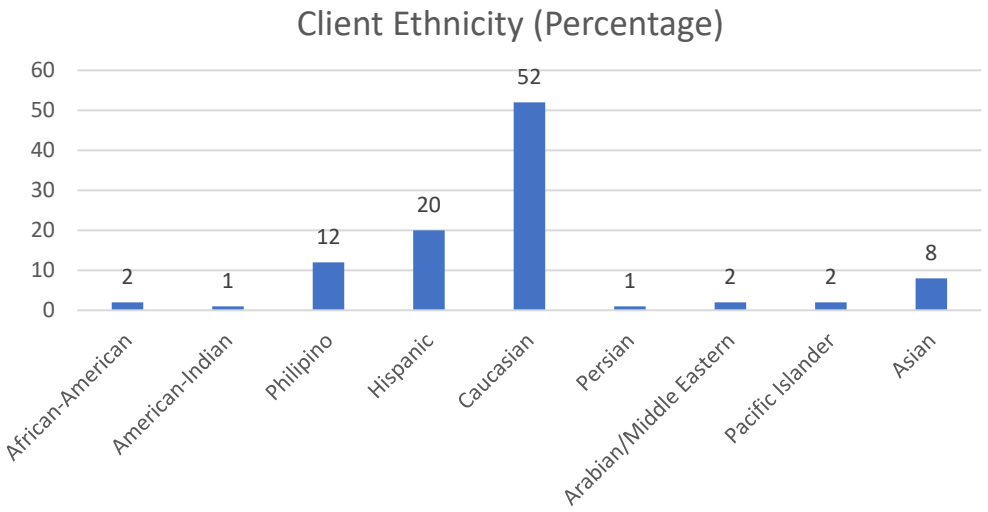


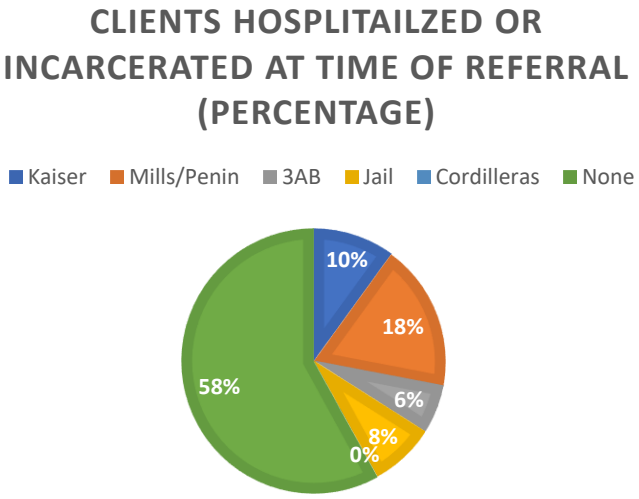
SUCCESSES/CHALLENGES

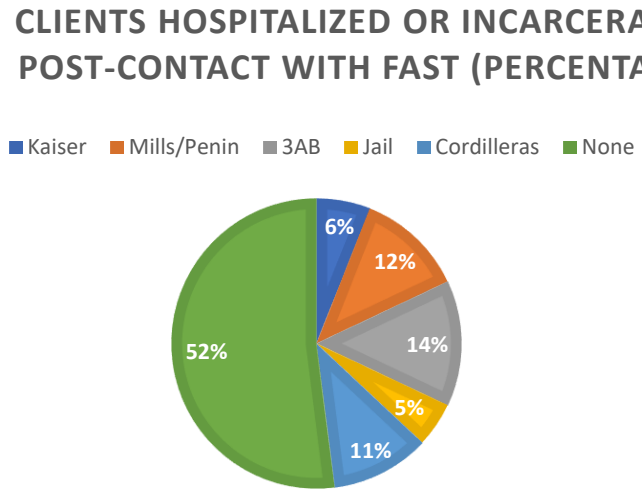
Due to the level of impairment of the clients referred, it has been challenging to make connection with the client when they do not show for their appointments. There are clients who are homeless, with no social support, who unless they contact the clinic or are in hospital or jail, could not be contacted. The Case Manager makes every attempt to meet clients in the community to ensure they have the basic needs of food, access to mental health services/primary care, and to further support their housing needs. Engagement strategies used are home visits, use of natural family support, and case conference with outpatient community partners, hospital, and jail.

DEMOGRAPHICS

Total Clients Served			
78			
Male	50 (64%)	Female	28 (36%)
Age			
18-30		37%	
31-45		33%	
46+		30%	
Cost per client			
$4,932			


Client Ethnicity (Percentage)
60
50
40
30
20
10
0
2
1
12
20
52
1
2
2
8
African-American
American-Indian
Philipino
Hispanic
Caucasian
Persian
Arabian/Middle Eastern
Pacific Islander
Asian


CLIENTS HOSPLITAILZED OR INCARCERATED AT TIME OF REFERRAL (PERCENTAGE)
Kaiser
Mills/Penin
3AB
Jail
Cordilleras
None
10%
18%
6%
8%
0%
58%


CLIENTS HOSPITALIZED OR INCARCERATED POST-CONTACT WITH FAST (PERCENTAGE)
Kaiser
Mills/Penin
3AB
Jail
Cordilleras
None
6%
12%
14%
5%
11%
52%

COMMUNITY OUTREACH COLLABORATIVES

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

During FY 2016-2017, SMC BHRS providers reported a total of 5,460 attendees at all outreach events. Of these, 602 attendees were reached through individual outreach events and 4,858 attendees were reached across 77 group outreach events. Each individual outreach event occurs with a single attendee. Group outreach events include multiple attendees. An attendee is not necessarily a unique individual because a person may have been a part of multiple individual or group outreach events. See Appendix 6 for the full report and evaluation of the Outreach Collaborative strategy.

NORTH COUNTY OUTREACH COLLABORATIVE (NCOC)

North County Outreach Collaborative outreach is conducted by Asian American Recovery Services (AARS), Daly City Peninsula Partnership Collaborative (DCP), Daly City Youth Health Center (DCYHC), Pacifica Collaborative, and Pyramid Alternatives. The goals of NCOC include: 1) establishing strong collaborations with culturally/ linguistically diverse community members; 2) referring 325 clients to BHRS for mental health and substance abuse services; 3) establishing strong linkages between community and BHRS.

PROGRAM IMPACT

NCOC partners are actively involved in the BHRS Health Equity Initiatives: PRIDE, Chinese Health Initiative, Spirituality Initiative, Pacific Islander Initiative, and the Filipino Mental Health Initiative. Through the partnership of this work, there are now sub committees formed to address specific needs such a LQBTQQ Filipino subcommittee, and a LGBTQQ North County subcommittee group, both addressing the needs of those specific groups. The Community Outreach Team (COT) also worked with the Spirituality Initiative and the Daly City Partnership to work directly with a few pastors in both Pacifica and Daly City and have discussions on ways to share information and resources.

Outreach Numbers

Provider Organization	2014-2015	2015-16	**2016-2017**
Asian American Recovery Services	1,221	1,652	**1,124**
Daly City Peninsula Partnership	127	201	**0**
Daly City Youth Health Center	118	499	**926**
Pacifica Collaborative	2,121	2,092	**2,750**
Pyramid Alternatives	802	300	**37**
Total (~3% of population)	*4,389*	*4,744*	***4,834***

RECOMMOMENDATIONS

Based on the FY 2016-2017 data NCOC and EPAMHO will focus on enhancing outreach and improving data collection in the coming years. To enhance outreach, it is suggested that SMC BHRS work with providers to:

- Continue efforts to tailor or increase outreach efforts for specific demographic groups, such as older adults and Latino/Hispanic persons from Central America.
- Consider how to best address the needs of individuals who report being uninsured or do not report their insurance status.
- Focus on increasing housing related resources and referrals

To improve data collection, it is suggested that SMC BHRS work with providers to:

- Make other/unspecified categories more clear.
- Treat race/ethnicity as mutually exclusive categories.
- Continue gathering the new demographic information that has been collected this year.

DEMOGRAPHICS FOR NORTH COUNTY OUTREACH COLLABORATIVE (NCOC)

Race/ Ethnicity

	2014-2015	2015-2016	**2016-2017**
White	335 (10%)	1052 (32%)	**2027 (35%)**
Filipino	577 (17%)	678 (14%)	**500 (9%)**
Chinese	192 (6%)	246 (5%)	**210 (4%)**
Latino	418 (12%)	353 (7%)	**1,263 (22%)**
Mexican	144	260	**1,181**
Other Latino	274	93	**82**
Pacific Islander	603 (18%)	659 (14%)	**444 (8%)**
Tongan	183	237	**143**
Samoan	353	343	**243**
Other Pacific Islander	67	79	**58**
Black	172 (5%)	153 (3%)	**138 (2%)**

FY 2016-17 Individual Race/Ethnicity by Organization

- AARS – 16% Samoan, 14% Tongan, 9% Mexican, 8% White
- DCYHC – 17% South Asian, 17% Tongan, 33% unknown
- Pacifica Collaborative – 86% White, 7% Black
- Pyramid Alternatives – 70% Chinese, 11% Filipino, 11%White

Referrals

	2015-2016	**2016-2017**
Mental Health	45%	**52%**
Substance Abuse	14%	**14%**
Social Services	483 Legal 22% Financial 17% Other 32%	**393** **Legal 28%** **Financial 13%** **Other 30%**

Special Populations

	2015-2016	**2016-2017**
At-Risk Homelessness	49%	**46%**
Homeless	9%	**17%**
Veterans	16%	**8%**

Cost per client
$43

EAST PALO ALTO PARTNERSHIP FOR MENTAL HEALTH OUTREACH (EPAPMHO)

Outreach and linkage services to gain access to Medi-Cal, other public health services, behavioral health, and other services is conducted by a partnership with El Concilio of San Mateo County, Free at Last, the Multicultural Counseling and Education Services of the Bay Area (MCESBA) and One East Palo Alto. EPA PMHO is committed to bridging the mental health divide through advocacy, systems change, resident engagement and expansion of local resources leading to increased resident awareness and access to culturally and linguistically appropriate services. EPAPMHO provides the following services including:

- Technical assistance to BHRS initiatives to increase community education activities and integration of mental health services with other community organizations.
- Community Outreach and Access (marketing and publicity, including translation).
- Promote increased East Palo Alto resident participation in County-wide mental health functions and decision-making processes.
- Sustain and strengthen education materials for and conduct outreach to residents regarding mental health education and awareness.

PROGRAM IMPACT

At the November 8th EPAPMHO meeting, the AIR FY 2016-17 data outcomes and the decreased outreach numbers overall were reviewed. The partnership members brought up the following topics as potential impacts to their outreach data.

1. Impact of Gentrification on East Palo Alto demographics -Between 2011 and 2015, rents increased 130% in East Palo Alto and this community continues to have the highest percentage of people living in one household, lowest incomes and largest percentage of households below poverty.
2. Impact of Drug MediCal on Outreach Cases
3. Impact of Immigration Policies/Fear of Deportation on outreach numbers
4. Tracking of Referrals to Ravenswood

Race/Ethnicity in East Palo Alto	Census 2000	Census 2010	**Census 2016***
Hispanic (any race)	58.8%	64.5%	**63.5%**
White	27%	28.8%	**38%**
African American	23%	16.7%	**12.4%**
Pacific Islander	7.6%	7.5%	**9.9%**

*American Community Survey 5_Year Estimates

Outreach Numbers

Provider Organization	2014-2015	2015-16	**2016-2017**
El Concilio	107	53	**96**
Free at Last	297	373	**212**
MCESBA	543	386	**315**
Total (% of population)	947 (3.2%)	812 (2.9%)	**623 (2.1%)**

DEMOGRAPHICS

Race/Ethnicity

	2014-2015	2015-2016	**2016-2017**
Black	131 (14%)	205 (25%)	**143 (23%)**
Latino	195 (20%)	201 (24%)	**91 (15%)**
Mexican	44	196	**82**
Other Latino	150	5	**9**
Pacific Islander	394(40%)	232 (28%)	**166 (26%)**
Tongan	283	121	**119**
Samoan	106	90	**43**
Other Pacific Islander	5	21	**4**
White	39 (4%)	82(10%)	**41 (7%)**

FY 2016-17 Individual Race/Ethnicity by Organization

- El Concilio – 29% Mexican, 15% Black, 9% White
- Free at Last – 51% Black, 22% Mexican, 10% White
- MCESBA – 47% Tongan, 16% Samoan, 8% Black

Referrals

	2014-2015	2015-2016	**2016-2017**
Mental Health	18% (80)	26% (200)	**14% (63)**
Substance Abuse	45% (202)	30% (229)	**25% (114)**

Social Services		1,416	**704**
Medical Care		26%	**20%**
Housing		23%	**32%**
Food		16%	**16%**

Special Populations

	2015-2016	**2016-2017**
At-Risk Homelessness	35%	**33%**
Homeless	45%	**30%**
Veterans	5%	**9%**

Referral Tracking

	2015-16 (N=137)	2016-2017 (N=101)
Ravenswood	32	44
EPA Clinic	19	16
Other*	86	48

Cost per client
$240

PRIMARY CARE-BASED EFFORTS

RAVENSWOOD FAMILY HEALTH CENTER

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

The intent of the collaboration with Ravenswood FHC is to identify patients presenting for healthcare services that have significant needs for mental health services. Many of the diverse populations that are now un-served will more likely appear in a general healthcare setting. Therefore, Ravenswood FHC provides a means of identification of and referral for the

underserved residents of East Palo Alto with SMI and SED to primary care based mental health treatment or to specialty mental health.

Unduplicated Total Clients Served
538

Cost per client
$31.50

PREVENTION & EARLY INTERVENTION (PEI)

PREVENTION AND EARLY INTERVENTION (PEI)

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

- **Early Intervention** programs provide treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence. Services shall not exceed eighteen months, unless the individual receiving the service is identified as experiencing first onset of a serious mental illness or emotional disturbance with psychotic features, in which case early intervention services shall not exceed four years.

- **Prevention** programs reduce risk factors for developing a potentially serious mental illness and build protective factors for individuals whose risk of developing a serious mental illness is greater than average and, as applicable, their parents, caregivers, and other family members. Services may include relapse prevention and universal strategies.

- **Outreach for Recognition of Early Signs of Mental Illness** to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.

- **Access and Linkage to Treatment** are activities to connect individuals with severe mental illness as early in the onset of these conditions as practicable, to medically necessary care and treatment, including, but not limited to, care provided by county mental health programs.

- **Stigma and Discrimination Reduction** activities reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or seeking mental health services.

- **Suicide Prevention** programs are not a required service category. Activities prevent suicide but do not focus on or have intended outcomes for specific individuals at risk of or with serious mental illness.

PEI AGES 0-25

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

STARVISTA: EARLY CHILDHOOD COMMUNITY TEAM (ECCT)

ECCT employs both prevention (60%) and early intervention (40%) strategies. ECCT incorporates several major components that build on current models in the community, in order to support healthy social emotional development of young children. The ECCT comprises a community outreach worker, an early childhood mental health consultant, and a licensed clinician and targets a specific geographic community within San Mateo County, in order to build close networking relationships with local community partners and support families.

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

The ECCT focuses services on the Coastside community - a low-income, rural, coastal community geographically isolated community - comprised of Half Moon Bay, La Honda, Pescadero, Moss Beach, Montara and the unincorporated coastal communities of El Granada, Miramar and Princeton-By-The-Sea. While comprised of very small cities and unincorporated areas located significant distances from one another, collectively Coastside comprises 60% of the total area of the entire County while having a small fraction of the population. To better serve this disperse community, ECCT has built strong relationships with key community partners and successfully refers families to the local school district, other StarVista services, Coastside Mental Health clinic and Pre-to-Three Program, among others. Additionally, ECCT works with these partners to address gaps and needs in the community and to address the existing system of care for families with young children living in the Coastside areas.

PROGRAM IMPACT

In completing its sixth year of the project, the Early Childhood Community Team (ECCT) continues to be a significant resource in the Half Moon Bay community for families and children under 5 years old. They continue to benefit from being able to use hours from the ECCT Pescadero clinician to service more families in Half Mon Bay. In addition to serving more

families, the ECCT Half Moon Bay team is also developing workshops for teen mothers at Pilarcitos High School. Additionally, the ECCT team has brought workshops to families with young children at the Half Moon Bay library, resulting in 36 (unduplicated) families receiving support from the program. ECCT Half Moon Bay also collaborated with Watch Me Grow to bring workshops focused on early development to 46 participants located in Moonridge. The Parent Child Activity Groups expanded to a local church, allowing ECCT to bring their valuable resources to families that are not able to reach their groups at Hatch Elementary. Finally, ECCT continues to provide drop in services to families that need support.

As a result of on-going mental health consultation, teachers at 4 childcare programs are reporting greater ability to understand and respond to the social-emotional needs of children in their centers. The results from our annual survey of teachers (further discussed with regards to satisfaction below show:

Respondents Reported that:

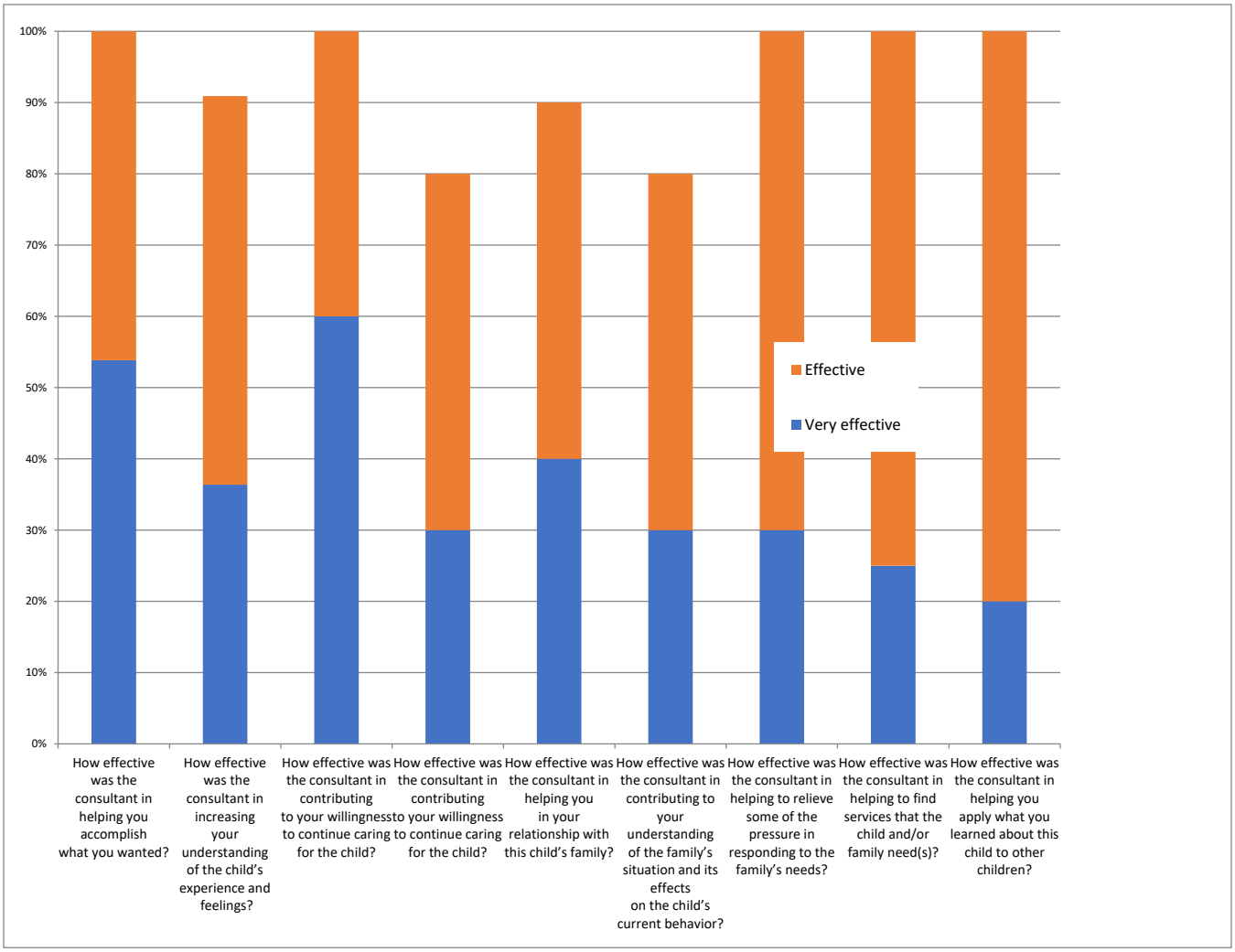
Consultation was very effective or effective in **helping them think about children's development and behavior**	93%
Consultation contributed to their **willingness to continue caring for a challenging child**	100%
Consultation was very effective or effective in **contributing to their ability to handle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

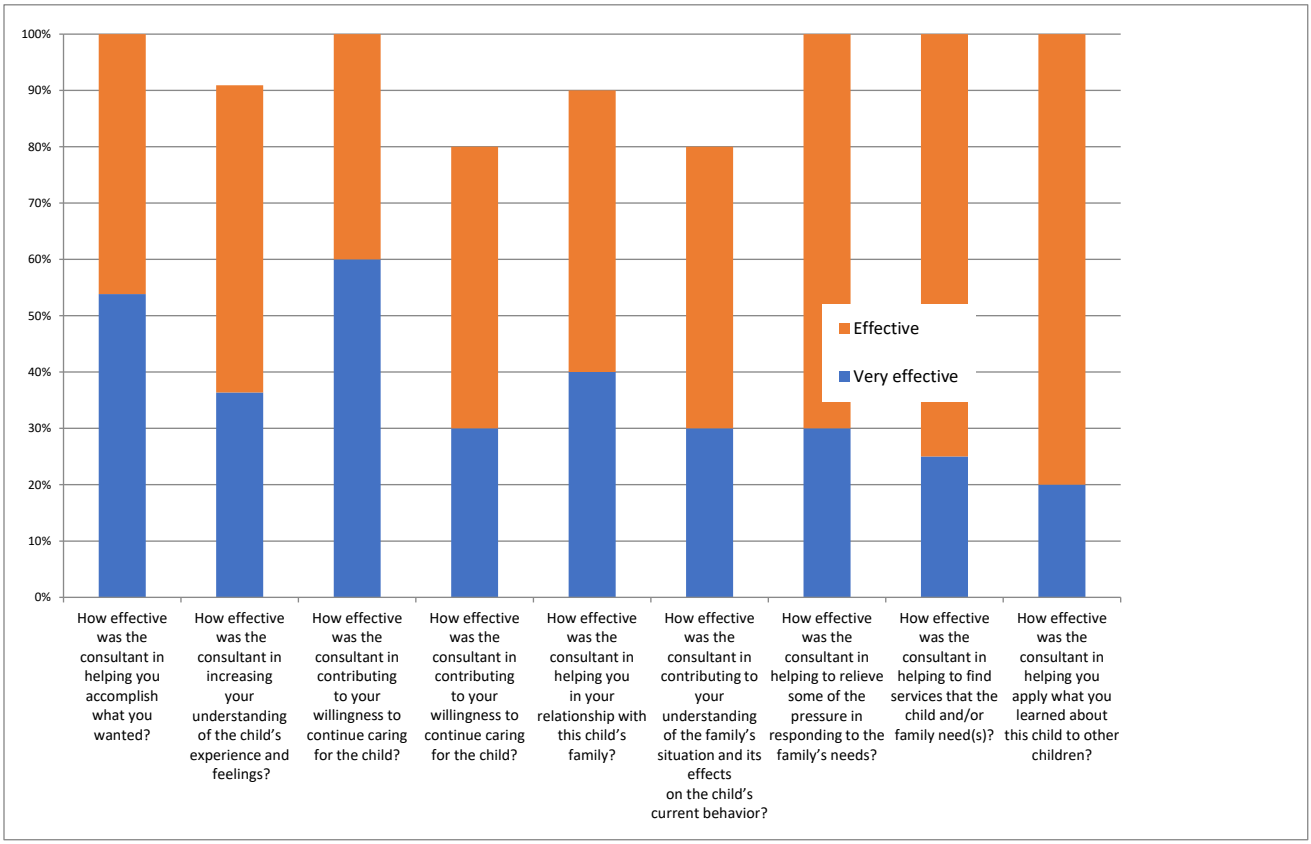
Moreover, though teachers reported struggling with several children throughout the year due to challenging behaviors in their classrooms, mental health consultation was supportive in retaining these children in their programs. In the past year, no children were expelled from their early care and education programs.

Program Satisfaction Surveys

The results from our annual provider satisfaction survey indicate overwhelmingly a continued satisfaction with the mental health consultation service. 100% of respondents rated the mental health consultation services as "Excellent" or "good" and 100% reported they would recommend mental health consultation services to someone in a similar situation or experiencing similar concerns.

The following charts further illustrate the results from this survey.





SUCCESSES

Increased capacity

As a result of mental health consultation services, 6 families increased their capacity to understand their child's behaviors and to respond effectively to their social-emotional needs. These changes have been observed through informal conversations with parents over the course of their work with the consultant. Parents and teachers also informally noted differences in children's behaviors: progress towards achieving goals formed at the beginning of case consultation was evidenced in 4 of the 6 more intensive consultation cases. Additionally, 12 families have received "light touch" services including parent education or referrals to additional services in the community.

ECCT has seen significant reductions in aggressive/defiant behaviors. They report is being a rewarding experience to bring teachers and administrators together to think more carefully and thoroughly about how to support children and respond to their needs and challenges. In one case in particular, a mother appeared much more engaged, speaking to teachers more often, spending more time at school, expressing a wider range of affect and showing greater involvement with her child.

Improved assessment approach

ECCT transitioned to completing a "Mid" assessment to capture data during the middle of the treatment and address the challenge of collecting data the previous year. This new assessment allows ECCT to assess how the client is progressing in treatment without having to wait until a family completes services. This new approach resulted in being able to capture data for 9 clients that have not yet completed services but have been in treatment for six months. In total of the 26 families receiving mental health services 9 reported an improvement in multiple areas related to their child's development and/or behavior. The remaining 17 families have completed a pre-assessment.

Increased outreach

As a result of increased outreach, the waitlist has continued to expand. In an effort to address the growing waitlist ECCT will attempt to recruit MFT trainees for the upcoming year.

CHALLENGES

Fewer satisfaction surveys

ECCT continues to struggle to have parents return consultation satisfaction surveys and is exploring other ways to receive formal feedback from parents.

Less time for teachers to collaborate with mental health clinicians

ECMH Consultants have continued to build relationships successful with staff at the four childcare programs however, they have identified an ongoing trend of teachers' having less time. Increased pressures from new measures and other initiatives may make teachers less available for thinking deeply about the roots of children's more complex behaviors, and an explicit wish to avoid expulsions may lead to increased rates of suspensions.

Limitations in seeking additional services for families

Extended waitlist, limitations to insurance coverage or school district support and parent's lacking their own health insurance limits services for families.

In spite of these challenges, and with the help of funding following an NMT evaluation, an ECMH consultant and the ECCT community worker were able to successfully support one client in accessing much needed occupational and speech therapy services. Reports from the child's mother indicate that the child is making great progress in both therapies and she is better able to understand his needs as well.

Political climate as a barrier

ECCT serves a high percentage of families who are immigrants or who have closely related family members who have recently immigrated. The current political climate acts as a barrier to parent's openness to participating in mental health services or being "tracked" in formal systems. It also has taken a toll on the staff and administrations of the systems to which ECCT consults. ECCT has noticed heightened uncertainty around continued funding and questions about sustainability of various programs.

ECCT is grateful for the ways that MHSA funding allows them to engage families who may be less inclined to pursue support through more formal systems such as clinics or services requiring insurance.

DEMOGRAPHICS

Total Clients Served			
32			
Male	13	Female	19
Race/Ethnicity			
Hispanic/Latino		88%	
Caucasian/White		3%	
African-American/Black		3%	
Multi-Ethnic		3%	
Other		3%	
Age			
0-15		100%	
Language			
Spanish 87.5%		English 12.5%	
Cost per client			
$12,784			

PROJECT SUCCESS

Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students) is an early intervention research-based program. Initiated in 2013, Puente de la Costa Sur delivers Project SUCCESS services at three San Mateo South Coast schools: La Honda Elementary, Pescadero Middle School and Pescadero High School, and in 2014-15, Puente added a fourth site, Pescadero Elementary School. Project SUCCESS groups introduces coping skills,

communication, decision-making and other social skills. The SUCCESS groups and the school-wide presentations also serve as a point-of-entry to individual counseling services available at all four schools. Groups are designed to meet once per week for 8 weeks with the exception of the high school group which has met consistently once per week since being launched in Sept 2013. In coordination with San Mateo County Health System Puente has adopted the Search Institutes Developmental Assets Profile (DAP) as a measurement tool. The DAP incorporates the Search Institutes 40 developmental assets framework when addressing the needs of young people in the community.

PROGRAM IMPACT

Project SUCCESS is designed for use with youth ages 9-18 and includes parents as collaborative partners in prevention through parent education programs. Project SUCCESS allows Puente's staff to have access to 100% of the students in our school district, ages 9-18. There is no barrier to access -- every student, family member, and school staff member has complete access to consultation, a direct referral to therapy, and case management for AOD or other services. All clinicians are culturally competent, bilingual, and trained in diversity and equity. Project SUCCESS serves San Mateo County's most underserved population. The team provides the same access to care free of charge to all members of our service area.

Overall, the statistics show that those students who participate in Project SUCCESS workshops show an increase in external and internal assets. Areas of relative strength are the categories of Support and Boundaries, and Expectations. Areas that are not strong are Positive Identity and the Constructive Use of Time. The area of Positive Identity is something that Puente's BHRS team focuses on. The team has developed some new tools to use, in particular, trauma focused interventions that involve Art Therapy, recreation, and movement-based activities.

SUCCESSES

The Puente BHRS team is proud of its ability to provide prevention and early intervention services through Project SUCCESS to all students, ages 9-18, and their families. The team has adapted the program to fit the needs of the community by tailoring their workshops and groups to meet the needs of their participants. Our region has some of the highest levels of generational trauma, and our families are some of the poorest in San Mateo County. There is no public transportation and so our families without vehicles are isolated. Many live in substandard housing and many share their housing with one or more families. The families served through this program struggle with domestic violence, sexual abuse, family drug and alcohol abuse, and for many of the migrant families who are monolingual Spanish, their children learn English and are then expected to take on enormous amounts of responsibility. Access through Project SUCCESS and other Puente programs allows families to have free

unrestricted access to tools like mental health services, case management and referrals for physical health, and parent education, in their own communities. Puente's ability to provide wraparound support is unique. Their commitment to free access and early intervention for all members of the community reduces stigma and decreases resistance to care.

CHALLENGES

Project SUCCESS requires a large time commitment to training for both the staff that is implementing it and the school district staff that will be supporting it. The curriculum is very detailed and maintaining fidelity to the model can be very difficult with certain groups. The pre and post testing is arduous especially for our region where there is limited access to the internet. Project SUCCESS has adapted by using the paper version of the DAP which then requires Puente staff time to input into the Search Institutes database. The screening requirements for entry into the different groups: users, non-users, COSAP etc. are prohibitive for the region. The school population is 330-360 students each year, to maintain fidelity and have an adequate number of students for each cohort, Puente and the La Honda Pescadero Unified School District decided to put all youth ages 9-18 through at least one 8-week workshop. It was difficult in the middle school to maintain program fidelity. Additionally, outreach for parenting groups has been difficult.

DEMOGRAPHICS

Project SUCCESS uses the Developmental Assets Profile from the Search Institute to collect demographic information and assess the strengths and supports in the lives of Puente Resource Center Youths' lives. The report breaks down the 131 youth that were serviced and surveyed during FY 16-17. Below are some of the key results.

Youth Served

	Number Served
Total Sample	131
Gender	
Female Male	84 45
Grade	
4	0
5	24
6	0
7	1
8	27
9	14
10	23
11	15
12	13

Race/ Ethnicity	Number Served & Surveyed
African American or Black	0
American Indian or Alaskan	0
Asian	0
Hispanic or Latino/Latina	99
Hawaiian or Pacific Islander	0
White	23
Multiracial	0

Cost per client
$2,090

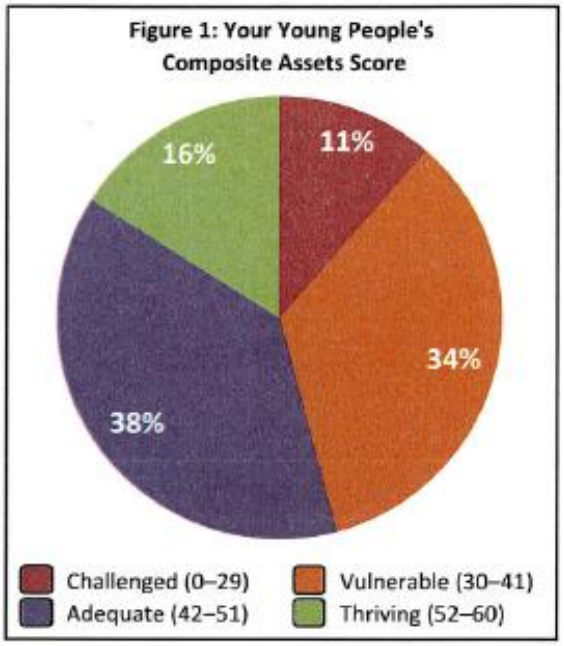


Figure 1: Your Young People's Composite Assets Score
11%
34%
38%
16%
Challenged (0–29)
Vulnerable (30–41)
Adequate (42–51)
Thriving (52–60)

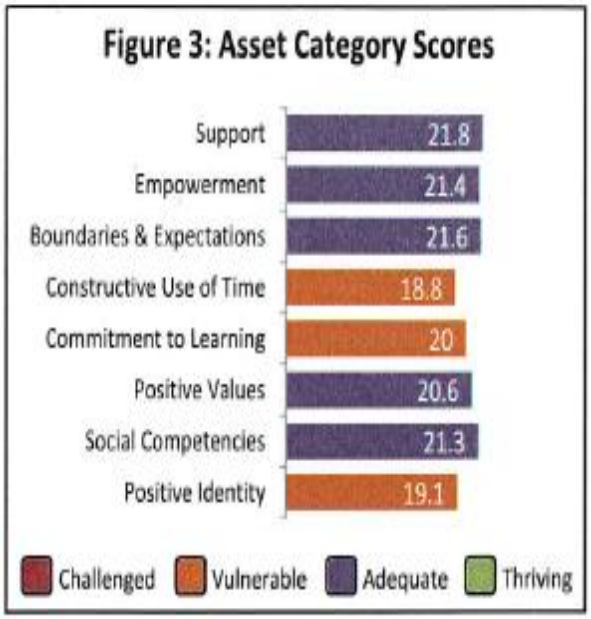
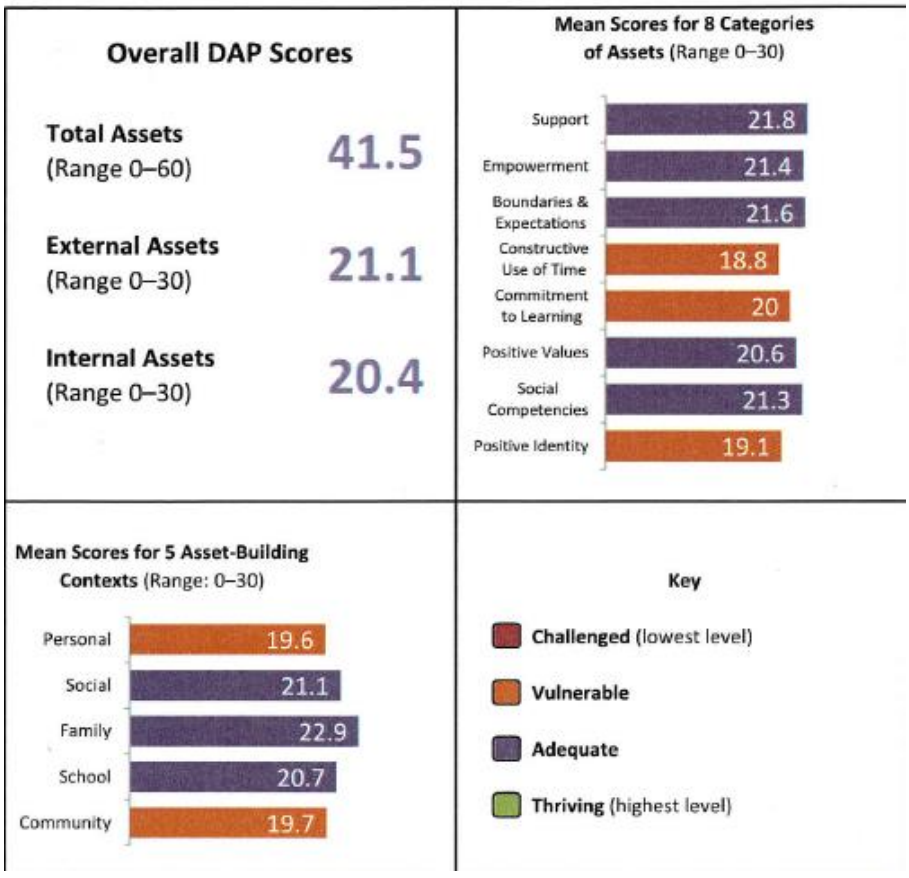


Figure 3: Asset Category Scores
Support 21.8
Empowerment 21.4
Boundaries & Expectations 21.6
Constructive Use of Time 18.8
Commitment to Learning 20
Positive Values 20.6
Social Competencies 21.3
Positive Identity 19.1
Challenged
Vulnerable
Adequate
Thriving


Overall DAP Scores
Total Assets (Range 0–60) 41.5
External Assets (Range 0–30) 21.1
Internal Assets (Range 0–30) 20.4
Mean Scores for 8 Categories of Assets (Range 0–30)
Support 21.8
Empowerment 21.4
Boundaries & Expectations 21.6
Constructive Use of Time 18.8
Commitment to Learning 20
Positive Values 20.6
Social Competencies 21.3
Positive Identity 19.1
Mean Scores for 5 Asset-Building Contexts (Range: 0–30)
Personal 19.6
Social 21.1
Family 22.9
School 20.7
Community 19.7
Key
Challenged (lowest level)
Vulnerable
Adequate
Thriving (highest level)

TEACHING PRO-SOCIAL SKILLS (TPS)

The Teaching Pro Social Skills (TPS) Program continued in the San Mateo County Human Services Agency Family Resource Centers for the 2016-17 fiscal year. The overall goal of TPS is for students to decrease negative behaviors by learning pro-social skills that enable them to more effectively get along with their peers, regulate their emotions, and make better choices. The groups were facilitated by the full time Community Worker (CW) and co-facilitated by Psychiatric Social Workers (PSWs) at various Human Service Agency (HSA) Family Resource Center (FRC) sites. As documented in the outcomes section of this report, there were several positive impacts of the program on the participating youth as well as overall program improvements. The noted improvements included increased communication with both the teachers and parents and increased frequency of the TPS homework by completed. There was also an increase in the TPS scores which indicated improvements in pro-social skills and behavior in areas such as friendship-making skills, aggression alternatives, and coping with their feelings.

PROGRAM IMPACT

There appeared to be significant improvements in the pro-social behaviors of the majority of TPS participants. In comparison to the previous 2015-2016 school year, there was more teacher and parent involvement. For the 2016-2017 TPS program, parents received information about the group on a regular basis. There were also phone calls made to the parents prior to the group starting which gave them an opportunity to ask the facilitator questions about the TPS program. The parents were more involved in practicing the skill with their child at home and provided feedback about how well the child applied their skill at home.

During the fiscal year 2016-2017, from October 2016 to June 2017, two 7 to ten week sessions have taken place in 8 Family resource centers. There were 17 total groups facilitated throughout the year. The groups consisted of:

FRC Location	Number of Groups Facilitated	Total Clients Served	Grade Level of Participants
Bayshore	2	13	1st & 2nd
Belle Haven	3	20	K & 1st
Taft	1	4	4th
Hoover	3	14	K, 3rd&4th
LEAD	3	19	
Sunset Ridge	2	13	
Fair Oaks	1	4	5th
Brentwood	2	9	3rd & 4th

Overall there was significant positive behavior change in the TPS participants as evidenced by the individual and overall improvement in scores.

Additionally, more teachers were aware of the TPS program because of the success of the TPS program during the previous school year, which likely contributed to an increase in the student referrals. This year there was also more consistent communication amongst the facilitators, teachers, school staff and parents. Finally, positive behavior changes, such as friendship-making skills, aggression alternatives, and coping with their feelings were observed by the lead TPS CW facilitator and PSWs.

SUCCESSES/CHALLENGES

The teachers have always been involved with the TPS groups because they are the ones that refer the students to the program. A few teachers asked to be sent a weekly email about the skill the students should be practicing so that they could help the student to apply the skill in the classroom and monitor the student's progress. Teachers also consulted with the CW and PSW facilitators about their students' behaviors and shared information that was impacting their students at home or in the classroom.

The number of students in each group appeared to have significant impact on the overall success of the TPS group. If there are fewer than 4 students, each student received less practice in observing and giving feedback to their peers. When a group had more than 6 participants, it was difficult to manage the behaviors and it was extremely difficult to have everyone participate in the role plays.

DEMOGRAHPICS

RACE/ETHNICITY	AFRICAN AMERICAN	PACIFIC ISLANDER	LATINO	NATIVE AMERICAN	MULTI-ETHNIC	OTHER	TOTAL
# OF CLIENTS	12	11	58	0	1	3	**96**
% OF CLIENTS	13.00%	12.00%	60.00%	0%	1%	3.00%	100%

LANGUAGE	ENGLISH	SPANISH	CHINESE	TAGALOG	SAMOAN	OTHER	TOTAL
# OF CLIENTS	41	51	0	0	0	4	96
% OF CLIENTS	43%	53%	0%	0%	0%	4%	100%

	LGTBQ	HOMELESS	AT-RISK OF HOMELESSNESS	VISION IMPAIRED	HEARING IMPAIRED	VETERANS	DISABILITY
# OF CLIENTS	*unknown*	1	4	*unknown*	1	0	8
% OF CLIENTS	*unknown*	1%	4.20%	*unknown*	1%	0	8.30%

Cost per client
$2083

STARVISTA: CRISIS HOTLINE – YOUTH OUTREACH AND INTERVENTION TEAM

The Crisis Hotline and Youth Outreach and Intervention Team employ both early intervention (70%) and prevention (30%) strategies for school age youth experiencing a mental health crisis. StarVista provides a free, confidential 24-hour, seven days a week crisis intervention hotline. Trained volunteers and staff provide referrals for community resources and services for anyone who feels sad, hopeless, or suicidal; family and friends who are concerned about a loved one; anyone interested in mental health treatment and service referrals; and/or anyone who just needs some support through a personal crisis.

The Youth Outreach Team MHSA-funded mental health clinician provides case management, follow-up phone consultation, youth outreach intervention in schools, clinical training and supervision, and outreach presentations in suicide prevention.

Case Management	
New Cases/Follow-Up Consultation	132
Total Session Provided	202
Youth Outreach Intervention at School Sites	

Initial Interventions/New Youth Served	91
Follow-Up Sessions	165
Follow-Up Contact with Collateral Contacts	154
Community Outreach Presentations	
Youth & Adults Served	5609
Presentations given	72
School-Community Training in Suicide Prevention (# presentations)	70
Crisis Hotline	
Number of calls	10574

Cost per client
$7.18

EARLY INTERVENTION

FELTON INSTITUTE: PREVENTION AND RECOVERY IN EARLY PSYCHOSIS (PREP)

The target age group for PREP is 70% youth ages 0-25. PREP braids together five evidence-based practices into one integrated treatment approach and uses community education and outreach to facilitate early identification of individuals at risk of psychosis. Felton Institute's (formerly Family Service Agency) PREP program identifies and intervenes with transition age youth (14-25 years) experiencing a recent onset episode of psychosis and their families. The PREP Program provides evidence-based treatment and support for youth and families through an intensive outpatient model of care that includes the provision of: algorithm-based medication management, cognitive behavioral therapy for psychosis (CBTp), individual placement and support (IPS), assertive outreach, multi-family groups, cognitive remediation, and strength-based care management services. PREP is administered by Felton Institute.

PROGRAM IMPACT

Hospitalizations Reduction:

There were 34 participants Enrolled in PREP for at least 12 months in FY16/17. Compared to 12 months prior to their admission, 20 (59%) of these participants experienced a reduction in acute hospitalization episodes and 20 (59%) experienced a reduction in days hospitalized.

Medication Adherence Increase:

71% of participants either improved or maintained good medication adherence with an ANSA score of 1 or better.

Satisfactory Vocational and Educational Engagement:

96% participants treated showed satisfactory participation with education while engaged in PREP services. Additionally, 23 (44%) of these 52 participants were also engaged in either part-time or full-time employment.

Service Satisfaction:

The results of the November semi-annual California Department of Health Care Services Consumer Perception Survey were used to judge service satisfaction and quality of life (results for the survey collected in May have not yet been reported).

Of the 11 PREP participants who completed this survey, 11(100%) agreed or strongly agreed that they found PREP services to be satisfactory.
9 (81%) out of the 11 respondents agreed or strongly agreed that as a direct result of the services they received they feel more effective at handling daily life.

SUCCESSES/CHALLENGES

	PREP		
	Served	Enrolled	% Enrolled
FY 14/15	105	60	57%
FY 15/16	74	55	74%
FY 16/17	74	62	**84%**

This year, PREP expanded services to include a semi-annual program orientation for incoming participants and families and a semi-annual graduation for outgoing participants and their families. The Orientation provides an opportunity for new participants and their families to meet the entire team, ask questions, and hear from program Alumni about their journey of recovery. While PREP has held graduations in the past, holding regularly scheduled graduations is a recent addition and is a testament to having a well-established census making meaningful steps toward recovery. As a result, PREP/BEAM SM is developing an Alumni network that can be used to advise future programming and to participate in speaking engagements to share hope. During the program's first orientation, three program graduates and one family member attended to share their story with new participants and their families creating a sense of hope during a delicate stage of recovery.

Another important success for PREP/BEAM SM this year has been increased engagement from program participants. A common challenge in working with transitional age youth is disengagement from services, particularly when entering adulthood and having full decision-making authority regarding treatment, and this challenge is just as prevalent in early intervention settings as it is in other community programs. As a result of staff restructuring in the Fall of 2016, PREP/BEAM SM was able to foster a greater sense of shared decision making and create multiple points of contact with program staff that results in greater engagement in program services.

During FY16/17, PREP/BEAM **SM discharged a total of thirty-four enrolled participants.** Seventeen of these participants graduated from services. There was a total of seventeen unplanned discharges; five moved outside of the service area and transitioned to local early psychosis programs as available, four transitioned to BHRS services during program staffing changes, and eight were discharged due to disengagement from services. Of those who disengaged, only two occurred after the staffing restructure. Additionally, four participants who were at risk to disengage did not do so as a result of Peer Staff engaging them.

Changes to the service environment

PREP and BEAM underwent significant staffing changes over the course of the past year. This period of transition also brought with it an opportunity to review and modify the program's service delivery by restructuring two hybrid support positions into three dedicated specialty positions; Employment and Education Specialist, Family Support Specialist, and Peer Support Specialist. The result of this restructure is increased participant engagement in the program and more points of contact with staff to work toward and maintain recovery. The program now runs a weekly Peer Support Group and a weekly Family Support Group that are open to current participants and Alumni of the program.

System of care

PREP/BEAM SM staff participates in regional CSA meetings, SBMH Collaborative meetings, the Contractor's Association, YTAC referral meetings, Health Equity Initiatives, and other outreach opportunities. In doing so, PREP/BEAM SM has maintained an incoming and outgoing referral stream with BHRS and its contract providers. PREP/BEAM SM mutually served participants along with Caminar, Pathways, NAMI, Star Vista, El Centro, SAYAT, the California Clubhouse, Edgewood, school-based services, and BHRS. As a result of these partnerships, many program participants are able to avoid homelessness and relapse while experiencing continued success in school, obtaining gainful employment, and making progress toward sustained recovery.

CHALLENGES

A major challenge faced by PREP/BEAM SM this year was the turnover of multiple staff between July and November. During this time, the program saw five therapists, one nurse practitioner, and the family partner/intake coordinator resign to pursue BHRS, Kaiser, private practice, and retirement. This turnover was a contributor to much of the unplanned discharges from the program during the first and second quarters and also resulted in some participants experiencing worsening symptoms requiring hospitalization. Additionally, while hiring and training new staff the remaining program staff has limited capacity to maintain an active Multi-Family Group (MFG) and to keep pace with referrals. In response to the implementation challenges;

1. A referral waitlist was formed, and an outside contractor was brought in to perform assessments so that remaining program staff could focus on the existing census.
2. The Multi-Family Group (MFG) was postponed. While the bi-weekly groups were not held, weekly Family Support Groups were offered and will continue to be offered concurrently with MFG and program staff actively engaged in other aspects of the MFG model.

Another challenge experienced within this year is modifications in the measures used for collecting data for the measurement of outcomes. Historically, PREP/BEAM SM on a semi-annual basis has used a number of evaluations to inform program outcomes. These measures are accurate and sensitive to incremental changes, but they have also proven to be burdensome for both staff and participants and new measurements are in the process of being initiated.

DEMOGRAPHICS

Total Clients Served	
104	
Race/Ethnicity	
Asian	13%
African-American/Black	9%

Pacific Islander	0%
Hispanic/Latino	27%
Filipino	11%
Native American	0%
White	34%
Multi-Ethnic	4%
Other	2%
Age	
0-15	7%
16-25	82%
26-59	11%
Language	
English	95%
Spanish	3%
Tagalog	1%
Chinese	1%
Underserved Communities	
LGBTQ	16%
Homeless	4%
At-risk of Homelessness	8%
Disability	7%
Vision Impaired	1%
Cost per client	
$5,480	

SAN MATEO COUNTY BHRS: PRIMARY CARE INTERFACE

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

PROGRAM IMPACT

The impact of the Primary Care Interface Medication Assisted Treatment (MAT) continues to be an important component of the team. Over the past fiscal year 620 clients (up from 495 the previous year) were referred for co-occurring case management. Clients are referred directly from PCP and assessed by an Interface IMAT case manager. As a result of providing this service several clients were able to reduce or abstain from use of substances, reconnect with family members, secure housing or employment and reduce symptoms of depression and anxiety.

Additionally, 21 SMI Clients were transferred to BHRS regional clinics over the past fiscal year.

SUCCESS/CHALLENGES

Expanding co-occurring case management to Daly City Youth Health Center (DCYHC) over the past fiscal year represented a change to the service environment. This expansion came as a result of clinic and community needs. Providers now have a co-occurring case manager onsite at DCYHC 1 ½ days per week to facilitate warm hand offs, resources and psychoeducation.

One of the challenges that spilt over from last fiscal year was staffing. Two licensed Spanish speaking clinicians resigned their position. It was a challenge to recruit for these positions due to the language requirement and several other programs looking to fill Spanish speaking positions. As a result, primary care was requested to scale back on non-urgent referrals for several months.

DEMOGRAPHICS

Total Clients Served
2508
Cost per client
$423

SAN MATEO MEDICAL CENTER: MENTAL HEALTH AND REFERRAL TEAM (SMART)

The SMART program began in 2005 with one unit covering the entire county. Due to the program's success and at the request of law enforcement, AMR began staffing SMART with two units in 2015 with additional funding from a variety of sources.

A memorandum of understanding was developed for the SMART team by the San Mateo County Health System and the American Medical Response West in which specially trained paramedic responds to law enforcement Code 2EMS requests for individuals having a behavioral health emergency. The SMART paramedic performs a mental health assessment, places a 5150 hold if needed and transports the client to Psychiatric Emergency Services or, in

consultation with County staff, arranges for appropriate services. Access to SMART is only available through the County's 911 system.

PROGRAM IMPACT

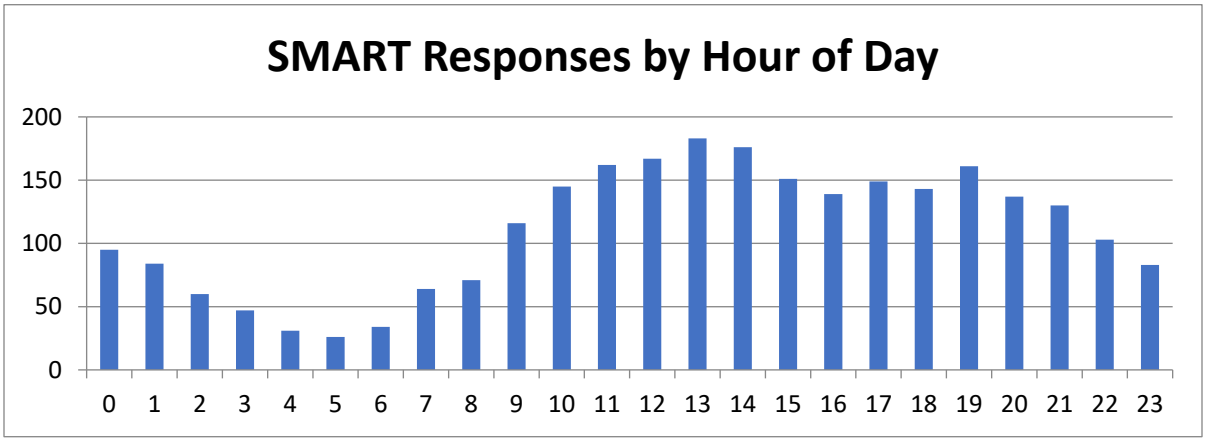
Paramedics in the SMART program, freed from the need to rush patients to a hospital and get back in service as quickly as possible, can interview family members or friends of a patient, contact a patient's therapist and conduct an assessment to determine the best course of action.

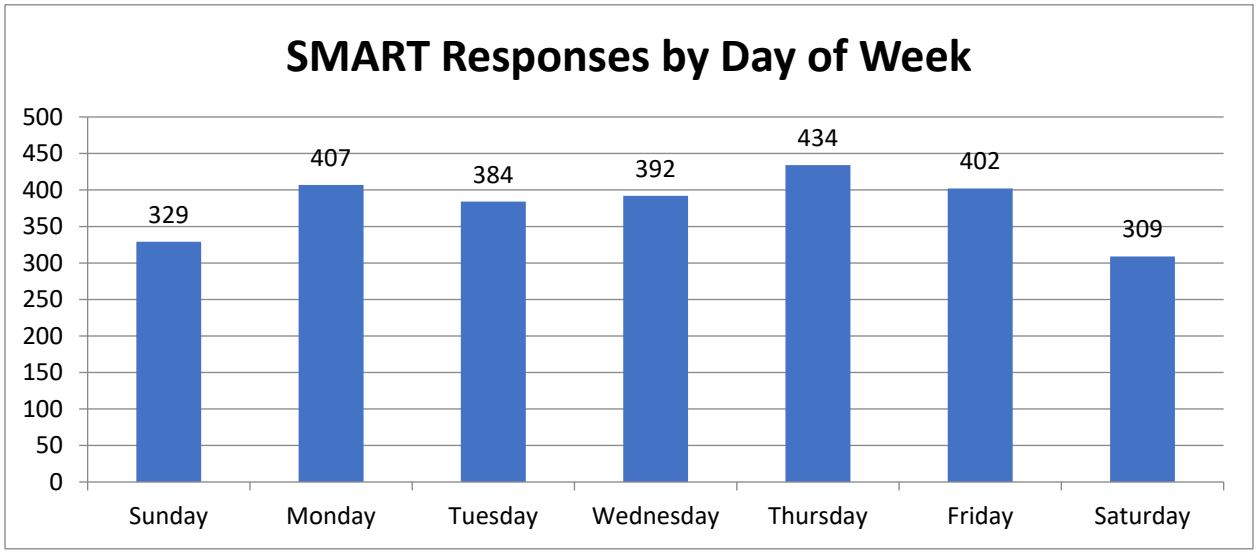
SUCCESS/CHALLENGES

The average response call time decreased from 18 minutes to 16 minutes between 2015 and 2016.

DEMOGRAPHICS

Total Calls Received
2,657
Cost per client
$54.57




SMART Responses by Day of Week
500
450
400
350
300
250
200
150
100
50
0
329
407
384
392
434
402
309
Sunday
Monday
Tuesday
Wednesday
Thursday
Friday
Saturday

PREVENTION

OFFICE OF DIVERSITY AND EQUITY (ODE)

The Mental Health Services Act provided dedicated funding to address cultural competence and access to mental health services for underserved communities; in San Mateo County this led to the formal establishment of the Office of Diversity and Equity (ODE) in 2009. ODE advances health equity in behavioral health outcomes of marginalized communities. Demonstrating a commitment to understanding and addressing how health disparities, health inequities, and stigma impact an individual's ability to access and receive behavioral health and recovery services, ODE works to promote cultural humility and inclusion within the County's behavioral health service system and in partnerships with communities through the following programs:

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

HEALTH EQUITY INITIATIVES (HEI)

The HEI strategy was created to address access and quality of care issues among underserved, unserved, and inappropriately served communities. ODE provides oversight to nine Health Equity Initiatives (HEIs) representing specific ethnic and cultural communities that have been historically underserved: African American Community Initiative; Chinese Health Initiative; Filipino Mental Health Initiative; Latino Collaborative; Native American Initiative; Pacific Islander Initiative; PRIDE Initiative; Spirituality Initiative; and the Diversity and Equity Council. HEIs are comprised of San Mateo BHRS staff, community-based health and social service agencies, clients and their family members, and community members. The HEIs are typically managed by two co-chairs, including BHRS staff and/or a community agency or leader. HEIs implement activities throughout San Mateo County that are intended to:

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

In FY16-17, through presentations, events, and trainings the HEIs reached an estimated 2500 community members.

Cost per participant
$88

DIVERSITY AND EQUITY COUNCIL (DEC)

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

Mission, Vision, & Objectives

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

Highlights & Accomplishments

In FY 16-17 the DEC focused some of their meetings on medication assisted substance use treatment, services available for individuals post incarceration and family involvement for individuals going through the criminal justice system. All of these are issues that disproportionally affect minority groups. This year the DEC began doing a survey to measure effectiveness of their presentations. In September 80% of participants stated that they have learned new information about the issues as a result of their participation. 80% of participants also stated that their knowledge of community resources has increased as a result of the meeting.

The April DEC meeting focused on family involvement as a major factor for individuals going through the criminal justice system. An organization named De-Bug presented on how their support families navigate the system and be advocates. They also addressed barriers for families such as stigma and shame. On a scale of 1-5, with 5 being "Strongly Agree", participants indicated their increase in knowledge regarding De-Bug at 4.5, they also rated their increased understanding of community resources as a result of the HAP-Y presentation at 4.3.

In May, the DEC partnered with the College of San Mateo on its 5th annual May Mental Health Kickoff event. This partnership allowed us to reach a new population, college students. **Over 50**

"Be the One" pledges were completed and students seemed interested in learning about community resources.

And in June, the DEC focused their meeting on receiving feedback and planning for the upcoming year. Consultant Sean Kirckpatrick facilitated a world cafe style meeting where small groups discussed various facets of the work of the DEC. The primary feedback from the groups was the desire to have a clearer link between DEC and BHRS leadership. In addition, CBO reps discussed the need for more support on taking the information back to their agencies in a meaningful way.

AFRICAN-AMERICAN COMMUNITY INITIATIVE (AACI)

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

Mission, Vision, and Objectives

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

Objectives:

Awareness: Increase overall community awareness and involvement of community members in African American Community Initiative

Utilization/Access: Increase knowledge and utilization of mental health services of BHRS among African American community members in San Mateo County.

Education/Training: Act as liaison between African American community and BHRS, assisting in linkage to services such as Black Infant Health and community trainings such as Mental Health First Aid, Photo Voice, and Applied Suicide Prevention.

Employment: To advocate for the staffing of at least one African American clinician or peer-support provider (MFT, LCSW, and other providers) in each Community Service Areas of San Mateo County's Behavioral Health and Recovery Services.

Research: To provide feedback and inform San Mateo County BHRS regarding African American community as result of surveying through the Office of Consumer Affairs, focus groups, and community-based research.

Outreach: Conduct at least one annual community-based event, such as in celebration of Black History Month, Juneteenth, or Kwanzaa to build support of AACI and to reach out to the African American community.

Partnership: Partner with other organizations and health equity initiatives from the Office of Diversity and Equity to support AACI and AA clients and professionals as well as other diverse groups; link and collaborate with other entities that work in various capacities with African American community members.

Highlights & Accomplishments

AACI organized a Health Fair for Black History Month that was held February 25, 2017. The Theme was Mind, Body and Spirit matters. The purpose of the event was to educate and motivate the community around issues concerning their physical, emotional and spiritual health.

This event was held at the East Palo Alto Community Church and attracted **over one-hundred people** consisting of community members, providers and consumers. The community recited verses of the National Black Anthem, as well our Keynote speaker's engagement of the audience in a call and response during her presentation were important strategies to bringing the community together.

One of the highlights of the event was the Black Lives Matter PhotoVoice presentation. Participants shared moving accounts of their experiences and encounters with law enforcement. This shared experience of emotions permeated the audience. Thereafter, a Mindfulness and Compassion practitioner led the audience in a meditation exercise.

There were over 15 organizations that tabled and provided resources at this event. During our AACI committee debriefing, members learned the importance of having events that offer resources and platforms to share life stories in the community and how events should be held throughout the county to reach the broader community. Members observed the positive impact that the resources and PhotoVoice had over the community.

CHINESE HEALTH INITIATIVE (CHI)

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

Mission, Vision, and Objectives

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

Highlights & Accomplishments

Since 2007, the Chinese Health Initiative has worked to ensure that BHRS services are culturally and linguistically appropriate, while also working to increase knowledge and utilization of BHRS services among Chinese community members.

In FY 16-17 the Chinese Health Initiative (CHI) completed a lot of strategic planning that involved updating their mission and articulating the perceived community needs and strategic directions for the upcoming fiscal year. Other accomplishments included supporting implementation of the mental wellness fair for older adults, engaging with interns about CHI, recommending a candidate for the Chinese outreach worker position and receiving approval for the CHI Social Media Plan.

In FY 16-17 CHI members completed the following activities:

- 4/26/17: 19 CHI Members/Supporters advocated for "Coordinated outreach to Chinese community to increase access to behavioral health services" which received 69 votes (stickers) and ranked 3rd under "Community Services & Supports (CSS).
- 5/4/17: Co-Chairs and Outreach Worker met with Supervisor David Canepa (District 5)
- 5/10/17: Honored May 10 Asian Pacific American (APA) Mental Health Day by creating and sharing Be the One Photo Booth Pledges on Facebook (reached 485 people - highest in CHI's short Facebook history).

Additionally, Westmoor Chinese International Student Support Group was very successful in eliciting discussion of difficulties with transitioning to USA and classmates realizing that there were others sharing similar experience. Joint discussion of coping and group process was helpful in developing initial group cohesion, but regular ongoing meetings would be important to continue in coming school year in order to consolidate this group as a resource for an inherently at-risk Chinese population.

CHI Members also advocated for Chinese outreach at the MHSA Prioritization Input Session. CHI learned the importance of their community speaking up and showing up to spaces where decisions are made in order to raise awareness about the needs of the Chinese community members who are not at the decision-making table.

FILIPINO MENTAL HEALTH INITIATIVE (FMHI)

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

Mission, Vision, & Objectives

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

Highlights & Accomplishments

FMHI members have worked with community members and community-based agencies to provide opportunities for young adults, parents, and individuals to discuss mental health issues in the context of Filipino cultural values and traditions. FMHI members also serve on one of three subcommittees focused on addressing the various cross-sections of the Filipino community: youth, elders, and LGBTQ individuals.

In FY16-17, FMHI participated and/or hosted the following events and activities:

- ALLICE event where members participated in a skit to depict Filipino/Filipino Americans in various situations where they are often disrespected
- Workshops in collaboration with Holy Child and St. Martin Episcopal Church to discuss mental health and other community challenges the Filipino community faces
- FMHI 10 year Anniversary where 42 people attended the celebration

LATINO COLLABORATIVE

While the Latino Collaborative (LC) efforts began in 2008, its founding members have been committed to giving voice to the Latino community since the late 1980s. During these initial meetings, a small group of Latino providers met informally to address issues pertaining to health disparities and access within the Latino community and San Mateo County mental health services. These meetings continued and in 2004, a core group of Latino providers requested a Latino-specific training for providers. At the time the County did not have the funds to provide the requested training. As a result, Latino providers organized regular meetings for San Mateo BHRS providers to come together to discuss client cases and strategies for serving the Latino population.

Mission, Vision, & Objectives

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

1. Creating stronger, safer, and more resilient families through holistic practices.
2. Promoting stigma-free environments.
3. Providing fair access to health and social services, independent of health insurance coverage.
4. Appreciating and respecting traditional practices.
5. Recognizing and incorporating Latino history, culture, and language into BHRS 2017 18

Highlights & Accomplishments

The Latino Collaborative's long-standing commitment to honoring the cultural and historical perspectives of Latinos has resulted in the creation of services, events, and resources that are grounded in the principles of cultural humility.

In FY16-17, FMHI participated and/or hosted the following events and activities:

- San Mateo County's annual Latino Health Forum: Sana Sana, Colita de Rana, **1200 people attended**
- National Night Out with Mid-Peninsula Collaboration
- Recovery Happens Resource Fair and Picnic
- Amazing Dialogue
- Attendance at Immigrant Integration Summit
- First Interfaith National Day of Prayer – **135 people attended**
- Immigration Health Forum – **26 people attended**
- Out Proud Families
- Cultural Awareness Trainings – **80 people attended**

NATIVE AMERICAN INITIATIVE (NAI)

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

Mission, Vision, & Objective

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

The NAI has further developed and articulated the following objectives:

Increase Awareness: Improve visibility of the challenges faced by Native Americans and provide support for the Native American community in San Mateo.

Outreach and Education: Outreach to and educate San Mateo County employees and community partners on how better to serve the Native American community.

Welcome and Support: Welcome community members, clients, consumers, and family. Assist individuals in accessing and navigating the San Mateo County health care system.

Strengthen our Community: Provide opportunities for Native Americans to strengthen their skills and create collaboration for guidance, education, and celebration of the Native American community.

Highlights & Accomplishments

The NAI has not only provided mental health resources to San Mateo County residents but has also contributed to the professional development of San Mateo BHRS providers through trainings and workshops Initiative members have organized.

In FY16-17, NAI participated and/or hosted the following events and activities:

- Native American Mental Health: Historical trauma and healing practices

PACIFIC ISLANDER INITIATIVE (PII)

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

Mission, Vision, & Objectives

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

The goals and objectives of the PII are organized into three main categories:

Education and Awareness: Increase the visibility of challenges experienced by Pacific Islanders and promotes community resources that support the community.

Prevention: Actively support activities that promote positive behavioral and physical health through community engagement.

Capacity Building and Leadership: Provide opportunities for service providers and local Pacific Islander leaders to develop their skills and capacity for providing services to Pacific Islanders that are culturally appropriate.

Highlights & Accomplishments

The PII's commitment to actively supporting and engaging with community members has allowed members to become trusted and valued resources within the community. This is particularly evident in the support they have provided family members and caregivers, as detailed below.

During FY 16-17 PII was able to provide a "How to serve the PI community" Training to North County Mental Health in Daly City. Based on the pre-post surveys conducted, this training was successful because each one of our audience members learned something new about the PI community. Attendees also reported an increase in their ability to understand and serve PI populations. More than half of the providers reported no prior training regarding serving the PI Community. The most significant jumps in knowledge were around challenges within the PI community and tools/approaches to working more effectively with PI community.

The highlight of the presentation was sharing a digital storytelling video shedding light on the difficult and taboo topics in the community. This particular story highlighted the struggled of a LGBTQ Samoan male who fought with his identity.

The PII looks forward to continuing their work in the community and continuing to build strong supportive relationships with each other.

PRIDE INITIATIVE

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

Mission, Vision, & Objectives

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

1. Engage LGBTQQI communities.
2. Increase networking opportunities among providers.

3. Provide workshops, educational events, and materials that improve care of LGBTQQI individuals.
4. Assess and address gaps in care.

Highlights & Accomplishments

In fiscal year 2016-17, the Pride Center undertook a number of foundational activities related to the planning and startup of the Pride Center (see Figure 1). The Pride Center secured a site in December 2016 and was in a period of "soft opening" from March through May 2017. The Pride Center held its Grand Opening on June 1, 2017 and carried out a full month of programming during June 2017. Beginning during the soft opening period, the Center started six monthly Older Adult LGBTQ+ Peer Counseling meetings. In the month of June, the Youth Program Coordinator successfully made contact with and conducted meetings with six high schools in San Mateo County to learn about youth's needs and desires for LGBTQ+ programming.

"We are making history right now with this place. There will be moments of, 'What did I get myself into? This is hard'. At the end of the day, [it's about] remembering that we're building something beautiful that will live on after us."

~ Pride Center Staff

SPIRITUALITY INITIATIVE (SI)

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

Mission, Vision, & Objectives

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

Hope. The Spirituality Initiative recognizes that hope is the simplest yet most powerful tool in fostering healing.

Inclusiveness. The Spirituality Initiative acknowledges that spirituality is a personal journey and that individuals should not be excluded from services based on their spiritual beliefs and practices.

Cultural humility. The Spirituality Initiative encourages an attitude of respect and openness in order to create a welcoming and inclusive space for everyone.

Highlights & Accomplishments

The SI has demonstrated how an HEI can work to impact both individual and system-level change.

In FY16-17, SI participated and/or hosted the following events and activities:

- National Day of Prayer
- Diversity and Equity Council monthly meetings
- Statewide County Liaison calls
- Mental Health Month
- Suicide Prevention Committee

HEALTH AMBASSADOR PROGRAM (HAP)

ODE launched the Health Ambassador Program (HAP) in 2013 as a response to feedback from the graduates of the Parent Project© who wanted to continue learning about how to appropriately respond behavioral health issues. Many of these graduates wanted to further what they learned from the PP classes but also wanted to remain connected to the ODE.

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

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

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

Initiatives. In this work, individuals engage in outreach, education and dialogue with members of our communities to reach our goal of a stigma free County.

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

RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS

ADULT MENTAL HEALTH FIRST AID (MHFA)

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

The 8-hour MHFA USA course has benefited diverse professions, including: primary care professionals, employers and business leaders, faith communities, school personnel and educators, state police and corrections officers, nursing home staff, mental health authorities, state policymakers, volunteers, young people, families and the general public.

PROGRAM IMPACT

In FY 16-17, there were 12 MHFA class sessions, where out of 247 attendees, 232 graduated the course. Three of the twelves sessions were focused on community colleges in San Mateo County, including Skyline and Cañada College. Other sessions included two for caregivers, two for probation staff, two for other County departments including administrative staff from Behavioral Health and Recovery Services and leadership staff from Family Health Services. Other trainings were provided for Second Harvest Food Bank staff, Peninsula Library System staff, and San Mateo Adult School.

The program has trained 1,119 individuals during 90 participant trainings county-wide with a 87% completion rate. With the program's growing success, the main challenge is increasing the instructor pool and retention to continue providing these trainings to communities in San Mateo County.

DEMOGRAPHICS

Total People Trained	
247	
Race/Ethnicity	
American Indian/Alaska Native	.5%
Asian	26%
Black/African American	7%
Caucasian/White	26%
Pacific Islander	1.5%
Mixed	2%
Other	10%
Blank/ Declined to state	27%
Age	
18-25	10.5%
26-29	11%
30-39	18%
40-49	22%
50-59	23%
60+	12.5%
Decline to state	2%
Blank	1%
Language	
English	94%
Spanish	3.5%
Chinese	1.2%
Tagalog	0%
Tongan	0%
Samoan	0%
Other	0.8%
Blank	0.5%
Cost per client	
$40.50	

*Language refers to trainees preferred language. * Race/Ethnicity is only representative of January 2017-June 2017 due to updated data collection methods being implemented during FY 16-17.

STIGMA DISCRIMINATION AND SUICIDE PREVENTION

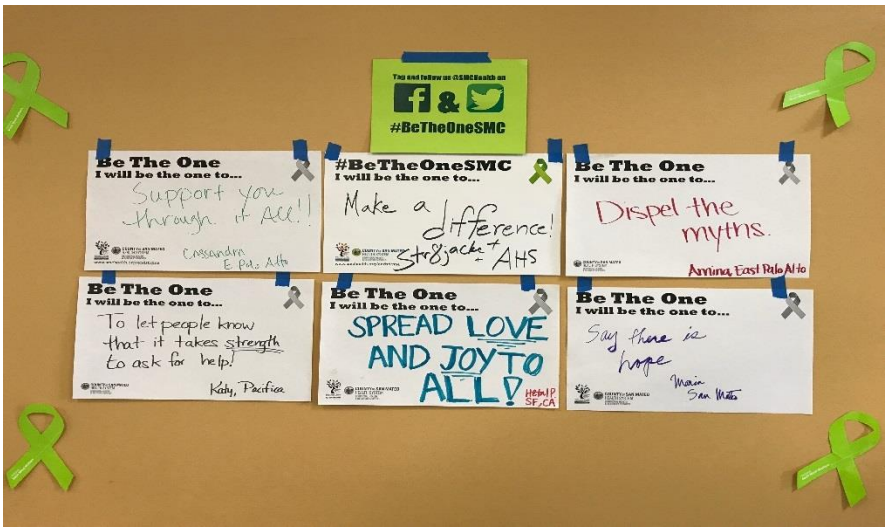
STIGMA FREE SAN MATEO COUNTY – BE THE ONE CAMPAIGN

Be the One is San Mateo County's anti-stigma initiative which aims eliminate stigma against those with mental health and/or substance use issues in our San Mateo County community. Be the One can mean many things to different people. Be the One can mean that ONE in four people have a mental health condition yet less than half are getting the help they need—many because they are afraid others will judge them. Be the One can also mean that ONE person or organization can make a difference in supporting wellness and recovery for others.

Throughout the 2016-2017 fiscal year, the *Be the One* campaign included educational and community events, including presentations, photo exhibits, speaker panels, interactive photo booth, annual proclamation and kickoff event.

Primary program activities and/or interventions provided include:

1. **ANNUAL MAY MENTAL HEALTH AWARENESS MONTH (MHAM) OBSERVANCE**: This is one of the biggest mental health observances of the year for San Mateo County. The 2017 MHAM consisted of
    a. Planning Committee which planned and implemented the 2017 MHAM Kickoff and advised on the Proclamation. Planning committee members included county staff and community-based organization staff.
    b. Proclamation which is the opportunity for the Board of Supervisors to officially proclaim and recommit to May MHAM. We had 4 lived experience speakers share their stories of hope and recovery.
    c. Kickoff which was a Mental Health Resource & Art Fair at the College of San Mateo. The theme was Be the One – Reach Out to Support Your Peers. We estimate 150 attendees.
    d. Directing Change Local Film Screening: On May 25, we hosted our first local screening of Directing Change Films created by local youth. The event recognized 7 film teams and 9 honorary mentions. There were able 25 attendees.
    e. Calendar of Events which featured 22 May MHAM events hosted by the County and community partners.
    f. Mini-Grants which is an opportunity for County and community partner groups to apply for funding to support their MHAM event. $1,000 were distributed to 5 grantee recipients.



2. **COMMUNICATION CAMPAIGN:** Throughout the year, Stigma Free San Mateo County promoted the Be the One Campaign through social media posts (Facebook, Twitter and Blog). Featured posts included 3 videos and photo pledges from 12 Be the One Photo Booth events. To date, they have collected 738 pledges from photo booths, online and post cards.

3. **PRESENTATIONS AT SKYLINE COLLEGE**: For every fall and spring semester, Stigma Discrimination Program Manager Sylvia Tang provides two stigma discrimination reduction presentations for Professor Jennifer Merrill's Abnormal Psychology Course: (1) Stigma and Its Consequences and (2) Stigma Reduction Strategies. These presentations supplement their Images of Stigma (photo voice project) series. Two were completed in the 2016-2017 fiscal year.

See Appendix 7: CalMHSA Statewide PEI Project FY 16/17 Impact Statement.

Cost per participant
$82

SUCCESSES

Within the Be the One (Stigma Discrimination Reduction), the program manager and supporting staff are especially proud of the Mental Health Resource & Art Fair (MHAM Kick off) hosted at the College of San Mateo. They are especially proud of this intervention because the event

helped them (1) reach out to a new audience (students) and (2) identify stories of hope and recovery which our new audience may find credible. For example, one student participated in the kickoff's Pop-Up Photo Voice activity and said,

"*I've been through depression a few times in my life. One major part of my life was after high school. I did not have any scholarship and became depressed. I hated life and everything to do with football. After all the support and love I've received from family and friends. I've overcome and never looked back*."

Depression

I've been through depression a few times in my life. One major part of my life was after highschool. I did not have any scholarship and became depressed. I hated life and everything to do with football. After all the support and love I've recieved from family and friends. I've overcome and never looked back.

CHALLENGES

Some of the challenges that exist are staffing to adequately support a robust communication campaign and low turn-out at Directing Change Local Film Screening. San Mateo's efforts for Be

the One will consider, contracting out the communication campaign planning and implementation and hosting more events online or collaborating with pre-existing events.

SAN MATEO COUNTY SUICIDE PREVENTION COMMITTEE (SPC)

The Suicide Prevention program aims to coordinate efforts to prevent suicide in the San Mateo County community. The primary program activities and/or interventions provided include:

1. SUICIDE PREVENTION COMMITTEE (SPC): The purpose of the SPC is to provide oversight and direction to suicide prevention efforts in San Mateo County. The SPC meets every two months. For 2016-2017, SPC focused on two projects to be implemented for September Suicide Prevention Month: (1) social media campaign and (2) older adult provider training.

2. SEPTEMBER SUICIDE PREVENTION MONTH (SPM): For September SPM, San Mateo County did the following:
    a. Social Media Campaign: During September Suicide Prevention Month, San Mateo County posted about suicide prevention on the Health System Facebook (1 post) and BHRS blog (7 posts). The Each Mind Matter Suicide Prevention Week toolkit was used for content and the content focused largely on suicide prevention among older adults.
    b. Older Adult Provider Training: Over 60 individuals attended the training. The purpose of this free training was to educate anyone serving the older adult (60+) population on why older adults are at higher risk for suicide and on how to help prevent suicides among older adults. The audience included clinicians, mental health staff, community partners, and other individuals supporting older adults.

3. SUICIDE PREVENTION TRAINING: Throughout the year, San Mateo County Behavioral Health and Recovery Services provides a variety of suicide prevention trainings, including Parenting skills and family relationship programs, Gatekeeper trainings (Applied suicide intervention training, mental health first aid, Question Persuade Refer, and Reconozca Las Señales) and Crisis intervention trainings.

SUCCESS/CHALLENGES

The Older Adult Provider Training received a great turnout and hosted a diverse panel of clinical providers and older adults with lived experience this year.

Some challenges that remain are creating systems change within the SPC projects, finding adequate staffing for communication campaigns, and coordinating the suicide prevention trainings that exist throughout the county.

Cost per participant
$130

DIGITAL STORYTELLING & PHOTOVOICE

The ODE storytelling program hosts a space in which people share their stories of recovery and wellness to make a meaningful impact on themselves and others. Participants engage in workshops that guide them in creating and sharing their stories in different forms. Beginning simply with a story circle or a framing question, participants continue developing their narrative as a digital story or a Photovoice project. Photovoice and Digital Storytelling are 4-day workshops in which participants share their stories of wellness and recovery. As final projects, Photovoice participants produce a single-page layout of a photo and short written piece and Digital Storytelling participants produce a 3-minute video.

During FY 16-17 5 Digital Storytelling and 7 Photovoice projects were completed. Additionally, the program:

- Developed framework, evaluation materials, facilitation guide, Pop-Up Photovoice approach.
- Supported and facilitated a total of four Photovoice programs and one Digital Storytelling program.
- Conducted a total of twelve presentations, panels, or gallery showings of Photovoices and Digital Stories.

Total Clients Served	Cost per Client
60	**$ 1,536**

- FY 16-17 was a startup year for the Photovoice program, resulting in a high cost per client. For FY 17-18 we expect an increase of at least twice as many workshops and participants.

IMPACT

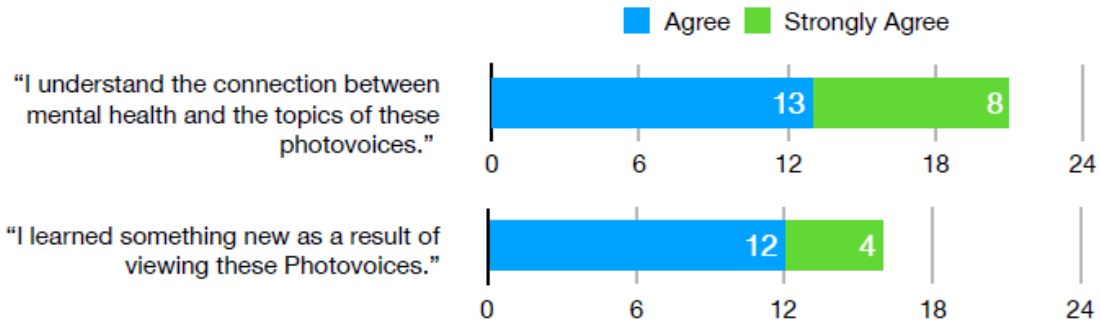
Photovoice is healing for its participants as they reframe their experiences throughout the story-circle, scripting exercises, and photography process. Consequently, communities heal as they view and relate to stories shown at events. Participants are invited to program with themes and framing questions most relevant to their experience to foster a participant-centered approach.

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

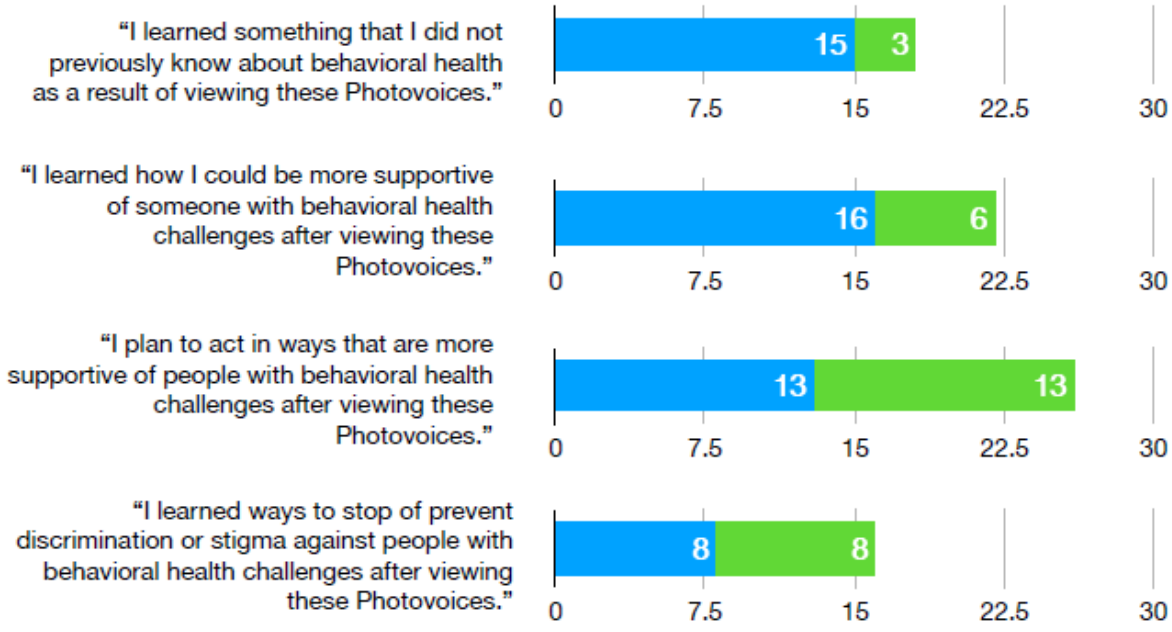
*"When looking through the gallery, I feel a sense of **empowerment** and inspired by others sharing their stories and not being afraid. I think the gallery affected our community at Harbor by making it a safe space to talk about mental health/substance use."*

*"I will continue my efforts to **bring restorative and mindful practices** to the schools and educating of staff about mental health and their role in addressing the mental health concerns of their participants."*

Below are results from the first trial of evaluations, with a sample size of 24, who endorsed, either, 'Agree' or 'Strongly Agree':



Below are results from the second trial of evaluations, with a sample size of 30, who endorsed, either, 'Agree' or 'Strongly Agree':



ACCESS AND LINKAGE TO TREATMENT

RAVENSWOOD FAMILY HEALTH CENTER

Ravenswood is a community-based Federally Qualified Health Center (FQHC) that serves East Palo Alto residents. Ravenswood provides outreach and engagement services and identifies individuals presenting for healthcare services that have significant needs for behavioral health services. Ravenswood Family Health Center services are funded at 40% under CSS and the remaining 60% is funded through Prevention and Early Intervention. The intent of the collaboration with Ravenswood FHC is to identify patients presenting for healthcare services that have significant needs for mental health services. Many of the diverse populations that are now un-served will more likely appear in a general healthcare setting. Therefore, Ravenswood FHC provides a means of identification of and referral for SMI and SED clients.

Total Clients Served	Cost per Client
538	**$47.30**

SENIOR PEER COUNSELING

The Senior Peer Counseling Program, provided by Peninsula Family Service, recruits and trains volunteers to serve homebound seniors with support, information, consultation, peer counseling, and practical assistance with routine tasks such as accompanying seniors to appointments, assisting with transportation, and supporting social activities. The Senior Peer Counseling program has been expanded to include Chinese, Filipino and LGBT volunteers. Senior Peer Counseling services are funded at 50% CSS and 50% PEI.

See full report for the Senior Peer Counseling program in the General System Development section.

INNOVATIONS (INN)

INNOVATIONS (INN)

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

In FY16-17, no MHSA INN project plans were presented for approval. The development MHSA Innovation Projects is part of the comprehensive Community Program Planning (CPP) process. Current programs include:

Pride Center

The San Mateo County Pride Center is a formal collaboration of four partner organizations: StarVista, Peninsula Family Services, Adolescent Counseling Services, and Daly City Partnership. The Pride Center also works collaboratively with the Pride Initiative of the Office of Diversity and Equity and the County of San Mateo LGBTQ Commission, co-sponsoring and consulting across many events, efforts and policy priorities.

While it is not new to have an LGBTQ center providing social services, there is no model of a coordinated approach across mental health, social and psycho-educational services for this marginalized community.

In fiscal year 2016-17, the Pride Center undertook a number of foundational activities related to the planning and startup of the Pride Center (see Figure 1). The Pride Center secured a site in December 2016 and was in a period of “soft opening” from March through May 2017. The Pride Center held its Grand Opening on June 1, 2017 and carried out a full month of programming during June 2017. Beginning during the soft opening period, the Center started six monthly Older Adult LGBTQ+ Peer Counseling meetings. In the month of June, the Youth Program Coordinator successfully made contact with and conducted meetings with six high schools in San Mateo County to learn about youth’s needs and desires for LGBTQ+ programming.

Figure 1. Pride Center Key Activities and Accomplishments

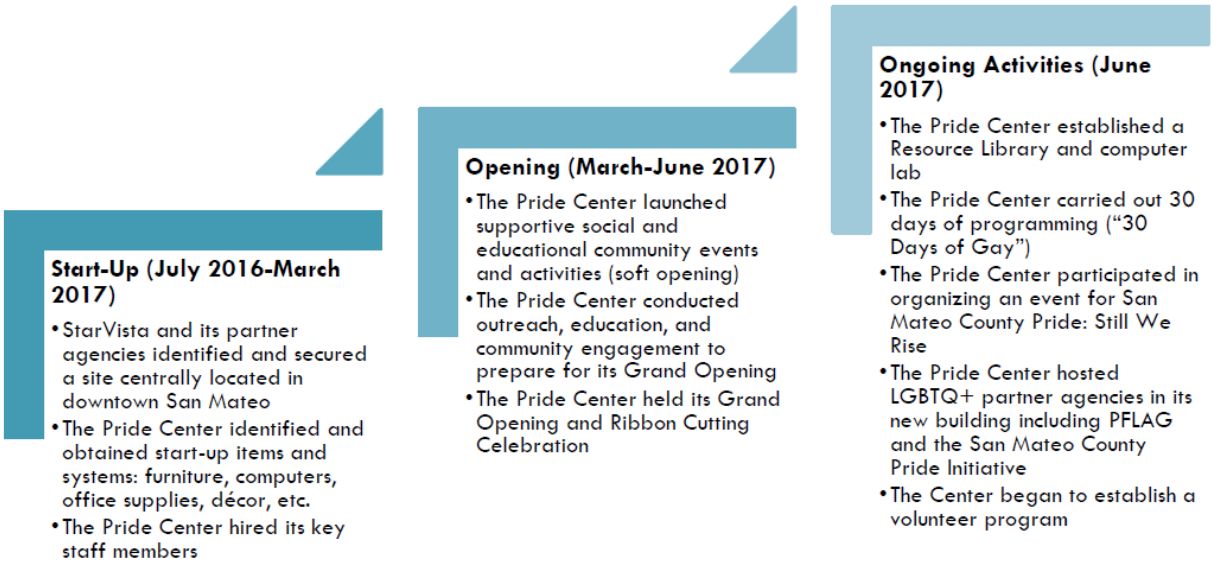


Table 2. Attendance at Pride Center Events, 2017

Event	Total Number in attendance
Grand Opening	400
30 Days of Gay	700
Pulse Night of Remembrance	25
1st San Mateo County Queer Prom	60
Queer Cumbia and Noche de Joteria	12
Total	1,197

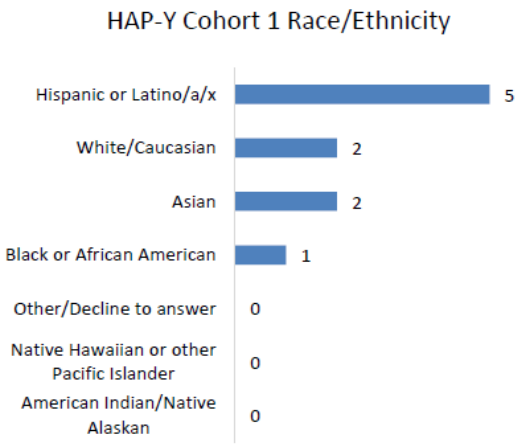
Health Ambassador Program for Youth (HAP-Y)

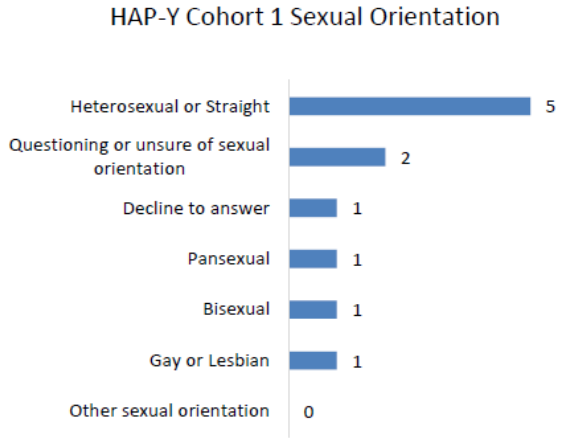
HAP-Y serves as a youth-led initiative where young adults act as mental health ambassadors to promote awareness of mental health, reduce mental health stigma, and increase service access for young people. The HAP-Y Innovation project is the first to offer formal evaluation of a training designed for youth peer educators and its effectiveness and impact on community awareness and stigma, increasing access to mental health services for youth, and addressing systemic changes, as well as supporting youth ambassadors' wellness and recovery.

Youth Ambassadors Recruitment and Training

Demographics

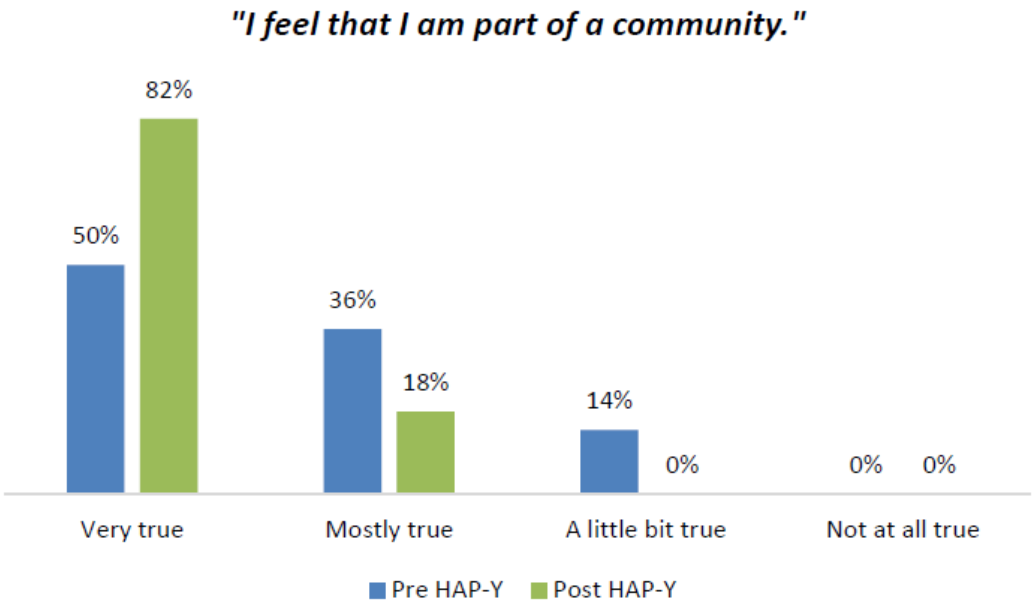
Eleven young adults (ages 16-25) participated in the inaugural cohort of the HAP-Y. Youth were recruited to represent a diverse cultural background (e.g., White, Latino, African American, Filipino, Pacific Islander, and Native American), gender identities, and sexual orientations. Youth with lived experienced were encouraged to apply. This section describes the Youth Ambassador demographics.



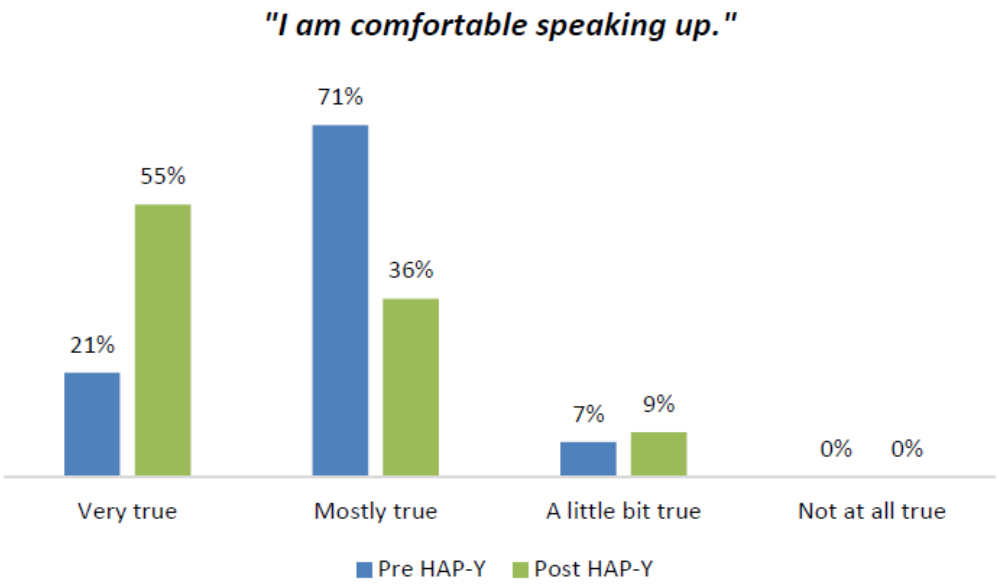


At the beginning of Cohort 1, 64% of Youth Ambassadors (n=9) felt that it was “very true” that they were comfortable talking about mental health, and 36% (n=5) responded “mostly true”. At the end of Cohort 1, 91% of Youth Ambassadors (n=10) felt that it was “very true” that they were comfortable talking about mental health, and one youth (9%) responded “mostly true”. Due to the small sample size, percentage change may seem exaggerated.

Another notable finding is that in the beginning of Cohort 1, 50% of Youth Ambassadors (n=7) felt it was “very true” that they were part of a community and at the end of Cohort 1, 82% of respondents (n=9) felt it was “very true” that they were part of a community.



As a group, there was consensus that everyone felt it was “very true” that they can make a positive change for the community. One of the tenets of participatory evaluation is to empower community members to be active members of research and evaluation. It is important for youth to feel they are a part of a community and to feel comfortable engaging in that community to make a change.



A notable finding from the teamwork section was in response to the question, "I listen to other people's opinions." At the beginning of Cohort 1, 93% of participants (n=13) felt this was "very true" and at the end of Cohort 1, 91% of respondents (n=10) felt it was "very true." In the group post-survey, there was group consensus that all respondents felt it was very true that they try to understand each other's perspectives. These findings indicate that Cohort 1 is supportive of listening to potentially different opinions and works towards understanding each other's perspectives.

Next Steps and Plans for Years 2 and 3

In the next two years of the program, StarVista will recruit new youth to participate as Cohort 2 and Cohort 3 Youth Ambassadors. Youth Ambassadors will receive psychoeducation training and conduct public education presentations. StarVista will incorporate the lessons learned from the first year of the program, including making the training more engaging for Youth Ambassadors. Additionally, the Youth Mental Health First Aid training will be replaced with Youth for Youth.

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

While NMT has been integrated into a variety of settings serving infants through young adults, there is no literature or research of NMT in a strictly adult setting or population. BHRS intends to adapt, pilot, and evaluate the application of the NMT approach to an adult population with a history of trauma. This expansion to and evaluation of NMT in an adult system of care is the first of its kind.

The Child Trauma Academy (CTA) developed NMT as an alternative approach to addressing trauma, typically used with children, that is grounded in neurodevelopment and neurobiology. NMT is not a single therapeutic technique or intervention. Rather, NMT uses assessments to guide the selection and sequence of a set of highly individualized therapeutic interventions (e.g., therapeutic massage, drumming, yoga, expressive arts, etc.) that best match each NMT consumer's unique strengths and neurodevelopmental needs.

In March 2017, providers began referring and implementing NMT with adult consumers. As providers were not yet fully trained and had just begun implementing the NMT approach with adult consumers in March, only 20 consumers received NMT-based services during this first training year. Most consumers (n=13, 65%) were adults ages 26-59, while seven consumers (35%) were TAY. No consumers were under the age 18. In addition, at least seven consumers

(35%), including both adults and TAY, were also part of the re-entry population. In subsequent years, when providers are fully trained, BHRS anticipates approximately 75 to 100 adult consumers will receive NMT services annually. There were no other project modifications during the reporting period.

NMT Outcomes

Although the NMT pilot was still in the early phases of implementation during FY16-17, providers reported changes in their approach to care as a result of the NMT training. Providers also observed some positive consumer outcomes. As was to be expected, providers experienced some difficulties in learning and adapting the NMT approach to an adult population. Some issues arose surrounding consumers' ability to recall information about past experiences, the length of the assessment, and the natural learning curve trainees experienced with learning and administering the NMT assessment with an adult population These findings are preliminary and will be further explored with quantitative data as the program matures and more consumers participate in NMT.

For the complete Year 1 FY 16/17 Evaluation Reports by independent consultant, Resources Development and Associates, see Appendix 8.

WORKFORCE EDUCATION & TRAINING (WET)

WORKFORCE EDUCATION AND TRAINING (WET)

WET exists to develop a diverse workforce. Clients and families/caregivers are given training to help others by providing skills to promote wellness and other positive mental health outcomes, they are able to work collaboratively to deliver client-and family-driven services, provide outreach to unserved and underserved populations, as well as services that are linguistically and culturally competent and relevant, and include the viewpoints and expertise of clients and their families/caregivers. WET was designated one-time allocation totaling $3,437,600 with a 10-year reversion period. In the spring of 2017, the BHRS Office of Diversity and Equity (ODE) hired an independent consultant to assess the impact of WET and identify priorities that would shape the future landscape recommending $500,000 to be transferred from CSS to WET to sustain the most effective and impactful elements of WET investments. Following are some highlights:

WET Impact

Prior to MHSA WET, there were fewer staff trainings offered annually and topics skewed toward direct clinical training due to norms and an emphasis on medical interventions. In more recent years, training topics included cultural humility, co-occurring care, trauma-informed care, crisis management and safety and self-care. **From 2014-17, 95 trainings were provided to over 3,000 staff, contract and community providers.** Additionally, MHSA WET allowed for trainings for and by clients/consumers and family members aimed to increase understanding of mental health issues and reduce stigma and increase knowledge of substance use/abuse issues, recovery and resilience, and available treatments and supports and support leadership development of clients/consumers and family members.

WET Recommendations

1: A Systemic Approach to Workforce Education and Training

Moving forward, a systemic approach to foundational knowledge and BHRS transformation goals should be the standard including cultural humility, trauma-informed care, standard of care, co-occurring and other integrated care, lived experience integration and self-care. 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.

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

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.

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.

Approximate total participants in WET programs and outreach for FY 16-17
1,422
Cost per participant
$351

WORKFORCE STAFFING AND SUPPORT

During 2016-2017, the BHRS WET program was staffed by 1 FTE WET Coordinator and 1 FTE WET Project Support Specialist. The Workforce Development and Education Committee (WDEC) and the Lived Experience Education Workgroup (LEEW) continued to serve as advisory committees/workgroups for the WET program during this fiscal year.

During 2016-2017, the WDEC met 8 times and focused on developing and planning the WET survey and stakeholder process, deciding what BHRS trainings to prioritize and schedule, revising the training evaluation form, and addressing workforce issues.

The LEEW also met 11 times and focused on developing a plan for the Lived Experience Academy trainings including an input session with former graduates, a refresher course, a new academy, and planning for an advocacy-focused academy.

TRAINING BY/FOR CONSUMERS AND FAMILY MEMBERS

LIVED EXPERIENCE ACADEMY (LEA)

The Lived Experience Academy is a training program designed for individuals living with mental health and/or substance use challenges and/or their family members. Participants learn how to share their stories to empower themselves, reduce stigma, and educate others about behavioral health conditions. The program upholds the core value that lived experience is its own form of expertise, and that integrating people with lived experience into the workforce is a vital type of workforce diversity. It includes an annual training and Speakers' Bureau.

LIVED EXPERIENCE ADVOCACY ACADEMY (LEAA)

The Lived Experience *Advocacy* Academy is a training program designed for individuals living with mental health and/or substance use challenges and/or their family members, who have graduated the Lived Experience Academy and want to get involved in advocacy work. It is considered a second-tier training which builds on the skills developed in the LEA. Its goal is to prepare graduates for joining and participating on BHRS committees and commissions.

Graduation from the *Advocacy* Academy results in the opportunity to participate on county commissions, committees, and other decision-making bodies. Participants improve on their skills in advocating for themselves and their communities and in bringing the voices of those with lived experience to the decision-making table. Participants are paid for participating in the training and are offered a stipend for attending committee and commission meetings.

LIVED EXPERIENCE EVENT SUPPORT TRAINING

The Lived Experience Event Support Training was piloted during fiscal year 2015-2016. It is a 3-hour training designed to teach LEA graduates how to provide technical and logistical support for BHRS training, events, and the anti-stigma campaign "Be the One" photo booth 27 LEA graduates participated in this training in 2016-2017 and then went on provide paid event support throughout the year (see Behavioral Health Career Pathways sections for more details).

TRAINING TO SUPPORT WELLNESS AND RECOVERY

WELLNESS RECOVERY ACTION PLAN (WRAP)

WRAP has served as an excellent way to promote wellness and recovery for clients/consumers and staff in the behavioral health system. In 2016-2017, Inspired at Work coordinated San Mateo County's WRAP efforts. This included a 2-day "Create Your Own WRAP" training in

November 2016 that 47 people attended, followed by a 5-day WRAP facilitator training in April 2017 in which 18 new facilitators were certified.

There were 3 WRAP group trainings offered throughout San Mateo County this year.

Additionally, WRAP groups are offered throughout San Mateo County. By FY 16-17 there were 427 unduplicated persons who participated in a WRAP group by a certified WRAP facilitator since WRAP was introduced to San Mateo County in 2009.

WISE RECOVERY 101 AND PEER SUPPORT 101

In 2015-2016, the Workforce Integration Support and Education (WISE) program of NorCal MHA provided two trainings on Recovery 101 and Peer Support 101. They held two separate sessions--one designed specifically for supervisors and the other for peer workers and peer volunteers. **48 participants attended these trainings.** WISE has offered a series of ongoing trainings to support peers in the workforce that will be offered in 2016-2017.

EVIDENCED-BASED, COMMUNITY-BASED, AND PROMISING PRACTICE TRAININGS FOR SYSTEM TRANSFORMATION

During this 2016-2017 fiscal year the Selection of Evidenced-Based and Community Defined Practice Policy was passed by the BHRS Quality Improvement Committee. This policy aims to provide an inclusive process for the selection of clinical and non-clinical interventions that can be utilized throughout BHRS. These interventions need to include evidence-based, promising and community based or defined practices. The policy was approved and the list of interventions that were already in practice before July 2014 (and are therefore pre-approved) was started in this fiscal year. In fiscal year, 2016-2017, the Practice Evaluation Committee will be chosen and will begin reviewing proposals for interventions.

CULTURAL COMPETENCE TRAININGS

CULTURAL HUMILITY

In March 2017, Leanna Lewis provided the training “Building Bridges to Diversity and Inclusion” for BHRS and contract staff to improve the cultural responsiveness of our system of care. Seventy-four participants attended the training. This system-wide training was followed by an in-depth 6-week Training of Trainers (TOT). The TOT included 9 BHRS and contract agency staff

who applied for the training to learn to provide the training throughout our system of care for other staff.

CULTURALLY RESPONSIVE CLINICAL SUPERVISION

Leanna Lewis, LCSW conducted a Culturally Responsive Clinical Supervision training that was offered three times in FY 16-17. 45 participants attended. This training focused on teaching supervisors how to use cultural humility and critical self-reflection to improve their supervision of their colleagues and to create a more collaborative and supportive work environment.

WORKING EFFECTIVELY WITH INTERPRETERS IN A BEHAVIORAL HEALTH SETTING

This training aims to enhance the cultural competency and humility of BHRS staff as well as to help providers learn to effectively communicate with clients when they do not speak the client's language. This mandatory training for direct service staff was offered twice in during 2016-2017. In November 2016, 51 people attended. And in April 2017, 46 people attended.

SPIRITUALITY TRAINING

In 2016, the Spirituality Initiative sponsored a Spirituality 101 training for BHRS and contract staff to educate behavioral health staff on how to better address clients' spirituality in treatment. More than 60 participants attended.

CULTURAL COMPETENCE TRAININGS ADDRESSING SPECIFIC POPULATIONS

The Health Equity Initiatives and workgroups took the lead in creating and/or sponsoring trainings on specific marginalized populations in San Mateo County. In 2017, the Arab Community Workgroup organized a training on Working with the Arab and Arab-American Community presented by Hazem Hajaj. 35 participants attended.

The African American Community Initiative sponsored a training for the African-American Community in San Mateo County on Mental Wellness: The Key to Complete Health in Celebration and Recognition of Black History month. 103 participants attended.

The PRIDE Initiative and LGBTQ Commission co-sponsored a Transgender 101: Creating an Inclusive Community by Project Outlet in honor of International Transgender Visibility Day. The training was followed by a panel discussion from transgender individuals living in the Bay Area sharing their experiences and perspectives. 75 participants attended.

BEHAVIORAL HEALTH CAREER PATHWAYS PROGRAM

The following three objectives were established from the MHSA guidelines and the 2014 stakeholder process for the WET Plan Update in San Mateo County to promote behavioral health career pathways.

1) Attract prospective candidates to hard-to-fill positions and increase staff diversity

The state-funded Mental Health Loan Assumption Program (MHLAP) continued to be implemented in San Mateo County BHRS to address 1) attracting, hiring, and retaining staff in hard-to-fill positions and 2) increasing diversity of staff and retaining diverse staff. The MHLAP program provides student loan forgiveness for BHRS and contract staff who work in hard-to-fill positions and exhibit cultural and linguistic competence and/or have experience working in underserved areas. Applicants receive up to $10,000 to repay educational loans in exchange for a 12-month service obligation.

2) Promote the Behavioral Health Field

Intern/Trainee Programs (Clinical and ODE)

The BHRS clinical intern/trainee program provides clinical training opportunities each year at BHRS worksites throughout the county. BHRS partners and contracts with multiple graduate schools in the Bay Area and other regions of the country to provide education, training, and clinical practice experiences for students. Interns and trainees are placed at different worksites throughout San Mateo County BHRS. The interns and trainees represent multiple professional disciplines including Alcohol and Other Drug certificate, doctoral psychology, MSW, MFT, and nurse practitioner students and interns. They receive multiple training opportunities including a 2-day orientation that includes sessions on crisis management, trauma-informed care, wellness and recovery, self-care, and health equity and a mid-year training on cultural humility. They each attend a weekly or biweekly regional didactic seminar at one of 4 sites.

The Office of Diversity and Equity (ODE) intern training program consists of college and graduate students who want experience in behavioral health careers through focusing on health equity and social justice work. **In 2016-2017, ODE had 3 interns** whose work focused on Prevention and Early Intervention initiatives including suicide prevention and stigma discrimination reduction related to behavioral health conditions. ODE interns receive a $5,000 stipend for their work.

3) Career Pathways and Ongoing Development for Clients/Consumers and Family Members

The Lived Experience Academy

By way of the Lived Experience Academy, clients/consumers and family members were offered many different paid opportunities during the 2016-2017 fiscal year. Opportunities included participating in up to 3 annual trainings, opportunities to speak in front of an audience, and opportunities to provide support to BHRS events. An "event" was classified as one organized program which could have included multiple clients/consumers and family members. An "opportunity" captured each client/consumer and family member paid to work an "event".

FY 2016-2017 Paid Opportunities for Clients/Consumers and Family Members:

- Number of Paid *Opportunities*
- Number of Paid *Events*
- Number of Paid *Speaking Opportunities*
- Number of Paid *Speaking Events*

OTHER PROJECTS TO ENHANCE WORKFORCE RETENTION AND DEVELOPMENT

BHRS NEW-HIRE ORIENTATION

The BHRS New-Hire Orientation was created and provided to new BHRS staff in fiscal year 2016-2017. The Orientation consisted of a series of three 3- hour hour sessions that took place over the course of 3 months. The goal was to help new staff understand how BHRS works and connects to other agencies and departments, to meet and learn from BHRS managers, to explore the possibilities for career advancement, and to feel invested in and supported by BHRS as an organization. The average number of attendees per session was 3. The session topics were as follows:

1. Who We Are and Who We Serve
2. How We Do It
3. What We Do

BHRS COLLEGE

The BHRS Leadership College provides an opportunity for BHRS staff to learn about facets critical to the successful operation of BHRS. The College supports staff in considering their career development goals and is part of a succession planning strategy. The information and experiences received from participation gives staff an understanding of key policy, fiscal, operational and planning responsibilities that BHRS executes as part of its business practices.

The BHRS College consists of 9-sessions. Staff need to attend 7 of 9 sessions to graduate the College. They are eligible to make up missed sessions the next time the College is offered. In 2016-2017, 22 completed the college. The nine session topics were as follows:

1. Behavioral Health: History and Policy
2. Strategic Planning
3. Health System and Health Policy
4. County Governance and Administration
5. Quality Improvement, Performance Measurement, and Customer Service
6. Finance and Budgeting
7. Community Partnerships, Requests for Proposals, and Contracting
8. LEAP Servant Leadership
9. BHRS Moves Toward the Future

PROMOTE THE BEHAVIORAL HEALTH FIELD

INTERN/TRAINEE PROGRAMS (CLINICAL AND ODE)

The BHRS clinical intern/trainee program provides clinical training opportunities each year at BHRS worksites throughout the county. BHRS partners and contracts with multiple graduate schools in the Bay Area and from other regions of the country to provide education, training, and clinical practice experiences for students. In 2015-2016, there were 41 BHRS interns and trainees placed at 15 different worksites throughout San Mateo County BHRS. The interns and trainees represented multiple professional disciplines including Alcohol and Other Drug certificate, doctoral psychology, MSW, MFT, and nurse practitioner students and interns. They received multiple training opportunities including a 2-day orientation that included sessions on crisis management, trauma-informed care, wellness and recovery, self-care, and health equity and a mid-year training on cultural humility. They each attended a weekly or biweekly regional didactic seminar at one of 4 sites. They were also invited to attend all of the system-wide trainings (listed earlier in this document). Fifteen of these trainees/interns received a $5,000 stipend as part of our Cultural Stipend Internship Program for their contributions to improving the cultural competence and cultural humility of our system of care (see full description below under Financial Incentives Programs).

The ODE intern training program consists of undergraduate, graduate and recent graduate students who want experience in behavioral health careers through focusing on health equity and social justice work. In 2015-2016, ODE had 3 interns whose work focused on our Suicide Prevention initiative, Parent Project program, and Mental Health First Aid and Digital

Storytelling programs. ODE interns receive a $5,000 stipend for their work. The 2015-2016 ODE internship program included a training series of 5 workshops introducing interns on the following topics: Organization, Trauma, Cultural Humility, Political Astuteness and Recovery.

FINANCIAL INCENTIVES

CULTURAL STIPEND INTERNSHIP PROGRAM

The Cultural Stipend Internship Program awarded a $5,000 annual stipend to 14 BHRS clinical interns for the 2016-2017 fiscal year. 12 out of the 15 completed the program. Interns were selected based on their identifying and having experience with a marginalized community. First priority was given to those from communities of color and those with fluency in a language spoken by communities of color. Secondary priority was put on identifying as Lesbian Gay Bisexual Transgender Queer, someone with a disability, from a rural area, or another marginalized group.

Intern demographics:

- White: 6%
- Mixed Race (any race):94 %
- People of color (POC) : 94%
- LGBTQ: only one person reported
- Non-POC, non-LGBTQ: no one reported

In exchange for the stipend award of $5,000, interns were asked to complete a year-long project and participate in one of nine community-led Health Equity Initiatives.

HOUSING

HOUSING

MHSA Housing funds provide permanent supportive housing through a program administered by the California Housing Finance Agency (CalHFA) to individuals who are eligible for MHSA services and meet eligibility criteria as homeless or at-risk of being homeless. BHRS collaborated with the Department of Housing and the Human Services Agency's Shelter Services Division (HOPE Plan staff) to plan and implement the MHSA Housing program in the County.

In September 2014, AB 1929 was passed which allowed counties to request and use unencumbered MHSA Housing Program funds to provide housing assistance. The San Mateo County Board of Supervisors adopted a resolution approving the request to release of these funds; a total of $1,073,038 was received from the Housing Program to be held in trust for housing assistance services. A plan for the use of unencumbered Housing funds was presented to the MHSA Steering Committee in March 2017 and BHRS contributed the unencumbered to the Affordable Housing Fund administered by the Department of Housing for the development of affordable housing, which led to 12 additional MHSA units as demonstrated below.

Year	Housing Development and Location	UNITS
2009	Cedar Street Apartments 104 Cedar St., Redwood City	5 MHSA units 14 total units
2010	El Camino Apartments 636 El Camino Real, South San Francisco	20 MHSA units 106 total units
2011	Delaware Pacific Apartments 1990 S. Delaware St., San Mateo	10 MHSA units 60 total units
Expected 2018	Waverly Place Apartments 105 Fifth Ave, North Fair Oaks	15 MHSA units 16 total units
Expected 2019	Bradford Senior Housing 707-777 Bradford Street, Redwood City	6 MHSA units 177 total units
Expected 2019	2821 El Camino Real, North Fair Oaks	6 MHSA units 67 total units
		62 Total MHSA units

CAPITAL FACILITIES & INFORMATION TECHNOLOGY (CF/IT)

ECLINICAL CARE

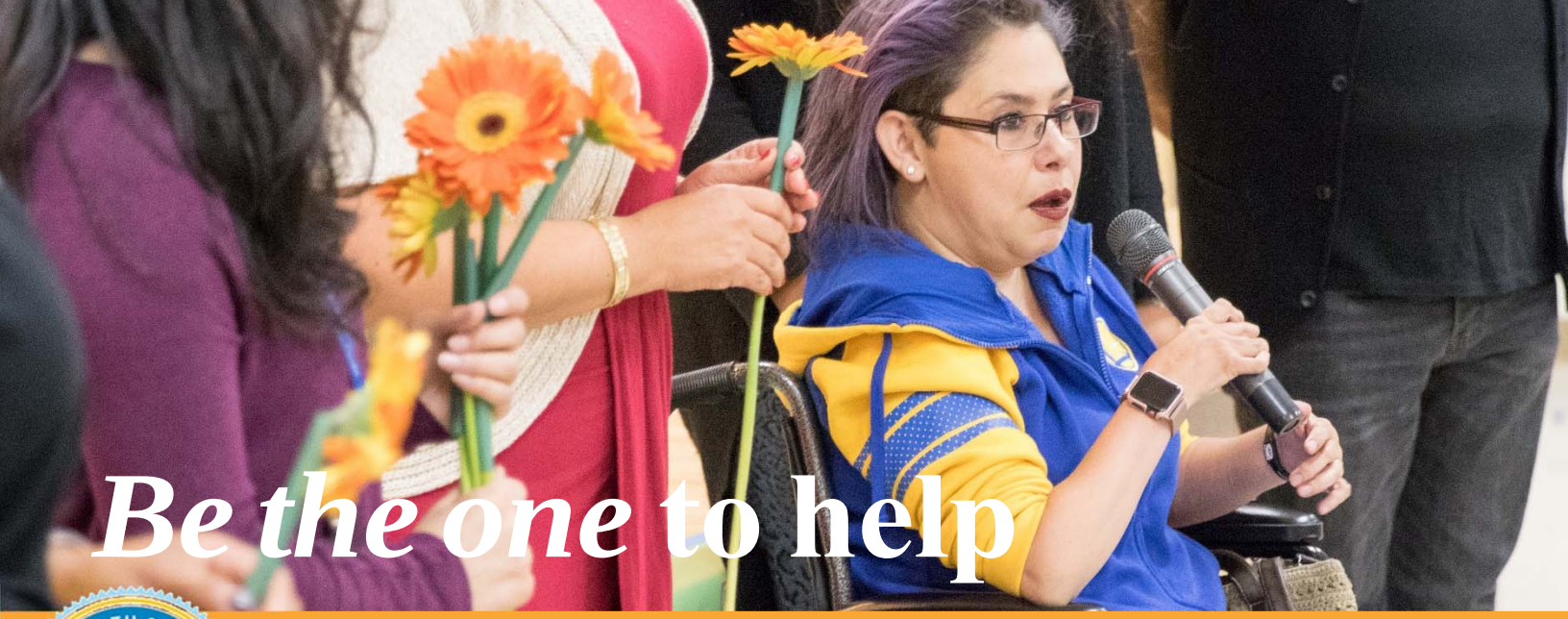
San Mateo County has had no viable opportunities under the Capital Facilities section of this component due to the fact that the guidelines limit use of these funds only to County owned and operated facilities. Virtually all of San Mateo's behavioral health facilities are not owned but leased by the County, and a considerable portion of our services are delivered in partnership with community-based organizations.

Through a robust stakeholder process it was decided to focus all resources of this component to fund eClinical Care, an integrated business and clinical information system (electronic health record) as well as ongoing technical support. The system continues to be improved and expanded in order to help BHRS better serve the clients and families of the San Mateo County behavioral health stakeholder community.

There are no additional programs planned or projected funding available for this component

APPENDICES

APPENDIX 1: MHSA STEERING COMMITTEE & PUBLIC COMMENTS



Mental Health Service Act (MHSA) Steering Committee Meeting

Open to the public! Join advocates, providers, clients and family members to provide input on MHSA funded initiatives.

Meeting objectives include:

- Provide input on MHSA funding priorities
- Learn about MHSA program outcomes
- Hear from Innovation program outcomes including the Neurosequential Model of Therapeutics (NMT) for Adults
  - ❖ Stipends are available for consumers/clients
  - ❖ Language interpretation is provided as needed*
  - ❖ Childcare is provided as needed*
  - ❖ Refreshments will be provided

*please reserve these services by January 25th, contact Brittany Ganguly at (650) 573-5062 or bganguly@smcgov.org

DATE

Wednesday, January 30, 2019
3:00 pm – 4:30 pm

Health System Campus, Room 100
225 37th Ave.
San Mateo, CA 94403

Contact:

Doris Estremera, MHSA Manager
(650)573-2889
mhsa@smcgov.org

www.smchealth.org/MHSA

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

MHSA provides a dedicated source of funding in California for mental health services by imposing a 1% tax on personal income in excess of $1 million.

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Services Act (MHSA) Steering Committee

Wednesday, January 30, 2019 / 3:00 - 4:30 PM
Health System Campus, Room 100, 225 37th Ave. San Mateo, CA 94403

AGENDA

1. **Welcome & Introductions** — 3:10 PM
   Supervisor Dave Pine

2. **MHSA Annual Update – Program Outcomes** — 3:15 PM
   - *Doris Estremera, MHSA Manager*

3. **MHSA Innovation Update** — 3:30 PM
   - Neurosequential Model of Therapeutics (NMT) – Adults
     Toni DeMarco, BHRS Youth Deputy Director

4. Funding Prioirities and Update to the Plan — 3:45 PM
   - *Steve Kaplan, BHRS Director,*

5. **Announcements/Public Comments** — 4:15 PM
   - New Innovation Funding Cycle Launch – flyer included
   - Technology Suite Advisory Committees – flyer included

6. **Adjourn** — 4:30 PM

Mental Health and Substance Abuse Recovery Commission (MHSARC)
Opening of a 30-day public comment period for the MHSA Annual Update will occur at the next MHSARC meeting:

February 6, 2019 from 3-5pm.
Silicon Valley Community Foundation
1300 S. El Camino Real, Suite 100, San Mateo

Mental Health Services Act (MHSA)

FY 18-19 Annual Update

January 30, 2019 / 3 - 4:30pm

MHSA Steering Committee Meeting
www.smchealth.org/mhsa

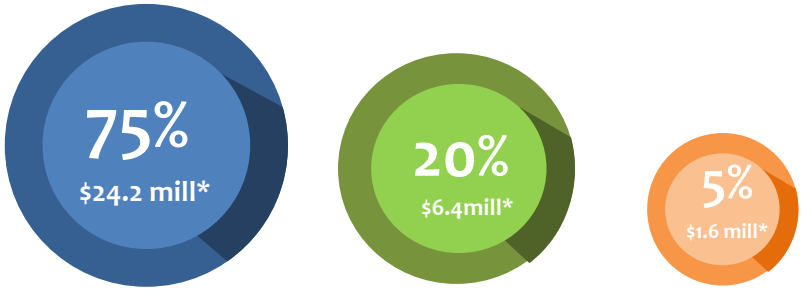
SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Agenda

1. MHSA Background
2. Annual Update – Program Outcomes
3. Program Highlight – NMT in Adult System of Care
4. Progress on Priority Expansions
5. Update to the Plan
6. Announcements & Public Comments

MHSA – Prop 63 (2004)

1% tax on personal income in excess of $1 mill



Community Services & Supports (CSS)

Direct treatment and recovery services for serious mental illness and serious emotional disturbance

Prevention & Early Intervention (PEI)

Interventions prior to the onset of mental health disorders and early onset of psychotic disorders

Innovation (INN)

New approaches and community-driven best practices

*Component amounts based on FY 17/18 revenue received

Annual Update – Program Outcomes

Community Services and Supports

Full Service Partnerships*		Outreach & Engagement		System Development	
06/07:	161	06/07:	314	06/07:	1,846
07/08:	281	07/08:	1,905	07/08:	3,896
08/09:	336	08/09:	4,707	08/09:	3,684
09/10:	350	09/10:	5,471	09/10:	4,159
10/11:	428	10/11:	9,996	10/11:	4,089
11/12:	426	11/12:	9,121	11/12:	4,585
12/13:	491	12/13:	6,235	12/13:	2,765
13/14:	482	13/14:	7,751	13/14:	2,571
14/15:	477	14/15:	6,328	14/15:	2,523
15/16:	516	15/16:	6,141	15/16:	2,047
16/17:	550	16/17:	6,073	16/17:	2,245

** there are 397 available FSP slots across all age groups*

Percent Improvement in Outcomes by Age Group

Year before FSP Compared with First Year with FSP

FSP Outcomes*	Child (16 years & younger)	TAY (17 to 24 years)	Adult (25 to 59 years)	Older adult (60 years & older)
Self-reported Outcomes (Survey data)				
Homelessness	22%	7%	28%	NR
Detention or Incarceration	(24%)	16%	30%	NR
Arrests	67%	65%	87%	NR
Mental Health Emergencies	89%	67%	57%	42%
Physical Health Emergencies	100%	88%	65%	29%
School Suspensions	47%	72%	NR	NR
Attendance Ratings	10%	(4)%	NR	NR
Grade Ratings	14%	1%	NR	NR
Employment	NR	NR	26%	NR

NR = Not Reported

Data is through June 30, 2017

Full Service Partnerships (FSP)

(EHR data from inception, all age groups, n=667)

- **Hospitalizations** improved significantly after first year of FSP, from a 23% (153) any hospitalization to 13% (87).

- **Psychiatric Emergency Services (PES) visits** improved significantly after first year of FSP, from 42% (280) any PES event to 29% (193).

Prevention and Early Intervention (PEI)

	Ages 0-25	Adults and Older Adults	All Age Groups	Early Onset of Psychotic Disorders
FY 12-13	420	771	3,786	35
FY13-14	414	1,245	3,601	46
FY 14-15	299	2,090	3,445	60

PEI Updated Guidelines Includes New Categories

	Ages 0-25	Early Intervention	Prevention	Recognition of Early Signs of MI	Stigma & Discrimination Prevention	Access & Linkage to Treatment
FY 15-16	420	680 2,977 – SMART calls	4,784	225	228	983
FY 16-17	482	724 2,657 SMART calls	4,831	247	272	1000

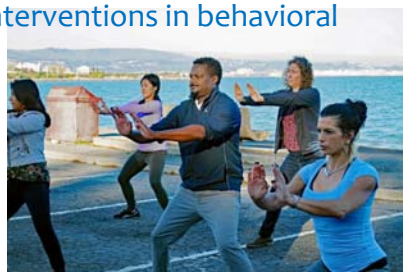
I Am Almighty – By Alexis

https://www.youtube.com/watch?v=crDvBYSGFF0&index=14&list=PLZgatuxFMMyHP9gSZdrkJIYHa5aNB0Ty9

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

Community Need

- MHSA FY 14/15 Three-Year planning process
  - Alternative treatment options to deepen focus on trauma informed care and provide improved outcomes for clients
  - Trauma is frequently undiagnosed or misdiagnosed leading to inappropriate interventions in behavioral health care settings.



MHSA Innovation

- Since 2012, BHRS Youth System has provided extensive training in with positive outcomes for children and youth.
- The expansion and evaluation of NMT in an adult system of care is the first of its kind.

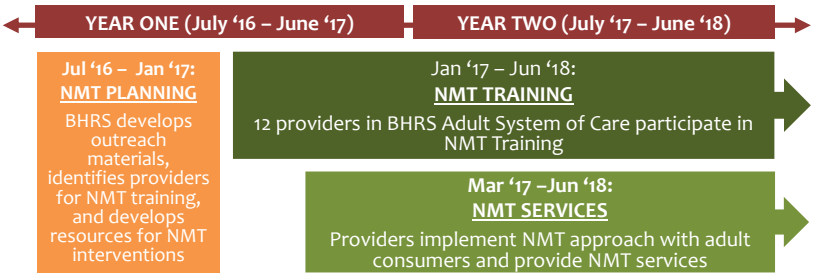
Learning Goal 1	Learning Goal 2
Can NMT, a neurobiology and trauma-informed approach, be adapted in a way that leads to better outcomes in recovery for BHRS adult consumers?	Are alternative therapeutic and treatment options, focused on changing the brain organization and function, effective in adult consumers' recovery?

About NMT

- Developed by Dr. Perry at the Child Trauma Academy as an alternative approach to addressing trauma
- NMT uses assessments to guide the selection of individualized alternative interventions (drumming, yoga, expressive arts, etc.)
- Interventions help clients better cope, self-regulate and progress in their recovery

Implementation

- Estimate 75-100 adults served annually
  - General adult clients (ages 26+) receiving specialty mental health services
  - Transition age youth (ages 18-25)
  - Criminal justice-involved clients re-entering the community

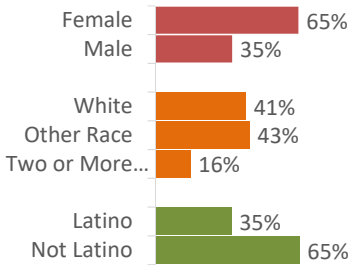


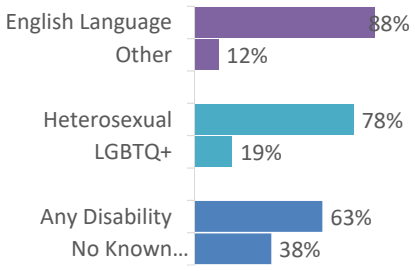
Accomplishments To-Date

- 6 providers completed the NMT training, 5 are continuing to become trainers
- Broad array of resources established
  - Clients: Yoga, drumming, therapeutic massage, animal-assisted therapy
  - Clinics: therapeutic lighting, art supplies, weighted blankets, sensory integration tools

Client Demographics

- 60 clients served total (doubled in Year 2)
  - 73% (44) adults, 23% (16) TAY

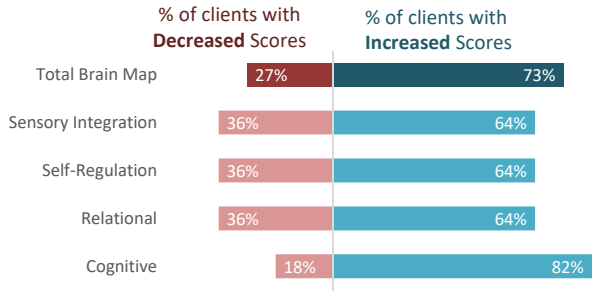




Client Outcomes

- Clients appear to be benefitting from NMT services

Percentage of Clients with Increased and Decreased Assessment Scores from Baseline to Follow-up, N=11, **FY17-18**



Client Outcomes (cont'd)

The moment you start, you get the anger out by massaging the clay. All the stress and tension I had in my hands and my mind, I didn't have it anymore. I didn't even remember the reason why I was so upset or hurt.

– NMT Client

- The NMT approach may make it easier for some clients to engage in therapy.

- NMT implementation may be helping clinics and programs within the BHRS adult system of care be more trauma-informed.

[NMT] doesn't feel like the normal going to the counselor and you just tell them your feelings and it's depressing and it's serious. [NMT] doesn't feel like that. It feels light.

– NMT Client

Expectations

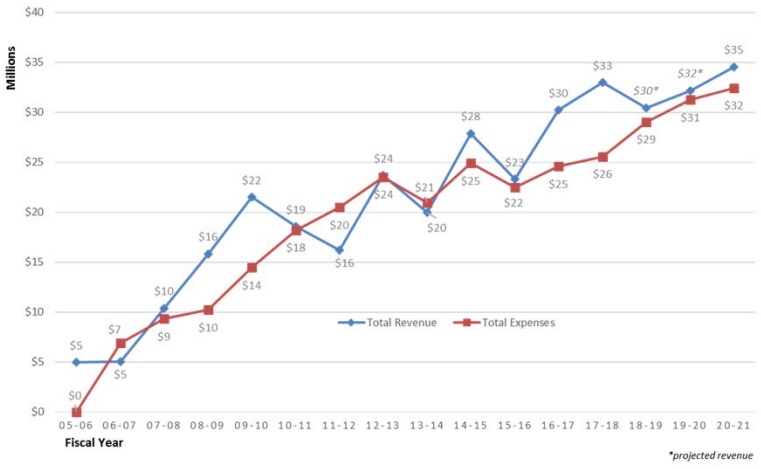
- Train 12-18 from up to 6 different BHRS adult system of care programs
- Once providers are fully trained, approximately 75-100 clients will receive an assessment and relevant interventions annually.
- Would like to increase intervention resources
- Sustainability and expansion leveraged through the train-the-trainer model
  - Total for sustainability: $200,000 annually (.3FTE MHS, maintenance and training, interventions)

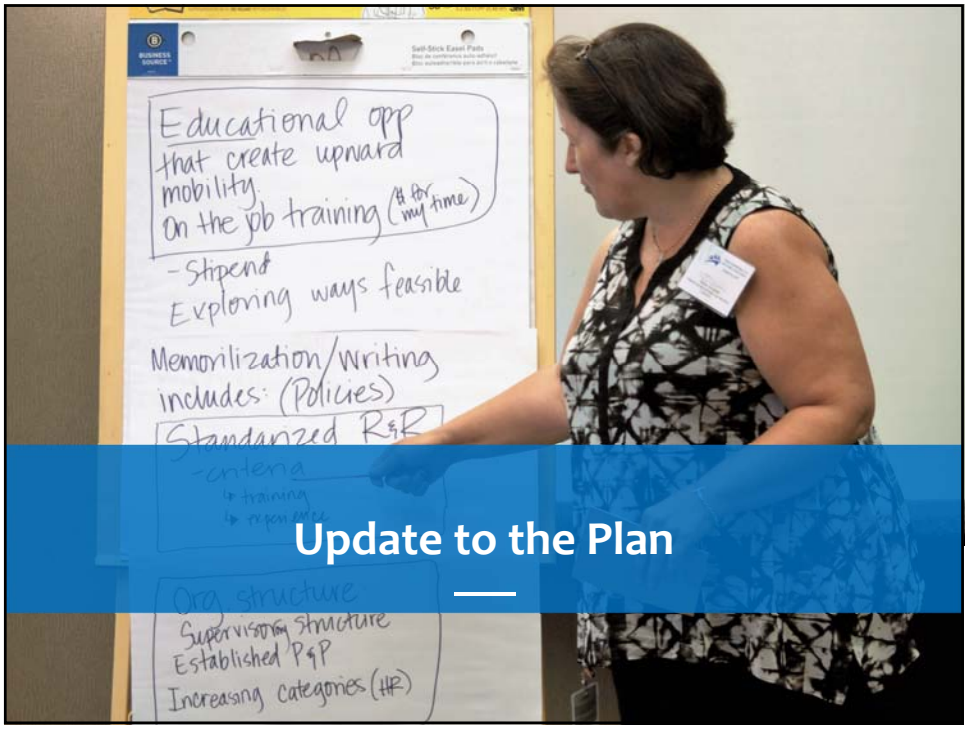
Progress on Priority Expansions

FY 17-18 to 19/20 Expansions

Component	Priority Expansions	Estimated Cost Per Fiscal Year	Implemented
CSS General Systems Development	Expansion of supports for older adults *	$130,000	YES – Partial Senior Peer Counseling OASIS expansion expected FY 18/19
	Mobile mental health and wellness services to expand access to Coastside	$450,000	In Progress
CSS Outreach & Engagement	Expansion of culturally responsive outreach strategies	$50,000	YES Chinese community outreach
Prevention & Early Intervention	Expansion of Stigma Free San Mateo, Suicide Prevention and Student Mental Health efforts*	$50,000	In Progress
	Youth mental health crisis support and prevention	$600,000	In Progress
	After-care services for early psychosis treatment	$230,000	YES PREP/BEAM After Care Services

MHSA Revenue & Expenditures





Update to the Plan

Update to the Plan

- San Mateo County is preparing for a predicted economic down turn. Current MHSA programs and prioritized expansions will not be reduced.
- MHSA funding must be optimized in accordance to the MHSA Funding Principles and continue to strengthen and build on MHSA priorities.
- **Proposed update:**
  - AOT FSP's (Laura's Law) - $890,639
  - Board & Care for SMI - $ 1,100,000

Input, public comments?

Motion to Amend

- Motion to amend the MHSA Three-Year Plan to include funding of Laura's Law FSPs and augmented Board and Care for serious mentally ill clients

MHSA Reserves

- A reserve is in place to allow counties to maintain programs during a recession
  - **Reserve Goal Recommendation:**
    50% of Highest Annual Revenue ($33M)

San Mateo County MHSA Funds	
Unspent	$35.7M
Reserve Goal	-$16.5M
Obligated	-$6.7M
Available to Spend	$12.5 M

"Available to Spend" Plan Development

- $12.5M "Available to Spend" will advance MHSA priorities:
  - Innovation Projects - Pride Center, HAP-Y, NMT for Adults, Tech Suite
  - One-time funding needs - Workforce Education and Training, Technology Needs
  - Other considerations - Total Wellness
  - Other Expansions from Three-Year Plan
- Late Spring – MHSA Steering Committee to reconvene

Public Comments

Announcements

- New Innovation Funding Cycle launched - flyer
  - Submit Your Ideas
  - Must address prioritized needs
  - Must complete an Innovation Project Form
    Deadline: 2/22/19
- Technology Suite Advisory Committees - flyer
  - Ongoing monthly meeting through April

Next Steps – Annual Update

- 30 day Public Comment
  - MHSARC 2/6/19 and 3/6/19 (Public Hearing)
  - Public Comment Form
- Presentation to the Board for adoption of the plan
- Controller to certify expenditures
- Submit to the State MHSOAC for approval

Thank you!

For more information: www.smchealth.org/MHSA
Doris Estremera, MHSA Manager
(650) 573-2889 or mhsa@smcgov.org

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

San Mateo County Health System
Behavioral Health and Recovery Services (BHRS)

Mental Health Services Act (MHSA)

Background

Proposition 63, now known as 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 one million dollars translating to about $27 million average for San Mateo County annually in the last five years through Fiscal Year 2017-18.

Principles and Core Values

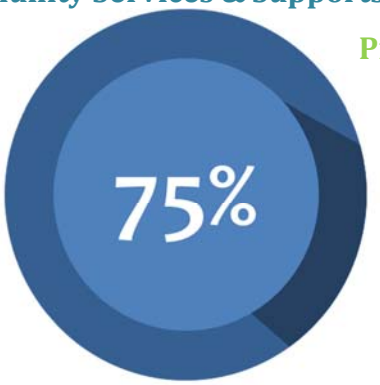
MHSA emphasizes transformation of the behavioral health system, improving the quality of life for individuals living with behavioral health issues and increasing access for marginalized communities.

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

Funding Allocation

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

Community Services & Supports (CSS)



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

Prevention & Early Intervention (PEI)

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

Innovation (INN)

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

San Mateo County Approach

In San Mateo County, MHSA dollars are virtually everywhere in the BHRS system and highly leveraged. MHSA-funded activities further BHRS' nine strategic initiatives to Advance Prevention and Early Intervention; Build Organizational Capacity; Empower Consumers and Family Members; Disaster Preparedness; Enhance Systems and Supports; Foster Total Wellness; Promote Diversity and Equity; Cultivate Learning and Improvement; and be Welcoming and Engaging to those who seek our services and work with us.

Program and Expenditure Planning

Counties are required to prepare for and submit a Three-Year MHSA Plan and Annual Updates**.**

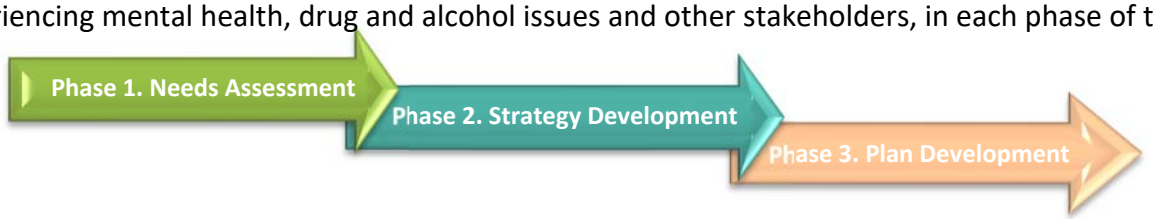
The **MHSA Three-Year Plan** is developed in collaboration with clients and families receiving services, community members, staff, community agencies and stakeholders and includes the following:

1. Existing MHSA funded program descriptions and goals for each of the required MHSA components
2. Priority needs or gaps in services as identified by the planning process
3. Expenditure projections based on estimated revenues and unspent funds

Each MHSA Three-Year Plan process builds upon existing funded programs and input received through previous planning. MHSA funded programs are evaluated throughout their implementation, adjustments are made as needed and outcomes shared to inform recommendations about continuing and or ending a program. All agencies funded to provide MHSA services go through a formal Request for Proposal (RFP) process to ensure an open and competitive process. To receive notification of BHRS funding opportunities, please subscribe at www.smchealth.org/rfps[1].

Stakeholder and Community Input

MHSA Three-Year planning uses a Community Program Planning (CPP) process to engage clients and families experiencing mental health, drug and alcohol issues and other stakeholders, in each phase of the process.



- Highlighting what's working well (programs, program components, efforts)
- Identifying what needs improvement, what's missing from both the CPP and services
- Prioritizing identified needs for potential future funding
- Developing ideas to address priority needs and potentially serve as the basis for future RFPs

Input is gathered at existing community meetings, specific input sessions, through surveys, and as formal public comment during the required 30-Day Public Comment and Public Hearing. To receive notification of input opportunities please subscribe at www.smhealth.org/mhsa.

Current Timeline

- Three-Year Plan Implementation: July 1, 2017 – June 30, 2020
- Annual Updates Due: December 2018, December 2019, December 2020
- Next Three-Year Planning Phase: January 2020 – June 2020
- Next Three-Year MHSA Plan Due: December 2020

[1] Counties receive monthly MHSA allocations based on actual accrual of tax revenue, making it difficult to know exact allocations of funding that will be available on an annual basis for new programs. Therefore RFP's can be released at any time within the Three-Year Plan implementation.

San Mateo County Health System Behavioral Health and Recovery Services (BHRS)

Mental Health Services Act (MHSA) Components and Programs

Fiscal Year 2017 – 2018

Community Services and Supports (CSS)	
Full Service Partnerships (FSP)	Children and Youth • Edgewood Short-term Adjunctive Youth and Family Engagement (SAYFE) FSP • Edgewood Comprehensive "Turning Point" FSP • Fred Finch Out-of-County Foster Care FSP Transition Age Youth • Edgewood Comprehensive "Turning Point" FSP o North and South Drop-in Centers o Caminar Enhanced Supportive Education Services o Mental Health Association Supported Housing Adult /Older Adult • Telecare - FSP and Housing Support • Caminar - FSP and Housing Support • Mateo Lodge - South County Integrated FSP
General System Development (GSD)	• Older Adult System of Integrated Services (OASIS) • Senior Peer Counseling Services (50% CSS; 50%PEI) • Pathways, Court Mental Health • Pathways, Co-Occurring Housing Services • Juvenile Girls Program • Co-Occurring AOD Services and Recovery Support • Child Welfare Partners Program • Puente Clinic for Intellectually Disabled Dual Diagnosis • Peer Consumer and Family Partners • The California Clubhouse • The Barbara A. Mouton Multicultural Wellness Center • Evidence Based Practices (EBP) and Services
Outreach and Engagement (O&E)	• Family Assertive Support Team (FAST) • North County Outreach Collaborative (NCOC) • East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) and East Palo Alto Behavioral Health Advisory Group (EPABHAG) • Ravenswood Family Health Center (40% CSS; 60%PEI) • HEI Outreach Worker Program (50% CSS; 50% PEI)

Innovations (INN)
Health Ambassador Program – Youth (HAP-Y) The Pride Center - Behavioral Health Coordinated Services Neurosequential Model of Therapeutics (NMT) in Adult System of Care

Mental Health Services Act (MHSA) Components and Programs

Fiscal Year 2017 – 2018

Prevention and Early Intervention (PEI)	
Prevention & Early Intervention (Ages 0 – 25)	• Early Childhood Community Team (ECCT) • Project SUCCESS • Seeking Safety • Teaching Pro-Social Skills • Crisis Hotline, Youth Outreach and Intervention Team
Early Intervention	• Prevention and Recovery in Early Psychosis (PREP) • Primary Care Interface • SMC Mental Health Assessment and Referral Team (SMART)
Prevention	Office of Diversity and Equity (ODE) • Health Equity Initiatives • The Parent Project • Health Ambassador Program
Recognition of Early Signs of MI	• Adult Mental Health First Aid
Stigma Discrimination and Suicide Prevention	• Digital Storytelling and Photovoice • Stigma Free San Mateo County – Be the ONE Campaign • San Mateo County Suicide Prevention Committee (SPC)
Access and Linkage to Treatment	• Ravenswood Family Health Center (40% CSS; 60%PEI) • Senior Peer Counseling (50% CSS; 50%PEI) • HEI Outreach Worker Program (50% CSS; 50% PEI)

One-time Funding Allocations (through FY 2017-18)	
Workforce and Education Training (WET)	• Training by/for Consumers and Family Members • System Transformation and Workforce Development • Behavioral Health Career Pathways Program • Financial Incentives – Cultural Stipends, Loan Assumption
Housing	• Cedar Street Apartments in Redwood City (2009) • El Camino Apartments in South San Francisco (2010) • Delaware Pacific Apartments in San Mateo(2011) • Waverly Place Apartments in North Fair Oaks (2017) • Bradford Senior Housing and 2821 El Camino Real (2018)
Capital Facilities and Information Tech	• eClinical Care (launched in 2008-09)

*In San Mateo County, MHSA funds are integrated throughout the BHRS system; many of these programs are also funded by other sources.

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MHSA Funding Principles

First adopted in November 2009, updated September 2018

These MHSA Funding Principles were developed to guide annual funding allocations and expansions; they also build from the County's and Health System budget balancing principles to guide MHSA reduction decisions when needed. Decisions regarding MHSA funding are based on the most current MHSA Three-Year Plan; any updates to the recommendations require MHSA Steering Committee approval and stakeholder engagement, which will include a 30-day public comment period and public hearing as required by the MHSA legislation.

Maintain MHSA required funding allocations

See attached MHSA Funding and Program Planning Guidelines document.

Sustain and strengthen existing MHSA programs

MHSA revenue should be prioritized to fully fund core services that fulfill the goals of MHSA and prevent any local or realignment dollars filling where MHSA should.

Maximize revenue sources

Billing and fiscal practices to draw down every possible dollar from other revenue sources (e.g. Medi-Cal) should be improved as relevant for MHSA funded programs.

Utilize MHSA reserves over multi-year period

MHSA reserves should be used strategically to mitigate impact to services and planned expansions during budget reductions.

Prioritize direct services to clients

Indirect services are activities not directly related to client care (e.g. program evaluation, general administration, staff training). Direct services will be prioritized as necessary to strengthen services to clients and mitigate impact during budget reductions.

Maintain prevention efforts

At minimum, 19% allocation to Prevention and Early Intervention (PEI) should be maintained and additionally the impact across the spectrum of PEI services and services that address the root causes of behavioral health issues in our communities should be prioritized.

Sustain geographic, cultural, ethnic, and/or linguistic equity.

MHSA aims to reduce disparities and fill gaps in services; reductions in budget should not impact any community group disproportionately.

Evaluate potential reduction or allocation scenarios

All funding decisions should be assessed against BHRS's Mission, Vision and Values and when relevant against County and Health System Budget Balancing Principles.

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MHSA Program Funding Guidelines – Summary

MHSA Component	Categories	Funding Allocation (% of total revenue)
Community Services and Supports (CSS)[1]	• Full Service Partnerships (FSP) • General Systems Development (GSD) • Outreach and Engagement (O&E)	76% FSP should be at least 51% of the CSS allocation
Prevention and Early Intervention (PEI)[2]	• Ages 0-25 • Early Intervention • Prevention • Recognition of Signs of Mental Illness • Stigma and Discrimination • Access and Linkages	19%* Ages 0-25 should be at least 51% of the PEI allocation
Innovations (INN)[3]	N/A	5%

* PEI expenditures may be increased in which the department determines that the increase will decrease the need and cost for additional services to severely mentally ill persons in that county by an amount at least commensurate with the proposed increase.

Reversion Period: Counties must expend the revenue received for each core component within 3 years (starting with the year revenue is received) or must return it to the State mental health fund.

One-time Funding Components: counties received a one-time allocation to fund strategies in Workforce Education and Training (WET) [4], Capital Facilities and Information Technology (CF/IT) [5], and Housing[6]. All one-time funding has been expended. These components can continue to be funded under CSS, as determined by the following additional funding guidelines.

- Up to 20% of the average 5-year total of MHSA funds can be allocated from CSS to the technological needs, capital facilities, human resources, and a prudent reserve.
- Assembly Bill 727 clarifies that counties can fund housing assistance, not just for FSP clients.

Three-Year Plan and Annual Updates:

- up to 5% of total annual MHSA revenues can be allocated for annual MHSA planning efforts.
- All expenditures must be consistent with the current three-year plan or annual update developed through a Community Program Planning (CPP)[7] process.
  - Current Three-Year Plan Implementation: July 1, 2017 – June 30, 2020
  - Annual Updates Due: December 2018, December 2019, December 2020
  - Next Three-Year Planning Phase: January 2020 – June 2020
  - Next Three-Year MHSA Plan Due: December 2020

Prudent Reserve (PR): Counties are required to establish and maintain a PR for revenue decreases.

- The 50% Local Prudent Reserve requirement was rescinded (Info Notice 11-05)
- Counties may fund to a level determined appropriate and that does not exceed 33% of the counties' largest annual distribution (Info Notice 18-033).
- All other policy and guidance remains in effect (Info Notice 09-16).

Non-supplantation:

- Funds shall not be used to supplant any state or county funds required to be utilized to provide mental health services, that was in effect on November 2, 2004.

Definitions

[1] **Community Services & Support (CSS)** provides direct treatment and recovery services to individuals of all ages living with serious mental illness (SMI) or serious emotional disturbance (SED):

a. **Full Service Partnership (FSP)** plans for and provides the full spectrum of services, mental health and non-mental health services and supports to advance client's goals and support their recovery, wellness and resilience.

b. **General Systems Development (GSD)** improves the mental health service delivery system. GSS may only be used for; treatment, including alternative and culturally specific; peer support; supportive services to assist with employment, housing, and/or education; wellness centers; case management to access needed medical, educational, social, vocational rehabilitative or other services; needs assessment; individual Services and Supports Plans; crisis intervention/stabilization; family education; improve the service delivery system; reducing ethnic/racial disparities.

c. **Outreach and Engagement (O&E)** is to reach, identify, and engage unserved individuals and communities in the mental health system and reduce disparities. O&E funds may be used to pay for strategies to reduce ethnic/racial disparities; food, clothing, and shelter, but only when the purpose is to engage unserved individuals, and when appropriate their families, in the mental health system; and general outreach activities to entities and individuals.

[2] **Prevention & Early Intervention (PEI)** targets individuals of all ages prior to the onset of mental illness, with the exception of early onset of psychotic disorders. PEI emphasizes improving timely access to services and reducing the 7 negative outcomes of untreated mental illness; suicide; incarcerations; school failure or dropout; unemployment; prolonged suffering; homelessness; and removal of children from their homes.

a. **Early Intervention** programs provide treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence. Services shall not exceed 18 months, unless the individual receiving the service is identified as experiencing first onset with psychotic features, in which case early intervention services shall not exceed 4 years.

b. **Prevention** programs reduce risk factors for developing serious mental illness and build protective factors for individuals whose risk of developing a serious mental illness is greater than average and, as applicable, their parents, caregivers, and other family members. Services may include relapse prevention and universal prevention.

c. **Outreach for Recognition of Early Signs of Mental Illness** to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.

d. **Access and Linkage to Treatment** connects individuals with severe mental illness as early in the onset of these conditions as practicable, to medically necessary care and treatment, including care provided by county mental health programs. Examples include screening, assessment, referral, help lines, and mobile response.

e. **Stigma and Discrimination Reduction** activities reduce negative feelings, attitudes, beliefs and/or discrimination related to mental illness or seeking services. Examples include social marketing campaigns, speakers' bureaus, targeted education and training, anti-stigma advocacy, and efforts to encourage self-acceptance.

f. **Suicide Prevention** programs are optional. Activities prevent suicide but do not focus on or have intended outcomes for specific individuals. Examples include campaigns, suicide prevention networks, capacity building, culturally specific approaches, survivor-informed models, screening, hotlines or web-based resources, training and education.

[3] **Innovation (INN)** projects are designed and implemented for a defined time period (not more than 5 years) and evaluated to introduce a new behavioral health practice or approach; make a change to an existing practice; apply a promising community-driven practice or approach that has been successful in non-behavioral health; and has not demonstrated its effectiveness (through mental health literature).

[4] **Workforce Education & Training (WET)** provides clients and families training to help others, promote wellness and other positive outcomes. Providers are able to work collaboratively to deliver client-and family-driven services, outreach to unserved and underserved populations, and provide linguistically and culturally relevant services.

[5] **Capital Facilities & Technological Needs (CF/TN)** includes facilities for the delivery of MHSA services to clients and their families or for administrative offices; support an increase in peer-support and consumer-run facilities; community-based settings; and technological infrastructure to facilitate the highest quality and cost-effective services and supports.

[6] **Housing** is used to acquire, rehabilitate or construct permanent supportive housing for clients with serious mental illness and provide operating subsidies. This service category is part of CSS.

[7] **Community Program Planning (CPP)** process is used to develop MHSA three-year plans and updates in partnership with stakeholders to identify community issues related to mental illness, lack of services and supports; analyze the mental health needs in the community; and identify and re-evaluate priorities and strategies and includes a 30-day public comment, a public hearing by the local mental health board and local board of supervisors.

MHSA Funding Available – Submit Your Innovative Ideas!

The Mental Health Services Act (MHSA) funds Innovative Projects to develop new best practices in behavioral health, ideas must:

1. Introduce a new practice or approach
2. Make a change to an existing practice, including application to a different population.
3. Apply a promising community-driven practice or approach that has been successful in non-behavioral health contexts or settings.
4. NOT have been demonstrated effective (in the literature, research, etc.).

Ideas should address the following prioritized needs:

- Engagement and integration of **older adults**
- **Culturally relevant** outreach and service delivery
- Integration of **peer/family** supports
- Integration of **co-occurring** practices
- Engagement services for **transition-age youth**
- Broader **housing** options across the continuum of care

** For more information visit, smchealth.org/mhsa. For your idea to be considered, you must complete an Innovation Project Form, available on smchealth.org/mhsa and submit it to mhsa@smcgov.org* ***by 2/22/19***

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Questions?
Doris Estremera, MHSA Manager
mhsa@smcgov.org or 650-573-2889

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Mental Health Services Act (MHSA) Steering Committee

Wednesday, January 30, 2019 / 3:00 - 4:30 PM
Health System Campus, Room 100, 225 37th Ave. San Mateo, CA 94403

MEETING MINUTES

1. **Welcome & Introductions** 3:10 PM
   Supervisor Dave Pine
   Informal introductions: Steering committee members, commissioners, New Director Scott Gilman
   - *Doris Estremera*
     - *Mary (Office of Education) new member on the Steering Committee*
     - *MHSA Steering Committee meets 2x year, attempt to have balanced approach toward decisions for funding*

2. **MHSA Annual Update – Program Outcomes** 3:15 PM
   Doris Estremera, MHSA Manager
   - *Every year we submit a 3-year plan, last plan 2017-2020*
   - *MHSA (Prop 63, passed in 2004) provides dedicated source of funding for transformational work.*
     - *76% of funding towards Community Services and Supports (direct treatment, recovery for individuals with SMI)*
     - *19% Prevention and Intervention*
     - *5% Innovation*
   - *Annual Update covers FY 16-17 data*
     - Full service partnerships
       - Increased number of clients served over the years
       - 606 youth, 427 adults served over history of funding
       - Shared success stories from FSP program provided by Edgewood (service provider)
       - 397 slots available in a year, but we see clients in and out throughout the year and so are able to serve more than 397
     - Outreach and Engagement – linking individuals to services
       - Outreach collaboratives do their work here
       - Numbers dipped in 10-12 because changed how we defined 'meaningful' outreach
     - System Development- strengthening and expanding internal capacity to respond to demands
       - Peer support services, Physicians trained in evidence-based practices, Supported Education and Employment, Integration work
     - Full Service Partnerships
       - 56% funding in SMC goes here
       - Data shows improvement made

        - We've seen improvements in all indicators except youth
            - Youth- small numbers for data collection may have impacted negative improvement indicator
        - 1 year in v. 2 years, 2 years shows more positive impact
    - Hospitalizations and Psychiatric Emergency Services
        - Improvements in both
    - Goal to increase data collection in future years
- Early Intervention
    - Required to spend 51% of funding on 0-25 years old
    - Early community response team, StarVista, Crisis Hotline, Teaching ProSocial Program, Early Psychosis Program, Mental Health First Aid, Office of Diversity and Equity
    - Shared 2-minute video from Story Telling program out of Office of Diversity and Equity

3. MHSA Innovation Update 3:30 PM

- Neurosequential Model of Therapeutics (NMT) – Adults
  Toni DeMarco, BHRS Youth Deputy Director
    - NMT program launched 7 years ago in youth system
    - NMT for adults is direct outcome of adult patients requesting
    - It is an evidence-based model for addressing trauma, chronic stress, neglect from a neurodevelopmental framework
    - SMC was an early adopter of the program from Dr. Perry and has been a pioneer in implementing in youth and adult programs
    - SMC provides a yearlong training program for clinicians
        - 1-year additional training (in addition to regular clinical training), minimum 4 hrs/wk
        - Teaches theory, how to use assessment tool, understand specific interventions
    - 5 clinicians are also becoming trainers for the program this year
    - This approach addresses underlying trauma in patients and families from systems perspective
    - 2 learning goals
        - Can NMT be adapted for adults in a way that leads to better outcomes for adults in BHRS system?
            - 1.5 years in and already seeing success
        - Are alternative therapeutic treatment options focused on changing brain organization effective?
            - So far seeing this as effective with adults as it is with children
    - Specific therapies used in NMT include:
        - Drumming, expressive arts, animal assisted therapy, yoga, massage, physical activity
    - Interventions help people cope and progress in recovery
    - NMT does not replace other treatments, it compliments
        - Fidelity achieved by doing these different interventions and tracking them
    - Implementation
        - At almost 100 clients
        - Estimate increased clients with more clinicians trained
    - Reassessments (Time 2, Time 3)
        - Report created to track changes in the brain that were targeted with sequential intervention
    - Goal to have 2-3 NMT clinicians at each clinic in system
    - Various NMT activities happening throughout county service providers, at different clinics

- There programs are changing the way teams are talking about services in general, their own self-care
- 60 clients evaluated
  - 40 adults, 16 TAY
  - 65% female, 35% male
- Outcomes
  - Look for 4 areas of improvement in the brain
    - Sensory integration, self-regulation, relational health, cognitive functioning
    - Adults seem to struggle with cognitive functioning and relational functioning
  - Clients attest to the helpfulness of therapy techniques
- Expectations going forward
  - Train more staff
  - Increase clients who receive NMT services
  - Increase resources to expand program
- Currently working with the ARM team to develop specialized trainings for board and care homes (for providers)
- Questions:
  - How do clients select to participate in this program if they don't self-identify as having trauma?
    - Staff trained for being able to recognize signs of trauma sooner
  - Next question in-audible due to construction in the room
  - What percentage of cost goes into salary v. materials?
    - 1/3 Program Specialist paid for out of MHSA dollars
    - Up until a few months ago people making this happen out of their regular time, no funds allocated specifically for programming
  - Is the program still available for youth?
    - Yes
    - Continue to take applicants to train providers for youth system
    - Program runs January – January
    - The youth system has always included partner agencies, to train providers outside of the county

4. Funding Priorities and Update to the Plan 3:45 PM

- *Steve Kaplan, BHRS Director*
  - *All funding priorities are in progress, we've seen good opportunities for this*
  - Changes to the plan
    - Facing $7.5 million gap in FY 19, $11million gap over next two years
    - Overall MHSA has continued to grow
    - Previous gap funds between spending and cost
      - These gap funds are put in trust account, available to use at time during recession or possible upcoming rainy-day funds
    - Facing cuts in county general funds – recommendation to supplement with MHSA funds
    - Board and Care for individuals with SMI- currently funded with realignment funds. Recommend using $1.1 million of MHSA to keep beds in place for these programs
    - Trust account contains $35 million (reserve for MHSA)
      - Recommending 50% of $35 million be in reserve account
      - $6 million for innovation
      - $12.5 million possibilities for how to use:

        - One-time funding for workforce
        - Total Wellness
        - Pride Center
    - Steering Committee meeting in spring to discuss how to use these funds
- Motion to move forward to discuss how to spend $12.5 million
    - Melissa made the motion
    - Mary seconds the motion
    - Motion approved

5. **Announcements/Public Comments** 4:15 PM
    - New Innovation Funding Cycle Launch – flyer included
    - Technology Suite Advisory Committees – flyer included
        - New Innovation planning cycle starting, applications are open

6. **Adjourn** 4:30 PM

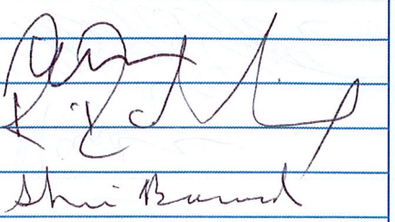
Mental Health and Substance Abuse Recovery Commission (MHSARC)

Opening of a 30-day public comment period for the MHSA Annual Update will occur at the next MHSARC meeting:

February 6, 2019 from 3-5pm.
Silicon Valley Community Foundation
1300 S. El Camino Real, Suite 100, San Mateo

Stakeholder Group	Name(s)	Title (if applicable)	Organization (if applicable)	Email	Signature
Provider of MH/SU Svcs	Adriana Furuzawa	Program Services Manager	SMC Health System, Aging & Adult Services	asawamura@smcgov.org	
Client/Consumer	Aisha Williams		Lived Experience Academy	aishamwilliams92@gmail.com	01/30/19
Other-Aging and Adult Services	Anna Sawamura	Program Services Manager	SMC Health System, Aging & Adult Services	asawamura@smcgov.org	
Public	Betty Savin*	MHSARC Commissioner		bettysavin@yahoo.com	
Family Member	Bill Nash*	MHSARC Commissioner		Bill.nash@kla-tencor.com	
Provider of MH/SU Svcs	Cardum Harmon	Executive Director	Heart & Soul, Inc.	cardumh@heartandsoulinc.org	
Client/Consumer- SA	Carol Marble*	MHSARC Commissioner		carolmarb@aol.com	
Member	Catherine Koss *	MHSARC Commissioner		catekoss@gmail.com	
Public	Cherry Leung	MHSARC Commissioner		cherry.leung@ucsf.edu	
Provider of MH/SU Svcs	Clarise Blanchard	Director of Substance Abuse and Co-occuring Disorders	Star Vista and BHRS Contractors Association	cblanchard@star-vista.org	
San Mateo County District 1	David Pine*	Supervisor, District 1	Board of Supervisors	DPine@smcgov.org	
Member	Donald Mattei*	MHSARC Commissioner		Donald.mattei@gmail.com	
Provider of MH/SU Svcs	Gloria Gutierrez	MH Counselor	BHRS	GGutierrez@smcgov.org	
Member	Isabel Uibel *	MHSARC Commissioner		Isabel.c.uibel@kp.org	
Client/Consumer- Adults	Jairo Wilches	Liaison and BHRS Wellness Champion	BHRS, Office of Family and Consumer Affairs	jwilches@smcgov.org	
Provider of MH/SU Svcs	Joann Watkins	Clinical Director	Puente de la Costa Sur	watkins3121@gmail.com	
Client/Consumer-Pathways	Jose Solano			jscompany22@gmail.com	
Family Member	Judith Schutzman			judyschutzman@aol.com	
Family Member	Juliana Fuerbringer		California Clubhouse	julianafuer@gmail.com	
Client/Consumer	Kate Pfaff*	MHSARC Commissioner		kate@redwoodgirl.com	
Provider of Social Services	Kava Tulua	Executive Director	One East Palo Alto and East Palo Alto Partnership for Mental Health Outreach	ktulua@1epa.org	
Public	Leticia Bido*	MHSARC Commissioner		leticia.bido@gmail.com	
Cultural Competence & Diversity	Maria Lorente-Foresti	Director	Office of Diversity and Equity	Mlorente-foresti@smcgov.org	
Law Enforcement	Mark Duri	MHSARC Commissioner		mduri@smcgov.org	
Provider of Social Services	Mary Bier	Mbier@juhsd.Net	North County Outreach Collaborative	marykbier@gmail.com	
Education	Mary McGrath	Admininstrator	San Mateo County Office of Education, Safe and Supportive Schools	mmcgrath@smcoe.org	
Provider of MH/SU Svcs	Melissa Platte	Executive Director	Mental Health Association	melissap@mhasmc.org	
Client/Consumer- Adults	Michael Lim			mhl-lim@outlook.com	
Client/Consumer- Adults	Michael S. Horgan	Program Coordinator	Heart & Soul, Inc.	michaelhorgan@me.com	
Family Member	Patricia Way*	MHSARC Commissioner	MHSARC	patcway@hotmail.com	
Client/Consumer- Adults	Patrick Field			pfield3311@gmail.com	

Client/Consumer	Patrisha Ragins*	MHSARC Commissioner		patrisharagins@yahoo.com	
Other- Advocate	Randall Fox	Health, Law and Policy Advocate	Former MHSARC Chairman	randallfox@sbcglobal.net	
San Mateo County District 1	Randy Torrijos*	Staff to David Pine	Board of Supervisors	Rtorrijos@smcgov.org	
Other- Peer Support	Ray Mills	Executive Director	Voices of Recovery	rmills@vorsmc.org	
Provider of Social Services	Rev. William Chester McCall	CMCCALL@IEPA.ORG	Multicultural Counseling & Education Services of the Bay Area LOVE EAST PALO ALTO	~~chester.wellness@gmail.com~~	
Client/ Consumer	Rodney Roddewig*	MHSARC Commissioner	MHSARC	rrodney2k6@gmail.com	
Member	Sheila Brar*	MHSARC Commissioner		sheila.nathan@gmail.com	
Provider of Social Services	Sheri Broussard		HIP Housing	sbroussard@hiphousing.org	
Client/Consumer	Wanda Thompson*	MHSARC Commissioner		w.thompson1967@yahoo.com	
Member	Yoko Ng*	MHSARC Commissioner		Yng15@mail.ccsf.edu	
Family Member	Yolanda Novello	Family Partner	BHRS	YNovelo@smcgov.org	



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Family Member	Bill Nash*	MHSARC Commissioner		Bill.nash@kla-tencor.com	
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Public	Cherry Leung	MHSARC Commissioner		cherry.leung@ucsf.edu	
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Client/Consumer- Adults	Michael S. Horgan	Program Coordinator	Heart & Soul, Inc.	michaelhorgan@me.com	
Family Member	Patricia Way*	MHSARC Commissioner	MHSARC	patcway@hotmail.com	
Client/Consumer- Adults	Patrick Field			pfield3311@gmail.com	

Stakeholder Group	Name(s)	Title (if applicable)	Organization (if applicable)	Email	Signature
	Scott Gilman	Director	BHRS		01/30/19
	Chantae Rochester	Exec Secretary	BHRS	on file	
	Tonji Demaree	Dep Dir BHRS			
	Maria Martinez Resendez	Peer Worker	BHRS | ODE	mmartinezresendez@smcgov.org	
Heart and Soul, Inc.	Yoshie Hill	Executive Assistant	Heart and Soul, Inc	YoshieH@heartandsoulinc.org	Yoshie Hill
BOS D1	Rondy Torrijos	Leg Aide (Pine)	SMC BOS D1	rtorrijos@smcgov.org	
	Cindy Donio	Program Specialist	BHRS	cdonio@smcgov.org	
	Tinki Lelei	Program F.A	1 East Palo Alto	Tinkeivili@gmail	
	Laurie Kanzen	Exec Dir.	Friends 4 Youth	Laurie@friendsforyouth.org	
	Lauren Vecchione		Consumer		
	Helene Zimmerman	Exec Dir.	NAMI SMC	hzimmerenamisanmateo.org	
	Karen Wilmer	CEO	Friends for Youth	Karen@friendsforyouth.org	
	Jessi Mislin	SPO	Sand Hill Foundation	jessi@sandhillfoundation.org	
BHRS -	Gloria Gutierrez	BHRS -	CCMTI	GGutierrez@smcgov.org	
	Jean Perry		Community	jeanpv70@gmail.com	

All Public Comments Received

January 30, 2019 – MHSA Steering Committee Meeting Public Comments

Topic: MHSA Innovation, Neurosequential Model of Therapeutics –Extension Request

- How do clients select to participate in this program if they don't self-identify as having trauma?
    - Staff trained for being able to recognize signs of trauma sooner
- What percentage of cost goes into salary v. materials?
    - 1/3 Program Specialist paid for out of MHSA dollars
    - Up until a few months ago people making this happen out of their regular time, no funds allocated specifically for programming
- Is the program still available for youth?
    - Yes
    - Continue to take applicants to train providers for youth system
    - Program runs January – January
    - The youth system has always included partner agencies, to train providers outside of the county

January 31, 2019 - email

Sheri Broussard, HIP Housing

HIP Housing owns a few properties where tenants qualify to live there because they have a special section 8 voucher due to a permanent disability. The nature of the disability is not disclosed to us but many of the tenants have shared that they suffer from a serious mental illness. These are very difficult properties to manage and we know from our other programs and services that it is helpful to have a social worker, therapist or care team to help the tenant with communication, life skills and supportive services.

We would like to figure out a way to work with BHRS better to provide more supportive services to existing tenants and new housing opportunities to your clients experiencing hardships. I am not sure if there is a way in which MHSA could support some of these ideas, but I just wanted to let you know that this is what our management team is suggesting to better support community members with serious mental illness.

February 4, 2019 – email

Melissa Platte, Mental Health Association of San Mateo County

It would be extremely helpful for the BHRS Division to actually have/support/contract for some type of Housing Assistance Program. Increasingly it is challenging to provide support to individuals who lose their housing, don't have housing or are at risk of losing housing. We

believe that the housing challenge will only increase in the future as rents increase and SSI and wages cannot keep up.

It has been demonstrated that it is close to impossible for individuals to maintain treatment connections when they don't have or are at risk of losing their housing. An increasing number of current and potential BHRS clients are in that situation now. Now and over the next few years there is and will be housing coming on line that they may be eligible to apply for but without the support and assistance of knowledgeable individuals their applications often are returned as incomplete or incorrect.

Having a team of people able to connect clients to appropriate housing, assist in completing applications and gathering needed documentation, and working with landlords to identify open units and provide ongoing support to landlords so that they will work with our clients, would fill a significant gap in not only securing and maintaining housing, but as a result it is likely to improve the health and well-being for the majority of individuals who are served.

April 22, 2019 – MHSA Steering Committee Public Comments

Topic: MHSA Innovation, Health Ambassador Program for Youth (HAP-Y) – Extension Request

- How many graduates?
  - 64 graduates
- What is the age range to participate as an ambassador and what are the requirements?
  - 16 to 24 and live and or go to school in San Mateo County
- How are youth recruited?
  - Outreach is done by Brenda Nunez and we take the flyer for HAP-Y to many organizations across the county
- How can we schedule presentations?
  - Email Islam
- What happens when someone graduates, do they age out?
  - If you are 24 you can be a part of the program
- Innovation projects were 3-year programs and were expected to end this fiscal year, not asking for more dollars, just want to spend the unspent dollars?
  - Yes, we received 250,000 per year but had a late start

Topic: MHSA Plan to Spend One-time Available Funding

- Comment: Where did all of the list of programs come from?
  - Response: Came through the fact that this is one-time spending, looked at what are those opportunities tech and WET to spend one-time dollars because there is a note that we can move up to 20% of CSS unspent dollars and you get 10 years of reversion. Looking at opportunity and priorities from MHSA plan to fund core service programs

    - Some also came out of focus group about the budget reduction for example appointment reminders in how to reduce costs when we don't have people show up
- Comment: On this graph that was just up there what happened during 17/18 that we had that huge increase? Because my pet peeve is that we are not hiring more peer support workers and family workers. We keep having increases; the economy is great the funding is there we are a rich resourced county. Yet we don't hire anymore, and we aren't even paying for them MHSA is paying for them. There is this huge increase and our expenses are low because we are not hiring.
    - Response Scott: that bubble you saw is already declining in other words the unspent revenue and what we are spending are becoming more parallel to each other. They are about a million apart.
    - Response Doris: Benefit for individuals to file their taxes. Don't get funding until millionaires file taxes, we do see spikes and then it drops down. The drop was also part of No Place Like Home, the state is taking a percentage off the top to develop housing
- Comment: In 2021 why are we spending 3 million less than the revenue?
    - Response: Gaps where we have an opportunity as we are doing system improvement, what are we not funding adequately want to close that gap the ideal is that we are spending the amount coming in.
- Comment: Ongoing budget we keep adding new programs that need to be funded over time, yet the original programs that MHSA was originated and was for are not being funded or increased. We still have the same amount of peer support workers. In other counties they have hundreds and hundreds, and in our County, we have 50. So, I am not understanding that part.
    - Response: This is something that we can look at, now these are projections we hope that there would be 3 million in additional funding. We did start a strategic planning process under the other Director, but one recommendation was to add more peer and support workers and that was heard loud and clear. The new director is on board with doing that. We have to identify a model of care for our system and we envision creating a similar model to health homes. Where you have a team assigned to you and among that team are peer and family and that would call for an expansion. We don't know what it will look like right now. We have been talking about the model of care in small circles, but also working with Health Plan to get a grant around health homes so that we can replace whole person care in 2 years. Consider it in the next funding cycle.
- Comment: Will those be county positions or county contracted organizational positions?
    - Response: No idea what it will look like. We have a new county manager that looks at staffing differently however we have a county retirement fund liability that we are still not done paying off. We are paying that liability down so that there is no

liability, may be the first in county to do that. We want to be able to pay retirement benefits. With the new County Manager, we will see changes over time.

- Comment: Are we using MHSA money to fund retirement?
  - Response: No, we are not. We are not adding new positions until county retirement liability retirement is paid down. We can consider funding support workers but right now we are not adding new positions, but we can do extra help and limited term. But for family and peer support workers we want permanent positions
- Comment: What is the possibility of putting together a small group that does budget planning?
  - Response: Group for budget planning? This is what we are doing now. The 3-year planning process is what informs this plan. It was WET, budget focus groups and the 3-year plan that informed this. It is also subject to a 30-day public comment period
- Comment: Are consumers a part of that 3-year planning process?
  - Response: Yes, they are.
- Comment: Can you tell us how much will be in the reserve? And how much we will need to add. 50% is based on highest current revenue; make sure it closes the gap so eventually we will be at a flat line correct?
  - Response: Yes, that is true, right now we are close between 1 and 3 million to close the gap. Once something goes into the reserve it will fund activities that are already approved, because this is a volatile funding source. Reversion also drives taking it out
- Comment: How much is in the prudent reserve?
  - Response: 600,000 but in the operational reserve our goal is 16.5. We want to use this reserve so that we have more control. We are not required to maintain a minimum in the prudent reserve.
- Comment: $4.4 million is not on this spreadsheet?
  - Response: We don't have all the information on what budget reduction will need us to do, so there may be a need for stop gaps. We have a variety of action to take depending on what is happening in that environment.
- Comment: 4.4 million here without a home. Second question on stop gap? We have Pride Center and HAPY. The Pride Center for 2021 is that over and above what the state has approved?
  - Response: Pride center money from state will end in 2021. HAPY and NMT with unspent money.
- Comment: I would like to see the Pride Center number increased
  - Response: They are one-time dollars
- Comment: We want to use the 4.4 that's unspent to give the pride center more money, why not take 2 million of that and allocate to the pride center.

- Comment: Looking at the workbook to supervisors Pines point, I am looking at system wide training, 50,000 dollars 5,000 dollars per training 10 times a year. And I don't know who came up with these numbers but why are we not investing money in investing our peer workforce and the people who supervise them. The peers are not happy in the work that they are doing they feel like gophers and chauffer's. We are going to spend 5,000 per training at 10 times a year to train peers that number needs to go up. Is there an RFP that will go out, so we can respond to it so that we can train peers and supervisors?
    - Response: We will reply with RFP rules and even if we don't use the RFP process we still have to look at multiple vendors
- Comment: How are we going to know if this number goes up? We submitted for innovative projects and none of them were selected. We submitted for peer workforce development and training supervisors, how will we know if this number changes?
    - Response: We will look at the line items and make those changes. Allocating funding for peer support related types of training. Will see updates when we take it to the commission, and we will try to get the word out and it will be open to public comment. May 1st it will open so in June it will close.
- Comment: Crisis coordination under WET?
    - Response: That's all you. Related to a lot of input during PEI planning, need to have a bucket of funding to support crisis so we will RFP out the mobile crisis unit
- Comment: Under workforce education are the system trainings going to be available to contractors? And technology?
    - Response: Yes, they will, the technology piece like the appointment reminds that will depend on the system we end up with. Budget reduction focus groups that determined how we can improve our productivity.
- Comment: Want to learn more about the process to select these items and the way it happened.
    - Response: We looked at the no show and the percentage. For adults it is not bad and for TAY it is a little worse. Look at specific populations for example foster youth almost 40% no show. Child psychiatrist started using business Skype software to take laptop to where that youth is. Instead of having the family come to our clinic. Laptop model and telecare services with the Coastside. How can we expand our presence in our smaller clinics? This wasn't a started from scratch process we looked at 3-year planning and budget reduction process. These are things that ended up here because we heard it in the needs assessment that's why we are opening up to public comment. We went back to all the input we received and pulled the items from there. The plan to spend is not set in stone, and we are willing to do a more intensive process around it.

- Comment: The use of consultants. I believe the division is smart enough to figure things out. People giving services and those receiving services know what is working and what is not working. Hire consultants from who knows where to do panels could be going directly to client services. I want everyone to think about it, it's a serious amount of money. I know providers provide different services, I think interviewing the right people is the thing to do and I think BHRS is smart enough to do it. We need more staff, don't want to pay pensions so they hire consultants and extra help.

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Services Act (MHSA)

Public Comment Form

Personal information (OPTIONAL)

Name: Fennel Schubert Agency/Organization: HAP-Y

Phone Number: 650-228-3988 Email address: Fennel.T.Schubert@gmail.com

Mailing address: 1105 Grove Ave., Burlingame

Stakeholder group you identify with:

___ Behavioral Health Client/Consumer ___ Family Member X Community Member

___ Youth/Transition Age Youth ___ Older Adult

___ Law Enforcement/Criminal Justice ___ Social Service Provider ___ Education/Schools

___Behavioral Health Service Provider Other (specify) _____

Your comments here (please use as many pages as you need):

Members of the Steering Committee, my name is Fen Schubert, He/Him Pronouns. I am in favor of the extention of the HAP-Y program beyond its innovational stage.

Please turn over →

You may also send your comments via email to Doris Estremera, San Mateo County MHSA Manager
destremera@smcgov.org, phone call 650.573.2889 or mail Attn: MHSA 310 Harbor Blvd. Bldg E Belmont, CA 94002

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Services Act (MHSA)

Public Comment Form

Personal information (OPTIONAL)

Name: Darcy Frost Agency/Organization: HAP-Y @ StarVista

Phone Number: 650-218-4149 Email address: darcylfrost@gmail.com

Mailing address: 2 Binnacle Lane

Stakeholder group you identify with:

___ Behavioral Health Client/Consumer ___ Family Member ___Community Member

__√__ Youth/Transition Age Youth ___ Older Adult

___ Law Enforcement/Criminal Justice ___ Social Service Provider ___ Education/Schools

___Behavioral Health Service Provider Other (specify) _____

Your comments here (please use as many pages as you need):

I'm here to show my support for HAP-Y + talk about why it should continue to receive funding.

Please turn over →

You may also send your comments via email to Doris Estremera, San Mateo County MHSA Manager
destremera@smcgov.org, phone call 650.573.2889 or mail Attn: MHSA 310 Harbor Blvd. Bldg E Belmont, CA 94002

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Services Act (MHSA)

Public Comment Form

Personal information (OPTIONAL)

Name: Florence Ye Agency/Organization: Star Vista

Phone Number: 415-760-5230 Email address: florenceye2020@gmail.com

Mailing address: 1732 Washington Street, San Mateo, CA 94403

Stakeholder group you identify with:

___ Behavioral Health Client/Consumer ___ Family Member ___Community Member

✓ Youth/Transition Age Youth ___ Older Adult

___ Law Enforcement/Criminal Justice ___ Social Service Provider ___ Education/Schools

___Behavioral Health Service Provider Other (specify) _____

Your comments here (please use as many pages as you need):

Advocate for HAP-Y

Please turn over →

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Services Act (MHSA)

Public Comment Form

Personal information (OPTIONAL)

Name: Vivian Valdez Agency/Organization: HAPY

Phone Number: (650) 276-6197 Email address: vivianvaldez2002@gmail.com

Mailing address: 3633 Colegrove St San Mateo

Stakeholder group you identify with:

___ Behavioral Health Client/Consumer ___ Family Member ___Community Member

√ Youth/Transition Age Youth ___ Older Adult

___ Law Enforcement/Criminal Justice ___ Social Service Provider ___ Education/Schools

___Behavioral Health Service Provider Other (specify) _____

Your comments here (please use as many pages as you need):

To come support and continue the program. To continue to collect funds for HAPY.

Please turn over →

You may also send your comments via email to Doris Estremera, San Mateo County MHSA Manager
destremera@smcgov.org, phone call 650.573.2889 or mail Attn: MHSA 310 Harbor Blvd. Bldg E Belmont, CA 94002

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Services Act (MHSA)

Public Comment Form

Personal information (OPTIONAL)

Name: Lisa Putkey Agency/Organization: San Mateo County Pride Center

Phone Number: 650-554-1234 Email address: lisa.putkey@sanmateopride.org

Mailing address: 1021 S. El Camino Real, San Mateo, CA 94402

Stakeholder group you identify with:

[X] Behavioral Health Client/Consumer [X] Family Member [X] Community Member

[ ] Youth/Transition Age Youth [ ] Older Adult

[ ] Law Enforcement/Criminal Justice [ ] Social Service Provider [ ] Education/Schools

[X] Behavioral Health Service Provider Other (specify) _____

Your comments here (please use as many pages as you need):

I fully support the extention of the Health Ambassadors for Youth Program! I have seen firsthand the powerful impact the program has had in the lives of local youth. As someone who has worked with youth in educator and organizing roles, I can attest to the importance of youth as peer leaders. Youth listen to other youth because they can better relate to each other, speak the same language, and share similar lived experiences. This program is groundbreaking in breaking stigma around mental health and connecting youth to resources for support and healing.

Please turn over →

You may also send your comments via email to Doris Estremera, San Mateo County MHSA Manager
destremera@smcgov.org, phone call 650.573.2889 or mail Attn: MHSA 310 Harbor Blvd. Bldg E Belmont, CA 94002

APPENDIX 2: INN EXTENSION REQUEST: THE PRIDE CENTER

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

KHATERA TAMPLEN
Chair
LYNNE ASHBECK
Vice Chair
TOBY EWING
Executive Director

April 2, 2019

Mr. Scott Gilman
Director, Behavioral Health and Recovery Services
San Mateo County Health
2000 Alameda de las Pulgas, Suite 235
San Mateo, CA 94403

Dear Mr. Gilman,

Congratulations, the Commission approved the LGBTQ Behavioral Health Coordinated Services (The Pride Center) innovation project extension on March 28, 2019 for an additional amount of $1,550,000 for two years.

On behalf of the Commission, I would like to thank you for all the work you do in your community.

If you have additional questions or need further assistance, feel free to contact me sharmil.shah@mhsoac.ca.gov or your county liaison Vicque Kimmel at Vicque.Kimmel@mhsoac.ca.gov.

Sincerely,

Sharmil Shah, Psy.D
Chief-Program Operations

Copy: Doris Estremera, MHSA Manager

Mental Health Services Act (MHSA) Innovation Extension Request

LGBTQ Behavioral Health Coordinated Services (The Pride Center)

November 19, 2018

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Table of Contents

Background

San Mateo County Pride Center

The Pride Center is an MHSA Innovation project, approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC) on July 28, 2016. There is no prior model of a coordinated approach across clinical services, psycho-educational and community/social events and resources for the LGBTQ+ community. It is a formal collaboration of community-based organizations; StarVista as the lead agency, Daly City Partnership, Peninsula Family Service and Adolescent Counseling Services. The services include:

- Clinical services for individuals at high risk of or with moderate to severe mental health challenges.
- Psycho-educational and community activities to provide support through peer-based models of wellness, recovery and stigma reduction.
- Resource hub for local, county and national LGBTQ+ services.

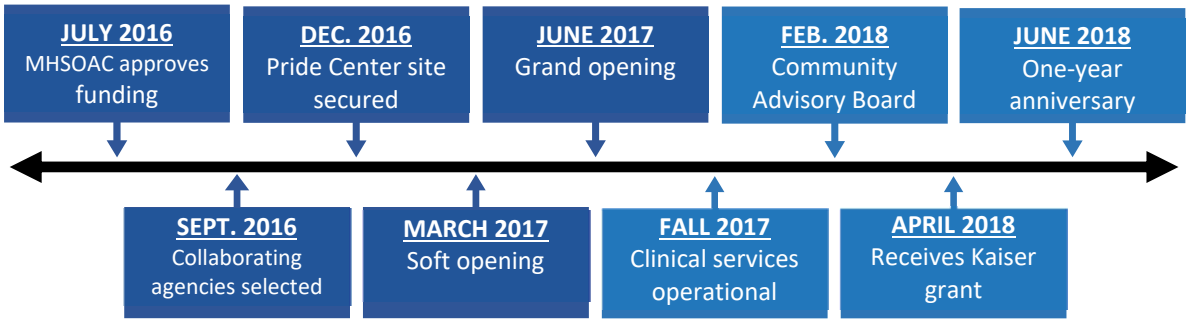
Community Need

High Risk of Mental Illness

LGBTQ+ are considered one of the most vulnerable and marginalized communities. Many experience multiple levels of stress and risk for Serious Mental Illness (SMI) due to constant subtle or covert acts of homophobia, biphobia and transphobia. LGBTQ+ individuals are at higher risk of mental illness compared to non-LGBTQ+.[1] Nationally, suicide is second leading cause of death for LGBTQ+ youth ages 10-24.[2]

The LGBTQ Commission in San Mateo County conducted a survey in 2018 of LGBTQ residents and employees. In San Mateo County, over half of LGBTQ+ adults surveyed responded that they needed access to a mental health professional in the past 12 months. Additionally, over three-quarters of the LGBTQ+ youth surveyed reported that they considered harming themselves in the past 12 months.[3]

[1]King, M. et al., 2008; [2]The Trevor Project; [3]San Mateo County LGBTQ Commission, 2017 Survey of LGBTQ Residents and Employees of San Mateo County



Culturally Appropriate Services

There is often mistrust of behavioral health care in LGBTQ+ communities due to historical trauma, shame and stigma around seeking care. In San Mateo County, surveyed residents reported limited access to LGBTQ-responsive behavioral health services.[4]

- 3 in 5 adults cited lack of local health professionals trained to serve LBGTQ+ clients
- 2 in 5 felt their mental health care provider had the expertise to care for their needs
- 2 in 3 youth did not know where to access LGBTQ-friendly healthcare

Linkages to Comprehensive Services

The LGBTQ Commission survey also indicated that there is a need for interagency coordination to connect under-served LGBTQ+ residents to social services and community resources.[5]

- LGBTQ+ county residents are socially isolated
- 2 in 5 adults struggle to pay for basic needs like rent and food
- 3 in 5 youth reported lack of LGBTQ+ inclusive sex education in school

Accomplishments

The Pride Center provides an array of programs, events and clinical and supportive services for the LGBTQ+ community. Additionally, the Pride Center has collaborated with and trained service providers and community members across San Mateo County. See Appendix A for a comprehensive list of onsite programming, training and engagement efforts.

Pride Center's Reach *(Fiscal Year 2017-18)*

- 1,092 individuals dropped in or attended a peer group on site.
    - 15% accessed therapy services
    - 4% used case management services
- 2,045 people attended offsite trainings, workshops and events.
- 69% of participants who completed the satisfaction survey visited more than once
    - 41% visited at least six times

[4-5]San Mateo County LGBTQ Commission, 2017 Survey of LGBTQ Residents and Employees of San Mateo County

Participant Demographics

Demographic data shows a diverse participant base for the Pride Center:

- 85% are between age 16 and 59; 8% were 60+; 5% were 15 or younger
- 52% were people of color or multiracial
- Over two-thirds identify as LGBTQ+
- 62% are cisgender, 16% are transgender, gender queer, questioning, or other
- 10% reported being unemployed
- 16% reported annual income < $25,000

Pride Center staff present to students at Thomas R. Pollicita Middle School

SAN MATEO COUNTY PRIDE CENTER

Learning Goals

Evaluation Findings To-Date

An independent consultant, Resource Development and Associates (RDA), was contracted to evaluate the Pride Center. RDA implemented a mixed methods approach to their evaluation, see Appendix B for an evaluation overview. Focus groups, surveys, and interviews with participants and service providers informed the *Learning Goals*:

Learning Goal #1 (Collaboration):

Does a coordinated approach improve service delivery for LGBTQ individuals at high risk for or with moderate to severe mental health challenges?

Process Evaluation	Outcome Evaluation
Baseline Objective. Examines how systems effectively collaborate currently to serve LGBTQ+ **Process Measures.** Examines the increase in communication, referrals, and interaction between service providers	Measures improved behavioral health indicators from pre/post scales and client satisfaction surveys

Wide Range of Services –the Pride Center's collaborative model has been instrumental in providing services for diverse participant needs.

- Each of the 4 partner organizations brings different specializations.

High Quality Services – team cohesion and commitment to continuous learning have enabled high delivery of services.

- Coordination helps participants who benefit from multiple services get the support they need like job opportunities, applying for public assistance, searching for housing.

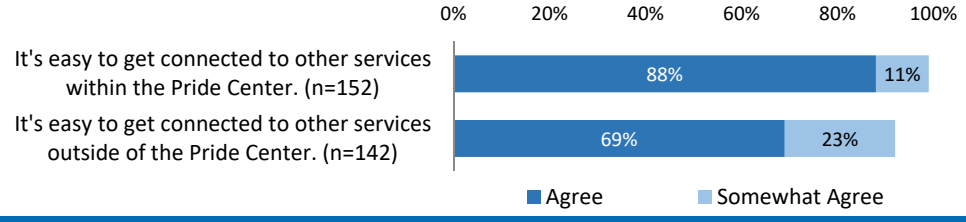
Increased Capacity – the Pride Center has developed strong relationships that facilitate referral pathways.

- The Pride Center is building capacity for LGBTQ+ appropriate care. More providers know the importance of asking sexual orientation and gender identity (SOGI) questions.
- Educators, public agencies, and private businesses have actively sought the Pride Center.

> *"I've been involved in a lot of LGBTQ organizations... focused on a particular issue. This [Center] brings it all together."*
>
> –Older adult participant

> *"It's a one-stop shop...[which is important] when you're homeless and have to get everywhere on foot. There's only so many places you can go in a day."*
>
> –Adult participant

> *"We're a gigantic resource for the San Mateo County community. We're educating the educators and the social service providers. We're building all kinds of networks."*
>
> –Community Advisory Board member



Learning Goal #2 (Access): Does the Pride Center improve access to behavioral health services for LGBTQ individuals at high risk for or with moderate to severe mental health challenges?

Process Evaluation	Outcome Evaluation
Baseline Objective. Examines extent staff are prepared to provide culturally responsive services to the LGBTQ+ community **Process Measures.** Examines improvement in access to behavioral health services for individuals that are high risk for or with moderate to severe mental health challenges	Measures clients experience with the Center services as helpful and culturally responsive

Culturally Responsive Services – services offered *by and for* LGBTQ+ engages individuals who might not otherwise access or remain in clinical care.

- Participants feel more understood and supported compared to previous experiences.
- Participants begin treatment with a sense of trust, setting the foundation for a strong patient/provider relationship.
- 85% agreed and 15% somewhat agreed that the services they were receiving were improving their mental health.

Reduced Stigma – having a physical location that is safe, inclusive space creates community, reduces stigma and isolation.

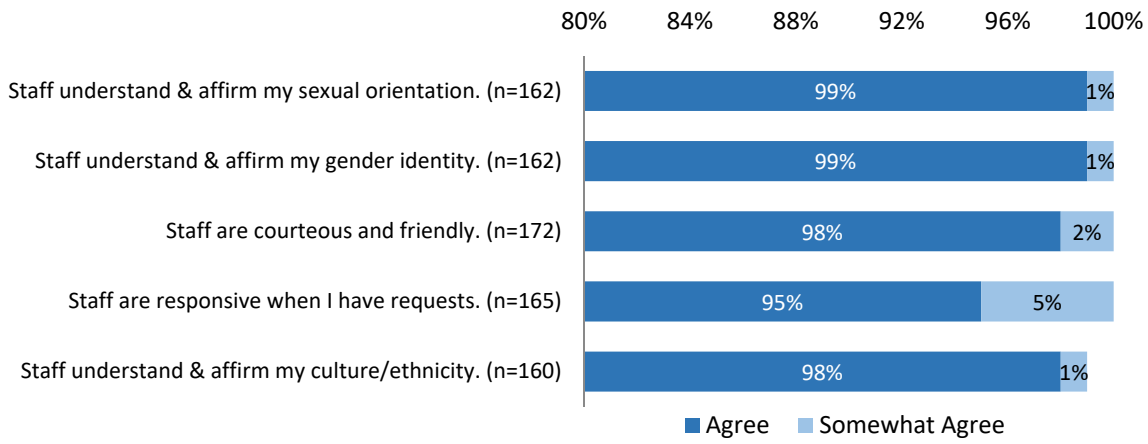
- Many participants said that the existence and prominent public location helps them feel welcome and proud.

> *"In the past when I needed mental health services, I needed to find someone supportive and understanding of what I was feeling…I would have felt much safer [at the Pride Center]."*
> –Youth participant

> *"To have a physical location is so much more meaningful than using online resources…to know that there is a place you can go to feel safe and find community."*
> –Adult participant

> *"When I went to cisgender, heteronormative therapists… They didn't get it. The [therapists] here understand it on the inside."*
> -Adult participant

> *"Every single time I come here, it's a lovely experience. There's not a single time I cross that door and someone doesn't ask me how I am."*
> –Youth participant



Extension Request

Why an Extension?

While the project was approved in July 2016, the Pride Center undertook several foundational activities related to planning and startup including identifying and securing a centrally located, accessible site, obtaining start-up items and systems and recruiting staff. Prior to the opening of the Pride Center there was a lack of LGBTQ+ services and infrastructure in San Mateo County, which created obstacles for hiring and community outreach. The Pride Center secured a site in December 2016 and was in a period of "soft opening" from March through May 2017. During the soft opening period, the Center held monthly community forums, started six monthly Older Adult LGBTQ+ Peer Counseling meetings and the Youth Program Coordinator conducted meetings with six high schools to learn about youth's needs and desires for LGBTQ+ programming. The Grand Opening was in June 2017.

Since opening there has been nearly twice the demand for services than anticipated. The Pride Center was originally estimated to serve 50-80 clinical clients in the first year. Even though the clinical component wasn't operational until the second quarter, it served 151 individuals in the first year alone. While it was estimated that the Pride Center would have 5,000 meaningful outreach encounters, there were actually over 10,000. Because the Pride Center was more successful than ever anticipated, staff and partners focused more on service provision than creating the necessary structures, policies, and strategic plan to ensure the long-term sustainability and replicability of the collaborative partnership as a statewide best practice.

Extension Goals

The Pride Center was approved for 3 years of MHSA Innovation funding. Given that one year was dedicated to start-up activities, having an additional two years of implementation would allow the Pride Center to accomplish the following goals:

1) **Strengthen internal and external collaboration efforts** to be able to demonstrate with more certainty whether the coordinated service approach improves service delivery *(Learning Goal #1).*
2) **Measure clinical outcomes of clients with severe mental illness (SMI)**, specifically improved mental health indicators for individuals who might not otherwise have accessed clinical services and/or received quality, culturally responsive care *(Learning Goal #1).*
3) **Develop a replicable best practice model to share statewide and nationally,** if the evaluation continues to demonstrate that the coordinated service approach improves health outcomes and access for LGBTQ+.

Spending the appropriate time to develop a robust network of community partnerships will help the County learn the impact of coordinated service approach. It takes time to repair historical mistrust within the LGBTQ+ community about mental health services. Stigma around seeking care takes time to overcome and this community experiences stigma having a mental health issue and identifying as LGBTQ+.

Activities Accomplished (2- Year Implementation, post start-up)	**Activities Planned** (with 2- Year Extension)
• Established a Community Advisory Board (CAB) and Youth Advisory Board • Launched a youth program including youth-friendly events (Queer Prom, Teen Booth, Film Screenings, Trans education series, Trans Visibility photo project and Peer Support Groups) • Launched an older adult program including monthly older adult LGBTQ+ counseling, Coffee Break, Sunshine Series for community resources, Bistro Brio lunch program, book club, All That Jazz art, music and poetry, mindfulness meditation and an oral histories project. • Launched supportive social/cultural and educational community events and activities (e.g. Pride Month 30 Days of Gay, Movie Nights, Queer Cumbia, Intergenerational Meals) • Developed clinical program - counseling, peer support and case management and referral system including Medi-Cal and sliding scale fee for service • Established as a drop-in center and gender and name change clinic • Actively consult with mental health providers, schools and community agencies seeking support in working with LGBTQ+ • Developed a training program for behavioral health providers, schools and other agencies • Ongoing assessment of community needs (countywide survey, in-person outreach and soliciting input) • Ongoing outreach, education and engagement • Established resource library, computer lab • Established a volunteer program • Established a resource hub and free store for LGBTQ+ affirming resources. • Developed policy and procedure manual • Developed website, online social media, e-newsletter and local news presence • Developed data system for clinical and case management program	• Develop the trainee program to allow trainees to see SMI Medi-Cal clients and provide pathways for queer and trans clinicians of color • Strengthen the training and consultation program to support mental health providers working with LGBTQ+ clients • Implement a monthly consultation group for regional providers • Undergo a comprehensive strategic planning process with collaborative partners, staff and CAB • Implement a best practice model of collaboration to strengthen the innovative coordinated service approach of the Pride Center • Collect outcome data for improved behavioral health indicators of clients • Develop a replicable model • Develop a sustainability plan • Establish a yearly fundraiser and donor community • Utilize community partnerships to extend the reach beyond central county by providing programs and services in the South, North, and Coastside regions • Enhance the Peer Support Program by training and certifying peer support specialists • Synchronize LGBTQ+ affirming practices of partner agencies (policies, procedures, data collection, services, marketing, and sites) • Increase collaboration with Bay Area, Statewide and national LGBTQ+ networks • Transition into the role of lead organizer for the annual Pride Celebration, a community defined practice reducing disparities • Develop eHealth services to better support clients with access barriers

Extension Request

San Mateo County is requesting a two-year MHSA Innovation extension for the Pride Center in the amount of $1,550,000.

- $700,000 per year for services
- $150,000 for evaluation and development of a replicable tool

The original Pride Center request was approved by the MHSOAC on July 28, 2016 for three years in the amount of $2,200,000. Due to a delay in start-up, we are also requesting to rollover $220,000 of the original approved amount into the two-year extension term. The Pride Center's budget, see Appendix C, includes this additional allocation of $110,000 per year. The original learning goals and target population will remain the same.

Added Value to an Extension

The extension will allow us to determine with more certainty *Learning Goal #1*: Does a coordinated approach improve service delivery for LGBTQ individuals at high risk for or with moderate to severe mental health challenges?

Despite high levels of collaboration in coordinating service delivery, Pride Center staff observed areas for improvement in establishing and formalizing processes for the internal operations of the Center. Multiple staff members commented on the Collaboration Survey that they could benefit from more support from the partner agencies on matters of organizational development. Subsequent reports will compare how the collaboration evolves.

The widespread demand for mental health services among LGBTQ+ county residents has challenged the Pride Center's clinical capacity to accommodate all participants' needs. The Pride Center has just begun to use trainees, who are multilingual, to serve Medi-Cal SMI clients. It is too early to determine with certainty the outcomes of the Center's collaborative approach on client clinical progress.

If the evaluation continues to demonstrate the coordinated service approach to improve health outcomes and access for LGBTQ+, a replicable best practice model will be developed to share statewide and nationally.

Sustainability

As part of the Request for Proposals, agencies were asked to develop a sustainability plan that identified diversified revenue sources including Medi-Cal billing, local government, including MHSA, grants and private donors.

The Pride Center staff continues to identify sustainability strategies. StarVista's CEO, Development Director, Clinical Director, and the Pride Center's Program Director and the full-time Grant Writer meet regularly to strategize grant applications, marketing, and fundraising.

The Pride Center has received support from the San Mateo County Board of Supervisors, which has consistently advocated for the Center; its activities; and the LGBTQ+ community, in general, through Board policy, resolutions and proclamations. Current Board President Dave Pine continues to demonstrate leadership in seeking out sustainable funding options for the Pride Center. Additionally, San Mateo County has an LGBTQ Commission whose members are committed to the long term viability of the Pride Center.

Recently, Kaiser Permanente awarded $90k to the San Mateo County Pride Center to reduce stigma around mental health and increase LGBTQ+ visibility on the Peninsula through education, outreach, and community building.

As the Development team looks to the future, they will focus on creating relationships with and applying to foundations that serve the LGBTQ+ community, creating a strong donor base in the Peninsula, and creating fundraising events.

Community Input

Community Program Planning (CPP) Process

The Mental Health Services Act (MHSA) Steering Committee plays a critical role in the development of MHSA programs and plans. The Mental Health and Substance Abuse Recovery Commission (MHSARC), our local mental health board, is also involved in all MHSA planning activities providing input, receiving regular updates as a standing agenda item on the monthly MHSARC meetings, and making final recommendations. The MHSARC commissioners are all members of the MHSA Steering Committee, which is comprised of over 40 community leaders representing the diverse San Mateo community including clients, advocates, family members, community partners, County and CBO staff, County leadership, education, healthcare, criminal justice, probation, among others.

The Pride Center accomplishments, evaluation outcomes and need for a 2-year MHSA Innovation extension was presented to the MHSA Steering Committee on September 24, 2018. The Steering Committee members unanimously voted for the recommendation to request a 2-year extension. On October 3, 2018, the MHSARC voted to open a 30-day public comment period and consequently conducted a public hearing and vote to close the 30-day public comment period on November 7, 2018. Please see Appendix D for all public comments received during the CPP process. Various means were used to circulate information about the Pride Center extension request and public comment:

- Flyers created and sent to/placed at County facilities, as well as other venues like family resource centers and community-based organizations;
- Announcements at numerous internal and external community meetings;
- Announcements at program activities engaging diverse families and communities (Parent Project, Lived Experience Academy, etc.);
- E-mails disseminating information to over 1,800 MHSA subscribers;
- Social media and word of mouth on the part of staff and stakeholders;
- Postings on smchealth.org/bhrs/mhsa, the BHRS Wellness Matters bi-monthly e-journal and the BHRS Blog www.smcbhrsblog.org

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Behavioral Health & Recovery Services
SAN MATEO COUNTY
Office of Diversity and Equity

Office of Diversity and Equity (ODE)
310 Harbor Blvd, Bldg. E
Belmont, CA 94002

smchealth.org/MHSA
mhsa@smcgov.org

SAN MATEO COUNTY PRIDE CENTER

STAR VISTA

Peninsula Family Service

ACS ADOLESCENT COUNSELING SERVICES
strength through support

DALY CITY PARTNERSHIP

Appendix A. Pride Center Services

Participants visit the Pride Center to access an array of programs, events, and supportive services.

SAN MATEO COUNTY PRIDE CENTER

Onsite programming at the Pride Center includes:

Clinical Services

Therapy Services:
- Individual
- Relationship
- Family
- Group

Case Management

Drop-In Center

Educational Resources & Supportive Services

Job Network

Name and Gender Changes for Identity Documents

Onsite Resource Library

Public Benefits Support

Sexual Orientation and Gender Identity (SOGI) trainings (monthly)

Trans Talks series (monthly)

Peer Support Groups

Gay Men's Circle (18+)

Grown Folks (18-30)

Lesbian Women's Circle (50+)

Parents of LGBTQ+ Youth

QT Chats
(College of San Mateo students)

Queer Latinx Circle/Queer Cumbia

Queers Have a Higher Power
(Alcoholics Anonymous)

Queers on the Autism Spectrum

Trans Support Group (18+)

Youth Support Group (10-18)

Older Adult Programs

Affordable Housing Workshop

Bistro Brio (monthly lunch)

Meditation & Mindfulness group

Sunshine Series
(monthly resource sharing meetings)

Social/Community Events

Community Forums (quarterly)

Movie Nights (weekly)

Crafternoons (monthly)

Book Club (monthly)

Intergenerational Dinners (quarterly)

Oral History Project

Pride Celebration (annually)

Queer Youth Prom (annually)

Transgender Day of Visibility:
In Bloom Project

Community Partner Meetings

PFLAG (San Jose/Peninsula chapter)

Pride Initiative (BHRS Office of Diversity and Equity)

County of San Mateo LGBTQ Commission

Pride Center staff have collaborated with and trained service providers and community members across San Mateo County.

SAN MATEO COUNTY PRIDE CENTER

Community engagement efforts during the 2018 fiscal year included:

Long-Term Partnerships

- County of San Mateo LGBTQ Commission
- Pride Initiative (BHRS Office of Diversity and Equity)
- Kennedy Middle School (youth support services)
- Notre Dame de Namur University
- PFLAG

Workplace Trainings

- ACCESS Call Center*
- Aging and Adult Services*
- Behavioral Health & Recovery Services*
- Boston Private Bank
- Court Appointed Special Advocates (CASA) of San Mateo County
- CuriOdyssey
- Health Insurance Counseling and Advocacy Program*
- Rape Trauma Services
- Sequoias - Portola Valley
- Youth Services Center (Probation)*

School Staff Trainings

- Aragon High School
- Burlingame High School
- Capuchino High School
- Hillsdale High School
- Mid-Peninsula High School
- Mills High School
- San Mateo Union High School District

Student Outreach

- Carlmont High School
- College of San Mateo
- Garfield Middle School
- Half Moon Bay High School
- Hillsdale High School
- Ingrid B. Lacy Middle School
- Mercy High School
- Notre Dame de Namur University
- Notre Dame Middle School
- Pescadero High School
- Sequoia High School
- Skyline College
- Thomas R. Pollicita Middle School
- Westmoor High School
- Woodside High School

***County of San Mateo public agency**

Event Cosponsorships

- Aging and Adult Services*
- Bay Area Legal Aid
- Billy DeFrank LGBT Community Center
- California Clubhouse
- CuriOdyssey
- Daly City Youth Health Clinic
- Edgewood Drop-in Center
- Elder and Adult Protection Team*
- Franklin Templeton Investments
- Gilead Sciences, Inc.
- Health Services Agency*
- Heart and Soul, Inc.
- HomeBase
- LifeMoves
- Oakland LGBTQ Community Center
- Office of Education*
- Planet Granite Belmont
- Planned Parenthood
- Silicon Valley Community Foundation
- Youth Leadership Institute

Appendix B. Evaluation Overview

San Mateo County Behavioral Health and Recovery Services
San Mateo County Pride Center Evaluation

Evaluation Overview

San Mateo County BHRS seeks to learn how the San Mateo County Pride Center enhances access to culturally responsive services, increases collaboration among providers, and, as a result, improves service delivery for LGBTQ+ individuals at high risk for or with moderate or severe mental health challenges. To guide the evaluation, RDA and BHRS developed the following evaluation questions in three domains.

Process: Services and Operations

- To what extent is the Pride Center reaching its intended target population?
- What activities and services does the Pride Center provide in the social and community, clinical, and resource components?
- What successes and challenges has the Pride Center experienced in implementing services as designed?
- To what extent are Pride Center staff prepared to provide services that are culturally responsive to the LGBTQ community?

Outcomes: Collaboration and Access

- To what extent does the Pride Center improve communication, coordination, and referrals for LGBTQ individuals at high risk for or with moderate or severe mental health challenges?
- To what extent does the Pride Center improve access to behavioral health services for individuals at high risk for or with moderate or severe mental health challenges?

Outcomes: Service Delivery

- To what extent do clients experience the Pride Center's services as helpful, culturally responsive, and reflective of MHSA values?
- Do clients receiving clinical services experience improved behavioral health indicators from intake to closure?

Evaluation Progress

The first two years of the Pride Center evaluation have included both implementation and outcome evaluation components. Table 1 lists the quantitative and qualitative data collected to measure indicators in the domains of services and operations, collaboration and access, and service delivery outcomes.

Table 1. Evaluation Measures and Data Collection: Years 1-2

Outreach and Implementation of Services	Data Sources
Number of individuals reached	• Participant Demographic Form • Participant Sign-In Sheets • Outreach and Meeting Tracking Sheets
Types of activities and services provided in the social and community, clinical, and resource components	• Participant Services Data • Focus Groups with Participants • Quarterly progress reports
Successes and challenges of implementing services as designed	• Focus Group with Community Advisory Board (CAB) • Regular communications with Pride Center leadership and staff
Cultural responsiveness of services	• Focus Groups with Participants • Participant Experience Survey
Collaboration and Access to Services	**Data Sources**
Effectiveness of communication, coordination, and referrals for LGBTQ+ individuals with moderate to severe mental health challenges	• Focus Group with CAB • Focus Groups with Participants • Participant Experience Survey • Partner Collaboration Survey (AITCS-II)
Improved access to behavioral health services for individuals with moderate to severe health challenges	• Focus Groups with Participants • Participant Experience Survey
Service Delivery Outcomes	**Data Sources**
Client service experience (E.g., Experience with services, facility, and service providers)	• Participant Experience Survey • Focus Groups with Participants
Improved health outcomes among clients	• Participant Experience Survey • Focus Groups with Participants

Data Collection to Identify Clinical Outcomes. The initial years of the evaluation have focused on setting up data collection and management processes to measure clinical outcomes. After the Pride Center INN Plan was approved, San Mateo County BHRS instituted a requirement that its mental health providers use the Child and Adolescent Needs and Strengths (CANS) to assess clients at intake and six-month follow-up. As a result, the Pride Center instituted both the CANS and the Adult Needs and Strengths Assessment (ANSA) for use with its clients. The Pride Center, which uses StarVista's ETO electronic health record, recently added the ANSA and CANS to ETO so that clinicians can enter client assessment data. In addition, the evaluation team is finalizing a brief client questionnaire that clients receiving clinical services will self-administer at intake and at regular points throughout their treatment. This questionnaire will be a useful

measure of clients' perceived progress in their mental health recovery. The evaluation has gathered and will continue to gather qualitative data on client outcomes.

Evaluation Plan

In the current fiscal year and the extension years, the Pride Center evaluation will delve further into *Learning Goal #1: Does a coordinated approach improve service delivery for LGBTQ individuals at high risk for or with moderate to severe mental health challenges?* As the Pride Center formalizes its internal and external collaboration, the evaluation will continue to document the innovative model and measure the impact of coordinated service delivery. In addition, as the Pride Center's clinical program progresses—including expanding the use of trainees to provide clinical services in multiple languages—the evaluation will be better able to assess the outcomes of Pride Center services on client clinical progress.

The current and future years of evaluation will incorporate all measures and data sources listed in Table 1 above. In addition, the outcome evaluation will use the data collection methods and sources shown in Table 2 below. Given the start-up time required for the Pride Center to build its clinical practice, as well the need to train clinical staff in the administration of data collection tools and data entry, the sample sizes for clinical outcome data are likely to be low in the current fiscal year. The extension period will enable the evaluation to expand the baseline dataset and gather follow-up data to assess client progress over time. It is anticipated that the Pride Center will serve approximately 150 clients per year in its clinical practice.

Table 2. Client Outcome Data Collection

	Fiscal Year 2018-19 Evaluation	Extension Evaluation
Provider Assessment of Clinical Needs *Adult Needs and Strengths Assessment (ANSA); Child and Adolescent Needs and Strengths (CANS)*	• Train clinical staff in administration and data entry for ANSA/CANS • Determine data analysis plan • Collect baseline data	• Increase sample size for baseline data • Implement follow-up data collection and increase sample size for follow-up data • Analyze changes in clients' needs and strengths over time
Client Mental Health Self-Assessment	• Finalize development of clinical client questionnaire • Implement and report on baseline data collection	• Increase sample size for baseline data • Implement follow-up data collection and increase sample size for follow-up data • Analyze changes in clients' perceived mental health status
Qualitative Data Collection with Clients	• Qualitative data collection such as focus groups and interviews will concentrate on clients at high risk for or with moderate to severe mental health challenges who have received clinical services from the Pride Center.	

Appendix C. Pride Center Budget

PRIDE CENTER BUDGET FOR FY19-20

REVENUE	
San Mateo County	700,000
Residual (pending approval)	110,000
Medi-cal	60,000
Donations	25,000
Foundations	90,000
Training	22,000
TOTAL REVENUE	**1,007,000**
EXPENSES	
Personnel	
Salaries	461,382
Taxes/Benefits/Workers Comp.	106,118
Total Personnel	**567,500**
Operations	
Program Supplies	4,000
Office Supplies	4,000
Rent/Office/Utilities	105,500
Equipment Lease/Rent	1,500
Food Costs for meetings	5,000
Computer Equipment	3,000
Telephone and internet	5,000
Mileage	3,000
Webpage/Social Media design	3,000
Training	6,000
Sub-Contractor (Partners)	140,000
Resource materials	2,500
Marketing and development Costs	7,000
Client Transportation	2,100
Translation Services	1,400
Recruitment	2,000
Total Operations	**295,000**
Total Personnel & Operations	**862,500**
Indirect	144,500
TOTAL EXPENSES	**1,007,000**
Net Profit (Loss)	**0**

PRIDE CENTER BUDGET FOR FY20-21

REVENUE	
San Mateo County	700,000
Residual (pending approval)	110,000
Medi-cal	60,000
Donations	27,000
Foundations	90,000
Training	25,000
TOTAL REVENUE	**1,012,000**
EXPENSES	
Personnel	
Salaries	461,355
Taxes/Benefits/Workers Comp.	106,112
Total Personnel	**567,467**
Operations	
Program Supplies	4,000
Office Supplies	4,000
Rent/Office/Utilities	108,500
Equipment Lease/Rent	2,000
Food Costs for meetings	5,000
Computer Equipment	3,000
Telephone and internet	5,000
Mileage	3,000
Webpage/Social Media design	3,000
Training	6,000
Sub-Contractor (Partners)	140,000
Resource materials	2,700
Marketing and development Costs	7,000
Client Transportation	2,300
Translation Services	1,500
Recruitment	2,200
Total Operations	**299,200**
Total Personnel & Operations	**866,667**
Indirect	145,333
TOTAL EXPENSES	**1,012,000**
Net Profit (Loss)	**0**

Appendix D. Public Comments Received

MHSA Steering Committee Meeting – September 24, 2018

Public Comments

Question: What do all partnered agencies bring to collaborative model

- Star vista is lead agency – they are the fiscal sponsor: admin, IT and technology, rich history of affirming mental health services for families
- Peninsula Family – history of serving families, history of senior peer counseling programs
- Outlet – rich history in providing youth spaces for LGBTQ youth
- Daly City Partnership – stronghold in North County; Rich history with families and schools in North County in providing series of different services

Question: Of the 1000 people who walked through the door, 15% getting clinical services. How does that compare with your goal? Where would you like to go in the next 2 years?

- Original vision was to serve 80 participants; serving over 125.
- Need was far greater than prepared for or expected. Outgrowing their own space.
- Broadening programs with languages.

Question: Do we have people from other counties coming in for the services?

- Yes; we are the only county in our region without an LGBTQ+ center so a lot of our community had to go to other counties but now we are seeing some from other counties as well.

Question: What is the plan to continue with innovation after the instrumental innovation portion is over in 5 years?

- Beyond innovation, would like to prove this is an innovative model that can be replicated in other counties.
- Not only continue to get government funding but even have donors for the long run

Question: Are you a 501C3?

- Yes; through our lead agency, Star-Vista

Question: How are you serving the developmentally disabled?

- Constantly checking accessibility audits
- For TDOR, wanting to do a march, figuring out the most accessible routes
- Recently started a peer group called peers on the autism spectrum

Question: Guesstimate of what percentage of participants have alcohol and drug related issues?

- A lot of clients are dual diagnosis
- Kat is most trained clinician with substance abuse; says one-third of participants fall under that population
- A lot of times questionnaire is anonymous so hard to get clear number

Question: Do you partner with LGBTQ+ specific members for services?

- Yes; community advisory board keeps us connected with community
- Thriving volunteer program- 2 of which will speak today
- Not assuming what community wants, but working side by side with them

Question: Does your organization bill insurance because most youth are covered until 26 years old? Is there a provision for that?

- Currently no; If we have patients coming in with private insurance, that's when we used our referral services. We are pretty well connected to clinicians throughout the Bay Area We are only on MediCal at this point
- Sliding scale typically for those whose insurance does not cover mental health illness

Question: How have other counties received the Pride Center? What kind of inquiries have been made with other counties?

- Lucky to be a part of the Bay Area; hub for LGBTQ+ folks
- Worked with San Jose, Office of LGBTQ+ affairs in Santa Clara, over 30 letters of VA support, South San Francisco, Oakland Center
- Hoping to do more regional work

Question: How many on your clinical team?

- Seven

Question: Do you offer Pro Bono or assists?

- Yes; currently developing allocation process for those who really need it most
- Sliding scale based off monthly income
- Have not turned anyone away so far

Question: Are you aware of studies of about the financial net benefit to county for providing these kinds of services?

- Studies show people who are in treatment in terms of their employment and stability, you can draw parallels
- This program is still very new so too early to draw conclusions

Question: Is the program restricted to only serving residents of SMC? Could someone from Santa Clara refer someone to the Pride Center?

- Yes, for free all and community services
- Clinical might be different because we work with the health plan of San Mateo so they might not be qualified for our county

Question: Do you provide support for hormone or transgender care or is that referred out?

- Do letter writing referrals for medical transitional care; no onsite endocrinologist

Teresa V., San Mateo County Office of Education
The work that the Pride Center is doing in encouraging and promoting the physical and emotional and mental health and wellness of the LGBTQ+ communities in San Mateo County through programs that support and nurture the mind, body and soul is of utmost importance to the mental health of LGBTQ students and community members. They've made a huge impact in just a short amount of time. The Pride Center offers the safe space for students to be their most authentic selves and works with schools to make school campuses emotionally safe for all students. Many LGBTQ students may not be out at home so the Pride Center's work with schools to make them emotionally safe places is very important. The San Mateo County Office of Education has been fortunate to partner with the Pride Center in working with the Gender Sexuality Alliance advisors from middle schools and high schools throughout the County. The Pride Center offers space for these meetings and technical assistance for the first annual GSA day to be held in December. The San Mateo County Office of Education wholeheartedly supports the Pride Center in their efforts to make our schools and county safe for all people. Imagine what they can do with more time to continue their programs and services.

Fennel S., student at Capuchino High School and intern last year at the Pride Center
I am for giving an extension to the pride center for the next two years. It has greatly improved my quality of life, as well as the lives of many others- the staff are wonderful and the events amazing, such as the intergenerational dinners, which bring together many age groups (& free food!!!) to talk about our lives on a panel and in conversation. I believe it would be a severe detriment to the county to cut funding, as this has been a vision for well over a decade, and a physical place for the past year and a few months, and it's truly needed for all the LGBTQ+ folk in the county to keep us sane, stable, and healthy.

On a personal note, the pride center is one of the few places I feel safe and at home to express myself in San Mateo county without fear of judgement or hatred towards myself. In school, slurs are dropped often with malintent. At the center, not only is that kind of behavior discouraged, things get actively done about it. Trainings are held, for the staff and the public, on how to be a decent and respectful human being. Often times, I feel safer at the center than I do at home, because of the quality of the place and the people.

Events such as the intergenerational dinner I mentioned before are a large part of what makes the center so wonderful- in addition to that, we've had Holigays, a Thanksgiving party, Queer Prom for the youth, the center's opening and first anniversary parties, and of course, San Mateo Pride. There are also smaller events that are just as meaningful, like drag workshops, movie nights, Wednesday Crafternoons, and LGBTeas, an event that I hosted. These events help foster a sense of community and establish a common goal of moving together to a healthier, happier future.

Because of these reasons, I ask that you please consider giving the center two more years of funding. It would truly mean the world to many of the citizens of San Mateo county.

Lyn K., Volunteer at San Mateo County Pride Center and frequent user.
I would regard the San Mateo County Pride Center, just the mere existence of it, as a mental health service. Especially for LGBT youth being out in the community or gen pop is very stressful. LGBT youth is one of the few groups that are actually kicked out of their homes for essentially being who they are. That sense of community, support and guidance is very important for young people in particular. For myself as a transgender woman, pronouns she/her, it's been very important to have that sense of community myself. Just being around people who understand and not having to explain myself all the time, which in the larger community I end up having to do. So, that is as you can imagine a constant source of stress. It's manageable but definitely helps to have a group of like-minded people to whom I don't have to explain myself all the time. Thank you very much.

Lynn S., resident of San Mateo County and LGBTQ Commission member
I live in Pacifica with my wife. We are empty nesters seeing our son off to college this fall. He grew up with two moms. What I want to point out as a mom who raised a son in this County with my partner is that there weren't a lot of services to help us be moms, to talk to other parents that were dealing with the same things we were dealing with. Boy did I wish the Pride Center was around at that time because it would've been terrific. I want to express the Commission's wholehearted request that support for the Pride Center's two-year extension and funding be extended. The Pride Center has served a vital role in providing access, it's increased the quality and breadth of services and it's supported a dynamic interagency collaboration. It's done all the things that innovation funding is supposed to do. Since the Pride Center opened its doors in 2017, it has created an array of services for the community including well developed education programs for our local schools and hosting two sold-out Queer Prom's for youth. This is particularly important because youth need opportunities to connect with one another. And, whether the youth found out about the prom because they were part of the Pride Center or not, the fact is that all were aware of the Pride Centers services after the Proms and that created a more connected and better served LGBTQ community. That's to say nothing of the wide array of services that are available for seniors and other special populations within the LGBTQ spectrum. The intergenerational events have been a blessing and a way to learn about other Pride Center activities, make new friends and engage the community. The Pride Center has also helped tremendously with the survey that you all have heard about. In 2000 there was a survey that was done to assess the LGBTQ needs and there was no center therefore there were fewer LGBTQ people that were surveyed. Because of the Pride Center's work and helping the commission to get the word out about the survey, we were able to tap into more than three times the number of adults and more than six times the number of youth, which has resulted in a more representative survey. So, when you see these statistics come out, it's really representative of the community and that's thanks to the Pride Center. I want to say thanks to the MHSA Steering Committee's vision to launch this program and I ask you to support two more years of services and thank you for your leadership and support.

Marvin

I found the Pride Center this year and as soon as I saw the LGBT flag I thought, what is this. I've been living in San Mateo County for 9 years and when I saw this, it felt so welcoming and I was so happy that the Center was there. I received therapy, case management. The staff at the Pride Center work with integrity. I have found not friends but family. I am so happy, everything is safe. I grow so much. We need what we are asking for and I'm so happy that the center is here so let's get it on baby.

Closing of the 30-day Public Comment Period and Public Hearing Public Comments

Dorothy C., MHSARC Commissioner
Do any of the people that go to the Pride Center have voices in their heads, are they paranoid schizophrenic and have voices in their head telling them to kill themselves or kill their family?

- Yes, we do have clients like this

Q: But is that because they have a medical diagnosis of paranoid schizophrenia or is it because they, I don't understand. Seriously mentally ill have voices in their heads and they are homeless, and they have all sorts of things going on. I'm not sure where the serious mental illness comes into this.

- The clinical team is not here, we don't have any of the mental health clinicians here right now to answer specifics about the clients.

Q: So, the 1.5 million could be going somewhere else to serve the seriously mentally ill. I don't understand. I've been doing this for 13 years and nothing has changed. I don't know where the money is going, nothing has changed. Homelessness is still a problem.

- 76% of MHSA funds have to be spent on services for seriously mentally ill, 51% of this goes to full service partnerships; 19% goes to prevention and early intervention and 5% goes to innovative projects. A stakeholder process helps us determine what we will spend the funding on… for something that isn't already being done, we can 't just use it for a need but meets the innovative criteria. The Pride Center came through the stakeholder process and meets the innovative criteria.
- Prevention and early intervention work and innovation is with the ultimate goal of preventing serious mental illness and linking individuals with serious mental illness to services, we have to demonstrate that we are doing this.

Q: When I voted for the millionaire tax, and I thought I read through it all, was this all in there? I missed it.

- There was also one-time funding for housing and for technology and for workforce education and training. The ongoing funding is for full service partnerships, prevention and early intervention and innovation to push the system to look for better and new ways to serve underserved populations, the LGBTQ community has been underserved

Q: My family has been underserved, my paranoid schizophrenic son has been underserved and I think I've made that clear in other meetings and so I don't get it.

- We can't use innovation dollars for ongoing services. There's been a local commitment to the Pride Center and it's meeting an unserved community

Q: And a million and a half dollars is gone after that, you're going to need money after the innovation.

- Our challenge is to determine if based upon services delivered and outcomes, the county wants to continue funding and find a way to do that.

Kate P., MHSARC Commissioner
You share peoples stories and peoples photos and do so much work to reduce double stigma that is a barrier to accessing services, the stigma of mental health and the stigma of

somebody's identity it makes it so hard to walk through a door and by removing the initial barrier of yes, it's ok to be here and share your story I think you're doing tremendous work in lowering that barrier to access treatment. We do know from the statistics just how many people in the community end up in really severe mental health, suicidal, engaging in self harm, self-medicating with substance use because they are not in a supportive community or they're facing family rejection, or they're isolated or homeless because of the stigma and the retaliation they get from the community at times. I really appreciate you being here.

Bill N., MHSARC Commissioner
Just curious, this particular use of the innovation funds, has it been effectively used in any other county in California, this program. Are you planning to share this with other counties?
No, this has not been done, that's why it was approved as an innovative program and one of the reasons why we would like to extend the funding is to allow us to document and learn and share the program

Rodney R., MHSARC Commissioner
I've been friends with people in psychosis, I've been in psychosis myself. They're not mutually exclusive but there isn't a way to take this innovation money and put it towards making more innovations in direct service. I've been living in San Mateo County since 2003 and since this Pride Center opened, and this movement towards making this a much more visible issue, it's the first time I've considered getting back involved with the gay community in 15 years. I was heavily involved with the gay community in mental health and substance use disorders in San Francisco and when I came here I had nothing. It's been a way for me to positively re-identify with a community that I'm a part of that I have been missing for 15 years. I am a person that as a professional and as a peer, help people that are in psychosis get treatment so it's not in that respect a mutually exclusive thing. If I feel more supported, I'm more likely to do well. If I'm more likely to do well, I'm more likely to be able to do outreach with people that are with more severe mentally ill than I have in order to get them the services they need. I think the Pride Center is incredibly important. I've had a chance to visit one time and it's not going to be my last visit and I was so blown away, like on a pink cloud that I had so many years ago. So please, don't see this as a waste of money because it's not.

MHSARC Commissioner
I've attended many of the events of the Pride Center and what I see is a very safe place for people to be and for people to go and you can feel the love and acceptance in the building and courtyard, everybody supporting each other. From my point of view, I would rather have someone walk in through the front door of the Pride Center than walk in front of a train in California. I think it's a great place and I support it 100%.

Susan Houston, Peninsula Family Service, member of MHSARC Older Adult Committee
I'm with one of the partner organizations that provide services at the Pride Center. I'm here to support the request for continual funding. Working with older adults throughout the years, I understand the special needs of LGBTQ older adults most who've experienced trauma just by being themselves. Loss of support from family members and friends, losing jobs and in the past

even ending up in jail. When we first started the LGBTQ component of the senior peer counseling program, where we have clinical supervision at the Pride Center, one of our counselors was visiting an LGBTQ client who shared a room with another man in a nursing home. Upon learning that the peer counseling client was gay, the man's wife became extremely emotional insisting that the gay man be moved so that her husband would not get AIDS. Our peer counselor was valuable in protecting the clients' rights and providing emotional support to him with this incident and he didn't get moved from the room. I feel it's really important for LGBTQ persons of all ages to have a place where they feel supported and can receive what they need to thrive in the community. The Pride Center has provided a place for older adults to be themselves, it also provides staff who are great about educating the public about the needs of LGBTQ individuals. We've received a lot of SOGI trainings from the staff and it's been great. Every morning we have coffee breaks for older adults where people can have a cup of coffee and talk about what's new in the community. One of the older members of the community came and spoke about the trials of being an older transgender person of color and a person dealing with mental health challenges at the Board and Care facility where he lived. A place where he had to dress and act in a socially conforming manner and against his true nature of being. For these reasons and others, I urge you to support the continual funding for the program. Thank you.

Andres, they/them/theirs and she/her/ella, Peer Support Worker at the Pride Center
As a transgender queer person, as a person of color, as a person from immigrant parents it has been such an extraordinary experience to really be myself at a place of work. A place where don't have to hide myself, a place where I need some of the services of the Pride Center and able to build community in such a special way. I've grown up all my life in the Bay Area, I'm 27 years young and I've lived in the East Bay most of my life, I've lived in San Jose and Oakland where a lot of Mexican people go and where my family can relate to people. Every time I've wondered, and I asked my dad, why did we never go to the Peninsula. I had never been to the Peninsula until the Pride Center opened. My dad said, we don't go there because we are looked down upon. We don't go there because it's not as safe. One of the best things about my job is that I get to work with Spanish-speaking parents and I get to blow their minds every single time I do a presentation because for the very first time they see someone like me. Someone who is able to embrace my culture and also be LGBTQ, also be trans. To see that and to come into this county every day and to have people mock me and have people make fun of me and to have people ask me very invasive questions, to feel very unsafe at times, it's very troubling and something very telling of what services and what things we need in this County. I just want to say that this is an opportunity, a golden moment for us, to really decide where do we stand in our history as San Mateo County. We see our history, we see things that have happened in the past, how do we rectify these things. How do we make ourselves stand out and be progressive, be out there, be bold, be the leaders of our County. This is our opportunity and our moment. This is the minimum. I want a new place, I want a new building, we are outgrowing ourselves already and we just need more time to really prove ourselves. If there's anything we take away from this it's how do we really want to show up for our community, how do we really want to come together in these very troubling times. Yes, that's me.

Ryan, he/him/his, Program Director of Outlet, Adolescent Counseling Services
Outlet is the provider that partners with the Pride Center to facilitate all youth programming. We host social support groups throughout the week where youth can come in and find a safe, welcoming environment. We also support youth leadership opportunities including a youth advisory board. We also utilize the Pride Center's centralized location to conduct outreach and supports to GSA's and school districts throughout San Mateo County. I think that the Pride Center in an essential resource for the LGBTQ+ community. It eliminates barriers to service access by allowing our communities to visit one space to receive social support, case management, mental health and substance use services and referrals to other vital resources. It also brings services closer to home for our community and reduces the need for community members to seek out spaces in other places like San Francisco or San Jose. Speaking to the Innovation, I think the collaboration, the four partners bringing together resources really supports individuals across the life span. This is really special because certain LGBTQ subgroups including older adults and youth have historically been isolated. The community that the Pride Center creates reduces stigma and increases the sense of belonging, which both directly impact improvements in physical and mental health. Prior to joining Outlet earlier this year, I'm a clinical social worker and my background is in working with homeless youth and young adults so I've worked for 13 years for young people for whom it has not yet gotten better. They face extreme challenges with mental health, substance use, rejection, shame. I really see the Pride Center and our work at the Pride Center as a way to offer prevention. We are stepping in, we are creating a space where we can prevent situations like this from happening to more people that's why I think it's really important, that's why we are asking you to continue supporting this for two more years of innovation funding. Thank you.

Ellen, she/her/hers, Peninsula Family Service
I've worked 28 years with older adults and I'd like to share some information about older adults. LGBTQ older adults age 50 and older are twice as likely to live alone, twice as likely to be single, and 3-4 times as likely to have no children than their non-LGBTQ community members around them. That's true also in San Mateo County. This creates higher incidents of social isolation and vulnerability, which we all know in terms of mental health what challenges this presents. The Pride Center provides programs and activities to support older LGBT adults in the community and includes senior peer counseling, mindfulness meditation intergenerational lunches and dinners, senior affordable housing workshops and is an opportunity for LGBT older adults to learn how to get on the list and be included in those communities. The Pride Center also partners with Notre Dame De Namur University with an oral history legacy project. What that project does is match students with older adults as an opportunity to preserve older adult LGBT history and culture that could be gone when older adults pass away. All of these events take place at the Pride Center and due to generational differences and the history and lack of legal protections many of our older adults haven't been out to anyone or don't come out to anyone. I had a client last year who was born in 1913 and was not out to a single person. The Pride Center provides a welcoming environment for the older adults, they're people who historically have not used any county resources or any official resources out of fear of discrimination and lack of cultural sensitivity from the providers. I just want to say that for

these reasons, for the people that I have worked with, for all they have been through I'm requesting that you support the additional funding for the Pride Center. Thank you very much.

Donald M., MHSARC Commissioner
There are two typos in the motion, it's 1,550,000 ($700,000 per year, plus $150,000 evaluation)

September 17, 2018

Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:

My name is David Fleishman, Executive Director of 4Cs of San Mateo County and I am writing to strongly support the two-year extension of time and funding for the Pride Center, an MHSA Innovation project of the San Mateo County Behavioral Health and Recovery Services.

As the county's resource and referral agency, 4Cs connects individuals with programs and services so that they can live and thrive in our diverse community. Pride Center offers services that span from drop-in centers to case management to peer support and more to an underserved population in San Mateo County. The first of its kind in San Mateo, the Pride Center needs to continue and expand their services.

The San Mateo County Pride Center, the first such location in all of San Mateo County, fills a gap in much needed services for LGBTQ+ community. The innovative design of four partnering agencies operating together in close collaboration to offer multiple services has allowed the Center to become a one-stop-shop for clients of all ages including children, youth, adults, and older adults.

4Cs of San Mateo County joins the San Mateo County Pride Center's quest to improve and expand services throughout the county, with a special emphasis on mitigating inequities and ensuring services are provided that will support the wellbeing of the LGBTQ+ community.

I hope that you will decide favorably regarding the Pride Center's current and future funding. Thank you for your consideration.

In partnership,

David Fleishman
Executive Director
4Cs of San Mateo County

SAN MATEO COUNTY HEALTH

BEHAVIORAL HEALTH & RECOVERY SERVICES

Service Connect
550 Quarry Road, 3rd Floor
San Carlos, CA 94070
650-508-6745 T
650-598-2860 F
smchealth.org

COUNTY OF SAN MATEO CALIFORNIA

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

September 17, 2018

Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:

We, Desirae Miller, BHRS Case Manager/Assessment Specialist II and Chyvonne Washington, Family Health Services Community Program Supervisor, are the Co-Chairs of the African American Community Initiative. We strongly support the two-year extension of time and funding for the Pride Center, an MHSA Innovation project of the San Mateo County Behavioral Health and Recovery Services.

We are appreciative that there is a safe place for the LGBTQ+ consumers of San Mateo County to receive strength based and trauma informed services. The presence of the Pride Center has given us as service providers a resource for our consumers who have been in the process of coming out to their family, experiencing gender identity crisis, changing their gender role and those who have completed the transition. This is a resource that prior to the opening of the pride center was not available, leaving our LGBTQ+ community in risky situations. The services offered at The Pride Center allow the community to have a healthy coping tool. It gives a great sense of pride to inform family, friends, community members and consumers, that there is a safe place for the LGBTQ+ community that encourages growth, provides community inclusion, and ultimately is a safe place.

The San Mateo County Pride Center, the first such location in all of San Mateo County, fills a gap in much needed services for LGBTQ+ community. The innovative design of four partnering agencies operating together in close collaboration to offer multiple services has allowed the Center to become a one-stop-shop for clients of all ages including children, youth, adults, and older adults.

The African American Community Initiative joins the San Mateo County Pride Center's quest to improve and expand services throughout the county, with a special emphasis on reducing

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

stigma, trauma informed services, crisis management, discrimination, and inequities to enhance the wellbeing of the LGBTQ+ community.

The African American Community Initiative stand in proud support of the San Mateo County Pride Center. Thank you for your consideration,

Warm Regards,

Chyvonne Washington, Family Health Services Community Program Supervisor,
Desirae Miller, BHRS Case Manager/Assessment Specialist II
Co-Chairs
African American Community Initiative

COUNTY OF SAN MATEO

Aging & Adult Services
San Mateo County Health

MAILING ADDRESS
PO Box 5892
San Mateo, CA 94402

LOCATION ADDRESS
225 37th Avenue
San Mateo, CA 94403

smchealth.org

September 17, 2018

Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:

Aging and Adult Services (AAS) in San Mateo County Health strongly support the two-year extension of time and funding for the Pride Center, an MHSA Innovation project of the San Mateo County Behavioral Health and Recovery Services.

The San Mateo County LGBTQ+ older adult and people with disability community greatly benefits from the Pride Center as a safe and supportive place to congregate and receive culturally appropriate services. For LGBTQ+ older adult clients and clients with disabilities, this center is a lifesaving environment given the isolation and fear of discrimination this population has faced all their lives and is a place where they can be seen as a whole person.

The Pride Center's convenient location between the two metropolitan LGBT centers, SF LGBT center in the north, and Billy DeFrank in the south both 25 miles on either direction makes the Pride Center the most accessible place for the LGBTQ+ community. This is especially necessary for older adults and people with disabilities who identify with the LGBTQ+ community because transportation and accessibility are one of the top barriers to accessing resources.

The partnership between AAS and the Pride Center has been of paramount importance to the implementation of Sexual Orientation and Gender Identity data collection, as stipulated by AB 959. The Pride Center trained all AAS staff and provides ongoing provided expertise and technical assistance that has prepared our workforce not only for the data collection of SOGI questions but to better serve the LGBTQ+ population in our County.

In addition to acting as a consultant to inform San Mateo County's culturally sensitive services, the Pride Center is a hub for collaboration and planning with community based agencies county-wide. The Pride Center's strong advocacy for

COUNTY OF SAN MATEO

client centered services has been instrumental in developing policies to better serve the LGBTQ+ by San Mateo County Health.

AAS joins the San Mateo County Pride Center's quest to improve and expand services throughout the county to enhance the wellbeing of the LGBTQ+ community.

AAS stands in proud support of the San Mateo County Pride Center. Thank you for your consideration,

Sincerely,

Chris Rodriguez
Deputy Director
San Mateo County Health
Aging and Adult Services

Gladys Balmas
Health Services Manager
San Mateo County Health
Aging and Adult Services

Aragon High School

900 Alameda De Las Pulgas, San Mateo, CA 94402-3399 www.smuhsd.org/aragonhigh

***E**xcellence and **E**quity* Telephone (650) 558-2999

September 12, 2018

Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:

As a classroom teacher and Gender and Sexuality Club advisor at Aragon High School, a member of the San Mateo Union High School District LGBTQ+ Taskforce and the San Mateo County Office of Education's LGBTQQ Alliance, I directly see the impact that the San Mateo Pride Center has on our community and our students. That is why I strongly support the two year extension of time and funding for the Pride Center, an MHSA Innovation project of the San Mateo County Behavioral Health and Recovery Services.

The Pride Center has filled an important gap in San Mateo County's mental health services for the LGBTQ+ population in the community. Specifically, the outreach for youth in our community has made a marked difference. Prior to the existence of the Pride Center, a *few* community organizations did *some* outreach to LGBTQ+ youth, one of the most at-risk populations. With the creation of the Pride Center, community groups are inspired and motivated to connect, share, and foster change up and down the San Mateo Peninsula.

The Pride Center outreach is directly impacting students in San Mateo county. With the help of the Pride Center, for the first time on the Peninsula, GSA club advisors are meeting regularly to discuss practices and share experiences. These gatherings are supporting teachers, staff, and administrators. But, most importantly, they are helping schools better serve LGBTQ stduents. It should be noted that the Pride Center was contracted by the San Mateo Union High School District to conduct onsite professional development for all teachers, staff, administrators, and district office personnel.

Additionally, the Pride Center has become an integral part of our Gender and Sexuality Club on Aragon's campus. Not only have they come to school to do trainings for staff and students, their events connect our students to the greater LGBTQ+ and ally

communities. Weekly, my students review the wide offerings at the Pride Center. Movie Night, drop-in hours, Trans Talk are just a few that our students are regularly participating in.

A connection to the greater San Mateo community confirm for my students and their families that there is a place for their authentic-self in our society. Too often, students look to an uncertain future and do not see themselves thriving. Thanks to the services and outreach of the Pride Center, our students feel validated at their present stage of life. They are counting on and expecting these resources to be available for them now and in the future.

I have seen first-hand how the Pride Center's innovative design of four partnering agencies operating together in close collaboration to offer multiple services has allowed the Center to become a one-stop-shop for clients of all ages including children, youth, adults, and older adults.

I would join the chorus of praise for the San Mateo County Pride Center's quest to improve and expand services throughout the county, with a special emphasis on preforessional development and outreach that reduces stigma and discrimination in our community.

Clearly, I stand in proud support of the San Mateo County Pride Center. Thank you for your consideration.

Sincerely,

Vincent Bravo
Aragon High School Teacher / GSA Advisor

Arts Unity Movement
149 South Blvd.
San Mateo, CA 94402
650569-1276 650 703-3309
www.artsunitymovement.com
artsunitymovement@gmail.com

September 7, 2018

Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing

My name is Roberta Wentzel-Walter. I am a co-founder and Director of a non-profit organization called Arts Unity Movement. We are affiliated with the BHRS Contractors Association. I strongly support the two year extension of time and funding for the Pride Center, an MHSA Innovation project of the San Mateo County Behavioral Health and Recovery Services.

The San Mateo County has been a pioneer in providing a safe space and resource center for the LGBTQ community. The center has filled a much needed function. I have heard from many of the people we serve that the Pride Center has been an important resource for them. It has been the consensus of my colleagues at the BHRS Contractors Association that the Pride Center is providing valuable support. I have been active in spreading the word about the ground breaking resource.

The Pride Center was in the planning stages for a very long time. As a consequence the needs of the community have been carefully thought out so that wrap around services can be provided. The center provides a focal point for the community by providing a drop in center and many social events such as Intergenerational Dinner and discussion groups, as well as practical services such as clinical services, case management and a resource center.

The San Mateo County Pride Center, the first such location in all of San Mateo County, fills a gap in much needed services for LGBTQ+ community. The innovative design of four partnering agencies operating together in close collaboration to offer multiple services has allowed the Center to become a one-stop-shop for clients of all ages including children, youth, adults, and older adults.

I stand in proud support of the San Mateo County Pride Center. Thank you for your consideration,

Sincerely,

Roberta Wentzel-Walter MA ATR BC
Co-Founder and Director
Arts Unity Movement

NEW GROUND Theatre Dance Company

BAYMEC

MOVING EQUALITY FORWARD

October 7, 2018

Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

RE: Support for San Mateo County Pride Center

Dear Mr. Ewing:

I am writing to you on behalf of the Bay Area Municipal Elections Committee (BAYMEC) in support of the two-year extension of time and funding for the San Mateo County Pride Center, an MHSA Innovation project of San Mateo County Behavioral Health and Recovery Services.

BAYMEC has advocated for the civil rights of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) people since 1984 in the counties of San Mateo, Santa Clara, Santa Cruz and Monterey.

The Pride Center was a vision ten years in the making, and since its opening last year has provided critical resources and space for the LGBTQ community of San Mateo County. Not only does the Pride Center provide a suite of vital services—peer support groups, drop-in and by appointment counseling and therapy services, case management, gender and name change assistance, and a general resource center—the Pride Center also builds resilience through community. The Pride Center does this through a number of fun and inclusive events, such as their Queer Prom and the Intergenerational Dinner, as well as educational events and workshops open to the public.

The Pride Center, the first such location in all of San Mateo County, provided needed services to the LGBTQ community that they would not otherwise have. The innovative design of four partnering agencies operating together in close collaboration to offer multiple services has allowed the Pride Center to become a one-stop-shop for clients of all ages.

BAYMEC strongly supports the Pride Center's effort to improve and expand services throughout the county, and to enhance the wellbeing of the LGBTQ community.

BAYMEC is proud to submit this letter of support. We are thankful for your leadership on and attention to this matter.

Sincerely,

Paul A. Escobar
BAYMEC President

1855 Hamilton Avenue
Suite 203
San Jose, CA
95125

1501 Magnolia Avenue
San Bruno, California 94066
Telephone: 650-558-2799
Fax: 650-558-2752

September 17, 2018

Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:

My name is Shannon Henricks, and I'm a counselor at Capuchino High School and the adviser for our SAGA club (Sexuality and Gender Alliance) and strongly support the two year extension of time and funding for the Pride Center, a MHSA Innovation project of the San Mateo County Behavioral Health and Recovery Services.

I have been a counselor for 18 years on the peninsula. We have always had a need for LGBTQ youth support. Often times parents are not comfortable sending their teen to the city to visit Queer youth agencies. Having the Pride Center so accessible for our youth, as well as training for our staff has filled a much needed gap. From Queer Prom, to movie nights, to intergenerational dinners, the Pride Center continues to offer relevant events for our youth; events that resonate with them, and where they are able to spend time with peers that share common experiences.

The Pride Center has and continues to come out to our schools to train faculty and staff on the Gender Binary. My teachers are passionate about supporting all their students. They understand that, often times, our trans youth are not being accepted for who they are at home. It's even more important that our Trans youth feel connected and supported in their school setting. That starts with proper professional development for our adults on campus.

The San Mateo County Pride Center, the first such location in all of San Mateo County, fills a gap in much needed services for LGBTQ+ community. The innovative design of four partnering agencies operating together in close collaboration to offer multiple services has allowed the Center to become a one-stop-shop for clients of all ages including children, youth, adults, and older adults.

1501 Magnolia Avenue

Capuchino's SAGA group joins the San Mateo County Pride Center's quest to improve and expand services throughout the county, with a special emphasis on reducing stigma, trauma informed services, crisis management, marginalization, discrimination, inequities to enhance the wellbeing of the LGBTQ+ community.

Capuchino High School stands in proud support of the San Mateo County Pride Center. Thank you for your consideration,

Sincerely,

Shannon Henricks, Counselor
Department Chair
SAGA (Sexuality and Gender Alliance) Advisor
Capuchino High School
San Bruno, CA

CASA of San Mateo County
Court Appointed Special Advocates
FOR CHILDREN

September 18, 2018

Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:
I am the Executive Director of CASA of San Mateo County and our nonprofit agency strongly supports the two year extension of time and funding for the Pride Center, an MHSA Innovation project of the San Mateo County Behavioral Health and Recovery Services.

CASA of San Mateo County serves Foster children/youth and Delinquent youth in San Mateo County and are well aware of the trauma and obstacles that LGBTQ+ children/youth/adults face in our community. Our CASA volunteers have supported LGBTQ+ youth through the years and we are very pleased with our partnership with the San Mateo County Pride Center. The mental health wellness and recovery services had not been available to our youth in the past and definitely fill a much needed void. As a result, we had to look to other counties to find resources and we are so grateful that those services are now available in our own county.

We recently had a very well received and informative training for our CASA volunteers by volunteers and staff of the Pride Center. This encouraged positive conversation amongst our CASA volunteers and gave them the knowledge and confidence to empower their youth. We believe that the Pride Center is a vital aspect of the county's mental health community and is greatly needed. In particular, we are so thankful for the availability of the drop-in center and peer support groups. It is our intention to deepen our partnership with the Pride Center and do all we can to let our CASA volunteers and youth know that this tremendous resource is available for them.

The San Mateo County Pride Center, the first such location in all of San Mateo County, fills a gap in much needed services for LGBTQ+ community. The innovative design of four partnering agencies operating together in close collaboration to offer multiple services has allowed the Center to become a one-stop-shop for clients of all ages including children, youth, adults, and older adults.

CASA of San Mateo County joins the San Mateo County Pride Center's quest to improve and expand services throughout the county, with a special emphasis on **trauma informed services** and crisis management to enhance the wellbeing of the LGBTQ+ child/youth community.

CASA of San Mateo County stand in proud support of the San Mateo County Pride Center. Thank you for your consideration,

Warm Regards,

Patricia Miljanich
Executive Director
CASA of San Mateo County

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

310 Harbor Boulevard
Building E
Belmont, CA 94002
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650-802-6440 F
smchealth.org

September 17, 2018

Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:

I am a Co-Chair for the Chinese Health Initiative (CHI) of San Mateo County Behavioral Health and Recovery Services, Office of Diversity and Equity. We strongly support the two year extension of time and funding for the Pride Center, an MHSA Innovation project of the San Mateo County Behavioral Health and Recovery Services.

There are many layers of stigma our Chinese community faces in San Mateo County. Many in the Chinese community face stigma and discrimination based on our race/ethnicity, our mental health or substance use diagnosis, and gender identity & sexual orientation. The Pride Center offers a space and services that peel back the layers of stigma and encourages LGBTQ+ community of all races/ethnicities to access underutilized mental health services.

Specific ways we partner with the Pride Center include (1) referring clients and family members to the Pride Center clinical services or support groups, (2) consulting with the Pride Center with questions about Sexual Orientation and Gender Identity and (3) having one of our CHI members has served on the Community Advisory Board for the Pride Center.

The San Mateo County Pride Center, the first such location in all of San Mateo County, fills a gap in much needed services for LGBTQ+ community. The innovative design of four partnering agencies operating together in close collaboration to offer multiple services has allowed the Center to become a one-stop-shop for clients of all ages including children, youth, adults, and older adults.

The Chinese Health Initiative joins the San Mateo County Pride Center's quest to improve and expand services throughout the county, with a special emphasis on reducing stigma and improving outreach to enhance the wellbeing of the LGBTQ+ community.

COUNTY OF SAN MATEO CALIFORNIA

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

The Chinese Health Initiative stand in proud support of the San Mateo County Pride Center.
Thank you for your consideration,

In Community,

Shiyu Zhang, Steve Sust, Sylvia Tang & Winnie Wu
Co-Chairs, Chinese Health Initiative
Office of Diversity & Equity
San Mateo County Behavioral Health & Recovery Services

CORA

COMMUNITY OVERCOMING
RELATIONSHIP ABUSE

September 17, 2018

Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:

I am writing to you on behalf of Community Overcoming Relationship Abuse (CORA). For over 40 years, CORA's mission has been to provide safety, support and healing for individuals who experience abuse in an intimate relationship, and educate the community to break the cycle of intimate partner abuse. At CORA, we provide victims and survivors of intimate partner abuse with effective supportive services as they deal with an exceptionally difficult period in their lives. Our free, trauma-informed programming includes: safe houses; supportive housing; 24-hour crisis, legal, and law enforcement referral hotlines; legal services; mental health support; children's programming; community advocacy; and community education. As the only agency of its kind in San Mateo County, we annually respond to over 12,000 requests for these services.

We at CORA strongly support the two-year extension of time and funding for the Pride Center, a MHSA Innovation project of the San Mateo County Behavioral Health and Recovery Services. CORA has seen first hand the benefits of the Pride Center's approach to mental health and wellness. The Center builds community, reducing isolation, and provides a safe space for connection. It has been a centralized HUB for the LGBTQ+ community, providing avenues to necessary resources, and specifically assisting in decreasing the effects of isolation, so commonly found in intimate partner abuse. The Pride Center is truly community driven by offering support groups, film screenings, workout facilities, and case management support.

The San Mateo County Pride Center, the first such location in all of San Mateo County, fills a gap in much needed services for LGBTQ+ community. The innovative design of four partnering agencies operating together in close collaboration to offer multiple services has allowed the Center to become a one-stop-shop for clients of all ages from children to older adults.

As an agency that supports survivors of intimate partner abuse, we often see LGBTQ+ survivors facing exploitation of systemic inequities as a part of the power and control used in their abusive relationship. By combating LGBTQ+ marginalization, the Pride Center helps empower LGBTQ+ survivors. The trauma-informed approach allows LGBTQ+ survivors to access appropriate services in ways that feel safe. By having an LGBTQ+ specific organization that offers crisis management services, survivors know there is somewhere they can turn to in a crisis even if their partner told them otherwise. Through our partnership with the Pride Center, we are able to reach individuals who otherwise might not know there is assistance available.

CORA stands in proud support of the San Mateo County Pride Center. Thank you for your consideration,

Sincerely,

Colsaria Henderson, MSW
Executive Director
Community Overcoming Relationship Abuse (CORA)

2211 Palm Avenue
San Mateo, CA 94403
650-652-0800

800-300-1080 (24-hr hotline)
www.corasupport.org

September 17, 2018

Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:

My name is Joan Martel and I am the Deputy Director of CuriOdyssey, a serious science playground and zoo for children. We strongly support the two-year extension of time and funding for the Pride Center, an MHSA Innovation project of the San Mateo County Behavioral Health and Recovery Services.

- The Pride Center's approach to mental health wellness and recovery services is extremely important in our diverse community and we fully support their efforts.
- The Pride Center conducted a special training for our employees and it was not only presented well but sparked great discussion while provoking a deeper understanding of being aware of diversity in our relationships to our visitors and employees.
- We will be honored to host the Queer Prom in February next year in our rental space, too!

The San Mateo County Pride Center, the first such location in all of San Mateo County, fills a gap in much needed services for LGBTQ+ community. The innovative design of four partnering agencies operating together in close collaboration to offer multiple services has allowed the Center to become a one-stop-shop for clients of all ages including children, youth, adults, and older adults.

CuriOdyssey joins the San Mateo County Pride Center's quest to improve and expand services throughout the county, with a special emphasis on reducing stigma, discrimination and inequities to enhance the wellbeing of the LGBTQ+ community.

CuriOdyssey stands in proud support of the San Mateo County Pride Center. Thank you for your consideration.

Sincerely,

Joan Martel
Deputy Director
CuriOdyssey

CuriOdyssey
AT COYOTE POINT
give@curiodyssey.org | curiodyssey.org/support
1651 Coyote Point Drive, San Mateo, CA 94401
650-340-7571

Daly City Youth Health Center
YOUR LIFE, YOUR DECISIONS

A collaborative program of the Jefferson Union High School District and the San Mateo Medical Center

September 17, 2018

Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:

For 27 years Daly City Youth Health Center has prepared our communities' teens and young adults for a healthy and productive adulthood through our holistic, comprehensive services. Each year, the Daly City Youth Health Center provides assistance to over 2,500 low-income teens and young adults in northern San Mateo County through our comprehensive services. Our Primary Care Clinic, which serves more than 600 young people a month, offers low-cost or no-cost services, including physicals, immunizations, tuberculosis skin tests and treatment, vision and hearing screenings and reproductive health exams. Our Behavioral Health Counseling program provides individual, family, couples and group counseling to youth and their families to more than 200 youth per year. Project PLAY is a reproductive health and pregnancy prevention education program encouraging more than 1,500 teens annually to make informed, healthy decisions.

The Pride Center and Daly City Youth Health Center (DCY) had been strong collaborators since its inception. There have not been services for LGBTQ+ youth in northern San Mateo County until the Pride Center opened. Our collaboration provides teens and young adults with the information and guidance they need to make healthy choices, to stay safe in school, and achieve a sound career path. Our comprehensive system allows for our clinic's primary health care and mental health providers to easily refer LGBTQ+ patients to various events and services provided by the Pride Center.

From January to end of May 2018, the Pride Center and DCY facilitated the very first weekly LGBTQ+ Youth Group at DCY. In addition, on March 31 and April 7, 2018, DCY hosted and facilitated two (2) 8-hour workshops. The Mural Project, which brought together eight (8) Filipinx LGBTQ youth worked together to create a Mural which explored the intersectionality of Filipinx, LGBTQ and youth cultures. Through dialog, shared stories and narratives, the youth created a common thread tying these disparate but interconnected experiences together. This common thread manifested itself in the Mural which depicts the various subcultures that exist within these larger cultures as banding

YOUR LIFE, YOUR DECISIONS
Daly City YOUTH Health Center

A collaborative program of the Jefferson Union High School District and the San Mateo Medical Center

together to stand as one to face and overcome the stigma that exists and which informs their lives.

Addressing the stigma of same sex love, the Mural states "Love Knows No Gender" and portrays the youth reaching out to others as a bridge to breaking through the daily stigma they all face.

Without outreach and collaboration with the Pride Center, these events wouldn't have been possible.

We strongly support the two year extension of time and funding for the Pride Center, an MHSA Innovation project of the San Mateo County Behavioral Health and Recovery Services.

The San Mateo County Pride Center, the first such location in all of San Mateo County, fills a gap in much needed services for LGBTQ+ community. The innovative design of four partnering agencies operating together in close collaboration to offer multiple services has allowed the Center to become a one-stop-shop for clients of all ages including children, youth, adults, and older adults.

Daly City Youth Health Center joins the San Mateo County Pride Center's quest to improve and expand services throughout the county, with a special emphasis on culturally appropriate youth services, stigma reduction, and increase access to services to enhance the wellbeing of the LGBTQ+ community.

Daly City Youth Health Center stand in proud support of the San Mateo County Pride Center. Thank you for your consideration,

Sincerely,

Jose Errol Feria, M.A., LMFT
Licensed Marriage and Family Therapist

Marianne LaRuffa, LMFT
Mental Health Manager/Supervisor

September 17, 2018

Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:

We, Stephanie Balon MA, AMFT and Christi Morales-Kumasawa MA, Co-Chairs of the Filipino Mental Health Initiative of San Mateo County, strongly support the two year extension of time and funding for the Pride Center, an MHSA Innovation project of the San Mateo County Behavioral Health and Recovery Services for the following reasons:

- The Pride Center has offered a safe, welcoming, and nurturing space for the LGBTQ+ community. This is not just demonstrated in the warmth and intentionality of the committed staff delivering services; it is also reflected in the vast and diverse array of services provided to those who access the center.
- Their special events and community gatherings, such as Queer Prom and Intergenerational Dinners, exemplify a creative and culturally responsive approach to cross-generational engagement that has not been offered at any other centers. Additionally, their trainings are crucial to ensuring providers are fostering an inclusive environment and equitable access to services.
- In terms of their targeted outreach, they have developed relationships with us and other partners beyond San Mateo and into North County where most of our Filipinx community resides, which speaks to their efforts to reach underserved and unserved populations who face strong cultural stigma around LGBTQ+ identity.
- Overall, the Pride Center will continue (if given the opportunity) to improve the mental health and wellness of the LGBTQ+ community by delivering the necessary, inclusive, and culturally relevant resources that have historically been lacking throughout San Mateo County.

The San Mateo County Pride Center, the first such location in all of San Mateo County, fills a gap in much needed services for LGBTQ+ community. The innovative design of four partnering agencies operating together in close collaboration to offer multiple services has allowed the Center to become a one-stop-shop for clients of all ages including children, youth, adults, and older adults.

The Filipino Mental Health Initiative of San Mateo County joins the San Mateo County Pride Center's quest to improve and expand services throughout the county, with a special emphasis on reducing stigma, trauma informed services, marginalization, and inequities to enhance the wellbeing of the LGBTQ+ community.

The Filipino Mental Health Initiative stands in proud support of the San Mateo County Pride Center. Thank you for your consideration.

Warmest Regards,

Stephanie Balon, MA, AMFT & Christi Morales-Kumasawa, MA
Co-Chairs, Filipino Mental Health Initiative of San Mateo County

September 18, 2018

Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:

My name is Lila Dickson, and I am a member of the Hillsdale High School Genders & Sexualities Alliance in San Mateo, California. On behalf of the GSA, I state that we strongly support the two year extension of time and funding for the Pride Center, an MHSA Innovation project of the San Mateo County Behavioral Health and Recovery Services.

The Pride Center is a major source of support of one of the most renowned minority groups of all time. To not be cisgender or to not be heterosexual is a huge impact on many people's lives, including that of mine, and the effects of that can be daunting. Members of the queer community often feel confused and isolated because they know that they are different. Many of them are bullied by others. Many are not accepted by their families. The Pride Center is a safe space for people, both physically and emotionally, and it provides resources that help create a better understanding of one's own identity and circumstances. It is extremely critical to maintain this, and the Pride Center needs the funding and time in order to do so.

The San Mateo County Pride Center, the first such location in all of San Mateo County, fills a gap in much needed services for LGBTQ+ community. The innovative design of four partnering agencies operating together in close collaboration to offer multiple services has allowed the Center to become a one-stop-shop for clients of all ages including children, youth, adults, and older adults.

The Hillsdale High School Genders & Sexualities Alliance and I join the San Mateo County Pride Center's quest to improve and expand services throughout the county, with a special emphasis on trauma informed services, crisis management, and marginalization to enhance the wellbeing of the LGBTQ+ community.

The Hillsdale High School Genders & Sexualities Alliance and I stand in proud support of the San Mateo County Pride Center. Thank you for your consideration.

Sincerely,
Lila Dickson

KAISER PERMANENTE®

September 17, 2018

Toby Ewing, Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:

I am writing in support of a two-year extension of time and funding for the San Mateo County Pride Center, an MHSA Innovation project of San Mateo County Behavioral Health and Recovery Services.

As the Director of Public Affairs for the Kaiser Permanente Redwood City Medical Center (KP-RWC) over the past 11 years, I have seen the incredibly impactful work that StarVista, which operates the Pride Center, has done for many San Mateo County residents.

I serve on KP-RWC's Community Health Advisory Committee, which oversees our grant funding. We have been long-time funders of Star Vista, and more recently of the Pride Center, because of the reach and effectiveness of their programs, which have strong, measurable outcomes. StarVista and the Pride Center's work align with our mission of improving the health of our communities.

We have had the privilege of partnering with StarVista since 2003 and have observed their ability to consistently execute on their mission to deliver high impact services through counseling, skill development, and crisis prevention to children, youth, adults and families to help all ages and stages through life's challenges.

While San Mateo County has been supportive of the LGBTQ+ community, it remained the only county in the Bay Area without a pride center. Residents of the 771,000+ county who needed to access pride center services would have to go to San Francisco or Santa Clara Counties. The opening of the Pride Center in the city of San Mateo in 2017 made a meaningful impact on the LGBTQ+ community because they can now access needed services in their own community. The Pride Center's innovative design of four partnering agencies operating together in close collaboration to offer multiple services has allowed the Center to become a one-stop-shop for clients of all ages from children to older adults.

In 2018, Kaiser Permanente was thrilled to provide funding for the San Mateo County Pride Center's Visibility and Stigma Reduction Campaign to reduce the stigma surrounding mental health within the LGBTQ+ community. This critical project reaches throughout the County and all 20 cities through educational trainings, outreach, peer support and social events.

On behalf of KP-RWC, I am proud to support the San Mateo County Pride Center's request for a two-year extension of the MHSA funds. They have been a proven partner through our long-term working relationship, and I am confident they will continue to be successful in their efforts.

Sincerely,

Stacey Wagner

Stacey Wagner, Director
Redwood City Public Affairs
1100 Veterans Blvd.
Redwood City, CA 94063

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

310 Harbor Boulevard
Building E
Belmont, CA 94002
650-802-6400 T
650-802-6440 F
smchealth.org

September 17, 2018

Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:

My name is Frances Lobos and I am a Co-Chair for the Latino Collaborative, a Health Equity Initiative of San Mateo County. I strongly support the two-year extension of time and funding for the Pride Center, an MHSA Innovation project of the San Mateo County Behavioral Health and Recovery Services.

The Pride Center's community focused approach is essential in providing mental health and recovery services. Activities such as Intergenerational Dinner and Queer Prom, workshops like Trans Talks, trainings, book clubs, Movie Nights, allow for our community members to feel safe and welcomed. More importantly, provides an opportunity for dialogue and education. The Pride Center has become an important source for information and resources for this County, and through its works advances the health equity of all communities.

The San Mateo County Pride Center, the first such location in all of San Mateo County, fills a gap in much needed services for LGBTQ+ community. The innovative design of four partnering agencies operating together in close collaboration to offer multiple services has allowed the Center to become a one-stop-shop for clients of all ages including children, youth, adults, and older adults.
The Latino Collaborative joins the San Mateo County Pride Center's quest to improve and expand services throughout the county, with a special emphasis on reducing stigma, marginalization, discrimination, inequities to enhance the wellbeing of the LGBTQ+ community.

Latino Collaborative stands in proud support of the San Mateo County Pride Center. Thank you for your consideration,

Sincerely,

Frances Lobos
Latino Collaborative Co-Chair

COUNTY OF SAN MATEO CALIFORNIA

COUNTY OF SAN MATEO
LGBTQ COMMISSION

County Government Center
455 County Center, 5th Floor
Redwood City, CA 94063
650-363-4872 T
650-363-4822 F
http://lgbtq.smcgov.org

September 17, 2018

Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:

On behalf of the San Mateo County Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) Commission, we strongly support the two-year extension of time and funding for the Pride Center, a Mental Health Services Act Innovation project of the San Mateo County Behavioral Health and Recovery Services. The Pride Center increases the visibility of LGBTQ adults and young people, and connects them to much-needed LGBTQ-affirming services available at the Center and across the County.

LGBTQ children and youth face health disparities across the board, including disproportionately high rates of isolation and related mental health concerns. The LGBTQ Commission recently conducted a county-wide youth survey which underscores the importance of these critical services for our children and youth. This survey showed that over 65% do not know where to get LGBTQ-friendly healthcare and they feel overwhelmingly isolated and depressed: (1) nearly ¾ considered harming themselves; (2) nearly ¾ reported that they stopped doing some usual activities during the past year because they felt so sad, hopeless, anxious almost every day for two weeks or more in a row (usual activities defined as not seeing friends, skipping meals, skipping school, after-school activity, not doing homework) and (3) nearly 2/3 felt stress quite a bit or very much (stress defined as feeling tense, restless, nervous, anxious, unable to sleep at night).

Research has demonstrated that family and community acceptance is critical to promoting positive mental and physical health. The Pride Center provides this safe place for our LGBTQ children and youth. Pride Center staff and volunteers work tirelessly to make our county's services more welcoming, respectful and responsive to their needs. Without this innovation grant extension, our LGBTQ children and youth would have no place to go and the great strides the Pride Center has made through its collaborations to extend those direct services would be jeopardized.

LGBTQ adults and seniors in San Mateo County also face health disparities across the board, including disproportionately high rates of isolation and mental health concerns. The adult survey showed that dealing with stress is common in the LGBTQ community. Close to half identified a time during the past 12 months when they felt that they might need to see a professional because of concerns with their mental health, emotions, nerves, or their use of alcohol or drugs. This was particularly true in respondents who described themselves as gender fluid (84%). Over one third (39%) felt quite a bit or very much stress, ranging from 33% in men to 70% in trans women. The Pride Center provides the full range of trauma-informed care that meets the needs of this community.

The San Mateo County Pride Center, the first such location in all of San Mateo County, fills a gap in much needed services for LGBTQ+ community. The innovative design of four partnering agencies operating together in close collaboration to offer multiple services has allowed the Center to become a one-stop-shop for clients of all ages including children, youth, adults, and older adults.

The San Mateo County LGBTQ Commission joins the San Mateo County Pride Center's quest to improve and expand services throughout the county, with a special emphasis on providing trauma-informed services and addressing inequities to enhance the wellbeing of the LGBTQ+ community.

The San Mateo County LGBTQ Commission stands in proud support of the San Mateo County Pride Center. Thank you for your consideration.

Sincerely,

Craig Wiesner
Co-Chair
LGBTQ Commission

Kristina Perez
Co-Chair
LGBTQ Commission

Family & Children Services
of Silicon Valley
A Division of Caminar for Mental Health

408.292.9353
650.326.6576
www.fcservices.org
www.caminar.org

September 17, 2018
Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:

My name is Adrienne Keel and I am the Director of LGBTQ Programs for Family & Children Services, a division of Caminar. We strongly support the two year extension of time and funding for the Pride Center, an MHSA Innovation project of the San Mateo County Behavioral Health and Recovery Services.

An easily accessible LGBTQ center is a critical resource for the LGBTQ+ community in San Mateo County. In theory, some county residents may be able to access LGBTQ+ affirming clinical and wellness services out of county, but that is simply not realistic for everyone. The Pride Center provides a wealth of centrally located clinical services, support groups, events, and activities that simply did not exist in the county before the center's inception. Culturally relevant community spaces are essential to the wellness of historically underserved or unserved populations.

The San Mateo County Pride Center, the first such location in all of San Mateo County, fills a gap in much needed services for LGBTQ+ community. The innovative design of four partnering agencies operating together in close collaboration to offer multiple services has allowed the Center to become a one-stop-shop for clients of all ages including children, youth, adults, and older adults.

The LGBTQ Youth Space and its parent agencies join the San Mateo County Pride Center's quest to improve and expand services throughout the county, with a special emphasis on reducing stigma, marginalization, and discrimination, to enhance the wellbeing of the LGBTQ+ community.

The LGBTQ Youth Space, Family & Children Services, and Caminar stand in proud support of the San Mateo County Pride Center. Thank you for your consideration.

Warmest Regards,

Adrienne Keel
Director of LGBTQ Programs
Family & Children Services and Caminar

Many Journeys Metropolitan Community Church
1150 W. Hillsdale Blvd, San Mateo, CA 94403
http://manyjourneysmcc.org 650-515-0900
Meeting every Sunday at 12:30

September 06, 2018

Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:

I am Rev. Terri Echelbarger, the Pastor of Many Journeys MCC, and a member of the San Mateo County LGBTQ Commission. I am writing this letter as an individual who strongly supports a two-year extension of funding and time to complete the extraordinary collaboration that created the Pride Center, an MHSA Innovation project of the San Mateo County Behavioral Health and Recovery Services.

As a Pastor who serves primarily LGBTQ people I am in a position to witness first hand the effects of ongoing discrimination against this community, and the benefits of a multiple agency approach to their needs. It is innovative, perhaps the first in the entire country, to coordinate services for this vulnerable population. If allowed to proceed it may well be a model that is copied all over the United States and other countries as well.

However, these innovation funds are much more innovative than might appear at first glance. There are extraordinary challenges not faced in other communities. In my view one primary challenge is that the center, this collaboration, is building on primary foundations still being poured.

The LGBTQ community has been in an era of significant change, same sex marriage was not fully realized until 2012 and youth who identify as LGBTQ are rapidly reshaping entire definitions of gender and sexual orientation. For that reason, the center is tasked with addressing cultural needs that have barley been studied, let alone established. They are innovating not only a collaboration but are also a part of developing a whole new range of best practices on the therapeutic level.

These challenges necessitate more time, and extra steps.

The San Mateo LGBTQ Commission administered a survey that showed LGBTQ people still have a very high-level isolation, a lack of access of safe spaces, and a very real fear of physical and verbal abuse and/or discrimination. The LGBTQ Center is a light on the hill that makes clear there is a safe space. This matters in terms of addressing mental health needs in our community, even if an individual never participates directly in a program or therapy. The Center is lighthouse that assures the community that even in the midst of current storms, there is shore.

I support the San Mateo County Pride Center's quest to improve and expand services throughout the county, to enhance the wellbeing of the LGBTQ+ community. There is no replacement for this service, there is no piece-meal approach to address these needs in an effective way, providing the range of services currently being innovated, in rapidly evolving community, and then provided in this collaboration. The provision of a one-stop-shop for people of all ages makes sense and should be allowed more time to prove it's worth to potential funders who could carry it on in the future.

In summary, I strongly support the San Mateo County Pride Center and the work it is doing. I hope you will continue supporting its evolving work for our community.

Thank you for your consideration,

Rev. Terri Echelbarger
Pastor

NAMI California
National Alliance on Mental Illness

October 11, 2018

Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:

As the Chief Executive Officer of the National Alliance on Mental Illness (NAMI) California, I would like to express strong support for the two-year extension of time and funding for the Pride Center, an MHSA Innovation project of the San Mateo County Behavioral Health and Recovery Services.

NAMI California first partnered with the Pride Center in May of 2018 to highlight the Center's programming at NAMI California's Annual Multicultural Symposium on May 31, 2018 in Monterey, CA. Through this event, NAMI California's members and supporters were able to learn more about the wonderful mental health work provided to LGBTQ+ folks that takes place at the San Mateo County Pride Center.

At NAMI California, we recognize that LGBTQ+ folks have an increased risk of mental health challenges, due to discrimination, and often do not receive adequate mental health services and resources. As such, it is integral that the Pride Center remain open to improve the lives of LGBTQ+ folks through crisis intervention, individual counseling, group therapy, family therapy, relationship therapy, case management, and home visits.

Importantly, the mental health clinicians at the Pride Center serve clients in a cultural competent manner by taking into consideration each person's multiple overlapping and intersecting identities (including gender identity, sexual orientation, gender expression, race, socio-economic status, and more). Clinicians at the center also specialize in LGBTQ+ issues including, but not limited to: anxiety, depression, gender identity, anger management, and couples counseling

In addition, providing clinical mental health services through the Pride Center reduces barriers to care from LGBTQ+ folks. Due to the stigma of mental health challenges and the fear of discrimination for being LGBTQ+ by mental health clinicians and other health professionals, offering mental health services in a safe space reduces barriers and increases access to care for LGBTQ+ folks.

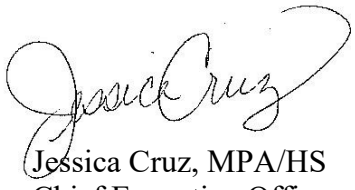
The San Mateo County Pride Center, the first such location in all of San Mateo County, fills a gap in much needed services for LGBTQ+ community. The innovative design of four partnering agencies operating together in close collaboration to offer multiple

services has allowed the Center to become a one-stop-shop for clients of all ages including children, youth, adults, and older adults.

NAMI California joins the San Mateo County Pride Center's quest to improve and expand services throughout the county, with a special emphasis on reducing stigma and increasing access to mental health services to enhance the wellbeing of the LGBTQ+ community.

NAMI California stands in proud support of the San Mateo County Pride Center. Thank you very much for your consideration,

Sincerely,



Jessica Cruz, MPA/HS
Chief Executive Officer
NAMI California
1851 Heritage Lane, Suite #150
Sacramento, CA 95815

September 17, 2018

Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:

Good day, Mr. Ewing. My name is Gloria Gutierrez and I'm the current chair of the Native and Indigenous Peoples Initiative in San Mateo County through the Office of Diversity and Equity. We strongly support the two-year extension of time and funding for the Pride Center, a Mental Health Service Act (MHSA) Innovation project of the San Mateo County Behavioral Health and Recovery Services.

In my role as a clinician in San Mateo County, I have been offered the ability to refer clients and families to the Pride Center to fill the much-needed gap for services to our LGBTQ+ communities. The Pride Center has provided a safe place for the clients and families I have referred and has decreased the barriers for our LBGTQ+ adult/youth communities that are receiving treatment.

The Pride Center offers outreach and education to increase mental health awareness, and more importantly, strengthens our communities. Further, the outreach and education the Pride Center has provided to employees and communities in San Mateo County has been tremendous and has supported our colleagues with the information necessary to successfully serve the LGBTQ+ community.

The first of its kind in all of San Mateo County, the San Mateo Pride Center fills a gap in much-needed services for the LGBTQ+ community. The innovative design of four partnering agencies operating together in close collaboration to offer multiple services has allowed the center to become a one-stop shop for clients and community members. This has enabled us to reach and support more clients and community members.

The Native and Indigenous Peoples Initiative joins the San Mateo County Pride Center's quest to improve and expand services throughout the county, with special emphasis on increasing awareness of the prevalence of those at risk with mental health issues.

Warmest Regards,

Native and Indigenous Peoples Initiative
Chair-Gloria Gutierrez

Bay Area OUTspoken Speech Services

Oneida Chi, MS, CCC-Speech Language Pathologist
1212H El Camino Real #373, San Bruno, CA 94066
(415)375-0279

September 17, 2018

Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:
My name is Oneida Chi, and I am a Speech Language Pathologist for Bay Area Outspoken speech services. We strongly support the two year extension of time and funding for the Pride Center, an MHSA Innovation project of the San Mateo County Behavioral Health and Recovery Services.

At the Pride Center, I currently work with transgender and gender non- conforming folks on vocal health and aligning their voices with their gender identity. The Pride Center has been a haven and safe space for many clients to visit and access the services they need. They can have access to mental health services, recovery, community, and voice training under one roof. So often, members of the LGBTQ community in San Mateo are stigmatized and have difficulty accessing services, and therefore this Pride Center is a necessity for the health and well-being of marginalized folks. I have clients who have accessed and used all the services listed and it greatly improved their mental health and well- being. The drop-in center, therapeutic/clinical services, case management, gender & name change clinics, resource center, peer support groups, AA groups, workshops like Trans Talks, trainings, book clubs, Movie Nights and a number of community events.

The San Mateo County Pride Center, the first such location in all of San Mateo County, fills a gap in much needed services for LGBTQ+ community. The innovative design of four partnering agencies operating together in close collaboration to offer multiple services has allowed the Center to become a one-stop-shop for clients of all ages including children, youth, adults, and older adults.

We join the San Mateo County Pride Center's quest to improve and expand services throughout the county, with a special emphasis on reducing stigma and decreasing inequities and discrimination to enhance the wellbeing of the LGBTQ+ community.

We, at Bay Area Outspoken speech therapy services stand in proud support of the San Mateo County Pride Center. Thank you for your consideration,

Warmest Regards,

Oneida Chi, MS, CCC-Speech Language Pathologist
Bay Area OUTspoken Speech Services

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

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310 Harbor Boulevard
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650-573-2541 T
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smchealth.org

September 17, 2018

Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing,

As the Office of Diversity and Equity, we support marginalized populations in our behavioral health system to ensure everyone in San Mateo County has a fair and just opportunity to experience wellness. The Office of Diversity and Equity strongly supports the two year extension of time and funding for the Pride Center, an MHSA Innovation project of the San Mateo County Behavioral Health and Recovery Services (BHRS).

Since the Pride Center first opened its doors, it has offered LGBTQ+ visibility, advocacy and expertise in San Mateo County (SMC). Our staff has had the privilege of collaborating with Pride Center staff on a number of mental health and wellness initiatives. The Pride Center has worked closely with our staff to provide community events for May Mental Health Awareness Month and September Suicide Prevention Month, creating brave spaces for LGBTQ+ community members to share their lived experiences and reduce stigma together. The Pride Center has also provided presentations to community members in our Parent Project (PP) courses. PP facilitators have shared how the Center staff's presentation style and ability to make the information culturally appropriate has impacted the classroom. They have made concepts easier to understand and opened space for dialogue even between people who were previously uncomfortable discussing queerness. For some this is the only opportunity to learn and ask questions openly around LGBTQ+ issues, so having speakers that present the material in a way that is relevant and approachable has improved community knowledge and helped change individual minds about queerness.

The Pride Center has provided enthusiastic support for our Cultural Humility Video series, with staff writing scripts and speaking on camera on the topics of "Gender Inclusive Restrooms" and "Using Gender Pronouns". Hundreds of providers at BHRS and our partner agencies have viewed the videos and use them to help themselves and their staff provide better services to the LGBTQ+ clients that come to their clinics. The Pride Center actively promotes the improvement of services across BHRS and our partner agencies. In the past year, the Center trained over 600 providers on recognizing sexual orientation and gender

COUNTY OF SAN MATEO CALIFORNIA

identity (SOGI) as a crucial step towards providing holistic mental health and recovery services. The Pride Center also advocates for LGBTQ+ advances that impact health in ways that our County Health department cannot, including for recognition of sexual orientation and gender identity (SOGI) by local businesses and organizations and for better conditions for incarcerated transgender individuals in our local jails. This is powerful work not being done by other groups in SMC. Ultimately, the Pride Center's community education efforts continue to empower providers and local organizations in our county to provide more effective and appropriate services to LGBTQ+ folks.

Prior to the Pride Center, our county's LGBTQ+ community lacked a physical space in which to gather and connect with each other. Because LGBTQ+ identities have been so stigmatized in San Mateo County, even within the liberal Bay Area, we have heard from plenty of individuals that they are not out in their workplaces, schools or at home, or don't often gather with other queer folks. The Center is a powerful symbol of acceptance and reminder of the importance of having community spaces in which we can experience feelings of visibility and connectedness. The Pride Center has truly become the heart of San Mateo County's LGBTQ+ community. This is evident with each intergenerational dinner, open mic event, and peer support group. Community members have expressed joy at seeing parts of themselves reflected in their home county for the first time. Gatherings are always abuzz with excitement for the next event, where people anticipate further building and deepening connections between queer folks, allies, and everyone else that comes to commune at the Center.

The Office of Diversity and Equity joins the San Mateo County Pride Center's quest to improve and expand services throughout the county, with a special emphasis on reducing stigma, marginalization, and health inequities to enhance the wellbeing of the LGBTQ+ community. We stand in proud support of the San Mateo County Pride Center. Thank you for your consideration.

Sincerely,

Office of Diversity and Equity
Behavioral Health and Recovery Services
San Mateo County Health

ADOLESCENT
COUNSELING SERVICES
strength through support

September 20, 2018

Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:

My name is Ryan Fouts, and I am the Program Director of Outlet, a program of Adolescent Counseling Services. Outlet serves LGBTQ+ youth ages 10-25 throughout San Mateo and Santa Clara County, and we are one of four collaborative partner agencies providing services at the San Mateo County Pride Center. I am writing to ask for your approval of the two year extension of the Pride Center's MHSA Innovation project funding through San Mateo County Behavioral Health and Recovery Services.

Outlet's role at the San Mateo County Pride Center is to implement youth programming and to provide trainings on supporting LGBTQ+ youth. We host multiple drop-in groups for LGBTQ+ youth each week, providing a vital space for young people to find social support in a safe, welcoming environment. We also support youth leadership opportunities, including a Youth Advisory Board, and we use the Pride Center's centralized location to provide outreach and support to GSA's in school districts throughout San Mateo County.

The San Mateo County Pride Center is an essential resource for the LGBTQ+ community. It eliminates barriers to service access by allowing our community to visit one space and receive social support, case management, mental health and substance use services, and referrals to other vital resources. The innovation of having four collaborative partners also serves to bring together LGBTQ+ individuals from across the lifespan. This is very special because certain LGBTQ+ subgroups, such as youth and older adults, have historically been isolated. The Pride Center's community reduces stigma and increases a sense of belonging, both of which have been shown to lead to better physical and mental health outcomes.

Outlet and ACS are proud to continue partnering with the Pride Center and its other partner agencies to serve San Mateo County's LGBTQ+ community. We envision a world where the LGBTQ+ community is safe, healthy, and thriving; please support us in making that vision possible by extending the Pride Center's MHSA funding.

Sincerely,

Ryan Fouts, LCSW

Ryan Fouts, LCSW
Outlet Program Director

September 12, 2018

Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:

Peninsula Family Service is a collaborating partner in San Mateo County Pride Center's quest to improve and expand services throughout the county, with a special emphasis on reducing stigma, discrimination and inequities to enhance the wellbeing of the LGBTQ+ community. We strongly support the two-year extension of funding for the Pride Center, an MHSA Innovation project of the San Mateo County Behavioral Health and Recovery Services.

The San Mateo County Pride Center, the first such location in all of San Mateo County, fills a gap in much needed services for LGBTQ+ community. The innovative design of four partnering agencies operating together in close collaboration to offer multiple services has allowed the Center to become a one-stop-shop for clients of all ages including children, youth, adults, and older adults.

Peninsula Family Service is a 68-year-old organization that serves over 12,000 people in our community. We believe that by supporting our region's vulnerable and overlooked populations, we strengthen the entire community. We create a strong network of resources for older adults as baby boomers look to age in place. We provide tools that encourage personal and financial stability for the increasing number of families affected by our region's widening income disparities. We also prevent the income-achievement gap in our children through a comprehensive early learning program, and prepare them for enhanced scholastic achievement.

Our Senior Peer Counseling Program addresses the need for access to mental health services for isolated older adults, and increases the ability of seniors to age in place. The program is county-wide and offered in collaboration with the County of San Mateo Behavioral Health and Recovery Services Department. We provide trained peer volunteers to conduct one-on-one visits with homebound seniors, and run support groups for at-risk seniors at various sites in the community. Most seniors are referred by the County of San Mateo, other providers, or family members for being at risk of out of home placement, mental illness, substance abuse, depression, and other issues.

Since June 2017 we have been able to build on our work with the LGBTQ+ community as a partner in the San Mateo PRIDE Center. As the first resource center for LGBTQ+ residents in San Mateo County, PFS was involved in the planning and design of the

program and currently provides a Master's level staff member at the site to run a variety of activities, a support group and conduct outreach for the older adult population.

As indicated in community needs assessment of the LGBTQ+ community, older adults face very different issues than younger members and need support in different ways. We are thrilled that there is now a central location where LGBTQ+ older adults can participate in activities and receive services in a comfortable, welcoming place that they call their second home. We see great value in the onsite counseling and resource services and the well-attended intergenerational activities.

Peninsula Family Service stands in proud support of the San Mateo County Pride Center, and strongly encourages the county to continue funding it. Thank you for your consideration.

Sincerely,

Heather Cleary
CEO

September 17, 2018

Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:

My name is Leah Carig, a Regional Program Manager with Planned Parenthood Mar Monte. We strongly support the two year extension of time and funding for the Pride Center, an MHSA Innovation project of the San Mateo County Behavioral Health and Recovery Services.

We have had the pleasure of partnering with the San Mateo County Pride Center to provide a much-needed safe space for LGBTQ+ teens to learn and ask questions about sexual health. It is so important for young people to have these spaces and trusted adults in their lives. It is clear they are an essential resource for people living in San Mateo County.

The San Mateo County Pride Center, the first such location in all of San Mateo County, fills a gap in much needed services for LGBTQ+ community. The innovative design of four partnering agencies operating together in close collaboration to offer multiple services has allowed the Center to become a one-stop-shop for clients of all ages including children, youth, adults, and older adults.

Planned Parenthood Mar Monte joins the San Mateo County Pride Center's quest to improve and expand services throughout the county, with a special emphasis on reducing stigma, trauma informed services, and increasing equitable access to health care to enhance the wellbeing of the LGBTQ+ community.

Planned Parenthood Mar Monte stands in proud support of the San Mateo County Pride Center. Thank you for your consideration.

Sincerely,

Leah Carig
Regional Program Manager

Planned Parenthood Mar Monte
1746 The Alameda
San Jose, CA 95126
408-795-3729

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

Office of Diversity and Equity
310 Harbor Boulevard
Building E
Belmont, CA 94002
650-573-2541 T
650-591-1383 F
smchealth.org

September 18, 2018

Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:

We are the current Co-Chairs of the PRIDE Initiative in San Mateo County through the Office of Diversity and Equity. We strongly support the two year extension of time and funding for the Pride Center, and Mental Health Service Act (MHSA) Innovation project of the San Mateo County Behavioral Health and Recovery Services.

The Pride Initiative has been closely collaborating with the Pride Center since their doors opened in June of 2016. We have witnessed first-hand the positive impact the Pride Center has had in reaching the LGBTQ+ community of San Mateo County. Prior to June of 2016, we did not have services focused exclusively on LGBTQ+ wellness and recovery.

The Pride Center has done an amazing job of networking with the various community based organizations of this county to offer much needed services for LGBTQ+ consumers and families. It is our safe hub and a much needed one-stop-shop for consumers of all ages.

The PRIDE Initiative is in full support of the San Mateo County Pride Center's quest to improve and expand services throughout the county, with special emphasis on providing trauma informed services, reducing inequities and discrimination for the LGBTQ+ community of San Mateo County.

Sincerely,

Dana Johnson, Co-Chair
Pride Initiative

Regina Moreno, Co-Chair
Pride Initiative

COUNTY OF SAN MATEO CALIFORNIA

September 12, 2018

Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:

Project Ninety has been providing comprehensive alcohol and drug recovery services since 1972. We merged with and into Caminar on June 1, 2018. Project Ninety strongly supports the two year extension of time and funding for the Pride Center, an MHSA Innovation project of the San Mateo County Behavioral Health and Recovery Services.

The San Mateo County Pride Center's mission statement delves into the creation of a welcoming, safe, inclusive, and affirming community climate that fosters personal growth, health, and opportunities to thrive for individuals of all ages, sexual orientations, and gender identities through education, counseling, advocacy, and support.

The San Mateo County Pride Center's vision that seeks to empower agents of social change mirrors our own mission statement of empowering and supporting individuals and families to move toward resilience, wellness, and independence.

We applaud their organization's innovative design of four partnering agencies operating together in close collaboration to offer multiple services has allowed the Center to become a one-stop-shop for clients of all ages including children, youth, adults, and older adults.

Project Ninety stands in proud support of the San Mateo County Pride Center.

Thank you.

Warmly,

Jim Buckner
Executive Director
Project Ninety
A Division of Caminar

rape trauma services
a center for healing & violence prevention

September 14, 2018

Dear Mr. Ewing:

Rape Trauma Services (RTS) is a nonprofit agency and San Mateo County's only rape crisis center. We strive to eliminate all forms of violence, with a special focus on sexual assault and abuse. We also facilitate healing and the prevention of violence by providing counseling, advocacy, and education. We strongly support the two-year extension of time and funding for the Pride Center, an MHSA Innovation project of the San Mateo County Behavioral Health and Recovery Services.

Rape Trauma Services has partnered with the Pride Center in several ways over the past year. An RTS Peer Counselor co-facilitated a Pride Center young adults' support group to offer trauma-informed support to transitional age youth. RTS and Pride Center staff provided cross-trainings on services and resources enabling both organizations to more inclusively support LGBTQ+ survivors.

RTS has referred many clients to the Pride Center. LGBTQ+ survivors and significant others of sexual violence face more barriers when it comes to access to services and resources. The San Mateo County Pride Center, the first such location in all of San Mateo County, fills a gap in much needed services for the LGBTQ+ community. The innovative design of four partnering agencies operating together in close collaboration to offer multiple services has allowed the Center to become a one-stop-shop for clients of all ages including children, youth, adults, and older adults.

Rape Trauma Services joins the San Mateo County Pride Center's quest to improve and expand services throughout the county, with a special emphasis on trauma-informed services and crisis management, to enhance the wellbeing of the LGBTQ+ community.

Rape Trauma Services stands in proud support of the San Mateo County Pride Center. Thank you for your consideration.

Warmest Regards,

Emily Abrams

Emily Abrams
Executive Director, Rape Trauma Services

1860 El Camino Real, Suite 406, Burlingame, CA 94010
p: (650) 652-0598 f: (650) 652-0596 e: info@rapetraumaservices.org w: www.rapetraumaservices.org 24-hour crisis line (650) 692-RAPE

County of Santa Clara
Office of the County Executive

County Government Center,
70 West Hedding Street
Eleventh Floor – East Wing
San Jose, California 95110
(408) 299-5105

September 17, 2018

Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:

I am writing today in support of the critical services provided by the San Mateo County (SMC) Pride Center. This Center provides resources that are of great benefit to the Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQQ) community in San Mateo County. The LGBTQQ community experiences many health disparities, and local resources are extremely helpful in improving health outcomes.

The SMC Pride Center provides clinical services, as well as serves as a community center for the whole LGBTQQ community. It also provides events that are available for no fee or a donation, including drop-in hours for youth and adults, movie screenings and social events for all, as well as community educational events and forums. The SMC Pride Center also serves as a resource center providing books, magazines and a computer lab to the community to access information in a safe setting. Staff provides training sessions and consult with various community organizations and county departments. The services provided by SMC Pride Center fill a very needed service gap in this community. Funding to support such critical services has a positive impact in the lives of LGBTQ local residents. Thank you for your consideration and time.

Sincerely,

Maribel Martinez
Director, Office of LGBTQ Affairs
County of Santa Clara

SAN MATEO COUNTY OFFICE OF EDUCATION
Anne E. Campbell · County Superintendent of Schools

September 20, 2018

To Members of the Mental Health Service Act Steering Committee:

The San Mateo County Office of Education (SMCOE) wholeheartedly supports the San Mateo County Pride Center and values the services it provides to our county's young people. The Pride Center prioritizes youth engagement and leadership. Our young people need more opportunities to meaningfully engage in their communities and to add their talents and voice to community dialogue. The Pride Center affords them the support, space, and time to do so.

SMCOE has also been fortunate to partner with the Pride Center in working with the Gender Sexuality Alliance (GSA) coordinators from various middle and high schools throughout the county. The Pride Center has offered space and technical assistance for these meetings ensuring a well-rounded approach to this work. One specific outcome of our collaboration is the county's first GSA conference, a day of community building and action for high school GSA members and their advisors that will take place in December 2018.

The work the Pride Center is doing is of utmost importance to our county's students, especially those who identify as LGBTQ. The Pride Center provides a safe space for students to be their most authentic selves. The Pride Center staff also works with schools to help make school campuses emotionally safe for all students. When a school supports a positive and safe school climate for its most vulnerable students, it will also be a safe place for <u>every student.</u>

Please consider granting the Pride Center additional funding and time to continue their programs and services. The Pride Center staff has made a huge positive impact on the mental health and well-being of LGBTQ youth in our county in a short amount of time. Imagine how much more they can accomplish!

Sincerely,

Nancy A. Magee

Nancy A. Magee
San Mateo County Superintendent of Schools-Elect

Behavioral Health & Recovery Services
SAN MATEO COUNTY
Office of Diversity and Equity

September 18, 2018

Toby Ewing, Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:
We are the co-chairs of the Spirituality Initiative of the San Mateo County Office of Diversity and Equity. We strongly support the two year extension of time and funding for the PRIDE Center, a MHSA Innovation project of the San Mateo County Behavioral Health and Recovery Services.

The inclusion of the PRIDE Center in San Mateo County has been an important step in assisting the clients of Behavioral Health and Recovery Services. It is apparent that the services they provide reach the LGBTQ+ community, as we see evidence of this in those who attend our ongoing meetings and participate in the life of the Spirituality Initiative. It is clear that the Center has added to the lives of many clients for they provide events and services such as AA groups, a drop-in center, therapeutic/clinical services, and case management, and movie nights among other events and services.

The Interfaith Community in San Mateo County is a part of those we see regularly. They talk about how the PRIDE Center has assisted those who participate in their faith communities and how important it has been for some of their congregants. The different faith communities who are supportive of their LGBTQ+ members understand its importance and its impact.

Members of the Spirituality Initiative attend events that the PRIDE Center authors - in particular the June PRIDE event where the community gathers together to celebrate PRIDE month. It has always been a celebration for all of San Mateo County.

The San Mateo County PRIDE Center, the first such location in all of San Mateo County, fills a gap in much needed services for the LGBTQ+ community. The innovative design of four partnering agencies operating together in close collaboration to offer multiple services has allowed the Center to become a one-stop-shop for clients of all ages including children, youth, adults, and older adults.

The Spirituality Initiative joins the San Mateo County PRIDE Center's quest to improve and expand services throughout the county, with a special emphasis on reducing stigma, providing trauma informed services, and working to reduce discrimination and inequities. These services enhance the wellbeing of the LGBTQ+ community and the health of all of San Mateo County.

The Spirituality Initiative stands in proud support of the San Mateo County PRIDE Center.
Thank you for your consideration,

William Kruse
Co-Chairs of the Spirituality Initiative
Office of Diversity and Equity of the SMCBHRS

Melinda Ricossa

TransFamilies
Celebrating our gender diverse children of every age

September 17, 2018

Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:

I'm the founder and director of TransFamilies of Silicon Valley, a community of 160+ families with young transgender children living throughout San Mateo and Santa Clara Counties. We strongly support the two year extension of time and funding for the Pride Center, an MHSA Innovation project of the San Mateo County Behavioral Health and Recovery Services.

The Pride Center has been invaluable to our community.

Our Children
Our children participate and benefit in all aspects of the Pride Center. They attend the many peer support groups, Queer Prom Night, drop-in center, events and activities such as movie nights, therapeutic services and more. The Pride Center is where they find community, safety, support, and, really, *home*.

Many of our children face immense challenges at school or work, and throughout their day-to-day living. As by and large hetero and cisgender parents--and precisely because we're their parents--there's a limit to how much our children will let us help them, and a limit to how much we're capable of helping. The Pride Center has stepped in to provide this crucial support and community.

Caregivers
Not only does the center offer services to our children but also to us as parents--services that we had beforehand mostly been going without.

Parents and guardians of transgender children have been overlooked by mental health and other service providers. We often need to educate ourselves in a matter of weeks or days, starting from what it even means to be transgender, in order to support our children. We also need to learn how to advocate for our children in school and medical settings, with health insurance, with family and neighbors and more. It's an enormous task, and one many caregivers try to accomplish while also tackling their own feelings of denial, grief, fear and isolation.

The Pride Center is the one place trying to fill this gap by offering services to caregivers.

Through the Pride Center, TFSV families have received one-on-one support, attended much-needed Gender & Name Change clinics and Trans Talks, which enable us to learn from industry experts about topics such as medical intervention and school advocacy for our children. Through these important Trans Talks, we're able to ask our questions in a safe and supportive environment and gain crucial knowledge that helps us to support our children.

The Pride Center also offers in-person support groups for caregivers of transgender children. This is the only support group for caregivers that we know of throughout San Mateo County.

The Pride Center, the first such location in all of San Mateo County, fills a gap in much needed services for the LGBTQ+ community. The innovative design of four partnering agencies operating together in close collaboration to offer multiple services has allowed the Center to become a one-stop-shop for clients of all ages including children, youth, adults, and older adults.

TransFamilies of Silicon Valley joins the San Mateo County Pride Center's quest to improve and expand services throughout the county, with a special emphasis on reducing stigma and marginalization to enhance the wellbeing of the LGBTQ+ community.

TransFamilies of Silicon Valley stands in proud support of the San Mateo County Pride Center. Thank you for your consideration.

Warm regards,

Lara
(last name withheld to protect my child's confidentiality)
Founder and Director
TransFamilies of Silicon Valley
www.TransFamiliesSV.org
TransFamiliesSV@gmail.com

University of California
San Francisco

UCSF

Department of Pediatrics
Division of Endocrinology

Stephen E. Gitelman, M.D.
Saleh Adi, M.D.
Gina Capodanno, M.D.
Christine T. Ferrara, M.D., Ph.D.
Maya B. Lodish, M.D., MHSc
Roger K. Long, M.D.
Robert H. Lustig, M.D.
Walter L. Miller, M.D.
Stephen M. Rosenthal, M.D.
Srinath Sanda, M.D.
Shylaja Srinivasan, M.D.
Jenise C. Wong, M.D., Ph.D.

Mission Hall
Global Health & Clinical Sciences
550 16th St., 4th Floor, Box 0434
San Francisco, CA 94143

September 17, 2018

Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:

I am the Medical Director of the UCSF Child and Adolescent Gender Center. I strongly support the two year extension of time and funding for the Pride Center, an MHSA Innovation project of the San Mateo County Behavioral Health and Recovery Services. The San Mateo County Pride Center has served as a highly valued partner as we provide multidisciplinary outreach services to gender expansive/ transgender youth and their families in San Mateo County. It is my strong impression that the San Mateo County Pride Center is providing educational and other support services to the families served by our clinic that are not available elsewhere.

The San Mateo County Pride Center, the first such location in all of San Mateo County, fills a gap in much needed services for LGBTQ+ community. The innovative design of four partnering agencies operating together in close collaboration to offer multiple services has allowed the Center to become a one-stop-shop for clients of all ages including children, youth, adults, and older adults.

The UCSF Child and Adolescent Gender Center joins the San Mateo County Pride Center's quest to improve and expand services throughout the county, with a special emphasis on reducing stigma, marginalization, and discrimination to enhance the wellbeing of the LGBTQ+ community.

The UCSF Child and Adolescent Gender Center stands in proud support of the San Mateo County Pride Center.

Thank you very much.

Sincerely,

Stephen M. Rosenthal

Stephen M. Rosenthal, MD
Professor of Pediatrics
Medical Director, Child and Adolescent Gender Center.

DEPARTMENT OF VETERANS AFFAIRS
Palo Alto Health Care System
3801 Miranda Ave.
Palo Alto, CA 94304

In reply refer to: 640/11

Toby Ewing
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Mr. Ewing:

I would like to express my strong support for a two-year extension of time and funding for the Pride Center, a Mental Health Services Act (MHSA) Innovation Project of San Mateo County Behavioral Health and Recovery Services. The VA Palo Alto Health Care System (VAPAHCS) has partnered with the San Mateo Pride Center for several events including a VAPAHCS conference on gender identity, a pride observance event for homeless lesbian, gay, bisexual, and transgender (LGBT) Veterans, and the San Mateo Pride Festival. Additionally, VAPAHCS and the San Mateo Pride Center have been working together to facilitate training regarding LGBT Veteran suicide prevention.

The San Mateo Pride Center is a community resource provider distinctive in its support of LGBT Veterans and has consistently participated as speakers at LGBT Veteran events hosted by VAPAHCS. The Center has demonstrated great leadership in hosting the Orlando Memorial for victims of the Pulse Night Club shooting in Orlando, Florida. This event gave special focus to military Service Members and Veterans who were affected by this tragedy. The Center's dedication and ongoing support of LGBT Veterans are truly commendable.

The San Mateo County Pride Center is the first and only center of its kind located in San Mateo County, filling a gap in much needed services for the LGBT community. Its innovative design comprised of four partnering agencies operating together in close collaboration to offer multiple services has allowed the Center to become a one-stop-shop for clients of all ages including children, youth, adults, and older adults.

I join the San Mateo County Pride Center's quest to improve and expand services throughout San Mateo County, with a special emphasis on culturally-specific services for military and Veteran populations to enhance the wellbeing of the entire LGBT community. Thank you for your consideration.

Sincerely,

Heliana Ramirez, PhD, LISW

Heliana Ramirez, PhD, LISW
LGBT Veteran Care Coordinator, VAPAHCS

Be the one to help

Mental Health Service Act (MHSA) Steering Committee Meeting

Open to the public! Join advocates, providers, clients and family members to provide input on MHSA funded initiatives.

Meeting objectives include:

- Review MHSA framework and principles for funding programs and expansions.
- Learn about the Pride Center outcomes and request for a 2-year extension.
- Hear next steps for the MHSA Innovation funding cycle.

❖ **Stipends** are available for consumers/clients

❖ **Language interpretation** is provided as needed*

❖ **Childcare** is provided as needed*

❖ Refreshments will be provided

*please reserve these services by September 17th, contact Krstie Lui at (650) 573-5037 or kflui@smcgov.org

DATE

Monday, September 24, 2018
3:00 pm – 4:30 pm

Foster City Community Cntr, Wind Room
1000 E Hillsdale Blvd.
Foster City, CA 94404

Caltrain Hillsdale Station to Mariners' Island Caltrain Shuttle to Shell Blvd & E. Hillsdale Blvd.

Contact:
Doris Estremera, MHSA Manager
(650)573-2889
mhsa@smcgov.org

www.smchealth.org/MHSA

COUNTY OF SAN MATEO HEALTH SYSTEM
BEHAVIORAL HEALTH & RECOVERY SERVICES

MHSA provides a dedicated source of funding in California for mental health services by imposing a 1% tax on personal income in excess of $1 million.

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Services Act (MHSA) Steering Committee

Monday, September 24, 2018 / 3:00 – 4:30 PM
Foster City Community Center, Wind Room
1000 E. Hillsdale Blvd, Foster City, CA 94404

AGENDA

1.	**Welcome**	3:05 PM
2.	**MHSA Background & Updates** ▪ Proposed Funding Principles ▪ Innovation Funding – Request for Interest opportunity	3:15 PM
3.	**Pride Center Outcomes Review and Extension Request** ▪ Q&A	3:30 PM
4.	**Announcements/ Public Comments**	4:20 PM
5.	**Adjourn**	4:30 PM

Mental Health and Substance Abuse Recovery Commission (MHSARC)
Vote to open of a 30-day public comment period for the Pride Center extension will occur at the next MHSARC meeting on October 3rd.

MHSARC Meetings are held the first Wednesday of the month from 3-5pm at the Health System Campus, Room 100, 225 37th Ave. San Mateo, CA 94403.

Meetings are open to the public!

Mental Health Services Act (MHSA)

Steering Committee Meeting

September 24, 2018 / 3 - 4:30pm

San Mateo County Health System
Behavioral Health and Recovery Services
www.smchealth.org/mhsa

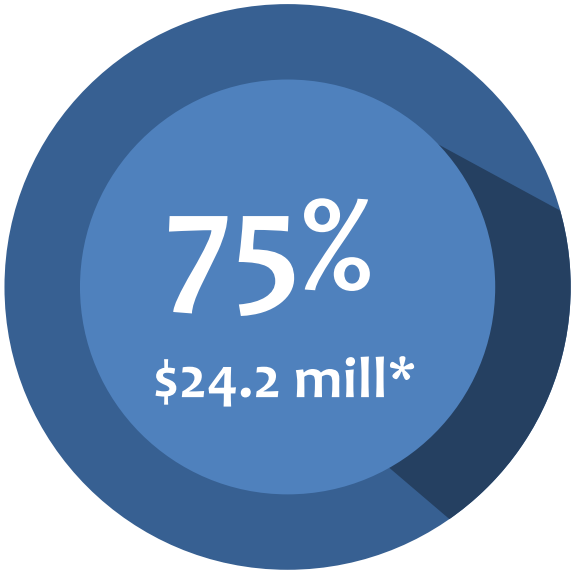
SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Agenda

1. MHSA Background
2. Funding Principles
3. Innovation Funding
4. Pride Center Outcomes and Extension Request
    - Q&A
5. Announcements/ Public Comments

MHSA – Prop 63 (2004)

1% tax on personal income in excess of $1 mill



Community Services & Supports (CSS)

Direct treatment and recovery services for serious mental illness and serious emotional disturbance

Prevention & Early Intervention (PEI)

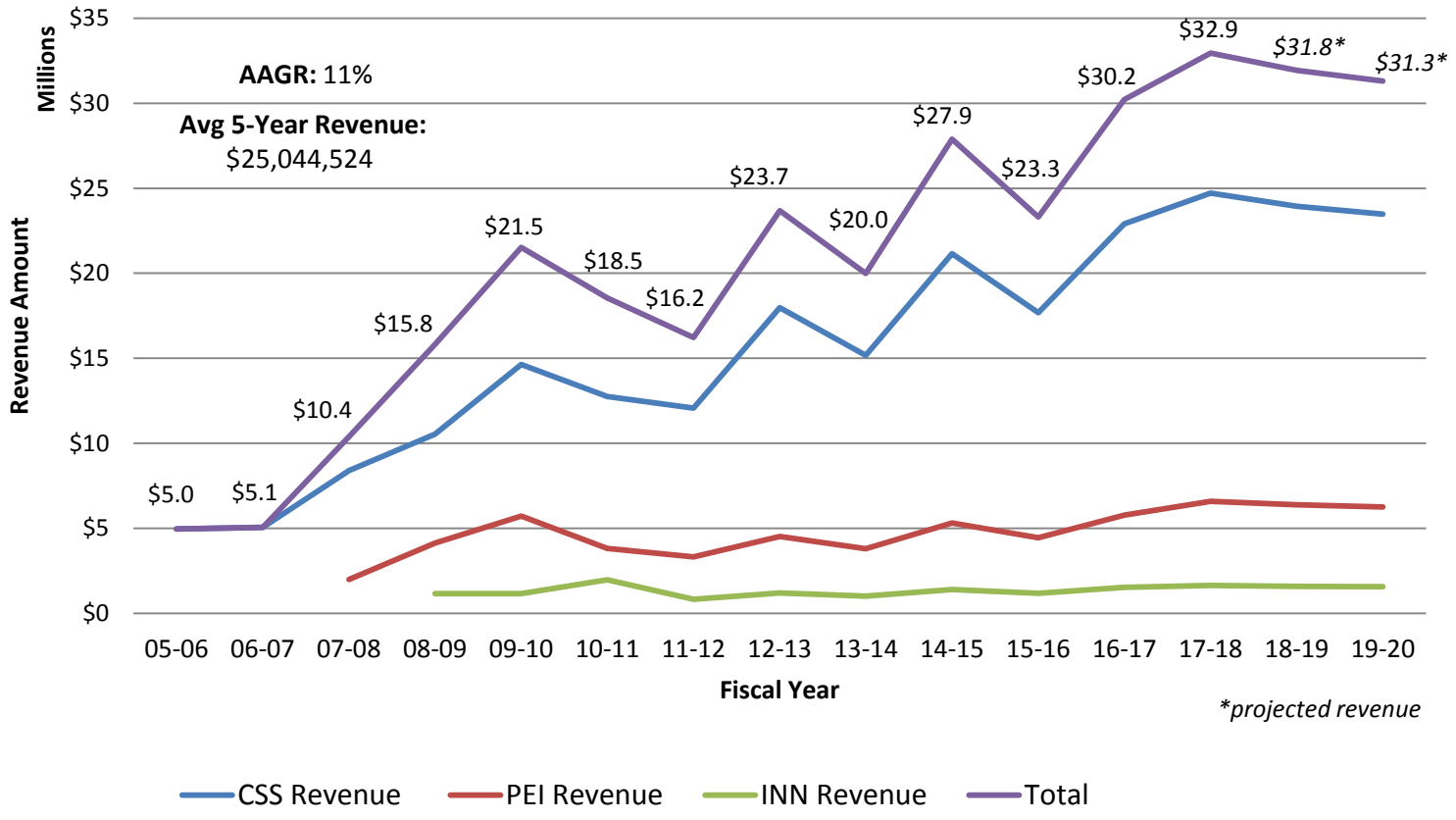
Interventions prior to the onset of mental health disorders and early onset of psychotic disorders

Innovation (INN)

New approaches and community-driven best practices

*Component amounts based on FY 17/18 revenue received

MHSA Revenue Growth



Funding Principles and Guidelines

- San Mateo County is preparing for an economic down turn; costs are increasing and federal and state revenues are not
- Current MHSA programs will not be reduced but can be optimized
- Decisions will need to be made regarding MHSA funding allocations
- Important time to re-embrace MHSA Funding Principles (see handout)

Open for input, comments, clarifications

MHSA Innovation Funding Cycle

- $1.9M will be available for FY 2019-20 INN projects; a request for Interest process will begin in January 2019
- Current Opportunity: Request for Interest Technology-based Behavioral Health Interventions
  - Funding may be available for two years to fund community-based agencies or programs as follows:
    - Peer and Family partner specialists $150,000/year
    - Spanish and Chinese community specialists $100,000/year
    - Older Adult peer and family partners $100,000/year
    - Youth peer workers $100,000/year

www.smchealth.org/bhrs/rfp

SAN MATEO COUNTY PRIDE CENTER

MHSA INNOVATION PROJECT REPORT: SAN MATEO COUNTY PRIDE CENTER

September 24, 2018

RDA

Presentation Agenda

- MHSA Innovation Overview
- About the Pride Center
- Pride Center Achievements
- Pride Center Learnings
- Pride Center Extension Request

Pride Center Innovation

MHSA INN Project Requirements

- INN projects must:
  - Contribute to learning about new approaches/ practices in mental health
  - Be developed through community participation
  - Avoid replicating programs in other jurisdictions
  - Align with MHSA values
- By nature, not all innovative strategies will succeed
- INN projects must measure the extent to which they improve:
  - Access to services, especially for underserved communities
  - Collaboration
  - Quality and service outcomes

Community Need: Services to Address High Risk of Mental Health Challenges

LGBTQ+ individuals are at higher risk of mental illness compared to non-LGBTQ+ people[1]

- In San Mateo County, 44% of LGBTQ adults needed access to a mental health professional in past 12 months[2]
  - Up to 84% among those who identified as gender fluid

Nationally, suicide is the second leading cause of death for LGBTQ+ youth ages 10-24[3]

- In San Mateo County, 3 of 4 LGBTQ youth considered harming themselves in past 12 months[2]

[1]King, M. et al., 2008; [2]San Mateo County LGBTQ Commission, 2018 Survey of LGBTQ Residents and Employees of San Mateo County; [3]The Trevor Project

RDA

Community Need: Access to LGBTQ+ Sensitive Mental Health Services

There is often mistrust of behavioral health care in LGBTQ+ communities

- Historical trauma of culturally insensitive care
- Shame and stigma around seeking care

San Mateo County residents reported limited access to LGBTQ-sensitive mental health services[1]

- 3 in 5 adults cited lack of local health professionals trained to serve LGBTQ+ clients
- Only 43% felt their mental health care provider had the expertise to care for their needs
- 2 in 3 youth did not know where to access LGBTQ-friendly healthcare

[1] *San Mateo County LGBTQ Commission, 2018 Survey of LGBTQ Residents and Employees of San Mateo County*

Community Need: Linkage to Services to Meet Multiple Needs

Many LGBTQ+ adults and youth San Mateo County have multiple service, educational, and social needs[1]

- Many LGBTQ county residents are socially isolated
- 2 in 5 adults struggle to pay for basic needs like rent and food
- 3 in 5 youth reported a lack of LGBTQ inclusive sex education in school

[1] *San Mateo County LGBTQ Commission, 2018 Survey of LGBTQ Residents and Employees of San Mateo County*

How Does the Pride Center Meet LGBTQ+ Community Needs?

The Pride Center is a service hub that meets the multiple needs of high-risk LGBTQ+ individuals

Social and Community Activities

Support LGBTQ+ individuals through peer-based models of wellness and recovery that include educational and stigma reduction activities

Clinical Services

Provide mental health services focusing on individuals at high risk of or already with moderate to severe mental health challenges

Resource Services

Be a hub for local, county, and national LGBTQ+ resources

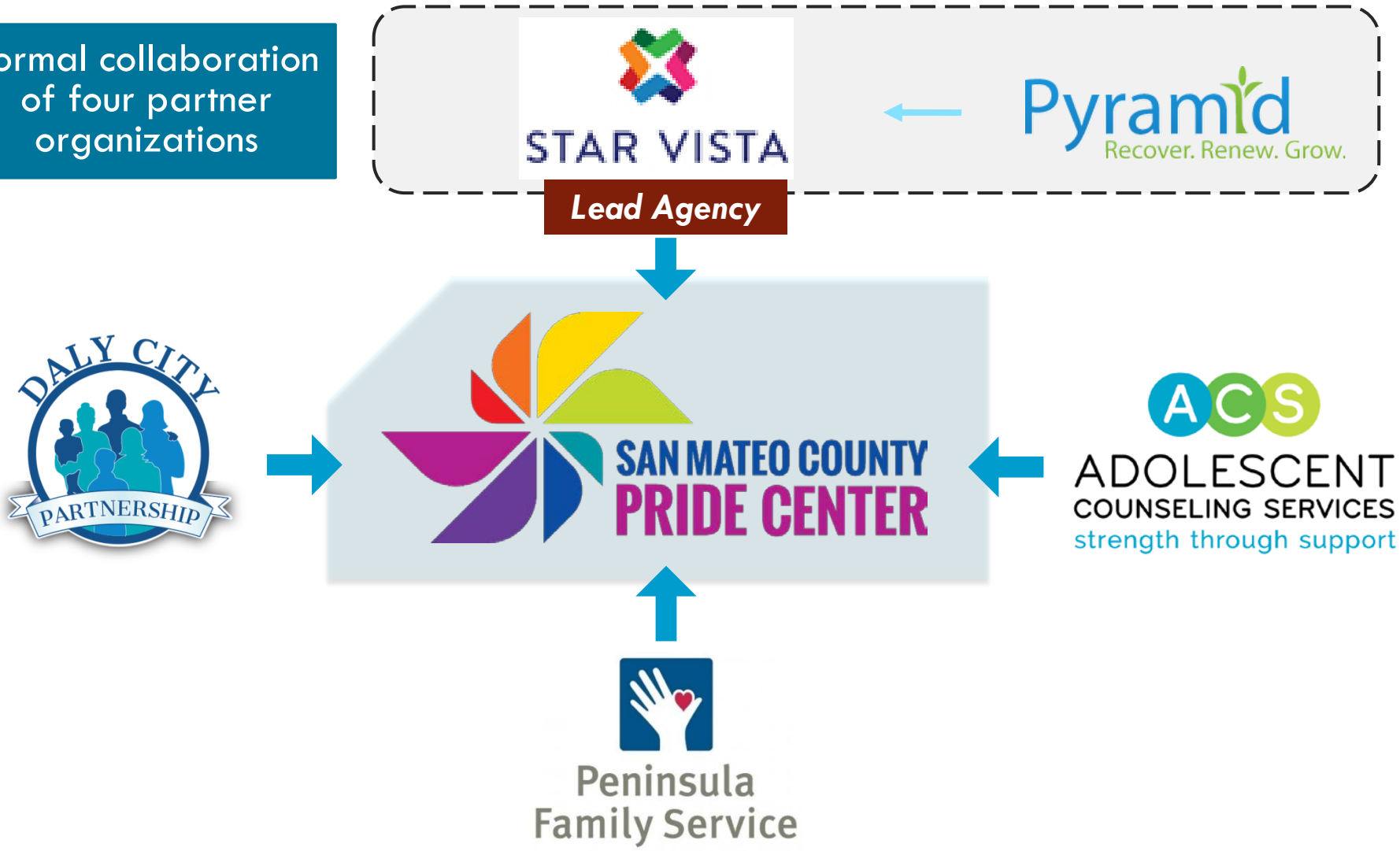
How is the Pride Center Innovative?

There is **no prior model of a coordinated approach** across mental health, social, and psycho-educational services for the LGBTQ+ community

- **Learning Goals**
  - Access: Does the Pride Center improve access to behavioral health services for the service population?
  - Collaboration: Does a coordinated approach improve service delivery for the service population?

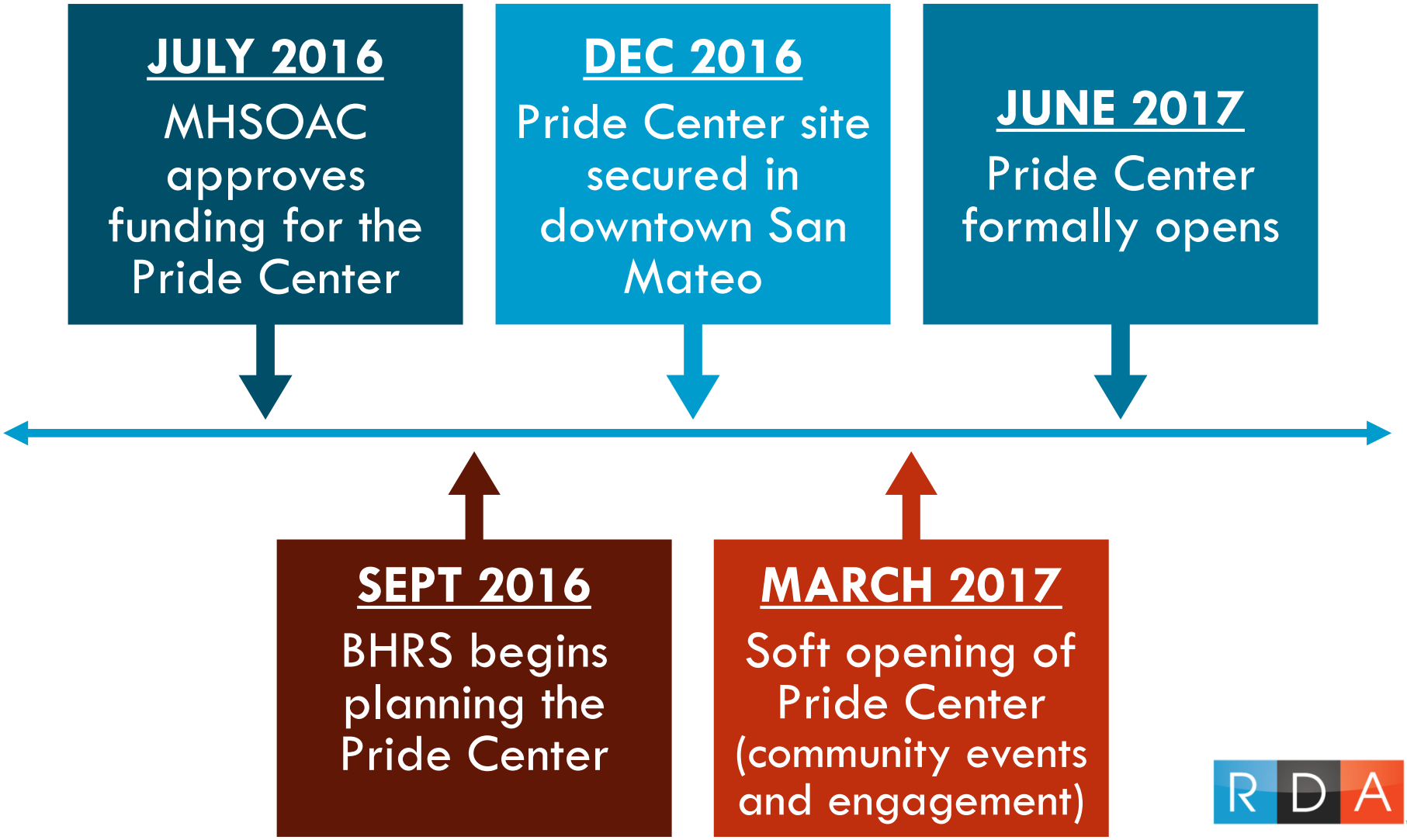
Pride Center Collaborative Model

Formal collaboration of four partner organizations



Pride Center Accomplishments

Timeline of the Pride Center



Onsite Programs and Services

- Psychotherapy
- Peer support groups
- Case management with linkage to other supportive services, including public benefits, employment search
- Social events, including movie nights, intergenerational dinners
- Informational sessions and service provider trainings

Please refer to handout for comprehensive list of onsite programs.

Collaboration and Training Services

- Long-term partnerships
  - County of San Mateo LGBTQ Commission
  - Pride Initiative, BHRS Office of Diversity and Equity
- Workplace trainings for service providers, school staff
- Student outreach, including info sessions, GSA development
- Co-sponsorships events with public agencies, providers, local businesses
- Outreach and tabling at community events, health fairs, conferences

Pride Center staff present to students at Thomas R. Pollicita Middle School

Please refer to handout for comprehensive list of community partnerships.

Figures on Participant Access, FY2018

- **1,011** individuals accessed programs on site
  - 15% accessed therapy services
  - 4% used case management services
- **Over 2,500** people accessed the Center's trainings, workshops, and events
- **69%** of participants who completed the Pride Center's satisfaction survey had visited the Pride Center more than once
  - **41%** had visited at least six times

Diversity of Pride Center Participants

- Two-thirds identify as LGBTQ+
- 76% are cisgender, 24% are transgender, gender queer, questioning, or other
- Most are between age 16 and 59
- 54% are people of color or multiracial
- 5 in 6 are below County's median household income
- 1 in 3 have annual income below $25,000

Pride Center Learnings: Access

Having LGBTQ+ Specific Services Engages an Underserved Population

- The Pride Center is reaching individuals who might not otherwise access clinical services
  - Having LGBTQ+ therapists draws clients
  - Pride Center prioritizes therapy for marginalized/vulnerable participants
    - Sliding scale and Medi-Cal
  - BHRS, educators, other providers now refer LGBTQ+ individuals seeking mental health services to the Pride Center

"In the past when I needed mental health services, I needed to find someone supportive and understanding of what I was feeling…I would have felt much safer [at the Pride Center]."

–Youth participant

Having a Physical Location Creates Community and Reduces Stigma

- The Pride Center is a safe, inclusive space for the LGBTQ+ community
  - Many participants said the existence of a physical space in a prominent public location helps them feel welcome and proud
- 99% agree that the Pride Center is a safe and welcoming environment
- 92% agree that the Pride Center offers a sense of community

(99% either agree or somewhat agree)

"To have a physical location is so much more meaningful than using online resources…to know that there is a place you can go to feel safe and find community."
–Adult participant

Sources: *Pride Center participant satisfaction survey (n=172)*
Pride Center participant focus groups

High Quality of Care Promotes Continued Engagement

- **99%** agree that Pride Center staff understand & affirm their sexual orientation, gender identity
- **85%** of participants agree that the services offered at the Pride Center are improving their mental health

(100% either agree or somewhat agree)

"When I went to cisgender, heteronormative therapists… They didn't get it. The [therapists] here understand it on the inside."

-Adult participant

"Every single time I come here, it's a lovely experience. There's not a single time I cross that door and someone doesn't ask me how I am."

–Youth participant

Source: Pride Center participant satisfaction survey (n=172)

Pride Center Learnings: Collaboration

Hub Model Provides Convenient Access to Multiple Services

- Partners and participants report on the value of the Pride Center's collaborative model
  - Four member organizations with different specializations
  - Coordination helps participants who benefit from multiple services
  - Shared physical site offers community-building, peer support

"I've been involved in a lot of LGBTQ organizations... focused on a particular issue. This [Center] brings it all together."

–Older adult participant

"It's a one-stop shop...[which is important] when you're homeless and have to get everywhere on foot. There's only so many places you can go in a day."

–Adult participant

Partnerships Increase Awareness of LGBTQ+ Community's Needs

- The Pride Center is a countywide educational resource on LGBTQ+ mental health & wellbeing
  - More providers know the importance of asking sexual orientation and gender identity (SOGI) questions
  - Referrals to Pride Center clinical services are increasing
  - Educators, public agencies, and private businesses have actively sought partnerships with the Center
- The Pride Center's presence at community events is an opportunity for attendees to learn about the available services

"We're a gigantic resource for the San Mateo County community. We're educating the educators and the social service providers. We're building all kinds of networks."

–Community Advisory Board member

Pride Center Extension Request

INN Learning Goal: Access

More time is needed to understand the full potential of the Pride Center to increase access to services

- It takes time to repair historical mistrust within the LGBTQ+ community about mental health services
- Stigma around seeking care takes time to overcome
  - Potential double stigma: having a mental health issue, and identifying as LGBTQ+
  - Shame and stigma in seeking mental health care is common in some populations, e.g. some Asian Pacific Islander/Latinx communities[2]

*Source: *The California LGBTQ Reducing Mental Health Disparities Report* (2013)

INN Learning Goal: Collaboration

More time to formalize internal and external collaboration would help the County document the innovative model and measure its impact

- It takes time to build internal policies and procedures among four partner organizations that have not worked together before
- Spending the time to develop a robust network of community partnerships will help the County learn the impact of coordinated service delivery

Extension Request

- San Mateo County BHRS is seeking approval to request a 2-year MHSA INN extension for the Pride Center in the amount of $700,000 per year
- The MHSARC will vote to open a 30-day public comment period
- The MHSARC will hold a public hearing and vote on 11/7 to approve the request and close the public comment period

Questions & Answers

- Is there anything else you would like to know about the Pride Center Learning Goals – Access and Collaboration?

Announcements & Public Comment

Thank you!

For more information: www.smchealth.org/MHSA
Doris Estremera, MHSA Manager
(650) 573-2889 or mhsa@smcgov.org

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Mental Health Services Act (MHSA) Innovation (INN) Component
Summary of INN Guidelines

Innovative Project Definition:

A project designed and implemented for a defined time period (not more than 5 years) and evaluated to develop new best practices in behavioral health services and supports.

What types of projects are considered "innovative"?

1. Introduces a behavioral health **practice or approach that is new**.
2. Makes a **change to an existing practice**, including application to a different population.
3. Applies a **promising community-driven practice or approach** that has been successful in non-behavioral health contexts or settings.
4. It has **not demonstrated its effectiveness** (in the literature).
    - A practice that has been demonstrated effective can be adapted to respond to a unique characteristic of the County for example.

Primary Purpose & Focus of an INN Project

County must select one of the following as its primary purpose for an INN project(s)*:

1. Increase access to behavioral health services to underserved groups,
2. Increase the quality of behavioral health services, including measureable outcomes,
3. Promote interagency and community collaboration,
4. Increase access to behavioral health services.

Innovative Projects may focus impact virtually any aspect, including but not limited to, administrative, governance, and organizational practices, processes, or procedures; advocacy; education and training for services providers, including nontraditional behavioral health practitioners; outreach, capacity building, and community development; system development; public education efforts; research; services and interventions, including prevention, early intervention, and treatment.

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MHSA Funding Principles

First adopted in November 2009, updated September 2018

These MHSA Funding Principles were developed to guide annual funding allocations and expansions; they also build from the County's and Health System budget balancing principles to guide MHSA reduction decisions when needed. Decisions regarding MHSA funding are based on the most current MHSA Three-Year Plan; any updates to the recommendations require MHSA Steering Committee approval and stakeholder engagement, which will include a 30-day public comment period and public hearing as required by the MHSA legislation.

Maintain MHSA required funding allocations

See attached MHSA Funding and Program Planning Guidelines document.

Sustain and strengthen existing MHSA programs

MHSA revenue should be prioritized to fully fund core services that fulfill the goals of MHSA and prevent any local or realignment dollars filling where MHSA should.

Maximize revenue sources

Billing and fiscal practices to draw down every possible dollar from other revenue sources (e.g. Medi-Cal) should be improved as relevant for MHSA funded programs.

Utilize MHSA reserves over multi-year period

MHSA reserves should be used strategically to mitigate impact to services and planned expansions during budget reductions.

Prioritize direct services to clients

Indirect services are activities not directly related to client care (e.g. program evaluation, general administration, staff training). Direct services will be prioritized as necessary to strengthen services to clients and mitigate impact during budget reductions.

Sustain geographic, cultural, ethnic, and/or linguistic equity.

MHSA aims to reduce disparities and fill gaps in services; reductions in budget should not impact any community group disproportionately.

Prioritize prevention efforts

At minimum, 19% allocation to Prevention and Early Intervention (PEI) should be maintained and additionally the impact across the spectrum of PEI services and services that address the root causes of behavioral health issues in our communities should be prioritized.

Evaluate potential reduction or allocation scenarios

All funding decisions should be assessed against BHRS's Mission, Vision and Values and when relevant against County and Health System Budget Balancing Principles.

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MHSA Program Funding Guidelines – Summary

MHSA Component	Categories	Funding Allocation (% of total revenue)
Community Services and Supports (CSS)[1]	• Full Service Partnerships (FSP) • General Systems Development (GSD) • Outreach and Engagement (O&E)	76% FSP should be at least 51% of the CSS allocation
Prevention and Early Intervention (PEI)[2]	• Ages 0-25 • Early Intervention • Prevention • Recognition of Signs of Mental Illness • Stigma and Discrimination • Access and Linkages	19%* Ages 0-25 should be at least 51% of the PEI allocation
Innovations (INN)[3]	N/A	5%

* PEI expenditures may be increased in which the department determines that the increase will decrease the need and cost for additional services to severely mentally ill persons in that county by an amount at least commensurate with the proposed increase.

Reversion Period: Counties must expend the revenue received for each core component within 3 years (starting with the year revenue is received) or must return it to the State mental health fund.

One-time Funding Components: counties received a one-time allocation to fund strategies in Workforce Education and Training (WET) [4], Capital Facilities and Information Technology (CF/IT) [5], and Housing[6]. All one-time funding has been expended. These components can continue to be funded under CSS, as determined by the following additional funding guidelines.

- Up to 20% of the average 5-year total of MHSA funds can be allocated from CSS to the technological needs, capital facilities, human resources, and a prudent reserve.
- Assembly Bill 727 clarifies that counties can fund housing assistance, not just for FSP clients.

Three-Year Plan and Annual Updates:

- up to 5% of total annual MHSA revenues can be allocated for annual MHSA planning efforts.
- All expenditures must be consistent with the current three-year plan or annual update developed through a Community Program Planning (CPP)[7] process.
  - Current Three-Year Plan Implementation: July 1, 2017 – June 30, 2020
  - Annual Updates Due: December 2018, December 2019, December 2020
  - Next Three-Year Planning Phase: January 2020 – June 2020
  - Next Three-Year MHSA Plan Due: December 2020

Prudent Reserve (PR): Counties are required to establish and maintain a PR for revenue decreases.

- The 50% Local Prudent Reserve requirement was rescinded (Info Notice 11-05)
- Counties may fund to a level determined appropriate and that does not exceed 33% of the counties' largest annual distribution (Info Notice 18-033).
- All other policy and guidance remains in effect (Info Notice 09-16).

Non-supplantation:

- Funds shall not be used to supplant any state or county funds required to be utilized to provide mental health services, that was in effect on November 2, 2004.

Definitions

[1] **Community Services & Support (CSS)** provides direct treatment and recovery services to individuals of all ages living with serious mental illness (SMI) or serious emotional disturbance (SED):

a. **Full Service Partnership (FSP)** plans for and provides the full spectrum of services, mental health and non-mental health services and supports to advance client's goals and support their recovery, wellness and resilience.

b. **General Systems Development (GSD)** improves the mental health service delivery system. GSS may only be used for; treatment, including alternative and culturally specific; peer support; supportive services to assist with employment, housing, and/or education; wellness centers; case management to access needed medical, educational, social, vocational rehabilitative or other services; needs assessment; individual Services and Supports Plans; crisis intervention/stabilization; family education; improve the service delivery system; reducing ethnic/racial disparities.

c. **Outreach and Engagement (O&E)** is to reach, identify, and engage unserved individuals and communities in the mental health system and reduce disparities. O&E funds may be used to pay for strategies to reduce ethnic/racial disparities; food, clothing, and shelter, but only when the purpose is to engage unserved individuals, and when appropriate their families, in the mental health system; and general outreach activities to entities and individuals.

[2] **Prevention & Early Intervention (PEI)** targets individuals of all ages prior to the onset of mental illness, with the exception of early onset of psychotic disorders. PEI emphasizes improving timely access to services and reducing the 7 negative outcomes of untreated mental illness; suicide; incarcerations; school failure or dropout; unemployment; prolonged suffering; homelessness; and removal of children from their homes.

a. **Early Intervention** programs provide treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence. Services shall not exceed 18 months, unless the individual receiving the service is identified as experiencing first onset with psychotic features, in which case early intervention services shall not exceed 4 years.

b. **Prevention** programs reduce risk factors for developing serious mental illness and build protective factors for individuals whose risk of developing a serious mental illness is greater than average and, as applicable, their parents, caregivers, and other family members. Services may include relapse prevention and universal prevention.

c. **Outreach for Recognition of Early Signs of Mental Illness** to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.

d. **Access and Linkage to Treatment** connects individuals with severe mental illness as early in the onset of these conditions as practicable, to medically necessary care and treatment, including care provided by county mental health programs. Examples include screening, assessment, referral, help lines, and mobile response.

e. **Stigma and Discrimination Reduction** activities reduce negative feelings, attitudes, beliefs and/or discrimination related to mental illness or seeking services. Examples include social marketing campaigns, speakers' bureaus, targeted education and training, anti-stigma advocacy, and efforts to encourage self-acceptance.

f. **Suicide Prevention** programs are optional. Activities prevent suicide but do not focus on or have intended outcomes for specific individuals. Examples include campaigns, suicide prevention networks, capacity building, culturally specific approaches, survivor-informed models, screening, hotlines or web-based resources, training and education.

[3] **Innovation (INN)** projects are designed and implemented for a defined time period (not more than 5 years) and evaluated to introduce a new behavioral health practice or approach; make a change to an existing practice; apply a promising community-driven practice or approach that has been successful in non-behavioral health; and has not demonstrated its effectiveness (through mental health literature).

[4] **Workforce Education & Training (WET)** provides clients and families training to help others, promote wellness and other positive outcomes. Providers are able to work collaboratively to deliver client-and family-driven services, outreach to unserved and underserved populations, and provide linguistically and culturally relevant services.

[5] **Capital Facilities & Technological Needs (CF/TN)** includes facilities for the delivery of MHSA services to clients and their families or for administrative offices; support an increase in peer-support and consumer-run facilities; community-based settings; and technological infrastructure to facilitate the highest quality and cost-effective services and supports.

[6] **Housing** is used to acquire, rehabilitate or construct permanent supportive housing for clients with serious mental illness and provide operating subsidies. This service category is part of CSS.

[7] **Community Program Planning (CPP)** process is used to develop MHSA three-year plans and updates in partnership with stakeholders to identify community issues related to mental illness, lack of services and supports; analyze the mental health needs in the community; and identify and re-evaluate priorities and strategies and includes a 30-day public comment, a public hearing by the local mental health board and local board of supervisors.

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Services Act (MHSA) Steering Committee

Monday, September 24, 2018 / 3:00 – 4:30 PM
Foster City Community Center, Wind Room
1000 E. Hillsdale Blvd, Foster City, CA 94404

MEETING MINUTES

Attendees: (See Sign in Sheet)

1. **Welcome** 3:05 PM
   Informal introductions: Steering committee members, commissioners, Director Steve Kaplan, Supervisor Pine

2. **MHSA Background & Updates** 3:15 PM
   - Proposed Funding Principles – Steve Kaplan
     - MHSA funding goes through peaks and valleys
     - From 2009 – 2013 is recession years so we see a dip in funding.
     - Onward it has continued to grow, but we need to now be prepared for budget planning.
     - Be mindful of what are the key principles we must adhere to incase we have a downturn.
     - Back in 2009, we had key principles to look at our way of decisions. Louise Rogers helped with them then, and we are bringing them back now.
     - Q: Are funding principles by the state or San Mateo County? – San Mateo County
     - Q: Where does MHSA come from? – 1% funding from millionaires aka millionaires tax.
   - Innovation Funding – Request for Interest opportunity – Doris
     - Pride Center is a current innovation project; reaching its 3rd year
     - In 2019, we'd like to open new projects
     - January 2019 we'll send out a request for interest in piloting a technology based behavioral health intervention; Information available online
     - Priority targeted areas: older adults, youth, Chinese and Spanish monolingual communities

3. **Pride Center Outcomes Review and Extension Request** 3:30 PM
   - Q&A
     Office of Diversity and Equity comment: The center is a powerful symbol of acceptance and a reminder of the importance of having community spaces in which

we can experience feelings of visibility and connectedness. The Pride Center has truly become the heart of San Mateo County's LGBTQ+ community.

- Alison Hamburg
  - How have the projects increased access, collaboration, quality, and outcome of services? Key themes of what we look for in evaluation.
  - How did Pride Center idea come up?
    - LGBTQ+ communities at higher risk of mental illness
    - 44% of LGBTQ adults reported needing access to mental health professional in past 12 months. Percentage even higher for those identifying as gender fluid. – LGBTQ Commission
    - Often mistrust of behavioral health care for those in LGBTQ+ community from decades of inappropriate care.
    - Shows there is a need for LGBTQ+ sensitive behavioral health care.
    - Pride Center envisioned as a service hub for social/ community activities, clinical support, and a resources hub for referrals for culturally appropriate care
    - What is the innovative portion of the Pride Center? This hub approach had not been done before. Being able to provide mental health as well as community based services.
    - Does the Pride Center increase access and collaboration? What are the key accomplishments?
    - What was learned from focus groups?
      - Pride center reaching individuals who might not otherwise access behavioral health services.
      - Knowing there was the Pride center, a lot of folks wish it were there in the past
    - How long does it take to build a collaborative model? Pride center is currently building on this. More time to achieve collaborative mode and figure out how to replicate it. Learned it takes more than 3 years to learn the certainty of how much impact on access and collaboration there has been.

- Lisa Putkey, Program Director of SMC Pride Center
  - Officially opened June 1st of 2017
  - Pride Initiative and LGBTQ Commission meet monthly on county wide events such as Pride celebration and Transgender Day of Remembrance
  - Trained over 2000 behavioral health professionals in LGBTQ affirming care
  - Worked closely with local schools and county office of education to provide appropriate care
  - Co-sponsored several community events
  - Over 1000 individuals accessed programs on site
    - 15% accessed therapy services
    - Majority of referrals come from county agencies, and some are self-referred
  - Over 2500 folks accessed trainings and events
  - Intersectionality viewed as a strength and influencing our experiences of homophobia, stigma, and microaggressions

        - Over 54% served are people of color or multiracial
        - 24% transgender, genderqueer or questioning
        - Majority between 16 and 59
        - 5/6 are below county's median household income
        - 1 in 3 have annual income of under $25000
    - Truly serving some of the county's most vulnerable communities

- Doris – opening to Q&A
    - Q: What do all partnered agencies bring to collaborative model
        - Star vista is lead agency – they are the fiscal sponsor: admin, IT and technology, rich history of affirming mental health services for families
        - Peninsula Family – History of serving families, history of senior peer counseling programs
        - Outlet – Rich history in providing youth spaces for LGBTQ youth
        - Daly City Partnership – Stronghold in North County; Rich history with families and schools in North County in providing series of different services
    - Q: Of the 1000 people who walked through the door, 15% getting clinical services. How does that number compare with your goal? Where would you like to move in the next 2 years?
        - Original vision was to serve 80 participants; serving over 125.
        - Need was far greater than prepared for or expected. Outgrowing their own space.
        - Broadening programs with languages.
    - Q: Do we have people from other counties coming in for the services?
        - Yes; we are the only county in our region without an LGBTQ+ center so a lot of our community had to go to other counties but now we are seeing some from other counties as well.
    - Q: What is the plan to continue with innovation after the instrumental innovation portion is over in 5 years?
        - Beyond innovation, would like to prove this is an innovative model that can be replicated in other counties.
        - Not only continue to get government funding but even have donors for the long run
    - Q: Are you a 501C3?
        - Yes; through our lead agency, Star-Vista
    - Q: How are you serving the developmentally disabled?
        - Constantly checking accessibility audits
        - For TDOR, wanting to do a march, figuring out the most accessible routes
        - Recently started a peer group called peers on the autism spectrum
    - Q: Guesstimate of what percentage of participants have alcohol and drug related issues?
        - A lot of clients are dual diagnosis
        - Kat is most trained clinician with substance abuse; says one-third of participants fall under that population
        - A lot of times questionnaire is anonymous so hard to get clear number
    - Q: Do you partner with LGBTQ+ specific members for services?

        - Yes; community advisory board keeps us connected with community
        - Thriving volunteer program- 2 of which will speak today
        - Not assuming what community wants, but working side by side with them
    - Q: Does organization bill insurance? Is there a provision for that?
        - Currently no; If we have patients coming in with private insurance, that's when we used our referral services
        - Sliding scale typically for those whose insurance does not cover mental health illness
    - Q: How have other counties received the Pride Center? What kind of inquiries have been made with other counties?
        - Lucky to be a part of the Bay Area; hub for LGBTQ+ folks
        - Worked with San Jose, Office of LGBTQ+ affairs in Santa Clara, over 30 letters of VA support, South San Francisco, Oakland Center
        - Hoping to do more regional work
    - Q: How many on your clinical team?
        - 7
    - Q: Do you offer Pro Bono or assists?
        - Yes; currently developing allocation process for those who really need it most
        - Sliding scale based off monthly income
        - Have not turned anyone away so far
    - Q: Are you aware of studies of about the financial net benefit to county for providing these kinds of services?
        - Studies show people who are in treatment in terms of their employment and stability, you can draw parallels
        - This program is still very new so too early to draw conclusions
    - Q: Is the program restricted to only serving residents of SMC? Could someone from Santa Clara refer someone to the Pride Center?
        - Yes, for free all and community services
        - Clinical might be different because we work with the health plan of San Mateo so they might not be qualified for our county
    - Q: Do you provide support for hormone or transgender care or is that referred out?
        - Do letter writing referrals for medical transitional care; no onsite endocrinologist
- Formally requesting approval to Steering Committee to request extension for funding
- Open 30-day public comment at next commission meeting and then close it and move to public hearing on November 7th.

4. Announcements/ Public Comments 4:20 PM

SMC Office of Education – Work Pride Center is doing through encouraging physical emotional and mental wellness of SMC through their programs is of utmost importance to LGBTQ+ community. Pride Center has offered space for first official GSA day in December. Makes school and county safe for all people. Imagine what they can do with more time on their programs and services.

Fennel Schubert – Capuchino High school, Pride Center greatly improved my quality of life. Staff wonderful and events amazing. This has been the best addition for well over a decade. Truly needed to get us sane, stable, and healthy. On a personal level, center is one of the few places I can feel safe without judgement. Often, I feel safer at the center than at home. These events help foster a sense of community. Please consider giving the center a few more years of funding.

Lynn Kaiser – Attended several peer support groups – The existence of the Pride Center already has a huge impact on mental health. That sense of community, support and guidance is very important for young people in particularly. For myself as a transgender woman, it has been very important to have that sense of community and not have to explain myself. It feels nice to be in a space of likeminded people where I don't need to explain myself all the time

Resident of San Mateo County and LGBTQ+ Commission – As a mom, there were not a lot of services over here to help me and my partner be moms. I wish the Pride Center had been around at that time. I want to express the commission's whole hearted request to extend the funding. It has increased the quality and breadth of services, access and collaboration. Since 2017, it has provided an array of services for schools. The intergenerational events have been a blessing to learn about other pride center activities and to make new friends. In 2000, there was a survey done to assess LGBTQ needs. There were very few surveyed, but because of the Pride Center's work to get out the survey, we could tap into more than 3 times the number of adults and 6 times the amount of youth. So, when the statistics come out, it is very representative of the community. I want to say thanks to the MHSA Steering Committee's vision to support this program.

Marvin – Found Pride Center this year and noticed the LGBTQ flag and noticed I had never seen the flag before. I am so happy that our center is here.

** Steering Committee members voting to approve the extension of funding for Pride Center. **Unanimously voted yes for the extension.** **

5. Adjourn 4:30 PM

Mental Health and Substance Abuse Recovery Commission (MHSARC)
Vote to open of a 30-day public comment period for the Pride Center extension will occur at the next MHSARC meeting on October 3rd.

MHSARC Meetings are held the first Wednesday of the month from 3-5pm at the Health System Campus, Room 100, 225 37th Ave. San Mateo, CA 94403.

Meetings are open to the public!

Stakeholder Group	Name(s)	Title (if applicable)	Organization (if applicable)	Email	Signature
Provider of MH/SU Svcs	Adriana Furuzawa	Division Director	Felton Institute - PREP	afuruzawa@felton.org	
Client/Consumer	Aisha Williams		Lived Experience Academy	aishamwilliams92@gmail.com	
Client/Consumer	Alan Cochran		Lived Experience Academy	ak_cochran@yahoo.com	
Public	Betty Savin*	MHSARC Commissioner		bettysavin@yahoo.com	
Other - Domestic Violence	Caitlin Billings		Community Overcoming Relationship Abuse - CORA	caitlinb@corasupport.org	
Provider of MH/SU Svcs	Cardum Harmon	Executive Director	Heart & Soul, Inc.	cardumh@heartandsoulinc.org	
Client/Consumer – Older Adult	Carmen Lee	Program Director	Stamp Out Stigma	carmensos@aol.com	
Client/Consumer - SA	Carol Marble*	MHSARC Commissioner		carolmarb@aol.com	
Member	Catherine Koss*	MHSARC Commissioner			
	Chantae Rochester*	MHSARC Commissioner			
Public	Cherry Leung*	MHSARC Commissioner		cherry.leung@ucsf.edu	
Provider of MH/SU Svcs	Clarise Blanchard	Director of Substance Abuse and Co-occurring Disorders	Star Vista and BHRS Contractors Association	cblanchard@star-vista.org	
Disabilities	David DeNola		Center for Independence	davidd@cidsanmateo.org	
San Mateo County District 1	David Pine*	Supervisor, District 1	Board of Supervisors	DPine@smcgov.org	
Member	Donald Mattaei*			donald.mattei@gmail.com	
HSA	Donovan Fong	Supervisor	SMCHSA	dfong@smcgov.org	

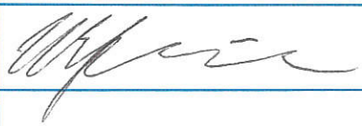
Client/Consumer	Wanda Thompson*	MHSARC Commissioner		w.thompson1967@yahoo.com	
Member	Yoko Ng	MHSARC Commissioner		yng@mail.ccsf.edu	
Family Member	Yolanda Novello	Family Partner	BHRS	YNovelo@smcgov.org	

Lisa Puttkey — Program Director — SMC Pride Center — lisa.puttkey@sanmateopride.org

Ryan Fukumori — Research Associate — Resource Development Associates — rfukumori@resourcedevelopment.net

Alisa Hamburg — Senior Associate — " " — ahamburg@resourcedevelopment.net

Family Member	Dorothy Christian*	MHSARC Commissioner		Dchristian28@yahoo.com	
Health Care	Dr. Dan Becker	Medical Director	Mills Peninsula Health Svcs	beckerdf@sutterhealth.org	
Client/Consumer - SA	Eduardo Tirado*	MHSARC Commissioner	Voices of Recovery	etirado@vorsmc.org	
Law Enforcement	Eric Wollman*	MHSARC Commissioner	Burlingame Police	mmortz@burlingamepolice.org	
Provider of MH/SU Svcs	Gloria Gutierrez	MH Counselor	BHRS	GGutierrez@smcgov.org	
Member	Isabel Uibel*	MHSARC Commissioner		isabel.c.uibel@kp.org	
Client/Consumer - Adults	Jairo Wilches	Liaison and BHRS Wellness Champion	BHRS, Office of Family and Consumer Affairs	jwilches@smcgov.org	
Cultural Competence & Diversity	Jei Africa	Director	Office of Diversity & Equity	jafrica@smcgov.org	
Education	Jenee Littrell	Administrator	San Mateo County Office of Education, Safe and Supportive Schools	jlittrell@smcoe.org	
Provider of MH/SU Svcs	Joann Watkins	Clinical Director	Puente de la Costa Sur	watkins3121@gmail.com	
Client/Consumer - Pathways	Jose Solano			jscompany22@gmail.com	
Family Member	Juliana Fuerbringer		California Clubhouse	julianafuer@gmail.com	
Client	Kate Pfaff*	MHSARC Commissioner			
Public	Leticia Bido*	MHSARC Commissioner		leticia.bido@gmail.com	
Provider of Social Services	Lynn Schuette		Community Overcoming Relationship Abuse- CORA	Lynns@corasupport.org	
Provider of Social Services	Mary Bier		North County Outreach Collaborative	marykbier@gmail.com	

Provider of MH/SU Svcs	Melissa Platte	Executive Director	Mental Health Association	melissap@mhasmc.org	
Client/Consumer - Adults	Michael Lim			mhl-lim@outlook.com	
Client/Consumer - Adults	Michael S. Horgan	Program Coordinator	Heart & Soul, Inc.	michaelhorgan@me.com	
Other - Aging and Adult Services	Michelle Makino	Program Services Manager	SMC Health System, Aging & Adult Services	mmakino@smcgov.org	
Family Member	Patricia Way*	MHSARC Commissioner	MHSARC	patcway@hotmail.com	
Client/Consumer - Adults	Patrick Field			pfield3311@gmail.com	
Client/Consumer	Patrisha Ragins*	MHSARC Commissioner		patrisharagins@yahoo.com	
Other - Advocate	Randall Fox	Health, Law and Policy Advocate	Former MHSARC Chairman	randallfox@sbcglobal.net	
San Mateo County District 1	Randy Torrijos*	Staff to David Pine	Board of Supervisors	Rtorrijos@smcgov.org	
Other - Peer Support	Ray Mills	Executive Director	Voices of Recovery	raymills71@gmail.com	
East Palo Alto Community	Rev. William Chester McCall		Multicultural Counselling & Educational Services of the Bay Area	chester.wellness@gmail.com	
Client/Consumer	Rocio Cornejo*	MHSARC Commissioner		rocio.cornejo9@yahoo.com	
Client/Consumer - Adults	Rodney Roddewig*	MHSARC Commissioner	MHSARC	rrodney2k6@gmail.com	
Law Enforcement	Sheila Brar*	MHSARC Commissioner		sheila.nathan@gmail.com	
Provider of Social Services	Sheri Broussard		HIP Housing	sbroussard@hiphousing.org	
Disabilities	Vincent Merola	Systems Change	Center for Independence	vincentm@cidsanmateo.org	

Stakeholder Group	Name(s)	Title (if applicable)	Organization (if applicable)	Email	Signature
	Roberta Gonzalez-Griggs	Outlook Updoo Co-Host / Producer	→	roberta2sg@sbcglobal.net	
	Alex Golding	Case Manager	San Mateo County Pride Center	alex.golding@sanmateopride.org	
	SHARON HEATH	PRG Mgr.	VORSMC	sheath@vorsmc.or	
	Janice Fernandez	Recovery Coach	VORSMC	JFernandez@VORSMC.Org	
	Robert ADAMSON & Gregory Zorapolis			travis94401@gmail.com	
	JEFF EDGERTON		VORSMC	JEDGERTON@VORSMC.ORG	
	Roxana Franco	Family Advocate	Nuestra Casa	rfranco@nuestracasa.org	
	Lynn Schuette	LGBTQ Commissioner	→	Lynn.Schuette@gmail.com	
	Melissa Greenfield	VORSMC Peer Mentor		mgreenfield@vorsmc.org	
	SMITHA GUNDAVAJHALA	Program Coordinator	Youth Leadership Institute (YLI)	sgundavajhala@yli.org	
	Fern Farley	Program Coordinator	Pride Center		
	Theresa Valez-Kelly	Program Coordinator	San Mateo County Office of Education	tvkelly@smcoe.org	
	Christi Morales-Kumasawa	StarVista / Pride Center	→ Mental Health Clinician	christi.kumasawa@sanmateopride.org	
	SUSAN TAKALO		PRIDE INITIATIVE SECOND HARVEST FB	stakalo@shfb.org	
	Marvin Melendez		San mateo Pride Center	~~Marvin~~	
	Diana Hernandez	Education coordinator	Outlet/ACS	diana@acs-teens.org	

Stakeholder group	Name	Title	Organization	Email	Signature
CORA	Brittney Reiser	Children's Program Clinical Coordinator	CORA	BrittneyR@corasupport.org	
	CASSANDRA NELSON	volunteer SanMateo Co. Pride Center →		cassnelson99@gmail.com	
CORA	Brenda Gonzalez	Client Advocate		brendag@corasupport.org	

Stakeholder Group	Name(s)	Title (if applicable)	Organization (if applicable)	Email	Signature
LGBTQ Commission	Craig Wiesner	Co-Chair		Commissioner.Craig@gmail.com	
LGBT comm. CHURCH	Terri Echelbarger	Pastor	Many Journeys MCC	Rector@ManyJourneysMCC	
	Ivon Hernandez	Grant Writer & Dev Assoc.	SMC Pride	ivon.hernandez@sanmateopride.org	
	Lowellyn Sungat	CMCPC Admin. Specialist	SMC Pride	lowellyn.sungat@sanmateopride.org	
	Catherine Haveter	Lead Mental Health Clinician	SMC Pride	Catherine.haveter@sanmateo-pride.org	
	Funnel Schubert		SMC Pride	fennel.t.schubert@gmail.com	
	Jason Espinoza	OHS Program Manager	OHS	jason.r.espinoza@mhn.com	
	Ryan Fouts	Outlet Program Director	Adolescent Counseling Services	ryan@acs-teens.org	Ryan Fouts
	Louise Dellana	Recovery Coach	VORSMC	LDellana@VORSMC	
	RONALD CLARKE	WRAP/Facilitator - Recovery Coach	VORSMC.	rclarke@vorsmc.org	
	Ray Mills	VORSMC	ED	RMills@VORSMC	
	Ishita Ferdous	VORSMC	—	iferdous@vorsmc.org	Ishita Ferdous
	Vash	ODE	→	szahoori@smcgov	
	Materesa López C	Promotora	Nuestra Casa	teredolfin@hotmail.com	Teresa López C.
	CANDICE HAWLEY	community		canajazz@gmail.com	C. Candice Hawley
Stipend	Cynthia Castro	Promotora	Nuestra Casa	Cynthia Castro01974@gmail.com	

Stakeholder group	Name	Title	Organization	Email	Signature
CORA	Kathryn Anderson	Law Enforcement Liaison	CORA	Kathryn@corasupport.org	
Mental Health Association	Melissa Platte	Exec. Dir.	Mental Health Association	melissap@mhasmc.org	
@ VORSMC	Mayra Diaz		BHRS	mgdiaz@smcgov.org	
	Andrea Willis	Wrap Facilitator	SMC	awilliams@vorsmc.org	
Peninsula Family Service	Ellyn Bloomfield	SPC Counseling Coordinator	PFS	ebloomfield@peninsulafamilyservice.org	Ellyn Bloomfield
CORA	Laura Suarez	Manager of Clinical Services	CORA	laurse@corasupport.org	
BHRS/Family member	Yolanda Ramirez	Family Partner	BHRS	yramirez@smcgov.org	
OneLife Counseling	Suzanne Styles	E.D.	OneLife	suzie@onelifecounselingservices.com	
Pride	Pat Bohm	Exec Director	Daly City Partnership	pat@dcpartnership.org	Pat Bohm

Stakeholder Group	Name(s)	Title (if applicable)	Organization (if applicable)	Email	Signature
	ALINA LABRADOR	MENTAL HEALTH CLINICIAN TRAINEE	SMC PRIDE CENTER	alina.labradot@sanmateopride.org	
	Kilani Louis	Community Outreach Coordinator	SMC Pride Center	Kilani.louise@sanmateopride.org	
	LYNN KEISER	VOLUNTEER – SMC PRIDE CTR	SMC PRIDE CENTER	LYNN56@GMAIL.COM	
	VANESSA FLORES	—	CSUEB	vflores900@gmail.com	
	Ulania Martinez	BHRS - ODE	Peer Worker		
	ESMERALDA GARCIA	VORSMC – ADMIN.	VORSMC	egarcia@VORSMC.org	
	STEPHANIE BAZÓN	YOUTH & FAMILY THERAPIST	DCYHC – FMHI	stephanie[illegible]garmabyon@gmail	
	Martin Fox	SMC VetsCoalition		martyfox@[illegible]	
	Bruce Adams	Program Director	Felton - PREP/BEAM	badams@felton.org	
	Ann Blick Hamer	Manager, SPC, PFS	Peninsula Family Svc	Ablickhamer@~~AnnB~~ peninsulafamilyservice.org	
	Andres Loyola	Mental health worker SMC pride center	SMC pride center	andres.loyola@smmateopride.org	
	Lynn Duncan	—	—	—	
crisis center	Islam Hassanein	Program Manager	Star Vista	islam.hassanein@starvista.org	
BHRS/ODE	Annette Pekelman	LGBTQ Community Outreach Worker	Office of Diversity & Equity (BHRS)	~~[illegible]~~ Epakhchian@smcgov.org	
	AL LANDUCCI		PRIDE CENTER	RZ35@aol.com	
	Suzanne Aubry	Dir of FA	BHRS	Saubry@smcgov.org	

Stakeholder group	Name	Title	Organization	Email	Signature
Nuestra Casa	Amada Espinoza		Nuestra Casa	amadaespinoza10@yahoo.com	
Leticia Bidó			MHSA Advisory Commission	leticia.bido@gmail	
Christina Hagen			Voices of Recovery		
LGBTQ Commission	Tanya Beat	Director	County	tbeat@smcgov.org	
StarVista / community member	Jessica Harders		StarVista	jessica.harders@starvistaorg	
CORA	Melissa Antoun	LGBTQ Clinical Coordinator	CORA	antounm@corasupport.org	
Mission Hospice & Home Care	Mary Matthiesen	Community Engagement + ED Dir	MHHC	mmatthiesen@missionhospice.org	
Volunteer	Lisa Wepfer			lisa.wepfer@icloud.com	
CORA	Viria Guzmen	Crisis Counselor	CORA	viriaclong@yahoo.com	
NAMI SMC	Cayden Cadsill	LGBTQ+ crisis counselor	CORA	rayderg@corasupport.org	
	Helene Zimmerman	Exec. Dir.			
	Chris Sturken	San Mateo County Pride Center Community	Advisory Board	csturken@mail.sfsu.edu	
Zena Andreani			CORA	zenaa@corasupport.org	

APPENDIX 3: INN EXTENSION REQUESTS: HAP-Y AND NMT- ADULTS

Be the one to help

Mental Health Service Act (MHSA) Steering Committee Meeting

Open to the public! Join advocates, providers, clients and family members to provide input on MHSA funded initiatives.

Meeting objectives include:

- Provide input on MHSA Plan to spend available one-time revenue
- Update on MHSA Innovation funding cycle
- Hear from current Innovation project, Health Ambassador Program for Youth
  - ❖ Stipends are available for consumers/clients
  - ❖ Language interpretation is provided as needed*
  - ❖ Childcare is provided as needed*
  - ❖ Refreshments will be provided

*please reserve language and childcare services by April 12th by contacting Tania Perez at (650) 650-573-5047 or tsperez@smcgov.org.

DATE

Monday, April 22, 2019
3:00 pm – 4:30 pm

County Health Campus, Room 100
225 37th Ave.
San Mateo, CA 94403

Contact:

Doris Estremera, MHSA Manager
(650)573-2889
mhsa@smcgov.org

smchealth.org/MHSA

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

MHSA provides a dedicated source of funding in California for mental health services by imposing a 1% tax on personal income in excess of $1 million.

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Services Act (MHSA) Steering Committee

Monday, April 22, 2019 / 3:00 - 4:30 PM
County Health Campus, Room 100, 225 37th Ave. San Mateo, CA 94403

AGENDA

1. **Welcome & New Member Introductions** 3:05 PM
   - *Supervisor Dave Pine*
   - *Doris Estremera, MHSA Manager*

2. **MHSA Background & Updates** 3:10 PM

3. **Health Ambassador Program for Youth** 3:20 PM
   Islam Hassanein, Program Manager, StarVista

   Action Item: Motion to Approve One-Year No-Cost Extension

4. **Budget and Plan to Spend One-Time Revenue** 3:40 PM
   - *Scott Gruendl, BHRS Assistant Director*

   Action Item: Motion to Approve Plan to Spend

5. **Announcements/Public Comments** 4:15 PM
   - Pride Center 2-year extension approved
   - Year Two INN Evaluation Reports now available

6. **Adjourn** 4:30 PM

Mental Health and Substance Abuse Recovery Commission (MHSARC)
Opening of a 30-day public comment period for one year no-cost extension of innovation projects and plan to spend one-time revenue:

May 1, 2019 from 3:30-5:00pm
County Health Campus, Room 100, 225 37th Ave. San Mateo

Mental Health Services Act (MHSA)

Steering Committee Meeting

April 22, 2019 / 3 - 4:30pm

www.smchealth.org/mhsa

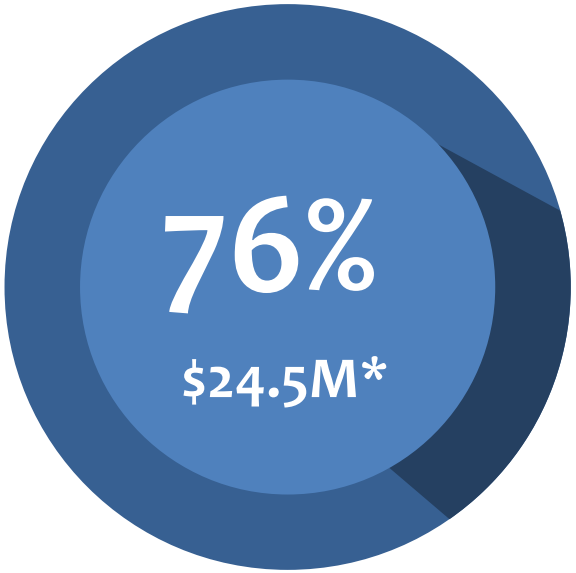
SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Agenda

1. MHSA Background - Innovation
2. Health Ambassador Program for Youth
   - ✓ Motion to approve
3. Budget and Plan to Spend
   - ✓ Motion to amend
4. Announcements & Public Comments

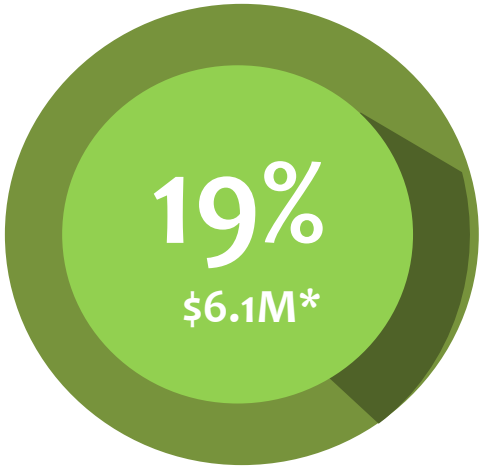
MHSA – Prop 63 (2004)

1% tax on personal income in excess of $1 million (M)



Community Services & Supports (CSS)

Direct treatment and recovery services for serious mental illness and serious emotional disturbance



Prevention & Early Intervention (PEI)

Interventions prior to the onset of mental health disorders and early onset of psychotic disorders

Innovation (INN)

New approaches and community-driven best practices

*Component amounts based on FY 17/18 revenue received

MHSA Innovation

- 3-5 year projects to develop new best practices
- New innovation funding cycle launched in January
  - 35 ideas received, 20 reviewed by Selection Committee
  - Considering 5-6 ideas (handout)
  - Next steps – develop proposals for input at next Steering Committee meeting in the fall and approval by the State MHSOAC

Health Ambassador Program for Youth

Public Comment & Motion to approve

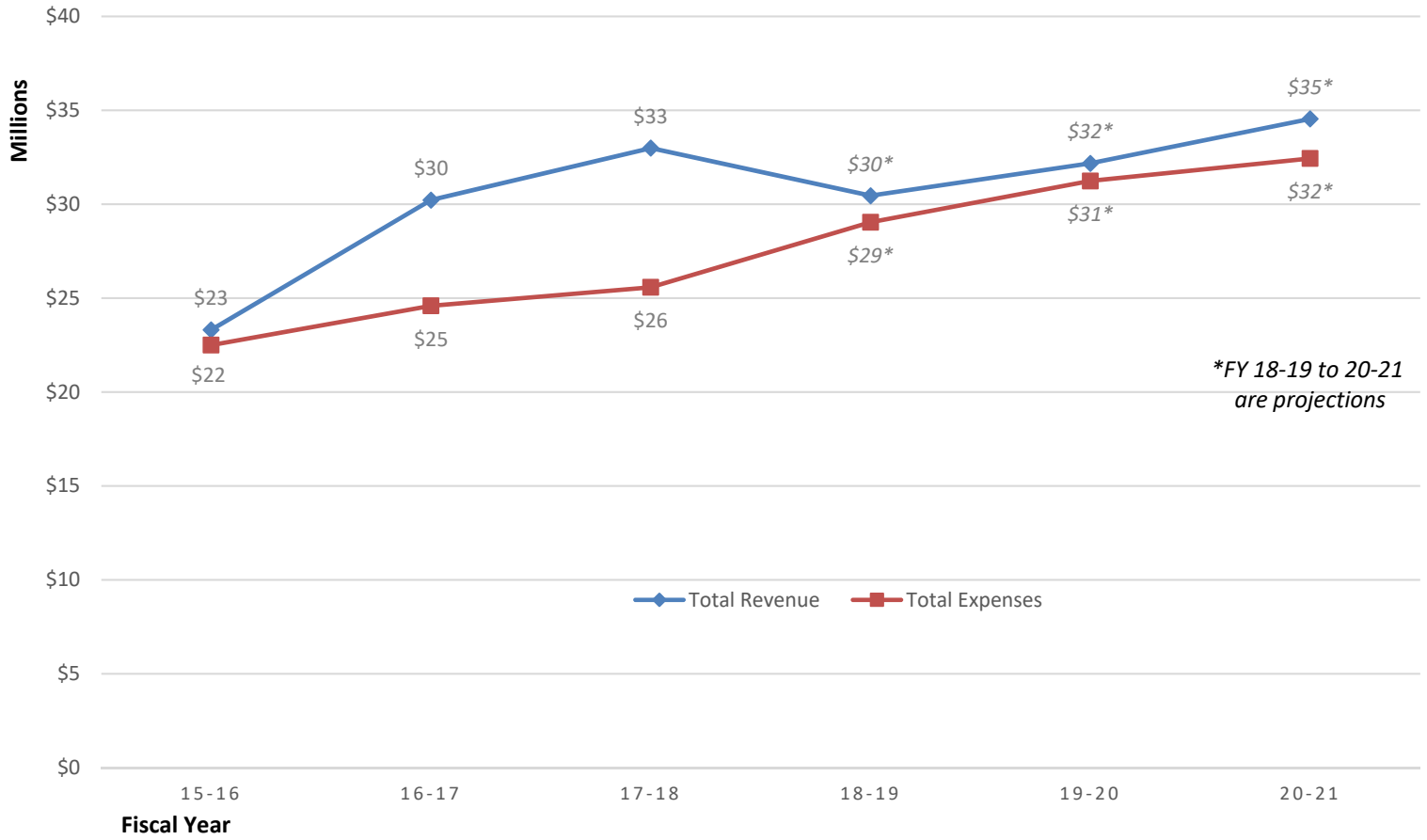
- Motion to approve a one-year no-cost extension of the MHSA Innovation projects, the Neurosequential Model of Therapeutics (NMT) in Adult System of Care and the Health Ambassador Program for Youth (HAP-Y)

County Budget Update & MHSA Plan to Spend One-time

County Budget Context

- San Mateo County is actively working on budget reductions to general funding.
- While there is a small decrease in MHSA revenue this fiscal year, increases are projected in the following two years.
- MHSA funding will be optimized in accordance to the MHSA Funding Principles and used to continue to strengthen and build on MHSA priorities across behavioral health care services.

MHSA Revenue & Expenditures



MHSA Reserves

- A reserve is in place to allow counties to maintain programs during a recession
  - **Reserve Goal Recommendation:**
    50% of Highest Annual Revenue ($33M)

San Mateo County MHSA Funds	
Unspent	$35.7M
Reserve Goal	-$16.5M
Obligated	-$6.7M
Available One-time	$12.5 M

Considerations & Priorities

Considerations:

- One-time funding must be spend on original allocated component
  - Only about $3M is PEI unspent
- Can 'buy us time' for 3-4 years for budget reductions
- Continued need to adequately fund core MHSA programs

Priorities:

- System improvement for MHSA core services
- Technology and Capital Facilities (IT/CF) and Workforce Training
- Stop-gap for budget reductions and other ongoing funding needs (Innovation projects)

Public Comment & Motion to Amend

- Motion to amend the MHSA Three-Year Plan to include a Plan to Spend for one-time available funds

Next Steps

- 30 day Public Comment
  - MHSARC 5/8/19
- No-cost extension to State MHSOAC for approval
- Plan to Spend in next Annual Update due December 2019

Announcements & Public Comments

Thank you!

For more information: www.smchealth.org/MHSA
Doris Estremera, MHSA Manager
(650) 573-2889 or mhsa@smcgov.org

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

MHSA Innovation Ideas Prioritization – April 2019
(3 to 5-year projects)

Target Population	Need	Potential Reach	Project Description	Innovation	Annual Cost
Pacific Islander college-aged youth	In San Mateo County Asian/Pacific Islanders have lowest rates of accessing specialty mental health service. Pacific Islander students demonstrate the lowest rate of student success of all ethnic groups. There is a need for culturally relevant mental wellbeing supports for college-age youth.	The largest number of Pacific Islanders in the Bay Area reside in San Mateo County (11,543). Pacific Islanders represent about 1.9% (510) of students in junior colleges in San Mateo County.	Empowerment program for junior college and surrounding community Pacific Islander youth addressing mental well-being and stigma. Program has 3 key components. 1) Leadership institute for cultural education, identity, history, community, mental health, institutions to develop knowledge, skills and mental health networks. 2) Mana sessions to provide a space to decompress, engage in group discussions around mental health and wellness, as well as skill building workshops. 3) Forward Movement Projects are opportunities to give back or be of service to their community.	Culturally relevant college student leadership, community development, mental health promotion program	$250,000
Low income young adults 18-25	Young adults have the highest prevalence of severe mental illness however, only 35% receive treatment. BHRS currently intervenes at PES, through referrals or the schools.	MidPen houses 500 low-income young adults throughout San Mateo County	Preventative mental health and harm reduction workshops, a peer support group, mental health screenings, referrals and linkages to resources for mental health and drugs and alcohol, crisis support in low-income affordable housing and surrounding community housing.	Co-location of prevention and early intervention services in low-income housing complexes	$250,000

Clients with co-occurring disorders	In San Mateo Health, addiction-related conditions account for 25-30% of ED and PES visits. Likely 60-80% of BHRS clients (15,000/year are co-occurring. In FY 17/18 33% (4,950) were identified co-occurring. The Youth Services Center has 75% (45-52) youth with co-occurring diagnosis.	A full-time fellow can potentially carry a caseload of 150 clients and see 100 clients/month	An addiction medicine fellowship in a community hospital setting to provide high quality, coordinated treatment of addiction for co-occurring clients. The fellowship would be housed under the psychiatry residency program. In addition to clinical work with diverse populations they would be assigned one advocacy activity outside their usual work responsibilities made for building opportunities for community change. They would also participate in the structural humility and advocacy training.	Addiction medicine fellowships sponsored by a government agency community hospital	$157,000
Housed older adults at risk of homelessness	43% of all elders age 65+ do not have enough income to meet their most basic needs as measured by the Elder Index. That's over 38,000 elders struggling to make ends meet in San Mateo County. TIES Lines intake unit social workers received 3,301 housing related calls and 598 calls regarding homelessness.	For FY 18/19 there were 1,577 eligible 60+ older adults received/receiving Home Delivered Meals in San Mateo County. 900-1,300 older adults currently served by providers can be potentially screened.	A mental health peer counselor would screen older adults for risk factors cited in the literature including social, economic, anxiety and depression to identify early behavioral health issues and economic stresses that would put older adults at increased risk of homelessness. The peer worker would conduct home visits through home delivered meals program, outreach, group sessions at the senior centers and other community-based settings (e.g., churches, non-profit social services providers), and referrals from senior center staff. Preventative interventions will include behavioral health coaching, mental health linkages, creating safe discussion groups.	Early intervention economic stress screening to prevent homelessness	$200,000

Filipino at-risk youth (16-24) in Daly City and North San Mateo County	Filipino youth have highest drop-out rates, highest rates of depression, and suicide.	33% (about 33,000) of Daly City population are Filipino. The Daly City Youth Health Center sees about 52 Filipino youth ages 13-22 for behavioral health counseling	KulturARTS Kafe is a school to career/youth development social enterprise Cafe, cultural arts and wellness center. The components of this program are school to career prep, mental health/wellness ambassadors, cultural identity formation, leadership development, and financial wellness. The social enterprise model will allow for sustainability. The space will also strengthen and build community.	Social enterprise as a cultural arts and wellness center	$700,000
				Total Funding	**$1,557,000**

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

Community Need

- MHSA FY 14/15 Three-Year planning process
  - Stakeholders identified the need for alternative treatment options to deepen focus on trauma informed care and provide improved outcomes for clients
  - Trauma is frequently undiagnosed or misdiagnosed leading to inappropriate interventions in behavioral health care settings

MHSA Innovation

- Since 2012, BHRS Youth System has provided extensive training with positive outcomes for children and youth.
- The expansion and evaluation of NMT in an adult system of care is the first of its kind.

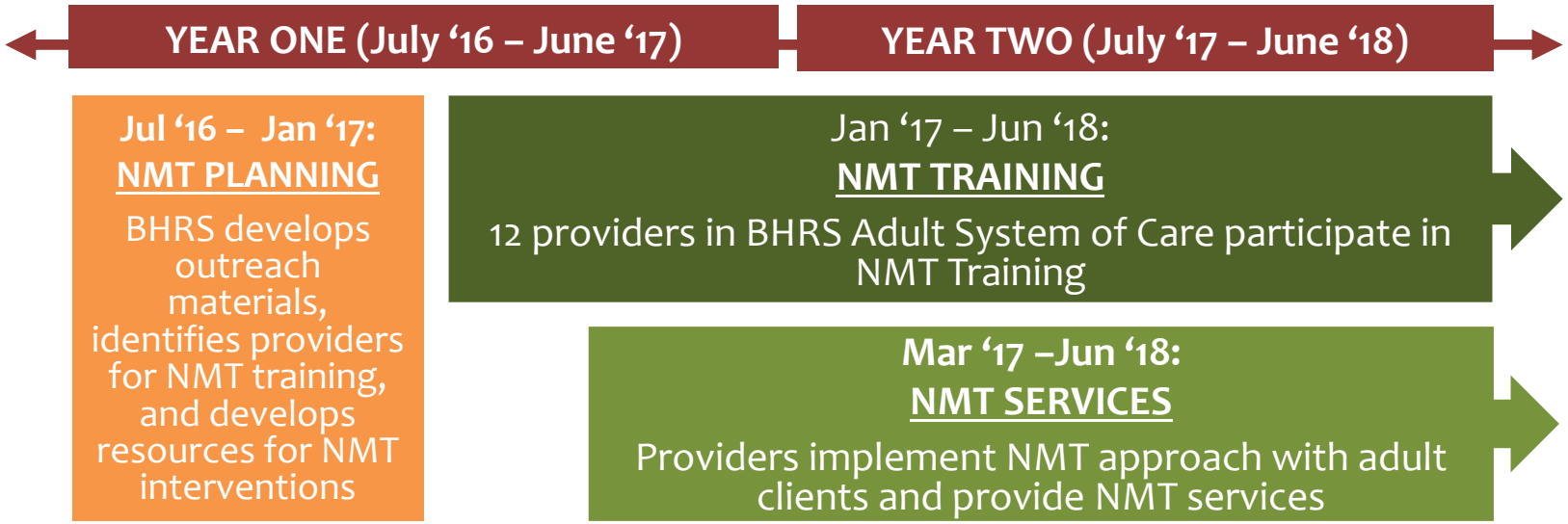
Learning Goal 1	Learning Goal 2
Can NMT, a neurobiology and trauma-informed approach, be adapted in a way that leads to better outcomes in recovery for BHRS adult consumers?	Are alternative therapeutic and treatment options, focused on changing the brain organization and function, effective in adult consumers' recovery?

About NMT

- Developed by Dr. Perry at the Child Trauma Academy as an alternative approach to addressing trauma
- NMT uses assessments to guide the selection of individualized alternative interventions (drumming, yoga, expressive arts, etc.)
- Interventions help clients better cope, self-regulate and progress in their recovery

Implementation

- Target population
  - General adult clients (ages 26+) receiving specialty mental health services
  - Transition age youth (ages 18-25)
  - Criminal justice-involved clients re-entering the community

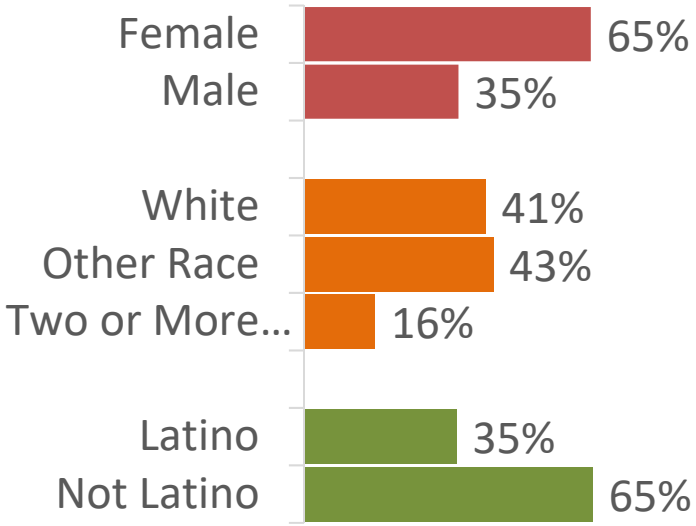


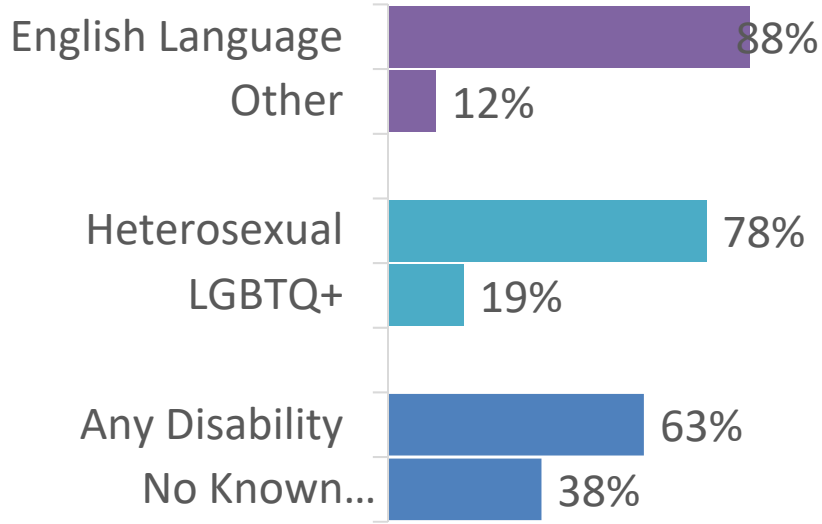
Accomplishments To-Date

- 6 providers completed the NMT training, 5 are continuing to become trainers
- Broad array of resources established
  - Clients: Yoga, drumming, therapeutic massage, animal-assisted therapy
  - Clinics: therapeutic lighting, art supplies, weighted blankets, sensory integration tools

Client Demographics

- 60 clients served total (doubled in Year 2)
  - 73% (44) adults, 23% (16) TAY

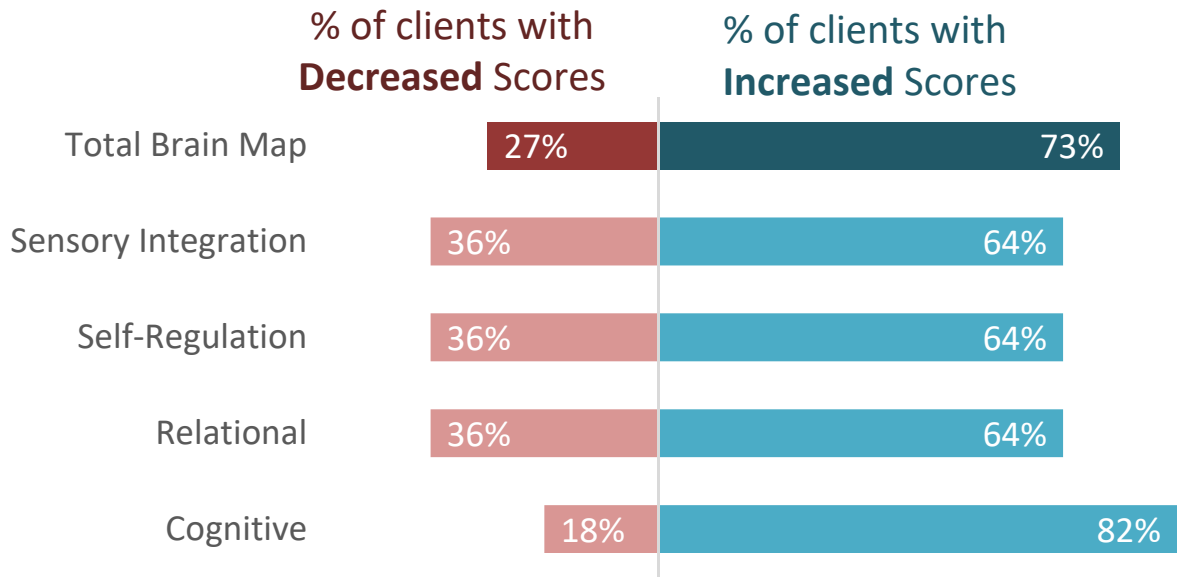




Client Outcomes

- Clients appear to be benefitting from NMT services

Percentage of Clients with Increased and Decreased Assessment Scores from Baseline to Follow-up, N=11, **FY17-18**



Client Outcomes (cont'd)

The moment you start, you get the anger out by massaging the clay. All the stress and tension I had in my hands and my mind, I didn't have it anymore. I didn't even remember the reason why I was so upset or hurt.

– NMT Client

- The NMT approach may make it easier for some clients to engage in therapy.

- NMT implementation may be helping clinics and programs within the BHRS adult system of care be more trauma-informed.

[NMT] doesn't feel like the normal going to the counselor and you just tell them your feelings and it's depressing and it's serious. [NMT] doesn't feel like that. It feels light.

– NMT Client

Next Steps

- Train 12-18 from up to 6 different BHRS adult system of care programs
- Once providers are fully trained, approximately 75-100 clients will receive an assessment and relevant interventions annually.
- Would like to increase intervention resources
- Sustainability and expansion leveraged through the train-the-trainer model
  - Total for sustainability: $200,000 annually (.3FTE MHS, maintenance and training, interventions)

3-Year Plan to Spend $12.5M Available One-time Funds

*up to $3M PEI

Priority	Item	FY 19/20	FY 20/21	FY 21/22	Notes	MHSA Component
System Improvements - Core MHSA Services	Recovery oriented, co-occurring capacity		$500,000	$500,000	$1M over 5 years to develop co-occurring capacity at all levels including FSPs (Comprehensive, Continuous, Integrated System of Care model)	CSS
	Full Service Partnerships (FSPs)	$100,000			FY 19/20 one-time system improvement consultant for cost and payment alignment and rate analysis. ~$3M projected revenue growth in FY 20/21 to cover ongoing needed to adequately fund FSPs	CSS/FSP
	MHSA data collection/analysis to allow for improvements and planning that is outcomes-oriented and data-informed	$100,000	$100,000	$100,000	Three-year consultant to support all CSS, currently have no CSS GSD data outside of clients served.	CSS
	Trauma-informed systems (BHRS, HSA, Probation, etc.)	$100,000	$50,000	$50,000	One-time consultant followed by training expenses	PEI
Technology Needs	Network Adequacy Certification Tool (NACT)	$100,000			Includes consultant fees	IT/CF
	M*Model (Dicitiation Software)		$110,000	$35,000	Includes professional services, hardware for 100 users and training. Ongoing fees beginning FY 21/22	IT/CF
	Automated Appointment Reminders		$5,000	$2,000	Ongoing fees beginning FY 21/22	IT/CF
	Orders Console (Rx Submission via Avatar)	$10,000	$3,000	$3,000	Ongoing fees beginning FY 20/21	IT/CF
	CareConnect Inbox (Direct Messaging via Avatar)			$50,000	Ongoing fees of $40,000 beginning FY 22/23	IT/CF
	CareConnect CarEquality (Interoperability)	$20,000	$3,000	$3,000	Ongoing fees beginning FY 20/21	IT/CF
	Training Consultant (create computer-based, in-person training, and written training materials)	$100,000	$80,000	$80,000	Support for ongoing training beginning FY 20/21	IT/CF
	Telepsychiatry/Telehealth	$20,000	$30,000	$30,000	Equipment needed for Skype Business, ongoing fees of $5,000 beginning FY 22/23	IT/CF
	Computer Monitors (larger for clinician 24")	$140,000			Increase productivity for all administrative and clinical staff	IT/CF
Workforce Education and Training	Web-based training capacity	$50,000				WET
	Psychodiagnostic Assesment	$15,000	$3,000	$3,000		WET
	EMDR Implementation	$8,000	$5,000	$5,000		WET
	Equipment (PA system, recorder, etc.)	$1,000				WET
	Training space fees ($500/day x 50)	$25,000	$25,000	$25,000		WET
	System wide training/conferences	$50,000	$50,000	$50,000	$5K per training/conference x 10/year	WET
	Cultural Competence Stipends for Interns	$24,000	$24,000	$24,000		WET
	Crisis Coordination	$200,000	$200,000	$200,000	trainings, regional collab, resources, materials	WET
Capital Facilities (must be County-owned)	SSF Clinic		$500,000			CF/IT
	EPA Clinic	$700,000				CF/IT
	Casia House Renovations	$100,000				CF/IT
Stop Gaps (Ongoing programs)	Total Wellness			$1,400,000		CSS
	Pride Center			$500,000		CSS/PEI
	HAP-Y		$250,000	$250,000		PEI
	NMT- Adults		$200,000	$200,000		PEI
	Tech Suite		$300,000	$300,000		PEI
TOTALS		**$1,863,000**	**$2,438,000**	**$3,810,000**	**$8,111,000**	**Total CSS/PEI**

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Services Act (MHSA) Steering Committee

Monday, April 22, 2019 / 3:00 - 4:30 PM
County Health Campus, Room 100, 225 37th Ave. San Mateo, CA 94403

MEETING MINUTES

1. **Welcome & New Member Introductions** 3:05 PM
   Supervisor Dave Pine
   Doris Estremera, MHSA Manager
   - *New Members*
     - Chris Kernes- Healthright 360
     - Michael Krechevsky- Family Support Specialist
     - Stephanie Morales- Peer Support Worker with OASIS
     - Helene Zimmerman- Executive Director for NAMI

2. **MHSA Background & Updates** 3:10 PM
   - Orientations will happen at the beginning of all the steering committee meetings, one hour before
   - Proposition 63 passed in 2004 by California it is a 1% tax on income over 1 million dollars
   - 76% of the funding – 27 million goes towards Community Services and Supports this is direct treatment
   - 19% is Prevention and Early Intervention- Interventions prior to the onset of mental illness this includes Office of Diversity and Equity
   - 5% is for Innovation- Trying something that has never been done before, state has full oversight over this category
   - Update:
     i. Innovation- 3 to 5 year programs
     ii. Just launched a new cycle of funding in January
     iii. Individuals were able to submit ideas and had to meet the needs prioritized by the steering committee
     iv. 37 ideas came through, they were reviewed across requirements and 20 were reviewed by a smaller committee
     v. We are moving forward with 5 ideas
     vi. In your packet you have the ideas and the next step are the full proposal and they will be presented to the steering committee and we will open the 30 day public comment

3. Health Ambassador Program for Youth 3:20 PM

Islam Hassanein, Program Manager, StarVista

- Innovative project that is funded under MHSA and implemented by StarVista
- Purpose: Increase access to mental health services in vulnerable populations specifically for Transitional Age Youth
    - First of its kind to have a youth led initiative where youth increase awareness, reduce stigma and increase access to services across the county
- 14 week over 50 hour program that trains youth on various topics including
    - QPR
    - 10 week NAMI Family to Family Course
    - 8 Week Wellness Recovery Action Plan for youth
    - Training for learning about stigma and how to destigmatize mental health
    - Trained on how to talk to the community about Mental Health
- Since inception of HAP-Y have gone through 5 cohorts, and are currently on the 6th cohort which is set to finish this week
    - Meet about 4 hours per week
    - Increasing youth access to mental health services
- Rotate the training in different geographical locations throughout San Mateo
        - Have hosted training: Redwood City, South San Francisco, San Mateo, Halfmoon Bay, East Palo Alto
    - Youth are ambassadors and they engage in presentation in the community on mental health and have served on panels, tabled at outreach events
- Impact
    - 67 youth have participanted in the HAP-Y program
    - 85% are youth of color
    - Over 100 presentation about mental health and served 2400 people
- Shared a video about Carolina a participant in the HAP-Y program
- Youth presenters from HAP-Y
- Questions:
    - How many graduates?
        - 64 graduates
    - Age range to participate as an ambassador and what are the requirements?
        - 16 to 24
        - Live and or go to school in San Mateo County
    - How are youth recruited?
        - Outreach is done by Brenda Nunez and we talk flyer for HAP Y at many organizations across the county
    - How can we schedule presentations?
        - Email Islam
    - What happens when someone graduates, do they age out?
        - If you are 24 you can be a part of the program
    - Innovation projects were 3 year programs and were expected to end this fiscal year, not asking for more dollars, just want to spend the unspent dollars
        - Received 250,000 per year but had a late start

    - **Action Item:** Motion to Approve One-Year No-Cost Extension
- NMT is also asking for a one year no cost extension

- Make a motion to approve a one year no cost extension of the MHSA innovation projects NMT and HAP-Y
    - Melinda made the motion
    - Rodney second the motion
    - No opposed
    - Motion passes
- Official 30 day public comment will open on May 1st at MHSARC
    - Public comment forms in the back, can also email them

4. Budget and Plan to Spend One-Time Revenue 3:40 PM

- *Scott Gruendl, BHRS Assistant Director*
- Anticipate some significant revenue impacts associated with federal revenue either flat or declining
    - Also, decline in the general fund because of an anticipated economic downturn
- 2.5% reduction, we are working on reductions higher than that
- MHSA is a volatile tax revenue source, and state has predicted a decline in the next couple of years
- One time spending- accumulated dollars that are unspent and there is reversion for certain categories and can be taken from us and go back to the state and can be reallocated
    - Want to use MHSA funding to assist with budget issues, but only where it is compliant with the act
- Continuously appropriate out of the same fund where dollars are deposited
    - Amend 3 year plan to add a reserve of 50%
- Prudent reserve- difficult reserves to work with, the state has the authority on when you can take it out, state has to provide approval
    - Local reserve of 50% of highest annual revenue
    - 16.5 million for the local reserve so leaves 12.5 of one time funding
    - One time dollars and we need to decrease the amount to avoid reversion
- Priorities for spending plan- system improvements for MHSA, technology, capital facilities, WET and stop-gap for budget reduction
    - System improvements
    - Full service Partnerships
        - Hiring consultants to look at our vendors and the disparity of costs so that there is more equity between contractors
- Help with data collection and analysis
    - Some vendors can provide data, some have a more difficult time, it is difficult to put together all the data we can do some analysis on
    - Pat vote to motion to amend the MHSA three year plan to include a plan to spend to approve a plan to spend
    - Judy seconds it

Action Item: Motion to Approve Plan to Spend

5. Announcements/Public Comments 4:15 PM

- Pride Center 2-year extension approved
- Year Two INN Evaluation Reports now available

6. **Adjourn** 4:30 PM

Mental Health and Substance Abuse Recovery Commission (MHSARC)
Opening of a 30-day public comment period for one year no-cost extension of innovation projects and plan to spend one-time revenue:

May 1, 2019 from 3:30-5pm.
County Health Campus, Room 100, 225 37th Ave. San Mateo

Stakeholder Group	Name(s)	Affiliations (Board Member or Employee)	Title (if applicable)	Email	Signature
Provider of MH/SU Svcs	Adriana Furuzawa	SMC Health System, Aging & Adult Services	Program Services Manager	asawamura@smcgov.org	
Other-Aging and Adult Services	Anna Sawamura	SMC Health System, Aging & Adult Services	Program Services Manager	asawamura@smcgov.org	
Public	Betty Savin		MHSARC Commissioner	bettysavin@yahoo.com	
Family Member	Bill Nash		MHSARC Commissioner	Bill.nash@kla-tencor.com	
Provider of MH/SU Svcs	Cardum Harmon	Heart & Soul, Inc.	Executive Director	cardumh@heartandsoulinc.org	
Client/Consumer- SA	Carol Marble		MHSARC Commissioner	carolmarb@aol.com	
Member	Catherine Koss		MHSARC Commissioner	catekoss@gmail.com	
Public	Cherry Leung		MHSARC Commissioner	cherry.leung@ucsf.edu	
Provider of MH/SU Svcs	Chris Kernes	Health Right 360		ckernes@healthright360.org	
Provider of MH/SU Svcs	Clarise Blanchard	Star Vista and BHRS Contractors Association	Director of Substance Abuse and Co-occuring Disorders	cblanchard@star-vista.org	
San Mateo County District 1	David Pine	Board of Supervisors	Supervisor, District 1	DPine@smcgov.org	
Member	Donald Mattei		MHSARC Commissioner	Donald.mattei@gmail.com	
Provider of MH/SU Svcs	Gloria Gutierrez	BHRS	MH Counselor	GGutierrez@smcgov.org	
	Helene Zimmerman	NAMI		hzimmer@namisanmateo.org	
Member	Isabel Uibel		MHSARC Commissioner	Isabel.c.uibel@kp.org	
Client/Consumer- Adults	Jairo Wilches	BHRS, Office of Family and Consumer Affairs	Liaison and BHRS Wellness Champion	jwilches@smcgov.org	
Provider of MH/SU Svcs	Joann Watkins	Puente de la Costa Sur	Clinical Director	watkins3121@gmail.com	
Family Member	Judith Schutzman ✓			judyschutzman@aol.com	✓
Family Member	Juliana Fuerbringer	California Clubhouse		julianafuer@gmail.com	
~~**Client/Consumer**~~	~~Kate Pfaff~~ R		MHSARC Commissioner	kate@redwoodgirl.com	
Provider of Social Services	Kava Tulua	One East Palo Alto and East Palo Alto Partnership for Mental Health Outreach		ktulua@1epa.org	
Public	Leticia Bido		MHSARC Commissioner	leticia.bido@gmail.com	
Cultural Competence & Diversity	Maria Lorente-Foresti ✓	Office of Diversity and Equity	Director	Mlorente-foresti@smcgov.org	✓
Law Enforcement	Mark Duri		MHSARC Commissioner	mduri@smcgov.org	
Provider of Social Services	Mary Bier ✓	North County Outreach Collaborative		marykbier@gmail.com	✓
Education	Mary McGrath	San Mateo County Office of Education, Safe and Supportive Schools	Admininstrator	mmcgrath@smcoe.org	
Provider of MH/SU Svcs	Melissa Platte ✓	Mental Health Association	Executive Director	melissap@mhasmc.org	✓
Family Member	Michael Krechevsky ✓	PREP/BEAM	Fmail	mkrechevsky@felton.org	✓
Client/Consumer- Adults	Michael Lim			mhl-lim@outlook.com	
Client/Consumer- Adults	Michael S. Horgan	Heart & Soul, Inc Mental Health Assn	Program Coordinator Community Wkr	michaelhorgan@me.com	
Family Member	Patricia Way ✓	MHSARC	MHSARC Commissioner	patway@hotmail.com	

MASTER LIST 04/22/19

Client/Consumer- Adults	Patrick Field			pfield3311@gmail.com	
Client/Consumer	Patrisha Ragins		MHSARC Commissioner	patrisharagins@yahoo.com	
Other- Peer Support	Ray Mills	Voices of Recovery	Executive Director	rmills@vorsmc.org	
Provider of Social Services	Rev. William Chester McCall	Multicultural Counseling & Education Services of the Bay Area		chester.wellness@gmail.com	
Client/ Consumer	Rodney Roddewig	MHSARC	MHSARC Commissioner	rrodney2k6@gmail.com	
Member	Sheila Brar		MHSARC Commissioner	sheila.nathan@gmail.com	
Provider of Social Services	Sheri Broussard	HIP Housing		sbroussard@hiphousing.org	
Provider of MH/SU Svcs	Stephanie Morales ✓	OASIS		smorales@smcgov.org	✓
Client/Consumer	Wanda Thompson		MHSARC Commissioner	w.thompson1967@yahoo.com	
Member	Yoko Ng		MHSARC Commissioner	Yng15@mail.ccsf.edu	
Family Member	Yolanda Novello	BHRS	Family Partner	YNovelo@smcgov.org	

04/22/19

MHSA Steering Committee 04/22/19

Name(s)	Affiliations (Board Member or Employee)	Title (If applicable)	Email	Signature
BROOK Pollard		Mental Health Clinician	brook.pollard@starvista.org	
Edith Arias		San Mateo County Resident	ariasedith870@	
Brenda Nuñez	StarVista		brenda.nunez@gmail.com	
Karina Chapa	StarVista		Karina.chapa@starvista	
Pernille Gutsklick	BHRS	Clinical Services Mgr	pgutsclick@smcgov.org	
Mona Cabada	BHRS	MFT II	MCabada@smcgov.org	
Dorice Loughery	BHRS		Dorice-James 2@	
Bruce Adams	Felton Early Psychosis	LMFT / Associate Director	badams@felton.org	
Darcy Frost	StarVista		darcyltrost@gmail.com	
Nargees Dillon	~	Dept Dir	narges.dillon@star-vista.org	
Alicia Vasquez	BHRS Intern			
Yolanda Ramirez	BHRS/OCFA	Family Education & Support	ymramirez@smcgov.org	

MHSA Steering Committee 04/22/19

Name(s)	Affiliations (Board Member or Employee)	Title (If applicable)	Email	Signature
Clarise Blanchard	Star Vista	Clinical Director	cblanchard@star-vista.org	
Lisa Purkey (They/Them)	SMC Pride Center	Program Director		
Vivian Valdez	Star Vista		vivianvaldez2002@gmail.com	
Pannel Schibuyt	Star Vista		pannel.t.schibuyt@gmail.com	
Florence Ye	Star Vista		florenceye2020@gmail.com	
YOSHIE HILL	Heart & Soul	Advocacy	yoshieh@heartandsoulinc.org	ann Yoshie Hill
Laura Wolff	Telecare	Regional Operations Director	lwolff@telecarecorp.com	
Jessica Castellanos	Starvista	Advocate	Castejillian@gmail.com	
Wayne Ruh	Copeland Center/OneNewLife	Interim CEO	wbroch@copelandcenter.com	
Claudia Saggese	OCTA	Director	csaggese@stanser.org	
Veronica Banco	Starvista		Vero.polanco@starvista	

APPENDIX 4: ANNUAL UPDATE FUNDING SUMMARY

FY 2018/19 Mental Health Services Act Annual Update
Funding Summary

County: San Mateo

Date: 1/27/19

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2018/19 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	20,223,066	3,005,647	6,765,522	0	0	0
2. Estimated New FY 2018/19 Funding	23,144,471	5,786,118	1,522,663	0	0	0
3. Transfer in FY 2018/19[a/]	0	0	0	500,000	0	0
4. Access Local Prudent Reserve in FY 2018/19	0	0	0	0	0	0
5. Estimated Available Funding for FY 2018/19	43,367,537	8,791,765	8,288,185	500,000	0	0
B. Estimated FY 2018/19 MHSA Expenditures	21,294,911	5,366,845	2,935,200	500,000	0	0
G. Estimated FY 2018/19 Unspent Fund Balance	22,072,626	3,424,920	5,352,985	0	0	0

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2018	600,000
2. Contributions to the Local Prudent Reserve in FY 2018/19	0
3. Distributions from the Local Prudent Reserve in FY 2018/19	0
4. Estimated Local Prudent Reserve Balance on June 30, 2019	600,000

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

FY 2018/19 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: San Mateo Date: 1/27/19

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Children and Youth	3,973,705	3,973,705	0	0	0	0
2. Transition Age Youth	2,662,910	2,662,910	0	0	0	0
3. Adults and Older Adults	4,789,067	4,789,067	0	0	0	0
4. Expansion - AOT FSPs	890,639	890,639	0	0	0	0
5. Expansion - Augmented Board and Care	1,100,000	1,100,000	0	0	0	0
6.	-		0	0	0	0
7.	-		0	0	0	0
8.	-		0	0	0	0
9.	-		0	0	0	0
10.	-		0	0	0	0
Non-FSP Programs			0	0	0	0
1. Community Outreach and Engagement	333,205	333,205	0	0	0	0
2. Criminal Justice Initiative	464,489	464,489	0	0	0	0
3. Older Adult System of Care	637,212	637,212	0	0	0	0
4. Co-Occurring Support Services	820,060	820,060	0	0	0	0
5. System Transformation	1,847,173	1,847,173	0	0	0	0
6. Peer and Family Supports	1,736,842	1,736,842	0	0	0	0
7. Expansion - Supports for Older Adults	130,000	130,000	0	0	0	0
8. Expansion - Coastside Wellness Center	450,000	450,000	0	0	0	0
9.	0		0	0	0	0
10.	0		0	0	0	0
CSS Administration	1,459,609	1,459,609	0	0	0	0
CSS Planning	0	0	0	0	0	0
CSS Evaluation	65,300	65,300	0	0	0	0
CSS MHSA Housing Program Assigned Funds	0	0	0	0	0	0
Total CSS Program Estimated Expenditures	21,294,911	21,294,911	0	0	0	0
FSP Programs as Percent of Total	63.0%					

FY 2018/19 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: San Mateo Date: 1/27/19

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Early Childhood Community Team	409,087	409,087	0	0	0	0
2. Community Interventions for School Age and TAY	653,065	653,065	0	0	0	0
3. Community Outreach and Capacity Building	437,471	437,471	0	0	0	0
4. Recognition of Early Signs of MI	10,000	10,000	0	0	0	0
5. Stigma, Discrimination and Suicide Prevention	148,174	148,174	0	0	0	0
6. Access & Linkage to Treatment	471,511	471,511	0	0	0	0
7.	-		0	0	0	0
8.	-		0	0	0	0
9.	-		0	0	0	0
PEI Programs - Early Intervention						
10. Early Onset of Psychotic Disorders	818,460	818,460	0	0	0	0
11. Primary Care/MH Integration	1,130,246	1,130,246	0	0	0	0
12. Youth Crisis Response and Prevention	118,246	118,246	0	0	0	0
13. Assessment and Referral Team (SMART)	145,000	145,000	0	0	0	0
14. Expansion - Early Onset of Psych Disorders After Care	230,000	230,000	0	0	0	0
15. Expansion - Crisis Intervention (expected 19/20)	0	0	0	0	0	0
16. Expansion - TIS Ages 0-25	150,000	150,000	0	0	0	0
17.	0		0	0	0	0
18.	0		0	0	0	0
19.	0		0	0	0	0
PEI Administration	514,456	514,456	0	0	0	0
PEI Assigned Funds - CalMHSA	131,129	131,129				
Total PEI Program Estimated Expenditures	5,366,845	5,366,845	0	0	0	0

FY 2018/19 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: San Mateo

Date: 1/27/19

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. LGBTQ Coordinated Services Center	767,000	767,000				
2. Health Amabassador Program - Youth	250,000	250,000				
3. NMT - Adults	78,000	78,000				
4. AB114 - Technology Collaborative	1,700,000	1,700,000				
5. Evaluation	140,200	140,200				
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	0					
Total INN Program Estimated Expenditures	2,935,200	2,935,200	0	0	0	0

FY 2018/19 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: San Mateo Date: 1/27/19

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and Technical Assistance	160,000	160,000				
2. Behavioral Health Career Pathways	20,000	20,000				
3. Cultural Competence Stipend Internship Program (CCSIP)	60,000	60,000				
4.	-					
5.	-					
6.	-					
7.	-					
8.	-					
9.	-					
10.	-					
11.	-					
12.	-					
13.	-					
14.	-					
15.	-					
16.	-					
17.	-					
18.	-					
19.	-					
20.	-					
WET Administration	260,000	260,000				
Total WET Program Estimated Expenditures	500,000	500,000	0	0	0	0

FY 2018/19 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: San Mateo

Date: 2/14/17

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0

APPENDIX 5: FULL SERVICE PARTNERSHIPS FY 16/17 ANNUAL OUTCOME REPORT

AIR®

AMERICAN INSTITUTES FOR RESEARCH®

Full Service Partnership (FSP) Outcomes

Findings from 2016-2017 Fiscal Year

Elizabeth Mokyr Horner, PhD, MPP

Yi Lu, PhD

Yongqiu Chen, MPA

APR 2018

Full Service Partnership (FSP) Outcomes

Findings from 2016-2017 Fiscal Year

Apr 2018

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Contents

Executive Summary

Full Service Partnerships (FSPs) are a set of enhanced, integrated services administered through San Mateo County contracted providers to assist individuals with mental and behavioral health challenges. American Institutes for Research (AIR) is working with San Mateo County ("the County") to understand how enrollment in an FSP promotes resiliency and improved health outcomes of individuals living with mental illness served by an FSP (hereafter referred to as "partners").

This report shows outcomes for child, transitional age youth (TAY), adult, and older adult clients (hereafter referred to as "partners") of the Full Service Partnership (FSP) program in San Mateo County using FSP program survey data and Avatar data, San Mateo County's electronic health records (EHR) system.

Exhibit 1, below, presents the percent improvement between the year just prior to FSP and the first year with FSP, by age group. Percent improvement is the percent change in the percent of partners with any events. For example, the percent of child partners experiencing homelessness changed from 6.7% before FSP to 5.2% in the first year with FSP, a 22% improvement.

In sum, the findings from self-reported outcomes (survey data) suggest that the vast majority of the outcomes improve (22 of 24 outcomes) for all reported age groups. As can be seen in Exhibit 1, there are improvements comparing the year prior to FSP to the first year of FSP for partners in all age groups for the following self-reported outcomes: homelessness, arrests mental health emergencies, and physical health emergencies. In addition, for children and TAY partners, school suspensions decrease, and for adult partners, the percent with any employment increases. Further, children also experience improvements to their school attendance and grade ratings, and a reduction in arrests. Finally, the percent of TAY and adult partners with an episode of detention or incarceration decreases.

However, there are three outcomes for which there is no improvement. First, the attendance ratings for TAY partners, and second, grade ratings for TAY partners both remain stagnant (a 4% decrease and 1% improvement, respectively). Third, the proportion of children who are incarcerated increases on the first year of FSP. However, the increase in incarceration is relatively small (26 in the first year with FSP compared to 21 in the year just prior) when compared to the decrease in arrests (8 in the first year with FSP compared to 24 in the year just prior) among child partners.

Moreover, the main finding from the hospitalization outcomes (EHR data) is that enrollment in a FSP program is associated with a reduction in hospital and psychiatric emergency service (PES) use for all cohorts. Specifically, compared to the year before joining an FSP, there are reductions in the percent of partners with any hospitalization, mean hospital days per partner, percent of partners using any PES, and mean PES event per partner. These reductions are consistently observed over the years since the inception of the FSP program.

Exhibit 1: Percent Improvement in Outcomes by Age Group, Year before FSP Compared with First Year with FSP

FSP Outcomes*	Child (16 years & younger)	TAY (17 to 24 years)	Adult (25 to 59 years)	Older adult (60 years & older)
Self-reported Outcomes (Survey data)				
Homelessness	22%	7%	28%	NR
Detention or Incarceration	(24%)	16%	30%	NR
Arrests	67%	65%	87%	NR
Mental Health Emergencies	89%	67%	57%	42%
Physical Health Emergencies	100%	88%	65%	29%
School Suspensions	47%	72%	NR	NR
Attendance Ratings	10%	(4)%	NR	NR
Grade Ratings	14%	1%	NR	NR
Employment	NR	NR	26%	NR
Healthcare Utilization (EHR data)				
Hospitalization	56%	24%	48%	54%
Mean hospital days per partner	56%	30%	24%	50%
Psychiatric Emergency Services (PES)	64%	41%	67%	7%
Mean PES admissions per partner	53%	20%	34%	58%

Hospitalization Outcomes	Overall	Range (Partnerships Beginning 2006 – 2015)
Healthcare Use (EHR data, N= 667)		
Partners with Hospitalizations	45%	21% – 65%
Mean Hospital Days	59%	(14%) – 83%
Partners with PES	32%	13% – 52%
Mean PES Events	34%	12% – 64%

* With the exception of attendance and grade ratings, the table above indicates the percent change in the percent of partners with any events, comparing the year just prior to FSP with the first year on FSP. Percent change in ratings indicates the change in the average rating for the first year on the program as compared to the year just prior to FSP. Value of NR means a change is not reported due to insufficient sample size.
** These outcomes are presented overall for all clients as well as by year of partnership; the range presented is from the lowest to highest percent changes among the calendar years.

Background and Introduction

The Mental Health Services Act (MHSA) was enacted in 2005 and provides a dedicated source of funding to improve the quality of life for individuals living with mental illness; a large component of this work is accomplished through Full Service Partnerships (FSP). FSP programs provide individualized integrated services, flexible funding, intensive case management, and 24-hour access to care ("whatever it takes" model) to help seriously mentally ill adults, children, transition-age youth and their families on their path to recovery and wellness. In San Mateo County (the County) there are currently four comprehensive FSP providers, Edgewood Center and Fred Finch Youth Center serve children, youth and transition age youth and Caminar and Telecare serve adults and older adults.

As part of San Mateo County's implementation and evaluation of the FSP programs, American Institutes for Research (AIR) is working with the County to understand how enrollment in the FSP is promoting resiliency and improved health outcomes of County's clients living with a mental illness.

This memo reports on outcomes for clients (hereafter referred to as "partners") of the Full Service Partnership (FSP) program in San Mateo County, who were served by Edgewood, Fred Finch, Caminar, and Telecare. The data used for this report are collected by providers via self-report from the partners as well as electronic health records (EHR) data obtained through the County's Avatar system.

Initial survey data are collected via an intake assessment, called the Partnership Assessment Form (PAF), which includes information on wellbeing across a variety of measures (e.g., residential setting), at the start of FSP and over the twelve months just prior. While a partner, survey data on partners is gathered in two ways. Life changing events are tracked by Key Event Tracking (KET) forms, which are triggered by any key event (e.g., a change in residential setting). Partners are also assessed regularly with Three Month (3M) forms. Changes in partner outcomes are gathered by comparing data on PAF forms to data compiled from KET and 3M forms.

EHR data collected through the SMC Avatar system contain longitudinal partner-level information on partner demographics, FSP program participation, hospital stays and PES uses before and after the enrollment date within the SMC health system. The Avatar system is limited to individuals who obtain care in the San Mateo county health system. Hospitalizations outside of San Mateo County, or in private hospitals, are not captured.

The following report will explore how the first year with FSP differs from the year just prior to joining the FSP program, for child, transitional age youth (TAY), adult, and older adult individuals who complete at least one full year with FSP. Then, we present trends in EHR data overall and over time, by year of FSP program enrollment.

Appendix A presents additional detail on each survey outcome. Outcomes for individual FSP providers can be found in Appendix B. Details on our methodology for both the FSP outcomes and hospitalization outcomes can be found in Appendix C.

Outcomes for Child Partners

The following section presents outcomes for the 134 child (aged 16 and younger) FSP partners.

1. **Partners with any reported homelessness incident:** measured by residential setting events of homelessness or emergency shelter (PAF and KET)
2. **Partners with any reported detention or incarceration incident:** measured by residential setting events of Department of Juvenile Justice, Juvenile Hall, Jail, or Prison (PAF and KET)
3. **Partners with any reported arrests:** measured by arrests in past 12 months (PAF) and date arrested (KET)
4. **Partners with any self-reported mental health emergencies:** measured by emergencies in past 12 months (PAF) and date of mental health emergency (KET)
5. **Partners with any self-reported physical health emergencies:** measured by emergencies in past 12 months (PAF) and date of acute medical emergency (KET)
6. **Partners with any reported suspensions**: measured by suspensions in past 12 months (PAF) and date suspended (KET)
7. **Average school attendance ranking**: an ordinal ranking (1-5) indicating overall attendance; measured for past 12 months (PAF), at start of FSP (PAF), and over time on FSP (3M)
8. **Average school grade ranking**: an ordinal ranking (1-5) indicating overall grades; measured for past 12 months (PAF), at start of FSP (PAF), and over time on FSP (3M)

Note that employment is not presented for this cohort because it is not relevant for this age group. The results below compare the first year on FSP to the year just prior to FSP for partners completing at least one year of FSP.

For a visual description on how these outcomes change over a longer partnership duration, see Appendix A. For additional details on outcomes broken apart by FSP providers, see Appendix B. For details on the methodological approach, see Appendix C.

This report also presents the four hospitalization outcomes for the 185 child partners using the Avatar system (EHR):

1. **Partners with any hospitalizations:** measured by any hospital admission in the past 12 months
2. **Partners with any PES:** measured by any PES event in the past 12 months
3. **Average length of hospital stay (in days):** the number of days associated with a hospital stay in the past 12 months;
4. **Average number of PES event:** the number of PES events in the past 12 months.

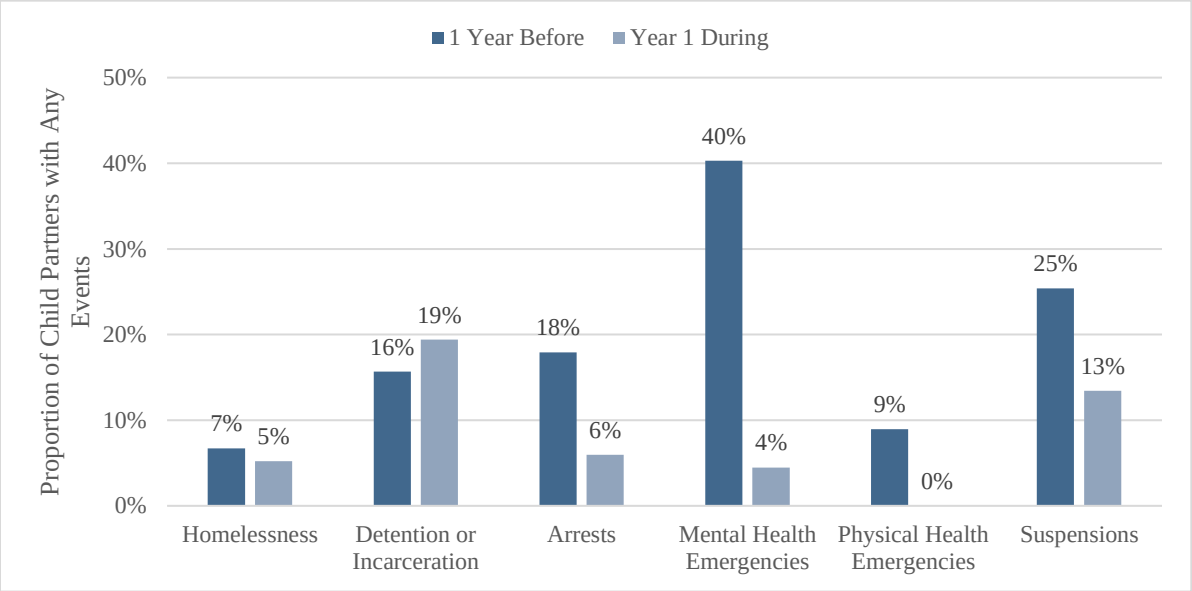
*Note that the difference in the number of partners across the data sources is due to the difference in age group definition (see Appendix C) and not every partner has a health care record in the County's EHR system.

Results

Exhibit 2 shows the comparison of outcomes in the year prior to FSP to the first year on the program for child partners. As can be seen, homelessness decreases. In addition, though there is a small increase in the percentage of partners who had any incarceration incident the percentage of partners with arrests decreases. However, the increase in incarceration is relatively small (26

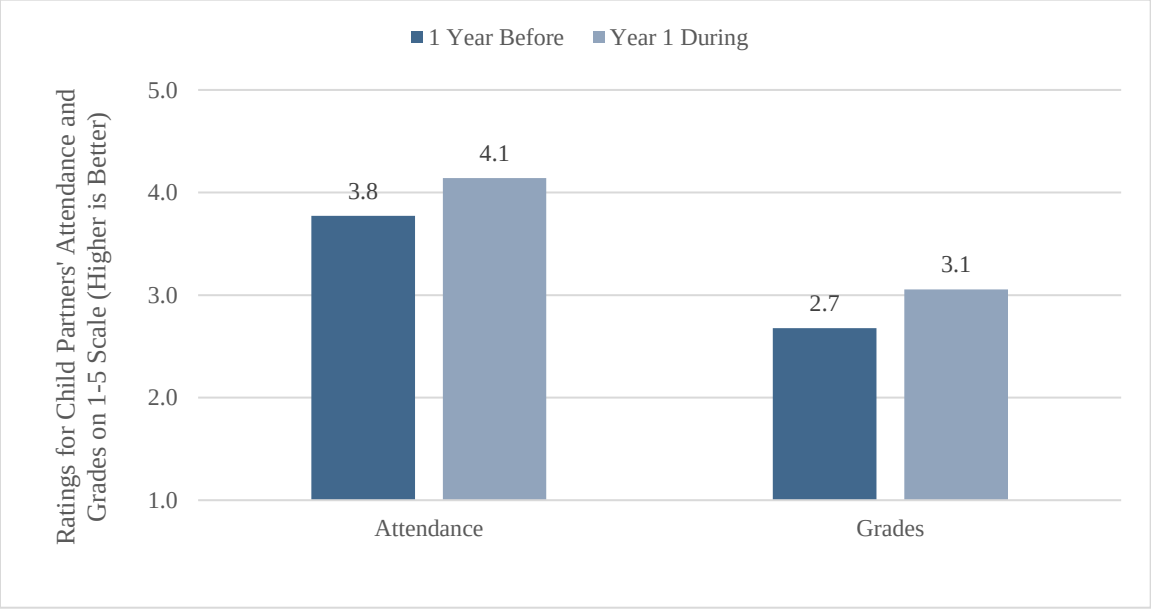
in the first year with FSP compared to 21 in the year just prior) when compared to the decrease in arrests (8 in the first year with FSP compared to 24 in the year just prior) among child partners. The percentage of partners with self-reported mental health and physical health emergencies decreases. Finally, there is a reduction in the percentage of child partners getting suspended from school.

Exhibit 2: Outcomes for Child Partners Completing One Year with FSP (n = 134)



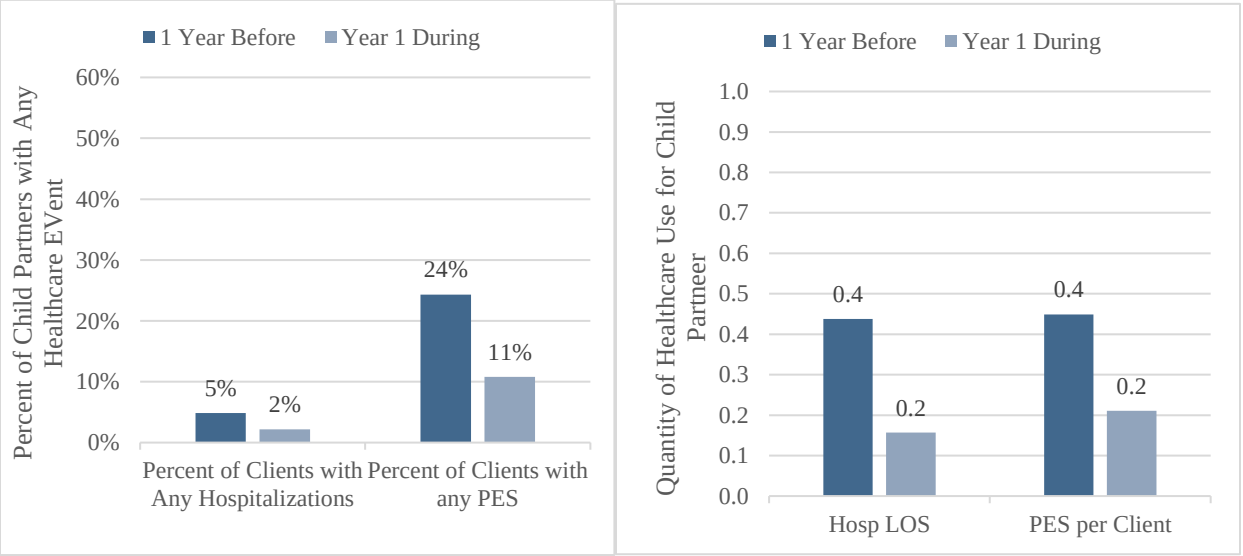
Outcomes on school attendance and grades are presented below in Exhibit 3. As can be seen, attendance and grades for child partners improve modestly. Recall that these ratings are on a 1-5 scale, coded such that a higher score is better.

Exhibit 3: School Outcomes for Child Partners Completing One Year with FSP (n = 134)



Hospitalization outcomes are presented in Exhibit 4. The percent of child partners with any hospitalization or PES event decreases after joining FSP. The mean number of hospital days experienced by FSP partners, as well as the average number of PES events decreases after FSP enrollment.

Exhibit 4: Hospitalization Outcomes for Child Partners Completing One Year with FSP (n = 185)



Outcomes for TAY Partners

The following section presents outcomes for the 203 TAY (aged 17 - 25) FSP partners.

1. **Partners with any reported homelessness incident:** measured by residential setting events of homelessness or emergency shelter (PAF and KET)
2. **Partners with any reported detention or incarceration incident:** measured by residential setting events of Department of Juvenile Justice, Juvenile Hall, Jail, or Prison (PAF and KET)
3. **Partners with any reported arrests:** measured by arrests in past 12 months (PAF) and date arrested (KET)
4. **Partners with any self-reported mental health emergencies:** measured by emergencies in past 12 months (PAF) and date of mental health emergency (KET)
5. **Partners with any self-reported physical health emergencies:** measured by emergencies in past 12 months (PAF) and date of acute medical emergency (KET)
6. **Partners with any reported suspensions***: measured by suspensions in past 12 months (PAF) and date suspended (KET)
7. **Average school attendance ranking***: an ordinal ranking (1-5) indicating overall attendance; measured for past 12 months (PAF), at start of FSP (PAF), and over time on FSP (3M)
8. **Average school grade ranking***: an ordinal ranking (1-5) indicating overall grades; measured for past 12 months (PAF), at start of FSP (PAF), and over time on FSP (3M)

* The 29 TAY in Telecare and Caminar are excluded from these outcomes because these providers do not reliably gather outcomes related to school attendance. Note that employment as an outcome is not presented for this cohort because many of these individuals are in school.

The results below compare the first year on FSP to the year just prior to FSP for partners completing at least one year of FSP. For a visual description on how these outcomes change over a longer partnership duration, see Appendix A. For additional details on outcomes broken apart by FSP providers, see Appendix B. For details on the methodological approach, see Appendix C.

This report also presents the four hospitalization outcomes for the 145 TAY partners using the Avatar system (EHR):

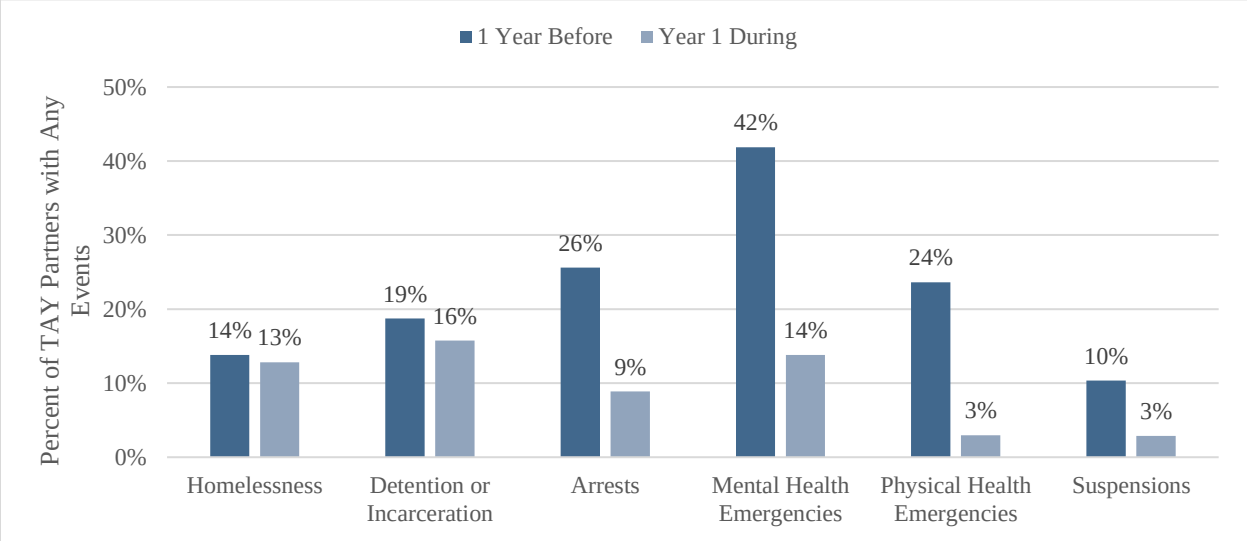
1. **Partners with any hospitalizations:** measured by any hospital admission in the past 12 months
2. **Partners with any PES:** measured by any PES event in the past 12 months
3. **Average length of hospital stay (in days):** the number of days associated with a hospital stay in the past 12 months;
4. **Average number of PES event:** the number of PES events in the past 12 months.

*Note that the difference in the number of partners across the data sources is due to the difference in age group definition (see Appendix C) and not every partner has a health care record in the County's EHR system.

Results

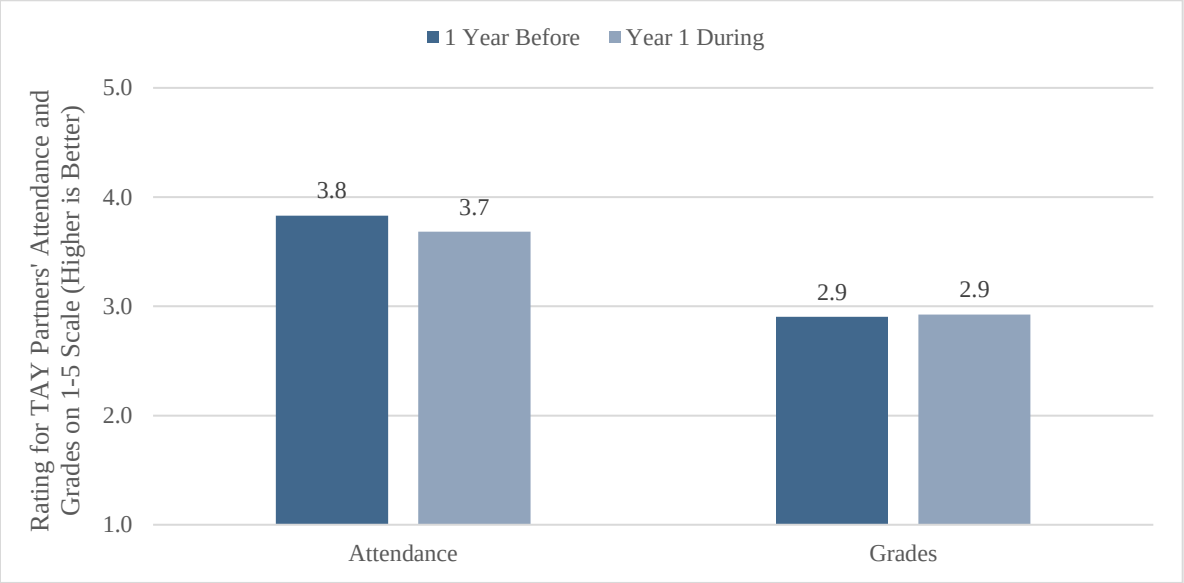
Results for TAY are presented below in Exhibit 5. The percentage of partners with days spent homeless decrease modestly. There are decreases across the other major outcomes: partners with incarceration incidents, arrests, self-reported mental and physical health emergencies, and suspensions. Note that the TAY sample for suspensions excludes the 29 Caminar and Telecare TAYs and the resulting number of partners is 174.

Exhibit 5: Outcomes for TAY Partners Completing One Year with FSP (n = 203)



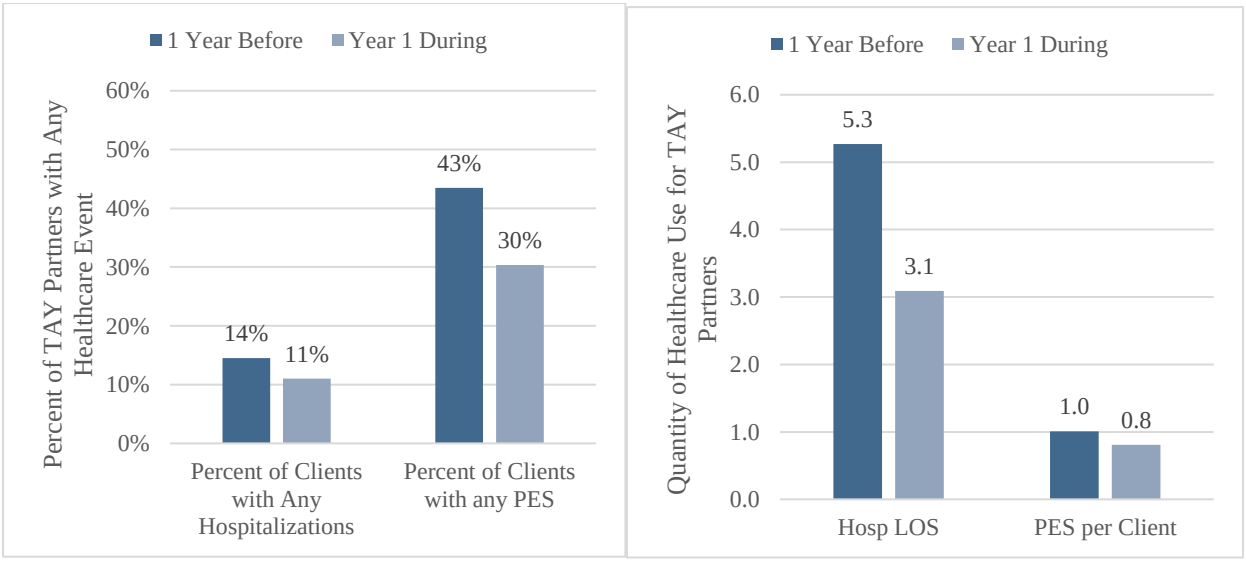
Outcomes on school attendance and grades are presented in Exhibit 6. Attendance and grades for TAY partners change very little. These ratings are on a 1-5 scale; a higher score is better.

Exhibit 6: School Outcomes for TAY Partners Completing One Year with FSP (n = 174)



Hospitalization outcomes are presented in Exhibit 7. The percent of TAY partners with any hospitalization or PES event decreases after joining FSP. The mean number of hospital days experienced by FSP partners, as well as the average number of PES events decreases after FSP enrollment.

Exhibit 7: Hospitalization Outcomes for TAY Partners Completing One Year with FSP (n = 145)



Outcomes for Adults

The following section presents outcomes for the 310 adult (aged 26-59) FSP partners.

1. **Partners with any reported homelessness incident:** measured by residential setting events of homelessness or emergency shelter (PAF and KET)
2. **Partners with any reported detention or incarceration incident:** measured by residential setting events of Jail or Prison (PAF and KET)
3. **Partners with any reported arrests:** measured by arrests in past 12 months (PAF) and date arrested (KET)
4. **Partners with any self-reported mental health emergencies:** measured by emergencies in past 12 months (PAF) and date of mental health emergency (KET)
5. **Partners with any self-reported physical health emergencies:** measured by emergencies in past 12 months (PAF) and date of acute medical emergency (KET)
6. **Partners with any reported employment**: measured by employment in past 12 months (PAF) and date employment change (KET)

Note that school outcomes are not presented for this cohort because it is not relevant for this age group.

Again, the results below compare the first year on FSP to the year just prior to FSP for partners completing at least one year of FSP. For a visual description on how these outcomes change over a longer partnership duration, see Appendix A. For additional details on outcomes broken apart by FSP providers, see Appendix B. For details on the methodological approach, see Appendix C. This report also presents the four hospitalization outcomes for the 294 adult partners using the Avatar system (EHR):

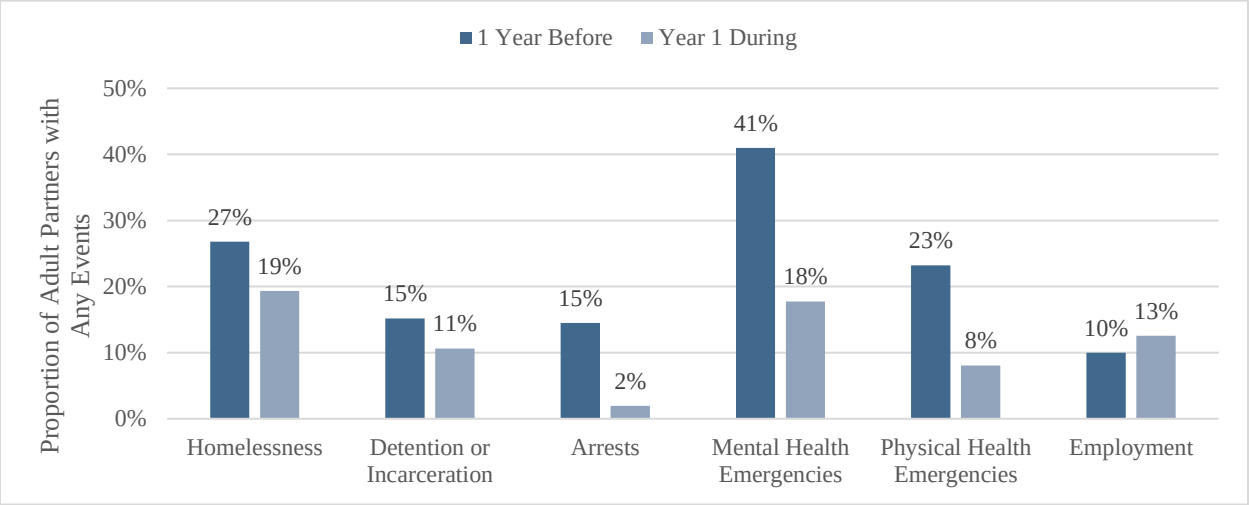
1. **Partners with any hospitalizations:** measured by any hospital admission in the past 12 months
2. **Partners with any PES:** measured by any PES event in the past 12 months
3. **Average length of hospital stay (in days):** the number of days associated with a hospital stay in the past 12 months;
4. **Average number of PES event:** the number of PES events in the past 12 months.

*Note that the difference in the number of partners across the data sources is due to the difference in age group definition (see Appendix C) and not every partner has a health care record in the County's EHR system.

Results

First, please find the comparison of outcomes in the year prior to FSP to the first year on the program for adult partners in Exhibit 8. Homelessness, incarceration, arrests, as well as self-reported mental and physical health emergencies all decrease. In addition, employment increases.

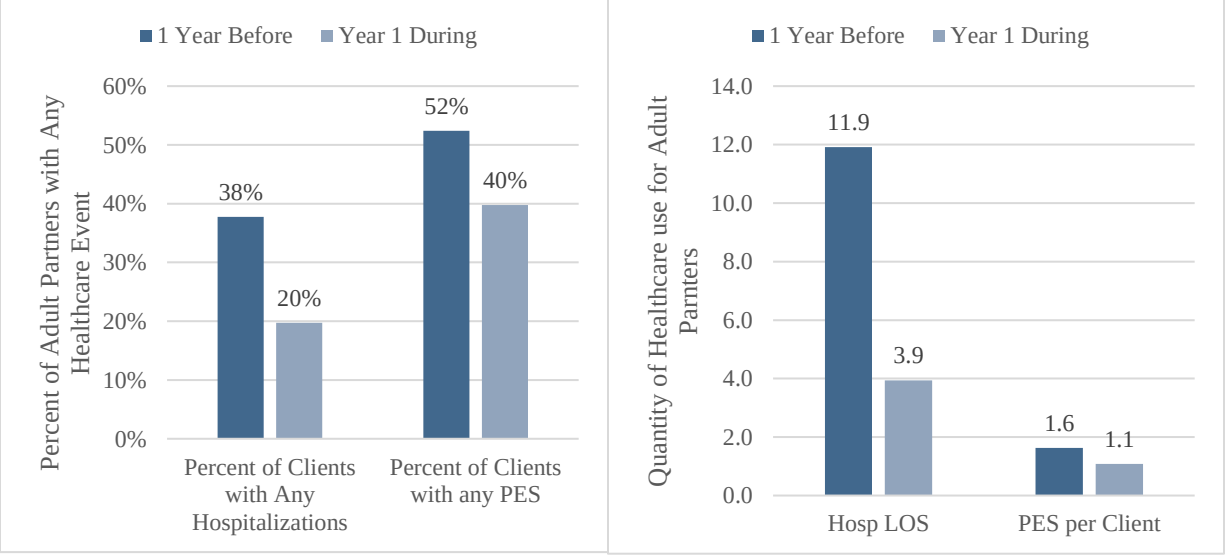
Exhibit 8: Outcomes for Adult Partners Completing One Year with FSP (n = 310)



Hospitalization outcomes are presented in Exhibit 9. The percent of adult partners with any hospitalization or PES event decreases after joining FSP. The mean number of hospital days experienced by FSP partners, as well as the average number of PES events decreases after FSP enrollment.

Among all age groups, Adults partners experienced the greatest percentage point reduction from 38% of partners with any hospitalization before FSP decreasing to 20% during FSP. Among all age groups, adults experienced the greatest changes from 11.9 days before FSP decreasing to 3.9 days during FSP."

Exhibit 9: Hospitalization Outcomes for Adult Partners Completing One Year with FSP (n = 294)



Outcomes for Older Adults

The following section presents outcomes for the 54 adult (aged 60 and older) FSP partners.

1. **Partners with any reported mental health emergencies:** measured by emergencies in past 12 months (PAF) and date of mental health emergency (KET)
2. **Partners with any reported physical health emergencies:** measured by emergencies in past 12 months (PAF) and date of acute medical emergency (KET)

Note that school outcomes are not presented for this cohort because it is not relevant for this age group. In addition, employment, homelessness, incarceration, and arrest outcomes are not presented for older adults, as there are insufficient observations in this age group for meaningful interpretation (i.e., there are less than 5 older adult partners total with any of these events).

This report also presents the four hospitalization outcomes for the 43 older adults using the Avatar system (EHR):

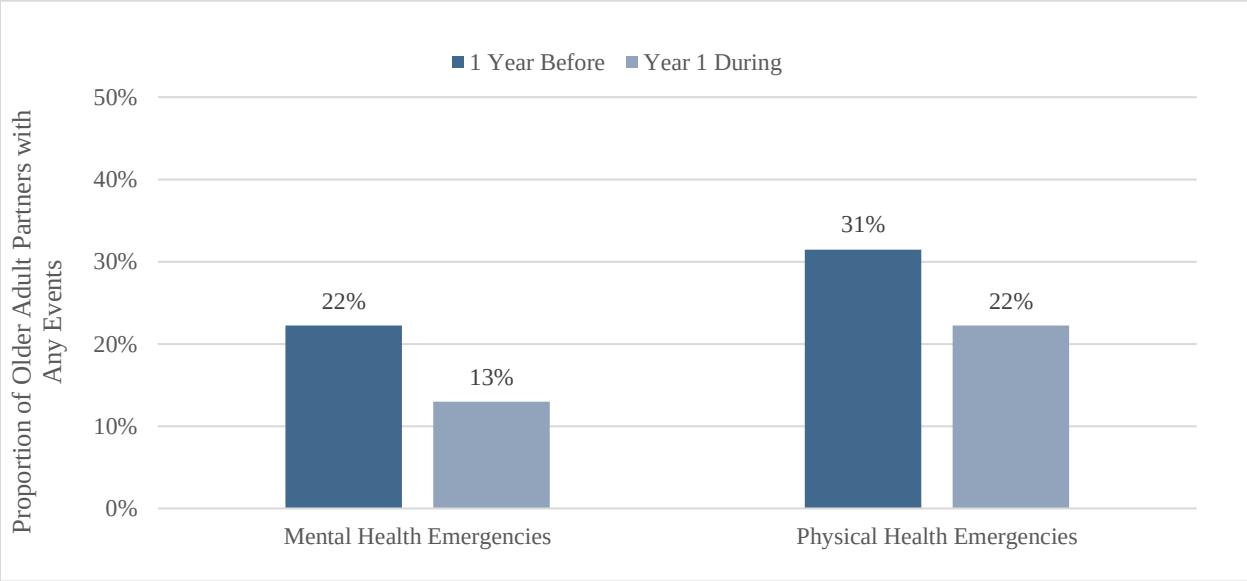
1. **Partners with any hospitalizations:** measured by any hospital admission in the past 12 months
2. **Partners with any PES:** measured by any PES event in the past 12 months
3. **Average length of hospital stay (in days):** the number of days associated with a hospital stay in the past 12 months;
4. **Average number of PES event:** the number of PES events in the past 12 months.

*Note that the difference in the number of partners across the data sources is due to the difference in age group definition (see Appendix C) and not every partner has a health care record in the County's EHR system.

Results

Next, below in Exhibit 10, please find the comparison of outcomes in the year prior to FSP to the first year on the program for older adult partners. Similar to adult partners, self-reported mental and physical health emergencies also decrease.

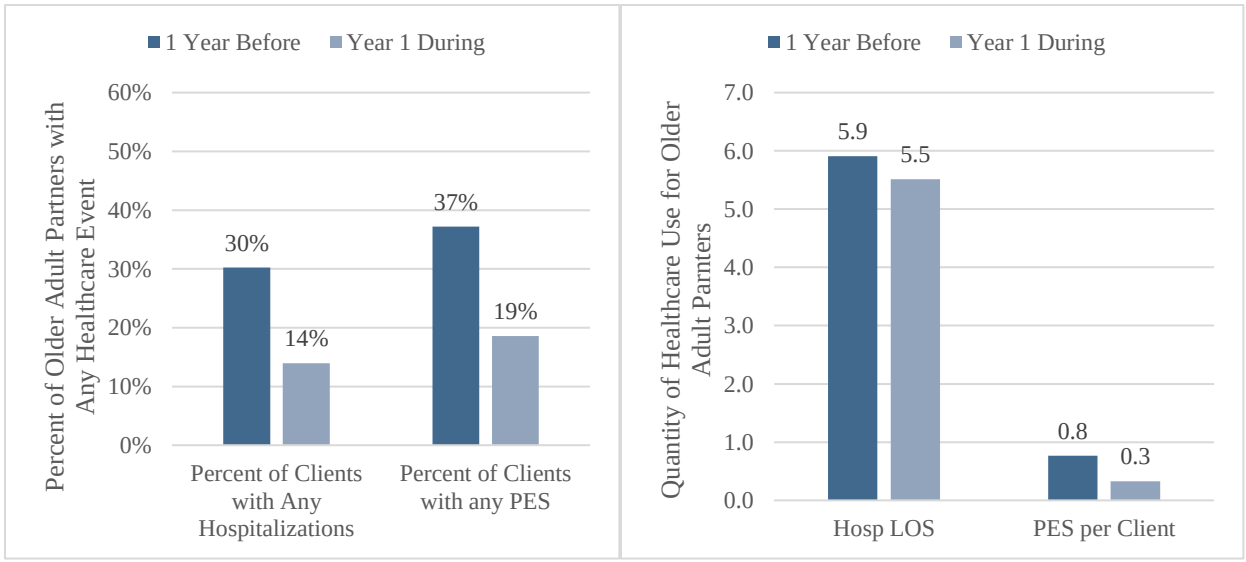
Exhibit 10: Outcomes for Older Adult Partners Completing One Year with FSP (n = 54)



Hospitalization outcomes are presented in Exhibit 11. The percent of older adult partners with any hospitalization or PES event decreases after joining FSP. The mean number of hospital days experienced by FSP partners, as well as the average number of PES events decreases after FSP enrollment.

Among all age groups, older adults experienced the greatest percentage point reductions; 37% of partners had a PES event before FSP compared to 19% during FSP. Among all age groups, adults and older adults experienced similar decreases of 0.5 events per partner before compared to during FSP.

Exhibit 11: Hospitalization Outcomes for Older Adult Partners Completing One Year with FSP (n = 43)



Hospitalization Outcomes Overall and Over Time

We detected statistically significant changes in outcomes from the year before FSP compared to the first year in FSP for all FSP partners. (Exhibit 12) Percent of partners with any hospitalization decreased from 23% before FSP to 13% during FSP. Days in the hospital decreased from 6.97 days before FSP to 2.86 days during FSP. Percent of partners with any psychiatric emergency services (PES) decreased from 42% before FSP to 29% during FSP. The average number of PES events decreased from 1.13 events before FSP to 0.74 events during FSP.

Exhibit 12: FSP Partners Have Significantly Improved Hospitalization Outcomes (n=623)

	Mean	95% Confidence Interval
Percent of Partners with Any Hospitalization*		
1 Year Before	23%	(20% - 26%)
Year 1 During	13%	(10% - 15%)
Mean Number of Hospital Days, per Partner*		
1 Year Before	6.90	(5.50 - 8.30)
Year 1 During	2.81	(1.91 - 3.70)
Percent of Partners with any PES Event*		
1 Year Before	42%	(38% - 45%)
Year 1 During	28%	(25% - 32%)
Mean PES Events, per Partner*		
1 Year Before	1.11	(0.95 - 1.28)
Year 1 During	0.73	(0.59 - 0.87)

*Results are statistically significant at the 95% level

Exhibit 13-16 show the four hospitalization outcomes, stratified by enrollment year. As can be seen in Exhibit 13, the percent of partners with any hospitalization decreased after joining an FSP program for all cohorts.

Exhibit 13: Percent of Partners with Any Hospitalization over Time

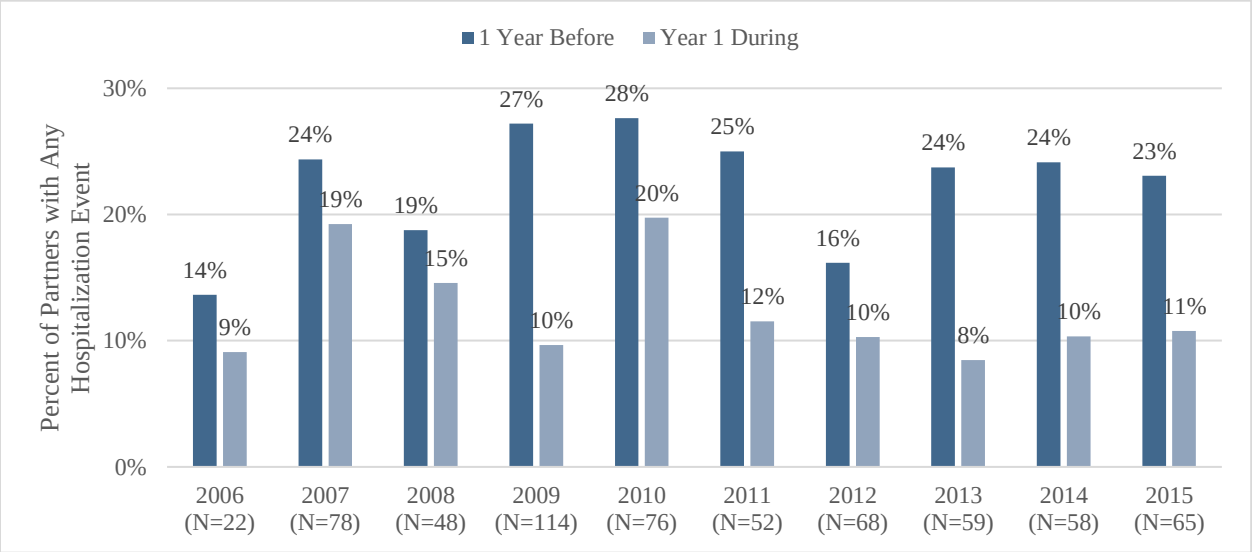


Exhibit 14 displays the mean hospital days per partner. With the exception of 2006 and 2007 cohorts, most partners experienced decreases in the mean number of hospital days.

Exhibit 14: Mean Number of Hospital Days over Time

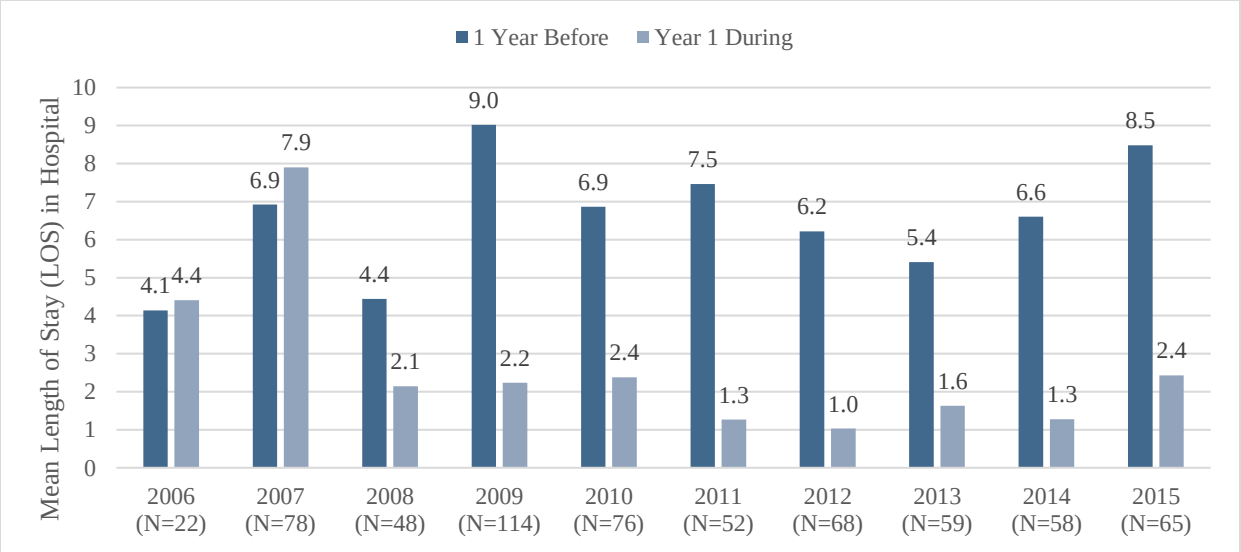
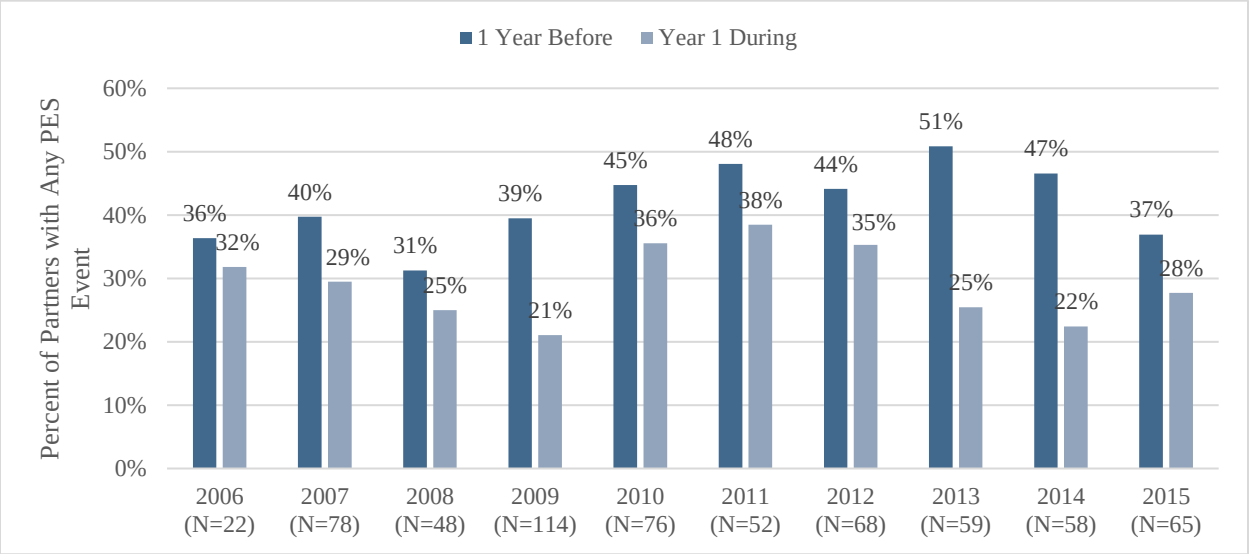


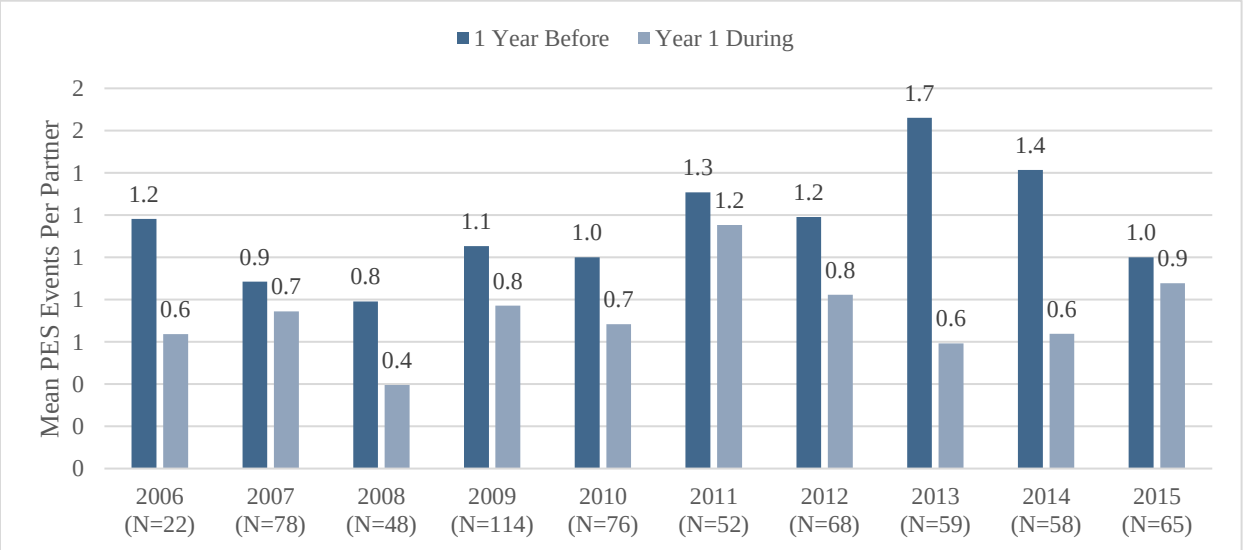
Exhibit 15 displays the percent of partners with any PES event by the year they began FSP. All cohorts experienced a decline in the likelihood of a PES event.

Exhibit 15: Percent of Partners with any PES Event over Time



Finally, Exhibit 16 displays the mean PES events per partner. Again, all cohorts experienced a reduction in PES events.

Exhibit 16: Mean PES Events over Time



Appendix A: Additional Detail on Survey Outcomes

This section provides more details on the results presented above. To show more granular outcomes for groups of individuals large enough to interpret, here we combine child with TAY partners and adult with older adult partners, except where explicitly noted. No outcomes are presented for any group of partners with 50 or fewer individuals.

Residential Setting

For residential setting outcomes (Exhibit A1-A2), we present all the categories of living situations and compare the percentages of partners spending any time in various residential settings the year prior to FSP and in the first year. A list of all residential settings and how they are categorized, is presented in Appendix C with the methodological approach.

First, Exhibit A1 presents the percentage of child and TAY partners spending any time in various residential settings. As can be seen, there are decreases in the percentage of clients with events in nearly all of the residential settings (except living alone or with others, paying rent).

Exhibit A1: Any Time in Residential Setting - Child and TAY Partners Completing 1 Year (n = 337)

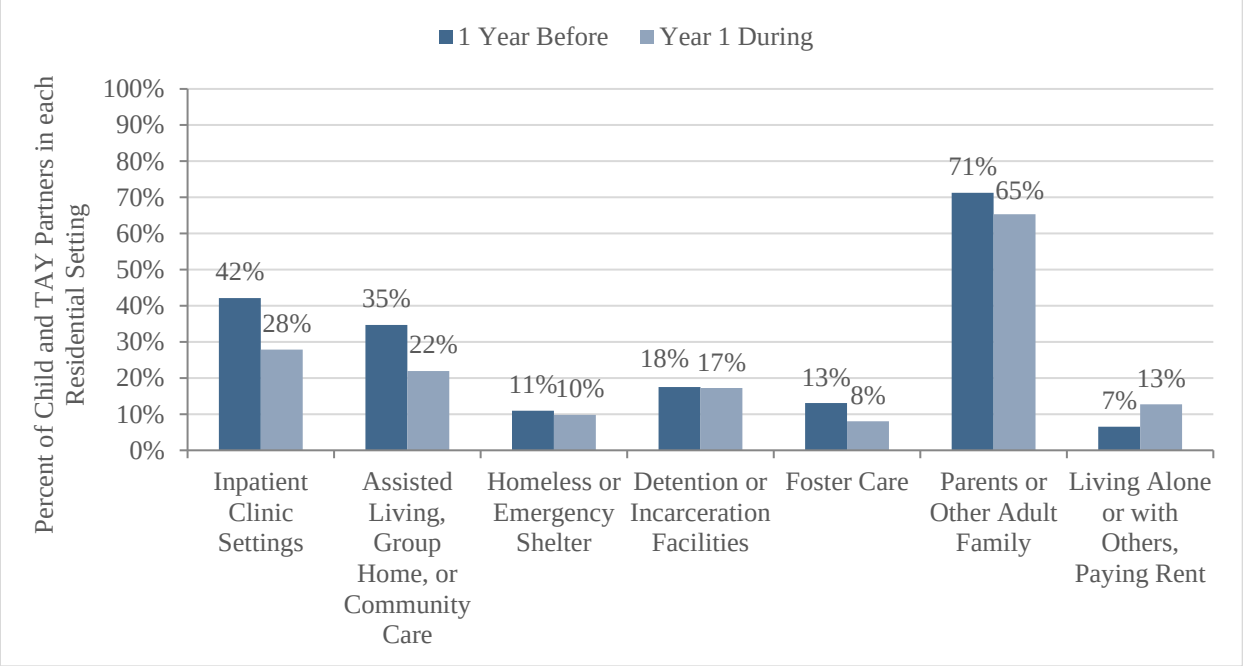
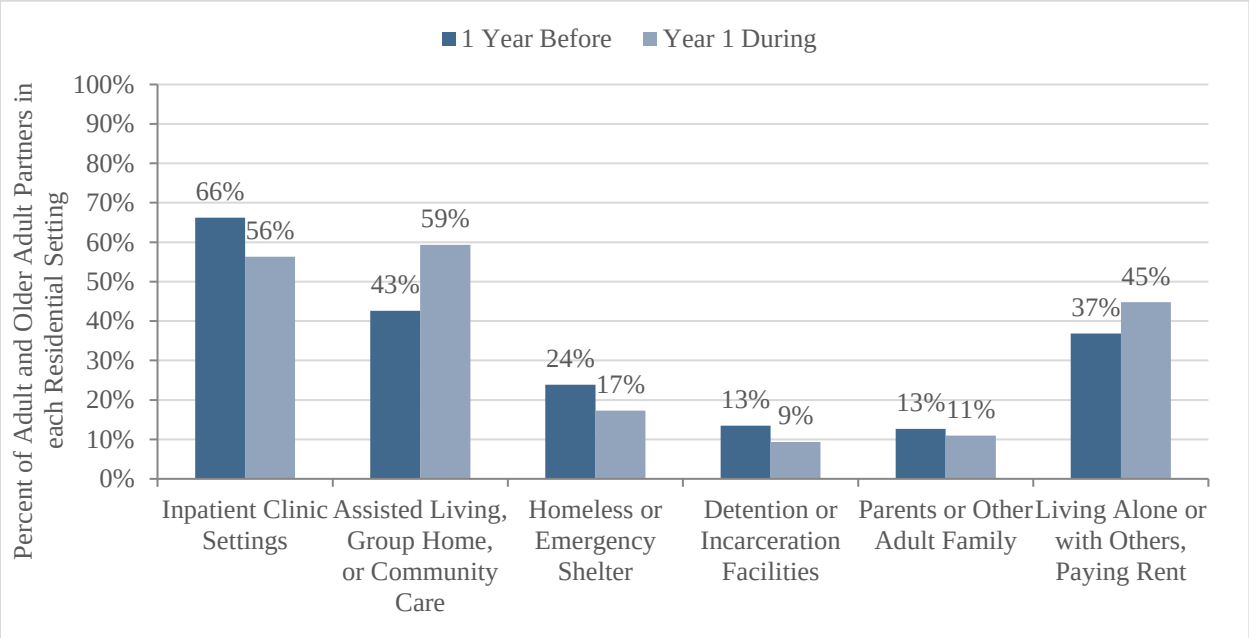


Exhibit A2 presents the residential settings for adult and older adult clients. As can be seen, the percent of clients reporting any time in an inpatient clinic, homeless, incarcerated, or living with parents decreases. In contrast, the percent living in an assisted living, group home, or community care environment, or living alone or with others, paying rent increases.

Exhibit A2: Any Time in Residential Settings – Adult and Older Clients Completing 1 Year (n = 357)



For outcomes of arrests, mental health emergencies, physical health emergencies, school and employment (Exhibit A3-A12), we present the results broken down by the number of years of partnership.

Arrests

Exhibit A3 presents the percentage of child and TAY partners with any arrests, broken down by tenure with FSP and year of program. Arrests are more common among child and TAY partners the year prior to FSP than in the first year. Gains are maintained across additional FSP years.

Exhibit A3: Any Arrests – Child and TAY Partners

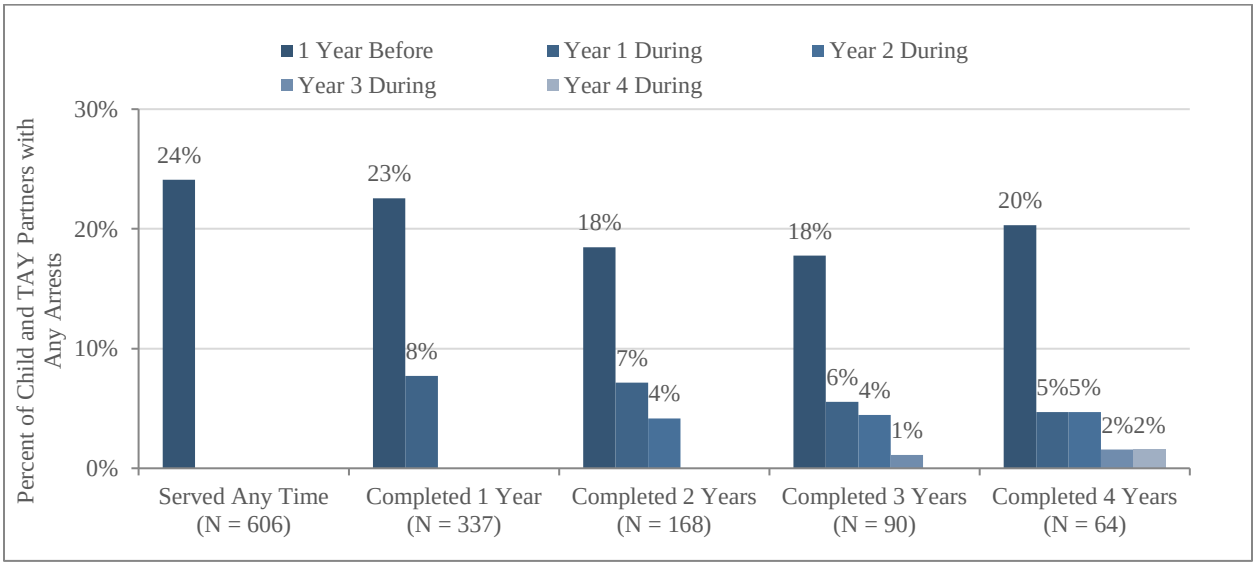
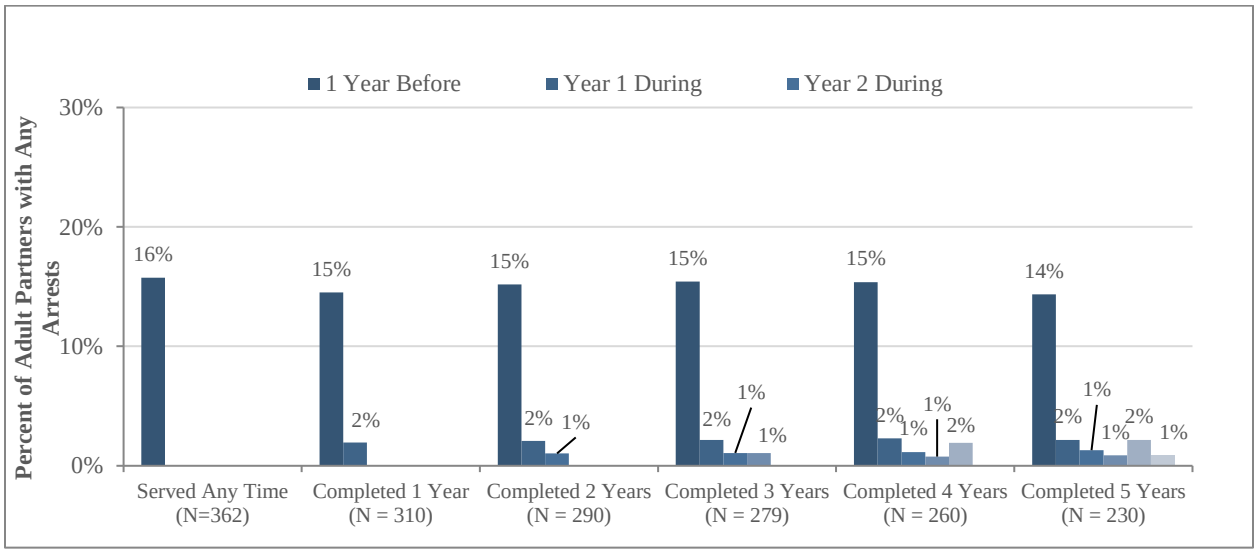


Exhibit A4 presents the percentage of adult partners with any arrests, broken down by tenure with FSP and year of program. Older adults are not included in these analyses because of insufficient observations with any arrests. As can be seen, arrests are more common among adult partners the year prior to FSP than in the first year. Gains are maintained across additional FSP years.

Exhibit A4: Any Arrests – Adult Partners



Self-reported Mental Health Emergencies

Exhibit A5 presents the percentage of child and TAY partners with any self-reported mental health emergencies, broken down by tenure with FSP and year of program. As can be seen, mental health emergencies as measured by self-report are more common among child and TAY partners the year prior to FSP than in the first year. Gains are maintained across additional FSP years.

Exhibit A5: Mental Health Emergencies – Child and TAY Partners

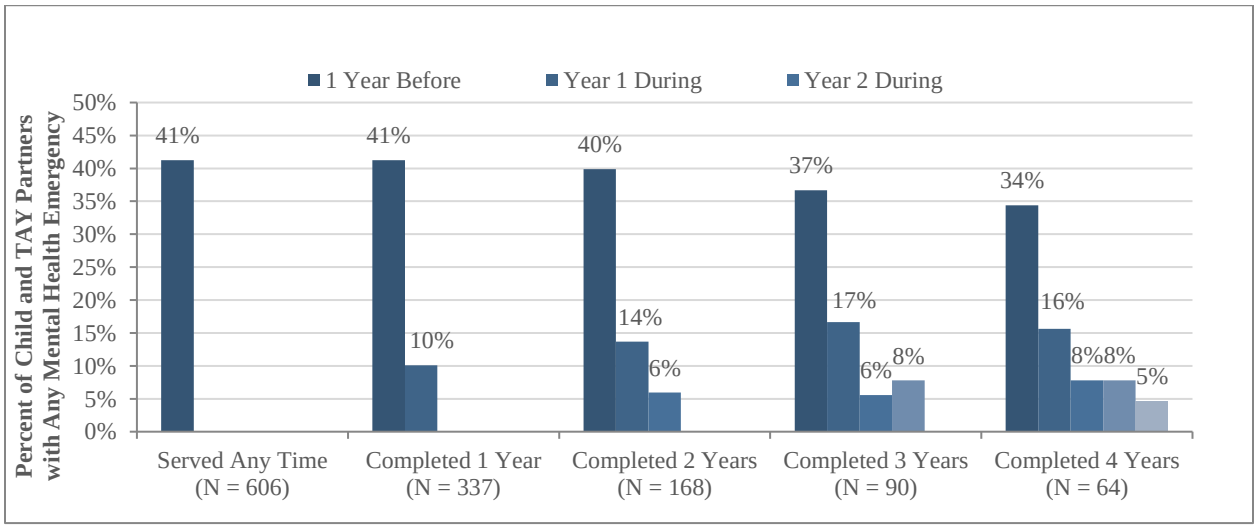
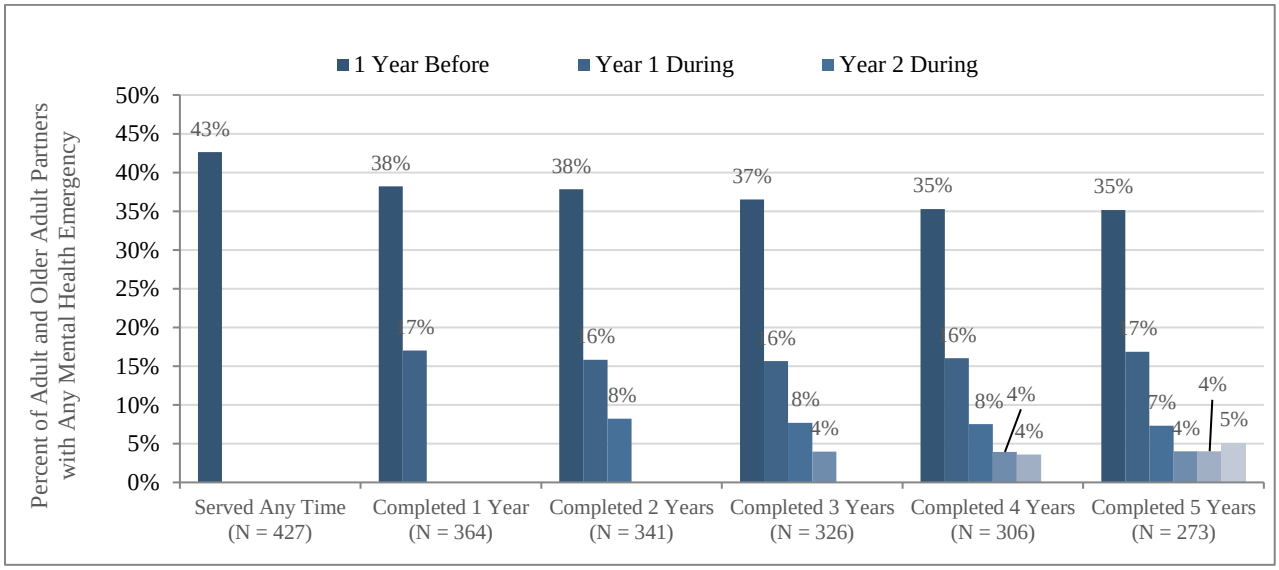


Exhibit A6 presents the percentage of adult and older adult partners with any self-reported mental health emergencies, broken down by tenure with FSP and year of program. Mental health emergencies as measured by self-report are more common among adult and older adult partners the year prior to FSP than in the first year. Gains are maintained across additional FSP years.

Exhibit A6: Mental Health Emergencies – Adult and Older Adult Partners



Self-reported Physical Health Emergencies

Exhibit A7 presents the percentage of child and TAY partners with any self-reported physical health emergencies, broken down by tenure with FSP and year of program. Physical health emergencies, as measured by self-report, are more common among child and TAY partners the year prior to FSP than in the first year. Gains are maintained across additional FSP years.

Exhibit A7: Physical Health Emergencies – Child and TAY Partners

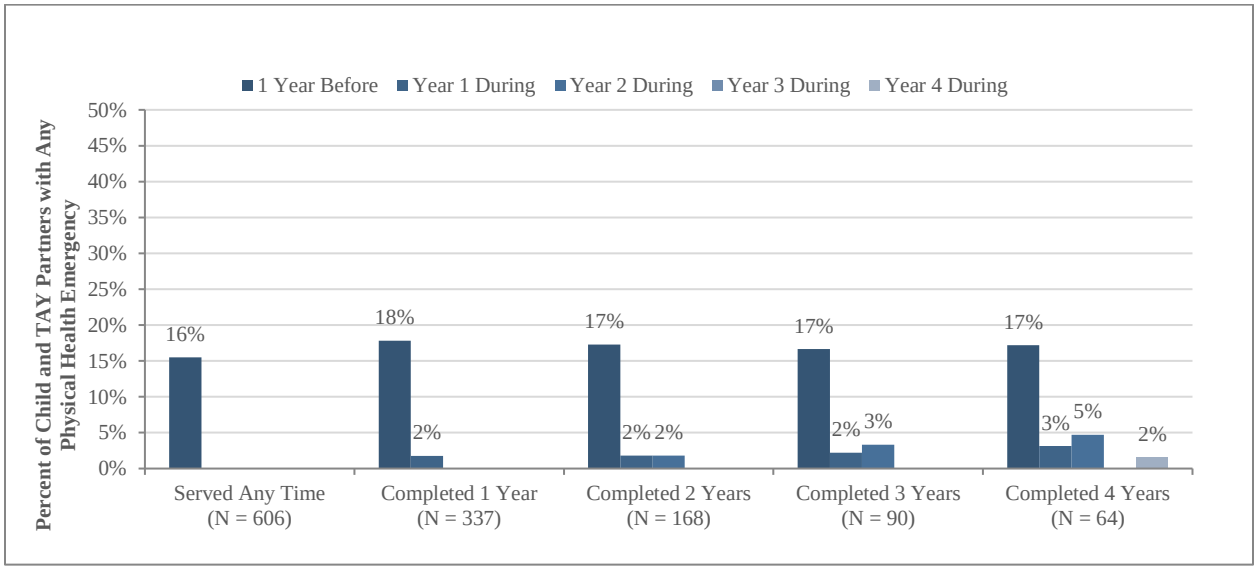
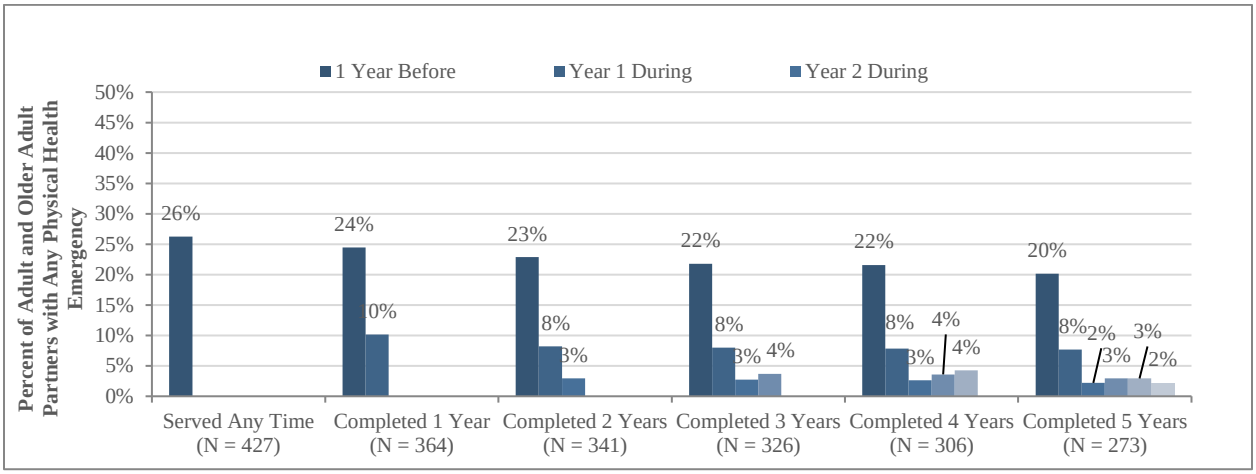


Exhibit A8 presents the percent of adult and older adult partners with any self-reported physical health emergencies, broken down by tenure with FSP and year of program. Physical health emergencies as measured by self-report are more common among adult and older adult partners the year prior to FSP than in the first year. Gains are maintained across additional FSP years.

Exhibit A8: Physical Health Emergencies – Adult and Older Adult Partners



School Outcomes

Exhibits A9, A10, and A11 present school outcomes for child and TAY partners affiliated with Edgewood and Fred Finch. The small number of TAY partners affiliated with Caminar and Telecare are omitted from these analyses due to limited data on school performance.

Exhibit A9 presents the percent of child and TAY partners with any reported school suspensions, broken down by tenure with FSP and year of program. School suspensions are more common among child and TAY partners the year prior to FSP than in the first year. Gains are maintained across the next FSP year.

Exhibit A9: School Suspensions – Child and TAY Partners

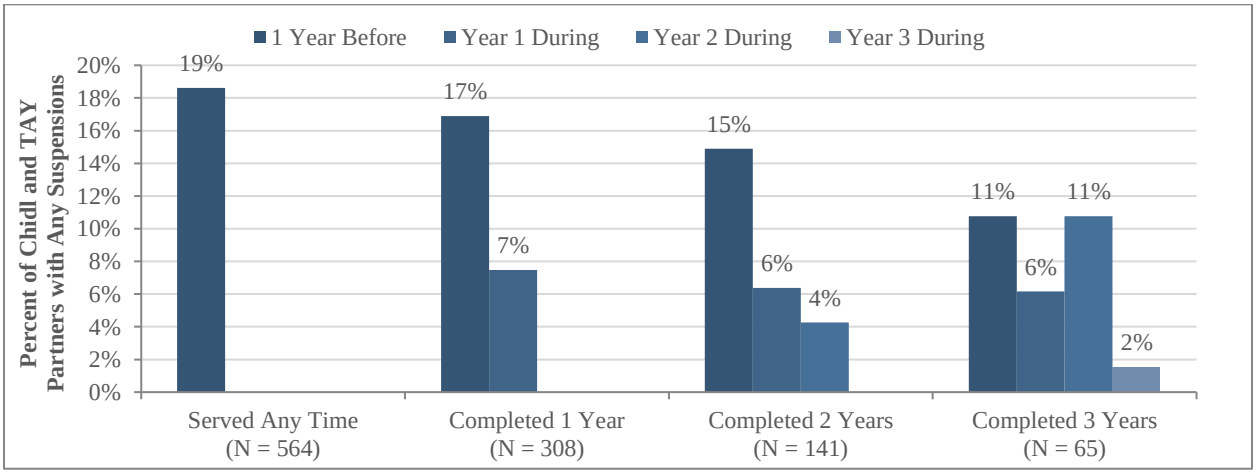


Exhibit A10 presents the average attendance rating (1-5) for child and TAY partners, broken down by tenure with FSP and year of program. Note that not all FSP partners in these age groups

have data on attendance, and those who do have data on attendance do not necessarily have it at every three-month assessment. School attendance increases slightly once partners are on FSP. Attendance appears to dip during the third year, but this represents a small number of individuals and should not be over interpreted.

Exhibit A10: Ratings of Attendance – Child and TAY Partners (Rating 1 – 5; Higher is Better)

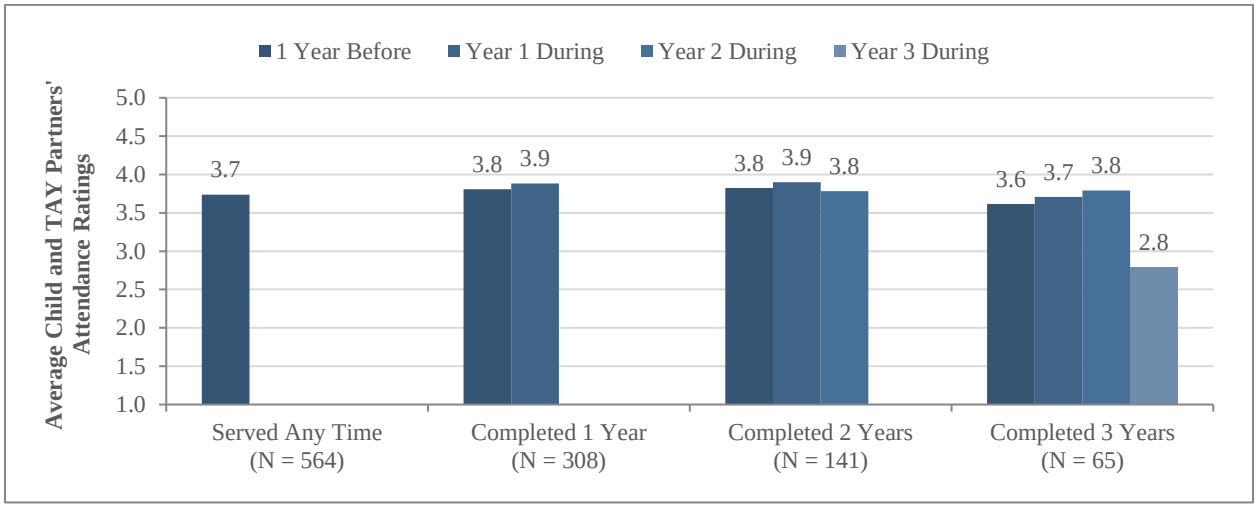
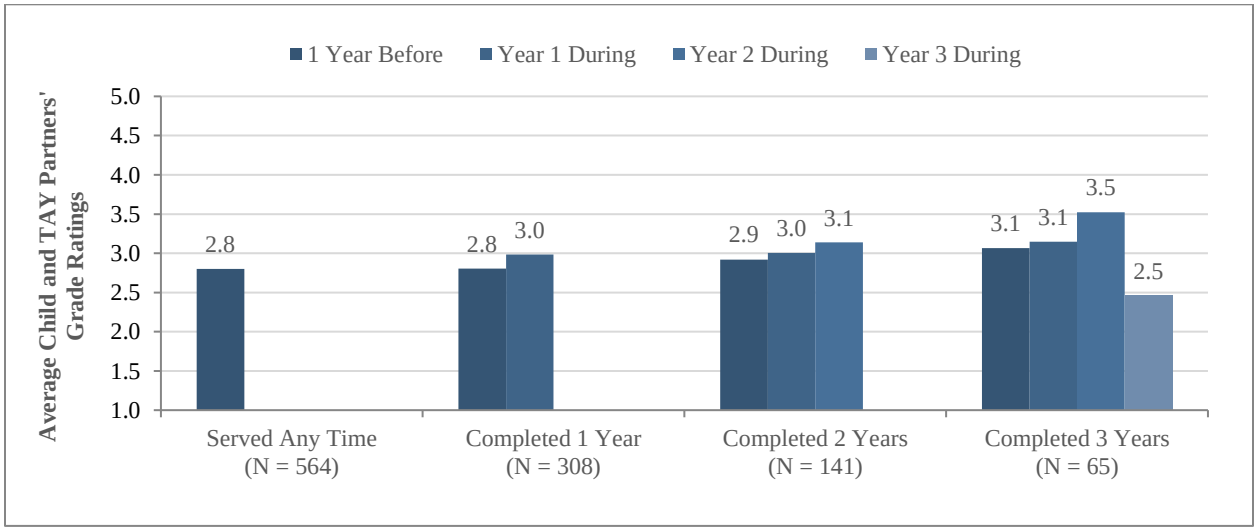


Exhibit A11 presents the average grades rating (1-5) for child and TAY partners, broken down by tenure with FSP and year of program. Note that not all FSP partners in these age groups have data on grades, and those who do have data on grades do not necessarily have it at every three-month assessment. School grades increase slightly once partners are on FSP. Grades appear to dip during the third year, but this represents a small number of individuals and should not be over interpreted.

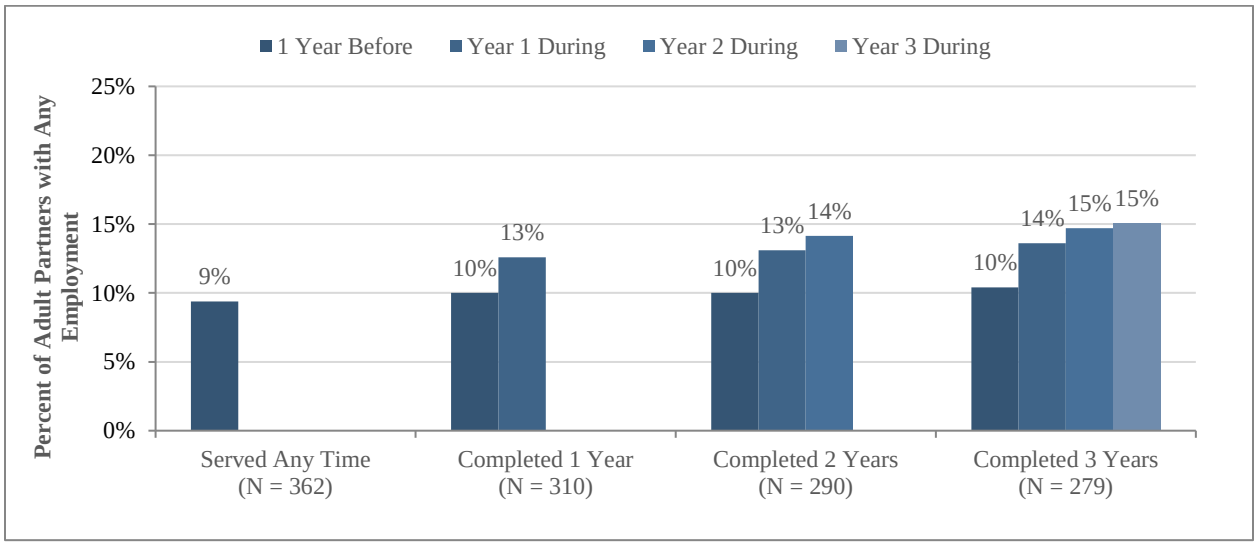
Exhibit A11: Ratings of Grades – Child and TAY Partners (Rating 1 – 5; Higher is Better)



Employment

Exhibit A12 presents the percent of adult partners with any reported employment, broken down by tenure with FSP and year of program. Older adults are not included in these analyses because of insufficient observations with any employment. Having any employment among adult partners the year prior to FSP than in the first year. Gains are maintained across additional FSP years.

Exhibit A12: Employment – Adult Partners



Appendix B: Additional Detail on Outcomes by FSP Providers

This section provides more details on the results presented in the main report. The outcomes in this section are broken apart by FSP providers, including Edgewood/Fred Finch, Caminar, and Telecare. Adult partnership organizations were broken apart but all children remain combined because the data from Fred Finch and Edgewood is stored together without organizational identifiers. No outcomes are presented for any group of partners with 50 or fewer individuals.

Exhibit B1-B3, presents the percent of partners with any events the year just prior to FSP and the first year on FSP, as well as the percent improvement for each FSP provider, with the exception of attendance and grade ratings. Percent improvement is the percent change in the percent of partners with any events. Outcomes of attendance and grade ratings in Exhibit B1-B3 present the average ratings for the year prior to FSP and the first year on FSP, as well as the percent change in the average ratings, for each FSP provider. In sum, the vast majority of the outcomes improve (18 of 19 outcomes) for all reported FSP provider groups.

As can be seen in Exhibit B1, there are improvements comparing the year prior to FSP to the first year during FSP for Edgewood / Fred Finch on the following self-reported outcomes: homelessness, mental health emergencies, physical health emergencies, school suspensions, attendance ratings and grade ratings. However, there is one outcome for which there is no improvement. The percent of partners with an episode of detention or incarceration increases.

Exhibit B1. Percent Improvement in Outcomes for Edgewood / Fred Finch, Year before FSP Compared with First Year with FSP

Survey Outcomes, Edgewood / Fred Finch	1 Year Before	Year 1 During	% Difference
Homelessness	9.4%	8.8%	6.9%
Detention or Incarceration	15.9%	17.2%	(8.2%)
Arrests	23.4%	8.1%	65.3%
Mental Health Emergencies	40.9%	8.8%	78.6%
Physical Health Emergencies	3.9%	1.6%	58.3%
School Suspensions	16.9%	7.5%	55.8%
Attendance Ratings	3.80	3.91	2.9%
Grade Ratings	2.79	2.99	6.7%
Employment	**	**	**

** Not Reported

As can be seen in Exhibit B2, there are improvements comparing the year prior to FSP to the first year during FSP for Caminar on all the available self-reported outcomes. The percent difference with any employment is reported as N/A because the percent of partners with employment increases from 0% to 2%. Thus, the denominator is 0.

Exhibit B2. Percent Improvement in Outcomes for Caminar, Year before FSP Compared with First Year with FSP

Survey Outcomes, Caminar	1 Year Before	Year 1 During	% Difference
Homelessness	21.4%	10.7%	50.0%
Detention or Incarceration	8.9%	3.6%	60.0%
Arrests	12.5%	1.8%	85.7%
Mental Health Emergencies	75.8%	17.7%	76.6%
Physical Health Emergencies	54.8%	16.1%	70.6%
School Suspensions	**	**	**
Attendance Ratings	**	**	**
Grade Ratings	**	**	**
Employment	0%	1.9%	N/A

** Not Reported

As can be seen in Exhibit B3, there are improvements comparing the year prior to FSP to the first year during FSP for Telecare on all the available self-reported outcomes.

Exhibit B3. Percent Improvement in Outcomes for Telecare, Year before FSP Compared with First Year with FSP

Survey Outcomes, Telecare	1 Year Before	Year 1 During	% Difference
Homelessness	27.9%	21.2%	24.1%
Detention or Incarceration	18.4%	12.7%	30.8%
Arrests	14.8%	2.1%	85.7%
Mental Health Emergencies	31.7%	17.5%	44.8%
Physical Health Emergencies	17.8%	8.5%	52.5%
School Suspensions	**	**	**
Attendance Ratings	**	**	**
Grade Ratings	**	**	**
Employment	12.0%	14.7%	22.6%

** Not Reported

Appendix C: Methods

Methodology for FSP Survey Data Analysis

The FSP survey data are collected by providers via discussions with partners and should thus be viewed as self-report. Among the providers included in these analyses (Fred Finch, Edgewood, Caminar, and Telecare), 701 partners completed a full year with FSP since program inception.

Three datasets were obtained: one from Caminar, one from Telecare, and one from Edgewood/Fred Finch. Caminar and Edgewood/Fred Finch provided their datasets in a Microsoft Excel format while Telecare provided a raw Microsoft Access database, which included data on individuals who were not affiliated with FSP.

For Telecare only, we limited the dataset to FSP partners using the Client Admission data and the System Agency Program.

Edgewood/Fred Finch serve child partners and TAY partners. Caminar and Telecare serve primarily adult and older adult partners, and a small number of older TAY clients. Exhibit C1 below describes the age group of partners completing at least one full year of FSP by provider. Note that Edgewood/Fred Finch data are presented together.

Exhibit C1: Summary of Partners One Full Year of FSP

Age Group	Edgewood/ Fred Finch	Caminar	Telecare	Total
Child (aged 16 and younger)	134	--	--	134
TAY (aged 17 – 25)	174	4	25	203
Adult (aged 26 -59)	--	52	258	310
Older Adult (aged 60+)	--	6	48	54
Total	308	62	331	701

A master assessment file with FSP start and end dates and length of FSP tenure was created at the client level. Note that for clients who stopped and then reestablished their FSPs, we only kept the record corresponding with their most recent Global ID, as indicated in the State's documentation.

Partner type (child, TAY, adult, and older adult) is determined by the PAF data.

- For Caminar and Edgewood/Fred Finch, this was done using the variable *Age Group*.
    - Caminar: a value of (7) indicated a TAY partner, a value of (4) indicated an adult partner, and a value of (10) indicated an older adult partner.
    - Edgewood/Fred Finch: a value of (1) indicated a child partner, and a value of (4) indicated a TAY partner.
    - In both cases, this was confirmed using the *Age* variable.
- For Telecare data, partners were given a PAF appropriate for their age; the partner type was identified by the *Form Type* variable (TAY_PAF; Adult_PAF; or OA_PAF).

Partnership date and *end date* were determined as follows: End date was determined by the reported date of the partnership status change in the KET, if the status is indicated to be "discontinued." For clients still enrolled as of the data acquisition at the end of the year, we assigned an end date of June 30, 2016.

All data management and analysis was conducted in Stata. All code is available upon request. Additional details on the methodology for each outcome are presented below.

Residential Setting

1. Residential settings were grouped into categories as described in the table below (Exhibit C2).
2. The baseline data were populated using the variable *PastTwelveDays* collected by the PAF. Individuals without any reported locations were assigned to the "Don't Know" category.
3. First residential status for partners once they join FSP is determined by the *Current* variable, collected by the PAF. Individuals without any reported current residence were assigned to the "Don't Know" category. Some individuals had more than one *Current* location. In this case, if there was one residence with a later value for *DateResidentialChange*, this value was considered to be the first residential setting. If the residences were marked with the same date, both were considered as part of the partner's first year on FSP.
4. Additional residential settings for the first year were found using the KET data if the *DateResidentialChange* variable is within the first year with FSP as determined by the partnership date. If no residential data were captured by a KET, it was assumed that the individual stayed in their original residential setting.

Exhibit C2: Residential Categories

Category	Telecare Setting Value[1]	Caminar, Edgewood, and Fred Finch Setting Value[2]
With family or parents		
With parents	1	1
With other family	2	2
Alone		
Apartment alone or with spouse	3	3
Single occupancy (must hold lease)	4	19
Foster home		
Foster home with relative	5	4
Foster home with non-relative	6	5
Homeless or Emergency Shelter		
Emergency shelter	7	6
Homeless	8	7
Assisted living, group home, or community care		
Individual placement	9	20
Assisted living facility	10	28
Congregate placement	11	21
Community care	12	22
Group home (Level 0-11)	16	11
Group home (Level 12-14)	17	12
Community treatment	18	13
Residential treatment	19	14
Inpatient Facility		
Acute medical	13	8
Psychiatric hospital (other than state)	14	9
Psychiatric hospital (state)	15	10
Nursing facility, physical	20	23
Nursing facility, psychiatric	21	24
Long-term care	22	25
Incarcerated		
Juvenile Hall	23	15
Division of Juvenile Justice	24	16
Jail	30	27
Prison	31	26
Other / Don't Know		
Don't know	0	18
Other	49	17

[1] Setting names determined by *Setting* variable in Telecare data.
[2] Setting names determined by the following guide:
https://mhdatapublic.blob.core.windows.net/fsp/DCR%20Data%20Dictionary_2011-09-15.pdf

Arrests

1. The baseline data were populated using the variable *ArrestsPast12* collected by the PAF. Individuals with blank data in this variable were assumed to have zero arrests in the year prior to FSP.

2. Ongoing arrests were populated using the variable indicating the date of arrest (variable names vary slightly by file) in the KET file, as long as the date is within the first year with FSP as determined by the partnership date. We assumed that no information on arrests in the KET indicated that no arrests had occurred in the first year on FSP.

Mental and Physical Health Emergencies

1. The baseline data were populated using the variable *MenRelated* and *PhysRelated* for mental and physical emergencies, respectively, as collected by the PAF. Individuals with blank data in this variable were assumed to have zero emergencies of that type in the year prior to FSP.

2. Ongoing emergencies were populated using the variable indicating the date of emergency (variable names vary slightly by file) in the KET file, as long as the date is within the first year with FSP as determined by the partnership date. The type of emergency was indicated by *EmergencyType* (1=physical; 2=mental). We assumed that no information on emergencies in the KET indicated that no emergencies had occurred in the first year on FSP.

Employment

Employment outcomes were generated for adults only. Therefore, Edgewood and Fred Finch data were excluded.

1. The baseline data were populated using the PAF data. An individual was considered as having had any employment if there was a non-zero, non-blank value for one of the following variables (note that variable names differ slightly by dataset):

    a. Any competitive employment in past twelve months (any competitive employment; any competitive employment for any average number of hours per week; any average wage for competitive employment)

    b. Any other employment in past twelve months (any other employment; any other employment for any average number of hours per week; any average wage for any other employment)

2. Ongoing employment was populated using the variable indicating the date of employment change (variable names vary slightly by file) in the KET file, as long as the date is within the first year with FSP as determined by the partnership date. A change is considered as indicating some employment if the new employment status code indicated competitive employment or other employment (again, variable names differ by data set).

We assumed that no information on employment in the KET indicated that the original employment status sustained.

School Outcomes

School outcomes were generated for child and TAY partners affiliated with Edgewood and Fred Finch only. Caminar and Telecare TAY, adult, and older adult partners were excluded. Note that these outcomes are presented as though they represent outcomes for *all* child and TAY partners; however, we do not know how many of these partners are enrolled in school.

Suspensions

1. The baseline data were populated using the variable *SuspensionPast12* collected by the PAF. Individuals with blank data in this variable were assumed to have zero suspensions in the year prior to FSP.

2. Ongoing suspensions were populated using the variable indicating the date of suspension (*DateSuspension*) in the KET file, as long as the date is within the first year with FSP as determined by the partnership date. We assumed that no information on suspensions in the KET indicated that no suspensions had occurred in the first year on FSP.

Grades and Attendance

Note that grades and attendance are cardinal rankings. They are reported as ranging from 1 to 5, where lower indicates a better outcome. For the purposes of reporting, we reverse-coded these outcomes such that a 5 indicates a better outcome.

1. The baseline data were populated using the variables *GradesPast12* and *AttendancePast12* from the PAF data. Individuals with blank data in this variable were excluded.

2. Ongoing rankings of grades and attendance were gathered using the *GradesCurrent* and *AttendanceCurrent* from the PAF (for the first ranking) and the 3M forms. Again, individuals with blank data are excluded.

3. Because there were multiple observations for each person in each year, first averages by person by year were created; then averages by year.

Methodology for Avatar Data Analysis

The hospitalization outcomes use electronic health records (EHR) data obtained through the Avatar system. Using EHR data avoids some of the reliability shortcomings of self-report, but presents challenges as well. The Avatar system is limited to individuals who obtain care in the San Mateo county hospital system. Hospitalizations outside of San Mateo County, or in private hospitals, are not captured. The hospitalization outcomes include 667 partners who completed one full year or more in a FSP program and were in the Avatar system. Individuals started FSP between July 2006 (the program's inception) and June 2016, completing at least one full year before June 2017.

All data management and analysis were conducted in Stata. Code is available upon request.

To count instances of psychiatric hospitalizations and PES admissions, we relied on the Avatar *view_episode_summary_admit* table. Exhibit C3 shows the program codes corresponding with the above measures. Additionally, FSP episodes were identified through the Avatar *episode_history* table.

Exhibit C3: Program codes among clients ever in the FSP

Program code	Program value
Psychiatric Hospitalizations	
410200	ZZ410200 PENINSULA HOSPITAL INPT-MSO I/A
410205	410205 PENINSULA HOSPITAL INPATIENT
410700	410700 SMMC INPATIENT
921005	921005 NONCONTRACT INPATIENT
926605	926605 JOHN MUIR MED. CTR INPT MAN CARE
Psychiatric Emergency Services	
410702	Z410702 SMMC PES -termed 10/31/14
410703	410703 PRE CONV SMMC PES~INACTIVE
41CZ00	41CZ00 SAN MATEO MEDICAL CENTER - PES

Notes: Data represent all utilization from FSP clients for these codes, as pulled from Avatar on April 5th, 2016.

Partner type (child, TAY, adult, and older adult) was determined by the partner's age on the start date of the FSP program, as derived from the "c_date_of_birth" variable from the view_episode_summary_admit table and the "FSP_admit_dt" variable from the episode_history table.

As we have discussed in the previous year's report, the distribution of partners by age group is different between the Avatar data and the FSP Survey data (reported in our previous report "Full Service Partnership (FSP) Outcomes: Findings from 2015"). This is likely due to the different ways age group was determined. For the survey data, AIR determined age group by whether the partner was evaluated using the child, TAY, adult, or older adult FSP survey forms. For the Avatar data, AIR assigned individuals to an age group based upon the date they joined FSP and their reported date of birth.

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APPENDIX 6: OUTREACH COLLABORATIVES FY 16/17 ANNUAL REPORT

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San Mateo County Behavioral Health and Recovery Services (SMC BHRS) Provider Outreach Efforts

FY 2016-2017

Yongqiu Chen, MPA;

Elizabeth Mokyr Horner, PhD, MPP;

Grace Wang, PhD, MPH;

Yi Lu, PHD

JANUARY 2018

San Mateo County Behavioral Health and Recovery Services (SMC BHRS) Provider Outreach Efforts

FY 2016-2017

January 2018

Charlotte Chen, MPA;
Elizabeth Mokyr Horner, PhD, MPP;
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Executive Summary

In 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA), to provide funding to Counties for mental health services by imposing a 1% tax on personal income in excess of $1 million. The Community Services and Supports (CSS) component of MHSA was created to provide direct services to individuals with severe mental illness and included Outreach and Engagement activities.

San Mateo County Behavioral Health and Recovery Services (SMC BHRS) funds the North County Outreach Collaborative (NCOC) and the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) to provide outreach and engagement activities throughout San Mateo County.

This report summarizes overall collaborative and provider-specific outreach efforts across individual and group outreach events that occurred in fiscal year (FY) 2016-2017 (July 1, 2016 through June 30, 2017). We also present some historical data from FY 2015-2016 to show how outreach has changed over time.

Total Attendance

For FY 2016-2017, SMC BHRS providers reported a total of 5,460 attendees at all outreach events. Of these, 602 attendees were reached through individual outreach events and 4,858 attendees were reached across 77 group outreach events.

Demographics of outreach attendees

NCOC

NCOC outreach attendees were primarily adults (39%) and transition-age youth (25%)and with unknown insurance (80%). Over half of individual and group outreach attendees were female (56%). Over half of attendees were White (35%) or Mexican (21%). All attendees also reported being part of one or more special populations (i.e., homeless, at risk for homelessness, vision impaired, hearing impaired, veterans). Of those reporting special population status, 63% were homeless or were at-risk for homelessness.

EPAPMHO

EPAPMHO outreach attendees were largely adults (51%) and transition-age youth (34%) and without insurance (42%). Over half of individual and group outreach attendees were female (51%). Over half of attendees were Black (23%), Tongan (19%) or Mexican (13%). Of those reporting special population status, 63% were homeless or were at-risk for homelessness.

Outreach event characteristics

NCOC

The average length of NCOC individual outreach events was 37.6 minutes in FY 2016-2017. Of all the 152 individual outreach events, most occurred in other community locations not listed (26%). Among the 39 individual outreach events which occurred in other community locations, most cited was “college class”. Other locations cited include Pacifica Community Center, Serramonte Mall, and others.

Most individual outreach events used Medicaid Administrative Activities (MAA) code 401 (Discounted Medi-Cal outreach, 45%), were in English (100%), and included mental health referrals (52%) and substance abuse referrals (14%). Providers also made 393 referrals to other services, including legal services and housing.

NCOC group outreach events lasted 115.9 minutes on average. Of all the 67 group outreach events, most were conducted in English (99%) and held in other community locations not listed (39%). Among the 26 group outreach events held in other locations, most were cited as being held in Legion of Honor Pacifica. Other locations include College of San Mateo, Daly City Partnership, San Mateo Central Park, Pacifica Community Center, and others. These events most frequently used MAA code 401 (Discounted Medi-Cal outreach, 37%).

EPAPMHO

The 450 EPAPMHO individual outreach events were an average of 39.2 minutes each. These events were typically administered in English (68%), occurred in unspecified locations (39%), and used MAA code 400 (Medi-Cal outreach, 53%). EPAPMHO individual outreach events also included mental health referrals (14%) and substance abuse referrals (25%). A total of 704 referrals were made to other services, including medical care and housing.

Of the 10 EPAPMHO group outreach events, the average event lasted 74.5 minutes. Most group outreach events were conducted in English (60%) and in home (30%)/other community locations not listed (30%). Other locations cited include Canada College and Rugby field. These events used MAA code 400 (Medi-Cal outreach, 100%).

Recommendations

We have several recommendations based on FY 2016-2017 data. These recommendations fall under two umbrellas: those aimed at enhancing outreach, and those to improve data collection. To enhance outreach, we suggest that SMC BHRS work with providers to:

- Continue efforts to tailor or increase outreach efforts for specific demographic groups, such as older adults and Latino/Hispanic persons from Central America.
- Consider how to best address the needs of individuals who report being uninsured or do not report their insurance status.

Focus on increasing housing-related resources and referrals. To improve data collection, we recommend SMC BHRS work with providers to:

- Make other/unspecified categories more clear.
- Treat race/ethnicity as mutually exclusive categories.
- Continue gathering the new demographic information that has been collected this year.

Introduction

In 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA), to provide funding to Counties for mental health services by imposing a 1% tax on personal income in excess of $1 million. Activities funded by MHSA are grouped into components, and the Community Services and Supports (CSS) component was created to provide direct services to individuals with severe mental illness. CSS is allotted 80% of MHSA funding for services focused on recovery and resilience while providing clients and families an integrated service experience. CSS has three service categories: 1) Full Service Partnerships; 2) General System Development Funds; and 3) Outreach and Engagement.

San Mateo County Behavioral Health and Recovery Services (SMC BHRS) MHSA Outreach and Engagement strategy increases access and improves linkages to behavioral health services for underserved communities. Strategies include community outreach collaboratives, pre-crisis response, and primary care-based efforts. SMC BHRS has seen a consistent increase in representation of underserved communities in its system since the strategies were deployed.

In particular, community outreach collaboratives funded by MHSA include the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO), which targets at-risk youth, transition-age youth and underserved adults [Latino, African American, Pacific Islander, and Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ)] in East Palo Alto, and the North County Outreach Collaborative (NCOC), which targets rural and/or ethnic communities (Chinese, Filipino, Latino, Pacific Islander, and LGBTQ) in the North County region including Pacifica. These collaboratives provide advocacy, systems change, resident engagement, expansion of local resources, education and outreach to decrease stigma related to mental illness and substance abuse. They work to increase awareness of and access and linkages to culturally and linguistically competent behavioral health, Medi-Cal and other public health services, and social services. They participate in a referral process to ensure those in need receive appropriate services. Finally, they promote and facilitate resident input into the development of MHSA funded services and other BHRS program initiatives.

Providers reported fiscal year (FY) 2016-2017 (July 1, 2016 through June 30, 2017) outreach data using an electronic form first implemented in quarter four (Q4) of FY 2014-2015. AIR created this form based on interviews with San Mateo County staff and focus groups with providers. This collective effort sought to improve the data collection process so that SMC BHRS and its providers could better understand the reach of their outreach efforts. After data are entered, AIR cleans the data and calculates aggregated counts and percentages to describe outreach activities. Please see Appendix H for information about calculations.

This report focuses on EPAPMHO and NCOC's outreach events that occurred during FY 2016-2017 and outreach event attendees. We also present some historical data from FY 2014-2015 and FY 2015-2016 to show how outreach has changed over time. Counts of attendees do not necessarily represent unique individuals because a person may have been part of more than one outreach event, taken part in both individual and group outreach events, and/or interacted with different providers. Provider summaries are also available to help SMC BHRS and its providers better understand each individual provider's outreach efforts. Please refer to Appendix A to G.

Overall Outreach

*this section was updated in April 2018 to include outreach data that was inadvertently left out for Daly City Peninsula Partnership Collaborative and Pacifica Collaborative.

During FY 2016-2017, SMC BHRS outreach providers reported a total of 6,939 attendees at outreach events—704 attendees reached through individual outreach events and 6,235 attendees reached across 99 group outreach events. Each individual outreach event occurs with a single attendee. Group outreach events include multiple attendees. An attendee is not necessarily a unique individual because a person may have been a part of multiple individual or group outreach events.

Please note that the data used in below **Table 1** and **Figure 1** include all the entries whose date of outreach ranged from July 1st, 2016 to June 30th, 2017.

Table 1 shows outreach attendees, by collaborative, provider, and event type (i.e., individual or group) for FY 2016-2017.

Table 1. Outreach Attendees, by Collaborative, Provider, and Event Type, FY 2016-2017

Provider Organization	Number of Individual Outreach Attendees	Number of Attendees at Group Outreach Events	Total Attendees Reported Across All Events**
North County Outreach Collaborative (NCOC)			
Asian American Recovery Services	132	992	1,124
Daly City Peninsula Partnership Collaborative	36	913	949
Daly City Youth Health Center	6	1,124	1,130
Pacifica Collaborative	21	2,996	3,017
Pyramid Alternatives	0*	37	37
Total (NCOC)	195	6,062	6,257
East Palo Alto Partnership for Mental Health Outreach (EPAPMHO)			
El Concilio	80	17	97
Free at Last	212	0*	212
Multicultural Counseling and Education Services of the Bay Area	172	156	328
The Barbara A. Mouton Multicultural Wellness Center	45	0	45
Total (EPAPMHO)	509	173	682
Total (NCOC and EPAPMHO)	704	6,235	6,939

Notes: *Providers did not report data for FY 2016-2017. **Counts are not necessarily unique individuals.

It is expected that the NCOC would serve a much larger proportion of the Outreach Collaborative effort as it serves the entire north region of San Mateo County (estimated population 140,149) including the cities of Colma, Daly City, and Pacifica, which is five times the population of the city of East Palo Alto, served by the EPAPMHO. The north region also

spans a much wider geographical area, making group events (vs. individual outreach) such as community wide fairs much more feasible and relevant. In contrast, East Palo Alto spans 2.5 square miles making an individual approach to outreach more effective.

Compared to FY2014-2015 and FY 2015-2016, the total number of NCOC outreach attendees increased each year, whereas EPAPMHO outreach attendees decreased (**Figure 1**).

While both collaboratives were reaching about 3% of the population in FY2014-15, EPAPMHO outreach numbers have been decreasing over the past three years and currently reaching about 2.5% of the population. According to EPAPMHO provider organizations there have been both staffing and community-level challenges that have led to decreased numbers; these are discussed further under the Recommendations section of this document.

Figure 1. Total Outreach Attendees by Collaborative, FY 2014-2017

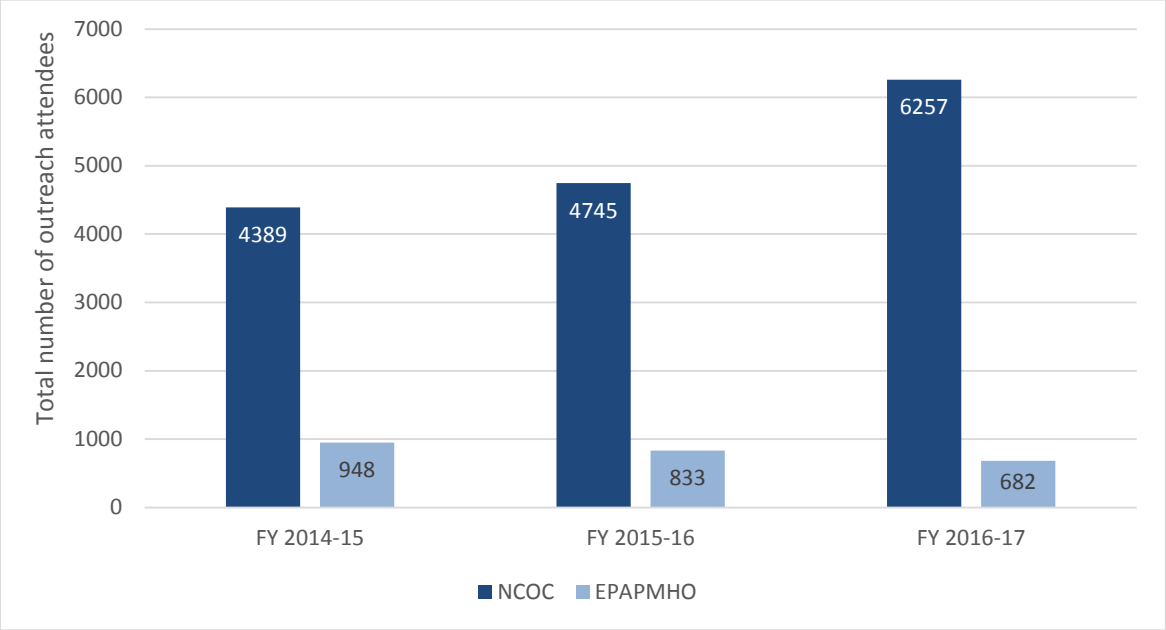


Table 2 presents outreach event attendees' race/ethnicity for FY 2014-2015, FY 2015-2016 and FY 2016-2017 within each collaborative. Increases of 5% or more between the two years are shaded in green; decreases of 5% or more are shaded in red. Additional details on race/ethnicity by quarter for FY 2016-2017 are presented later in the report (pages 9 and 15).

Table 2. Race/Ethnicity by Collaborative, FY 2014-2015 to FY 2016-2017*

	NCOC			EPAPMHO		
Race/Ethnicity	**2014-2015**	**2015-2016**	**2016-2017**	**2014-2015**	**2015-2016**	**2016-2017**
Black	152 (4.1%)	153 (3.2%)	138 (2.4%)	150 (9.1%)	205 (24.5%)	143 (23.0%)
White	930 (25.2%)	1502 (31.5%)	2027 (35.1%)	444 (26.9%)	82 (9.8%)	41 (6.6%)
American Indian	7 (0.2%)	48 (1.0%)	69 (1.2%)	0 (0.0%)	8 (1.0%)	4 (0.6%)
Middle Eastern	7 (0.2%)	60 (1.3%)	51 (0.9%)	0 (0.0%)	0 (0.0%)	1 (0.2%)
Eastern European	0 (0.0%)	0 (0.0%)	10 (0.2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
European	0 (0.0%)	0 (0.0%)	6 (0.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Mexican	147 (4.0%)	260 (5.5%)	1181 (20.5%)	43 (2.6%)	196 (23.4%)	82 (13.2%)
Puerto Rican	1 (0.0%)	6 (0.1%)	28 (0.5%)	1 (0.1%)	4 (0.5%)	0 (0.0%)
Cuban	0 (0.0%)	0 (0.0%)	9 (0.2%)	0 (0.0%)	1 (0.1%)	0 (0.0%)
Central American	0 (0.0%)	0 (0.0%)	31 (0.5%)	0 (0.0%)	0 (0.0%)	8 (1.3%)
South American	0 (0.0%)	0 (0.0%)	14 (0.2%)	0 (0.0%)	0 (0.0%)	1 (0.2%)
Caribbean	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Other Latino	192 (5.2%)	87 (1.8%)	0 (0.0%)	228 (13.8%)	0 (0.0%)	0 (0.0%)
Filipino	336 (9.1%)	678 (14.2%)	500 (8.7%)	248 (15.0%)	18 (2.2%)	17 (2.7%)
Chinese	96 (2.6%)	246 (5.2%)	210 (3.6%)	96 (5.8%)	2 (0.2%)	2 (0.3%)
Japanese	11 (0.3%)	30 (0.6%)	56 (1.0%)	3 (0.2%)	0 (0.0%)	0 (0.0%)
Korean	17 (0.5%)	29 (0.6%)	45 (0.8%)	4 (0.2%)	0 (0.0%)	0 (0.0%)
South Asian	15 (0.4%)	16 (0.3%)	43 (0.7%)	11 (0.7%)	2 (0.2%)	2 (0.3%)
Vietnamese	1 (0.0%)	23 (0.5%)	11 (0.2%)	35 (2.1%)	2 (0.2%)	0 (0.0%)
Cambodian	18 (0.5%)	1 (<0.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Laotian	0 (0.0%)	2 (<0.1%)	0 (0.0%)	1 (0.1%)	4 (0.5%)	0 (0.0%)
Mien	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Other Asian	37 (1.0%)	0 (0.0%)	0 (0.0%)	4 (0.2%)	0 (0.0%)	0 (0.0%)
Tongan	287 (7.8%)	237 (5.0%)	143 (2.5%)	172 (10.4%)	121 (14.5%)	119 (19.1%)
Samoan	280 (7.6%)	343 (7.2%)	243 (4.2%)	123 (7.5%)	90 (10.8%)	43 (6.9%)
Fijian	9 (0.2%)	24 (0.5%)	0 (0.0%)	1 (0.1%)	14 (1.7%)	3 (0.5%)
Hawaiian	31 (0.8%)	29 (0.6%)	35 (0.6%)	16 (1.0%)	7 (0.8%)	1 (0.2%)
Guamanian	10 (0.3%)	26 (0.5%)	23 (0.4%)	1 (0.1%)	0 (0.0%)	0 (0.0%)
Multi	72 (2.0%)	414 (8.7%)	499 (8.6%)	39 (2.4%)	66 (7.9%)	62 (10.0%)
Other Race	402 (10.9%)	101 (2.1%)	147 (2.5%)	14 (0.8%)	2 (0.2%)	1 (0.2%)
Unknown Race	626 (17.0%)	446 (9.4%)	250 (4.3%)	16 (1.0%)	12 (1.4%)	93 (14.9%)
Total**	**3684**	**4761**	**5769**	**1650**	**836**	**623**

Note: Percentages may not sum to 100% because of rounding.
**Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Table 3 presents the numbers and percentages of the mental health and substance abuse referrals made to the overall outreach events by collaborative for FY 2014-2015, FY 2015-2016 and FY 2016-2017.

While the NCOC has seen increases in outreach numbers overall, there are a few key differences in the racial/ethnic demographics of the outreach attendees. In particular, White and Mexican

participant percentages each more than tripled and Filipino participant percentages decreased by about half, from FY 2014-15 through FY 2016-17.

The EPAPMHO continues to serve primarily Black, Mexican and Tongan and Samoan throughout the three years, although there has been a notable decrease in Tongan and Samoan, which made 40% of the outreach participants in FY 2014-15 and closer to 25% in FY 2016-17.

These shifts in the racial/ethnic makeup of outreach participants are discussed further under the Recommendations section of this document

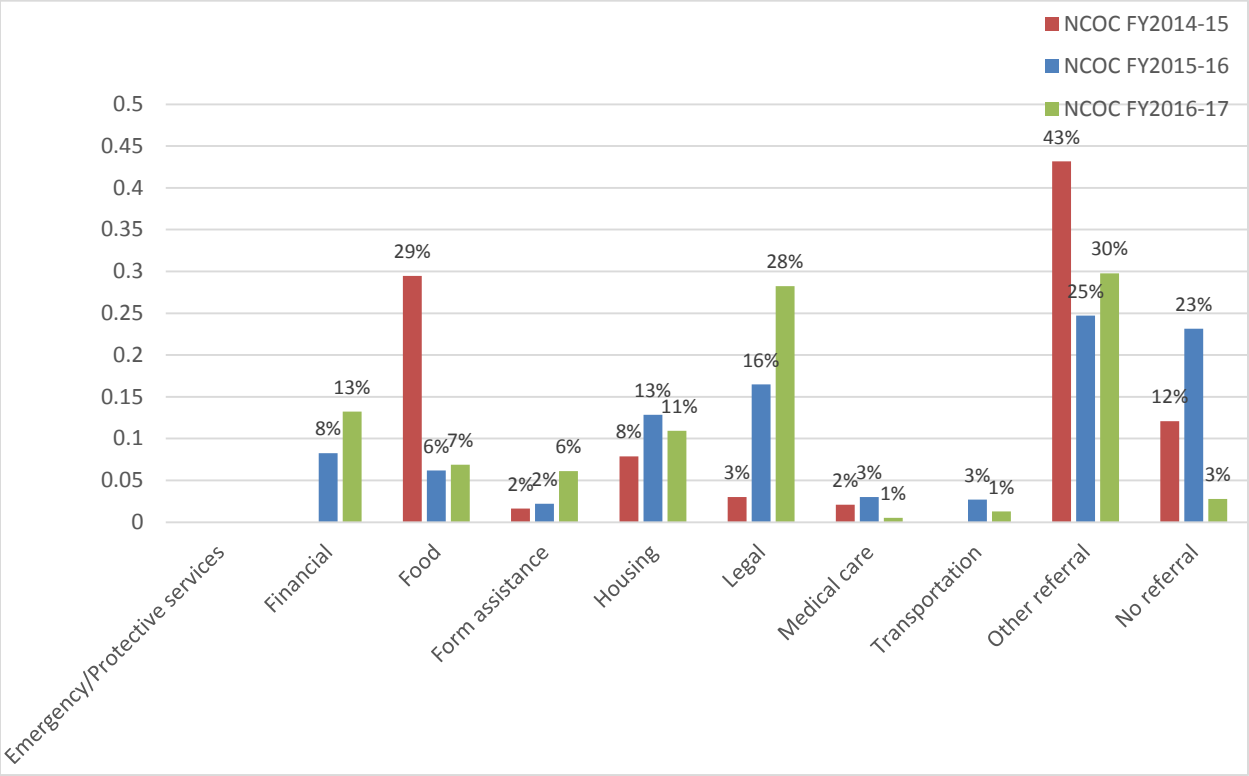
Table 3. Mental Health/Substance Abuse referrals by Collaborative, FY 2014-2015 to FY 2016-2017

	NCOC			EPAPMHO		
	2014-2015	2015-2016	2016-2017	2014-2015	2015-2016	2016-2017
Mental Health Referrals	67 (14.9%)	159 (44.9%)	79 (52.0%)	80 (17.8%)	200 (26.2%)	63 (14.0%)
Substance Abuse Referrals	33 (7.3%)	51 (14.4%)	22 (14.5%)	202 (44.9%)	229 (30.0%)	114 (25.3%)

Figure 2 and Figure 3 present referrals to social services in FY 2014-2015, FY 2015-2016 and FY 2016-2017 by each collaborative. The percentages represent percent of total referrals to social services.

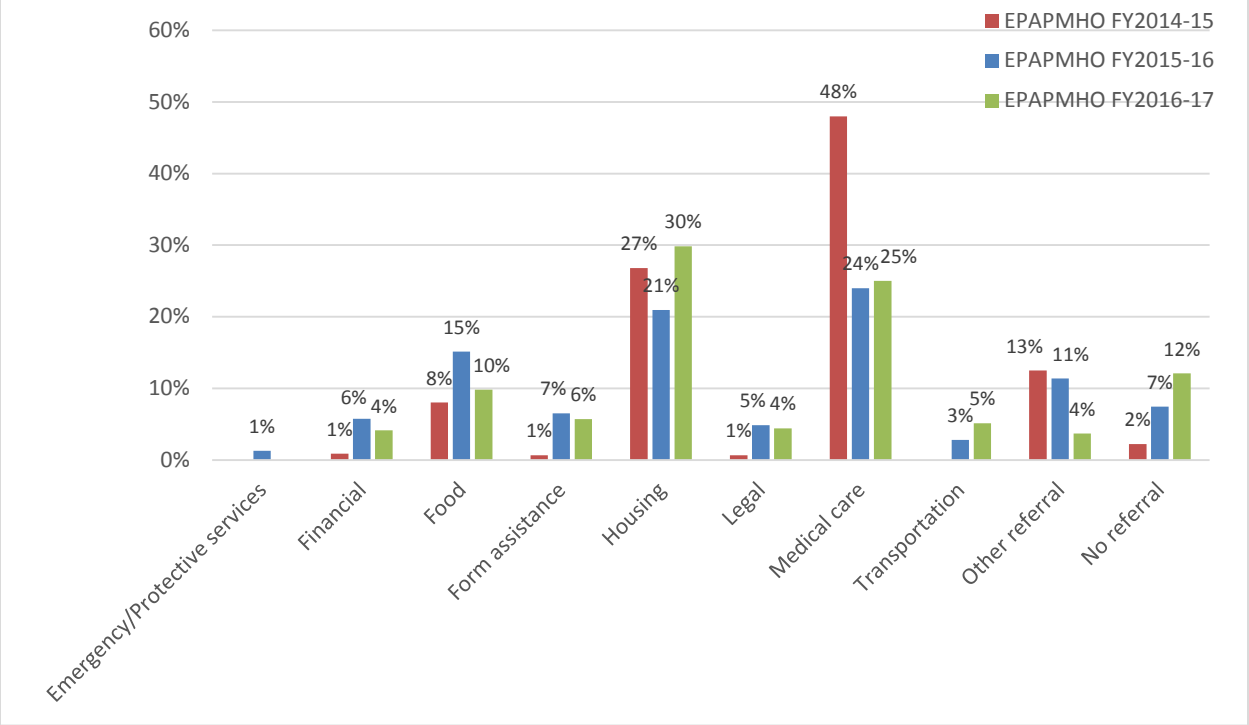
- In FY 2016-2017, NCOC had 393 referrals to social services, as compared to 631 referrals in FY 2015-2016 and 431 referrals in FY 2014-2015. In FY 2016-2017, EPAPMHO had 704 referrals to social services, as compared to 1,548 referrals in FY 2015-2016 and 448 referrals in FY 2014-2015.
- In FY 2016-2017, NCOC had decreases in the percent of financial, form assistance, and legal referrals compared to the prior two FY.
- In FY 2016-2017, EPAPMHO had decreases in the percent of housing, transportation, and no referrals compared to the prior two FY.

Figure 2. Referrals to Social Services made by NCOC, FY 2014-2015 to FY 2016-2017*



Note: Percentages may not sum to 100% because of rounding.

Figure 3. Referrals to Social Services made by EPAPMHO, FY 2014-2015 to FY 2016-2017*



Note: Percentages may not sum to 100% because of rounding.

NCOC

In FY 2016-2017, there were 4,837 attendees at individual and group outreach events across the four provider organizations in the NCOC.

Demographics

Age: Attendees across NCOC individual and group outreach events were adults (26-59 years, 39%), transition-age youth (16-25 years, 25%), children (0-15 years, 19%), and older adults (60 years or older, 15%) in FY 2016-2017. One percent of attendees were of an unknown age. See **Table 4** for the number of total outreach attendees representing each reported age group, by quarter.

Table 4. Age of Total Outreach Attendees Served by NCOC, FY 2016-2017

Age Group	Q1	Q2	Q3	Q4	Total
Children (0-15)	512 (19.8%)	266 (17.3%)	106 (29.7%)	19 (4.9%)	903 (18.6%)
Transition-age youth	464 (18.0%)	490 (31.9%)	49 (13.7%)	227 (58.2%)	1230 (25.3%)
Adults (26-59)	1074 (41.6%)	556 (36.2%)	162 (45.4%)	118 (30.3%)	1910 (39.3%)
Older adults (60+)	479 (18.6%)	213 (13.9%)	40 (11.2%)	21 (5.4%)	753 (15.5%)
Unknown age	53 (2.1%)	9 (0.6%)	0 (0.0%)	5 (1.3%)	67 (1.4%)
Total**	**2582**	**1534**	**357**	**390**	**4863**

Note: Percentages may not sum to 100% because of rounding. ** Total count for age reported may exceed the total number of attendees, because some providers may have reported individuals in two or more age groups, leading to extra counts in some cases for the group outreach attendees. The denominator for age percent is the sum of all age data reported.

Sex at birth: Attendees across NCOC individual and group outreach events were females (56%), males (36%), and other genders (8%) in FY 2016-2017. See **Table 5** for the number of individual and group outreach attendees reporting each sex type, by quarter.

Table 5. Sex at Birth of Outreach Attendees Served By NCOC, FY 2016-2017

Sex	Q1	Q2	Q3	Q4	Total
Male	879 (33.8%)	578 (38.9%)	131 (36.7%)	163 (41.1%)	1751 (36.2%)
Female	1372 (52.7%)	876 (59.0%)	219 (61.3%)	221 (55.7%)	2688 (55.5%)
Other gender	351 (13.5%)	32 (2.2%)	7 (2.0%)	13 (3.3%)	403 (8.3%)
Total**	**2602**	**1486**	**357**	**397**	**4842**

Note: Percentages may not sum to 100% because of rounding. ** Total count for sex reported may exceed the total number of attendees, because some providers may have reported individuals in two or more sex groups, leading to extra counts in some cases for the group outreach attendees. The denominator for age percent is the sum of all sex data reported.

Gender: Attendees across NCOC individual and group outreach events identified themselves as female (54%), male (36%), unknown gender (8%), and queer (2%) in FY 2016-2017. See **Table 6** for the number of individual and group outreach attendees reporting each gender type, by quarter.

Table 6. Gender of Outreach Attendees Served By NCOC, FY 2016-2017

Gender	Q1	Q2	Q3	Q4	Total
Male	874 (34.8%)	523 (35.4%)	130 (36.4%)	163 (42.3%)	1690 (35.7%)
Female	1324 (52.7%)	829 (56.1%)	218 (61.1%)	206 (53.5%)	2577 (54.5%)
Transgender	3 (0.1%)	0 (0.0%)	0 (0.0%)	4 (1.0%)	7 (0.1%)
Queer	0 (0.0%)	70 (4.7%)	1 (0.3%)	5 (1.3%)	76 (1.6%)
Questioning	4 (0.2%)	2 (0.1%)	1 (0.3%)	0 (0.0%)	7 (0.1%)
Other	2 (0.1%)	1 (0.1%)	2 (0.6%)	4 (1.0%)	9 (0.2%)
Unknown	304 (12.1%)	54 (3.7%)	5 (1.4%)	3 (0.8%)	366 (7.7%)
Total**	**2511**	**1479**	**357**	**385**	**4732**

Note: Percentages may not sum to 100% because of rounding. ** Total count for gender reported may be less than the total number of attendees due to the missing data. The denominator for gender percent is the sum of all gender data reported.

Race and ethnicity: In FY 2016-2017, the four largest racial/ethnic groups represented by all NCOC attendees were White (35%), Mexican (20%), Filipino (9%), and multi-racial (9%). Four percent of attendees were of an unknown race. See **Table 7** for the number of attendees representing each reported racial/ethnic group, by quarter.

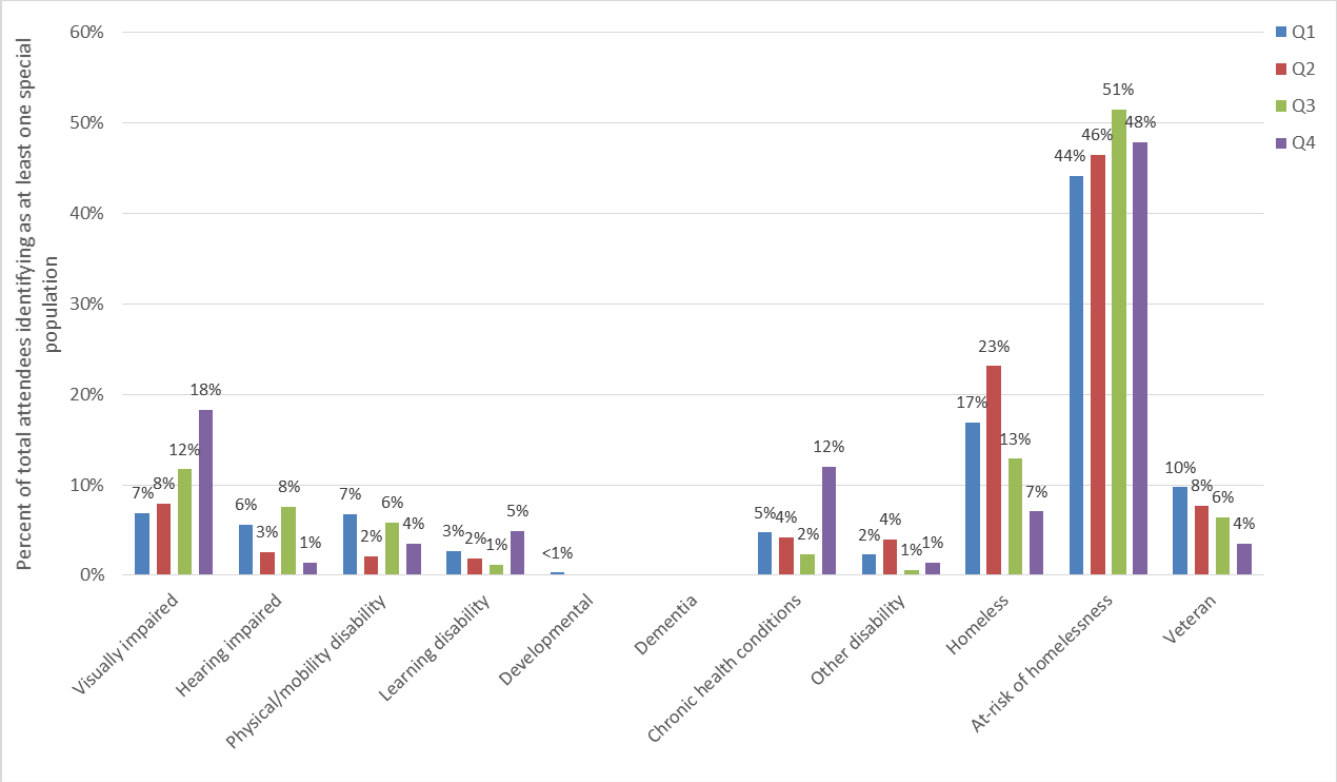
Table 7. Race and Ethnicity of Outreach Attendees Served By NCOC, FY 2016-2017

Race/Ethnicity	Q1	Q2	Q3	Q4	Total
White	1130 (36.3%)	659 (35.5%)	206 (50.6%)	32 (8.2%)	2027 (35.1%)
Black	69 (2.2%)	50 (2.7%)	11 (2.7%)	8 (2.1%)	138 (2.4%)
AmericanIndian	37 (1.2%)	20 (1.1%)	10 (2.5%)	2 (0.5%)	69 (1.2%)
MiddleEastern	22 (0.7%)	22 (1.2%)	2 (0.5%)	5 (1.3%)	51 (0.9%)
EasternEuropean	10 (0.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	10 (0.2%)
European	4 (0.1%)	2 (0.1%)	0 (0.0%)	0 (0.0%)	6 (0.1%)
Mexican	682 (21.9%)	395 (21.3%)	60 (14.7%)	44 (11.3%)	1181 (20.5%)
PuertoRican	12 (0.4%)	15 (0.8%)	0 (0.0%)	1 (0.3%)	28 (0.5%)
Cuban	6 (0.2%)	3 (0.2%)	0 (0.0%)	0 (0.0%)	9 (0.2%)
CentralAmerican	6 (0.2%)	17 (0.9%)	0 (0.0%)	8 (2.1%)	31 (0.5%)
SouthAmerican	3 (0.1%)	7 (0.4%)	1 (0.2%)	3 (0.8%)	14 (0.2%)
Caribbean	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Cambodian	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Chinese	123 (3.9%)	57 (3.1%)	10 (2.5%)	20 (5.1%)	210 (3.6%)
Filipino	278 (8.9%)	141 (7.6%)	32 (7.9%)	49 (12.6%)	500 (8.7%)
Japanese	37 (1.2%)	17 (0.9%)	1 (0.2%)	1 (0.3%)	56 (1.0%)
Korean	30 (1.0%)	14 (0.8%)	1 (0.2%)	0 (0.0%)	45 (0.8%)
Laotian	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Mien	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
SouthAsian	27 (0.9%)	15 (0.8%)	0 (0.0%)	1 (0.3%)	43 (0.7%)
Vietnamese	6 (0.2%)	5 (0.3%)	0 (0.0%)	0 (0.0%)	11 (0.2%)
Samoan	105 (3.4%)	64 (3.4%)	16 (3.9%)	58 (14.9%)	243 (4.2%)
Hawaiian	24 (0.8%)	5 (0.3%)	3 (0.7%)	3 (0.8%)	35 (0.6%)
Tongan	61 (2.0%)	20 (1.1%)	10 (2.5%)	52 (13.3%)	143 (2.5%)
Guamanian	12 (0.4%)	5 (0.3%)	4 (1.0%)	2 (0.5%)	23 (0.4%)
Fijian	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Multi	253 (8.1%)	134 (7.2%)	36 (8.8%)	76 (19.5%)	499 (8.6%)
OtherRace	67 (2.2%)	62 (3.3%)	4 (1.0%)	14 (3.6%)	147 (2.5%)
UnknownRace	110 (3.5%)	129 (6.9%)	0 (0.0%)	11 (2.8%)	250 (4.3%)
Total**	**3114**	**1858**	**407**	**390**	**5769**

Note: Percentages may not sum to 100% because of rounding. ** Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Special populations: NCOC individual and group outreach event attendees reported being part of one or more special populations. Of the special populations, 46% were at risk for homelessness, 17% were homeless, 9% were visually impaired, 8% were veterans, 5% were hearing impaired, 5% had a physical/mobility disability, 5% had chronic health conditions, 3% had a learning disability, and 3% had other disabilities. Refer to **Figure 4** for the percentage of attendees representing each special population in FY 2016-2017, by quarter.

Figure 4. Special Populations Served By NCOC, FY 2016-2017



Note: Attendees could be included in more than one special population.

Additional outreach characteristics (individual outreach events only)

Insurance Coverage: NCOC individual outreach attendees were with unknown insurance (80%), with MediCal (12%), with other insurance (3%), without insurance (3%), with Medicare (2%), or with HealthyKids (1%) in FY 2016-2017. See **Table 8** for the total number of individual outreach attendees reporting each insurance type, by quarter. Providers were not asked to report group outreach data for insurance coverage.

Table 8. Insurance Coverage for NCOC Outreach Attendees, FY 2016-2017

Insurance Type	Q1	Q2	Q3	Q4	Total
HealthyKids	0 (0.0%)	0 (0.0%)	1 (2.6%)	0 (0.0%)	1 (0.7%)
MediCal	7 (13.5%)	5 (17.2%)	3 (7.9%)	3 (9.1%)	18 (11.8%)
Medicare	0 (0.0%)	1 (3.4%)	0 (0.0%)	2 (6.1%)	3 (2.0%)
Other Insurance	2 (3.8%)	1 (3.4%)	1 (2.6%)	0 (0.0%)	4 (2.6%)
Uninsured	1 (1.9%)	0 (0.0%)	2 (5.3%)	2 (6.1%)	5 (3.3%)
Unknown	42 (80.8%)	22 (75.9%)	31 (81.6%)	26 (78.8%)	121 (79.6%)
Total	**52**	**29**	**38**	**33**	**152**

Note: Percentages may not sum to 100% because of rounding. Provider organizations were not asked to report group outreach data on insurance status/type for FY 2016-2017.

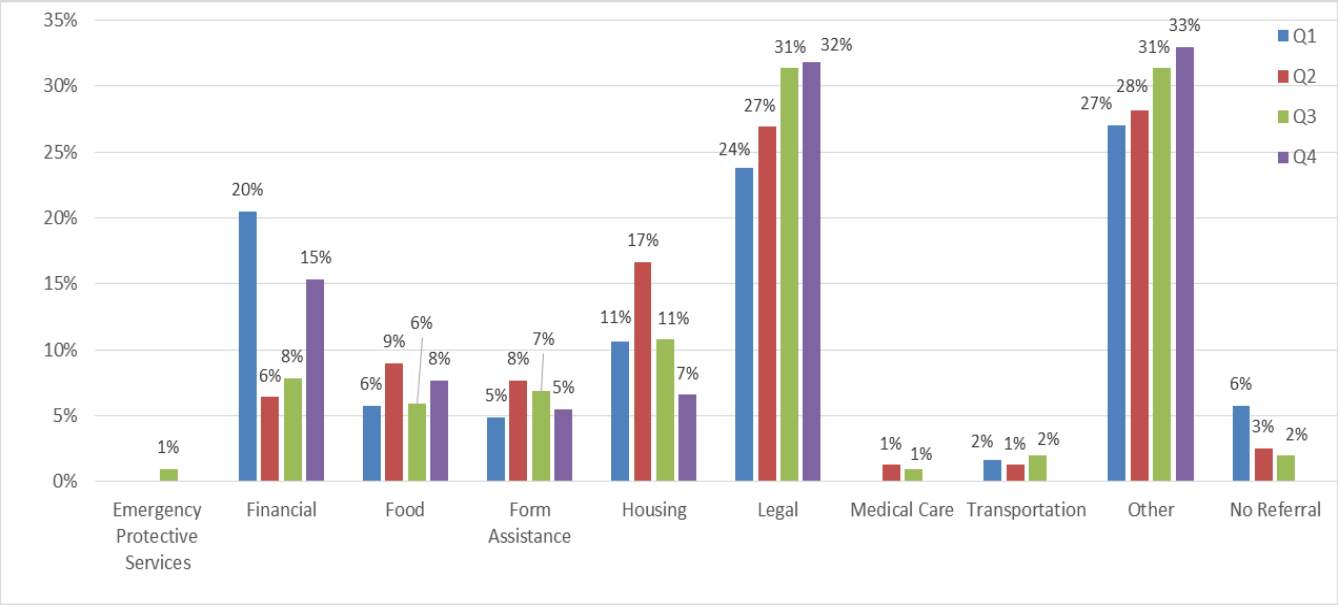
Previous Contact: Nine percent of individual outreach events were conducted with attendees who had a previous outreach contact with NCOC.

Mental Health/Substance Abuse Referrals: NCOC individual outreach events included mental health referrals (52%) and substance abuse referrals (14%) in FY 2016-2017.

Mental Health/Substance Abuse Referral Destinations: Among all the NCOC individuals who were referred for mental health service, 32% were referred to providers. (5% were referred to Daly City Youth Health Center, 5% were referred to Pacifica Collaborative, and 22% were referred to Pyramid Alternatives.) 68% were referred to other destinations. Among the 54 individuals who were referred to other destinations, half of them were referred to StarVista-On Your Mind. Other referral destinations include Parent Support Line-StarVista, ACCESS, North County Mental Health, and others. Among all the NCOC individuals who were referred for substance abuse service, 9% were referred to providers. (9% were referred to Pyramid Alternatives.) 91% were referred to other destinations. Among the 20 individuals who were referred to other destinations, most of them were referred to ODASA. Other referral destinations include Detox and Kaiser CDRP.

Referrals to Social Services: Providers made 393 referrals to 152 NCOC individual outreach attendees. Of the different referral types, the top three types of referrals made for attendees were for other referrals not listed (30%), legal services (28%), and financial (13%). In **Figure 5**, we summarize the percentage of attendees receiving a given type of referral, by quarter.

Figure 5. Referrals to Social Services, FY 2016-2017

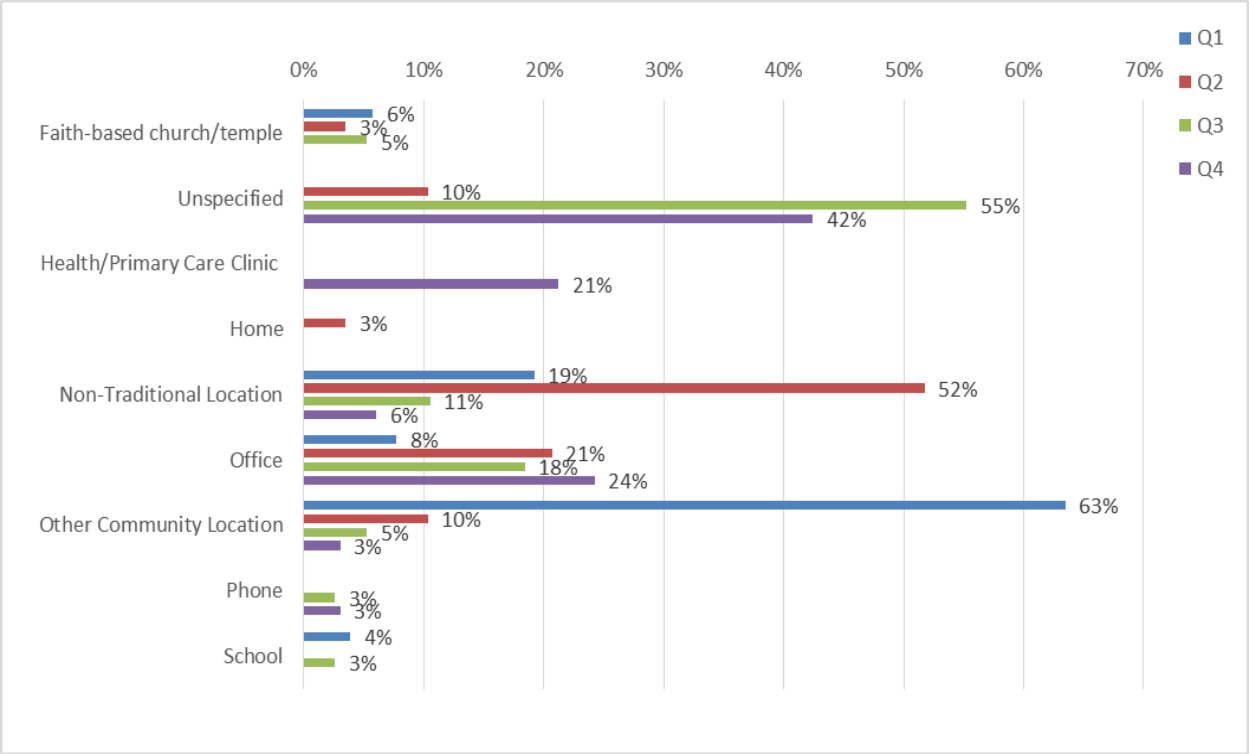


Note: Percentages may not sum to 100% because of rounding. Provider organizations were not asked to report group outreach data on referral type for FY 2016-2017.

Individual outreach event characteristics

Location: NCOC individual outreach events primarily occurred in other community locations not listed (26%) and unspecified (25%) in FY 2016-2017. **Figure 6** presents individual outreach event locations in FY 2016-2017, by quarter.

Figure 6. Locations of NCOC Individual Outreach Events, FY 2016-2017



Note: Percentages may not sum to 100% because of rounding.

Length of contact: For FY 2016-2017, the average length of NCOC individual outreach events was 37.6 minutes. Average length was 36.6 minutes in Q1, 33.3 minutes in Q2, 40.4 minutes in Q3, and 39.8 minutes in Q4.

MAA code: NCOC individual outreach events used MAA codes 401 (Discounted Medi-Cal outreach, 45%), 400 (Medi-Cal outreach, 3%) in FY 2016-2017. Fifty-one percent of MAA codes were reported as N/A.

Language used: NCOC individual outreach events were conducted only in English (100%) across four quarters in FY 2016-2017.

Preferred language: NCOC individual outreach attendees preferred English (91%), Tongan (3%), Spanish (2%), Cantonese (1%) and Samoan (1%). See **Table 9** for the total number of individual outreach attendees reporting each preferred language.

Table 9. Preferred Languages for NCOC Individual Outreach Attendees, FY 2016-2017

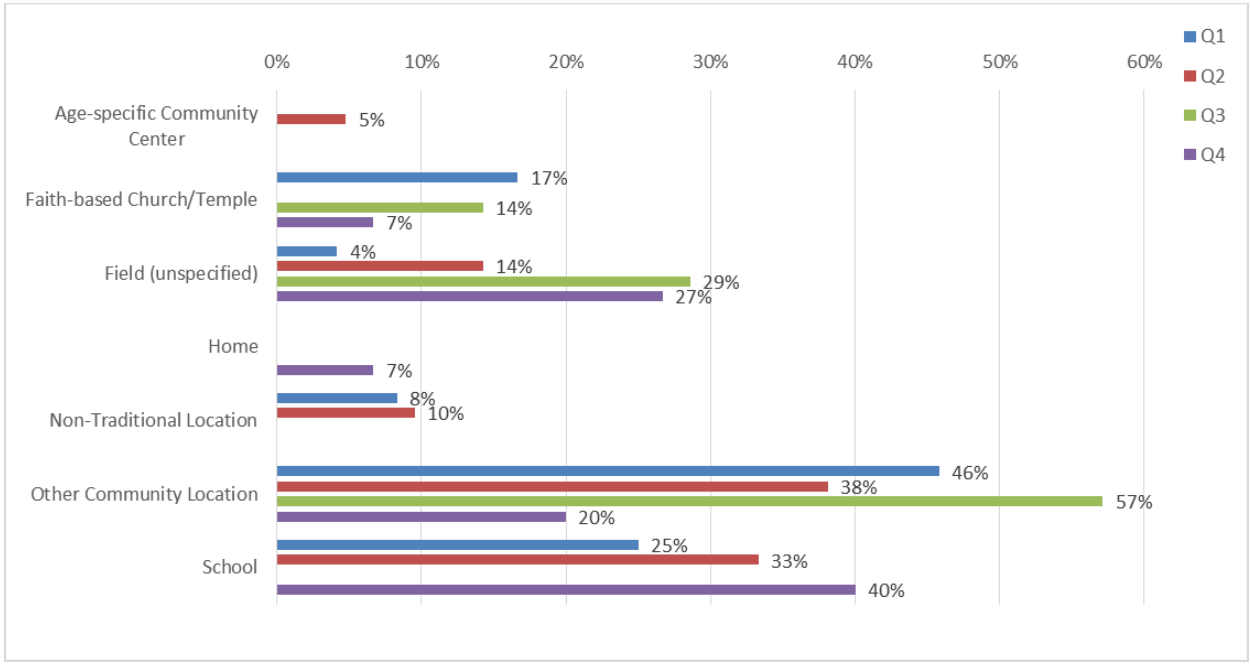
Language	Q1	Q2	Q3	Q4	Total
Cantonese	0 (0.0%)	0 (0.0%)	2 (5.3%)	0 (0.0%)	2 (1.3%)
English	51 (98.1%)	29 (100.0%)	32 (84.2%)	27 (81.8%)	139 (91.4%)
Samoan	0 (0.0%)	0 (0.0%)	1 (2.6%)	1 (3.0%)	2 (1.3%)
Spanish	0 (0.0%)	0 (0.0%)	1 (2.6%)	2 (6.1%)	3 (2.0%)
Tongan	0 (0.0%)	0 (0.0%)	2 (5.3%)	3 (9.1%)	5 (3.3%)
Unknown	1 (1.9%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.7%)
Total	**52**	**29**	**38**	**33**	**152**

Note: Percentages may not sum to 100% because of rounding.

Group outreach event characteristics

Location: NCOC group outreach events largely occurred at other community locations not listed (39%) and at school (28%) in FY 2016-2017. Among the 26 group outreach events held in other locations, most were held in Legion of Honor Pacifica. Other locations include College of San Mateo, Daly City Partnership, San Mateo Central Park, Pacifica Community Center, and others. **Figure 7** presents group outreach event locations in FY 2016-2017, by quarter.

Figure 7. Location of NCOC Group Outreach Events, FY 2016-2017



Note: Percentages may not sum to 100% because of rounding.

Length of contact: For FY 2016-2017, the average length of NCOC group outreach events was 115.9 minutes. By quarter, average length of outreach was 115.8 minutes in Q1, 122.4 minutes in Q2, 111.4 minutes in Q3, and 109.0 minutes in Q4.

MAA code: NCOC group outreach events used MAA codes 401 (Discounted Medi-Cal outreach, 37%), 400 (Medi-Cal outreach, 17%), and 410 (Non-SPMP case management of non-open cases, 6%) in FY 2016-2017. Forty percent of MAA codes were reported as N/A.

Language used: NCOC group outreach events were conducted in English (98.5%) and Mandarin (1.5%) in FY 2016-2017.

Preferred Language: NCOC group outreach attendees preferred English (92%), Spanish (3%), Tagalog (2%), and Cantonese (1%). See **Table 10** below for the breakdown of group outreach events by preferred language.

Table 10. Preferred Languages for NCOC Group Outreach Attendees, FY 2016-2017

Language	Q1	Q2	Q3	Q4	Total
English	2319 (90.1%)	1388 (95.1%)	309 (97.2%)	330 (92.7%)	4346 (92.3%)
Cantonese	51 (2.0%)	2 (0.1%)	1 (0.3%)	4 (1.1%)	58 (1.2%)
Mandarin	4 (0.2%)	1 (0.1%)	1 (0.3%)	1 (0.3%)	7 (0.1%)
Samoan	2 (0.1%)	3 (0.2%)	0 (0.0%)	6 (1.7%)	11 (0.2%)
Spanish	82 (3.2%)	44 (3.0%)	4 (1.3%)	7 (2.0%)	137 (2.9%)
Tagalog	83 (3.2%)	18 (1.2%)	3 (0.9%)	3 (0.8%)	107 (2.3%)
Tongan	7 (0.3%)	1 (0.1%)	0 (0.0%)	4 (1.1%)	12 (0.3%)
Other	27 (1.0%)	2 (0.1%)	0 (0.0%)	1 (0.3%)	30 (0.6%)
Total**	**2575**	**1459**	**318**	**356**	**4708**

Note: Percentages may not sum to 100% because of rounding. ** Total count for preferred language reported may exceed the total number of attendees, because some providers may have reported individuals in two or more preferred language groups, leading to extra counts in some cases for the group outreach attendees. The denominator for age percent is the sum of all preferred language data reported.

EPAPMHO

In FY 2016-2017, there were 623 attendees at individual and group outreach events across the three provider organizations in the EPAPMHO.

Demographics

Age: EPAPMHO individual and group outreach attendees were adults (26-59 years, 51%), transition-age youth (16-25 years, 34%), older adults (60+ years or older, 8%), and children (0-15 years, 7%) in FY 2016-2017. No attendees were of an unknown age. See **Table 11** for the number of individual and group outreach attendees representing each reported age group, by quarter.

Table 11. Age of Individual and Group Outreach Attendees Served By EPAPMHO, FY 2016-2017

Age Group	Q1	Q2	Q3	Q4	Total
Children (0-15)	1 (0.8%)	0 (0.0%)	40 (15.7%)	0 (0.0%)	41 (6.6%)
Transition-age youth	45 (37.5%)	60 (41.4%)	77 (30.2%)	32 (30.8%)	214 (34.3%)
Adults (26-59)	62 (51.7%)	72 (49.7%)	127 (49.8%)	56 (53.8%)	317 (50.8%)
Older adults (60+)	12 (10.0%)	13 (9.0%)	11 (4.3%)	16 (15.4%)	52 (8.3%)
Unknown age	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total**	**120**	**145**	**255**	**104**	**624**

Note: Percentages may not sum to 100% because of rounding. ** Total count for age reported may exceed the total number of attendees, because some providers may have reported individuals in two or more age groups, leading to extra counts in some cases for the group outreach attendees. The denominator for age percent is the sum of all age data reported.

Sex at birth: Attendees across EPAPMHO individual and group outreach events were male (51%) and female (49%) in FY 2016-2017. See **Table 12** for the number of individual and group outreach attendees representing each reported sex, by quarter.

Table 12. Sex at Birth of Outreach Attendees Served By EPAPMHO, FY 2016-2017

Sex	Q1	Q2	Q3	Q4	Total
Male	57 (47.9%)	75 (51.7%)	133 (52.2%)	54 (51.9%)	319 (51.2%)
Female	62 (52.1%)	70 (48.3%)	122 (47.8%)	50 (48.1%)	304 (48.8%)
Other gender	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	**119**	**145**	**255**	**104**	**623**

Note: Percentages may not sum to 100% because of rounding.

Gender: Attendees across EPAPMHO individual and group outreach events identified themselves as female (51%), male (46%), and trans-gender (2%) in FY 2016-2017. See **Table 13** for the number of individual and group outreach attendees representing each reported gender, by quarter.

Table 13. Gender of Outreach Attendees Served By EPAPMHO, FY 2016-2017

Gender	Q1	Q2	Q3	Q4	Total
Male	53 (44.5%)	70 (48.3%)	74 (44.3%)	50 (48.1%)	247 (46.2%)
Female	63 (52.9%)	70 (48.3%)	91 (54.5%)	51 (49.0%)	275 (51.4%)
Transgender	3 (2.5%)	4 (2.8%)	2 (1.2%)	2 (1.9%)	11 (2.1%)
Queer	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Questioning	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (1.0%)	1 (0.2%)
Other	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Unknown	0 (0.0%)	1 (0.7%)	0 (0.0%)	0 (0.0%)	1 (0.2%)
Total**	**119**	**145**	**167**	**104**	**535**

Note: Percentages may not sum to 100% because of rounding. ** Total count for gender reported may be less than the total number of attendees due to the missing data. The denominator for gender percent is the sum of all gender data reported.

Race and ethnicity: In FY 2016-2017, the three largest racial/ethnic groups represented by all EPAPMHO attendees were Black (23%), Tongan (19%), and unknown race (15%). See **Table 14** for the number of attendees representing each reported racial/ethnic group, by quarter.

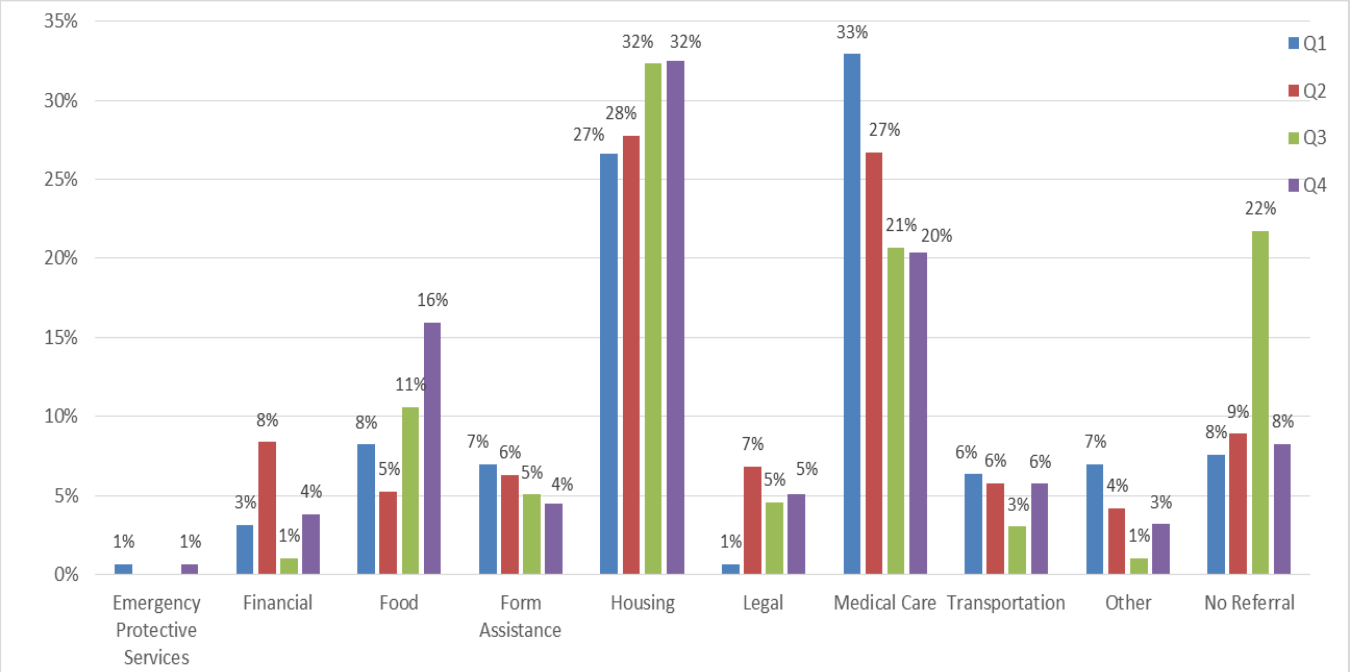
Table 14. Race and Ethnicity of Outreach Attendees Served By EPAPMHO, FY 2016-2017

Race/Ethnicity	Q1	Q2	Q3	Q4	Total
White	12 (10.1%)	6 (4.1%)	18 (7.1%)	5 (4.8%)	41 (6.6%)
Black	35 (29.4%)	33 (22.8%)	50 (19.6%)	25 (24.0%)	143 (23.0%)
American Indian	0 (0.0%)	2 (1.4%)	2 (0.8%)	0 (0.0%)	4 (0.6%)
Middle Eastern	0 (0.0%)	0 (0.0%)	1 (0.4%)	0 (0.0%)	1 (0.2%)
Eastern European	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
European	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Mexican	23 (19.3%)	19 (13.1%)	21 (8.2%)	19 (18.3%)	82 (13.2%)
Puerto Rican	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Cuban	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Central American	0 (0.0%)	1 (0.7%)	7 (2.7%)	0 (0.0%)	8 (1.3%)
South American	0 (0.0%)	1 (0.7%)	0 (0.0%)	0 (0.0%)	1 (0.2%)
Caribbean	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Cambodian	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Chinese	0 (0.0%)	0 (0.0%)	2 (0.8%)	0 (0.0%)	2 (0.3%)
Filipino	3 (2.5%)	5 (3.4%)	5 (2.0%)	4 (3.8%)	17 (2.7%)
Japanese	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Korean	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Laotian	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Mien	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
South Asian	0 (0.0%)	0 (0.0%)	1 (0.4%)	1 (1.0%)	2 (0.3%)
Vietnamese	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Samoan	1 (0.8%)	10 (6.9%)	15 (5.9%)	17 (16.3%)	43 (6.9%)
Hawaiian	1 (0.8%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.2%)
Tongan	40 (33.6%)	37 (25.5%)	25 (9.8%)	17 (16.3%)	119 (19.1%)
Guamanian	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Fijian	0 (0.0%)	1 (0.7%)	2 (0.8%)	0 (0.0%)	3 (0.5%)
Multi	4 (3.4%)	27 (18.6%)	17 (6.7%)	14 (13.5%)	62 (10.0%)
Other Race	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (1.0%)	1 (0.2%)
Unknown Race	0 (0.0%)	3 (2.1%)	89 (34.9%)	1 (1.0%)	93 (14.9%)
Total	**119**	**145**	**255**	**104**	**623**

Note: Percentages may not sum to 100% because of rounding.

Special populations: EPAPMHO individual and group outreach event attendees reported being part of one or more special populations. Of the special populations, 33% were at-risk of homelessness, 30% were homeless, 10% were visually impaired, 9% were veteran, 6% were hearing impaired, 6% had chronic health conditions, 3% had a physical/mobility disability. Refer to **Figure 8** for the percentage of attendees representing each special population in FY 2016-2017, by quarter.

Figure 8. Special Populations Served by EPAPMHO, FY 2016-2017



Note: Attendees could be included in more than one special population.

Additional outreach characteristics (individual outreach events only)

Insurance Coverage: EPAPMHO individual outreach attendees were without insurance (42%), with Medi-Cal (41%), with other insurance not listed (6%), with unknown insurance (5%), with HealthyKids (3%), or with Medicare (3%). See **Table 15** for the total number of individual outreach attendees reporting each insurance type, by quarter. Providers were not asked to report group outreach data for insurance coverage.

Table 15. Insurance Coverage, FY 2016-2017

Insurance Type	Q1	Q2	Q3	Q4	Total
HealthyKids	0 (0.0%)	8 (6.5%)	2 (1.6%)	3 (3.2%)	13 (2.9%)
MediCal	31 (30.4%)	46 (37.1%)	69 (53.5%)	40 (42.1%)	186 (41.3%)
Medicare	5 (4.9%)	1 (0.8%)	2 (1.6%)	5 (5.3%)	13 (2.9%)
Other Insurance	10 (9.8%)	5 (4.0%)	10 (7.8%)	2 (2.1%)	27 (6.0%)
Uninsured	56 (54.9%)	56 (45.2%)	36 (27.9%)	41 (43.2%)	189 (42.0%)
Unknown	0 (0.0%)	8 (6.5%)	10 (7.8%)	4 (4.2%)	22 (4.9%)
Total	**102**	**124**	**129**	**95**	**450**

Note: Percentages may not sum to 100% because of rounding. Provider organizations were not asked to report group outreach data on insurance status/type for FY 2016-2017.

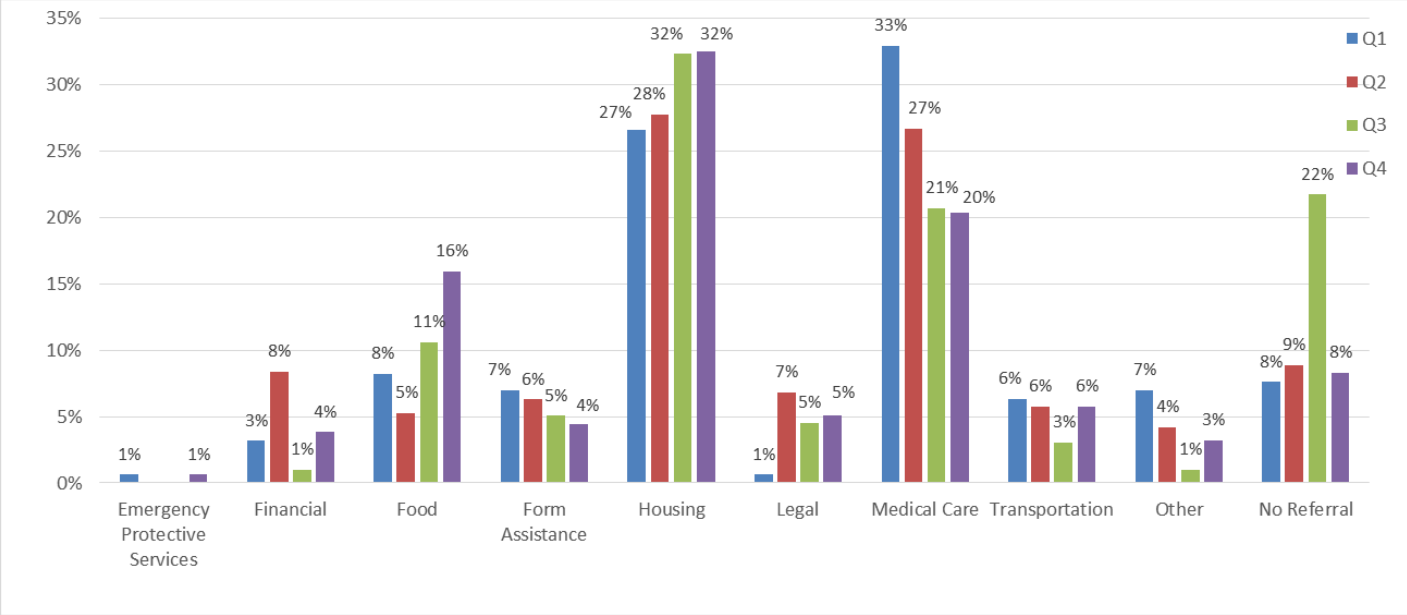
Previous contact: Thirty-four percent of individual outreach events were conducted with attendees who had a previous outreach contact with EPAPMHO.

Mental Health/Substance Abuse Referrals: EPAPMHO individual outreach events included mental health referrals (14%) and substance abuse referrals (25%) in FY 2016-2017.

Mental Health/Substance Abuse Referral Destinations: Among all the EPAPMHO individuals who were referred for mental health service, 19% were referred to providers. (18% were referred to El Concilio and 2% were referred to Free at Last.) 81% were referred to other destinations. Among the 46 individuals who were referred to other destinations, most of them were referred to EPACCC or Ravenswood Family Health Center. For all the EPAPMHO individuals who were referred for substance abuse service, 51% were referred to providers. (51% were referred to Free at Last.) 49% were referred to other destinations. Among the 57 individuals who were referred to other destinations, most were referred to Ravenswood Family Health Center or Project90. Other destinations also include Latino Commission, Our Common Ground, WRA women residential, and others.

Referrals to Social Services: Providers made 704 referrals to 450 EPAPMHO individual outreach attendees. Of the different referral types, the top three types of referrals made for attendees were for housing (32%), medical care (20%), and food (16%). **Figure 9** summarizes the percentage of attendees receiving a given type of referral, by quarter.

Figure 9. Referrals to Social Services, FY 2016-2017

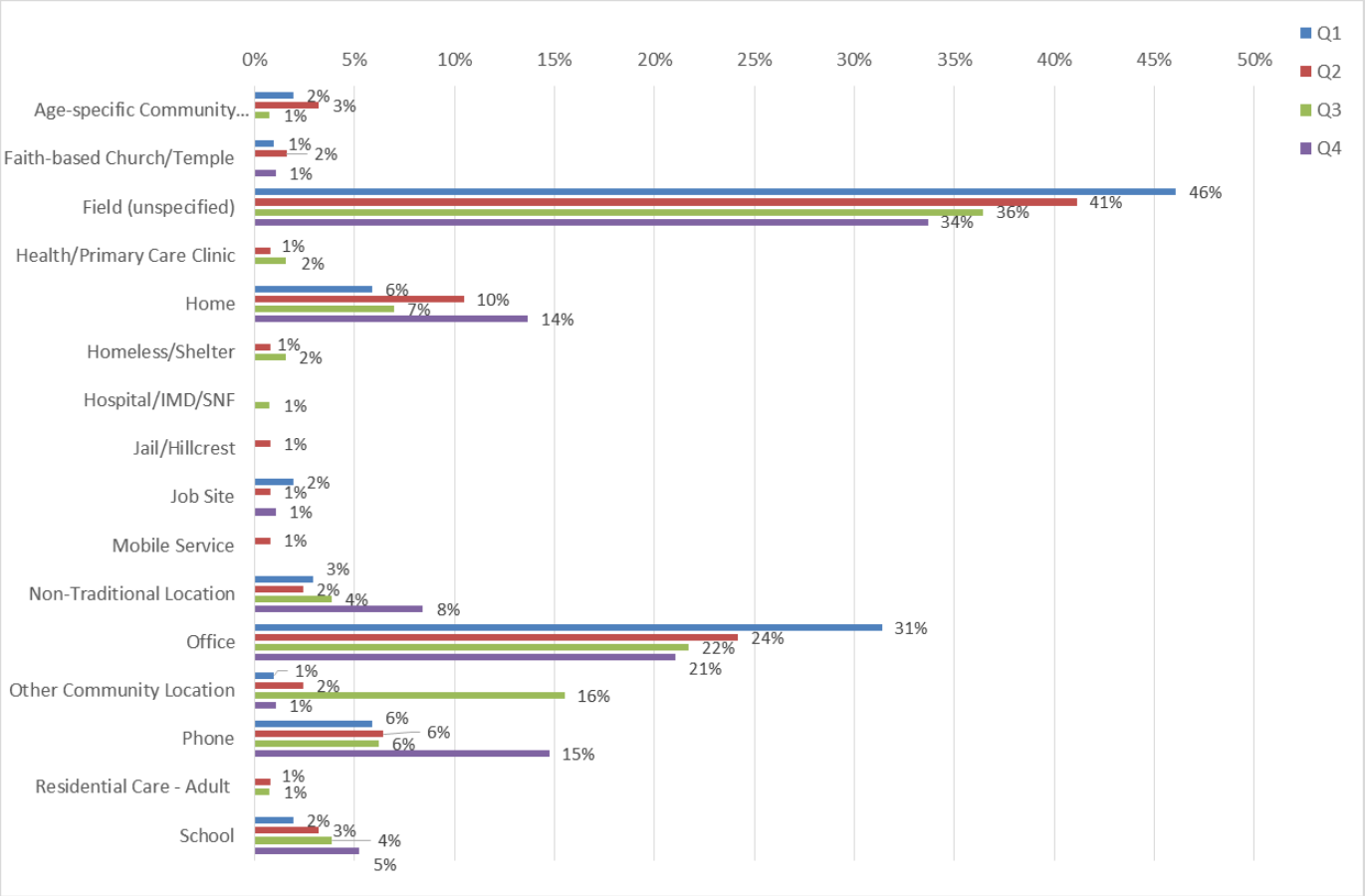


Note: Provider organizations were not asked to report group outreach data on referral type for FY 2016-2017.

Individual outreach event characteristics

Location: EPAPMHO individual outreach events typically occurred in unspecified locations (39%), offices (24%), and home (9%) in FY 2016-2017. See **Figure 10** for a summary of individual outreach events by location.

Figure 10. Location of EPAPMHO Individual Outreach Events, FY 2016-2017



Note: Percentages may not sum to 100% because of rounding.

Length of contact: For FY 2016-2017, the average length of EPAPMHO individual outreach events was 39.2 minutes. By quarter, average length of outreach was 41.5 minutes in Q1, 43.9 minutes in Q2, 35.5 minutes in Q3, and 35.7 minutes in Q4.

MAA code: EPAPMHO individual outreach events used MAA codes 400 (Medi-Cal outreach, 53%), 401 (Discounted Medi-Cal outreach, 46%), and MAA codes 403 (Referral in crisis situations for non-open cases, <1%). None of the MAA codes were reported as N/A.

Language used: EPAPMHO individual outreach events were conducted in English (68%), Spanish (20%), Tongan (8%), and Samoan (4%). See **Table 16** below for the breakdown of group outreach events by the language of administration.

Table 16. Languages of administration in EPAPMHO individual outreach events, FY 2016-2017

Language	Q1	Q2	Q3	Q4	Total
English	72 (70.6%)	85 (68.5%)	93 (72.1%)	54 (56.8%)	304 (67.6%)
Mandarin	1 (1.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.2%)
Samoan	0 (0.0%)	3 (2.4%)	9 (7.0%)	7 (7.4%)	19 (4.2%)
Spanish	23 (22.5%)	23 (18.5%)	16 (12.4%)	26 (27.4%)	88 (19.6%)
Tagalog	0 (0.0%)	1 (0.8%)	0 (0.0%)	0 (0.0%)	1 (0.2%)
Tongan	6 (5.9%)	12 (9.7%)	11 (8.5%)	8 (8.4%)	37 (8.2%)
Total	**102**	**124**	**129**	**95**	**450**

Note: Percentages may not sum to 100% because of rounding.

Preferred Language: Most EPAPMHO individual outreach attendees preferred English (64%), Spanish (20%) and Tongan (8%). See **Table 17** below for the breakdown of EPAPMHO individual outreach events by preferred language.

Table 17. Preferred Languages for EPAPMHO Individual Outreach Attendees, FY 2016-2017

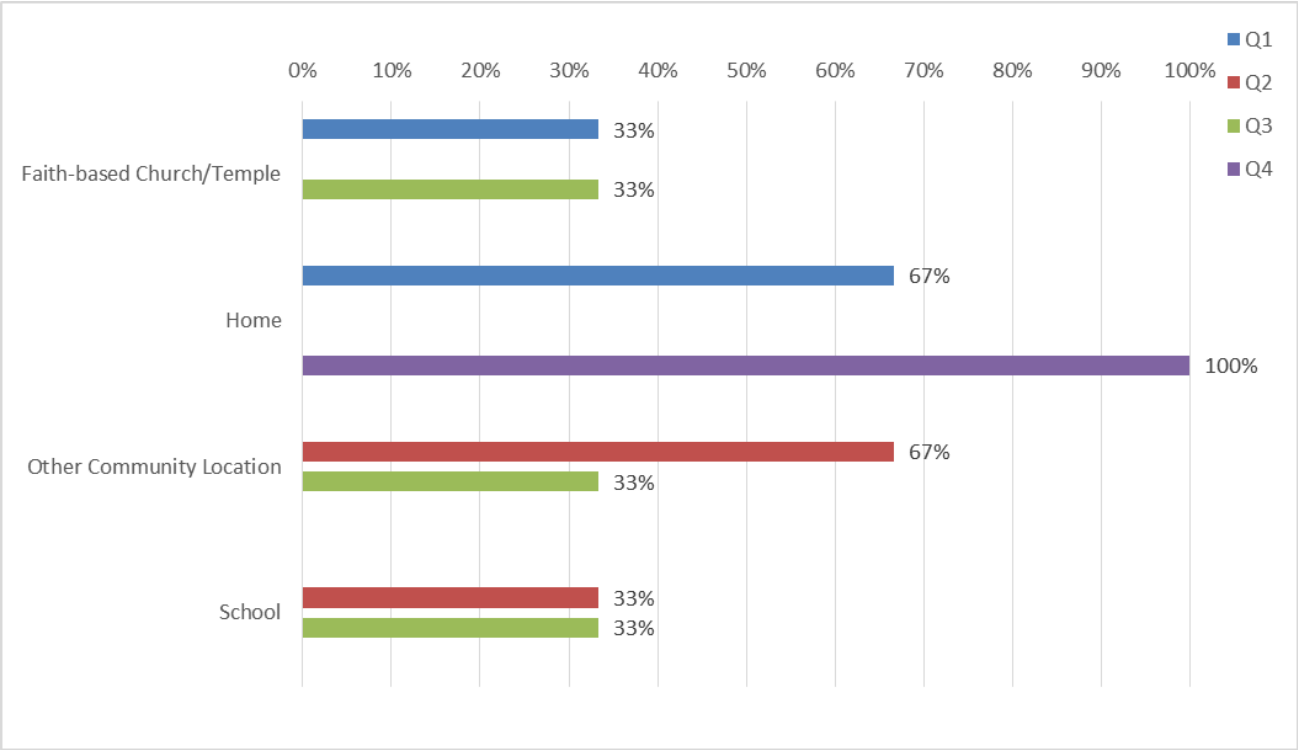
Language	Q1	Q2	Q3	Q4	Total
English	70 (68.6%)	75 (60.5%)	92 (71.3%)	53 (55.8%)	290 (64.4%)
Other	0 (0.0%)	0 (0.0%)	1 (0.8%)	0 (0.0%)	1 (0.2%)
Samoan	0 (0.0%)	5 (4.0%)	6 (4.7%)	9 (9.5%)	20 (4.4%)
Spanish	23 (22.5%)	24 (19.4%)	19 (14.7%)	26 (27.4%)	92 (20.4%)
Tagalog	3 (2.9%)	5 (4.0%)	0 (0.0%)	2 (2.1%)	10 (2.2%)
Tongan	6 (5.9%)	15 (12.1%)	11 (8.5%)	5 (5.3%)	37 (8.2%)
Total	**102**	**124**	**129**	**95**	**450**

Note: Percentages may not sum to 100% because of rounding.

Group outreach event characteristics

Locations: EPAPMHO group outreach events were held at home (30%), at other community locations not listed (30%), at faith-based churches/temples (20%), and in schools (20%) in FY 2016-2017. Other community locations include Canada College and Rugby field. Refer to **Figure 11** for a breakdown of group outreach events by location.

Figure 11. Locations of EPAPMHO Group Outreach Events, FY 2016-2017



Note: Percentages may not sum to 100% because of rounding.

Length of contact: For FY 2016-2017, the average length of EPAPMHO group outreach events was 74.5 minutes. By quarter, average length of outreach was 40.0 minutes in Q1, 75.0 minutes in Q2, 123.3 minutes in Q3, and 30.0 minutes in Q4.

MAA code: EPAPMHO group outreach events used only MAA code 400 (Medi-Cal outreach, 100%) in FY 2016-2017.

Language used: EPAPMHO group outreach events were conducted in English (60%), Tongan (30%), and Samoan (10%). See **Table 18** below for the breakdown of group outreach events by the language of administration.

Table 18. Languages of Administration in EPAPMHO Group Outreach Events, FY 2016-2017

Language	Q1	Q2	Q3	Q4	Total
English	0 (0.0%)	3 (100.0%)	3 (100.0%)	0 (0.0%)	6 (60.0%)
Samoan	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (100.0%)	1 (10.0%)
Tongan	3 (100.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	3 (30.0%)
Total	**3**	**3**	**3**	**1**	**10**

Note: Percentages may not sum to 100% because of rounding.

Preferred Language: EPAPMHO group outreach attendees preferred English (78%), Tongan (13%), Samoan (5%), and Spanish (3%). See **Table 19** below for the breakdown of group outreach events by the language of administration.

Table 19. Preferred Languages for EPAPMHO Group Outreach Attendees, FY 2016-2017

Language	Q1	Q2	Q3	Q4	Total
English	5 (29.4%)	14 (93.3%)	112 (88.9%)	0 (0.0%)	131 (78.3%)
Cantonese	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Mandarin	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Samoan	0 (0.0%)	0 (0.0%)	3 (2.4%)	6 (66.7%)	9 (5.3%)
Spanish	0 (0.0%)	0 (0.0%)	5 (4.0%)	0 (0.0%)	5 (3.0%)
Tagalog	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Tongan	12 (70.6%)	0 (0.0%)	6 (4.8%)	3 (33.3%)	21 (12.8%)
Other	0 (0.0%)	1 (6.7%)	0 (0.0%)	0 (0.0%)	1 (0.6%)
Total**	**17**	**15**	**126**	**9**	**167**

Note: Percentages may not sum to 100% because of rounding. ** Total count for preferred language reported may be less than the total number of attendees due to the missing data. The denominator for preferred language percent is the sum of all preferred language data reported.

Outreach Summaries by Provider

We analyzed outreach efforts by provider and created provider-specific summaries to help SMC BHRS and its providers better understand each organization's outreach efforts. Please refer to **Appendix A-G** for these provider-specific summaries. In each provider summary, we highlighted key observations on outreach location, language, insurance, race/ethnicity, and specific groups of interest for both individual and group outreach efforts.

Recommendations

We have several recommendations based on FY 2016-2017 data. These recommendations fall under two umbrellas: those aimed at enhancing outreach, and those to improve data collection.

Enhance outreach

Continue to tailor or increase outreach efforts for specific demographic groups, such as older adults and Latino/Hispanic persons from Central America. EPAPMHO and NCOC have made improvements to meeting the needs of the seniors (aged 65 and older), but additional targeting may still be necessary. According to a survey of San Mateo residents in 2015, 19% of the county's senior population reported needing help for emotional/mental health problems or use of alcohol/drugs.[1] This year, 15% of the attendees were older adults, a major improvement over FY 2015-2016 (during which 7% of the attendees were seniors) and FY 2014-2015 (during which 8% of the individual outreach attendees were seniors).

In addition, similar to last year, among persons who identified as Latino/Hispanic, individuals from Central American descent were underrepresented at outreach events. According to a survey of San Mateo residents in 2015, among persons who identified as Latino/Hispanic and reported needing help for emotional/mental health problems or use of alcohol/drugs in San Mateo County

[1] UCLA Center for Health Policy Research. AskCHIS 2015. Available at http://ask.chis.ucla.edu.

in 2015, 57% were Central American and 14% were Mexican.[2] However, 93% of Latino/Hispanic outreach attendees were identified as Mexican and only 3% were identified as Central American among the two collaboratives. Note that the ethnicity of Central American was first added in FY 2016-2017, thus no data on Central American was available for FY 2014-2015 and FY 2015-2016.

Consider how to meet the changing needs of uninsured individuals. A large proportion of attendees did not report being insured by a specific health plan. In FY 2016-2017, 56% reported being uninsured or had unknown insurance status across two collaboratives, which is similar to last year FY an 2015-2016 (54%) and a decrease from FY 2014-2015 (64%). Disentangling uninsured status from unknown insurance status is a data quality issue to be discussed below, but regardless, this group deserves special attention. The county should consider how to best meet the needs of uninsured individuals, who may become more reticent to respond to outreach events particularly if they are concerned about treatment costs. The size of this group may also grow if the insurance marketplaces destabilize.

Focus on increasing housing-related resources and referrals. Last year, AIR recommended considering whether adequate housing-related resources were being given; since then the number of attendees reporting homelessness or risk of homelessness has increased from about 1,000 in FY 2015-2016 to around 1,260 in FY 2016-2017, which is a 26% increase. Note that attendees may not be unique individuals. In FY 2016-2017, a total of 253 housing-related referrals were made, which is 23% of the total referrals. In FY 2015-2016, a total of 405 housing-related referrals were made, which is 19% of the total referrals. Thus, compared to last FY, the number of housing-related referrals made in FY 2016-2017 decreases but the percent of housing-related referrals increases by 4 percentage points.

Improve data collection

Make other/unspecified categories more clear. Last year, AIR recommended minimizing missing data, and there is less missing data this year. However, there are still relatively high proportions of individuals in other/unspecified categories for some topics. For example, 80% of the NCOC outreach attendees were identified as having unknown insurance status. In addition, 15% of the EPAPMHO outreach attendees were identified as other/unknown races. Providers may consider categorizing unspecified responses, inquiring why certain fields have been left blank, or by creating more categories to capture as many responses as possible.

Treat race/ethnicity as mutually exclusive categories. Last year, AIR recommended that mutually exclusive race/ethnicity categories, including a "two or more races" category. At this time, total counts for race/ethnicity in EPAPMHO group outreach events perfectly match the total number of group outreach attendees, which has been a great improvement since last year. But, total counts for race/ethnicity in NCOC group outreach events are still larger than the total number of group outreach attendees.

[2] UCLA Center for Health Policy Research. Ask CHIS 2015. Available at http://ask.chis.ucla.edu.

Continue gathering the new demographic information that has been collected this year. Last year, the California State Mental Health Services Oversight and Accountability Commission included new demographic requirements for MHSA prevention and early intervention reporting. New options for gender identity and sexual orientation, disabilities and client needs, and county of residence were added. These data have been collected in FY 2016-2017 and were of use in the creation of this report.

BHRS Discussion on Outreach characteristics and trends

After three years of summarizing comprehensive outreach data, it is imperative that we look at the trends and challenges in outreach from a perspective that considers sociocultural context and its impact on community demographics and the need for updating outreach goals and integration across other BHRS outreach efforts.

Outreach characteristics where we specifically looked at trends across the three fiscal years 2014-2017 included;

1. Outreach Attendees – while there were differences amongst the collaboratives as shown in the report, overall numbers and reach increased.
2. Race/Ethnicity – overall, individuals identifying as Mexican and White increased while other ethnicities decreased in particular, Other Latino/Central American, Tongan and Samoan and Filipino and Black.
3. Referrals to Mental Health/Substance Abuse –while the total number of referrals made to both mental health and substance use providers decreased by almost half, the percentage of those referred to these services increased. This could point to the idea that outreach is getting more targeted to those with mental health and substance use needs.
4. Referrals to Social Services – the collaboratives differed in the types of referrals, while EPAPMHO primarily refers to medical care and housing, the NCOC primarily refers to legal, financial and housing.
5. Special Populations – Overall, at-risk for homelessness continues to be the highest special populations group reported.

While we are well aware that staff and agency transitions and data reporting/tracking have had direct impact on the outreach numbers; there are also socio political factors that may influence some of the shifts in racial make-up, referrals made and participant characteristics.

Gentrification

Recent changes in economic, educational and racial make-up of historically disinvested neighborhoods is happening across the Bay Area including the communities served by the Outreach Collaboratives. The Urban Displacement Project (http://www.urbandisplacement.org; Zuk, M., & Chapple, K. (2015), which analyzes regional data and has identified cities such as Colma, Daly City and East Palo Alto susceptible to ongoing and advanced gentrification including loss of low income housing, displacement of low income communities and changing demographics.

Drug Medi-Cal Waiver

In April 2016, San Mateo County was the second in the State of California to receive approval to create a local Drug Medi-Cal Organized Delivery System (DMC-ODS) providing individuals with substance use disorders greater access to a wider range of behavioral healthcare services. Community-based agency representatives are reporting an increase in more complex co-occurring cases. It will be important to attempt to track the impact of DMC-ODS on outreach.

Immigration policies

The current policy changes impacting immigrants has led undocumented immigrants to avoid safety-net programs. Community based agency representatives across San Mateo County have been reporting a drop in enrollment and eligible families pulling out of health and social service initiatives out of fear of deportation. It is expected that this will impact outreach characteristics.

Tracking of Referrals

Moving forward we will need to strengthen the tracking of unduplicated referrals to behavioral health services to demonstrate specifically how outreach efforts increase access and linkages to treatment and improve timely access for underserved populations. In particular, guidelines released by the State of California Mental Health Oversight and Accountability Commission are requesting the following data points to demonstrate effectiveness of programs funded to create access and linkages to services: 1) number of referrals for Serious Mental Illness (SMI), 2) the type of treatment received, 3) the number that followed through and engaged, 3) average duration of untreated mental illness and 4) average interval between referral and engagement.

Updates to Outreach Collaborative Deliverables

Outreach characteristics as outlined in this report will continue to be collected. It is important to keep the intention of the collaboratives focused on reaching underserved populations in low income communities including at-risk youth, transition-age youth and adults of diverse ethnic and cultural backgrounds. Given the many challenges to tracking and reporting unduplicated reach, the focus will shift to unduplicated referrals made to behavioral health services in particular and follow through where appropriate. Following are overall considerations outlined last year that will be incorporated into 2018 updates to the Outreach Collaborative deliverables.

- ✓ Coordinate and articulate the goals of the outreach collaborative strategy across both the north county region, including Pacifica and the East Palo Alto community.
    - Benchmarks and activities are expected to look different given the unique needs and demographics of each community but the overall goals should align.
    - Integrate broader outreach and support goals and activities, recognizing the intersection of outreach to increase access for individuals with severe mental illness (SMI) and outreach efforts for prevention, stigma reduction and meaningful engagement.

- ✓ Identify meaningful indicators of success for the outreach collaboratives including tracking SMI referrals and follow through where appropriate.
- ✓ Integrate efforts and activities to include special populations as identified in the AIR report, at-risk for homelessness, older adults and emerging communities and expanded needs in the broader San Mateo County (e.g. Arab-American, LGBTQ, geographically isolated communities, etc.)
- ✓ Coordinate and articulate MHSA-wide efforts and indicators to measure stigma reduction and improvements in cultural and ethnic disparities as they relate to access to behavioral health services in San Mateo County.

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Appendix A. FY 2016-2017 Outreach, Asian American Recovery Services

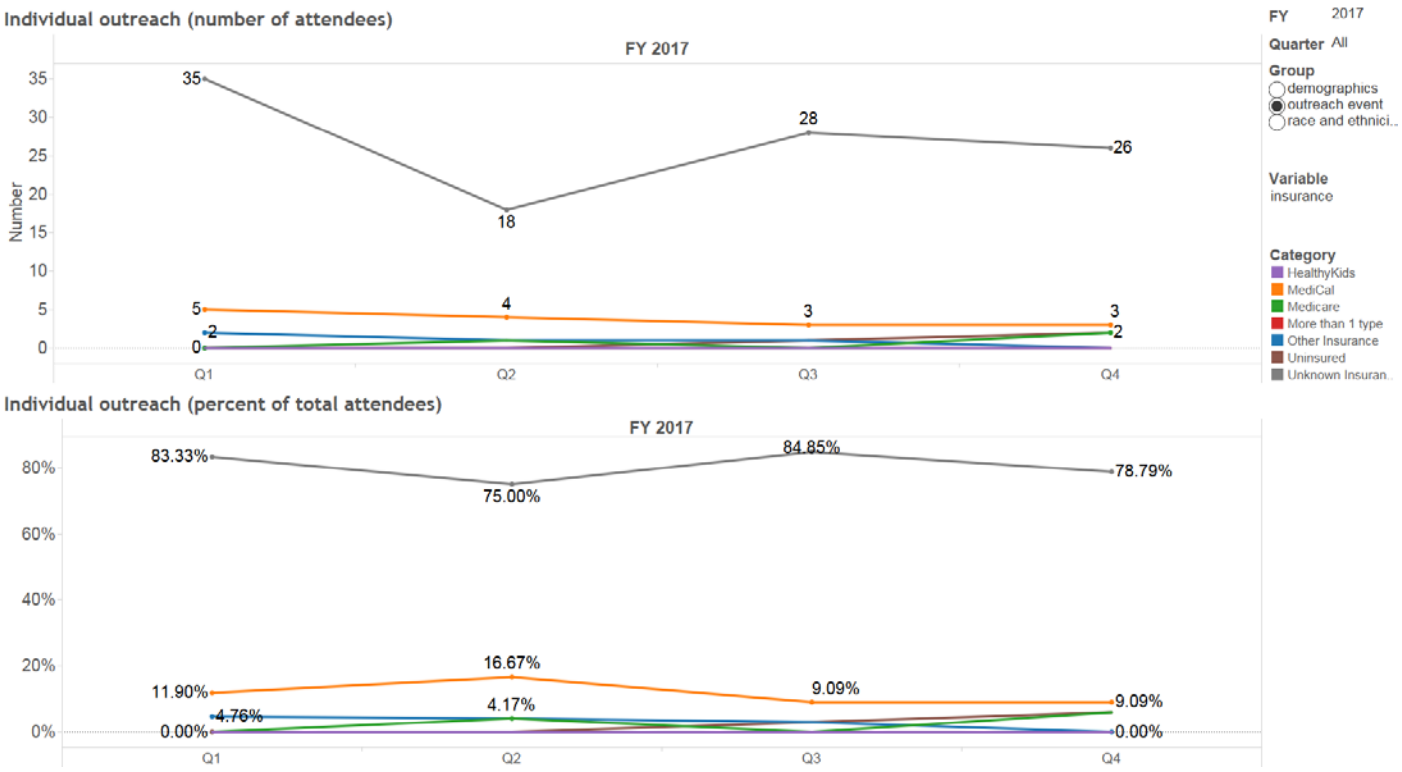
Individual outreach

For FY 2016-2017, Asian American Recovery Services (AARS) reported a total of 132 individual outreach events—42 individual outreach events in Q1, 24 events in Q2, 33 events in Q3, and 33 events in Q4. The average length of individual outreach events was 40 minutes, ranging from an average of 37 minutes in Q2 to 42 minutes in Q3.

Individual outreach events:

- Took place in unspecified locations (**28.8%**; n=38), followed by non-traditional locations (**23.5%**, n=31) and other community locations (**22.7%**; n=30).
- Were categorized under MAA 401 (**51.5%**; n=68).
- Were conducted in English (**100%**; n=132).
- Had different types of insurance reported during FY 2016-2017. Unknown insurance and Medi-Cal were most common (**Figure 1**).

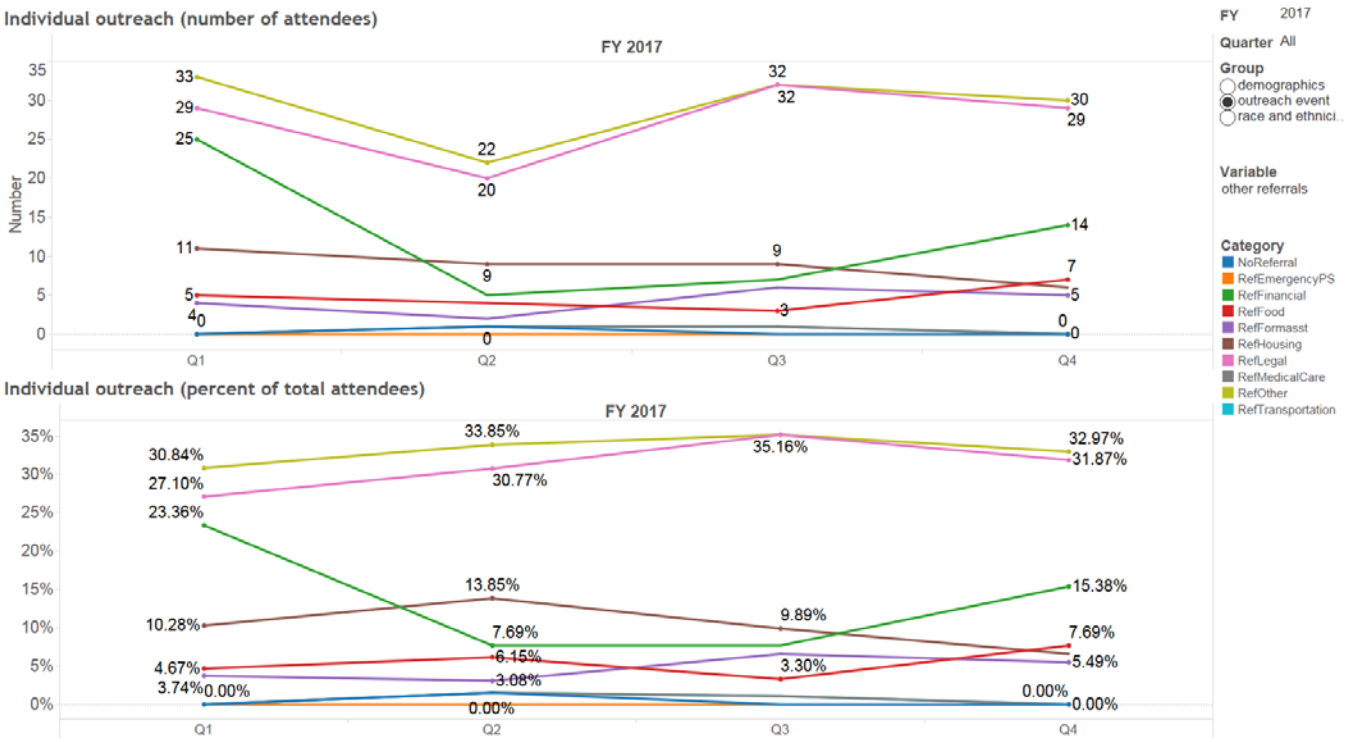
Figure 1. Type of Insurance, Q1-Q4



- Resulted in 67 mental health referrals and 19 substance abuse referrals.

- Resulted in 354 other referrals (**Figure 2**). An individual outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. AARS made other (n=117), Legal (n=110), and Financial (n=51) referrals the most often.

Figure 2. Other Referrals, Q1-Q4

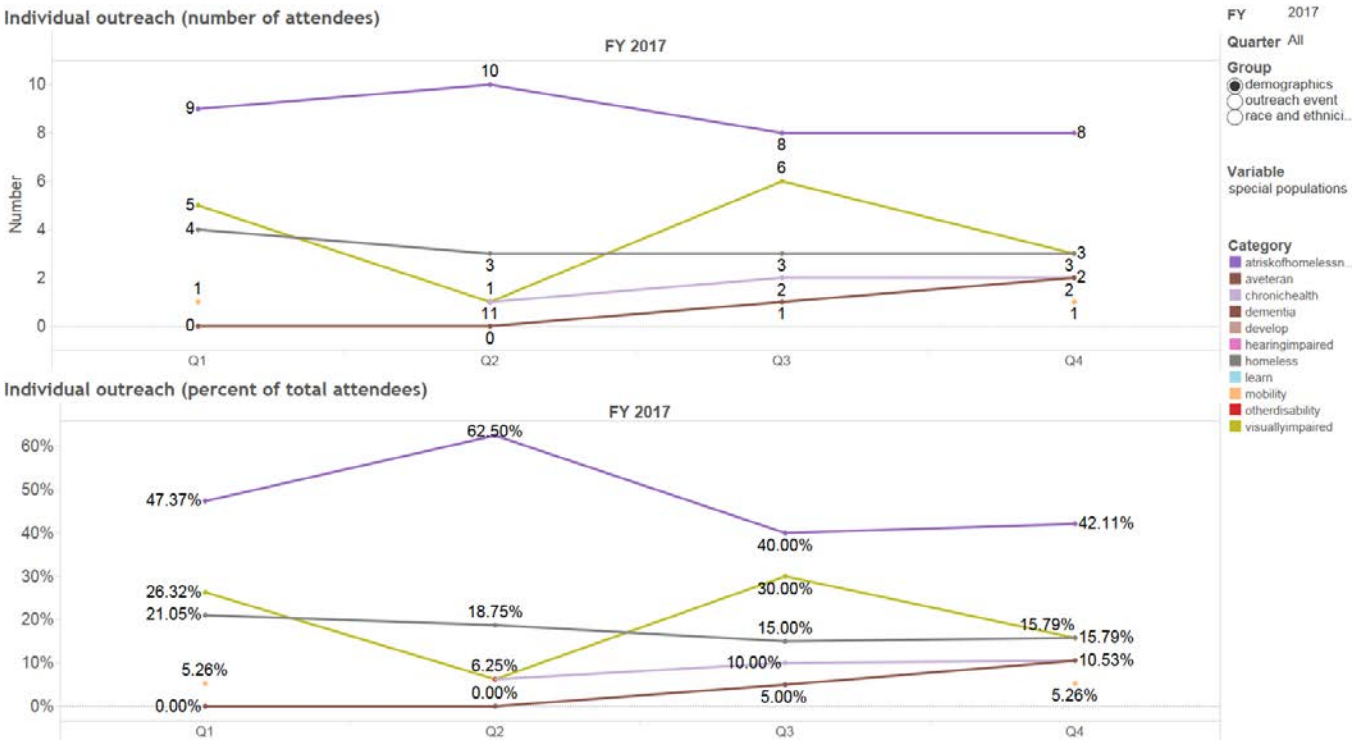


Individual outreach event attendees:

- Self-reported as female (**57.6%**; n=76), male (**42.4%**; n=56), or unknown gender (**0%**; n=0).
- Self-reported as Heterosexual (**92.4%**; n=122), Gay/Lesbian (**3.8%**; n=5), Questioning (**1.5%**; n=2), Unknown (**1.5%**; n=2), or Queer (**<1%**; n=1).
- Were adults (26-59 year, **57.6%**; n=76), transition-age youth (16-25 years, **34.8%**; n=46), older adults (60+ years, **4.5%**; n=6), or children (0-15 years, **3.0%**; n=4).
- Were two or more races (**39.4.0%**; n=52), Samoan (**15.9%**; n=21), Tongan (**13.6%**; n=18), Mexican (**9.1%;** n=12), White (**7.6%**; n=10), Chinese (**3.0%**; n=4), Filipino (**3.0%**; n=4), Hawaiian (**3.0%**; n=4), Guamanian (**2.3%**; n=3), Black (**1.5%**; n=2), or Central American (**1.5%**; n=2).

Special populations include those who are veterans, are homeless, are at risk of homelessness, are hearing impaired, are vision impaired, have dementia, have chronic health conditions, have a mobility disability, have a learning disability, or have a developmental disability. In FY 2016-2017, AARS reported 74 individual outreach attendees representing these populations as presented in **Figure 3**.

Figure 3. Special Populations, Q1-Q4



Group outreach

For FY 2016-2017, Asian American Recovery Services (AARS) reported a total of 32 group outreach events, corresponding to 992 group outreach attendees—363 attendees in Q1, 244 attendees in Q2, 28 attendees in Q3, and 357 attendees in Q4. The average length of group outreach events is 128 minutes, ranging from an average of 68 minute per event in Q3 to 173 minutes per event in Q1.

Most group outreach events:

- Took place in schools (**31.3%;** n=10), followed by other community locations (**25.0%**; n=8), unspecified locations (**25.0%;** n=8), and non-traditional locations (**12.5%;** n=4).
- Were categorized under MAA 401 (**78.1%**; n=25).
- Were conducted in English (**100%**; n=32).

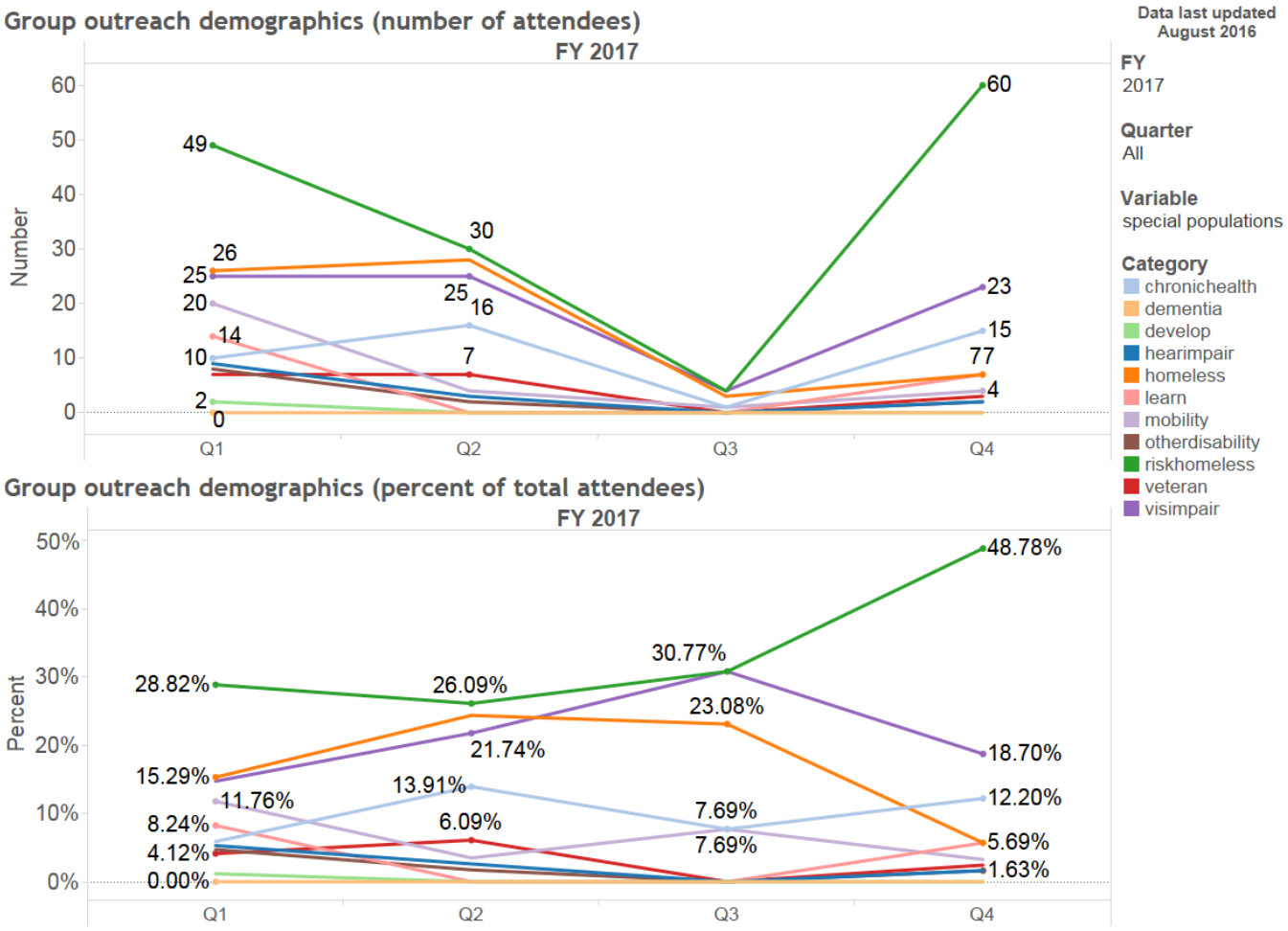
Group outreach event attendees:

- Self-reported as female (**60.7%**; n=606), male (**38.0%**; n=379), or other gender (**1.4%**; n=14).
- Identified as Heterosexual (**79.2%;** n=733), Gay/Lesbian (**8.4%;** n=78), Unknown (**5.0%;** n=46), Bisexual (**4.5%;** n=42), Queer (**1.1%;** n=10), Other **(<1%;** n=9) or Questioning (**<1%**; n=8).
- Represented many races and ethnicities (**Table 1**):

Table 1. Group Outreach Attendees by Race/Ethnicity			
Race/ethnicity	**Number (%)**	**Race/ethnicity**	**Number (%)**
Two or more races	237 (23.9%)	Unknown race	13 (1.3%)
Samoan	168 (16.9%)	Central American	8 (0.8%)
Filipino	122 (12.3%)	Middle Eastern	8 (0.8%)
Tongan	98 (9.9%)	South American	5 (0.5%)
White	90 (9.1%)	American Indian	4 (0.9%)
Mexican	82 (8.3%)	European	4 (0.4%)
Black	37 (3.7)	Puerto Rican	3 (0.3%)
Other race	32 (3.2%)	Japanese	2 (0.2%)
Chinese	30 (3.0%)	South Asian	2 (0.2%)
Guamanian	20 (2.0%)	Vietnamese	2 (0.2%)
Hawaiian	19 (1.9%)		

In FY 2016-2017, AARS reported 421 group outreach attendees representing special populations, with the majority of that outreach occurring in Q1 as presented in Figure 4. During FY 2016-2017, AARS most commonly reached attendees who were at risk for homelessness (n=143), vision impaired (n=77), and/or homeless (n=64); these categories are not mutually exclusive. Of note, the number of group outreach attendees representing these populations decreased from Q1 to Q3, but increased from Q3 to Q4 during FY 2016-2017.

Figure 4. Special Populations, Q1-Q4



Appendix B. FY 2016-2017 Outreach, Daly City Peninsula Partnership Collaborative

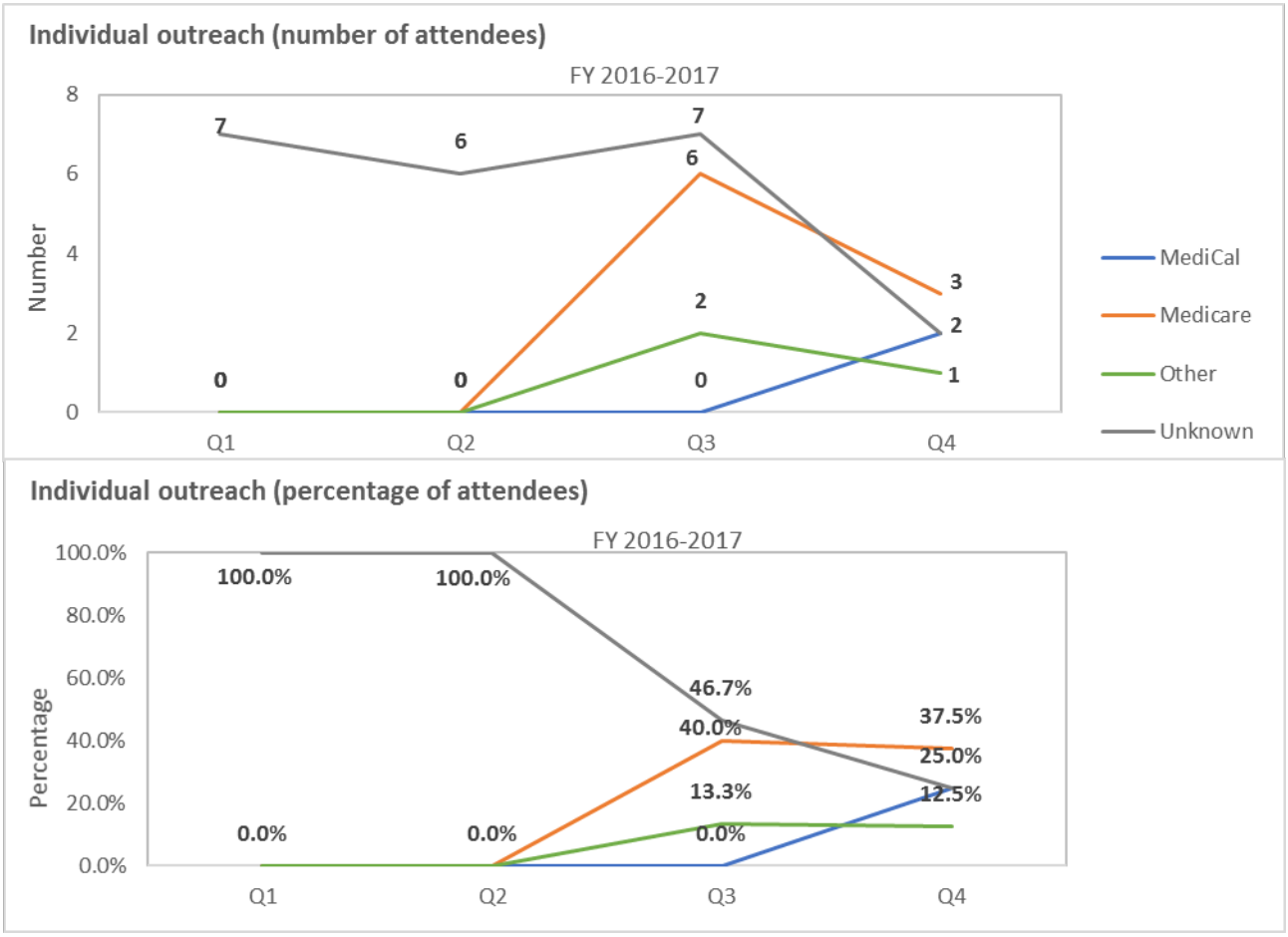
Individual outreach

For FY 2016-2017, Daly City Peninsula Partnership Collaborative reported a total of 36 individual outreach events—7 individual outreach events in Q1, and 6 events in Q2, 15 events in Q3, and 8 events in Q4. The average length of individual outreach events was 35 minutes, ranging from an average of 15 minutes in Q3 to 69 minutes in Q1.

Most individual outreach events:

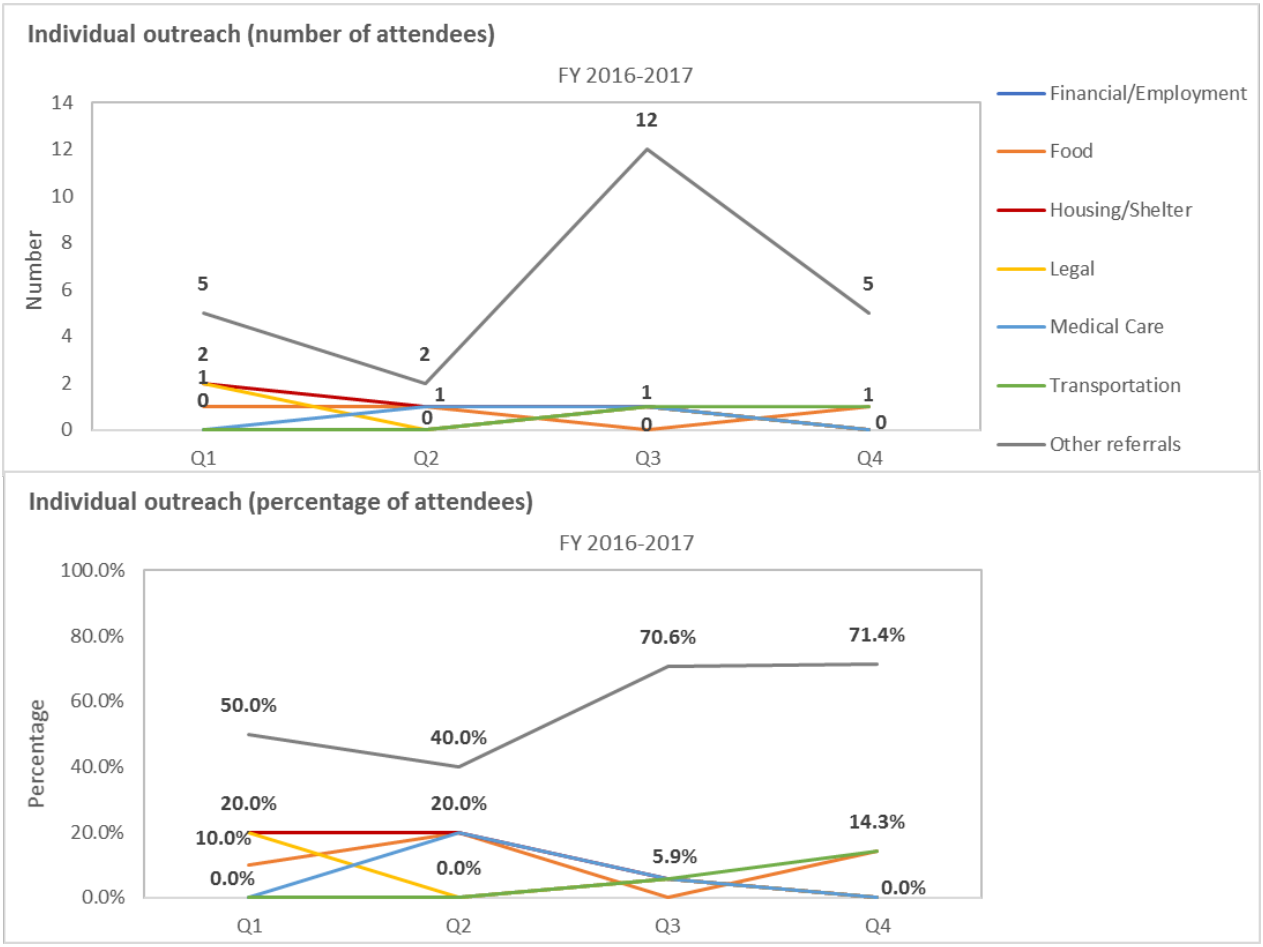
- Took place in home (**22.2%;** n=8), office (**8.3%**; n=3), other community locations (**44.4%**; n=16), phone (**13.9%;** n=5), and school (**11.1%**; n=4). For the 16 events taking place in other community location, 13 events took place in a mall and 3 took place in shine family event.
- Were reported as N/A (**100%**; n=36).
- Were conducted in Cantonese (**2.8%;** n=1), English (**61.1%;** n=22), Samoan (**2.8%;** n=1), Spanish (**16.7%;** n=6), and Tagalog (**16.7%;** n=6).
- Had Unknown Insurance as the most common insurance type (**Figure 1**).

Figure 1. Types of Insurance, Q1-Q4



- Resulted in 10 mental health referrals and 0 substance abuse referrals.
- Resulted in 39 other referrals. An individual outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Daly City Peninsula Partnership Collaborative made 1 financial/employment referral, 3 food referrals, 4 housing/shelter referrals, 3 legal referrals, 2 medical care referrals, and 2 transportation referrals, and 24 other referrals. **(Figure 2)**

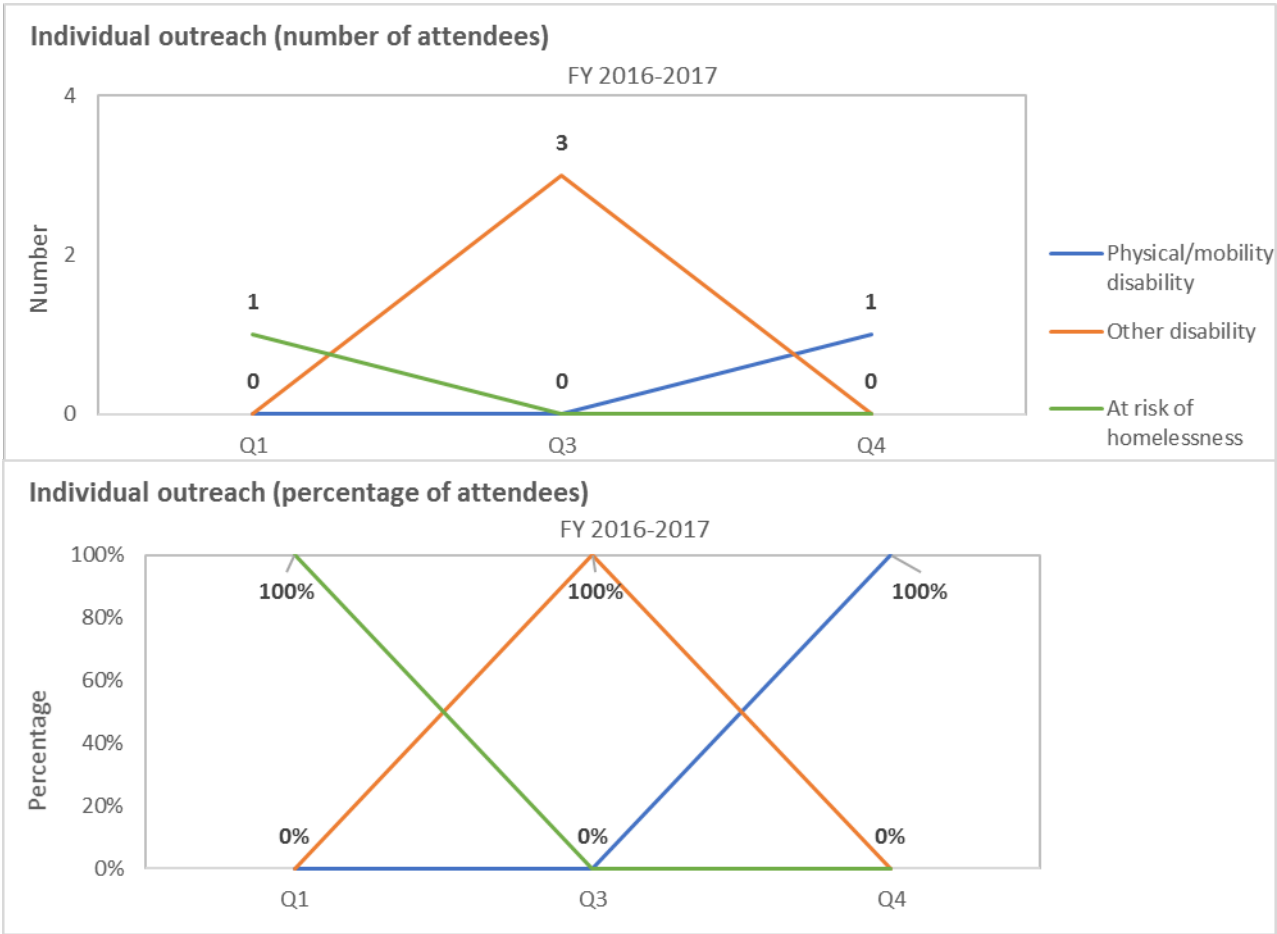
Figure 2. Other Referrals, Q1-Q4



Individual outreach event attendees:

- Self-reported as female (**80.6%**; n=29), and male (**19.4%**; n=7) for both sex at birth and gender identity.
- Self-reported as Bisexual (**5.6%;** n=2), Heterosexual (**38.9%;** n=14), Unknown (**55.6%**; n=20).
- Were transition-age youth (16-25 years**; 2.8%;** n=1), adults (26-59 years, **61.1%**; n=22), or older adults (60+ years; **36.1%;** n=13).
- Were American Indian (**2.8%;** n=1), two or more races (**8.3%;** n=3), Central American (**11.1%;** n=4), Chinses (**8.3%;** n=3), Filipino (**33.3%;** n=12), Mexican (**11.1%;** n=4), Middle Eastern (**2.8%;** n=1), White (**19.4%;** n=7), and other race (**2.8%;** n=1).
- Special populations include those who are veterans, homeless, at risk of homelessness, hearing impaired, vision impaired, dementia, having chronic health conditions, having difficulty in mobility, learning, or development. In FY 2016-2017, Daly City Peninsula Partnership Collaborative reported 5 individual outreach attendees as these special populations. (**Figure 3**)

Figure 3. Special Populations, Q1-Q4



Group outreach

For FY 2016-2017, Daly City Peninsula Partnership Collaborative reported a total of 16 group outreach events, corresponding to 913 group outreach event attendees—no attendees in Q1, 48 attendees in Q2, 353 attendees in Q3, and 512 attendees in Q4. The average length of group outreach events was 104 minutes, ranging from an average of 82 minutes per event in Q3 to 126 minutes per event in Q4.

Most group outreach events:

- Took place primarily in other community locations (**50.0%**; n=8), followed by school (**43.8%**; n=7), and age-specific community center (**6.3%;** n=1). For the 8 events taking place in other community locations, 1 event was at a gym, 4 events were at a mall, 1 was at the Philippine Consulate, 1 was at the Senior Banquet, and 1 was at the Serramonte del Rey.
- Were reported as N/A (**100%;** n=16).
- Were conducted in Cantonese (**6.3%;** n=1), English (**75.0%**; n=12), and Tagalog (**18.8%;** n=3).

Group outreach event attendees:

- Self-reported as female (**60.2%;** n=550), male (**37.5%**; n=342), or other gender (**2.3%**; n=21) for sex at birth.
- Self-reported as female (**53.7%;** n=490), male (**35.5%;** n=324), Transgender (**0.5%;** n=5), and unknown gender (**10.3%;** n=94) for gender identity.
- Identified primarily as Heterosexual (**55.5%;** n=507), Gay/Lesbian (**0.5%;** n=5), other sex orientation (**0.9%;** n=8), and unknown sex orientation (**43.0%;** n=393).
- Represented many races and ethnicities (**Table 1**).

Table 1. Group Outreach Attendees by Race/Ethnicity

Race/ethnicity	Number (%)	Race/ethnicity	Number (%)
Tongan	300 (25.2%)	Black	35 (2.9%)
Mexican	177 (14.9%)	Central American	33 (2.8%)
White	175 (14.7%)	South American	10 (0.8%)
Filipino	175 (14.7%)	Unknown race	9 (0.8%)
Two or more races	122 (10.3%)	American Indian	2 (0.2%)
Samoan	95 (8.0%)	Middle Eastern	2 (0.2%)
Chinese	53 (4.5%)	Other race	2 (0.2%)

* Total counts for race/ethnicity are larger than the total number of group outreach attendees reported because providers may have classified an attendee under several race/ethnicity categories and as “two or more races.”

- Special populations include those who are veterans, homeless, at risk of homelessness, hearing impaired, vision impaired, dementia, having chronic health conditions, having difficulty in mobility, learning, or development. In FY 2016-2017, Daly City Peninsula Partnership Collaborative reported 34 group outreach attendees as special populations. All these 34 attendees were reported as veterans in Q4.

Appendix C. FY 2016-2017 Outreach, Daly City Youth Health Center

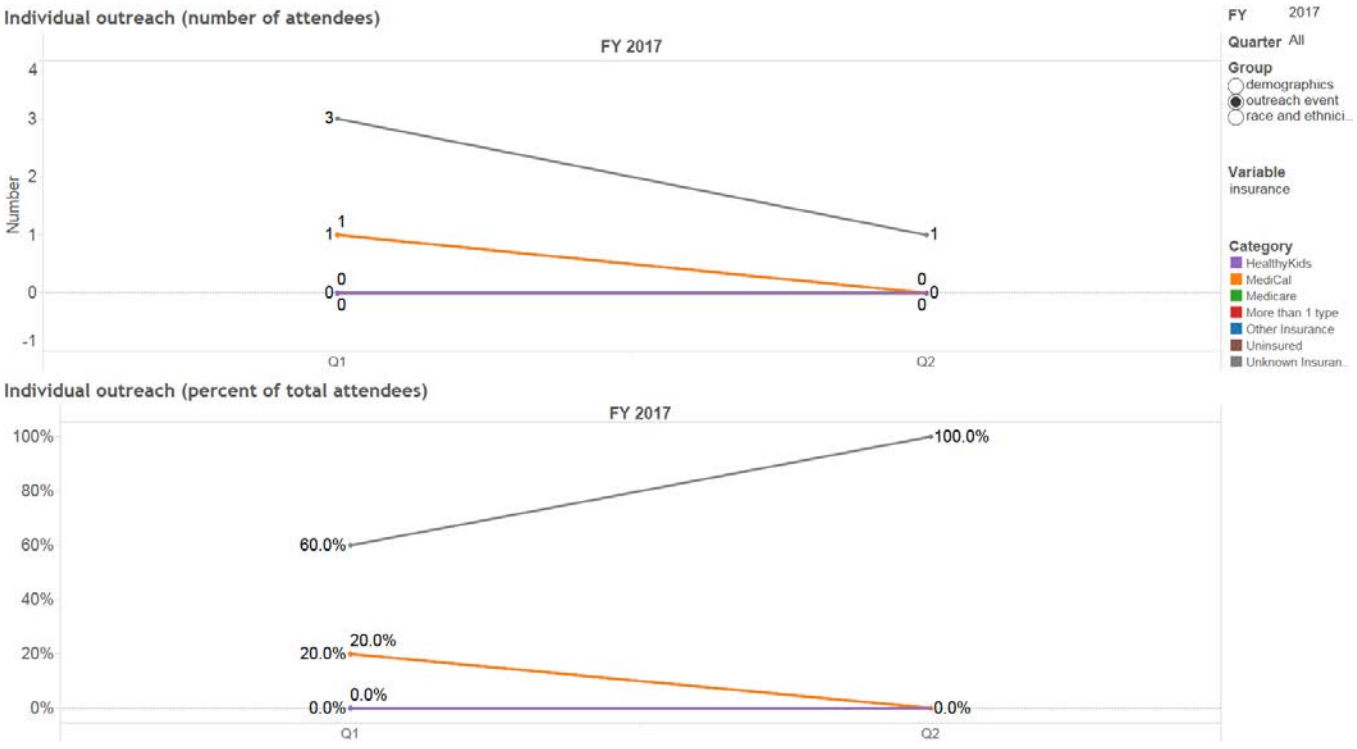
Individual outreach

For FY 2016-2017, Daly City Youth Health Center reported a total of 6 individual outreach events—5 individual outreach events in Q1, and 1 events in Q2. The average length of individual outreach events was 13 minutes, ranging from an average of 10 minutes in Q2 to 13 minutes in Q1.

Most individual outreach events:

- Took place in office (**33.3%**; n=2), other community locations (**33.3%**; n=2), and school (**33.3%**; n=2).
- Were categorized under MAA 400 (**50.0%**; n=3) and MAA 401 (**16.7%**; n=1). 33.3% (n=2) were reported as N/A.
- Were conducted in English (**100%**; n=6).
- Had Unknown Insurance as the most common insurance type (**Figure 1**).

Figure 1. Type of Insurance, Q1-Q4



- Resulted in 1 mental health referrals and 0 substance abuse referrals.
- Resulted in 0 other referrals.

Individual outreach event attendees:

- Self-reported as female (**50.0%**; n=3), and male (**50.0%**; n=3).
- Self-reported as Heterosexual (**50.0%;** n=3), Unknown (**33.3%**; n=2), Gay/Lesbian (**16.7%;** n=1).
- Were transition-age youth (16-25 years**; 50.0%;** n=3), adults (26-59 years, **33.3%**; n=2), or older adults (60+ years; **16.7%;** n=1).
- Were unknown race (**33.3%;** n=2), two or more races (**16.7%;** n=1), other race (**16.7%**; n=1), South Asian (**16.7%;** n=1), or Tongan (**16.7%;** n=1).
- Special populations include those who are veterans, homeless, at risk of homelessness, hearing impaired, vision impaired, dementia, having chronic health conditions, having difficulty in mobility, learning, or development. In FY 2016-2017, Daly City Youth Health Center did not reported any individual outreach event attendees as special populations.

Group outreach

For FY 2016-2017, Daly City Youth Health Center reported a total of 18 group outreach events, corresponding to 920 group outreach event attendees—636 attendees in Q1, 266 attendees in Q2, 18 attendees in Q3, and no attendees in Q4. The average length of group outreach events was 102.1 minutes, ranging from an average of 74 minutes per event in Q1 to 155 minutes per event in Q3.

Most group outreach events:

- Took place primarily in schools (**50.0%**; n=9), followed by other locations (**43.8%**; n=7), age-specific community center (**5.6%;** n=1), and unspecified location (**5.6%;** n=1).
- Were categorized under MAA 400 (**44.4%**; n=8), MAA 410 (**22.2%**; n=4). 33.3% (n=6) were reported as N/A.
- Were conducted in English (**100%**; n=18).

Group outreach event attendees:

- Self-reported as female (**38.9%**; n=358), other gender (**31.5%**; n=290), or male (**29.6%**; n=272).
- Identified primarily as unknown sex orientation (**86.3%;** n=512), Heterosexual (**10.5%;** n=62), Bisexual (**1.5%;** n=9).
- Represented many races and ethnicities (**Table 1**).

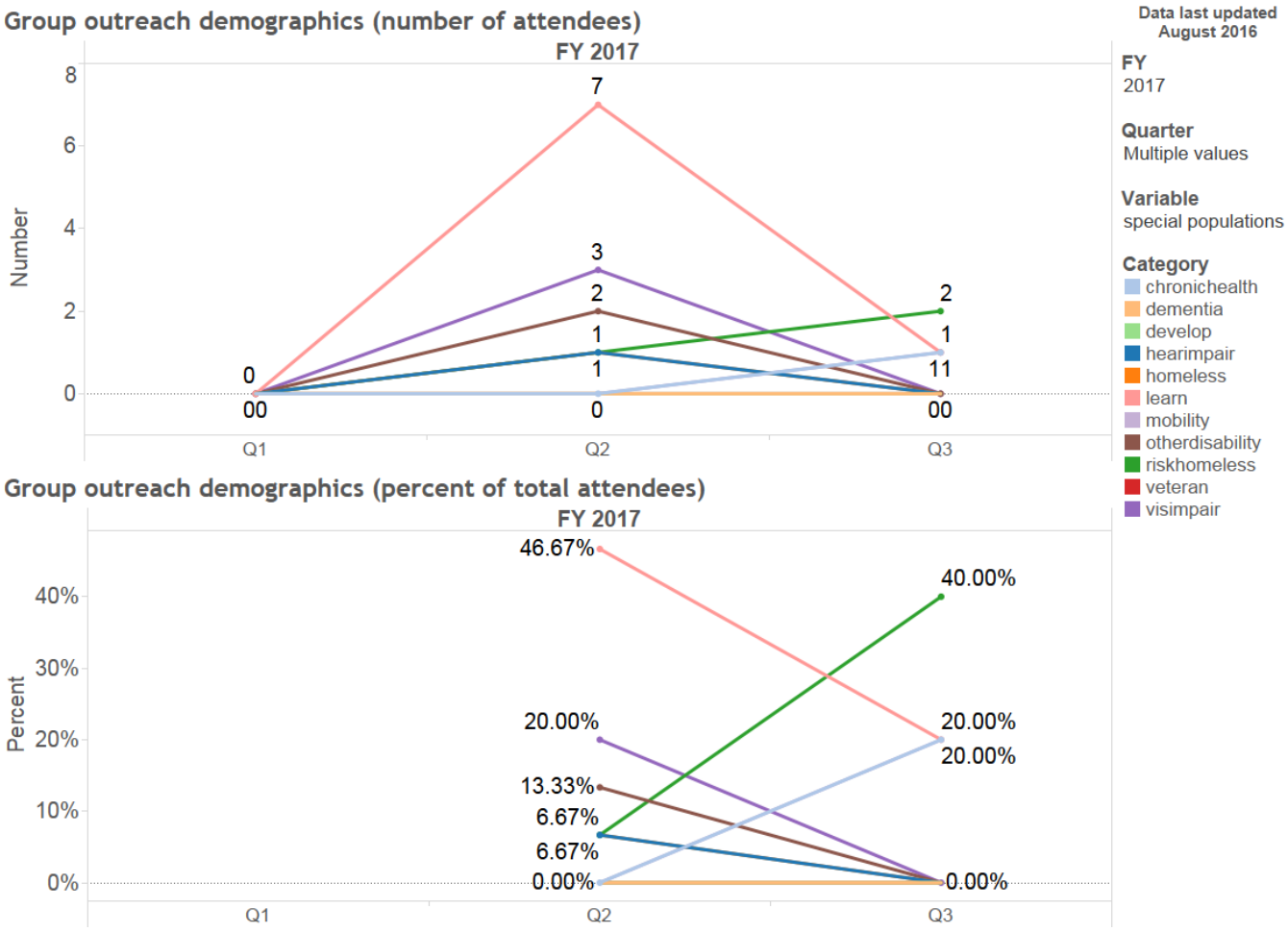
Table 1. Group Outreach Attendees by Race/Ethnicity

Race/ethnicity	Number (%)	Race/ethnicity	Number (%)

Filipino	218 (23.1%)	East European	10 (1.1%)
Mexican	180 (19.1%)	South American	7 (0.7%)
White	170 (18.0%)	Middle Eastern	4 (2.1%)
Two or more races	129 (13.7%)	Vietnamese	4 (0.4%)
Chinese	83 (8.8%)	Hawaiian	3 (0.3%)
Unknown race	45 (4.8%)	European	2 (0.2%)
South Asian	35 (3.7%)	American Indian	1 (0.1%)
Black	25 (2.7%)	Japanese	1 (0.1%)
Other race	14 (1.5%)	Puerto Rican	1 (0.1%)
Central American	10 (1.1%)	Samoan	1 (0.1%)

In FY 2016-2017, Daly City Youth Health Center reported 20 group outreach attendees representing special populations, with the majority of that outreach occurring in Q2 as presented in Figure 4. During FY 2016-2017, Daly City Youth Health Center most commonly reached attendees who had learning difficulty (n=8), were at risk for homelessness (n=3), and/or vision impaired (n=3); these categories are not mutually exclusive. Of note, the number of group outreach attendees representing these populations increased from Q1 to Q2 but decreased from Q2 to Q3 during FY 2016-2017. No special populations were reported in Q4.

Figure 4. Special Populations, Q1-Q4



Appendix D. FY 2016-2017 Outreach, El Concilio

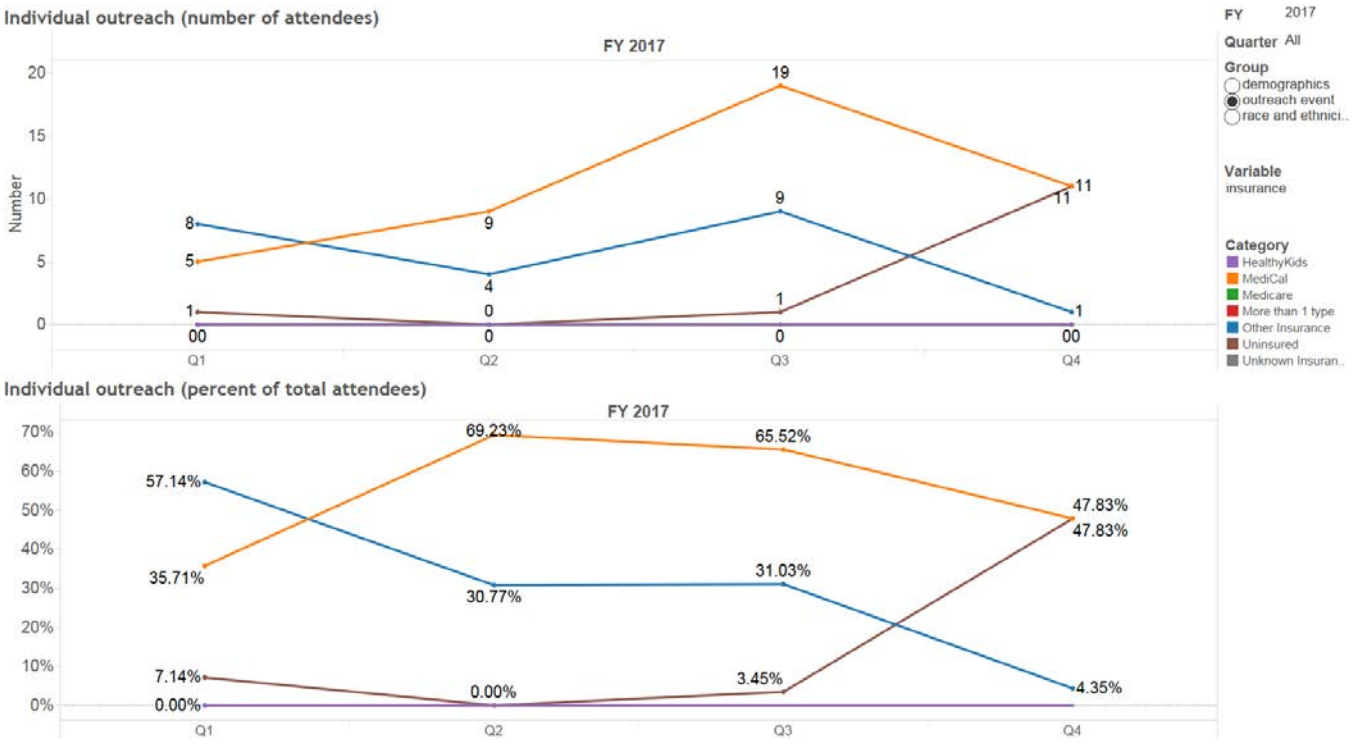
Individual outreach

For FY 2016-2017, El Concilio reported a total of 79 individual outreach events—14 individual outreach events in Q1, 13 events in Q2, 29 events in Q3, and 23 events in Q4. The average length of individual outreach events was 19 minutes, ranging from an average of 14 minutes in Q3 to 30 minutes in Q1.

Most individual outreach events:

- Took place in the office (**64.5%**; n=51), followed by other community locations (**22.7%;** n=18), Non-traditional locations (**6.3%**; n=5), and phone (**6.3%**; n=5).
- Were categorized primarily under MAA 400 (**97.5%**; n=77).
- Were conducted in Spanish (**53.2%**; n=42), or English (**46.8%**; n=37).
- Had Medi-Cal as the most common insurance type, followed by Other Insurance (**Table 1**).

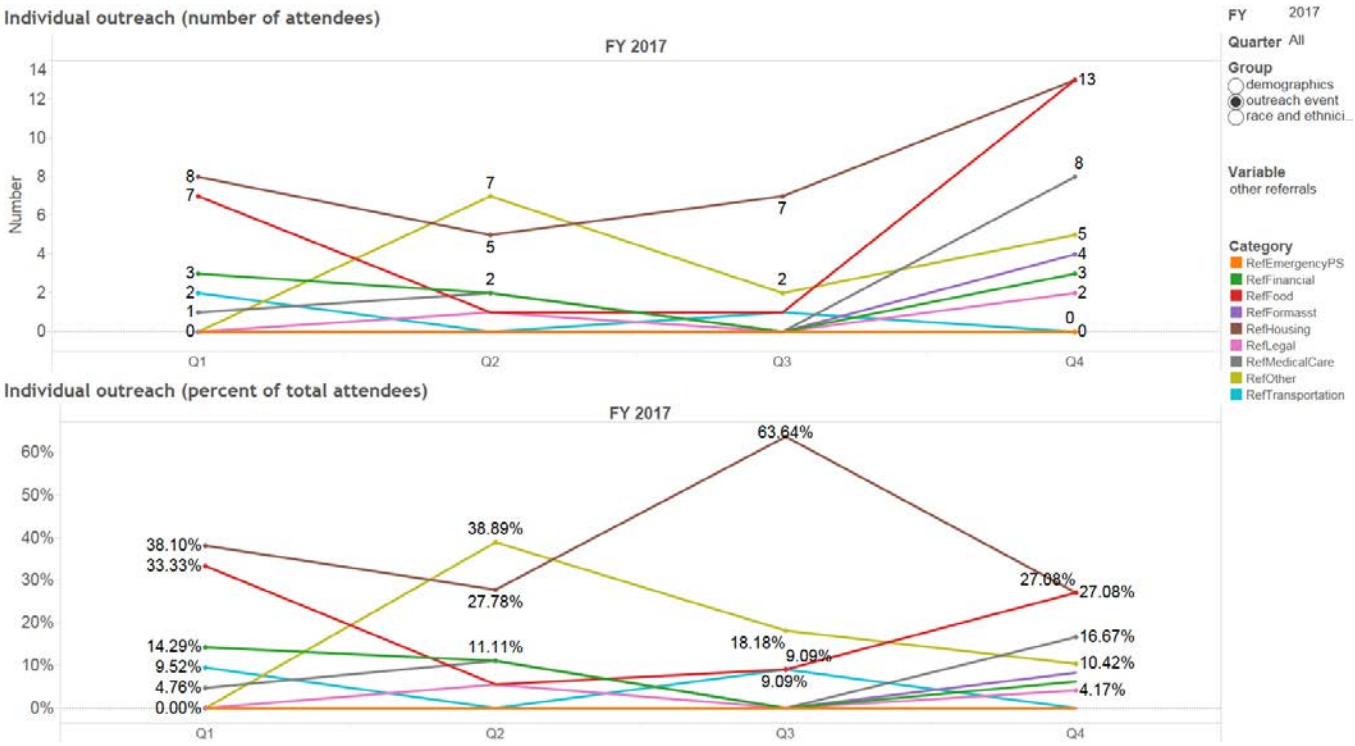
Figure 1. Type of Insurance, Q1-Q4



- Resulted in 6 mental health referrals and 2 substance abuse referrals.

- Resulted in 98 other referrals (**Figure 2**). An individual outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. El Concilio primarily made referrals to Housing (**33.7%;** n=33), Food (**22.4%;** n=22), other referrals (**14.3%;** n=14), Medical Care (**11.2%;** n=11), and Financial (**8.2%;** n=8).

Figure 2. Other Referrals, Q1-Q4

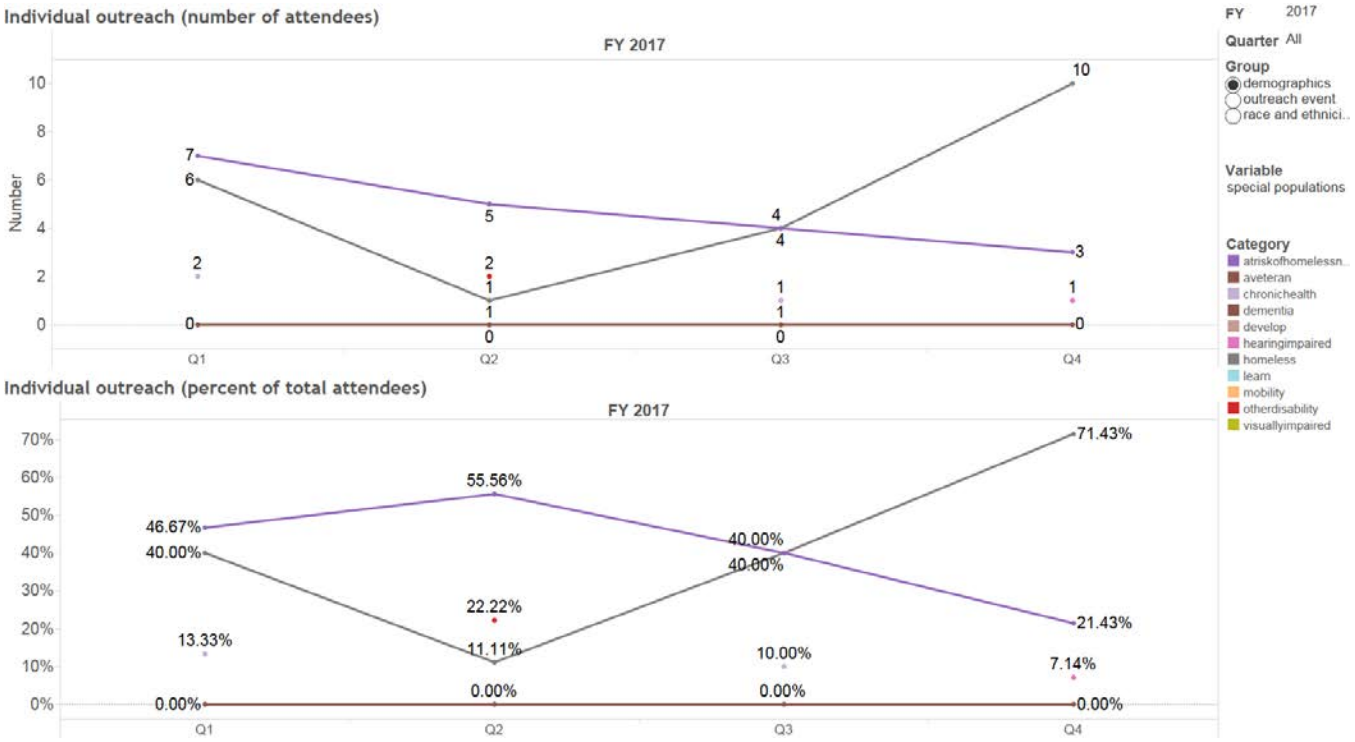


Individual outreach event attendees:

- Self-reported as female (**64.6%**; n=51) or male (**35.4%**; n=28).
- Self-reported as Heterosexual (**94.9%;** n=75), Bisexual (**2.5%;** n=2) Unknown (**1.3%;** n=1), Gay/Lesbian (**1.3%;** n=1).
- Were adults (26-59 years, **70.9%**; n=56), transition-age youth (16-25 years, **24.1%**; n=19), older adults (60+ years, **5.1%**; n=4).
- Were primarily two or more races (**31.6%;** n=25), Mexican (**29.1%;** n=23), Black (**15.2%;** n=12), or white (**8.9%;** n=7).

Special populations include those who are veterans, homeless, at risk of homelessness, hearing impaired, vision impaired, dementia, having chronic health conditions, having difficulty in mobility, learning, or development. In FY 2016-2017, El Concilio reported 48 individual outreach event attendees representing these populations in **Figure 3**.

Figure 3. Special Populations, Q1-Q4



Group outreach

For FY 2016-2017, El Concilio reported a total of 1 group outreach event, corresponding to 17 group outreach event attendees—all of them were in Q3. The average length of group outreach events was 40 minutes.

Most group outreach events:

- Took place in other community location that is not listed (**100%;** n=1)
- Were categorized under MAA 400 (**100%**; n=1).
- Were conducted in English (**100%**; n=1).

Group outreach event attendees:

- Self-reported as female (**82.4%**; n=14), or male (**17.6%**; n=3).
- Identified as Heterosexual (**100%;** n=17).
- Represented many races and ethnicities (**Table 1**).

Table 1. Group Outreach Attendees by Race/Ethnicity

Race/ethnicity	Number (%)	Race/ethnicity	Number (%)
Mexican	8 (47.1%)	Middle Eastern	1 (5.9%)
Central American	5 (29.4%)	White	1 (5.9%)
Black	2 (11.8%)		

In FY 2016-2017, El Concilio reported 17 group outreach attendees representing special populations. During FY 2016-2017, El Concilio reached attendees who were veteran (**100%;** n=17).

Appendix E. FY 2016-2017 Outreach, Free At Last

Individual outreach

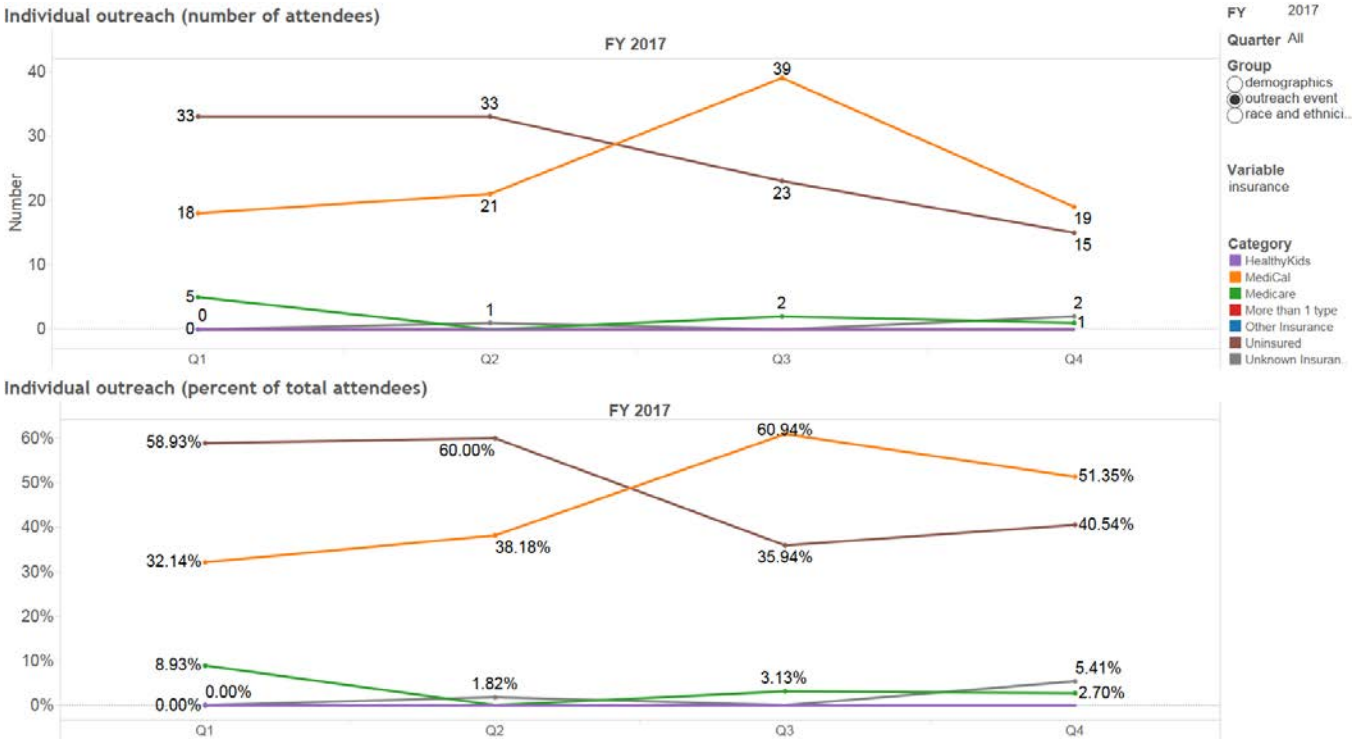
For FY 2016-2017, Free At Last reported a total of 212 individual outreach events—56 individual outreach events in Q1, 55 events in Q2, 64 events in Q3, and 37 events in Q4.

The average length of individual outreach events was 34 minutes, ranging from an average of 32 minutes in Q2 to 38 minutes in Q4.

Most individual outreach events:

- Took place primarily in unspecified locations (**72.6%**; n=154), and in the office (**26.9%**; n=57).
- Were categorized as MAA 401 (**98.6%**; n=209).
- Were conducted in English (**76.9%**; n=163) or Spanish (**21.2%**; n=45).
- Were mostly with the uninsured (**49.1%;** n=104). For those whose insurance was known, Medi-Cal was the most common insurance type (**Figure 1**).

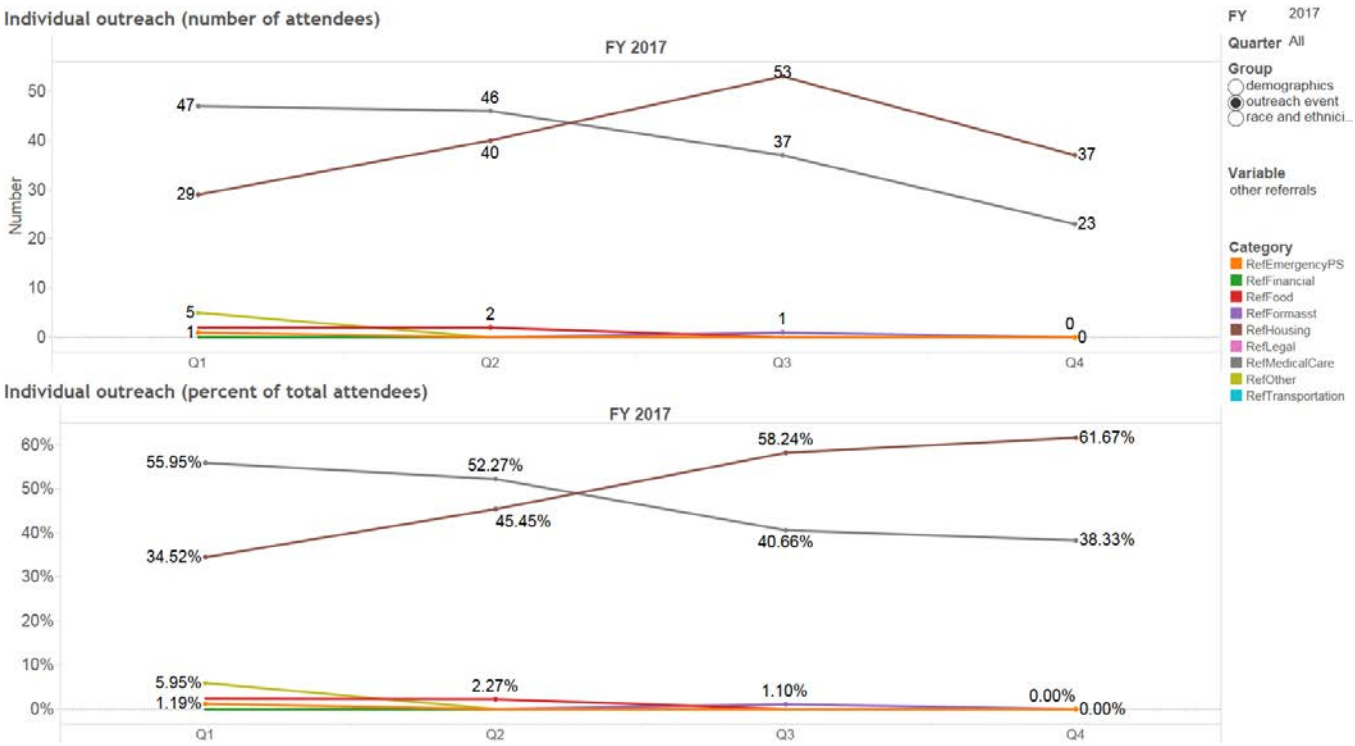
Figure 1. Type of Insurance, Q1-Q4



- Resulted in 22 mental health referrals and 108 substance abuse referrals.

- Resulted in 323 other referrals (**Figure 2**). An individual outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Free At Last primarily made referrals to Housing (n=159) and Medical Care (n=153).

Figure 2. Other Referrals, Q1-Q4

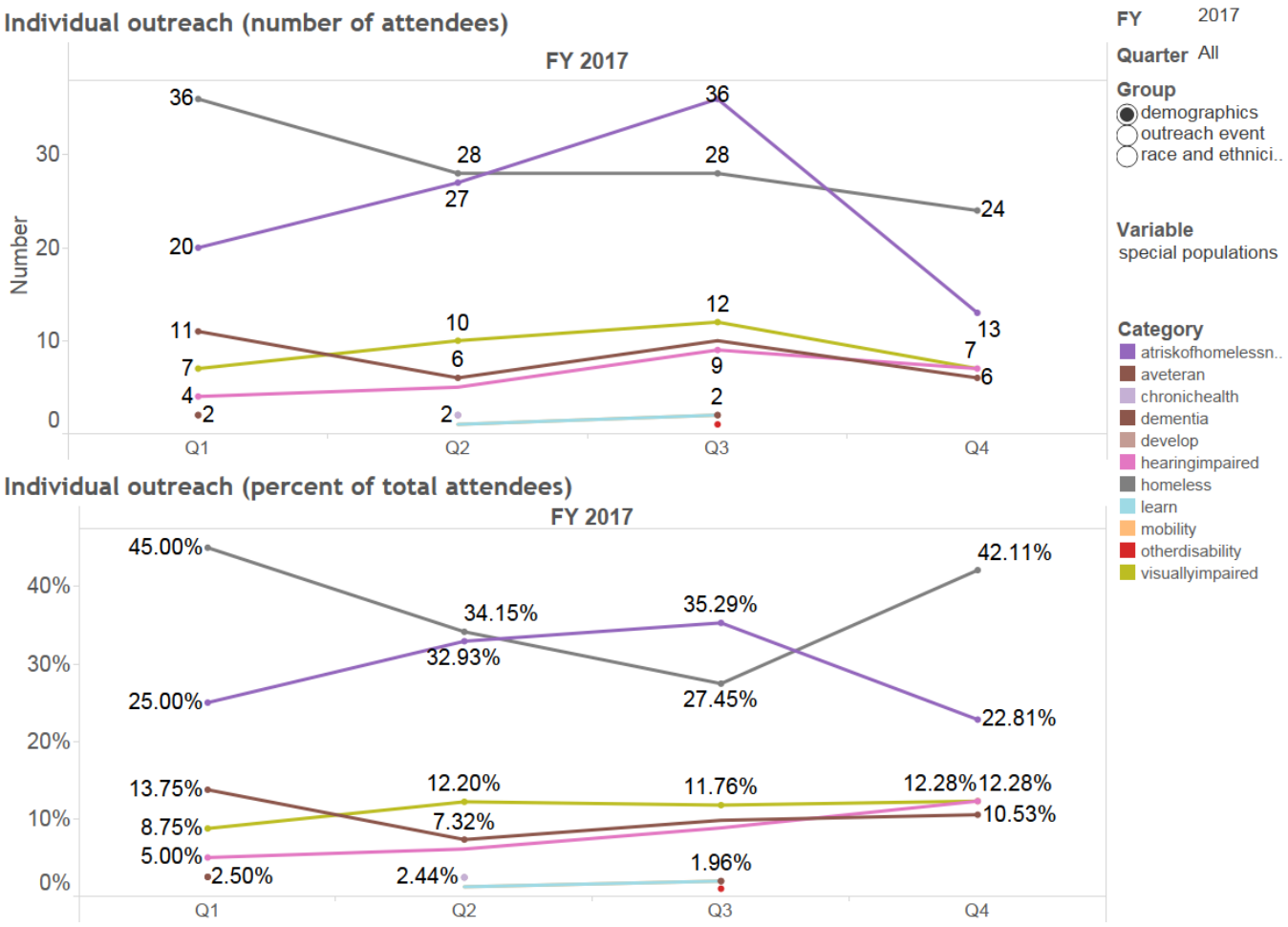


Individual outreach event attendees:

- Self-reported as male (**56.6%**; n=120), female (**43.4%**; n=92).
- Self-reported as Heterosexual (**64.6%;** n=137), Bisexual (**20.8%;** n=44), Gay/Lesbian (**12.7%;** n=27), Queer (**1.4%;** n=3), and Questioning (**<1%;** n=1).
- Were adults (26-59 years, **70.8%**; n=150), transition-age youth (16-25 years, **19.3%**; n=41), older adults (60+ years, **9.4%**; n=20), or children (0-15 years, **<1%**; n=1).
- Were primarily Black (**50.9%**; n=108), Mexican (**21.7%**; n=46), White (**9.9%**; n=21), Filipino (**6.6%**; n=14) and with two or more races (**2.8%**; n=6).

Special populations include those who are veterans, homeless, at risk of homelessness, hearing impaired, vision impaired, dementia, having chronic health conditions, having difficulty in mobility, learning, or development. In FY 2FY 2016-2017, Free At Last reported 321 individual outreach attendees representing these populations (**Figure 3**).

Figure 3. Special Populations, Q1-Q4



Group outreach

Free At Last did not report any data on group outreach encounters during FY 2016-2017.

Appendix F. FY 2016-2017 Outreach, Multicultural Counseling and Education Services of the Bay Area

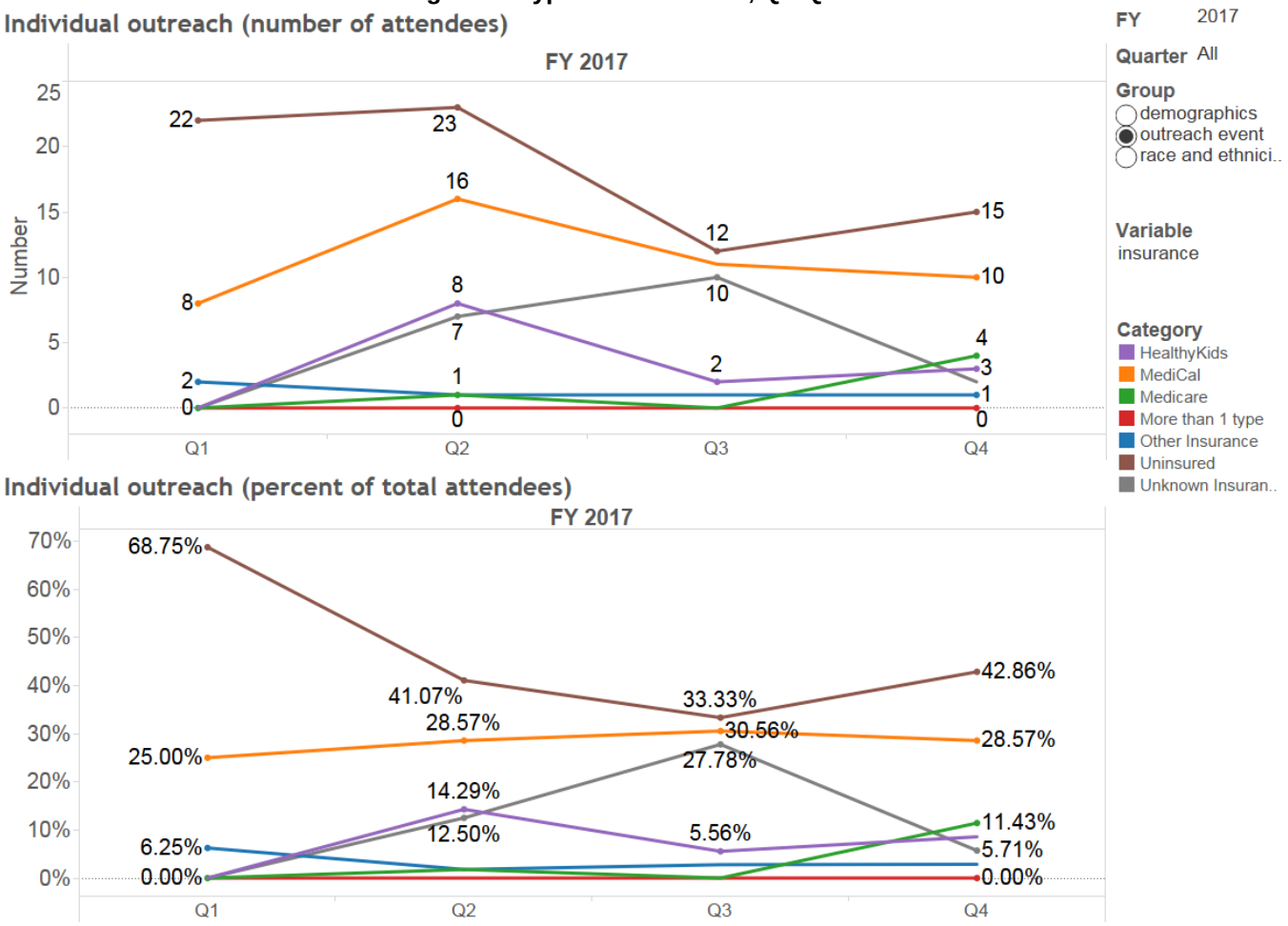
Individual outreach

For FY 2016-2017, Multicultural Counseling and Education Services of the Bay Area (MCESBA) reported a total of 159 individual outreach events—32 individual outreach events in Q1, 56 events in Q2, 36 events in Q3, and 35 events in Q4. The average length of individual outreach events is 56 minutes, ranging from an average of 45 minutes in Q4 to 61 minutes in Q1 and Q2.

Most individual outreach events:

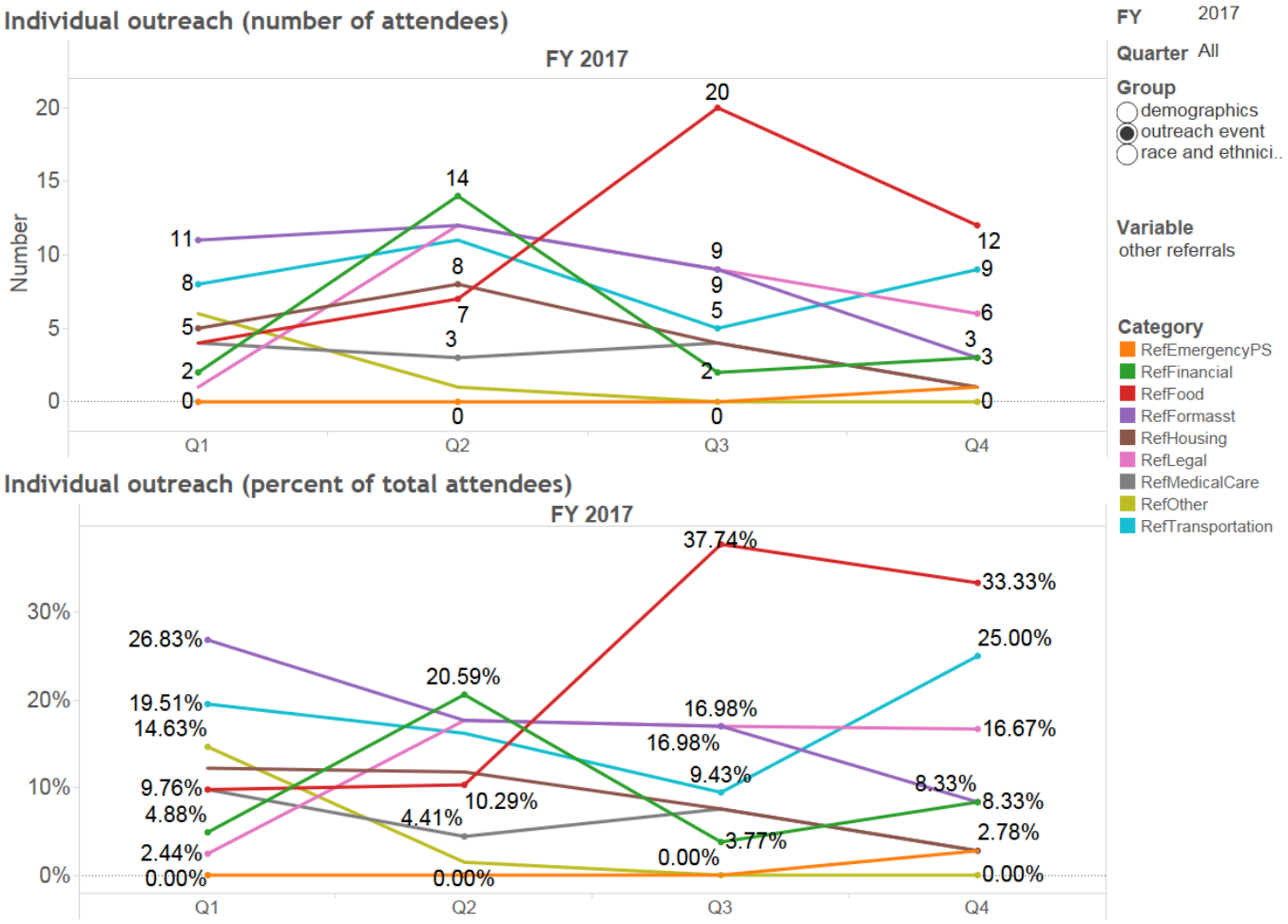
- Took place in home (**25.8%**; n=41), phone (**19.5%**; n=31), unspecified locations (**14.4%**; n=23), school (**10.1%**; n=16), non-traditional locations (**8.8%;** n=14), age-specific community center (**4.4%;** n=7), and other community locations (**4.4%;** n=7).
- Were categorized under MAA 400 (**100%**; n=159).
- Were conducted in English (**65.4%**; n=104), Tongan (**19.5%**; n=31), Samoan (**11.3%**; n=18), or Spanish (<1**%**; n=1).
- Were mostly with the uninsured (n=72). For those whose insurance was known, Medi-Cal was most common insurance type (**Figure 1**).

Figure 1. Types of Insurance, Q1-Q4



- Resulted in 35 mental health referrals and 4 substance abuse referrals.
- Resulted in 198 other referrals (**Figure 2**). An individual outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. MCESBA primarily made referrals to Food (n=43), Form Assistance (n=35), Transportation (n=33), Legal (n=28), Financial (n=21), Housing (n=18), Medical Care (n=12), and other referrals (n=7).

Figure 2. Other Referrals, Q1-Q4

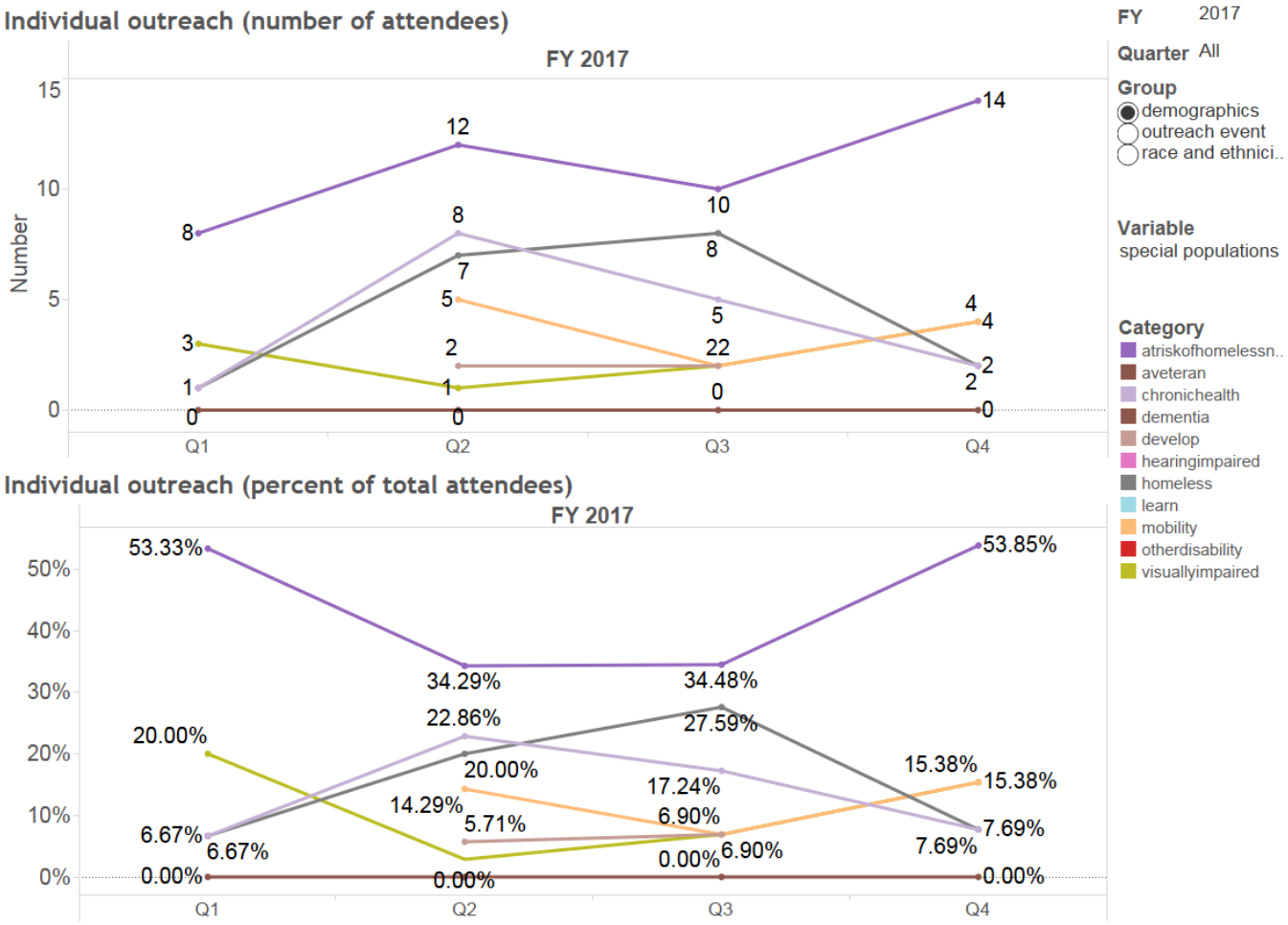


Individual outreach event attendees:

- Self-reported as female (**50.3%**; n=80), male (**49.7%**; n=79).
- Self-reported as Heterosexual (**88.1%;** n=140), Bisexual (**4.4%;** n=7), Gay/Lesbian (**4.4%;** n=7), Unknown (**1.9%;** n=3) and Questioning (**1.3%;** n=2).
- Were transition-age youth (16-25 years, **65.4%**; n=104), adults (26-59 years, **25.8%**; n=41), and older adults (60+ years, **8.8%**; n=14).
- Were primarily Tongan (**47.2%**; n=75), two or more races (**18.9%**; n=30), Samoan (**15.7%**; n=25), Black (**8.2%**; n=13), and White (**4.4%;** n=7).

Special populations include those who are veterans, homeless, at risk of homelessness, hearing impaired, vision impaired, dementia, having chronic health conditions, having difficulty in mobility, learning, or development. In FY 2016-2017, MCESBA reported 105 individual outreach event attendees representing these populations (**Figure 3**).

Figure 3. Special Populations, Q1-Q4



Group outreach

For FY 2016-2017, MCESBA reported a total of 9 group outreach events, corresponding to 156 group outreach event attendees—17 attendees in Q1, 21 attendees in Q2, 109 attendees in Q3, and 9 attendees in Q4. The average length of group outreach events is 78.3 minutes, ranging from an average of 30 minutes per event in Q4 to 165 minutes per event in Q3.

Most group outreach events:

- Took place in the home (**33.3%**; n=3), followed by faith-based church/temple (**22.2%**; n=2), other community locations (**22.2%**; n=2), and school (**22.2%**; n=2).
- Were categorized under MAA 400 (**100%**; n=9).
- Were conducted in English (**55.6%**; n=5), Tongan (**33.3%**; n=3), and Samoan (**11.1%**; n=1)

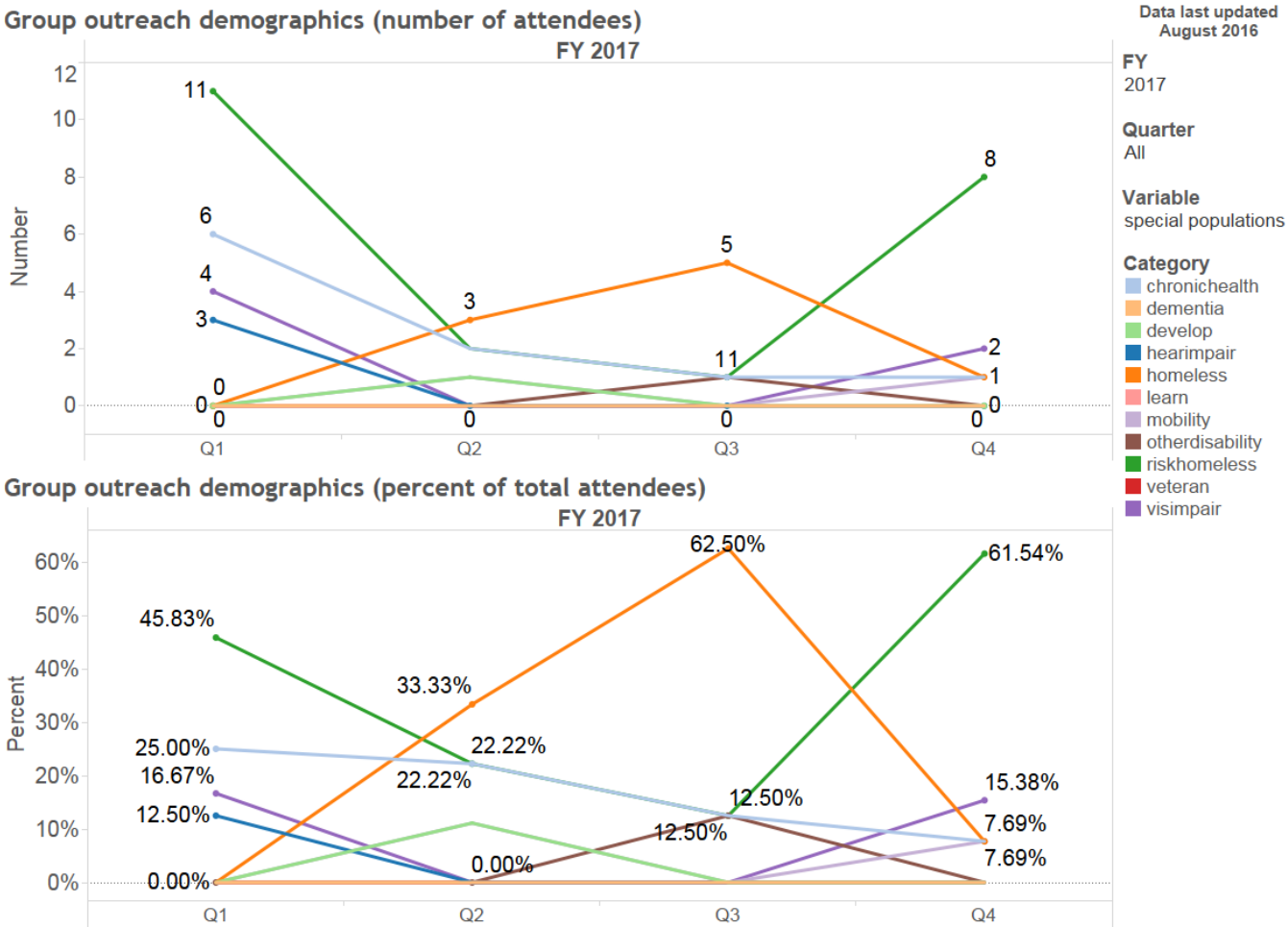
Group outreach event attendees:

- Self-reported as male (**57.1%**; n=89) or female (**42.9%**; n=67)
- Self-reported as Heterosexual (**96.2%;** n=50), Bisexual (**1.9%;** n=1) and Queer (**1.9%;** n=1)
- Represented many races and ethnicities (**Table 1**).

Table 1. Group Outreach Attendees by Race/Ethnicity	
Race/ethnicity	**Number (%)**
Unknown race	92 (59.0%)
Tongan	38 (24.4%)
Samoan	11 (7.1%)
Black	8 (5.1%)
White	5 (3.2%)
Mexican	1 (<1%)
Two or more races	1(<1%)

In FY 2016-2017, MCESBA reported 54 group outreach event attendees representing special populations, with the majority of that outreach occurring in Q1 as presented in **Figure 4**. During FY 2016-2017, MCESBA most commonly reached attendees who were at risk for homelessness (n=22), having chronic health conditions (n=10), and/or homeless (n=9); these categories are not mutually exclusive.

Figure 4. Populations of Interest, Q1-Q4



Appendix G. FY 2016-2017 Outreach, Pacifica Collaborative

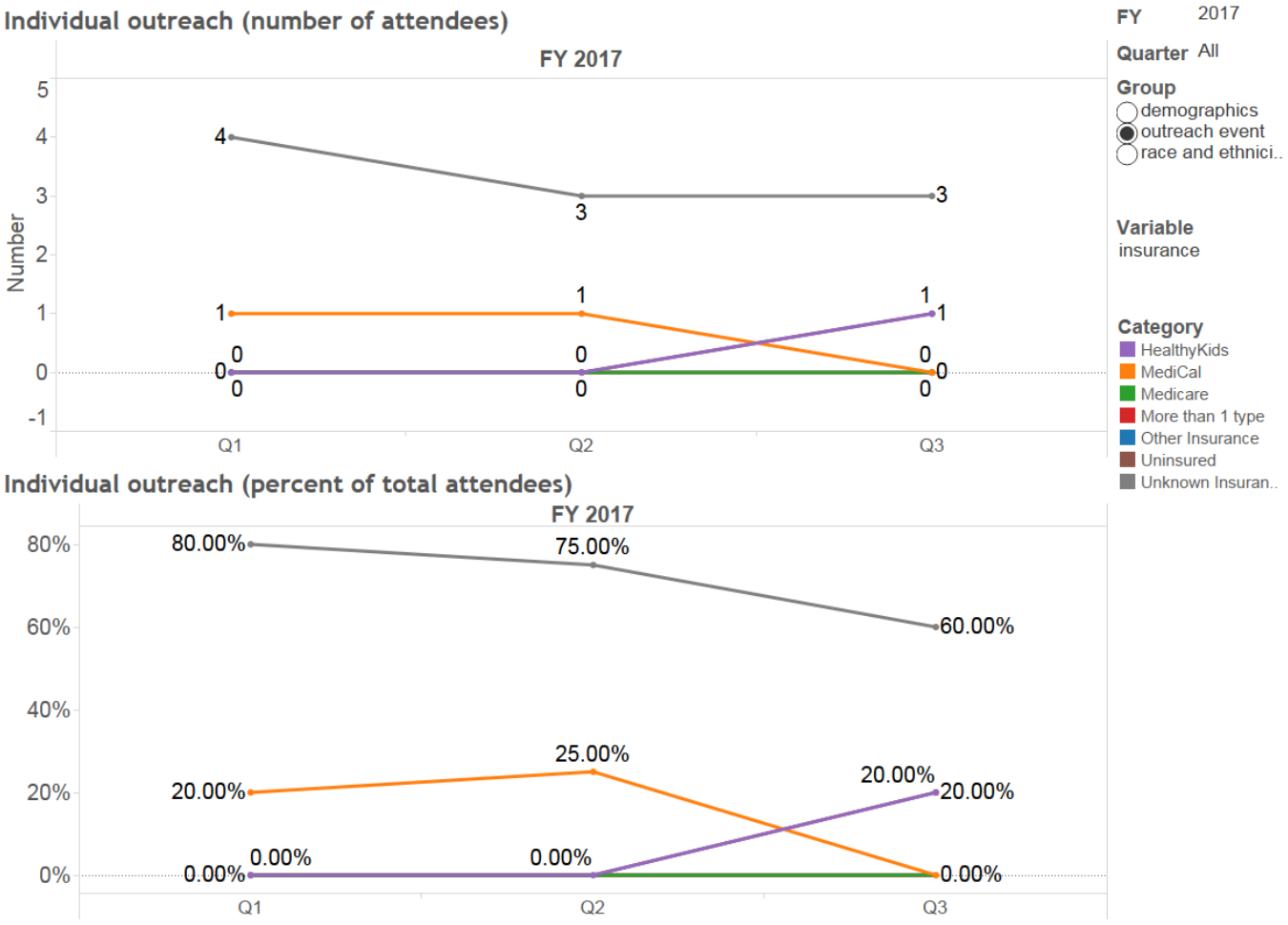
Individual outreach

For FY 2016-2017, Pacifica Collaborative reported a total of 14 individual outreach events—5 individual outreach events in Q1, 4 events in Q2, and 5 events in Q3. No individual outreach data was reported for Q4. The average length of individual outreach events was 26 minutes, ranging from an average of 18 minutes in Q2 to 29 minutes in Q1.

Most individual outreach events:

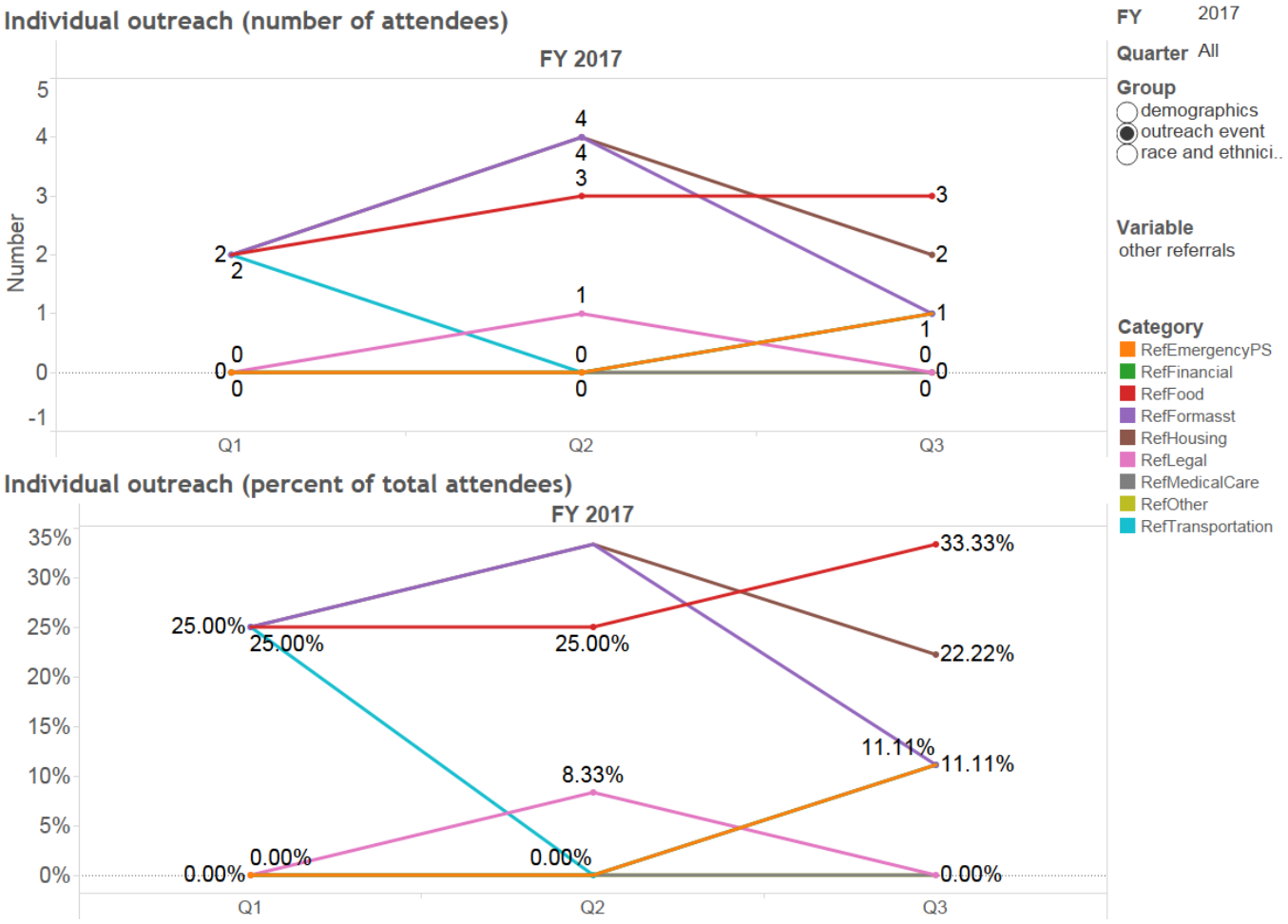
- Took place in other community location (**50.0%;** n=7), followed by faith-based churches/temples (**42.9%**; n=6) and school (**7.1%;** n=1).
- Were categorized under MAA 400 (**7.1%**; n=1). Most were reported as N/A (**92.9%;** n=13).
- Were conducted in English (**100%**; n=14).
- Were mostly with the unknown insurance (n=10). For those whose insurance was known, Medi-Cal was most common insurance type (**Figure 1**).

Figure 1. Types of Insurance, Q1-Q4



- Resulted in 11 mental health referrals and 3 substance abuse referrals.
- Resulted in 29 other referrals (**Figure 2**). An individual outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Pacifica Collaborative primarily made referrals to Food (n=8), Housing (n=8), Form Assistance (n=7), and Transportation (n=3).

Figure 2. Other Referrals, Q1-Q4

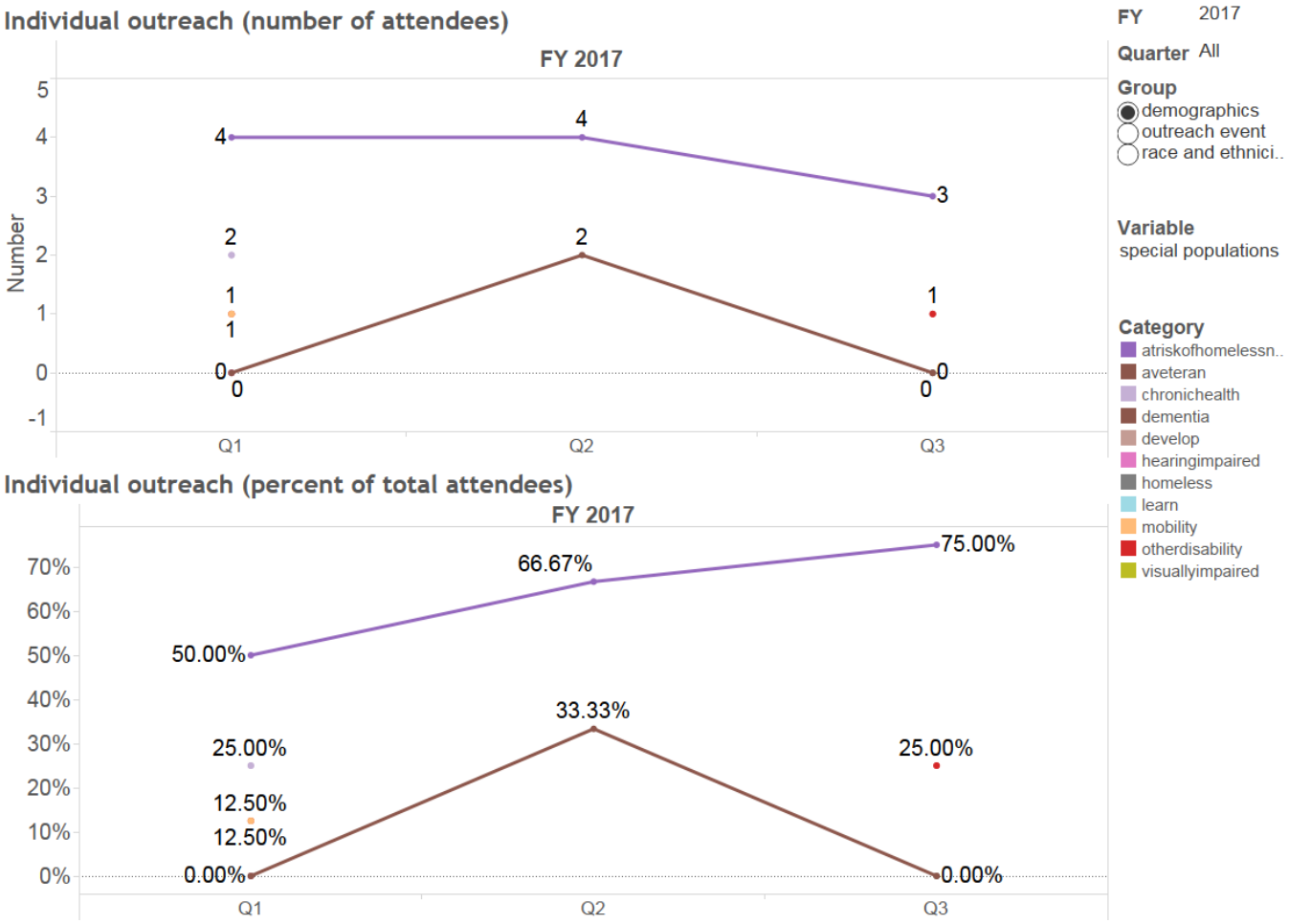


Individual outreach event attendees:

- Self-reported as male (**50.0%**; n=7) or female (**50.0%**; n=7).
- Self-reported as unknown sex orientation (**53.8%;** n=7), Heterosexual (**38.5%;** n=5), and Gay/Lesbian (**7.7%;** n=1).
- Were adults (26-59 years, **71.4%**; n=10), transition-age youth (16-25 years, **14.3%**; n=2), children (0-15 years, **7.1%;** n=1), or older adults (60+ years, **7.1%**; n=1).
- Were primarily White (**85.7%;** n=12), Black (**7.1%;** n=1), and other race (**7.1%;** n=1).

Special populations include those who are veterans, homeless, at risk of homelessness, hearing impaired, vision impaired, dementia, having chronic health conditions, having difficulty in mobility, learning, or development. In FY 2016-2017, Pacifica Collaborative reported 18 individual outreach attendees representing these populations. (**Figure 3**).

Figure 3. Special Populations, Q1-Q4



Group outreach

For FY 2016-2017, Pacifica Collaborative reported a total of 15 group outreach events, corresponding to 2,736 group outreach event attendees—1,514 attendees in Q1, 949 attendees in Q2, and 273 attendees in Q3. Pacifica Collaborative did not report any group outreach events during Q4. The average length of group outreach events is 105.7 minutes, ranging from an average of 90 minutes per event in Q3 to 110 minutes in Q1.

Most group outreach events:

- Took place in other community locations (**73.3%**; n=11) and faith-based churches/temples (**26.7%**; n=4).
- Were categorized under MAA 400 (**6.7%**; n=1). **93.3%** (n=14) were reported under N/A.
- Were conducted in English (**100%**; n=15).

Group outreach event attendees:

- Self-reported as female (**59.1%**; n=1,615), male (**37.4%**; n=1,023), or other gender (**3.5%**; n=96).
- Self-reported as unknown sex orientation (**55.0%;** n=310), Heterosexual (**36.3%;** n=205), and Gay/Lesbian (**5.0%;** n=28), or Bisexual (**3.7%;** n=21)
- Represented many races and ethnicities (**Table 1**).

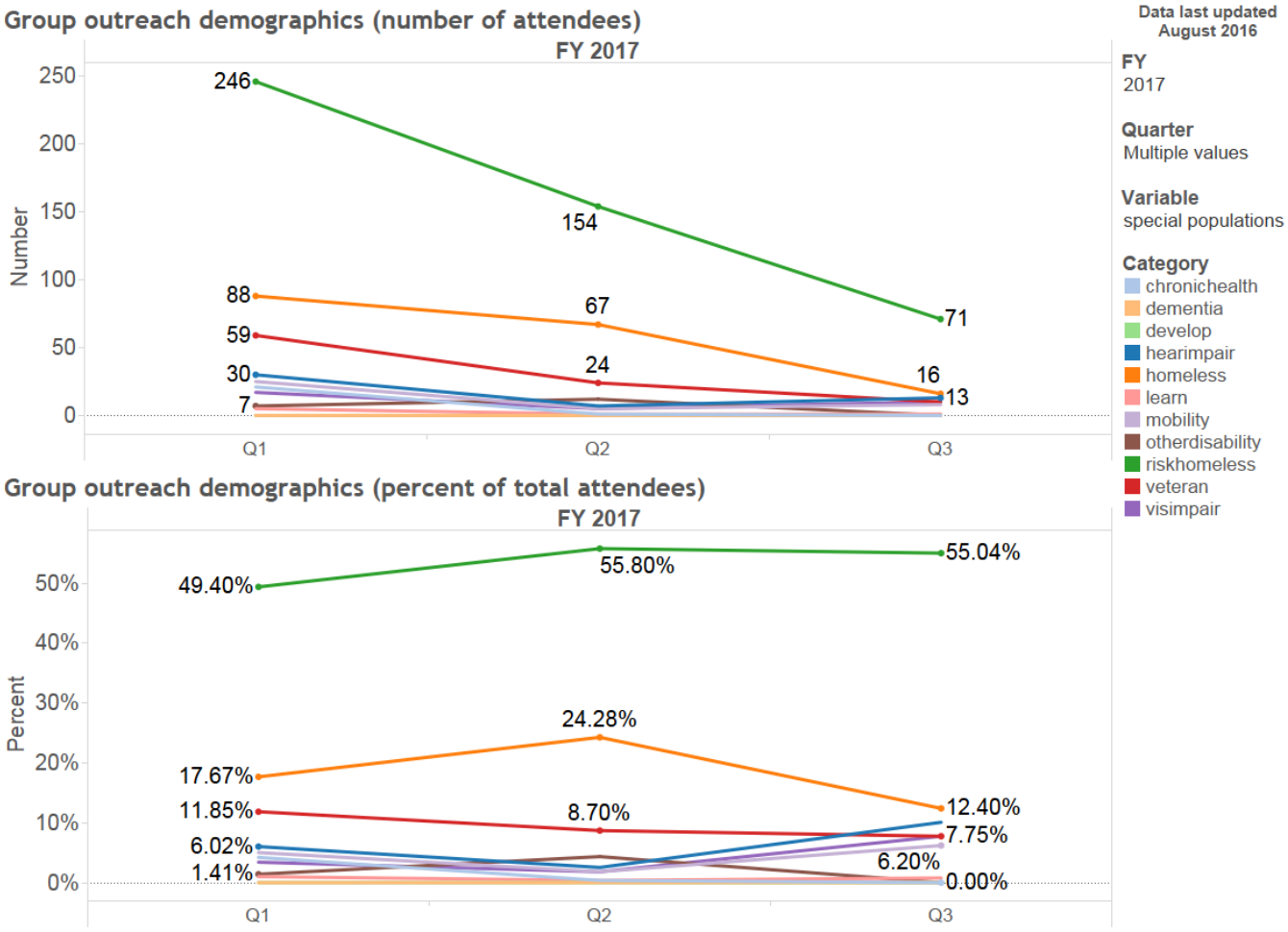
Table 1. Group Outreach Attendees by Race/Ethnicity

Race/ethnicity	Number (%)	Race/ethnicity	Number (%)
White	1,741 (47.8%)	Korean	45 (1.2%)
Mexican	905 (24.8%)	Middle Eastern	39 (1.1%)
Unknown Race	189 (5.2%)	Tongan	26 (0.7%)
Filipino	152 (4.2%)	Puerto Rican	24 (0.7%)
Other Race	99 (2.7%)	Cuban	9 (0.2%)
Two or more races	80 (2.2%)	Hawaiian	9 (0.2%)
Black	72 (2.0%)	Central American	6 (0.2%)
Chinese	67 (1.8%)	South Asian	5 (0.1%)
American Indian	64 (1.8%)	Vietnamese	5 (0.1%)
Japanese	53 (1.5%)	South American	2 (0.1%)
Samoan	53 (1.5%)		

* Total counts for race/ethnicity are larger than the total number of group outreach attendees reported because providers may have classified an attendee under several race/ethnicity categories and as “two or more races.”

In FY 2016-2017, Pacifica Collaborative reported 903 group outreach event attendees representing special populations (**Figure 4**). During FY 2016-2017, Pacifica Collaborative most commonly reached attendees who are at risk for homelessness (n=471), homeless (n=171); and/or veterans (n=93), these categories are not mutually exclusive.

Figure 4. Populations of Interest, Q1-Q4



Appendix H. FY 2016-2017 Outreach, Pyramid Alternatives

Individual outreach

For FY 2016-2017, Pyramid Alternatives did not report any individual outreach events.

Group outreach

For FY 2016-2017, Pyramid Alternatives reported a total of 2 group outreach events, corresponding to 37 group outreach event attendees—all attendees in Q1. The average length of group outreach events was 120 minutes.

Most group outreach events:

- Took place in faith-based church/temple (**50.0%**; n=1) or unspecified location (**50.0%;** n=1).
- Were categorized under MAA 400 (**100%**; n=2).
- Were conducted in English (**50.0%**; n=1) or Mandarin (**50.0%;** n=1).

Group outreach event attendees:

- Self-reported as female (**62.2%**; n=23), male (**29.7%**; n=11), or other gender (**8.1%**; n=3).
- Self-reported as Heterosexual (**86.7%;** n=13), unknown sex orientation (**6.3%;** n=1), and other (**6.3**%; n=1).
- Represented many races and ethnicities (**Table 1**).

Table 1. Group Outreach Attendees by Race/Ethnicity

Race/ethnicity	Number (%)
Chinese	26 (70.3%)
Filipino	4 (10.8%)
White	4 (10.8%)
Mexican	2 (5.4%)
Black	1 (2.7%)

In FY 2016-2017, Pyramid Alternatives reported 3 group outreach event attendees representing special populations (**Figure 2**). During FY 2016-2017, Pyramid Alternatives most commonly reached attendees who are veteran (n=2), and/or vision impaired (n=1); these categories are not mutually exclusive.

Appendix I. Methods

For the **individual outreach forms**, we report the number and percent of attendees with a given demographic characteristic.

- Numerator = number of attendees in a given category (e.g., location in the office setting), per quarter
- Denominator = total number of attendees, per quarter

For the **group outreach forms**, we report the number of group outreach events and total number of attendees during an event.
For Medicaid Administrative Activities (MAA) codes, location, and language, we report the number and percent of group events.

- Numerator = number of group event(s) with a certain MAA code, location, or language, per quarter
- Denominator = total number of group events, per quarter

Demographic characteristics are reported as the number and percent of attendees.

- Numerator = number of attendees in a given category (e.g., race), per quarter
- Denominator = total number of attendees, per quarter

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APPENDIX 7: CALMHSA STATEWIDE PEI PROJECT - FY 16/17 IMPACT STATEMENT

California Mental Health Services Authority
Statewide Prevention & Early Intervention (PEI) Project

FY 2016-2017 Reach and Impact in San Mateo County

San Mateo County contribution to the Statewide PEI Project in FY 2016-2017: $95,965.00

The Statewide PEI Project: Achieving More Together

In Fiscal Year 2016-2017, 41 counties collectively pooled local Prevention and Early Intervention (PEI) funds through the California Mental Health Services Authority (CalMHSA) to support the ongoing implementation of the Statewide PEI Project. The Statewide PEI Project is publicly known as *Each Mind Matters: California's Mental Health Movement*, which represents an umbrella name and vision to amplify individual efforts from the county and other organizations that are taking place across California under a united movement to reduce stigma and discrimination and prevent suicides.

Strategies of the Statewide PEI Project in Fiscal Year 2016-2017

In Fiscal Year 2016-2017, funding to the Statewide PEI Project supported programs such as maintaining and expanding public awareness and education campaigns, creating new outreach materials for diverse audiences, providing technical assistance and outreach to county agencies, schools and community based organizations, providing mental health/stigma reduction trainings to diverse audiences, engaging youth through the Directing Change program, and building the capacities of schools to address mental health, stigma reduction and suicide prevention.

Outcomes to Date

Since counties began pooling funds through CalMHSA to implement the Statewide PEI Project in 2011, the following short-term outcomes have been achieved. Given the outcomes so far, independent evaluators of the Statewide PEI Project, the RAND Corporation, have identified the following outcomes from the Statewide PEI Project:

- 15.4% more Californians exposed to Each Mind Matters turn to help for mental health challenges.
- Over 50% of Californians were exposed to Know the Signs.
- Individuals exposed to the Know the Signs campaign report higher levels of confidence to intervene with someone at risk for suicide.[1]
- The Know the Signs campaign was rated by experts to be aligned with best practices and be one of the best media campaigns on the subject.[2]

[1] https://www.rand.org/pubs/research_reports/RR1134.html
[2] https://www.rand.org/pubs/research_reports/RR818.html

Funded by counties through the voter-approved Mental Health Services Act (Prop 63).

- Students exposed to the Walk In Our Shoes website demonstrate significantly higher knowledge of mental health.[3]
- 63% of teachers and administrators who saw the Walk In Our Shoes performance started a conversation about mental health in the classroom.[4]
- 87% of students have a better understanding of mental illness and suicide after participating in Directing Change.[5]
- 97% of students who participated in Directing Change pledged to support a friend with a mental health challenge.[6]
- 87% of those who completed the Kognito training report that they are better prepared to identify, approach and refer students exhibiting signs of psychological distress.[7]
- 66% of California Community College faculty who completed Kognito training report an increase in the number of conversations they had with other faculty and staff about students that they were concerned about.[8]

Statewide achievements in FY 2016-2017

The effects of the Statewide PEI Project go beyond county lines. Influencing all Californians in the message of Each Mind Matters is critical for creating a culture of mental health and wellness regardless of where individuals live, work or play. Key statewide achievements of the Statewide PEI Project in FY 2016-2017 include:

- Reaching the milestone of disseminating over 1 million lime green ribbons
- Over 1 million hardcopy materials were disseminated in counties, schools, and CBOs
- Over 450 people attended the inaugural Each Mind Matters webinar series
- Over $250,000 in mini-grant funds were provided to CBOs, NAMI affiliates, Active Minds Chapters and Community Colleges to host community outreach events utilizing Each Mind Matters resources and messaging
- The Directing Change Program received over 480 videos submissions from over 100 schools across California, engaging over 1,300 students
- Over 25 new Each Mind Matters culturally adapted resources were developed
- Over 70 news broadcasts, news articles and radio reports discussed programs implemented by the Statewide PEI Project
- Nearly 700 county agencies, schools, local and statewide organizations across California were touched by programs implemented by the Statewide PEI Project

[3] http://walkinourshoes.org/content/NORCReportonWIOSWebsite.pdf
[4] http://walkinourshoes.org/content/NORCReportonWIOSWebsite.pdf
[5] http://www.directingchangeca.org/wp-content/uploads/CalMHSA%20DC%20Eval%20Report.pdf
[6] http://www.directingchangeca.org/wp-content/uploads/CalMHSA%20DC%20Eval%20Report.pdf
[7] https://www.rand.org/pubs/research_reports/RR954.html
[8] https://www.rand.org/pubs/research_reports/RR954.html

Projected Outcomes of the Statewide PEI Project

Changing the current culture around mental health and suicide prevention requires a long-term commitment. Ongoing investment in the unprecedented statewide investment in strategies implemented by the Statewide PEI Project PEI will result in larger social impact (e.g., changing attitudes, increasing knowledge, and modifying behaviors) by implementing programs that can benefit counties regionally and statewide, procuring resources at lower cost (e.g., cost efficiencies), and ultimately making a significant impact on preventing mental illnesses from becoming severe.

Projected 10 year outcomes:

- Increased intervention and provision of support by a community helper
- Increased proactive inclusion of individuals with mental health challenges
- Increased community encouragement and acceptance of seeking services early
- Increased knowledge and skills for recognizing and facilitating help seeking

Projected 20 year outcomes:

- Reduced discrimination against persons with mental illnesses
- Reduced social isolation and self-stigma
- Improved functioning at school, work, home and in the community
- Reduced suicidal behavior
- Reduced societal costs related to untreated mental illness

The information below provides a comprehensive summary of activities that were implemented by CalMHSA Statewide PEI Project contractors and their subcontractors in 2016-2017:

- RSE
- The Directing Change Program and Film Contest
- Each Mind Matters Outreach & Engagement
- NAMI California
- Active Minds
- California Community Colleges Student Mental Health Program
- RAND Corporation

Organizations Reached

In FY 2016-2017, **9** local county agencies, schools and organizations received outreach materials, a training, technical assistance or a presentation about stigma reduction, suicide prevention and/or student mental health through the collective efforts of all programs implemented under the Statewide PEI Project. These include:

County agencies

- San Mateo County Health System, Equity Behavioral Health & Recovery Services

K-12 Schools and School Systems

- San Mateo Foster City School District
- Woodside High School
- Aragon High School
- Burlingame High School

Colleges & Universities

- College of San Mateo
- Notre Dame de Namur University
- Canada College
- Skyline College

Training, Presentations and Outreach

Trainings, presentations and other forms of in-person outreach provide additional skills and knowledge to communities about stigma reduction and suicide prevention. Multitudes of individuals were reached through trainings, presentations and various outreach efforts with stigma reduction, suicide prevention and student mental health messages, resources, tools and materials through the collective efforts of all programs implemented under the Statewide PEI Project. These include:

Trainings: Trainings allow community members to learn valuable skills in how to address stigma reduction and suicide prevention

- **Kognito Suicide Prevention and Mental Health trainings:** Online avatar-based suicide prevention and mental health trainings for college students, faculty and staff. All California Community Colleges staff and students were provided with the opportunity to utilize the Kognito training.
    - Total number of student, faculty and staff trained: 1,233
    - Campuses that participated in the training: Skyline College; College of San Mateo; Canada College
- **Directing Change Judges Training:** Online trainings that provided an overview of best practices in suicide prevention and mental health messaging, as a platform for judging submitted Directing Change videos
    - Total number of people trained: 3
    - Organizations that received the training: San Mateo County Behavioral Health and Recovery Services Office of Diversity and Equity; San Mateo County Department of Behavioral Health.

- **California Community College Student Mental Health Trainings:** Distance learning training and technical assistance webinars for campus staff on relevant topics to improve local community colleges' student mental health programs and services.
    - Total number of people trained: 1
    - Training topics: Crisis Text Line
    - Campuses receiving the training: Skyline College

Outreach/Events: Outreach and other events are public events in which community members can learn about Each Mind Matters.

- **Active Minds Chapter Events:** Active Minds Chapters utilized Each Mind Matters materials and messaging to host outreach events on their higher education campuses
    - Total estimated number of attendees: 865
    - Campuses where the event took place: College of San Mateo

E-Newsletters: Online communications for various audience to engage them in Each Mind Matters, stigma reduction and suicide prevention.

- **Each Mind Matters Insiders Newsletter**: A monthly electronic newsletter created specifically for service providers that provides information about relevant resources, upcoming events and opportunities for providers to get involved in California's Mental Health Movement.
    - Total number of Each Mind Matters Insider Newsletter Subscribers: 5
    - Organizations subscribed: San Mateo County Behavioral Health; Star Vista

Technical Assistance

Technical assistance (TA) is provided by all Statewide PEI Project contractors, each targeting a different audience. Technical assistance includes providing crisis support, capacity building, guidance, and resource navigation on stigma reduction, suicide prevention and student mental health. It also includes building and maintaining a statewide network of providers and organizations who collaborate and learn from each other to implement more effective efforts and reach broader audiences. In addition, an Each Mind Matters Resource Navigation Team provides regular communication in the form of in person meetings and TA emails covering a range of topics with practical tools and information. During the FY 2016-2017, sixteen TA emails covered topics such as the Suicide Prevention and Mental Health Awareness Month Toolkits, Veteran's Mental Health, Supporting PEI Efforts in Schools and others. During FY 2016-2017, specific TA consultations included:

- **TA to counties**
    - Technical Assistance Support included:
        - Support to county staff on updating the county resources section of the Know the Signs Campaign website and providing additional guidance on how the county can implement their suicide prevention social media efforts.

  - Providing a selection of Directing Change films to be used in conjunction with the county's QPR trainings for youth providers
  - Developing a brief data summary of the Directing Change Program and updates about the FY 16/17 Directing Change contest and local San Mateo participation
- **TA to Active Minds Chapters**
  - Total technical assistance consultations: 4
  - Campuses receiving Technical Assistance: College of San Mateo, Notre Dame de Namur University

Dissemination of Hardcopy Materials

Between July 1, 2016 and June 30, 2017, a total of **19,326** physical, hardcopy materials across Each Mind Matters programs and initiatives were disseminated throughout San Mateo County. In addition, county contacts received numerous emails to access and share resources electronically via the Each Mind Matters Resource Center (www.emmresourcecenter.org).

- **Each Mind Matters Promotional Items**: 2,108
- **Each Mind Matters Educational Materials**: 4,238
- **SanaMente Materials**: 1,007
- **Know the Signs/El Suicidio Es Prevenible Educational Materials**: 11,150
- **Directing Change Materials**: 85
- **Walk In Our Shoes/Ponte En Mis Zapatos Materials:** 8
- **California Community College Student Mental Health Program Materials**: 650

Directing Change

The Directing Change program offers young people the exciting opportunity to participate in the movement by creating 60-second films about suicide prevention and mental health that are used to support awareness, education and advocacy efforts on these topics. NORC at the University of Chicago conducted a comprehensive cross-sectional control study in 2017. Findings from the study found Directing Change to be highly effective in increasing knowledge, behavior and attitudinal outcomes related to suicide prevention and mental health and demonstrated changes in school climate. In addition to providing technical assistance and social media engagement:

- Total number of films submitted: 7

- Schools, organizations and colleges/universities that submitted videos: Woodside High School; Aragon High School; Burlingame High School; Mental Health Advocacy Club; Str8jacket Studio
- Total number of youth participating: 17
- Examples of local use: San Mateo Counties hosted a screening in May and San Mateo County expressed interest in using films in QPR in the future

Media

Activities implemented under the Statewide PEI Project received significant media attention in FY 2016-2017. In San Mateo County, the following news outlets reported on these activities:

Half Moon Bay Review: *There is help available to prevent suicide*
http://www.hmbreview.com/opinion/editorials/there-is-help-available-to-prevent-suicide/article_12abd786-8035-11e6-b21c-4bbe9df33de3.html

APPENDIX 8: INN PROJECTS - FY 16/17 EVALUATION REPORTS

San Mateo County Pride Center
Fiscal Year 2016-17 Evaluation Report

A Mental Health Services Act Innovation Project

Prepared by:

Resource Development Associates

December 2017

Table of Contents

Introduction

Project Overview

The San Mateo County Pride Center is an Innovation (INN) program under the Mental Health Services Act (MHSA) that is funded by the San Mateo County Behavioral Health Recovery Services (BHRS) department. The San Mateo County Pride Center is a formal collaboration of four partner organizations: StarVista, Peninsula Family Services, Adolescent Counseling Services, and Daly City Partnership. The Pride Center also works collaboratively with the Pride Initiative of the Office of Diversity and Equity and the County of San Mateo LGBTQ Commission, co-sponsoring and consulting across many events, efforts and policy priorities.

- **MHSA INN Project Category:** Introduces a new mental health practice or approach.
- **MHSA Primary Purpose:** 1) Promote interagency *collaboration* related to mental health services, supports, or outcomes and 2) Increase *access* to mental health services to underserved groups.

The Mental Health Services Oversight and Accountability Commission (MHSOAC) approved the project on July 28, 2016 and BHRS began implementation in September 2016. In 2017, San Mateo County Behavioral Health Recovery Services (BHRS) contracted Resource Development Associates (RDA) to evaluate the San Mateo County Pride Center implementation and outcomes. This report report provides findings from the first year of implementing the San Mateo County Pride Center.

Project Need

Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and other (LGBTQ+) individuals commonly experience depression, anxiety, suicidal thoughts, substance abuse, homelessness, social isolation, bullying, harassment, and discrimination. LGBTQ+ individuals are at higher risk of mental disorders compared to non-LGBTQ+ individuals given that they face multiple levels of stress, including subtle or covert homophobia, biphobia, and transphobia.[1]

Project Innovation

While it is not new to have an LGBTQ center providing social services, there is no model of a coordinated approach across mental health, social and psycho-educational services for this marginalized community.

BHRS developed the San Mateo County Pride Center (Pride Center or the Center) as a behavioral health coordinated services center to address the need for culturally specific programs and mental health services for the LGBTQ+ community. The establishment of the Center also fulfills the MHSA principle to promote interagency collaboration and increase access to mental health services for underserved groups.

[1] King, M., Semlyen, J., Tai, S. S., Killaspy, H., Osborn, D., Popelyuk, D., & Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self-harm in lesbian, gay and bisexual people. BMC Psychiatry, 8:70

Project Description

As a coordinated service hub that meets the multiple needs of high-risk LGBTQ+ individuals, the Pride Center offers services in three components.

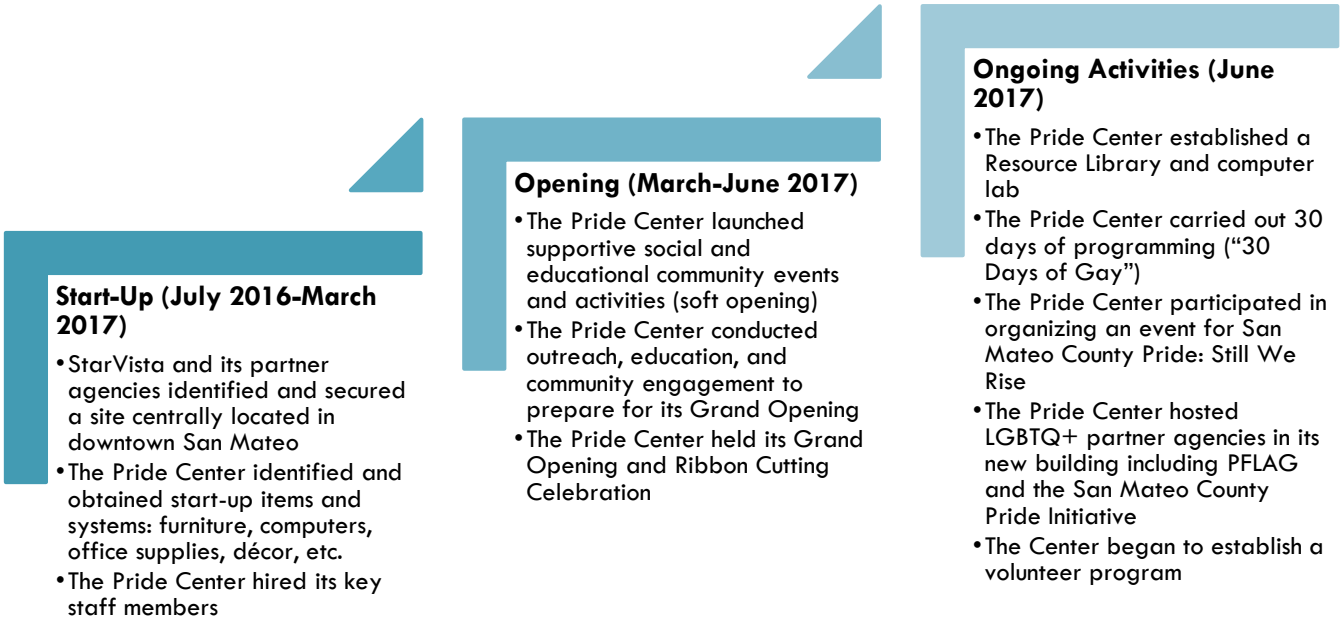
1. *Social and Community Activities*: The Pride Center aims to outreach, engage, reduce isolation, educate, and provide support to high-risk LGBTQ+ individuals through peer-based models of wellness and recovery that include educational and stigma reduction activities.
2. *Clinical Services*: The Pride Center provides mental health services focusing on individuals at high risk of or already with moderate to severe mental health challenges.
3. *Resource Services*: The Pride Center serves as a hub for local, county, and national LGBTQ+ resources, including the creation of an online and social media presence.

Project Timeline and Implementation Update

In the current reporting period, BHRS successfully planned, opened, and began programming at the San Mateo County Pride Center. BHRS contracted the administration of the Pride Center to a collaborative of partner agencies. Initially, when BHRS released its request for proposals (RFP) for the administration of the Pride Center, BHRS was concerned that the applicants did not demonstrate the capacity to effectively serve the community of interest, thus BHRS did not award the grant at this point and instead re-released the RFP. The second time, five partner agencies applied as a collaborative: StarVista (a San Mateo County mental health nonprofit founded in 2003) as the lead agency, along with Daly City Partnership, Peninsula Family Services, Adolescent Counseling Services, and Pyramid Alternatives (which has since merged with StarVista). BHRS was confident that together, the collaborative could effectively serve the demographic and geographic diversity of San Mateo County.

In fiscal year 2016-17, the Pride Center undertook a number of foundational activities related to the planning and startup of the Pride Center (see Figure 1). The Pride Center secured a site in December 2016 and was in a period of "soft opening" from March through May 2017. The Pride Center held its Grand Opening on June 1, 2017 and carried out a full month of programming during June 2017. Beginning during the soft opening period, the Center started six monthly Older Adult LGBTQ+ Peer Counseling meetings. In the month of June, the Youth Program Coordinator successfully made contact with and conducted meetings with six high schools in San Mateo County to learn about youth's needs and desires for LGBTQ+ programming. ***Appendix D includes the Pride Center's full report to BHRS detailing the activities and accomplishments during the reporting period.***

Figure 1. Pride Center Key Activities and Accomplishments



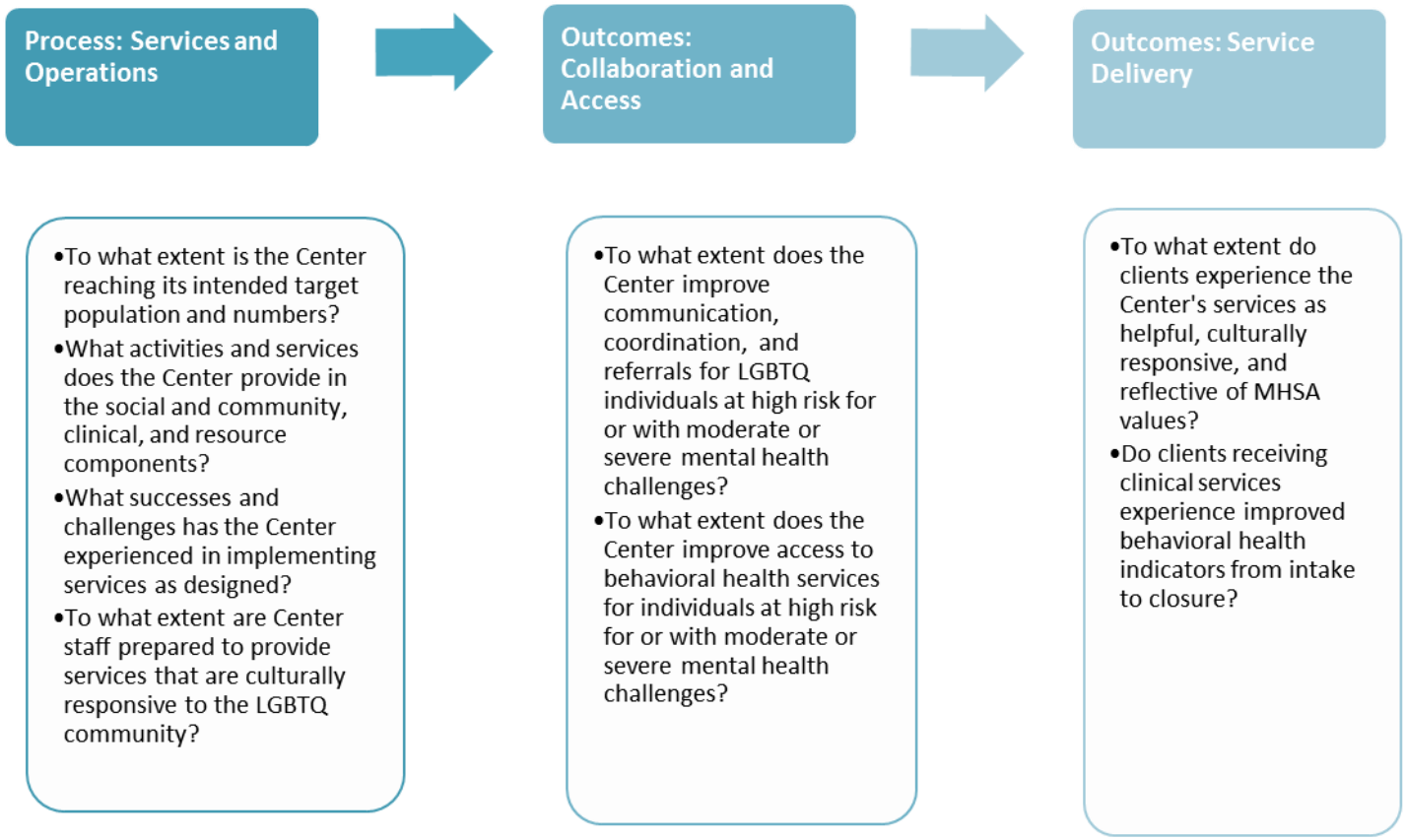
Evaluation Overview and Learning Goals

BHRS contracted Resource Development Associates (RDA) to carry out the evaluation of the Pride Center implementation and outcomes. RDA collaborated with BHRS staff, Center leadership staff, and Center partners to develop data collection tools measure program and service outcomes. In order to maximize RDA's role as research partners and fulfill MHSA Innovation evaluation principles, this evaluation uses a collaborative approach throughout every process of this evaluation that include operationalizing goals into measurable outcomes, interpreting, and responding to evaluation findings.

Pride Center Learning Goals	
	Learning Goal 1 (Collaboration): Does a coordinated approach improve service delivery for LGBTQ+ individuals at high risk for or with moderate to severe mental health challenges?
	Learning Goal 2 (Access): Does The Center improve access to behavioral health services for LGBTQ+ individuals at high risk for or with moderate or severe mental health challenges?

BHRS seeks to learn how the Pride Center enhances access to culturally responsive services, increases collaboration among providers, and, as a result, improves service delivery for LGBTQ+ individuals at high risk for or with moderate to severe mental health challenges. To guide the evaluation, RDA and BHRS have developed evaluation questions in three categories (see **Error! Not a valid bookmark self-reference.**). By reaching the Pride Center's goals in terms of service and operations, and by improving collaboration, the Pride Center hopes to improve access and overall service outcomes for clients.

Figure 2. Evaluation Domains and Questions



Evaluation Methods

RDA developed a mixed methods evaluation that incorporates both process evaluation and outcome evaluation components.

- A **mixed methods** approach allows the evaluation to track quantitative measures of service delivery and outcomes, while also gathering qualitative input on how and why activities and outcomes occurred. Using multiple sources to explore the evaluation questions also enables comparison and corroboration of findings across the data sources.
- The **process evaluation** component explores the extent to which the Pride Center has been implemented as planned and the strengths and challenges the county has experienced in implementation from the perspective of various stakeholders. This exploration enables BHRS, Pride Center leadership staff, and Center partners to make real-time adjustments that may improve the operations and outcomes of the Center.
- The **outcome evaluation** component assesses how the Pride Center—through its collaborative approach to service delivery—produces changes in access to services and in client-level behavioral health outcomes.

Data Collection

In line with RDA's mixed methods approach to evaluation, the evaluation includes quantitative and qualitative tools to measure indicators in the domains of services and operations, collaboration and access to services, and service delivery outcomes. Below we describe the measures that the evaluation will use along with the data collection methods that we will use to measure each of the indicators. Please see Appendix A for a detailed data collection plan.

Collaboration Survey

As collaboration is the key innovative element of this MHSA INN project, it was crucial for the evaluation team to operationalize the concept of collaboration so that it could be measured over time. RDA researched validated survey tools that are intended to measure collaboration among a team of service providers, with a specific focus on tools that would measure levels of coordination, which forms the core of the Pride Center's innovative approach to service delivery. It was important to locate a tool that contained questions that could apply both to management-level staff (who may not work directly with clients) as well as direct service staff. RDA and BHRS selected the *Assessment of Interprofessional Team Collaboration Scale II (AITCS-II)*, developed by Dr. Carole Orchard.[2]

The AITCS-II is a diagnostic instrument that is designed to measure the interprofessional collaboration among health services team members. It consists of 23 statements considered characteristic of interprofessional collaboration, representing three elements that are considered to be central to a

[2] Orchard, C. A., King, G. A., Khalili, H. and Bezzina, M. B. (2012), Assessment of Interprofessional Team Collaboration Scale (AITCS): Development and testing of the instrument. J. Contin. Educ. Health Prof., 32: 58–67. doi:10.1002/chp.21123

collaborative practice: 1) Partnership, 2) Cooperation, and 3) Coordination. Measuring levels of partnership and cooperation ultimately inform how well providers are able to coordinate services for clients. Respondents indicate their general level of agreement with items on a 5-point rating scale that ranges from 1 = "Never"; 2 = "Rarely"; 3 = "Occasionally"; 4 = "Most of the time"; to 5 = "Always". The survey takes approximately 10 minutes to complete. To facilitate survey administration, RDA transferred the survey content into the online survey platform, Survey Gizmo.

RDA obtained permission from Dr. Orchard to make some slight modifications to the survey language in order to be more appropriate for the Pride Center team. For example, we replaced "his/her" with "their" as a gender neutral pronoun. See Appendix B for a copy of RDA's online version of the AITCS-II.

Attendance and Demographic Reporting

To document the population that the Pride Center is serving, the Pride Center and RDA collaborated to create a protocol for monitoring the number and characteristics of individuals who participate in Pride Center programs and services. Because the Pride Center provides an array of services with varying degrees of participation—including drop-in services, one-time community events, ongoing peer support groups, and clinical services—it was important to define what constitutes "meaningful participation" at the Pride Center for the purposes of collecting and reporting demographic data to the MHSOAC.

The Pride Center serves marginalized populations that may be hesitant to provide personal information on paper, even anonymously. Asking new attendees to fill out an extensive demographic form could feel unwelcoming to individuals who have experienced fear, stigma, and trauma related to their LGBTQ+ identity or may otherwise experience distrust around providing personal information. Therefore, the Pride Center determined that individuals who attend the Center *more than once*, as well as any client receiving clinical services, would be considered meaningful participants and would be asked to complete a demographic form. The Center's Administrative Specialist, who greets all individuals who enter the Center, asks individuals whether they have been to the Center before. If they have not, the Administrative Specialist asks the individual to fill out a paper version of the demographic form. To capture the total number of individuals served, the Pride Center decided to also track attendance through a sign-in sheet that captures basic personal information, but does not include the full range of demographic variables listed in the updated INN regulations.

The demographic form was designed to capture all elements required by the MHSOAC. The Pride Center and its partners decided to add additional categories to the items about sexual orientation and gender identity in order to be inclusive of the diversity of LGBTQ+ identities. The revision of the response options for the items on sexual orientation and gender identity were aligned with BHRS's initiative to revise Sexual Orientation and Gender Identity (SOGI) questions on health intake forms. The Pride Center and its partners also decided to add three additional items to the demographic form: housing status, income, and employment status.

RDA developed an online format using a HIPAA-compliant version of Survey Gizmo; the Pride Center administrative specialist enters the demographic forms into the online form monthly. The demographic form designed for the Pride Center is included in Appendix C.

Focus Groups with Staff and Partners

RDA conducted focus groups with Center staff and partners to enable the evaluation team to gather in-depth information from individuals working directly in the design and implementation of the Pride Center. With feedback from BHRS and the Pride Center Director, the evaluation team developed a semi-structured focus group guide to learn from staff and partners about what is working well and what is challenging about implementation, how they perceive collaboration and access to services for the target population, and any suggestions for improvement. RDA held two focus groups: one with Center partners, who provided their perspective on collaboration at a management level, and one with Center staff, who provided their perspective on collaboration as direct service providers.

Interview with Center Director

While the Pride Center Director participated in the focus group for partner agencies, RDA also conducted a one-on-one interview to gather any additional information the Director could provide about the Center's implementation and outcomes. To facilitate the interview, RDA summarized the results of the focus groups conducted with staff and partners and used the summary as a starting point for validating and/or adding to the data gathered up to that point.

Future Data Collection Activities

Once the Pride Center begins providing clinical services, the evaluation will incorporate the following additional data collection activities:

- **Clinical services data**, including a summary of clinical services and referrals provided and results from a clinical tool to measure client progress over time;
- A **participant satisfaction survey** to learn about clients' experiences of the Pride Center environment, staff, and impact; and
- **Participant focus groups**, including participation from a Community Advisory Board, to gather in-depth information from participants about their perceptions of the Center service delivery and how the Center has impacted them.

Measures and Data Sources

The following tables indicate the key measures and data sources the evaluation will use to assess outreach and implementation, collaboration and access to services, and service delivery outcomes.

Table 1. FY2016-17 Evaluation Measures and Data Sources

Outreach and Implementation of Services	Data Sources
Number of individuals reached	• Participant Demographic Form • Participant Sign-In Sheets • Outreach and Meeting Tracking Sheets
Types of activities and services provided in the social and community, clinical, and resource components	• Participant Services Data • Focus Groups with Participants • Focus Groups with Service Providers

Successes and challenges of implementing services as designed	• Interviews with Center Leadership • Focus Groups with Service Providers
Cultural responsiveness of services	• Focus Groups with Participants • Focus Groups with Service Providers • Interview with Center Leadership • Participant Satisfaction Survey
Collaboration and Access to Services	**Data Sources**
Effectiveness of communication, coordination, and referrals for LGBTQ+ individuals with moderate to severe mental health challenges	• Focus Group with Service Providers • Focus groups with Participants • Partner Collaboration Survey (AITCS-II)
Improved access to behavioral health services for individuals with moderate to severe health challenges	• Focus groups with Participants • Participant Satisfaction Survey
Service Delivery Outcomes	**Data Sources**
Client service experience (E.g., Experience with services, facility, and service providers)	• Participant Satisfaction Survey • Focus Groups with Participants
Improved health outcomes among clients	• Clinical Progress Survey • Focus Groups with Participants • Participant Satisfaction Survey

Data Analysis

To analyze the quantitative data from demographic forms and the collaboration survey, RDA examined frequencies and ranges. To analyze qualitative data, RDA transcribed focus group and interview participants' responses to appropriately capture the responses and reactions of participants. RDA thematically analyzed responses from participants to identify commonalities and differences in participant experiences.

Implementation Update

Numbers and Characteristics of Individuals Served

As described in the section on Evaluation Methods, the Pride Center tracks attendance for all visits and Center programs and captures demographic data for meaningful participants, defined as individuals who visit the Center more than once.

Attendance tracking. The Center has already reached more than 1,000 people including its Grand Opening and programming during the month of June (this number may be duplicated across events). Since its Grand Opening, the Pride Center has hosted several social events intended to foster relationships among the LGBTQ+ community in San Mateo County. Table 2 below shows the number of attendees for its events during the reporting period.

Table 2. Attendance at Pride Center Events, 2017

Event	Total Number in attendance
Grand Opening	400
30 Days of Gay	700
Pulse Night of Remembrance	25
1st San Mateo County Queer Prom	60
Queer Cumbia and Noche de Joteria	12
Total	1,197

Demographic tracking. Based on the Pride Center's criteria for meaningful participation, a total of 41 individuals visited the Center more than once and completed a demographic form during the month of June 2017 (after the Center's Grand Opening). As of June 30, 2017, the Pride Center had not yet begun providing clinical services. The following tables provide an overview of the characteristics of individuals that the Pride Center served during the reporting period.

Note on reporting: To comply with HIPAA requirements and protect the confidentiality of participating individuals, the tables below only present data for response categories with at least five responses. Where fewer than five responses were received, some categories have been combined. The total number of responses for each question may not add to 41 because some individuals did not answer every question on the form, and some questions allowed participants to select multiple responses. Tables for questions where it is possible to present categories with at least five responses are presented in Appendix E.

Table 3. Participant Demographic Background, June 2017 (n=41)

Age. The Pride Center served people from every age range. Most survey respondents (83%) were adults.

Language. Nearly all respondents reported that English was their preferred language.

Race. Half of respondents reported their race as White/Caucasian. The next most frequently reported race was Asian, followed by Hispanic/Latino/a/x. Other responses included American Indian/Alaskan Native, Black/African American, and Other.

Ethnicity. Over one-third of respondents (39%) reported a European or Eastern European ethnicity. Approximately one-third (31%) reported an Asian or South Asian ethnicity and another third (31%) reported a South or Central American or Caribbean ethnicity. Twenty-two percent reported another ethnicity (African, Middle Eastern, or Other) or declined to answer the question.

Sex. Just over three-quarters of respondents (76%) reported their assigned sex at birth as female.

Gender Identity. The most commonly reported gender was cisgender female (44%), followed by cisgender male (21%). The remaining respondents reported another gender identity.

Sexual Orientation. Nearly half (46%) of respondents identified their sexual orientation as gay or lesbian. Another 19% identified as bisexual. The remaining respondents identified in other sexual orientation categories (asexual, queer, pansexual, questioning or unsure of sexual orientation, indigenous sexual orientation, heterosexual or straight).

Disability Status. Most respondents reported having no disability. Close to one-third (30%) of respondents reported having a disability.

Education. Over half of respondents (56%) reported having an associate's degree, bachelor's degree, or graduate degree. Most remaining respondents either had less than a high school diploma (keep in mind some respondents were high school-aged children), or had a high school diploma, some college, or a vocational or trade certificate.

Employment. Approximately one-third of respondents (34%) reported being employed full time, while one-quarter (26%) reported being students. One-quarter (26%) were unemployed or retired, and 13% of respondents were employed part time.

Housing. Just over two-thirds of respondents (69%) reported having stable housing. Another 28% reported staying with friends or family (some of these reports may have been from children living with their families), living in a shelter or transitional housing, or another housing status.

Income. Of respondents over age 18, one-third (34%) reported making less than $25,000 a year. Sixteen percent reported making between $25,000 and $50,000 a year, and just over one-third (34%) reported making above $50,000.

Veteran Status. Of those over age 18, no respondents reported being a veteran; respondents either stated they were not a veteran or declined to answer the question.

Changes to Innovation Project during Reporting Period

There have been several minor operational and staffing changes at the Pride Center during the reporting period.

- The professional background requirements for the Pride Center director changed from the initial RFP. The initial RFP requested that the Pride Center Director have a background in clinical services. However, in order to fulfill its vision of creating a collaborative hub for the LGBTQ+ community, BHRS prioritized hiring a director with a background in community building and community organizing.
- The starting salary for the Pride Center's Clinical Coordinator was increased. Additionally, the Clinical Coordinator was given management responsibilities.
- The Pride Center changed the role of the receptionist to an Administrative Specialist who would take on the responsibility of managing the Pride Center's social media platforms in addition to

reception duties. The Pride Center leadership made this change after realizing that the Pride Center needed a staff person to take on some marketing and communications duties.

- The Pride Center decided to wait to convene its Community Advisory Board until after the initial planning and startup process to avoid confusion of roles with the Center partners.
- One of the collaborative partners, Pyramid Alternatives, has merged with StarVista; thus four collaborative partners, not five, now operate the Pride Center.

Implementation Successes and Challenges

This section highlights successes and challenges in the early implementation of the San Mateo County Pride Center. The key findings below are presented according to the following domains: planning and startup, staffing, and target population and outreach.

Planning and Startup

Pride Center partners agreed that as a collaborative, they were able to combine their strengths to launch the Pride Center more effectively than any one partner could have done alone. After an initial struggle to find a space for the Pride Center that would be centrally located and accessible, the Center partners identified a prime location in downtown San Mateo. Center partners also leveraged their professional expertise and resources in building the Center's capacity to serve diverse demographics.

Planning for the Pride Center was done collaboratively among partner agencies as well as with the community, with stakeholders weighing in on decisions about the Center's name and logo, the design of the Center interior, and the direction of Center programming. To fulfill the Center's mission of stakeholder engagement at all phases of planning and implementation, in March 2017 the Center began conducting monthly community meetings with local community members to ask for community input regarding the Center.

Pride Center partners reported that as their partnership matures, they will benefit from guidance and training on best practices in working together as a collaborative, including how to develop policies and procedures for delineating tasks, decision-making structures, accountability structures, and processes for handling disagreements among partners. The Pride Center is also in the process of establishing a Community Advisory Board (CAB) with members from different parts of the community to help guide the direction and evaluation of the Center.

Hiring and Staffing

StarVista, as the lead agency, manages the hiring process for the Pride Center with input from other partner agencies. Because StarVista and BHRS were committed to hiring competent staff with experience working with the LGBTQ+ population, hiring for the staff positions took somewhat longer than originally anticipated. One of the initial challenges in getting the Center off the ground was hiring a Center Program Director who was qualified to manage a new collaborative and who had experience working with the LGBTQ+ population. StarVista took the task of hiring the Center Program Director seriously, taking time

to make sure they found the right fit. Ultimately, StarVista selected a Program Director with a background in peace and justice studies as well as community organizing and who has successfully hired a strong team of staff, built a sense of team engagement, and provided support and supervision to staff.

In hiring the Pride Center staff, the Director prioritized the following qualities: 1) knowledge and understanding of issues impacting the LGBTQ+ youth, families, and older adults, 2) experience and passion for serving the LGBTQ+ community, 3) understanding of social justice and cultural humility, and 4) lived-experience, cultural identities, and linguistic abilities that are reflective of San Mateo County's LGBTQ+ community and enhance the Center's capacity to provide culturally responsive services.

A challenge with hiring during the reporting period was filling the position of Lead Clinical Supervisor with someone who is licensed, can supervise, has expertise in working with the LGBTQ+ population, reflects the diversity of the community, and would accept the salary StarVista can afford to offer. StarVista met with the Office of Diversity to creatively address the clinical vacancy, and ultimately decided to increase the starting salary of the Clinical Coordinator, given the extremely high cost of living in San Mateo County. Another challenge during the reporting period was that the Pride Center does not have Chinese and Tongan language abilities on staff. The partners are working to address these challenges with support from the language capabilities among their own staff. Another staffing challenge is that the RFP did not specify staff positions to oversee education and training as well as marketing and communication roles. Consequently, other Center staff must take on these tasks in addition to their assigned roles.

Center staff noted that collaboration can increase staff's workload if staff are providing services for outside agencies while simultaneously providing services at the Center. Center staff felt it would be mutually beneficial for the Center to support these outside organizations on a consultation basis, rather than by providing services directly. This would allow the Center to focus on service delivery within the Center, while also building the service delivery capacity of external partners.

Target Population and Outreach

The Pride Center's mission is to serve the full spectrum of the LGBTQ+ population in San Mateo County, with a focus on serving high-risk individuals who have not had access to LGBTQ-competent services in the past. Drawing on connections from the partners, the Center has established relationships with a number of public agencies and community-based organizations (CBOs) throughout the county to enhance its outreaching efforts (*see discussion of partnerships in Collaboration section).* The Center has hired a Community Outreach Coordinator, though all staff are involved in outreach to some degree. Staff have conducted extensive outreach at high-traffic public areas such as libraries, community centers, restaurants, and senior centers, and have so far covered most of North County and the Coast.

Unlike in other parts of the Bay Area where LGBTQ centers are located (e.g., San Francisco and San Jose), it has been challenging for the Pride Center to reach LGBTQ+ communities of color due to the socio-economic climate of San Mateo County and stigma related to being LGBTQ+ and/or to seeking mental health services. Consequently, high-income and white individuals primarily visit the Center. Center staff also reported challenges in reaching all of the geographic areas of the county. Center staff expressed the desire to serve clients in cities and neighborhoods like Half Moon Bay and Pescadero but staffing remains

a barrier to penetrate those geographic communities. As one staff member responded, *"It's hard to reach people or have them reach us outside of the city of San Mateo."*

Preliminary Outcomes

The purpose of this MHSA Innovation project is to achieve two goals: 1) promote interagency collaboration related to mental health services, supports, or outcomes, and 2) increase access to mental health services to underserved groups. The following sections discuss preliminary outcomes that the Pride Center has seen in its early stages of implementation. It is important to note that because the Pride Center was only in operation for approximately one month before the end of the reporting period, outcomes are preliminary and, for the most part, cover process rather than outcome components.

Learning Goal 1: Collaboration

To measure the Pride Center's progress toward achieving its goals related to collaboration, BHRS identified both process and outcome evaluation components. The process component explores the mechanics of collaboration among service providers, while the outcome component explores how this collaboration influences the client experience (see Table 4).

Table 4. Collaboration Process and Outcome Measures

Process Evaluation	Outcome Evaluation
Baseline Objective. Examines how systems effectively collaborate currently to serve the population of interest **Process Measures.** Examines the increase in communication, referrals, and interaction between service providers	Measures improved behavioral health indicators from pre/post scales and client satisfaction surveys

Note on measurement: The measures of collaboration presented in this report represent early levels of collaboration—after the Pride Center collaborative was formed, but still in the beginning stages of implementation. Because the Pride Center partners started operating collaboratively in the RFP phase and before the project evaluation began, it is not possible to measure a true baseline level of collaboration before the existence of the Pride Center. That being said, based on BHRS's knowledge of the service landscape in San Mateo County, it is clear that before the Pride Center launched, county partners may have been working together on an informal and case-by-case basis, but there was not a formal structure for collaboration around serving LGBTQ+ consumers. Subsequent reports will compare how collaboration evolves from the early stages of collaboration documented in this report. Because the Pride Center is early in its implementation and did not begin providing clinical services during the current reporting period, it is too early to measure the outcomes of the Center's collaborative approach. During the next reporting period, the Pride Center will work with RDA to develop and implement measures of client progress.

When looking at levels of communication, referrals, and interaction between service providers, it is useful to distinguish between collaboration *internally* among Pride Center staff and collaboration *externally*

between Pride Center staff and service providers outside the Center. The sections below discuss early levels of collaboration in each of these arenas.

Internal Collaboration among Center Partners and Staff

> *"Everyone [on staff] has something to offer. I'm always learning new things, for example, how to facilitate a training, or wording on how to approach a subject with a client. We bounce ideas off each other."*
>
> *-Pride Center staff*

Leadership from the Center's four partner agencies emphasized that in coming together to design and implement the Pride Center, they have shared information, resources, and knowledge that has enabled the Center to create programming for the diverse members of the LGBTQ+ community. For example, the Center partner from Peninsula Family Services specializes in older adult services, and brings her expertise to designing programs for older adults. The Center partner and staff from Adolescent Counseling Services specializes in youth programming, and contribute their expertise to creating youth and peer programs at the Center. Partners agreed that their interaction has strengthened the development of the Pride Center as a whole.

From the time that the Pride Center service providers were hired, the team has collaborated with one another to build their internal capacity for service delivery. Center staff reported that their skill levels, for example in conducting outreach, have increased simply by observing other staff.

Staff retreats and meetings have also helped create team cohesion and wellbeing among staff. One staff member shared, "*My first day [as an employee] was a staff retreat and we all took a hike. It seemed like [the Center Director] really cared and was thinking about the wellbeing of the staff and everyone getting to know each other."*

Collaboration Survey Results. Ten staff and six partners responded to the survey for a total of 16 responses. Center staff were asked to complete all sections of the survey, while partners were instructed to indicate "not applicable" for questions that focus on direct service provision, as most partners are in leadership positions and do not provide direct services.

Responses to the collaboration survey demonstrate that even at early stages, the reported level of partnership around serving clients was high, with nearly all respondents rating the items in the *partnership* and *cooperation* sections as occurring most of the time or always. These responses illustrate that partners and staff perceive their work together as inclusive of one another and clients and founded on a sense of trust and honesty.

The survey results corroborate findings from the partner and staff focus groups that pointed to areas for improvement in defining roles, responsibilities, and procedures for the collaborative operation of the Pride Center. Those who responded to the survey indicated that they only occasionally "understand the boundaries of what each partner can do," which aligns with feedback from focus group discussions that the Center would benefit from external guidance on how to best define roles and responsibilities in a collaborative project. Items in the *coordination* section were generally rated highly. At the same time, the

coordination section had the most items that respondents noted occurred occasionally or rarely, including: "equally (equitably) dividing agreed upon goals amongst the team," and "using an agreed upon process to resolve conflicts." These responses suggest that while the Pride Center is beginning its implementation with strong values and practices around partnership and coordination, there is more work to do to put infrastructure in place to ensure streamlined coordination. The collaboration survey results reflect observations in focus groups that the Pride Center will need to set policies and procedures for how to make decisions when conflicts or disagreements arise. Partners also explained that work responsibilities are not intended to be divided equally, as different partners take on tasks based on their areas of expertise and receive different levels of funding for their role in the Center.

External Collaboration with Stakeholders and Partners

Since its opening, the Center has received high levels of support from community members and other county stakeholders. These new or strengthened relationships have helped publicize the Center's services across the county. Center staff and partners expressed that County stakeholders have been supportive of the Center and assist with outreach by sharing flyers. To promote the Center, staff have presented information about the Center's services to county collaboratives including school-based mental health collaboratives, culturally specific Mental Health Initiatives of the BHRS department, the San Mateo County Board of Education, and the Commission on Aging. The Center has received press through local television stations and cultural-specific newspapers and numerous recognitions from multiple sectors such as the Bay Area Municipal Elections Committee (BAYMEC), a four-county lesbian, gay, bisexual, and transgender (LGBT) political action committee (PAC). Partners attribute the high attendance at the Grand Opening, which included an opening address by Board of Supervisor, David Pine, to their collective knowledge and relationships in the county. Center partners and staff agreed that the existence of the Center has added legitimacy to the work of individual partner agencies, which has positively affected the access that Center partners have to other county-level groups. One staff member shared, *"I work with a lot of contractors in the County, [and] people are talking about the Center—how we are amazing; and it changes the conversations."*

> *"I have worked with the Center on organizing a trans clothing donation drive, as well as San Mateo's first queer prom. The people at the Center are more than willing to help and educate the community; their event coordinators have been speakers at my high school's Gender and Sexuality Alliance."*
>
> *-High school student in San Mateo County*

In addition to support from external partners in publicizing the Pride Center's activities, the creation of the Center has led to opportunities to build knowledge about LGBTQ+ issues and increase LGBTQ+ competence among other service providers in the county. For example, Center staff have provided trainings to other healthcare professionals on the county's adoption of Sexual Orientation and Gender Identity (SOGI) identifiers on healthcare forms.

Learning Goal 2: Access

> *"The Pride Center is a great place where me and my family can just be. I love the atmosphere, the support, the intersectionality, and all the rainbows!"*
>
> *-High school student in San Mateo County*

Considering that the Center opened on June 1, 2017, it is too early to measure whether access to behavioral health services has increased for the LGBTQ+ population. Nevertheless, the Center has already reached hundreds of individuals in its short period of operation. The high attendance rate of over 400 people at the Center's Grand Opening (some attendees remarked that it was one of the best events the county had ever had), the positive response to the county's first ever Queer Prom, and participation throughout the month of June's "30 Days of Gay" suggest that the Pride Center is filling a longstanding need in the community for many individuals who have not had access to health and social services designed to address their specific needs.

> *"I'm proud to be a part of San Mateo County and LGBTQ family. The San Mateo Pride Center is a great place to do just that—to be proud of who we are, no matter where we are on our journey…I'm grateful this center opened up in my community. Finally a safer place for the people who just want to feel supported and accepted, and more importantly, for people to be proud of who they are as individuals and feel welcomed in their community."*
>
> *-Community member and Pride Center volunteer*

The central location of the Center provides access by public transportation, and the presence of co-located services reduces barriers to accessing multiple services at once. The Pride Center also provides offsite services, such as its peer support group at the College of San Mateo, which has had regular participation. However, Center staff and partners do recognize that there are barriers to ensuring access for all geographic and demographic subgroups in the county, and are internally developing strategies to address those barriers to increase access for community members. Lastly, the Center will be receiving Medi-Cal certification for its clinical services, which may increase the number of people it can serve.

Conclusion

The San Mateo County Pride Center aims to develop a coordinated approach across mental health, social and psycho-educational services for high-risk LGBTQ+ individuals. As a service hub that meets the multiple needs of high-risk LGBTQ+ individuals, the Pride Center offers social and community activities, clinical services, and resource services.

In fiscal year 2016-17, the Pride Center undertook a number of activities related to the planning and startup of the Pride Center. Securing a location and creating a warm and welcoming environment for diverse members of the LGBTQ+ community, the Center reached more than 1,000 people during its first

month of opening, June 2017, through its Grand Opening, special events, and peer counseling meetings. The Center's four partner agencies have built a collaborative relationship at both the leadership and staff levels. Partners make collaborative decisions and together lead the direction of the Center. A team of dedicated staff who are culturally reflective of the LGBTQ+ community support one another to strengthen each other's capacity to serve Center participants. Along with strong internal collaboration, the Pride Center partners have leveraged existing relationships to enhance partnerships with a number of external organizations, thereby increasing the capacity of agencies across the county to provide culturally responsive services to LGBTQ+ individuals and families.

> *"We are making history right now with this place. There will be moments of, 'What did I get myself into? This is hard.' At the end of the day, [it's about] remembering that we're building something beautiful that will live on after us."*
>
> *-Pride Center staff*

Appendix A: San Mateo Pride Center Data Collection Plan

	Data Collection	Administration Plan				
		To whom	By whom	What format	What frequency	Data entry plan
Participant Surveys	**Participant Demographic Form**	All participants with a minimum of 2 visits	Center administration staff	Paper form	On individual basis	Center staff enter into Survey Gizmo
	Participant Satisfaction Survey	Any participant at a point in time (voluntary)	Center administration staff	Paper and online survey	Annual	Center staff enter into Survey Gizmo
	Clinical Progress Survey	All clients who receive clinical services	Center clinicians	Paper survey	At intake, at 6-month follow-up, and at discharge	Center staff enter into ETO database
Center Forms/Data	**Participant Sign-In Sheets**	Any person who enters the Center	Center front desk staff	Paper form	Ongoing	Center staff enter service numbers into online form
	Clinical Participant Service Data	Clients receiving clinical services	Center clinical staff	Center database	Ongoing	Center staff enter into ETO database
	Outreach and Meeting Tracking Sheets	All partner meetings at the Center ***and*** All Center outreach activities held outside the Center	Center administration staff	Paper forms	Ongoing	Center staff enter into ETO database
RDA-Administered Data	**Focus Groups with Staff**	One focus group with direct service staff and one focus group with managers from Center partners	RDA	In-person discussion	Semi-annual	N/A
	Focus Groups with Participants	Center participants	RDA	In-person discussion	Annual	N/A
	Interviews with Center Leadership	Interview with Center Director	RDA	Telephone interview	Annual	N/A
	Partner Collaboration Survey (AITCS-II)	All Center staff and leadership	RDA	Online survey	Baseline and annual	N/A (online)

Appendix B: Collaboration Survey

Assessment of Interprofessional Team Collaboration Scale

Instructions:

The Assessment of Interpersonal Team Collaboration Scale (AITCS) is a validated instrument that is designed to measure the interprofessional collaboration among team members. It consists of 23 statements considered characteristic of interprofessional collaboration (how team works and acts). Scale items represent three elements that are considered to be key to collaborative practice. These subscales are: (1) Partnership— 8 items, (2) Cooperation—8 items, and (3) Coordination—7 items.

Respondents indicate their general level of agreement with items on a 5-point rating scale that ranges from 1 = "Never"; 2 = "Rarely"; 3 = "Occasionally"; 4 = "Most of the time"; to 5 = "Always".

It takes approximately 10 minutes to complete.

Note: Several terms are used for the person who is the recipient of health and social services. For the purpose of this assessment, the term 'patient' will be used. We acknowledge that other terms such as 'client' 'consumer' and 'service user' are preferred in some disciplines/jurisdictions.

Please mark the value which best reflects how you currently feel your team and you, as a member of the team, work or act within the team.

1 = Never
2 = Rarely
3 = Occasionally
4 = Most of the time
5 = Always

Respondent Information

*1) Please select your affiliation status at the Center**

[ ] Staff member at the Center

[ ] Partner with the Center

Section 1. PARTNERSHIP

*2) When we are working as a team, all of my team members... **

	1- Never	2- Rarely	3- Occasionally	4- Most of the time	5- Always	Not Applicable
a. include patients in setting goals for their care	( )	( )	( )	( )	( )	( )
b. listen to the wishes of their patients when determining the process of care chosen by the team	( )	( )	( )	( )	( )	( )
c. meet and discuss patient care on a regular basis	( )	( )	( )	( )	( )	( )
d. coordinate health and social services (e.g. financial,	( )	( )	( )	( )	( )	( )

occupation, housing, connections with community, spiritual) based upon patient care needs						
e. use consistent communication with the team to discuss patient care	( )	( )	( )	( )	( )	( )
f. are involved in goal setting for each patient	( )	( )	( )	( )	( )	( )
g. encourage each other and patients and their families to use the knowledge and skills that each of us can bring in developing plans of care	( )	( )	( )	( )	( )	( )
h. work with the patient and their relatives in adjusting care plans	( )	( )	( )	( )	( )	( )

***Partners may select "Not Applicable" for this section**

Section 2. COOPERATION

3) When we are working as a team, all of my team members…

	1- Never	2- Rarely	3- Occasionally	4- Most of the time	5- Always	Not Applicable
a. share power with each other	( )	( )	( )	( )	( )	( )
b. respect and trust each other	( )	( )	( )	( )	( )	( )
c. are open and honest with each other	( )	( )	( )	( )	( )	( )
d. make changes to their team functioning based on reflective reviews	( )	( )	( )	( )	( )	( )
e. strive to achieve mutually satisfying resolution for differences of opinions	( )	( )	( )	( )	( )	( )

f. understand the boundaries of what each other can do	( )	( )	( )	( )	( )	( )
g. understand that there are shared knowledge and skills between health providers on the team	( )	( )	( )	( )	( )	( )
h. establish a sense of trust among the team members	( )	( )	( )	( )	( )	( )

Section 3. COORDINATION

4) When we are working as a team, all of my team members…

	1 - Never	**2- Rarely**	**3 - Occasionally**	**4 - Most of the time**	**5 - Always**	**Not Applicable**
a. use a new or unique model of collaborative practice	( )	( )	( )	( )	( )	( )
b. equally (equitably) divide agreed upon goals amongst the team	( )	( )	( )	( )	( )	( )
c. encourage and support open communication, including the patients and their relatives during team meetings	( )	( )	( )	( )	( )	( )
d. use an agreed upon process to resolve conflicts	( )	( )	( )	( )	( )	( )
e. support the leader for the team varying depending on	( )	( )	( )	( )	( )	( )

the needs of our patients						
f. together select the leader for our team	( )	( )	( )	( )	( )	( )
g. openly support inclusion of the patient in our team meetings	( )	( )	( )	( )	( )	( )

Additional Comments

5) Is there anything else you would like to share about your experience with collaboration at the San Mateo County Pride Center?

_____

_____

_____

_____

Demographics

6) What is your age category?

( ) 0-15

( ) 16-25

( ) 26-39

( ) 40-59

( ) Ages 60 and above

( ) Decline to answer

7) Which race/ethnicity do you identify with? (Check all that apply)

[ ] American Indian

[ ] Asian

[ ] Black or African American

[ ] Hispanic or Latino/a/x

[ ] Native Hawaiian or Pacific Islander

[ ] White

[ ] Other: _____

[ ] Decline to answer

8) What is your assigned sex at birth?

( ) Male

( ) Female

( ) Intersex

( ) Decline to answer

9) What is your current gender identity?

( ) Cisgender Man

( ) Cisgender Woman

( ) Trans Man

( ) Trans Woman

( ) Genderqueer

( ) Indigenous gender identity: _____

( ) Questioning or unsure of gender identity

( ) Another gender identity: _____

( ) Decline to answer

10) How do you identify your sexual orientation?

( ) Gay or Lesbian

( ) Heterosexual or Straight

( ) Bisexual

( ) Questioning or unsure of sexual orientation

( ) Queer

( ) Pansexual

( ) Asexual

( ) Indigenous sexual orientation: _____

( ) Another sexual orientation: _____

( ) Decline to answer

11) What is your individual annual income?

( ) 0-$24,000

( ) $25,000-$50,000

( ) $50,001-$75,000

( ) $75,001-$100,000

( ) Above $100,000

( ) Decline to answer

Appendix C: Demographic Form

San Mateo County Pride Center
Participant Information Form

For office use:

Form #_____

Thank you for visiting the San Mateo County Pride Center! This form will help us understand who is receiving services at The Pride Center. Completing this form will support the Center's efforts in implementing its programs. The questions are voluntary and anonymous. Thank you for your time!

Please write today's date: _____

Please write your zip code: _____

1. **What is your age category?** *(mark one)*

- ☐ 0-15
- ☐ 16-25
- ☐ 26-39
- ☐ 40-59
- ☐ Age 60 and above
- ☐ Decline to answer

2. **What is your preferred or primary language?** *(mark one)*

- ☐ English
- ☐ Spanish
- ☐ Mandarin
- ☐ Cantonese
- ☐ Russian
- ☐ Vietnamese
- ☐ Tagalog
- ☐ Hindi
- ☐ Farsi
- ☐ American Sign Language
- ☐ Other:_____
- ☐ Decline to answer

3. **How do you define your race?**

(mark all that apply)

- ☐ American Indian/Native American/Native Alaskan
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino/a/x
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White/Caucasian
- ☐ Other:_____
- ☐ Decline to answer

4. **How do you define your ethnicity?**

(mark all that apply)

Hispanic/Latino Ethnicity:

- ☐ Caribbean
- ☐ Central American:_____
- ☐ Mexican/Mexican-American/Chicano/a/x
- ☐ Puerto Rican
- ☐ El Salvadorian
- ☐ South American:_____

Non-Hispanic/Latino Ethnicity:

- ☐ African
- ☐ Asian Indian/South Asian
- ☐ Cambodian
- ☐ Chinese
- ☐ Eastern European
- ☐ European
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Middle Eastern
- ☐ Pacific Islander
- ☐ Indigenous Nation
- ☐ Vietnamese
- ☐ Other:_____
- ☐ Decline to answer

☐ **What is your assigned sex at birth?** *(mark one)*

☐ Male
☐ Female
☐ Intersex
☐ Decline to answer

☐ **What is your gender identity?** *(mark one)*

☐ Cisgender Man
☐ Cisgender Woman
☐ Female-to-Male (FTM)/Transgender Male/Trans Man/Trans-masculine/Man
☐ Male-to-Female (MTF)/Transgender Woman/Trans Woman/Trans-feminine/Woman
☐ Genderqueer/Gender nonconforming/neither exclusively male nor female
☐ Indigenous gender identity:_____
☐ Questioning or unsure of gender identity
☐ Another gender identity:_____
☐ Decline to answer

☐ **How do you identify your sexual orientation?** *(mark one)*

☐ Gay or Lesbian
☐ Heterosexual or Straight
☐ Bisexual
☐ Questioning or unsure of sexual orientation
☐ Queer
☐ Pansexual
☐ Asexual
☐ Indigenous sexual orientation:_____
☐ Another sexual orientation:_____
☐ Decline to answer

☐ **Do you have any of the following disabilities or health conditions?** *(mark all that apply)*

A disability is defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness.

☐ Difficulty seeing
☐ Difficulty hearing, or having speech understood
☐ Other communication challenges:_____
☐ Limited physical mobility
☐ Learning disability
☐ Developmental disability
☐ Dementia
☐ Chronic health condition
☐ Other disability or health condition:_____
☐ None
☐ Decline to answer

5. **What is your highest level of education?** *(mark one)*

☐ Less than high school diploma
☐ High school diploma or GED
☐ Some college
☐ Vocational or trade certificate
☐ Associate's Degree
☐ Bachelor's Degree
☐ Graduate Degree
☐ Decline to answer

6. **What is your current employment status?** *(mark one)*

☐ Full time employment
☐ Part time employment
☐ Unemployed and looking for work
☐ Unemployed and not looking for work
☐ Retired
☐ Student
☐ Decline to answer

7. **What is your current housing status?** *(mark one)*

☐ I have stable housing
☐ I am staying with friends or family
☐ I am living in a shelter or transitional housing
☐ I am homeless
☐ Other housing status:_____
☐ Decline to answer

Complete questions 12 &13 if you are 18 years old and over

8. **What is your individual annual income?** *(mark one)*

☐ 0-$24,999
☐ $25,000- $50,000
☐ $50,001- $75,000
☐ $75,001- $100,000
☐ Above $100,000
☐ Decline to answer

9. **Are you a veteran?** *(mark one)*

☐ Yes, I am a veteran
☐ No, I am not a veteran
☐ Decline to answer

Appendix D: San Mateo County Pride Center End of Year Report

San Mateo County Pride Center
End of Year Report
July 1, 2017
Submitted by Lisa Putkey

Background

Over a decade in the making, the San Mateo County Pride Center is the first LGBTQ+ (lesbian, gay, bisexual, trans, non-binary, queer, questioning, asexual, intersex, pansexual, polyamorous) community center to open in San Mateo County. It is an innovative collaboration operated by five partner organizations: Daly City Partnership, Outlet of Adolescent Counseling Services, Peninsula Family Service, Pyramid Alternatives, and StarVista who is the lead fiscal agent. The Pride Center combines direct mental health services with community building and educational programming.

The LGBTQ+ community experiences disproportionally higher rates of depression, anxiety, suicidal thoughts, substance abuse, homelessness, social isolation, bullying, harassment, and discrimination. The Pride Center seeks to mitigate these risks by increasing access to and quality of behavioral health and wellness services for the LGBTQ community. LGBTQ+ individuals and communities in San Mateo County finally have a space to call their own, whether to seek services or to just gather in community with others, building a foundation of peer acceptance and support.

Timeline

Phase 1: Location and Outreach

Accomplished:

- Identified and secured site
- Ongoing outreach, education and community engagement
- Identified and obtained start-up items and systems: furniture, computers, phones, office and program supplies, security system, painting, décor, databases, etc
- Recruited Staff: Program Director, Administrative Specialist, Community Outreach Coordinator, Peer Support Worker, Youth Program Coordinator, Older Adult Program Coordinator, Mental Health Clinician, Case Manager, Temporary Event Planner, and Temporary Administrative Assistant
- Established Resource Library and computer lab
- Launched supportive social and educational community events and activities
- Grand Opening and Ribbon Cutting Celebration
- Active in organizing San Mateo County Pride Celebration: Still We Rise

Still in Progress:

- Establish Core Advisory Board
- Recruit Lead Clinical Supervisor
- Develop and implement clinical programs at the Center
- Develop policy and procedure manual
- Develop website
- Develop training services
- Develop data system

Space

Accessibility

Pride Center staff have been reviewing accessibility requirements and audits such as this one to improve accessibility at the Center. The center is located one block north of the ECR and 12th Avenue stop for Samtrans 397 and ECR. There is one disabled parking spot located in the lot behind the center off of 11th street. There is a wheel-chair accessible entrance to the rear of the building, located in the parking lot off of 11th street. Signage posted on the front entrance directs the public to this accessible entrance. Our kitchen and conference room are not wheelchair accessible and cannot be improved upon due to the existing building structure, so we installed a water dispenser and a miniature refrigerator in our main facilities downstairs for accessibility.

We have two single stall gender neutral bathrooms located near the front and rear entrances with railing for accessibility. One is a family bathroom in which we installed a baby changing table. We installed a motion detector light in one of the bathrooms and are working with an electrician to prepare the second bathroom for sensor installation to support our older adults and others who have difficulty seeing in the dark. To further accommodate our older adult community, we obtained sturdy office chairs with armrests. This is currently not a scent-free/fragrance-free space. To make the space more accessible to those with Multiple Chemical Sensitivities we have placed cups of backing soda around the center with educational descriptions on how this helps neutralize chemical fragrances. The center is a smoke free space.

Information Technology

StarVista's IT team has worked hard to get the Center technology set-up and running. The Center has seven phones installed with voicemail and conference call capabilities. All phones are connected to StarVista's main office phone system. The main line for the Pride Center is 650-591-0133. The Program Director and Outreach Coordinator have been assigned cell phones. Key clinical staff will also be assigned cell phones. The Center has two Internet connections: one for center staff and one for guests. We have obtained a total of eight desktop computers for staff, three desktop computers for the resource lab, a laptop computer, a tablet (for reception, donations, and outreach tabling), and an external disk drive (to screen

documentaries). We also purchased a Bose speaker for Center activities, a larger portable speaker for major events, a handheld microphone, a projector and installed a motorized screen.

Art and Décor

We have received some art donations from the community and have purchased additional posters and frames to bring the Center to life. We purchased art from local and queer artists of color. To create a safer space we sought out art that our culturally diverse community members could see themselves in, resonate with, and be inspired by. The posters depict intersectional LGBTQ communities, centering queer, trans and non-binary communities of color with affirming messages of unity, empowerment, healing, and justice.

One of our walls is dedicated to a collective art piece started at the Grand Opening in which community members are invited to share their vision and hopes for the Center. We also envision creating a community mural on one of our walls and hope to showcase art from program participants. We have met with a San Mateo County Arts Commissioner to brainstorm collaboration and plan for an exhibit in June 2018 for Pride Month.

Community Agreements

Drawing upon our collective experience working and organizing in community spaces as well as the work of community-based organizations like the Anti-Oppression Resource and Training Alliance, Pride Center staff collectively created a living document of community agreements to create safer space at the Center. The agreements are ever evolving and provide a guideline for respectful interactions and community building within the Center. They are posted at the Center and reviewed by staff, volunteers and participants at Center meetings, events, and forums. The Community Agreements are attached in the appendices.

Security

We replaced the locks on the building and installed lighting in the back parking lot. We are currently working with Suntech to install five security cameras around the building with the ability to access recoded footage from within the past two weeks. Anyone that uses the space is briefed on procedures for opening and closing the space. A hard copy of these will soon be accessible in our Policies and Procedures manual.

Furnishing and Layout

The Pride Center is located at 1021 S. El Camino Real in San Mateo. The Center is roughly 3,000 square feet and has two main entrances, a reception area, one large multipurpose room with a lounge area, a staff office, a director office that doubles as clinical meeting space, a clinical meeting lounge, an outdoor patio space, a conference room, a kitchen, two bathrooms, and four supply closets. There is a space with four offices adjacent to the Pride Center that we are

subletting to StarVista's Counseling Center. StarVista's operations team has been working hard with Pride Center director and staff to prepare the space for operations. The Pride Center has been furnished with the following:

- 2 oval high tables
- 8 high office chairs
- 3 6ft, 9 4ft, and 3 5ft tables
- 5 foldable tables
- 30 Office chairs
- 59 foldable chairs
- 4 large double-sided locked file cabinets
- 2 small and 6 medium locked file cabinets
- 3 couches
- 2 lounge chairs
- 3 coffee tables
- 1 reception desk
- 4 bookshelves
- 1 armoire
- 1 rolling whiteboard
- 1 water dispenser
- 1 mini refrigerator

We have obtained office supplies, art supplies, kitchenware, cleaning and bathroom supplies, and a color printer/copy machine. We continue to seek furniture donations and discounts from local community and LGBTQ+ friendly businesses on Pink Spots. We have an ever-evolving wish list that we share with community and donors.

Staff and Hiring

The collaborative partners collectively hired Program Director Lisa Putkey, a local LGBTQ+ community member with a background in peace and justice education and community organizing. Lisa started mid February and began recruiting staff in March. She prioritized the following qualities in hiring Pride Center staff: 1) knowledge and understanding of issues impacting the LGBTQ+ youth, families, and older adults, 2) experience and passion for serving LGBTQ community, 3) lived-experience, cultural identities and linguistic abilities that are reflective of and relevant to the community we serve, 4) understanding of social justice and cultural humility, 5) balancing the staff make-up as a whole. The positions were posted on StarVista's website, Craigslist, Indeed, Localwise, Idealist, Gaylesta, schools and community boards, social media and online forums, forwarded to partner list serves and shared with local community organizations. The program director screened resumes and cover letters and then conducted screening phone interviews with candidates. Qualified applicants were then invited to interview at the Center with panels made up of collaborative partners. For clinical positions, applicants were also required to respond to a written question set of hypothetical scenarios.

The following positions were hired under StarVista between April and May:

- Administrative Specialist: Lowellyn Sunga
- Peer Support Worker: Andres Loyola
- Community Outreach Coordinator: Kilani Louis
- Temporary Administrative Assistant: Alyssa Canfield
- Temporary Event Planner Leila Perreras
- Case Manager, Alexander Golding

The following positions were assigned to the Center by Partner Organizations:

- Older Adult Program Coordinator: Ellyn Bloomfield of Peninsula Family Service
- Youth Program Coordinator: Gilbert Gammad of Outlet
- Mental Health Clinician: Cat Haueter of Pyramid Alternatives

Currently, all staff are a part of the LGBTQ community themselves, with non-binary, lesbian, pansexual, gay, Bakla, polyamorous, and queer identities represented. Two of the county threshold languages are represented: Spanish and Tagalog. Half of the staff members are people of color.

Staff meetings are every Tuesday from 1-2:30. Staff have taken trainings on the following topics since joining the Pride Center team:

- Compassion Fatigue
- Cultural Humility for non-clinical staff
- Mental Health First Aid
- Latino Collaborative Cultural Humility Training
- HIPPA and Confidentiality
- Sexual Harassment
- Bystander Intervention
- Social Media
- Embracing the LGBTQ Experience
- Creating an LGBTQ Affirming Organization
- Transgender Student Rights
- Rape Trauma Services
- LGBTQQI Youth work
- LGBTQQI and Addiction
- Active Substance Abuse
- Motivational Interviewing
- Domestic Violence
- StarVista Leadership Institute
- Human Trafficking, CSEC

Partner Collaboration

The San Mateo County Pride Center is an innovative collaborative between five longstanding local nonprofits, each with strong community roots who came together to create a safer space for LGBTQ community to thrive with faster, easier access to direct services. The five partner agencies are: StarVista, Peninsula Family Service, Outlet of Adolescent Counseling Services, Daly City Partnership and Pyramid Alternatives. During this first phase the partners have met biweekly and then weekly leading up to the Grand Opening on June 1.

The partners have been active in organizing event logistics and conducting outreach throughout the County to promote visibility of the Pride Center and build strategic relationships. Each partner holds a programmatic piece of the Pride Center program: Outlet –youth program, Peninsula Family Service –older adult program, Pyramid Alternatives –mental health clinician and coast side outreach, Daly City Partnership –north county outreach and training, and StarVista-fiscal sponsor and infrastructure support. The partner agencies are the ultimate decision making body for major decisions regarding the Center's program (ie: Grand Opening, logo, website, etc).

Grand Opening

From March through May the Pride Center was in a period of "soft opening," in which we held increased social/community programming (from partners and groups outlined in our proposal) while we built our capacity and hired staff. The collaborative partners chose to officially open the Pride Center on June 1st to kick off Pride Month. It was a historic day for San Mateo County as over 400 people gathered to celebrate the Grand Opening and Ribbon Cutting Ceremony of the first ever LGBTQ+ Pride Center in the county. A sense of community, joy and hope was palpable amongst the culturally diverse and intergenerational crowd of LGBTQ+ community members and allies. The celebration included dynamic speakers, powerful performances, lively bands, a community art project and delicious food. Speakers included Pride Center staff Andres Loyola, Health System Chief Louise Rogers, former Assembly Member Rich Gordon, and Supervisor Dave Pine. Performers included Broadway by the Bay, the San Francisco Gay/Lesbian Freedom Band and the Dixieland Dykes. There were opportunities for community and business sponsorships through which the Pride Center raised over $5,000. Many community leaders, nonprofits, and elected officials were in attendance and various sectors were represented including the San Mateo County Health System, Human Services Agency, probation, teachers and School Districts, Law Enforcement, and communities of faith.

Social/Community Program

Since officially opening on June 1st, the programmatic focus has been on building community visibility, assessing needs and fostering relationships. The Center celebrated Pride Month with 30 Days of Gay, which included community-based events such as the 5th Annual San Mateo County Pride Celebration: Still We Rise (estimated 700 in attendance), a Pulse Night of Remembrance (partnership with Skylawn with 25 in attendance), and the county's first Queer Prom on June 17th

(over 50 youth and 10 volunteer chaperones). We have also hosted culturally responsive events such as Queer Cumbia and Noche de Joteria (attended by 12).

Assessing Community Needs

There is little documented data about LGBTQ community demographics and needs in San Mateo Community. The Pride Center aims to be responsive to the needs of local community members, particularly of the most marginalized. To assess the community needs we are employing a variety of tactics. We actively promote the LGBTQ Community Wellness Survey created by the LGBTQ Commission and look forward to analyzing the responses. Pride Center Staff have been making visits to school GSAs, collaborative meetings of local community-based organizations and providers, and community centers to present about the center and solicit feedback on LGBTQ community needs.

Every month since April, we have hosted a Community Forum at the Center in which we invite community to share about their vision and hopes for the Center, what specific programming they would like to see, what they do not want to see, who we should reach out to, how we can make the center a safer space, and how they would like to get involved. Ten community members attended the first Community Forum, and the participation doubled to 20 community members at the second forum. We also created a collective art piece on one of the Center walls for visitors to add to with their visions and commitment to the Center. There is a suggestion box at the center to collect anonymous feedback.

Drop in Center

The newly opened Pride Center combines direct behavioral health services, such as counseling, peer support, and case management, with community supports and services. The Pride Center is a safer space that welcomes everyone. Community members are invited to drop in during open hours, which are 10-7pm Monday through Thursday, 10-9pm Friday, and 11-4 on Saturday. Since our Administrative Specialist started on May 1st, we have been tracking visitors to the center via a sign in sheet at our reception desk. Throughout May and June, 183 visitors have signed in at the Center (this does not include the over 400 people who attended the Grand Opening, the over 50 youth that attended Queer Prom, AA participants, or visitors who are uncomfortable signing in for various reasons such as not being documented). Upon arrival, visitors of the Pride Center are warmly welcomed by a receptionist who offers them refreshments, takes them on a Center tour, introduces them to staff, and connects them with resources or peer support.

Youth Program

Outlet leads the Pride Center's youth program. The Youth Program Coordinator Gilbert Gammad has done an excellent job engaging youth. Over the course of one month, the YPC was able to get into contact with and create meetings/forums for 6 different high schools in the middle and

northern San Mateo county region before the end of the school year. The following is a summary of youth feedback gathered:

> *What do you want to see?* High school participants in the GSA forums shared a strong desire for three types of programming: workshops (educational and skill-sharing), long-term consistent programming (support groups, discussions, book clubs and advisory council) and annual or one-time events (dances, music festivals, etc..).
>
> *How can we make the center safe?* A number of students are concerned for physical safety at the center and in the area in general. Many suggested the creation of a self-defense curriculum for folks to participate in so that they know what to do if they experience violent attacks. There is also desire for a level of official security on the site, meaning cubbies/lockers and security cameras; as well as a protocol for what happens when a physical emergency/crisis situation does occur.
>
> *How do you want to get involved?* Many youth were interested in volunteering in any sort of capacity available as long as they could put this on their resumé. The idea of the youth council seemed to strike folks the most.
>
> *What might keep you from coming to the center?* Two big barriers arose for folks: (1) Not being out of the closet and figuring out how to access and do work with the center without outing one's self. (2) Timing of events, because many youth have after school activities such as jobs, sports, other volunteering activities and other forms of commitment that are preventing them from accessing services. Creating programming centered on weekends and Friday evenings as well as emphasizing the participation of "allies" seems to be the best way to reach the most folks.

In addition to assessing the needs and vision of local youth, Gilbert and Pride Center staff have collaborated with local youth and youth serving organizations to organize several events at the Pride Center and throughout the community:

> *Queer Prom:* Shortly after the Center's location was secured, a number of local youth came forward expressing the desire to have a Queer Prom, where they could be free to be themselves without the fear of bullying and violence. A group of about 10 youth met regularly at the Pride Center from February-June to plan event logistics. Pride Center Staff and an LGBTQ commissioner provided guidance and support for the youth leaders. The theme for Queer Prom was masquerade, and the Center hosted a Prom Prep and mask-making event that was attended by 15 youth. Queer Prom was held on Saturday June 17th at the Pride Center and was a huge success as the first ever LGBTQ prom in San Mateo County. They sold out of tickets with over 50 youth in attendance and 11 adult volunteer chaperones including professional photographers. Here is a link to youth interviews in one of two segments by Channel 7 News covering the event. We hope it was the first of many to come.

Teen Booth: Pride Center staff coordinated with the Pride Initiative and youth volunteers to plan, fundraise for, and implement a teen area for the 5th Annual Pride Celebration: Still We Rise. Their booth was a great success and included art and wellness activities to engage dozens of local youth that attended the festival.

Film Screenings: Outlet organized a screening and discussion of *Major!* -a documentary about the life and campaigns of Miss Major, a formerly incarcerated Black trans woman who has been an active leader in trans justice movements for over four decades. The showing brought over 15 community members to the Pride Center. Since then, the Center has hosted movie nights that have brought in up to 15 youth at a time.

Trans Talks: Outlet has organized two Trans Talks events for youth and families to learn about transitioning from a UCSF clinician. One was held at the Center and attended by 15 community members. Another is going to be held at Daly City Partnership to improve access for North County residents. We hope to hold them monthly.

Peer Support: Outlet has moved their San Mateo LGBTQ youth peer support group to the Pride Center in June and thus far there have been 1-5 youth that are attending. We believe that participation will increase when school starts in the Fall, as summer groups at Outlet have tended to have lower attendance than during the school year.

Older Adult Program

Peninsula Family Service leads the Pride Center's older adult program. The Older Adult Program Coordinator for the Center is Ellyn Bloomfield. Her expertise and experience in providing affirming and supportive services for LGBTQ seniors is evident in her coordination of the Center's older adult LGBTQ peer counseling and programs. She worked diligently to support the opening of the San Mateo County Pride Center this year by participating in regular, ongoing operational partners' meetings, as well as staff meetings and interview panels to help hire staff for the Center. In addition, six regular monthly Older Adult LGBTQ Peer Counseling & Programs meetings are held at the Center on a continuing basis. The programs include the following:

- "Coffee Break" is an opportunity to socialize with other LGBTQ community members.
- "Sunshine Series" invites a community member to provide community resources. Examples of past sessions include:
    - Helen Greve from Pets in Need presented in March about animal companions for LGBTQ seniors.
    - Older adult LGBTQ Peer Counseling and Programs held a workshop on "Senior Affordable Housing" in May when seven people came to the Pride Center, most for the very first time.
    - Brenda Gilbert, Job Developer, spoke in June about strategies to explore when seeking employment after age 55.

- "Bistro Brio" is a monthly lunch program, with pizza, salads and sandwiches and a lively discussion.
- "All That Jazz" is an afternoon dedicated to art, music, poetry, and crafts. A movie matinee on the "Life and Times of Harvey Milk" headlined our May event.
- "Accepting Ourselves" is a monthly discussion group.
- Senior Peer Counseling LGBTQ volunteers also meet monthly at the Pride Center. Volunteer counselors and staff have seen six LGBTQ clients this quarter.

The Older adult LGBTQ Peer Counseling and Programs team was well represented at the annual San Mateo County Pride event, with staff and five volunteers present on June 10. Ten people came to the Pride Center to celebrate Gay Pride as a community on June 19 including several older adults had not been to the Center previously. Older adult LGBTQ Peer Counseling outreached at the Senior Expo, held in the East Palo Alto Senior Center and established a presence with fourteen members on Meetup, a social media platform.

Collaboration with External Groups

Alcoholic Anonymous: An LGBTQ AA group, Queers Have a Higher Power, formed at the Pride Center in March and has been holding open meetings every Thursday room 7-8pm. They have a range or 5-12 people in attendance each week.

PFLAG: A local PFLAG chapter has been meeting at the Center on the second Monday of each month from 7-9pm since March. They have roughly a dozen community members attend and often have new families and parents join. PFLAG and the Pride Center held our first event in collaboration on June 23. It was a documentary screening and discussion on the National Geographic's film Gender Revolution. There were 10 community members in attendance and it was the first of many film screenings we plan to host together.

Pride Initiative: The Pride Initiative meets at the Pride Center on the second Wednesday of each month from 3:30-5pm. Pride Center Staff attend the Initiative meetings and were very active in organizing *Still We Rise,* the 5th annual Pride celebration for San Mateo County, which had an estimate of 700 community members participate. Pride Staff were responsible for a number of components for the Pride celebration including the teen space, raffle, performances, information booths, and decoration of the stage which brought over 13 community members to the center for an art party.

County Commissions: The LGBTQ Commission has been meeting at the Pride Center on the first Tuesday of the month from 6:30-8:30 since February. We have collaborated on several events including a documentary showing and Queer Prom. The Pride Center has also met with the Arts Commission to brainstorm future collaboration on projects such as an art exhibit to be held in June 2018 for Pride month.

Pride Center staff have been on a number of training panels for organizations throughout the community (CORA, StarVista, etc) to share their experience being a part of the LGBTQ community. State and National wide, we have connected with Center link and the California Health and Human Services Network.

Volunteers

Over 30 individuals have come forth excited to be a part of the Pride Center and contribute their time, energy, skills and talents as volunteers. We had 15 community members attend our Volunteer Orientation in June and fill out applications. We have also had three inquiries from local corporations who want to donate staff time for larger projects. Examples of specific services and skills our volunteer would like to offer for the Pride Center include professional development and job search mentoring, personal finance consulting, a sex therapy group, cooking and nutrition classes, yoga, zumba, crafts activities, library management, reception support, maintenance and handiwork, health and wellness classes, social meet-ups, and general support for special events and regular programming.

Clinical Program

Counseling

Our Clinical program is still in progress and is set to launch in full by the end of the summer. Our main challenge to implementing this program has been the hiring of a Lead Clinical Supervisor whose role it is to design and implement our clinical program component. The major roadblock we have encountered is that we have not been able to pay a high enough salary to recruit a licensed supervisor in the Bay Area who is an expert in working with LGBTQ community and reflects the diversity of the populations we will serve. We have worked to remedy this is by offering other incentives such as flexible hours, generous benefits, and lowering the work week to 32 hours so that the Supervisor can maintain a private practice. As we continue recruiting for this position, we have been building a foundation for the program. We have been forging relationships with key community providers and resources outside of the Center to build our referral sources. We are in talks with BHRS staff to support clinical training of our staff.

We have on-boarded our Mental Health Clinician from Pyramid Alternatives, Catherine Haueter. Catherine is a part of the LGBTQ community herself and has experience providing therapy and support to LGBTQ clients. She is an MFTI currently being supervised by Clinical Director Clarise Blanchard and is ready to counsel individuals, couples and families for the Center as she winds down her Pyramid caseload. The site will be medical certified in mid July at which point she can start seeing clients in need. She will also be providing parenting classes to provide support and education to parents of LGBTQ youth -particularly those struggling to accept and understand their child's LGBTQ identities so that parents can provide more supportive and affirming care. She has obtained play therapy toys for the Center and is in conversation with the Program Director

and Clinical Director to build the foundations of our counseling program while we continue to search for a Lead Clinical Supervisor.

Peer Support

Our Peer Support program will begin in July with the goal of reducing high-risk symptoms such as self-harming behaviors and trauma symptoms by providing space for affirming peer support and education. Our bilingual Peer Support Worker Andres Loyola, was brought on board for her ability to provide knowledge, experience, emotional, social and practical support to clients based on her lived experience. She has built a solid foundation for the Center's peer support groups by reaching out to community groups and individuals to assess needs and identify community leaders to help facilitate groups. Andres is finalizing the creation of a facilitator application, screening and training program as well as documentation such as intake forms and tools to track client and group progress. She has connected with other organizations offering peer support groups and attends a group at the Pacific Center to become familiar with their model for group facilitation.

Our Youth Program Coordinator is already leading a weekly peer support group for LGBTQ youth. The weekly AA group, Queers Have a Higher Power, provides recovery peer support. Specific peer support groups to start this July at the Pride Center include:

- Trans Support Group: for Trans individuals, held on the 1st and 3rd Tuesday
- Questioning Support Group: for individuals who are questioning their sexual orientation and gender identity, held on the 2nd and 4th Monday
- Queer Latinx Support Group: to provide culturally specific support, held on the 2nd and 4th Friday
- Lesbians 40+ Support Group: for Lesbians age 40+, held on the 1st and 3rd Thursday
- LGBTQ TAY Support Group: for transitional age youth, held on the 2nd and 4th Wednesday

Each peer support group will be 1.5 hours and run by two facilitators. Additional peer support groups in the making include ones for Asian and Pacific Islanders, Queer People of Color, Disabled LGBTQ Community, and a Spanish PFLAG group.

Case Management

Our part-time Temporary Administrative Assistant Alyssa Canfield is an experienced case manager and had been creating a foundation for our case management program by developing a binder of documents to manage our caseload including intake and progress forms. Alyssa and Michaela Woodward, LCSW from Daly City Partnership have developed scenarios for applicants to our Case Manager position and reviewed candidate responses. We have hired our Case Manager who is set to start in July.

Resource Hub

The Pride Center is building its capacity to provides access to LGBTQ safe and affirming support services within the county and the larger Bay Area for crisis, mental health, health and wellness, financial and vocational, affordable and emergency housing, legal, education, transportation, disabilities, spiritual communities, and community enrichment. A resource committee composed of Pride Center staff is meeting to collect, review and compile these resources and services for a comprehensive database that will be housed on our website and printed pamphlets. We will develop a process to vet referral sources to designate which resources are safe and affirming. Currently, we have local and national crisis hotlines posted on site and refer to the LGBTQ section of the San Mateo Community Handbook and other existing databases for community members seeking services.

In the entryway of the Pride Center we have a large community bulletin board and a wall of mounted flyer and brochure holders full of flyers and pamphlets about LGBTQ affirmative community organizations, resources, and upcoming events and services. Literature such as Pink Spot magazines and Bay Area Reporter newspapers are delivered in bulk to the center for community distribution.

One of the rooms in the Pride Center is designated as our Resource Room. Pride Center staff are continually organizing and building out our resource room. Inside there are three computers for guests to access online resources, classes, and trainings as well as print out documents. The room contains three large bookshelves with LGBTQ literature, reports, and resource guides. We have secured several donations of books from places like Reach and Teach, Good Vibrations, and PFLAG. From children's books to health and wellness guides, the library includes a variety of LGBTQ affirming literature and multimedia for all ages. There is also a wardrobe in the resource room that we aim to fill with hygiene products and trans specific items such as chest binders and make-up for community members to access free of charge.

We are building credibility as a go-to resource for accessing LGBTQ information, resources, and education. We are in the initial phases of creating workshops, presentations and trainings to provide at the Pride Center and throughout the community in schools and community mental health agencies to reduce stigma. Training topics we have discussed providing in response to emerging needs include Sexual Orientation and Gender Identity, working with LGBTQ and trans clients, and best practices in working with LGBTQ youth, families, and older adults. Curriculum will be created in collaboration with Outlet and ODE.

We have partnered with outside organizations such as the Transgender Clinic at San Mateo Hospital and UCSF Gender Clinicians to provide Trans Talks for youth and families hosted at the Center and Daly City Partnership. Two volunteers from the local LGBTQ community have begun hosting Job Network at the Center twice a month to provide mentorship with resume design, job search tricks, networking techniques, and mock interviews.

Outreach

The San Mateo County Pride Center firmly believes in community. As a centralized hub for the LGBTQ+ community, the Center makes a conscious effort to remain open, malleable, and capable of addressing the needs and wants of the people we serve. To do so successfully, the Center places a very strong value and emphasis on outreach.

We want all members of the LGBTQ+ community to feel like they are part of the Center, regardless of their geographical location. So far, our Outreach Coordinator Kilani Louis has made a heavy effort to cast a wide net and reach out to areas further from the center such as Coastside, Northern and Southern County. We have also deliberately engaged other community centers, libraries, and organizations to help spread the word about the Center.

The LGBTQ+ community is incredibly expansive and diverse. To further our efforts to meet our community where they are, the Center has been invited to and represented at a number of different events including a mental health film festival, a roller derby bout, and a vigil hosted by the Skylawn Funeral Home. Just as we want members of our community to feel like they have a place when they come to us, we also want them to know that we are supportive and will come to them as well.

We continuously seek out and build relationships of reciprocity and trust with community leaders of non-represented intersectional community stakeholders. We've worked to identify engagement barriers (transportation, location, childcare, timing and time commitment, food, incentives, power dynamics, stigma, and language) and come up with ways to bridge divides (interpretation, food at meetings, family friendly facilities, promoting allies involvement so people don't have to out themselves, accessibility, varying hours of meetings, meeting community where they are throughout the county, community agreements, hiring queer people of color, hosting cultural events, providing diverse opportunities to get involved).

Moving forward, the Center aims to increase outreach by visiting every city within the county to get the word out and make people aware of this great new resource. We are continuing to form partnerships and work with various other community centers, organizations, and corporations. A volunteer program is currently being developed and has already engaged 20 individuals who are interested in helping the Center grow and thrive. We are also looking to increase communication with our community by means of creating a monthly newsletter to keep folks up-to-date with what is happening at the Center, as well as developing a quarterly Zine to provide greater detail about what we are doing. Most importantly, we are striving to be as responsive to feedback from our community as possible. Monthly forums will continue to be held so we can hear directly from this population and make sure that we are suiting and addressing their needs in the best ways we can.

Marketing and Development

Logo

The Pride Center contracted with Design Action Collective to design the Center's logo. This decision was made in the interests of time, budget, and integrity with our values. They are a worker-owned and managed cooperative and a union shop made up of social justice activists and organizers who are majority people of color, women, and trans folks. After initial information gathering, they developed several design concepts that the partners voted on. We then went through several rounds of revision to refine the concept, typography and colors. The final version was presented on May 2nd along with a style guide. The Pride Center logo represents the values of inspiration, hope, growth, diversity, and empowerment. It employs a lot of movement and there is an energy of collective power radiating from the center. It reflects the story of the Pride Center originating from the vision and work of a diversity of partners and community leaders who came together to build a vision larger than the sum of their parts. The overall look and feel is modern and minimal, reflecting clarity looking towards the future.

Promotional Materials

Working with the beautiful logo and branding created by Design Action Collective, the Pride Center Staff and StarVista Marketing Manager have developed content for, designed and produced a number of promotional and informative outreach materials including an English and Spanish brochure, business cards, nametags, banners, signs, decals, stickers, totebags, t-shirts, a table runner, pens, event flyers, letterhead, remittance envelopes and the Grand Opening program.

Online Communications

We are currently working with Look Agency (local: San Carlos and female led agency) to develop our website. We have reserved the domain name www.sanmateopride.org and currently we have a temporary webpage where community members and clients can sign up for our list serve and access the Center calendar. In the month of June we had 210 people visit our website –a 213% increase from May, and 164 people ask for direction to the Center on Google –a 193% increase from May.

We established a membership with Constant Contact to maintain our outreach lists and develop dynamic e-blasts. We currently have about 600 people on our mailing list (from website sign-ups, visitor sign-ins, and our opening day rsvp list). We are currently sending our one e-blast per month and will increase to biweekly. We also plan to host a community blog on our website and print an annual zine: Voices of the Unheard.

Pride Center staff have been meeting to create and implement a comprehensive social media campaign. We received an excellent training on utilizing social media platforms facilitated by the San Mateo County Health System Communications team. We are working with StarVista's Marketing Director to develop more in depth training for our Administrative Specialist who will take the lead on our social media campaigns. We have active Facebook, Instagram, Twitter, LinkedIn and Eventbrite accounts and are looking to utilize Meet Up and Next Door platforms.

Staff and Partners came up with the following hashtags: #sanmateopride, #smcpridecenter, and #herequeersmc. We have received over 300 followers and likes on Facebook and several five star reviews.

Press

Pride Center Partners and staff created and maintain a comprehensive database of press outlets and contacts, which we utilized to send out a press release for our Grand Opening. We have received news coverage from local and LGBTQ focused outlets including the San Mateo Journal, Bay Area Reporter, NBC Bay Area, Philippine News, Rappler, San Francisco Examiner, Outlook Video, KTVU channel 2 (Sunday morning in studio interview about opening), Chron channel 4 (covering Pulse Memorial), and KGO channel 7 (covering Queer Prom).

Development

We have an ever-evolving Wish List that we share with community and donors. Our website has a PayPal link where people can donate. Our opening day provided opportunities for community and business sponsorship through which we raised over $5,000.

Data Tracking and Evaluation

Resource Development Associates is working hard to create data collection tools and evaluation methods so that we can track and measure the impact of our collaboration and services. Thus far, in collaboration with our partners, we have created a demographics form and surveys to measure our LGBTQ competence, collaboration, and client satisfaction. Since we opened in June we have been asking community members who have meaningfully participated in more than one program or service at the Center to fill out demographics surveys and have collected 60 forms. You will find the results of 56 of these forms attached. Notable indicators are:

- **Age:** 14.3% 0-15; 26.5% 16-25; 26.5% 26-39; 18.4% 50-59; 14.3% 60 and above
- **Race:** 1.9% American Indian/Native Alaskan; 27.8% Asian; 1.9% Black of African American; 22.2% Hispanic or Latinx; 53.7 % White; 1.9% other
- **Ethnicity:** 13.7% Mexican/Mexican-American/Chicanx; 33.3% European; 19.6% Filipino
- **Gender:** 42% Cisgender Woman; 24% Cisgender Man; 6% Trans Man; 6% Questioning/Unsure; 4% Genderqueer; 2% Trans Woman; 2% Two-Spirit
- **Sexual Orientation:** 51% Gay/Lesbian; 13.7% Bisexual; 13.7% Straight; 7.8% Asexual; 3.9% Pansexual; 2% Queer; 2% Questioning; 2% Two-Spirit
- **Housing:** 78% stable; 14% staying w/ family/friends; 4% shelter or transitional housing
- **Income:** 30.4% 0-$24,999; 17.4% $25-$50,000; 17.4% above $100,000; 15.2% $50-75,000

We are working with StarVista's Data Manager to create touch points in an Efforts To Outcomes database so that we can securely track client and participant data, attendance, and progress. We also have evaluation forms for participants to fill out after attending Pride Center events.

Challenges

The major challenge we are experiencing is filling the position of Lead Clinician Supervisor with someone who is licensed, can supervise, has expertise in working with the LGBTQ population, reflects the diversity of the community, and will accept the salary we can afford to offer. Another shortcoming is that we do not have Chinese and Tongan language abilities on staff. The partners are working to address these challenges with support from the language capabilities amongst their own staff. We are also meeting with the Office of Diversity and to creatively address our clinical vacancy.

Appendix E. Data Tables

Demographic Data

To comply with HIPAA requirements and protect the confidentiality of participating individuals, the tables below only present data for response categories with at least five responses. Where fewer than five responses were received, some categories have been combined. RDA was unable to create a table displaying demographic data on preferred language due to most responses having fewer than five responses. The total number of responses for each question may not add to 41 because some individuals did not answer every question on the form, while some questions allowed participants to select multiple responses.

Table 1. Participants served by age

Age	Count	Percent
0-15	6	17%
16-25	10	28%
26-39	8	22%
40-59	6	17%
Age 60 and above	6	17%
Total	**36**	**100%**

Table 2. Participants served by race

Race	Count	Percent
White/Caucasian	20	50%
Other (Asian, Hispanic or Latino/a/x, American Indian/Native Alaskan, Black or African American, Other, Decline to answer)	26	65%

Table 3. Participants served by ethnicity

Ethnicity	Count	Percent
European or Eastern European	14	39%
Asian or South Asian (Filipino, Japanese, Korean, Asian Indian/South Asian, Chinese)	11	31%
South or Central American or Caribbean (Mexican/Mexican-American/Chicano/a/x, Central American, El Salvadorian, South American)	11	31%
Other (African, Middle Eastern, Other) or Decline to answer	8	22%

Table 4. Participants served by sex

Sex	Count	Percent
Female	29	76%
Male	8	21%
Decline to answer	1	3%
Total	38	100%

Table 5. Participants served by gender

Gender identity	Count	Percent
Cisgender Woman	17	44%
Cisgender Man	8	21%
Female-to-Male (FTM)/Transgender Male/Trans Man/Trans-masculine/Man; Genderqueer/Gender nonconforming/neither exclusively male nor female; Another gender identity; Male-to-Female (MTF)/Transgender Woman/Trans Woman/Trans-feminine/Woman; Indigenous gender identity; Questioning or unsure of gender identity	14	36%
Total	39	100%

Table 6. Participants served by sexual orientation

Sexual orientation	Count	Percent
Gay or Lesbian	17	46%
Bisexual	7	19%
Heterosexual or Straight, Asexual, Queer, Pansexual, Questioning or unsure of sexual orientation, indigenous sexual orientation	12	32%
Decline to answer	1	3%
Total	**37**	**100%**

Table 7. Participants served by disability status

Disability Status	Count	Percent
None	27	73%
Difficulty hearing, or having speech understood, Learning disability, Other communication challenges, Limited physical mobility, Chronic health condition, Decline to answer	5	14%

Other disability or health condition	5	14%
Total	**37**	**100%**

Table 8. Participants served by level of education

Level of Education	Count	Percent
Less than a high school diploma	7	18%
High school diploma or GED, Some college, vocational or trade certificate	6	15%
Bachelor's or Associate's Degree	15	38%
Graduate Degree	7	18%
Decline to answer	4	10%
Total	**39**	**100%**

Table 9. Participants served by income

Income	Count	Percent
0-$24,999	11	34%
$25,000-$50,000	5	16%
$50,001-$100,000	6	19%
Above $100,000	5	16%
Decline to answer	5	16%
Total	**32**	**100%**

Table 10. Participants served by employment status

Employment Status	Count	Percent
Full-time employment	13	34%
Student	10	26%
Part-time employment	5	13%
Unemployed and not looking for work, Retired, Unemployed and looking for work, Decline to answer	10	26%
Totals	**38**	**100%**

Table 11. Participants served by housing status

Housing status	Count	Percent
I have stable housing	25	69%
I am staying with friends or family, I am living in a shelter or transitional housing, Other housing status	10	28%

Decline to answer	1	3%
Total	**36**	**100%**

Collaboration Survey Results

Section 1: Partnership

When we are working as a team, all of my team members...	*Total Responses*	1-Never	2-Rarely	3-Occasionally	4-Most of the time	5-Always
a. include patients in setting goals for their care	**6**	0	0	0	1	5
b. listen to the wishes of their patients when determining the process of care chosen by the team	**6**	0	0	0	1	5
c. meet and discuss patient care on a regular basis	**6**	0	0	0	1	5
d. coordinate health and social services (e.g. financial, occupation, housing, connections with community, spiritual) based upon patient care needs	**7**	0	0	0	1	6
e. use consistent communication with the team to discuss patient care	**6**	0	0	0	2	4
f. are involved in goal setting for each patient	**5**	0	0	1	2	2
g. encourage each other and patients and their families to use the knowledge and skills that each of us can bring in developing plans of care	**5**	0	0	0	1	4
h. work with the patient and their relatives in adjusting care plans	**5**	0	0	0	1	4

Section 2: Cooperation

When we are working as a team, all of my team members...	*Total Responses*	1-Never	2-Rarely	3-Occasionally	4-Most of the time	5-Always
a. share power with each other	**12**	0	0	0	9	3
b. respect and trust each other	**12**	0	0	0	8	4
c. are open and honest with each other	**12**	0	0	1	5	6
d. make changes to their team functioning based on reflective reviews	**10**	0	0	0	5	5
e. strive to achieve mutually satisfying resolution for differences of opinions	**12**	0	0	0	4	8
f. understand the boundaries of what each other can do	**12**	0	0	3	7	2
g. understand that there are shared knowledge and skills between health providers on the team	**12**	0	0	0	5	7
h. establish a sense of trust among the team members	**12**	0	0	1	6	5

Section 3: Coordination

When we are working as a team, all of my team members...	*Total Responses*	1-Never	2-Rarely	3-Occasionally	4-Most of the time	5-Always
a. use a new or unique model of collaborative practice	**12**	0	3	1	6	2
b. equally (equitably) divide agreed upon goals amongst the team	**12**	0	0	3	4	5
c. encourage and support open communication, including the patients and their relatives during team meetings	**9**	0	0	0	5	4
d. use an agreed upon process to resolve conflicts	**10**	2	1	0	5	2
e. support the leader for the team varying depending on the needs of our patients	**9**	0	0	1	3	5
f. together select the leader for our team	**6**	0	1	1	3	1
g. openly support inclusion of the patient in our team meetings	**5**	0	2	0	1	2

San Mateo County
Health Ambassador Program-Youth
Fiscal Year 2016-17 Evaluation Report

A Mental Health Services Act Innovation Project

Prepared by:

Resource Development Associates

December 2017

Table of Contents

Acknowledgements

We wish to express our appreciation for the contributions from all the agencies, organizations, and individuals who participated in the efforts to develop the Health Ambassador Program-Youth (HAP-Y) to address the mental health needs of youth and young adults living in San Mateo County.

A special thanks to the following individuals from the Health Ambassador Program-Youth Cohort 1, whose participation was invaluable to this effort:

- Claire Bai
- Michelle Buzzbee
- Jessica Castellanos
- Sophia Davirro
- Andora Fess
- Dylan Fuhs
- Angelica Gonzales
- Sara Martinez
- Chelsea Javier
- Tiffany Yu
- Madeline Wung

Your cooperation and energy resulted in the development of this project, the collection of extensive data, and allowed us to prepare this report. The County and the HAP-Y facilitation and evaluation teams deeply admire and appreciate your commitment to the health and wellbeing of youth and young adults in San Mateo County.

Introduction

Project Overview

The Health Ambassador Program-Youth (HAP-Y) is an Innovation (INN) program under the Mental Health Services Act (MHSA) that is funded by the San Mateo County Behavioral Health Recovery Services (BHRS) department. HAP-Y is a collaboration between two partner agencies, StarVista and Pyramid. The MHSA INN project category and primary purpose of the HAP-Y are as follows:

- **MHSA INN Project Category:** Makes a change to an existing mental health practice that has not yet been demonstrated to be effective.
- **MHSA Primary Purpose:** Increase access to mental health services.

The Mental Health Services Oversight and Accountability Commission (MHSOAC) approved the project on July 28, 2016 and BHRS began implementation in September 2016. In 2017, BHRS contracted Resource Development Associates (RDA) to evaluate HAP-Y using a Participatory Action Research (PAR) approach. The following report provides findings from the first year of HAP-Y implementation, which focused on recruiting and training the first cohort of Youth Ambassadors, as well as designing the evaluation.

Project Need

Through the MHSA Community Planning Process (CPP) in San Mateo, the need to increase access to services for youth and young adults emerged. Youth and young adults, especially between the ages of 16-25, commonly experience challenges transitioning into adulthood and are notably underserved in the mental health system. Transition Aged Youth (TAY) navigate more adult-like challenges without having yet mastered the tools and cognitive maturity of adulthood[1]. Given this, community members advocated adapting the existing Health Ambassador Program (HAP), a program created in the County's Office of Diversity and Equity, for youth participants.

In the original HAP, adult participants with lived experience completed a set curriculum to enhance their skills and knowledge about behavioral health. HAP graduates served as a critical liaison to the County by doing outreach, speaking at panels and community

Project Innovation

HAP-Y serves as a youth-led initiative where young adults act as mental health ambassadors to promote awareness of mental health, reduce mental health stigma, and increase service access for young people. The HAP-Y Innovation project is the first to offer formal evaluation of a training designed for youth peer educators and its effectiveness and impact on community awareness and stigma, increasing access to mental health services for youth, and addressing systemic changes, as well as supporting youth ambassadors' wellness and recovery.

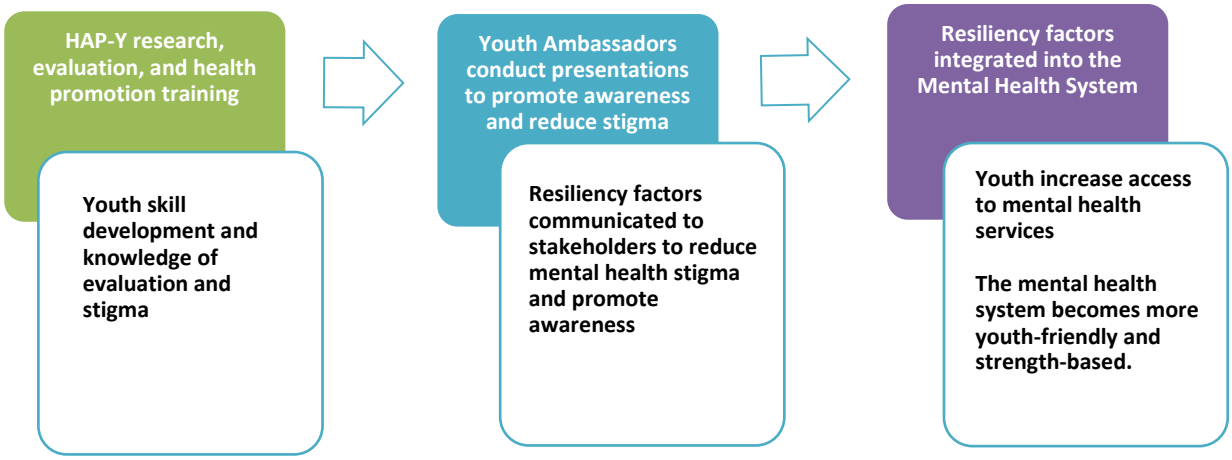
[1] Wilens, T., Rosenbaum, J. (2013) Transition Aged Youth: A New Frontier in Child and Adolescent Psychiatry. Child and Adolescent Psychiatry, 52:9. M.

events, and teaching psycho-educational classes. The idea for a youth-focused HAP evolved from the recognition that informed youth could take a more proactive role as leaders in their communities; promote health, recovery, and wellness with their peers, families, and communities; and work towards reducing the stigma of mental health and facilitate access to mental health services for youth and young adults.

Project Description

The HAP-Y engages, trains, and empowers transition age youth (ages 16-25) as Youth Ambassadors to promote awareness of mental health and increase the likelihood that young people will access needed mental health services. For this project, Youth Ambassadors receive psycho-educational training to build their own mental health knowledge and advocacy skills. Youth Ambassadors then engage in outreach and educational activities with other young people and deliver mental health presentations in the community.

Theory of Change



As is illustrated in the Theory of Change model, HAP-Y is intended to support and influence Youth Ambassadors, youth and community members, and the Mental Health System as a whole. HAP-Y intends to accomplish this by first training Youth Ambassadors in research and evaluation principles and mental health promotion. The Youth Ambassadors then engage in a series of outreach and educational training activities to promote mental health awareness and reduce stigma with youth, the community, and youth-serving adults. As a result of HAP-Y activities, youth increase their access to and participation in mental health services, and the mental health system becomes more responsive to youth needs. HAP-Y is designed to have a lasting change for individuals directly engaging with the program as well as the community-at-large.

HAP-Y Facilitator

StarVista—a non-profit organization that provides counseling, prevention, early intervention, and education resources throughout San Mateo—is the lead agency of this initiative. For over 30 years,

StarVista has offered mental health services and resources to more than 34,000 people from diverse communities throughout San Mateo. StarVista was selected through a Request for Proposal (RFP) process to implement and manage the HAP-Y project, including the administration, participant recruitment, and data collection aspects of the evaluation plan. StarVista worked with their community-based partner, Pyramid Alternatives, Inc., to identify, recruit, and provide mental health training to the 11 youth selected as the first cohort of Youth Ambassadors (Cohort 1). Youth who showed interest in HAP-Y participation were asked to submit an application and go through a formal interview process conducted by StarVista. StarVista staff were responsible for providing training in targeted storytelling and for collaborating with outside agencies to provide additional trainings for Youth Ambassadors. Throughout the duration of the program, StarVista staff also engaged youth to remain involved and attentive in the program.

See **Appendix 1** and **Appen**dix **2** for the HAP-Y application and StarVista interview protocol.

HAP-Y Evaluator

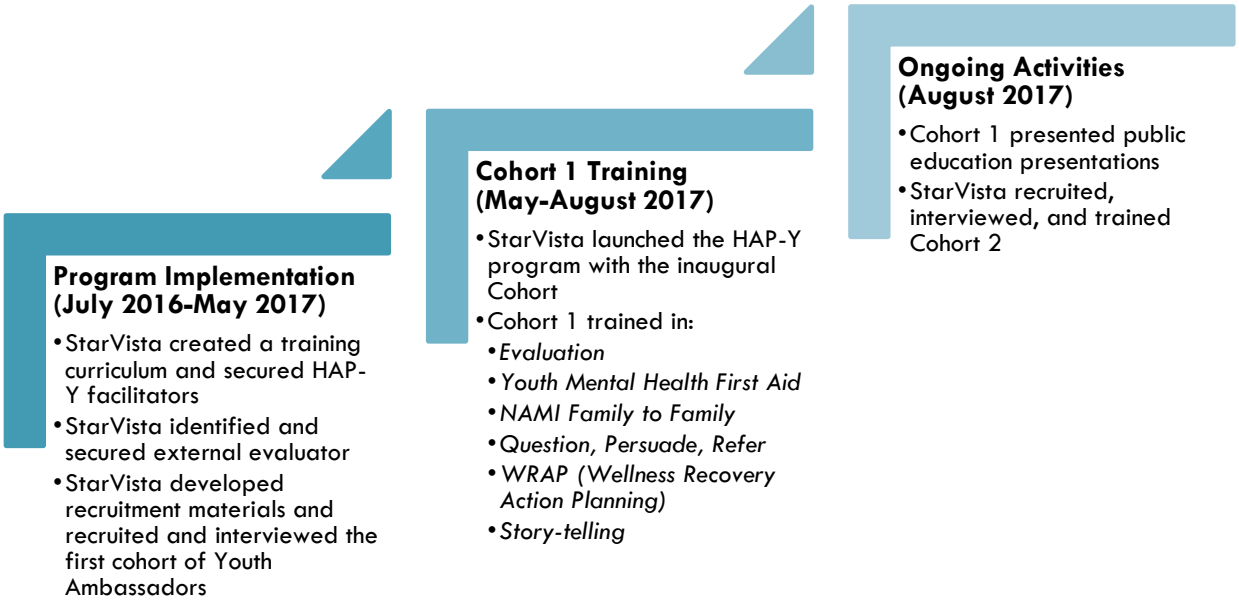
RDA has a long history of providing a full spectrum of mission-driven consultancy services that have lasting impacts across many public systems. As a consulting firm that specializes in participatory approaches to evaluation, RDA collaborates with key partners to design, implement, and evaluate participants' own best ideas. BHRS selected RDA through an RFP process to conduct a participatory evaluation of the HAP-Y project. RDA partnered with Cohort 1 to design the evaluation, data collection methods, and data collection tools to evaluate the impacts of youth's presentations on their audience and the mental health system. RDA worked closely with Cohort 1, providing training and technical assistance to build youth's capacity to understand how the evaluation can support continuous program improvement. The RDA evaluation team also collected baseline data from Youth Ambassadors to measure youth's own change and experiences throughout the program cycle.

Project Timeline and Implementation Update

In the current reporting period, BHRS successfully implemented the HAP-Y, including a competitive procurement process for facilitation and evaluation services, developing the training curriculum, recruiting Youth Ambassadors, and training the first cohort. The first year of HAP-Y primarily focused on launching the program and training the first cohort of youth ambassadors.

In Fiscal Year 2016-17, StarVista undertook a number of foundational activities related to the implementation of HAP-Y (see Figure 2). StarVista created a training curriculum and secured HAP-Y facilitators to lead the trainings. Concurrently, StarVista developed recruitment materials and recruited and interviewed the first cohort of Youth Ambassadors. From May through August, StarVista and its partner training agencies trained Cohort 1 of the HAP-Y. Simultaneously, RDA developed the evaluation training and baseline data collection tools. In the coming year, HAP-Y will focus on delivering outreach and educational presentations as well as recruiting Cohort 2.

Figure 1. HAP-Y Key Activities and Accomplishments



Evaluation Overview and Learning Goals

Evaluation Purpose

The purpose of the HAP-Y evaluation is to help San Mateo County: 1) measure the impact of the program; 2) support data-driven decisions throughout implementation; and 3) increase knowledge about what works in mental health and youth-specific mental health programs. As the youth participants promote mental health resources, RDA measures the leadership skills and resiliency of the young people as part of their involvement in the program as well as their impact on the mental health network.

Evaluation Approach and Learning Goals

As previously mentioned, HAP-Y takes an innovative approach to engaging young adults in self-advocacy roles to collectively impact their community's mental health. As such, the evaluation design was intended to mirror that innovation. In order for youth participants to truly "*meaningfully engage in evaluation*" the evaluation concepts needed to be interesting, accessible, and relevant to their goals. Furthermore, the Youth Ambassadors needed to feel inspired by the impact that HAP-Y might have on the mental health system and transform that spirit into an evaluation plan. To that end, the HAP-Y evaluation employs a mixed-methods, Participatory Action Research (PAR) approach to respond to the INN learning goals, listed below.

HAP-Y Learning Goals

Learning Goal 1: To what extent does participating in HAP-Y build the Youth Ambassadors' capacity to serve as mental health advocates?

Learning Goal 2: How does HAP-Y increase mental health knowledge and decrease mental health stigma?

Learning Goal 3 : How does HAP-Y increase youth access to mental health services?

Learning Goal 4: How does HAP-Y influence the mental health system?

PAR is a unique orientation to research, which equitably involves all partners in the research process and recognizes the unique strengths that each brings.[2] Because this evaluation seeks to engage Youth Ambassadors with the hope that their lived experiences, both as youth and as persons with mental illness, may provide a unique perspective on how to better serve and increase youth access to mental health services, the RDA evaluation team believed that PAR would be the most appropriate approach to measure their progress.

The intent of PAR is to transform research from a relationship where researchers *act upon* a community to answer a research question to one where researchers *work side-by-side* with community members to define the questions and methods, implement the research, disseminate the findings, and apply them. Through the active participation of community members in the full spectrum of research, PAR offers a protective element for communities who may have been stigmatized and/or harmed historically, and encourages trust between researchers and community members to mitigate these historical experiences. Participation of community members also helps to incorporate local knowledge into the evaluation and strengthens the capacity of communities to effect change in community health, systems, programs, and policies.

RDA approached this evaluation with a belief that in order to have youth engaged as Youth Ambassadors, they should have a meaningful role in determining *how* HAP-Y success is measured. In every interaction with the Youth Ambassadors, RDA evaluators sought to create an agenda that paired youth-friendly activities with the evaluation curriculum. The Youth Ambassadors continuously participated in activities to build their capacity to understand evaluation and data collection approaches.

First, RDA provided historical context of the role of evaluation at the state level as well as the impact that research plays in policy at the local level. Youth Ambassadors learned about their and RDA's roles in the evaluation, quantitative and qualitative data collection tools and strategies, and the importance of being active members of the evaluation design and process. Then, the Youth Ambassadors worked to create the

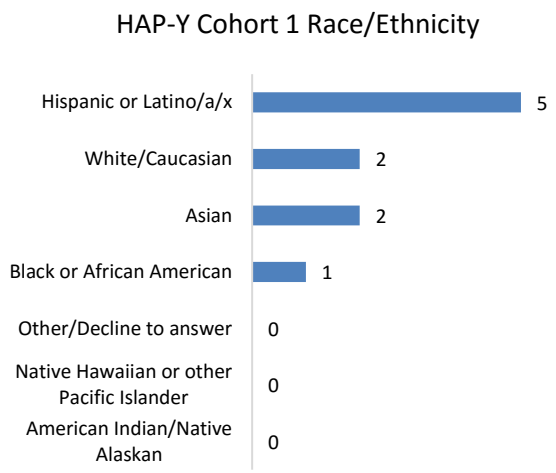
[2] National Institutes of Health, Office of Behavioral and Social Sciences Research. (2015). Community-Based Participatory Research. Retrieved from: https://obssr.od.nih.gov/scientific_areas/methodology/community_based_participatory_research/

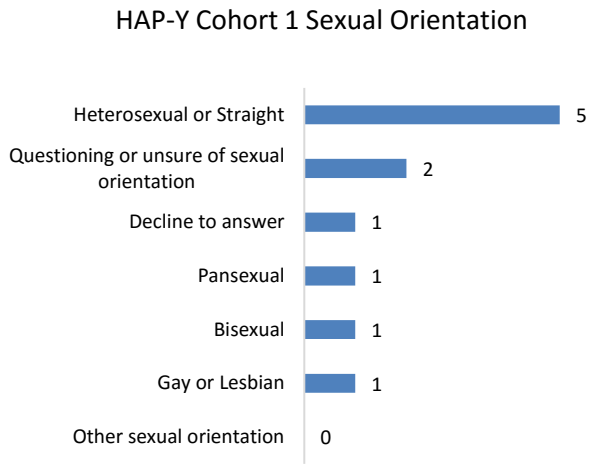
HAP-Y evaluation plan, which included developing and refining the evaluation questions based on the INN learning goals as well as developing and finalizing the data collection tools.

Youth Ambassadors Recruitment and Training

Demographics

Eleven young adults (ages 16-25) participated in the inaugural cohort of the HAP-Y. Youth were recruited to represent a diverse cultural background (e.g., White, Latino, African American, Filipino, Pacific Islander, and Native American), gender identities, and sexual orientations. Youth with lived experienced were encouraged to apply. This section describes the Youth Ambassador demographics.





Half of participants (50%) identified as Hispanic or Latino/a/x. Twenty percent (20%) of participants identified as White/Caucasian, 20% identified as Asian, and 5% identified as Black or African American.[3] All participants' preferred language was English. Seventy percent (70%) of participants identified as female, 10% identified as male, and 20% identified as gender fluid or gender neutral. Half of Youth Ambassadors (50%) identified as heterosexual or straight, 20% as questioning, 10% as pansexual, 10% as bisexual, 10% as gay or lesbian, and 10% declined to answer.[4] Fifty percent of participants reported having less than a high school diploma, 20% having a high school diploma or GED, 20% as having some college, and 10% as having a bachelor's degree. The majority of participants (60%) were employed part-time. Additionally, at least nine Youth Ambassadors were individuals with lived experience.

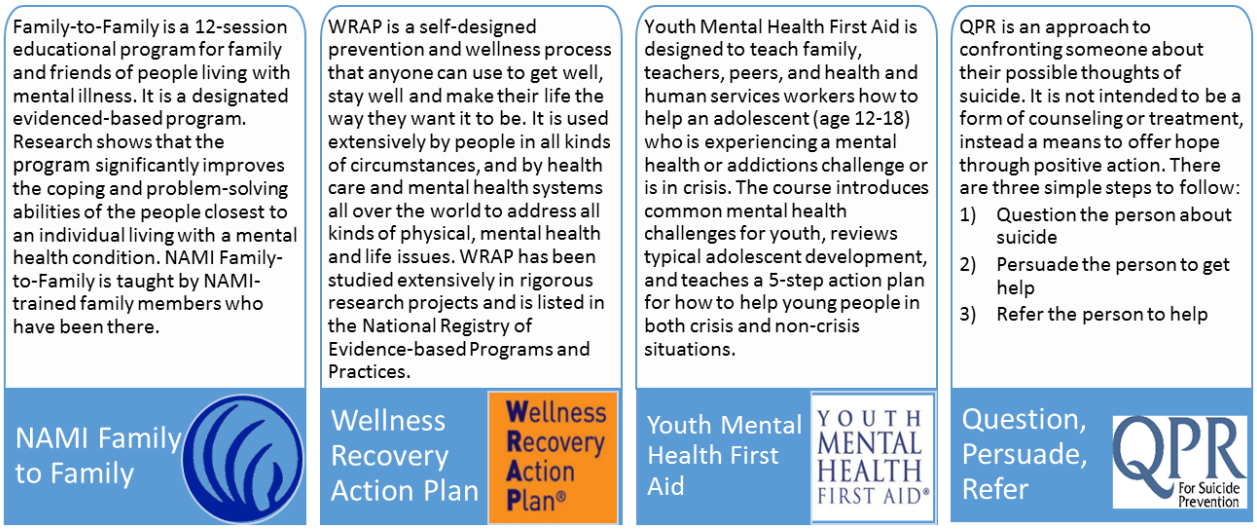
HAP-Y Training

The original HAP training model was adapted to make the process and curriculum appropriate for HAP-Y youth participants. Youth were provided psychoeducational training as well as training on conducting data analysis and public speaking. The purpose of the training is to build youth capacity to:

[3]Race/ethnicity information was only available for 10 youth.
[4]Sexual orientation data sum to greater than 100% as one youth provided more than one response.

- Outreach and speak at panels and community events on mental health,
- Work with schools and other youth teaching psycho-educational classes,
- Facilitate discussions or focus groups, and
- Provide resources to increase access to mental health services.

The HAP-Y Training primarily focused on topics of wellness and recovery and included learning the signs and risks of suicide, suicide prevention, and information on how to access mental health services. The formal curricula used included Youth Mental Health First Aid, Question Persuade Refer (QPR), Wellness Recovery Action Plan (WRAP), and NAMI Family to Family. Outside trainers led the WRAP and Family to Family trainings, and Star Vista led the Youth Mental Health First Aid and QPR trainings. These programs are described briefly below.



StarVista also conducted trainings on targeted storytelling to build youth capacity to outreach and speak at panels and community events on mental health, work with schools and other youth teaching psycho-educational classes, facilitate discussions or focus groups, provide resources to increase access to mental health services, and decrease stigma through lived-experience presentations.

RDA trained Youth Ambassadors on data collection, including developing data tools, collecting data, and conducting analysis. RDA provided training throughout the course of the project to ensure that youth were engaged in the data evaluation process for the duration of the program.

See **Appendix 3** for the Cohort 1 Training Schedule.

Collaborative Evaluation Planning

RDA worked with the Youth Ambassadors to collaboratively design the HAP-Y evaluation. First, RDA facilitated discussions with the Youth Ambassadors, which invited them to think critically about what types of change they wanted to make and how they would they measure that change. This approach

allowed Youth Ambassadors to envision what kind of impact their presentations might have, and think about how they would successfully measure this change.

After a review of the learning goals and draft evaluation questions, RDA incorporated the feedback from Youth Ambassadors, which informed a series of exercises to design the data collection tools.

The evaluation questions included:

1. To what extent does participating in HAP-Y build the Youth Ambassadors' capacity to serve as mental health advocates?
2. How does HAP-Y increase mental health knowledge and decrease mental health stigma?
3. How does HAP-Y increase youth access to mental health services?
4. How does HAP-Y influence the mental health system?

See **Appendix 4** for a copy of the evaluation plan.

Measuring Mental Health Knowledge, Stigma, and Access

Over three data work sessions, Cohort 1 and RDA developed an audience survey tool to capture the impact of the HAP-Y educational presentations.

In the first data work session, RDA provided background on the role of evaluation and data, both as a concept and as an integral component of HAP-Y. RDA then presented the evaluation questions to the Youth Ambassadors to have participants help determine how to best answer the evaluation questions. Part of this process included group brainstorms, where the Youth Ambassadors were encouraged to examine what "reducing stigma" meant to them personally and how this concept connected to improved mental health outcomes for young adults.

As a result of these conversations, Cohort 1 opted to design a pre/post survey assessing the audience's knowledge prior to and after the HAP-Y presentation to determine whether the presentation (a) increased audience knowledge of mental health, (b) reduced audience level of mental health stigma, and (c) increased access to mental health services.

Simultaneously, RDA utilized different techniques to "demystify" evaluation. For example, to highlight the importance of evaluation and support self-advocacy development, RDA invited the Youth Ambassadors to evaluate every data work session. At the end of each meeting, Youth Ambassadors were asked "what worked" and "what didn't work". The Youth Ambassadors were able to articulate their preferred learning styles, activities and approaches they enjoyed, and how the data work sessions could be improved. In subsequent meetings, the RDA evaluation team incorporated feedback from the group to further illustrate how evaluation can be useful.

With youth's input, RDA created the first iteration of the pre/post audience survey tool and in the following meeting presented the survey to Cohort 1. During the second data work session, the RDA evaluation team solicited feedback from Cohort 1 to ensure the survey questions used accessible

language, could be answered by an audience, and mapped back to the evaluation questions. After receiving feedback from Cohort 1 about survey accessibility and user-design, RDA created the final draft. In the third and final work session, RDA presented the final version of the survey and incorporated youth feedback prior to finalizing the tool. The audience survey tool will be administered to audiences once the Cohort 1 completes their training schedule and conducts their educational presentations.

Measuring Youth Ambassador Growth and Development

RDA measured growth and development within the Youth Ambassadors through individual and group surveys. An individual survey was given to HAP-Y participants at the beginning of the HAP-Y program and again at the end of the training period. The group survey was administered orally, and HAP-Y participants answered the questions together. In order for a response to be logged, it was necessary for the participants to reach a consensus on the question. While youth actively participated in the group survey exercise, they asked to change the way in which their input was gathered to allow for differing perspectives. At the end of year 1, in lieu of the group survey, RDA conducted a focus group with Youth Ambassadors to debrief and learn about youth's experience in the program. During the focus group, youth discussed their change in knowledge and skills, comfort around discussing mental health, and leadership skills gained. RDA also asked youth about their thoughts on the training and curriculum and any changes they felt may help future cohorts.

StarVista Staff Perspectives

RDA also worked directly with StarVista staff throughout the first year of the project. Initial discussions focused on developing a shared understanding of the project and evaluation. Subsequent conversations focused on learning about StarVista staff's experience, changes they saw in participants, and lessons learned throughout the year.

Preliminary Outcomes

Given that the first year of HAP-Y implementation focused on recruitment and training of Youth Ambassadors, preliminary data are only available to answer the first evaluation question:

1. **To what extent does participating in HAP-Y build the Youth Ambassadors' capacity to serve as mental health advocates?**

RDA measured Youth Ambassadors' change in knowledge and stigma through individual and group surveys. The individual survey had 24 questions grouped by the following categories: *mental health advocacy*, *leadership*, and *teamwork*. The group survey had 22 questions with the same categories as the individual survey. For the group survey, Youth Ambassadors collectively answered the survey questions.

Fourteen participants completed the individual pre-survey and 11 individuals completed the individual post-survey. Respondents measured their reaction to questions based on the following Likert Scale measurements: 1) not at all true, 2) a little bit true, 3) mostly true, and 4) very true.

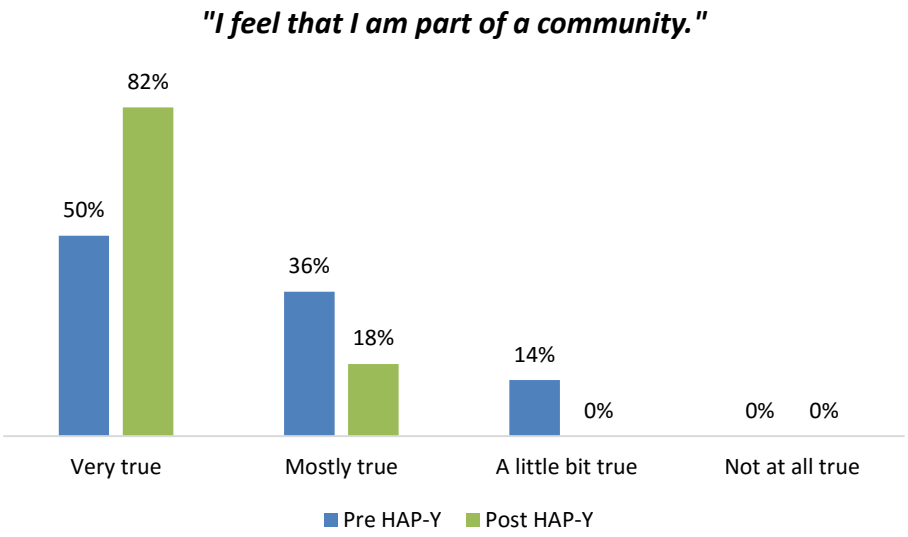
Mental Health Advocacy

The first section of the Youth Ambassadors' survey measured self-determination of mental health advocacy. This section included the following statements:

Mental Health Advocacy - Self	Mental Health Advocacy - Group
1. I am comfortable talking about mental health. 2. I am interested in learning more about mental health. 3. I have a positive attitude about myself. 4. I have the courage to say difficult things. 5. My involvement in this project is important. 6. I feel that I am part of a community. 7. I can contribute to other people's learning about mental health.	1. We are comfortable talking about mental health. 2. We feel confident in pursuing our goals. 3. Our personal experiences should be included in the planning of mental health programs. 4. We respect each other's background and stories. 5. Our presence here is important. 6. We can make a positive change for our communities.

At the beginning of Cohort 1, 64% of Youth Ambassadors (n=9) felt that it was "very true" that they were comfortable talking about mental health, and 36% (n=5) responded "mostly true". At the end of Cohort 1, 91% of Youth Ambassadors (n=10) felt that it was "very true" that they were comfortable talking about mental health, and one youth (9%) responded "mostly true". Due to the small sample size, percentage change may seem exaggerated.

Another notable finding is that in the beginning of Cohort 1, 50% of Youth Ambassadors (n=7) felt it was "very true" that they were part of a community and at the end of Cohort 1, 82% of respondents (n=9) felt it was "very true" that they were part of a community.



As a group, there was consensus that everyone felt it was "very true" that they can make a positive change for the community. One of the tenets of participatory evaluation is to empower community members to be active members of research and evaluation. It is important for youth to feel they are a part of a community and to feel comfortable engaging in that community to make a change.

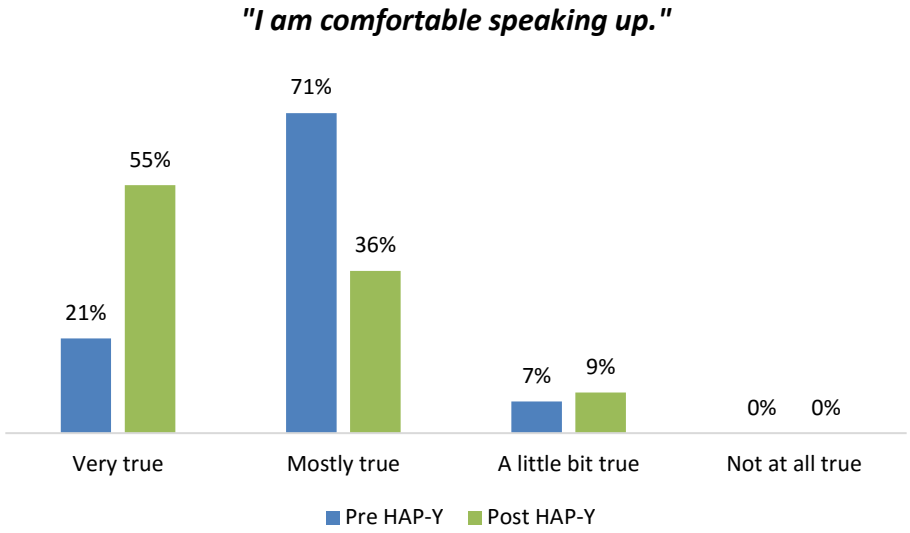
Leadership

The second section of the individual survey measured Youth Ambassadors' self-determination of their leadership skills. This section included the following statements:

Leadership - Self	Leadership - Group
1. I know things that I do well. 2. My opinion is important. 3. I am comfortable speaking up. 4. I am capable of learning from my mistakes. 5. If I mess up, I try again. 6. I can gain professional skills from this project. 7. I am able to make a plan to achieve my goals. 8. I can finish something that I have started.	1. We are able to learn and grow together. 2. We are able to agree and disagree effectively. 3. We are capable of completing tasks and doing our best. 4. We can create plans together to achieve our goals. 5. We are inclusive of individuals from different background. 6. Our participation will get us more involved in our community. 7. We hold each other accountable.

One of the goals of the HAP-Y is to empower youth. At the beginning of Cohort 1, 21% of Youth Ambassadors (n=3) felt it was "very true" that they were comfortable speaking up. At the end of Cohort 1, 55% of participants (n=6) felt it was "very true" that they were comfortable speaking up. As a group, there was consensus that all felt it was "very true" that they were able to agree and disagree effectively

and that the group holds each other accountable. These findings indicate that Cohort 1 felt comfortable speaking up and engaging in productive disagreement and group growth.



When asked to gauge their response to the question "my opinion is important," 29% of respondents in the individual pre-survey (n=4) felt this was "very true". At the end of the program, 55% of Youth Ambassadors (n=6) felt this was a very true statement. In the group post-survey, there was consensus that all felt it was very true that they are inclusive of individuals from different backgrounds. These findings indicate that the HAP-Y youth are gaining comfort in speaking up and voicing their opinion. Being comfortable speaking up and giving voice to one's thoughts are integral components to empowerment, particularly for individuals from diverse or vulnerable backgrounds.

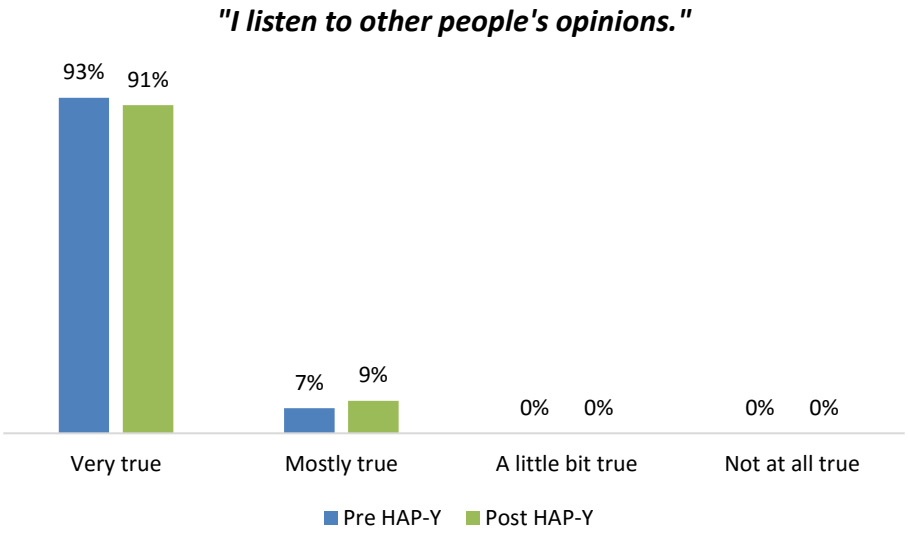
Teamwork

The third section of the individual survey measured Youth Ambassadors' teamwork skills. This section included the following statements:

Teamwork - Self	Teamwork - Group
1. I work well on my own.	1. We are confident in our ability to work cooperatively as part of a group.
2. I aim to understand the other person's point of view.	2. We can make decisions together.
3. I listen to other people's opinions.	3. We encourage and support each other.
4. I support team members to participate and contribute.	4. We hear each other out.
5. I can make decisions as part of a group.	5. We communicate with each other about decisions, changes, and updates on the project.
6. I can speak up for myself in a group.	6. We are capable of learning from each other.
7. I am willing to learn from others.	

Teamwork - Self	Teamwork - Group
8. I follow through on commitments to my teammates.	7. We try to understand each other's perspectives. 8. We acknowledge that each person has a strength. 9. We are able to forgive each other.

A notable finding from the teamwork section was in response to the question, "I listen to other people's opinions." At the beginning of Cohort 1, 93% of participants (n=13) felt this was "very true" and at the end of Cohort 1, 91% of respondents (n=10) felt it was "very true." In the group post-survey, there was group consensus that all respondents felt it was very true that they try to understand each other's perspectives. These findings indicate that Cohort 1 is supportive of listening to potentially different opinions and works towards understanding each other's perspectives.



In response to the question, "I work well with others," 57% of respondents (n=8) felt this was a very true statement at the beginning of the program. At the end of the program, 45% of respondents (n=5) felt this was a very true statement. Despite this reduction, as a group there was consensus that the following were very true statements: "We encourage and support each other", "We hear each other out", and "We acknowledge that each person has a strength." These findings indicate that individually, participants may periodically find it challenging to work well with others, but as a group they are supportive of one another.

Implementation Lessons

The curriculum should be interactive to best connect with youth.

Youth Ambassadors shared that one of the main challenges during the training was connecting with the curriculum. Youth reported that the training provided by the NAMI was particularly challenging to engage with because of its lecture style format. Youth discussed that having more interaction would make it easier to stay focused for the duration of the training.

> *"They could have engaged us, done activities. I don't work well with lecture style, so I like different things. I was reading ahead and highlighting. It was two hours of talking."*
>
> *-Youth Ambassador*

In response to this reported challenge, StarVista staff worked with the NAMI facilitator to update the training to be more engaging for youth. Staff worked with the NAMI trainer to include videos, worksheets, and speakers into every session. While the curriculum will remain true to NAMI fidelity, StarVista staff used the feedback to make the training more accessible and engaging for future cohorts.

Running the program during the summer is challenging.

StarVista staff and Youth Ambassadors shared that is was challenging to run the program during the summer months. Youth shared that it was challenging and stressful to attend all the training sessions during the summer due to vacation, work, and other obligations. Scheduling HAP-Y presentations was also a challenge of running the program during the summer. Schools are one of the target audiences for HAP-Y presentations and thus presentations could not be scheduled during the summer vacation. Because of this, no presentations were completed during the Year 1 reporting period. Youth shared that staff were flexible and created alternative opportunities for youth to conduct public education around mental health, such as making a video about the HAP-Y program.

Next Steps and Plans for Years 2 and 3

In the next two years of the program, StarVista will recruit new youth to participate as Cohort 2 and Cohort 3 Youth Ambassadors. Youth Ambassadors will receive psychoeducation training and conduct public education presentations. StarVista will incorporate the lessons learned from the first year of the program, including making the training more engaging for Youth Ambassadors. Additionally, the Youth Mental Health First Aid training will be replaced with Youth for Youth.

In Year 1, preliminary data were only available to answer the first evaluation question—to what extent does participating in HAP-Y build the Youth Ambassadors' capacity to serve as mental health advocates. In the next two years of the program, RDA will expand its evaluation to measure how HAP-Y influences mental health knowledge and mental health stigma, youth access to mental health services, and the mental health system as whole.

Appendix 1: HAP-Y Application

Health Ambassador Program for Youth

DESCRIPTION:
Health Ambassador Program-Youth (HAP-Y) is a new program established by StarVista in partnership with Pyramid Alternatives. We are looking for youth health ambassadors who are passionate about serving communities that have been affected by mental health challenges, interested in raising awareness, and increase access to behavioral health services. Interested youth will participate in trainings focusing on mental wellness. After completion of training, Health Ambassadors will be community agents ready to help others in the community through information sharing or providing referrals when appropriate. Stipend of up to $700 will be provided for youth who complete the training program. Public transportation passes and child care are available upon request. **People who have family, communities or they themselves have been affected by mental health challenges are highly encouraged to participate.**

REQUIREMENTS:
Be between the ages of 16 to 24.
Able to commit to 70+ hours of training.
Participation in community events.

GENERAL RESPONSIBILITIES:
Training

Participate in the entire training program. Training will be focused on topics of mental wellness. Some of the trainings cover the common challenges in mental wellness, learning the signs and risks of suicide, suicide prevention, and information on access to mental health services. Snacks and light refreshments will be provided at each training.

Community Involvement

After completing required training, health ambassadors will have the opportunity to represent HAP-Y in community events such as health fairs, outreach events, and trainings. Opportunities to receive pay will be available.

PLEASE EMAIL APPLICATION TO: hapy@star-vista.org
OR
PLEASE MAIL APPLICATION TO:

StarVista Crisis Center, Attn: HAP-Y
610 Elm Street, Suite 212
San Carlos, CA 94070

Please submit applications by 4/24. Selected applicants will be contacted for interview. Any applications received after this date will be considered for the next round.

PERSONAL INFORMATION:

NAME:

DATE OF BIRTH: **AGE:**

GENDER IDENTITY:

ADDRESS:

PHONE NUMBER:

EMAIL ADDRESS:

DO YOU PREFER TO BE CONTACTED BY PHONE, TEXT OR EMAIL?

SCHOOL (IF APPLICABLE):

NOTE: PARENTAL PERMISSION REQUIRED FOR PARTICIPATION FOR THOSE UNDER 18.

BACKGROUND INFORMATION:

1. List any jobs or extracurricular activities that you are currently involved in or participated in previously.

Job/Activity	Description of involvement	How long have you been or were you involved?

2. What language(s) other than English do you speak? Would you need interpretation services to participate in the program?

3. What location would be most convenient for you to attend trainings (check all that apply)?
   - ☐ Redwood City
   - ☐ San Mateo

- Half Moon Bay
- North County

4. What qualities do you possess that will make you successful as a Health Ambassador?

5. How have you, your family, or your community been affected by mental health and behavioral health challenges?

6. How does becoming a health ambassador fit with your personal and professional goals?

Appendix 2: StarVista HAP-Y Interview Protocol

Start by describing the program (combination of trainings and outreach)

Applicant Name:	**Interviewer:**

1. Tell us a little about yourself and why you are interested in participating in a program focusing on mental health?

2. What is something you hope to get out of participating in this program?

3. How do you feel about representing the program at community events like health fairs or in classroom presentations?

4. Tell us about a time you worked in a team: what were some challenges and what were some things that made is successful?

5. How do you think this will fit with your other commitments? How will you manage your time?

6. Our meetings would be in the afternoon starting at 4:30 starting in September lasting for 13 weeks. Do you expect any challenges to regular participation in the program? (For example: do you have transportation, any scheduling conflicts? Will you need vouchers?)

7. If you are under 18, have you discussed this program with your parents? Are they supportive? Would it be ok for us to contact them?

8. How did you hear about the program?

9. What do you think are your strengths and areas you are working to improve?

10. Why do you think it's important for young people to learn more about mental health?

11. Think about a teacher you liked, what made them effective?

12. What are you most proud of?

13. How would your friends describe you? (If more experienced, how would your supervisor describe you)?

14. What 3 words would you choose to describe yourself?

Appendix 3: Cohort 1 Training Schedule

HAP-Y Cohort 1 Training Schedule: May 2017 – August 2017

Date	Training Topic
Wednesday, May 3	HAP-Y Orientation
Monday, May 8	Resource Development Associates
Wednesday, May 10	Youth Mental Health First Aid, Part 1
Monday, May 15	Youth Mental Health First Aid, Part 2
Wednesday, May 17	NAMI Class 1
Monday, May 22	Youth Mental Health First Aid, Part 3
Wednesday, May 24	NAMI Class 2
Monday May 29	*Holiday*
Wednesday May 31	NAMI Class 3
Monday, June 5	QPR
Wednesday, June 7	NAMI Class 4
Monday June 12	WRAP, Part 1
Wednesday, June 14	NAMI Class 5
Monday, June 19	WRAP, Part 2 and Resource Development Associates
Wednesday, June 21	NAMI Class 6
Monday, June 26	WRAP, Part 3
Wednesday, June 28	NAMI Class 7
Monday, July 3	WRAP, Part 4
Wednesday, July 4	NAMI Class 8
Monday, July 10	WRAP, Part 5
Wednesday, July 12	NAMI Class 9
Monday, July 17	WRAP 6
Wednesday, Jul 19	NAMI Class 10
Monday, July 24	WRAP 7
Wednesday, July 26	NAMI Class 11
Monday, July 31	WRAP 8
Wednesday, August 2	Presentation and Outreach
Monday, Aug 7	Story Circle
Wednesday, Aug 9	Presentations/Graduation

Appendix 4: San Mateo BHRS HAP-Y Evaluation Plan

Introduction

The Healthy Ambassador Program-Youth (HAP-Y) was developed as part of the San Mateo County Behavioral Health Recovery Services (BHRS) Mental Health Services Act (MHSA) three-year Innovation plan. Innovation programs seek to increase access to mental health programs for underserved groups, increase quality of services and outcomes, and promote interagency collaboration. In alignment with the Innovation regulations, the HAP-Y serves as a youth-led initiative, where young adults act as mental health ambassadors to promote awareness of mental health, increase service access for young people, and reduce mental health stigma. Resource Development Associates (RDA) was selected by BHRS to provide an evaluation of the HAP-Y.

The INN plan sets forth two learning questions and project goals:

1) **Building youth capacity and engagement to reduce stigma.**

2) **Increasing youth access to mental health services.**

The HAP-Y evaluation incorporates the youth ambassadors as research partners to work with RDA throughout the course of the project. Youth Ambassadors will work with RDA to design the evaluation and tools as well as collect, analyze, and interpret data. RDA plans to work with the youth at each stage of the evaluation and build their capacity to:

1. Design and implement program and evaluation;
2. Incorporate the use of data to inform program improvement; and
3. Ensure the program and evaluation meet their intended objectives.

RDA's approach to evaluation is collaborative throughout all stages, and provides continuous opportunity for BHRS and its stakeholders to build capacity for evaluation and engage in continuous program improvement.

Program Background

What does HAP-Y do?

The HAP-Y seeks to engage and empower transition age youth (ages 16-25) as mental health ambassadors to promote awareness of mental health and increase the likelihood that young people will access needed mental health services. For this project, the youth ambassadors will receive training to build their own mental health knowledge and advocacy skills and then engage in outreach and educational activities with other young people as well as participate in advocacy efforts (e.g. committees, advisory groups, panel discussions).

Who is supporting the health ambassadors?

StarVista, a non-profit organization that provides counseling and prevention and early intervention education resources throughout San Mateo, is the lead agency of this initiative. StarVista will identify, recruit, and provide mental health training intended to build youth capacity to reduce stigma and increase youth access to mental health services. StarVista will work with their community-based partner, **Pyramid Alternatives, Inc.** to recruit youth to participate through a variety of outreach methods to be implemented throughout the regionally diverse communities of San Mateo County. Youth who want to participate in the program will submit an application and go through a formal interview process, similar to a job interview. HAP-Y participants will receive training on mental health related topics including recovery and resiliency, mental health stigma, suicide intervention skills, and mental health resources in San Mateo County. Participants will also receive. **Resource Development Associates (RDA)**, a consulting firm specializing in participatory approaches to evaluation, will provide training on assessing and implementing a variety of research methods that youth, in partnership with RDA, will use to collect program data, perform analysis, and identify key research findings.

What are the health ambassadors program activities?

The youth health ambassadors will be trained in **Youth Mental Health First Aid, Question Persuade Refer, Wellness Recovery Action Plan, NAMI Family to Family, and targeted story-telling** that builds their capacity to:

- Outreach and speak at panels and community events on mental health
- Working with schools and other youth teaching psycho-educational classes
- Facilitate discussions or focus groups
- Provide resources to increase access to mental health services

Youth health ambassadors will provide 1) educational outreach presentations to other youth and youth-serving adults, and 2) participate in other mental health advocacy efforts, such as advisory boards, steering committees, and other mental health stakeholder initiatives.

The youth ambassadors will also learn approaches to decrease stigma through lived-experience presentations, which may include digital storytelling and Photovoice.

What does this program hope to accomplish?

HAP-Y intends to **prepare youth ambassadors** to increase their knowledge and perceptions about mental health and concepts of recovery and resiliency. Additionally, the program seeks to support their ability to respond to an individual experiencing a mental health crisis as well as understanding the appropriate community supports that ultimately help improve the youth access to services for those at risk of developing a serious mental illness.

By preparing youth to engage in outreach, education, and advocacy efforts, HAP-Y seeks to **increase knowledge about youth mental health**, including recovery and resiliency; **decrease the stigma associated with mental health**; and **increase youth access to mental health services**.

Evaluation Overview

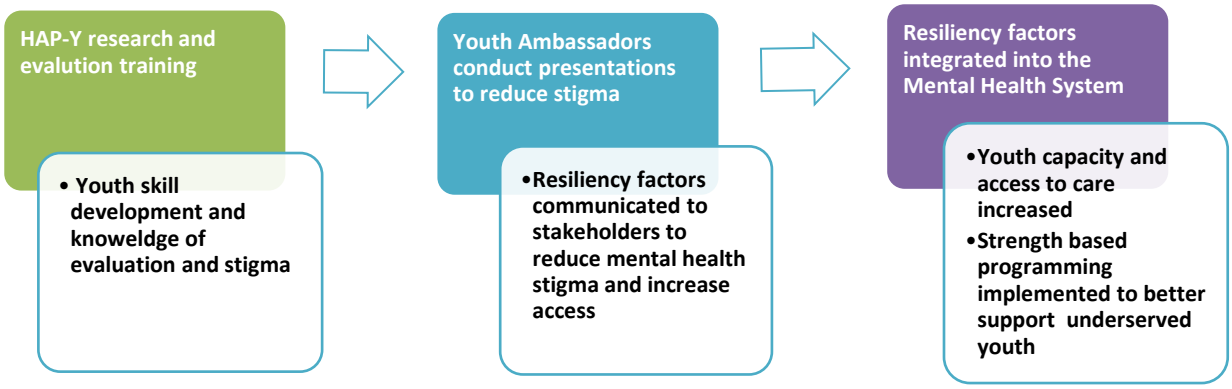
BHRS retained RDA to evaluate the efficacy of the HAP-Y program in obtaining its desired outcomes. RDA's evaluation tools have been designed to answer the following three evaluation questions:

Evaluation Questions

1. To what extent does participating in HAP-Y build the youth ambassadors' capacity to serve as mental health advocates?
2. How does HAP-Y increase mental health knowledge and decrease mental health stigma?
3. How does HAP-Y increase youth access to mental health services?
4. How does HAP-Y influence the mental health system?

RDA will be responsible for developing data collection methods with youth in the form of surveys, focus groups, and other documentation to discover the impacts of the HAP-Y on their audiences and the mental health system. RDA will also collect baseline data from youth ambassadors to evaluate changes throughout the life of the program. **Error! Reference source not found.** below provides a simplified illustration of the theory of change that is believed to result from successful implementation of the HAP-Y program.

Theory of Change



Measurable Goals

RDA will partner with youth to design the evaluation to measure their progress. RDA will be responsible for working with youth to identify and co-create data collection tools as well as creating and recommendations from the information gathered together. The table below includes possible data collection methods that the HAP-Y intends to answer through the data collection activities by each of the program goals.

Increase Knowledge of Services and Reduce Stigma of Mental Health Issues

Types of measures to determine mental health knowledge and stigma	Who is responsible for Tool Development?
Youth Ambassador Pre/Post Tests (group and individual; Appendix e)	RDA
Audience surveys (Appendix f), quantitative, and other qualitative data measures	RDA and Youth Ambassadors
Focus groups with Youth Ambassadors (Appendix g)	RDA

Increase Access to Mental Health Services

RDA will partner with StarVista, Pyramid Alternatives Inc., and the Youth Ambassadors to measure the increase in access to services RDA plans on co-creating tools and methods with youth, HAP-Y providers, and BHRS. However, below is a list of the types of measures RDA will be tracking.

Types of measures to determine an increase in access to mental health services.	Where will this information be found?
The number of youth asking for a follow up call after a HAP-Y presentation.	HAP-Y follow-up forms
The number of youth who reach out for help to gain access to mental health services.	HAP-Y call logs
The baseline number of calls a community resource line (e.g. crisis hotline) receives annually.	Resource line call log
The number of calls to a community resource line for services in the week following a presentation compared to the baseline.	Resource line call log
The number of new calls to a community resource line/provider (e.g. crisis hotline).	Resource line call log/ Provider in-take forms

Influence the Mental Health System

RDA will partner with StarVista, Pyramid Alternatives Inc., and the Youth Ambassadors to measure how the HAP-Y program influences the mental health system. RDA plans on co-creating tools with youth. However, below is a list of the types of measures RDA will be tracking.

Types of questions to assess how the HAP-Y program influenced the mental health system.	How might these questions be answered?
What activities did the youth conduct?	HAP-Y focus groups, staff interviews
How were the youth received?	HAP-Y focus groups, staff interviews
What did the youth accomplish?	HAP-Y focus groups, staff interviews, BHRS

Data Analysis

RDA will begin our analysis by organizing and cleaning data collected during surveys and focus groups. To evaluate qualitative data, focus group participants' responses will be transcribed so that participants' responses and reactions are appropriately captured. RDA will then thematically analyze responses from participants to identify any recurring themes and key takeaways from the focus groups. To analyze the quantitative data, we will conduct both descriptive and inferential statistics, as appropriate, to describe the outcomes, as well as to identify if changes across time are statistically significant.

RDA will triangulate qualitative findings with quantitative findings to develop a complete picture of the extent to which the HAP-Y program goals have been achieved. Utilizing mixed methods allows the evaluator to not only identify the correlation between program participation and outcomes but also to identify the strengths and challenges associated with the program from the participants' perspective. This allows program staff to make real-time adjustments to the program and further to reevaluate changes that may need to be made to the program in the future.

Reporting

On an annual basis, RDA will draft reports that provide a comprehensive understanding of the implementation and impact of the HAP-Y project to date as well as comply with new MHSA Innovation component regulations. The report will include an update about the progress of HAP-Y implementation and related process indicators, preliminary outcome measures, and recommendations for actionable program improvements as well as guidance for using data to further refine the program model. These reports will be shared with the youth ambassadors to support continuous quality improvement and solidify their role as research partners.

Appendix e: HAP-Y Self-Determination Survey 2017

Part 1: Individual Survey

In your opinion, how true are these things? Please mark the box that matches with how true each statement is to you.

Mental Health Advocacy	Not at all true	A little bit true	Mostly true	Very true
I am comfortable talking about mental health.	❑	❑	❑	❑
I am interested in learning more about mental health.	❑	❑	❑	❑
I have a positive attitude about myself.	❑	❑	❑	❑
I have the courage to say difficult things.	❑	❑	❑	❑
My involvement in this project is important.	❑	❑	❑	❑
I feel that I am part of a community.	❑	❑	❑	❑
I can contribute to other people's learning about mental health.	❑	❑	❑	❑

Leadership	Not at all true	A little bit true	Mostly true	Very true
I know things that I do well.	❑	❑	❑	❑
My opinion is important.	❑	❑	❑	❑
I am comfortable speaking up.	❑	❑	❑	❑
I am capable of learning from my mistakes.	❑	❑	❑	❑
If I mess up, I try again.	❑	❑	❑	❑
I can gain professional skills from this project.	❑	❑	❑	❑
I am able to make a plan to achieve my goals.	❑	❑	❑	❑
I can finish something that I have started.	❑	❑	❑	❑

Teamwork	Not at all true	A little bit true	Mostly true	Very true
I work well on my own.	❑	❑	❑	❑
I work well with others.	❑	❑	❑	❑
I aim to understand the other person's point of view.	❑	❑	❑	❑
I listen to other people's opinions.	❑	❑	❑	❑
I support team members to participate and contribute.	❑	❑	❑	❑
I can make decisions as part of a group.	❑	❑	❑	❑
I can speak up for myself in a group.	❑	❑	❑	❑
I am willing to learn from others.	❑	❑	❑	❑
I follow through commitments to my teammates.	❑	❑	❑	❑

Part 2: Group Survey

Mental Health Advocacy	Not at all true	A little bit true	Mostly true	Very true
We feel comfortable talking about mental health.	❑	❑	❑	❑
We feel confident in pursuing our goals.	❑	❑	❑	❑
Our personal experiences should be included in the planning of mental health programs.	❑	❑	❑	❑
We respect each other's background and stories.	❑	❑	❑	❑
Our presence here is important.	❑	❑	❑	❑
We can make a positive change for our communities.	❑	❑	❑	❑

Leadership	Not at all true	A little bit true	Mostly true	Very true
We are able to learn and grow together.	❑	❑	❑	❑
We are able to agree and disagree effectively.	❑	❑	❑	❑
We are capable of completing tasks and doing our best.	❑	❑	❑	❑
We can create plans together to achieve our goals.	❑	❑	❑	❑
We are inclusive of individuals from different backgrounds.	❑	❑	❑	❑
Our participation will get us more involved in our community.	❑	❑	❑	❑
We hold each other accountable.	❑	❑	❑	❑

Teamwork	Not at all true	A little bit true	Mostly true	Very true
We are confident in our ability to work cooperatively as part of a group.	❑	❑	❑	❑
We can make decisions together.	❑	❑	❑	❑
We encourage and support each other.	❑	❑	❑	❑
We hear each other out.	❑	❑	❑	❑
We communicate with each other about decisions, changes, and updates on the project.	❑	❑	❑	❑
We are capable of learning from each other.	❑	❑	❑	❑
We try to understand each other's perspectives.	❑	❑	❑	❑
We acknowledge that each person has a strength.	❑	❑	❑	❑
We are able to forgive each other.	❑	❑	❑	❑

Appendix f: Health Ambassador Program Youth Audience survey

Thank you for listening to our presentation today! Please use the scale below to rate your level of knowledge before and after the presentation:

1 = No 2 = Sometimes 3 = Most of the time 4 = All of the Time NA = Not Applicable

	For the check boxes in the left column, please rate your knowledge/feelings **Before Presentation:**	For the check boxes in the left column, please rate your knowledge/feelings **After Presentation:**
I know where to go to get support if I am emotionally struggling.	☐1 ☐2 ☐3 ☐4 ☐NA	☐1 ☐2 ☐3 ☐4 ☐NA
I know who to call or access online if I need mental health services.	☐1 ☐2 ☐3 ☐4 ☐NA	☐1 ☐2 ☐3 ☐4 ☐NA
I know of services that are available evenings and weekends.	☐1 ☐2 ☐3 ☐4 ☐NA	☐1 ☐2 ☐3 ☐4 ☐NA
I can get services that I need.	☐1 ☐2 ☐3 ☐4 ☐NA	☐1 ☐2 ☐3 ☐4 ☐NA
I'm uncomfortable discussing topics related to mental health challenges.	☐1 ☐2 ☐3 ☐4 ☐NA	☐1 ☐2 ☐3 ☐4 ☐NA
I think people with mental health challenges are unstable.	☐1 ☐2 ☐3 ☐4 ☐NA	☐1 ☐2 ☐3 ☐4 ☐NA
I feel comfortable seeking mental health services.	☐1 ☐2 ☐3 ☐4 ☐NA	☐1 ☐2 ☐3 ☐4 ☐NA

Which of the following statements about what your family/loved ones has experienced is true? ***Select one***

☐ Myself or someone in my family has experienced mental health challenges and we have used mental health services.
☐ Myself or someone in my family has experienced mental health challenges, but we/I have never received services.
☐ Myself or someone in my family has never experienced mental health challenges.
☐ I do not know if my family has ever received mental health services.

If you've ever attempted to get mental health services: – ***Select multiple***

☐ I did not qualify for any services
☐ It took too long to be seen after I had a crisis
☐ The hours of services do not match with my schedule
☐ The appointments are always full
☐ There were not enough services available
☐ I had no problems getting into services
☐ Other_____(please write in)

Was this presentation helpful for you?

☐ Yes ☐ No **If yes, please share why:**_____

What is something we could do better?

_____

_____

_____

_____

What do you need more information about?

_____

_____

_____

Please use the following scale to rate your level of satisfaction.

1 = Poor	2 = Fair	3 = Good	4 = Very Good	5 = Excellent
How would you rate the effectiveness of this presentation?	☐1	☐2	☐3	☐4	☐5
How would you rate the effectiveness of the presenters?	☐1	☐2	☐3	☐4	☐5
Overall, my experience with the presentation was:	☐1	☐2	☐3	☐4	☐5

Are you experiencing a mental health problem? Would like a follow up call, text, or email about getting mental health support? If so, please provide the appropriate information below, and someone from our team will follow up with you.

Name: _____
Phone Number: _____

Email Address: _____
Please contact me by:

☐ Text Message ☐ Email
☐ Phone Call

Appendix g: Focus Group Protocol

County of San Mateo BHRS Innovation HAP-Y / Focus Group Protocol (Pre Program Evaluation)

Date	
FG Type/Size	
Location	
Facilitator	

Introduction

Thanks for making the time to join us today. My name is _____ and this is _____. We are with a consulting firm called Resource Development Associates and we are here to help the County of San Mateo Behavioral Health and Recovery Services Department with the Health Ambassador Program – Youth. I will be facilitating our talk today and _____ will take notes, but we won't use your name unless we specifically ask if we can use your comment as a quote.

The purpose of these projects is to learn more about your experience in the program. This is **your** process and **your** opportunity to make your voice heard about your experience.

This is your conversation, but part of my job as facilitator is to help it go smoothly and make sure that everyone has a chance to say what's on their mind in a respectful way. We have a few guidelines to help us do that. Please:

- Put your phone on silent and don't text
- Engage in the conversation – this is your meeting!
- Limit "side conversations" or "cross talk" so that everyone can hear what is being said
- And remember, there are no "wrong" or "right" opinions: please share your opinions honestly and listen with curiosity to understand the perspective of others

Does anyone have any questions before we begin? **Raise your hand if you've ever been part of a focus group.**

Interview Guide

Introductions

1. How did you learn about HAP-Y?

2. By joining HAP-Y, what impact are you hoping to have on the community? What impact are you hoping that HAP-Y has on you?

Skills and training

3. What skills/knowledge do you **currently** have that you think will help you with the HAP-Y program? (prompt: public speaking, leadership, knowledge of mental health)

4. What skills/knowledge **are you hoping to gain** that will help you with the HAP-Y program? (prompt: public speaking, leadership, knowledge of mental health)

Stigma

5. When you think of mental health, what words come to mind?

6. Do you feel comfortable talking about mental health with friends and family?

Knowledge

7. If you or a friend was experiencing a mental health challenge, what would you do? Who would you talk to? Where would you go?

8. Is evaluation important? Why or why not?

San Mateo County Adult NMT Pilot Fiscal Year 2016-17 Evaluation Report

A Mental Health Services Act Innovation Project

Prepared by:

Resource Development Associates

December 2017

Table of Contents

Introduction

Project Overview

San Mateo Behavioral Health and Recovery Services (BHRS) implemented the Neurosequential Model of Therapeutics© (NMT) within the Adult System of Care as part of the three-year Mental Health Services Act (MHSA) Innovation (INN) plan. The MHSA INN project category and primary purpose of the NMT pilot project are as follows:

- **MHSA INN Project Category:** Makes a change to an existing mental health practice that has not yet been demonstrated to be effective.
- **MHSA Primary Purpose:** Increase quality of mental health services, including measurable outcomes.

The Mental Health Services Oversight and Accountability Commission (MHSOAC) approved the project on July 28, 2016 and BHRS began implementation in September 2016. In 2017, BHRS contracted Resource Development Associates (RDA) to evaluate the adult NMT pilot project. This report provides findings from the first year of NMT implementation in the BHRS Adult System of Care.

Project Need

Through the MHSA Community Planning Process in San Mateo, BHRS and community stakeholders identified the need to provide alternative treatment options to broaden and deepen the focus on trauma informed care and provide better outcomes in recovery for adult BHRS consumers. To address this need, BHRS proposed implementing the NMT approach within the BHRS Adult System of Care. NMT is an innovative approach to treating trauma that is grounded in neurodevelopment and neurobiology. Subsequent sections provide a more in-depth description of NMT and its application to adults.

Project Innovation

While NMT has been integrated into a variety of settings serving infants through young adults, there is no literature or research of NMT in a strictly adult setting or population. BHRS intends to adapt, pilot, and evaluate the application of the NMT approach to an adult population with a history of trauma. This expansion to and evaluation of NMT in an adult system of care is the first of its kind.

Project Description

NMT Background

The Child Trauma Academy (CTA) developed NMT as an alternative approach to addressing trauma, typically used with children, that is grounded in neurodevelopment and neurobiology. NMT is not a single therapeutic technique or intervention. Rather, NMT uses assessments to guide the selection and sequence of a set of highly individualized therapeutic interventions (e.g., therapeutic massage, drumming,

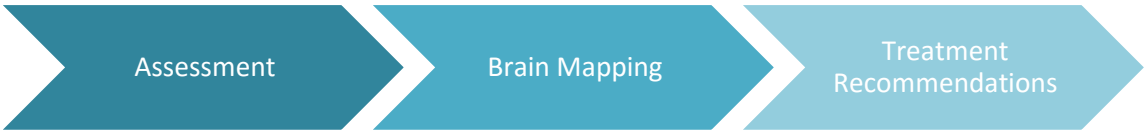
yoga, expressive arts, etc.) that best match each NMT consumer's unique strengths and neurodevelopmental needs.[1]

NMT is guided by the principle that trauma during brain development can lead to dysfunctional organization of neural networks and impaired neurodevelopment. The selected set of therapeutic interventions intends to help change and reorganize the neural systems to replicate the normal sequence of brain and functional development. Selected interventions first target the lowest, most abnormally functioning parts of the brain. Then, as consumers experience functional improvements, interventions are selected that target the next, higher brain region. The sequence of interventions aims to help consumers better cope, self-regulate, and progress in their recovery.

NMT Processes and Activities

As depicted in Figure 1, the NMT process consists of three main phases: 1) assessment, 2) brain mapping, and 3) the development of individualized treatment recommendations. These phases are briefly described below.

Figure 1. Key phases of the NMT Process



Assessment. NMT-trained providers collect information pertaining to the consumer's history of adverse experiences—including their timing, nature, and severity—as well as any protective factors. This information is used to estimate the risk and timing of potential developmental impairment. The assessment also includes an examination of current functioning and relationship quality (e.g., with parents, family, peers, community, etc.).

Brain Mapping. NMT-trained providers enter assessment data into a web-based tool designed by the CTA, which uses assessment data to generate a brain map illustrating the brain regions most affected by developmental impairment. Through this "mapping" process, scores are calculated in four functional domains: 1) Sensory integration, 2) Self-regulation, 3) Relational, and 4) Cognitive. The functional domain values are compared with age typical domain values to assess the degree of developmental impairment and identify the consumer's functional strengths and challenges.

Treatment Recommendations. Therapeutic interventions are identified that address the consumer's needs in the four functional domains, first targeting the lowest brain regions with most severe impairment. Throughout treatment, assessments and brain mapping are performed at regular intervals to evaluate any changes in functional domains, and treatment recommendations are adapted as appropriate.

[1]Perry, B.D. & Hambrick, E. (2008) The Neurosequential Model of Therapeutics. *Reclaiming Children and Youth*, *17*(3), 38-43.

Application of NMT to Adults

Since its development, NMT has been most widely used with children who experienced maltreatment and/or trauma, and BHRS has been using the NMT approach with children since 2012. However, the use of NMT with adults is limited. Given the high prevalence of trauma among adult behavioral health consumers and the relationship between childhood trauma and behavioral health issues in adulthood, there is a strong theoretical basis to predict that adult mental health consumers could benefit from the NMT approach.[2,3]

Nevertheless, NMT's effectiveness in the adult population is unknown. As mentioned, NMT has not been formally implemented into an adult system of care, and no outcome studies have been conducted to evaluate NMT in an adult population. BHRS is adapting, piloting, and evaluating the application of the NMT approach to an adult population with hopes of increasing the quality of mental health services and improving recovery outcomes for adult mental health consumers with a history of trauma.

BHRS NMT Pilot Project

NMT Providers

As mentioned, BHRS has been using the NMT approach with youth since 2012. In that time, 30 clinical staff in the BHRS Child and Youth System of Care and 10 clinical staff from community-based partner agencies received training through CTA.[4] In addition, 10 BHRS providers have become certified NMT trainers, and certify other providers in NMT through the CTA training. These trainers teach NMT principles and provide consultation to other providers. To expand NMT to the adult population, 12 providers within the BHRS Adult System of Care began NMT training with CTA in January 2017. The providers work in a variety of settings and programs, including BHRS specialty mental health or regional clinics as well as programs targeted toward consumers re-entering the community following incarceration.

Target Population

BHRS estimates that the adult NMT pilot project will serve approximately 75 to 100 adult consumers annually once the BHRS providers in the Adult System of Care are fully trained. Providers refer existing

[2]It is estimated that 40-80% of adults with mental illness and/or substance use issues also have experiences of trauma.
Source: Missouri Institute of Mental Health. (2004). Trauma among people with mental illness, substance use disorders and/or developmental disabilities. *MIMH Fact Sheet, January 2004.* Retrieved from: https://dmh.mo.gov/docs/mentalillness/traumafactsheet2004.pdf

[3]Anda, R.F., Felitti, V.J., Bremner, J.D., Walker, J.D., Whitfield, C., Perry, B.D., … Giles, W.H. (2006). The enduring effects of abuse and related adverse experiences in childhood: a convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neuroscience, 256*(3), 174-186.

[4]CTA operates the formal training certification program. The training takes place over one year, with trainees learning through a combination of readings, videos, webinars, and case-based trainings. Trainees begin implementing the NMT model with consumers shortly after the training commences and must conduct a minimum of 10 NMT assessments annually. In order to ensure fidelity to the NMT model, CTA requires that all certified NMT providers complete fidelity assessments twice annually, wherein the providers evaluate the same client data and inter-rater reliability scores are calculated.

BHRS consumers from their caseloads to NMT, targeting three populations of adult mental health consumers:

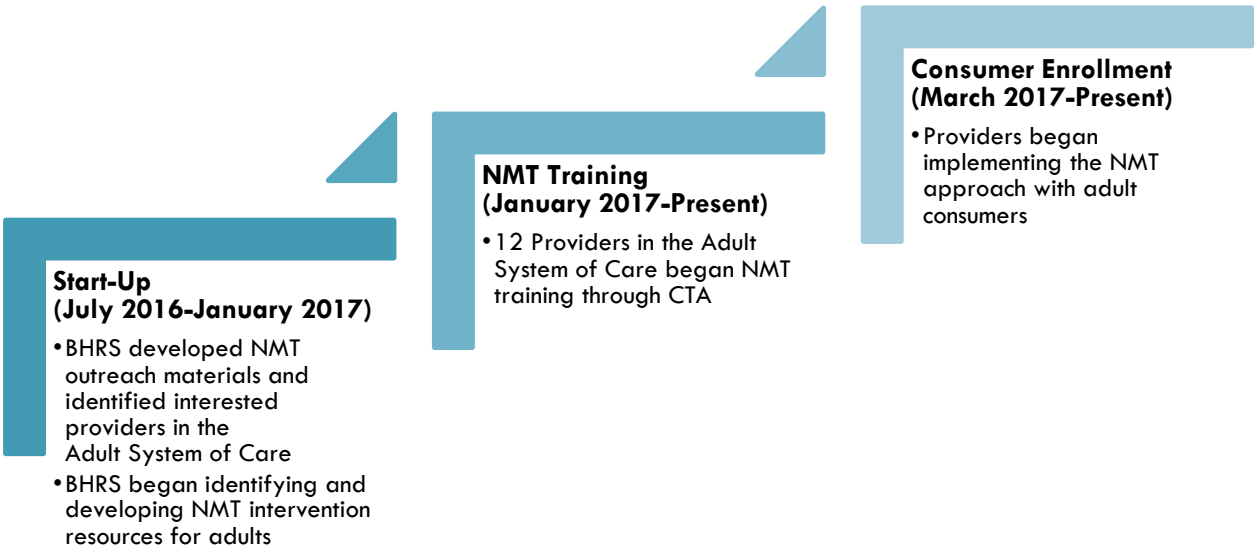
- General adult consumers (ages 26+) receiving specialty mental health services;
- Transition age youth (TAY) consumers (ages 18-25); and
- Criminal justice-involved consumers re-entering the community following incarceration.

The three target populations likely have different experiences, needs, and coping skills and, as a result, could respond to NMT differently. For example, TAY are still undergoing brain development and therefore may be more responsive to neurodevelopmental treatment approaches such as NMT. In addition, the re-entry population might have different coping mechanisms than the general adult and TAY consumer populations, such as engaging in high-risk behaviors that might lead to incarceration. For the re-entry population, the experience of incarceration could also further contribute to trauma.

Project Timeline and Implementation Update

As mentioned, the NMT pilot was approved in July 2017, at which time BHRS began preparing for NMT implementation in the Adult System of Care. Figure 2 highlights key activities and accomplishments during the first year of pilot project.

Figure 2. NMT Pilot Key Activities and Accomplishments



The NMT provider training was scheduled for January 2017, allowing time for BHRS to disseminate information about NMT, identify interested providers, prepare for training implementation, and begin identifying and establishing NMT intervention resources for adult consumers. In January, 12 providers in the BHRS Adult System of Care—all of whom are at least master's level clinicians—began the scheduled CTA NMT training. The NMT training occurs over a one-year period, therefore providers in the adult system completed approximately half of the training by the end of the reporting period.

When beginning NMT training, providers conduct practice assessments on "typical" individuals—individuals without known trauma or neurodevelopmental impairment. As providers progress through the training and become more comfortable with the assessment, providers begin implementing NMT with clinical cases. In March 2017, providers began referring and implementing NMT with adult consumers. As providers were not yet fully trained and had just begun implementing the NMT approach with adult consumers in March, only 20 consumers received NMT-based services during this first training year. In subsequent years, when providers are fully trained, BHRS anticipates approximately 75 to 100 adult consumers will receive NMT services annually. There were no other project modifications during the reporting period.

Evaluation Overview and Learning Goals

As mentioned, BHRS contracted RDA to evaluate the pilot and support project learning. BHRS developed two learning goals for the NMT evaluation. The first learning goal pertains to the adaptation and implementation of the NMT approach in the adult consumer population, while the second learning goal pertains to the effectiveness and impact of the NMT approach in improving recovery outcomes. To further guide the NMT evaluation, RDA developed evaluation sub-questions associated with each learning goal. The learning goals and evaluation questions (EQ) are listed below. To the extent possible, the evaluation will examine implementation and outcome differences across the three target populations to identify how BHRS can adapt the NMT approach to best meet each population's unique needs. More in-depth information about the evaluation is available in the evaluation plan included in the Appendix.

Learning Goal 1: Can NMT, a neurobiology and trauma-informed approach, be adapted in a way that leads to better outcomes in recovery for BHRS adult consumers?

> **EQ 1.1.** How is the NMT approach being adapted to serve an adult population?
>
> **EQ 1.2.** Who is being served by the adult NMT project, what types of NMT-based services are consumers receiving, and with what duration and frequency?

Learning Goal 2: Are alternative therapeutic and treatment options, focused on changing the brain organization and function, effective in adult consumers' recovery?

> **EQ 2.1.** To what extent is the NMT approach supporting improvement in adult consumers' functional outcomes and overall recovery and wellbeing?
>
> **EQ 2.2.** To what extent is the experience of care with the NMT approach different from consumers' previous care experiences?

During fiscal year 2016-2017 (FY16-17)—July 1, 2016, through June 30, 2017—RDA developed the evaluation plan, worked with BHRS staff to inform modifications to their Electronic Health Record (EHR), and developed additional data collection tools. RDA worked with CTA and BHRS when planning the evaluation to validate the theory of change for NMT specific to the adult population and the types of

variables that may support or complicate outcomes in adults (e.g., current substance use, psychiatric medication, and current trauma from homelessness and/or jail).[5]

This first year of the evaluation focuses on Learning Goal 1 to identify how BHRS is implementing and adapting the NMT approach with the adult population. As NMT implementation progresses and more consumers participate in NMT, the evaluation will focus on NMT effectiveness and changes in consumers' functional and recovery outcomes.

Evaluation Methods

Data Collection

RDA employed a mixed-methods evaluation approach (i.e., using both qualitative and quantitative data) to identify who is participating in NMT and how BHRS is adapting the NMT approach for the adult population. This report includes information about NMT implementation as well as about the adults who participated in NMT services during the evaluation period, FY16-17.

RDA worked closely with BHRS to identify and obtain appropriate outcome measures and data sources to address the evaluation questions. RDA collected quantitative information about NMT consumers from BHRS's EHR, Avatar, as well as from the NMT Database operated by CTA. RDA also conducted a focus group with BHRS NMT providers on October 3, 2017 to gather qualitative data about the adaptation of the NMT approach to the adult population. Table 1 outlines the outcome data available for FY16-17 as well as the respective data sources. The Data Collection and Analysis section of the Appendix includes the types of additional outcome data expected to be available in later reports.

Table 1. Measurable Outcomes and Data Sources

Outcome Type	Outcome Measures	Data Sources
Process Outcomes	Provider experience of NMT training and NMT implementation with the adult population	Focus Group with NMT Providers
	Number of consumers participating in NMT services	Electronic Health Records
	Characteristics of NMT consumers	Electronic Health Records
	Types of recommended NMT interventions	Provider Focus Group[6]
Consumer Outcomes	Baseline functional domain values[7]	NMT Database
	Baseline participation in BHRS outpatient services	Electronic Health Records
	Baseline psychiatric emergency service utilization and psychiatric hospitalization	Electronic Health Records

[5]A discussion of the application of NMT to adults and the theory of change are included in the Appendix.
[6]In September 2017, BHRS began including NMT services in their EHR. For subsequent reports, RDA will obtain NMT service data from Avatar to include quantitative information about NMT-related services.
[7]At the time of this report, baseline functional domain values were only available for half of NMT consumers and are therefore not reported. Functional domain values will be included in subsequent reports as more consumers participate in NMT and complete assessments.

Data Analysis

To analyze the quantitative data (e.g., consumer characteristics and service utilization), RDA used descriptive statistics to examine frequencies and ranges. To analyze qualitative data, RDA transcribed focus group responses to appropriately capture the responses and reactions of NMT providers. RDA then thematically analyzed responses from participants to identify commonalities and differences in providers' experiences.

NMT Implementation

NMT Provider Selection and Training

NMT Provider Selection

NMT training was voluntary, and all clinical staff opted in. Providers received information about NMT and the NMT training opportunity from supervisors, team members, and a training announcement circulated by BHRS. Eligibility requirements were minimal for licensed clinicians and the provider's interest and commitment to the project were key selection criteria. Providers shared that they chose to participate in the training because they were already working with consumers with a history of trauma and adverse experiences. Providers indicated interest in strengthening their abilities to respond to and treat the impact of trauma. They also felt that the NMT approach sounded promising in helping to better serve the consumers with whom they were working.

NMT Training

The NMT training model relies on a case conference or group supervision approach with intensive, weekly self-study. In this approach, the providers attend an initial training and then begin implementing NMT. To conduct their self-study throughout training year, providers receive a detailed training syllabus with variety of training materials and resources and must participate in NMT study groups and learning communities. Clinicians also participate in a monthly meeting where they discuss real-life cases. These group discussions are the foundation for supervision of NMT implementation, provide opportunities for clinicians to refine their knowledge and skills, and allow for fidelity monitoring.

Providers shared that they found the NMT training interesting and they appreciated learning about the neurobiology and impact of trauma. Their increased knowledge and understanding about the impact of trauma has helped them better understand the behaviors and presentation of consumers. Many of the providers noted that their previous education and training did not necessarily include brain development. As the majority of providers who opted in are master's level clinicians, this training provided an opportunity for more advanced training in neuropsychology related to trauma. However, for providers

who have not had substantial training in neuropsychology, there may be a steeper learning curve to understand the NMT principles.

> *"NMT was recommended to me by my then supervisor… it sounded really logical and made a lot of sense, so I decided to do it. I liked that it was a new approach being applied to adults."*
> *–NMT Provider*

The NMT training uses a variety of instructional techniques that clinicians felt were helpful in promoting learning, particularly because much of the information was new. The training includes videos, lectures, recordings, readings, and other tools as well as exposure to real-life cases and scenarios. Providers mentioned that the case studies in particular helped give a broader understanding of the assessment process, theoretical underpinnings, and the types of interventions most likely to be successful. However, providers also acknowledged that the videos, readings, meetings, and trainings take dedication and require a lot of time in addition to their existing caseloads and other responsibilities.

> *"It's a bigger group [of trainees] and less train-the-trainers this year…[The mentorship to new trainees] was impacting our own daily work, but we've noticed it's impacting them, not having someone to talk to and ask questions. There was also more contact with the supervisor in the past, which helped them be more supportive of the process."*
> *–NMT Trainer*

As mentioned, BHRS also had 10 providers within the Child and Youth System of Care who became certified as NMT trainers. These providers bring more senior experience with implementing NMT. The trainers noted that this year's cohort of NMT trainees is larger than in previous years, primarily because of this INN project. In addition, in recent years, two trainers left BHRS due to job changes. As a result, there are more trainees per trainer and new trainees may not be getting as much mentorship and support as in previous years. Given the novel nature of the pilot, clinicians who are applying NMT in the adult mental health population may have a need for additional support and consultation to address questions and issues that arise related to modifying the program for adults.

NMT Consumer Population

Demographics

As mentioned previously, BHRS aims to serve three adult populations through the NMT pilot project: adult consumers (ages 26+) receiving specialty mental health services, TAY (ages 18-25) receiving mental health services, and criminal justice-involved consumers re-entering the community following incarceration.

During FY16-17, 20 adult consumers received NMT services, all of whom reflect the intended target population. Most consumers (n=13, 65%) were adults ages 26-59, while seven consumers (35%) were TAY.

No consumers were under the age 18. In addition, at least seven consumers (35%), including both adults and TAY, were also part of the re-entry population.[8]

Figure 3. NMT Consumer Population, FY16-17, N=20

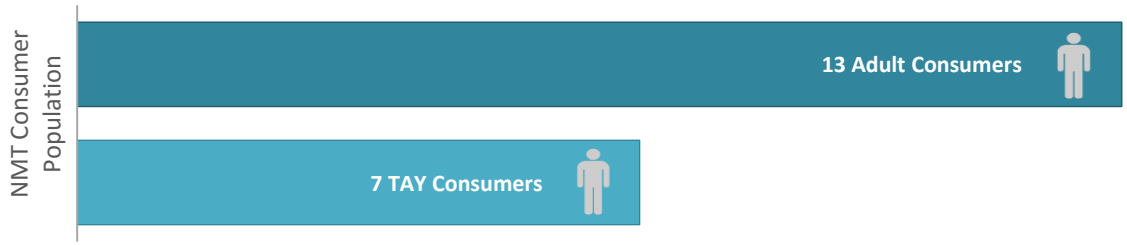


Table 2 describes the demographic characteristics of the NMT consumers. Two-thirds of consumers reported they were female (n=13, 65%) and one-third reported they were male (n=7, 35%); no consumers reported a different sex.[9] The largest racial group was White (n=8, 40%), while the remaining consumers reported Asian, Native Hawaiian or other Pacific Islander, Other, or more than one race.[10] Among the 19 consumers who reported their ethnicity, approximately one-third were Hispanic/Latino (n=7, 37%).

Nearly all consumers (n=16, 80%) spoke English as their primary language, while some consumers primarily spoke another language or more than one language. Of the 18 consumers who reported sexual orientation, the majority reported heterosexual (n=14, 78%) and the others reported LGBTQ+.[11] Over half of consumers (n=11, 69%) had a known disability, including a chronic health condition, an intellectual disability, or another type of disability. No consumers reported that they were a veteran.

Table 2. Demographic Characteristics of Consumers, FY16-17[12]

Characteristic	Consumers	% of Total
Gender (N=20)		
Female	13	65%
Male	7	35%
Race (N=20)		
White	8	40%
Other	12	60%
Ethnicity (N=19)		
Hispanic/Latino	7	37%

[8]Consumers were identified as part of the criminal justice/re-entry population if they received behavioral health services in custody, services through the BHRS mental health court, or services through a provider aimed at serving the re-entry population (e.g., Service Connect).

[9]Information regarding gender identity was not available for this report. However, BHRS is actively working to incorporate gender orientation questions into their EHR.

[10]In accordance with HIPAA, demographic categories comprised of fewer than five consumers were aggregated to protect consumer privacy.

[11]LGBTQ+ refers to lesbian, gay, bisexual, transgender, questioning or gender queer, intersex, asexual, or other sexual orientations.

[12]For some characteristics, information was unknown or not reported for all consumers. As a result, the total number of consumers may be less than 20.

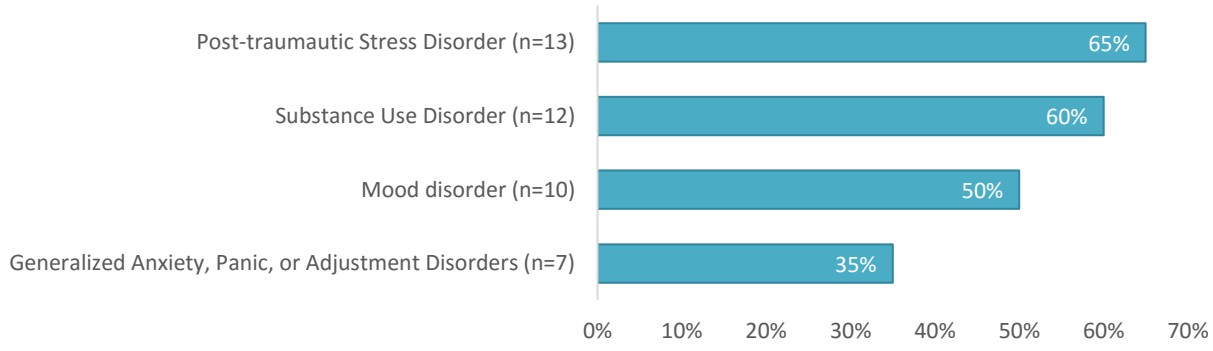
Characteristic	Consumers	% of Total
Not Hispanic/Latino	12	63%
Primary Language (N=20)		
English	16	80%
Other	4	20%
Sexual Orientation (N=18)		
Heterosexual	14	78%
Other	4	22%
Disability (N=16)		
Any Disability	11	69%
No Known Disability	5	31%

Clinical Profile

Consumers who participated in NMT had a variety of mental health diagnoses. Typically, the majority of adult consumers receiving specialty mental health services have been diagnosed with a psychotic disorder (e.g., schizophrenia or schizoaffective disorder) or a mood disorder (e.g., bipolar or major depressive disorders). However, the NMT population served in this first year of implementation had a wider variety of behavioral health diagnoses.

The majority of consumers (n=13, 65%) had a posttraumatic stress disorder (PTSD) diagnosis (Figure 4). Half of consumers had a primary or secondary diagnosis of a mood disorder (n=10, 50%). Additionally, 35% (n=7) were diagnosed with generalized anxiety, panic, or adjustment disorders. Over half of consumers (n=12, 60%) also had a documented substance use disorder. Of these 12 consumers, most reported using several substances, while some were diagnosed with specific cannabis, alcohol, or amphetamine use disorders.

Figure 4. Behavioral Health Diagnoses of NMT Consumers, N=20, FY16/17



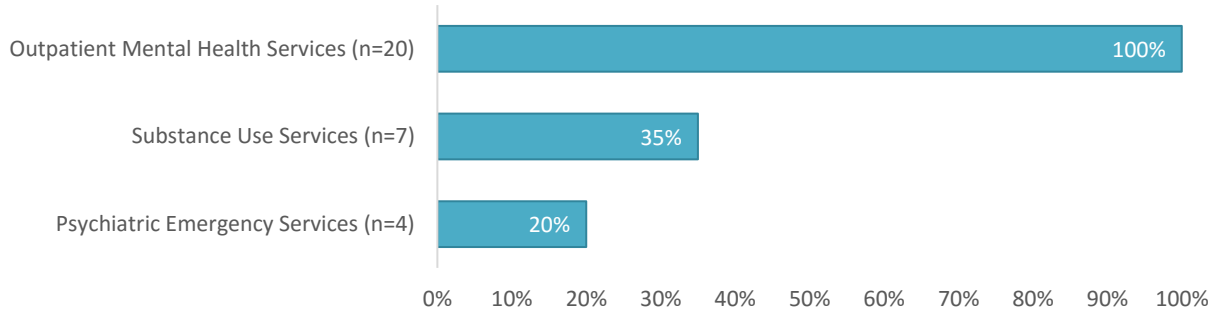
This variability in terms of specific diagnoses aligns with some of the diagnostic challenges that arise when working with individuals who have experienced significant trauma. Adults who have experienced trauma often have a more complex clinical presentation, frequently characterized by symptoms of anxiety, depression, and other mood fluctuation. Symptoms reflective of trauma may not clearly align to any one diagnosis within the existing diagnostic classification systems (e.g., DSM-IV TR or DSM-V). NMT consumers

were also more likely to have documented personality disorders, which may be indicative of pervasive childhood trauma. The clinical profile of NMT consumers may also suggest that providers are referring consumers with less intensive mental health needs (e.g., those without psychotic disorders) to the program. As more consumers participate in NMT, it will be possible to explore consumers' clinical profile in greater depth.

Behavioral Health Service Utilization

All consumers who received NMT services were enrolled in and receiving outpatient mental health services. This aligns with the model of integrating NMT within existing mental health services rather than creating a stand-alone program. In addition to outpatient mental health services, one-third of consumers (n=7, 35%) also participated in outpatient and/or residential substance use services; most of these consumers were involved with the criminal justice system. Additionally, in the year prior to NMT enrollment, 20% of consumers (n=4) experienced a mental health crisis that required psychiatric emergency services.

Figure 5. Behavioral Health Service Utilization, N=20, FY16-17



Preliminary Findings

Learning the NMT Assessment Tool and Consumer Selection

The NMT assessment process is fairly intensive, and includes a number of detailed questions to understand a consumer's developmental history and past experiences of trauma. For all new NMT trainees—in both adult and youth systems of care—it takes time for providers to learn and gain comfort with the assessment tool, which is a natural aspect of the training process. Providers in adult systems may also have a slightly steeper learning curve with the assessment, as these providers do not regularly conduct developmental histories with the adult population with the same level of detail required for the

> *"The first client I did the [NMT assessment] on, I knew he didn't have too much trauma. I purposely chose him for that reason because I could go through the assessment at a good pace and there would be minimal risk of re-traumatization."*
>
> *–NMT Provider*

NMT assessment. In contrast, taking detailed developmental history is a more common aspect of the intake and treatment process in youth systems of care. Nevertheless, as *all* NMT trainees first learn the assessment questions and process, the providers often administer the assessment in a direct way, going question by question. This approach may trigger or risk re-traumatizing consumers who are not accustomed to direct questions about past trauma and may not have developed the necessary coping skills. As providers become more experienced with the assessment and more familiar with the questions, providers often make the assessment more of a conversation and obtain the necessary information with less direct questions. This conversational approach may be less triggering for consumers.

When referring consumers to NMT, providers are mindful of their own comfort with the assessment. Providers mentioned that while the consumers that could most benefit from NMT are the ones with significant trauma, providers consider the risk of the assessment process based consumers' coping skills and ability to self-regulate as well as on providers' own experience with the assessment.

When weighing the risks of engaging in the assessment itself with the potential benefits of NMT, some of the factors that contributed to providers' clinical decision-making included:

- Providers' experience and comfort with the assessment questions and process;
- Providers' rapport and trust with the consumer;
- Consumers' willingness and ease in talking about their trauma; and
- Consumers' coping skills to manage whatever thoughts, feelings, and reactions that may arise as a result of the assessment.

In addition, some providers mentioned that they only referred higher functioning or stable consumers that are compliant with medication, not actively abusing substances, and are not floridly psychotic.

NMT Assessment Process

Assessment Differences between Children and Adults

As BHRS has already been implementing NMT with children, some providers serving both children and adults noted differences in the NMT assessment process. For children and youth, NMT assessment questions are often directed toward the caregiver or parent. In addition, child providers are often accustomed to taking detailed developmental histories and parents may be more accustomed to answering similar questions to those in the in the NMT assessment. For adults, the consumers are the primary respondents. However, adults may not be as used to providing developmental history about themselves, and providers may be less familiar with taking detailed

> *"I work with children and adults, and the children are a lot easier. With the adults, the assessment can trigger because they don't recall things or it brings up memories. So, we have to stop, and take a break. With one consumer, we're on the third session, and we're only halfway through the assessment."*
>
> *–NMT Provider*

developmental histories from adults. Providers noted three main factors that make it more challenging to administer and complete the assessments with adults than with children.

First, the adult consumer may not know or recall information about their childhood experiences. In comparison, for children, the information is more recent and parents may more easily recall experiences. For some adult consumers, not being able to answer all of the questions may result in anger or frustration, a sense of inadequacy, or feeling like they disappointed their provider. The consumers sometimes reach out to a family member to ask for additional information. Although this is not necessarily problematic, it could present challenges if the consumer is estranged from their family member or if the family relationships are unhealthy.

Second, as adult consumers may be less accustomed to discussing early experiences—including trauma—the developmental history questions may bring up emotions that the consumer is not prepared to manage. Some providers expressed concern that there may be a risk of re-traumatization for adult consumers in these situations, particularly for NMT trainees who are still learning the assessment and may be less experienced conducting developmental histories with adult consumers. This contributes to providers' decision to primarily refer higher functioning consumers and/or consumers who are comfortable discussing past experiences of trauma until the providers are more experienced in the NMT approach.

Third, the NMT assessments are more time consuming with adult consumers. For adults, the NMT assessment is longer because the assessment collects information for a consumers' entire developmental history—fetal stages through adulthood. For children, the assessment is shorter as it only collects information through the child's current developmental stage. The assessments are also more time consuming for adults if consumers cannot recall information and/or they need to take breaks or stop the assessment if it brings up difficult experiences.

NMT Assessment Adaptations

To address the concerns related to gaps in information or recollection, the length of the assessment, and the risk of re-traumatization, providers discussed how they are adapting the assessment process to the adult population. The primary adaptations to administering the assessment to the consumer were:

1) Breaking up the assessment over multiple visits if the consumer had reactions to the questions or struggled to focus long enough to complete the assessment; and
2) Asking broader questions or combining questions to help make the assessment more conversational, less burdensome, and less-time consuming for the consumer and to reduce the risk of re-traumatization.

It should be noted that the first strategy—breaking up the assessment—can be and is adopted by all NMT providers, regardless of their level of comfort and experience with the assessment. However, as mentioned previously, learning how to ask broader questions requires more familiarity with the assessment and practice taking developmental histories. As is to be expected, newer trainees who are still

learning the tool are more likely to ask the assessment questions as written, and learn to make the assessment more conversational as they progress through the training and gain more NMT experience.

> *"There are a lot of questions that ask similar things, so sometimes I'll just ask an adult, do you remember domestic violence in your early life? Then I'll ask if they remember around what age. So, I don't go through every stage because it would take too long, especially with lower functioning clients."*
>
> *–NMT Trainer*

During the assessment process, consumers may not be able to answer all questions, and providers are handling this inconsistently. Some providers noted that they sometimes give a "neutral" score to an item if the consumer does not know how to respond. Other providers stated that they sometimes reach out to an additional respondent who may have information about the consumer, such as another provider who is familiar with the consumer's history.

Another factor that appears to influence the assessment process is the relationship of the provider to the NMT consumer. Some clinicians are administering the assessment to consumers for whom they are the primary clinician. In this case, the consumer is already receiving mental health services from the clinician so the clinician is familiar with the consumer's mental health history. In other situations, the clinician administering NMT may administer the assessment to a consumer who is primarily being served by a different therapist. In this scenario, the NMT assessor completes the assessment and then serves as a consultant to the primary therapist for developing and implementing NMT-informed recommendations. The relationship of the assessor to the consumer may influence the consumer's level of comfort with the assessor as well as the assessment process (e.g., the consumer's willingness to share information, reliance on other providers to obtain information, etc.).

NMT Interventions

> *"It's not just what we're connecting them to, but how we do it…we build scaffolding and support…and take into account developmentally where they are socially."*
>
> *–NMT Provider*

The types of recommended interventions that NMT consumers receive depend on consumers' specific strengths and needs. As BHRS expands NMT to include adult consumers, the breadth of NMT interventions for adults has thus far been limited by available resources. Providers noted that many children's clinics already have tools and resources that could be used for NMT interventions, such as weighted blankets. Additionally, children have easier access than adults to adjunct therapies, such as occupational therapy, which are closely related to many of the NMT-informed recommendations. These kinds of resources and therapies are typically not as readily available in adult systems of care. Currently, BHRS is working to equip adult clinics with supplies that would be useful for NMT-informed interventions and is establishing relationships with other types of services and programs, such as yoga classes, drumming, a community pool, and animal-assisted therapy.

That being said, not all interventions require connections to external resources. Several providers noted they are incorporating NMT principles into the overall approach to care and treatment with the resources they have available. Some of these interventions include:

- Using treatment sessions to support consumers in a relationship they trust;
- Encouraging the consumer to sit in a park or attend a church or a community center for 15 minutes;
- Practicing social skills interactions with social behavior cards;
- Using parallel play with adults to support social development; and
- Having fidget spinners, weighted blankets, rocking chairs, and different kinds of lighting to make consumers more comfortable in therapy rooms.

Regardless of the specific intervention, providers agreed that any recommended NMT interventions must support consumers and align with consumers' unique needs—developmentally, functionally, and socially.

NMT Outcomes

Although the NMT pilot was still in the early phases of implementation during FY16-17, providers reported changes in their approach to care as a result of the NMT training. Providers also observed some positive consumer outcomes. These findings are preliminary and will be further explored with quantitative data as the program matures and more consumers participate in NMT.

Provider Approach to Care

> *"NMT can be geared more toward youth and children, and the fact that there's curiosity and engagement with NMT [in the adult system of care] is a big accomplishment."*
>
> *–NMT Provider*

Providers noted that being trained in NMT and the neurodevelopmental impacts of trauma has changed the way they approach care, regardless of whether they implement NMT with consumers. Moreover, providers observed that the presence of NMT is beginning to influence other providers who are not trained in NMT but work with NMT-trained providers. NMT-trained providers noted that they and non-NMT providers have made changes to their office set-up and have added objects in therapy rooms to increase consumer comfort. NMT-trained providers have also received requests to conduct NMT assessments for consumers who are not on their caseload. This suggests that training providers in the adult system of care in NMT principles may support adult clinics in being more trauma-informed and trauma-capable organizations overall.

Preliminary Consumer Outcomes

Although preliminary, providers noted that some consumers appear to be benefiting from the NMT approach. For example, providers suggested that while the NMT assessment process may be challenging for both providers and consumers, the assessment also appears to be helping some consumers process their experiences and better understand the impact that trauma has had on their current behaviors. Providers also reported that consumers appreciate and enjoy the NMT-informed interventions, particularly the interventions related to movement and music. One provider mentioned that she thinks NMT has helped one consumer better self-regulate and observed decreases in this consumer's impulsivity and suicidal ideation since beginning NMT interventions.

> *"The adults I'm working with, they're doing the rhythm and movement. It's starting to make sense to them and they want more of it."*
>
> *–NMT Provider*

Conclusion

During FY16-17, BHRS began the expansion and evaluation of NMT in an adult system of care, the first undertaking of its kind. Twelve providers within the BHRS Adult System of Care began NMT training and served 20 consumers from diverse populations. As was to be expected, providers experienced some difficulties in learning and adapting the NMT approach to an adult population. Some issues arose surrounding consumers' ability to recall information about past experiences, the length of the assessment, and the natural learning curve trainees experienced with learning and administering the NMT assessment with an adult population.

To address these issues, providers carefully select who they refer for NMT—typically referring higher functioning consumers until providers are more experienced and comfortable with the NMT assessment—and are adapting the assessment process to limit the burden on consumers and prioritize consumers' well-being. Given the positive reception by NMT-trained and non-trained providers alike, as well as indications that NMT is benefiting consumers, NMT shows promise in supporting the adoption of trauma-informed practices and treatment options in the BHRS Adult System of Care. Over the next year, BHRS and RDA will continue to evaluate implementation progress to identify facilitators, challenges, and possible recommendations for adapting NMT in an adult system of care and will continue to collect consumer-level data to examine changes in consumer outcomes.

Appendix. Adult Neurosequential Model of Therapeutics Evaluation Plan

Introduction

The Neurosequential Model of Therapeutics© (NMT) within the Adult System of Care was developed as part of the San Mateo Behavioral Health and Recovery Services (BHRS) three-year Mental Health Services Act (MHSA) Innovation plan. At their core, MHSA programs are intended to provide counties with funding to create fundamental changes to the access and delivery of mental health services. The goal of MHSA Innovation (INN) programs are to test novel approaches and interventions created by local communities through an inclusive Community Program Planning (CPP) process. INN programs seek to do the following:

- Increase access to mental health programs for underserved groups,
- Increase quality of services and outcomes, and
- Promote interagency collaboration.

Through the CPP process, BHRS identified the need to provide alternative treatment options to broaden and deepen the focus on trauma informed care and provide better outcomes in recovery for BHRS consumers. To address this need, BHRS proposed implementing the NMT approach within the BHRS Adult System of Care. NMT is an innovative approach to treating trauma, typically used with children, that is grounded in neurodevelopment and neurobiology.

BHRS intends to adapt, pilot, and evaluate the application of the NMT approach to an adult population in order to increase the quality of mental health services and recovery outcomes for adult mental health consumers with a history of trauma. The NMT pilot meets INN requirements as it represents a change to an existing practice which has not yet been demonstrated to be effective. This expansion and evaluation of NMT within an adult system of care will be the first of its kind.

The San Mateo County Board of Supervisors approved the Adult NMT project on May 24, 2016, and BHRS began implementation of the three-year pilot in September 2016. BHRS selected Resource Development Associates (RDA) to conduct a two-year evaluation of the adult NMT pilot project beginning in January 2017. The NMT evaluation is intended to help BHRS achieve the following objectives:

1. Meaningfully engage stakeholders throughout the evaluation process;
2. Measure the impact of the program;
3. Support data-driven decisions about program implementation and continuation;
4. Increase knowledge about what works in mental health and with the adult consumers; and
5. Comply with INN regulatory and reporting requirements.

NMT Literature Review: Support for NMT

NMT Background

Adverse childhood experiences (ACEs) (e.g., chronic stress, neglect, abuse, trauma, etc.) can profoundly impair neurodevelopment and brain functioning. Disordered brain functioning can in turn contribute to a myriad of physical, cognitive, emotional, and behavioral problems that may persist throughout the lifespan (Perry, Pollard, Blakly, Baker, & Vigilante, 1995; Felitti et al., 1998; Anda et al., 2006). The impact of adverse experiences on brain development and the resulting functional and behavioral issues also vary with the timing, severity, pattern, and nature of the trauma, as well as by the unique experiences and genetic characteristics of each individual. However, many treatment approaches designed to help individuals cope and progress in their recovery do not consider or adequately address the complexity and variability of neurodevelopmental impairment caused by childhood trauma.

The Child Trauma Academy (CTA) developed NMT as an alternative approach to trauma-informed treatment that is grounded in neurodevelopment and neurobiology (Perry, 2008). NMT is not a single therapeutic technique or intervention. Rather, NMT aims to guide the selection and sequence of a set of highly individualized educational, enrichment, and therapeutic interventions (e.g., therapeutic massage, drumming, yoga, expressive arts, etc.) that best match each NMT consumers' unique strengths and neurodevelopmental needs to help consumers better cope, self-regulate, and progress in their recovery. (Perry & Hambrick, 2008).

As trauma during brain development can lead to dysfunctional organization of neural networks and impaired neurodevelopment, the selected set of interventions are intended to help change and reorganize the neural systems to replicate the normal sequence of both brain and functional development (Perry & Hambrick, 2008). Interventions are selected to first target the lowest, most abnormally functioning parts of the brain. Then, as functional improvements are made, therapies are selected that target the next, higher brain region (Perry & Hambrick, 2008). The sequence of interventions aim to help consumers better cope, self-regulate, and progress in their recovery.

Since its development, NMT has been implemented in various behavioral health settings (Perry & Dobson, 2013), including BHRS which has been using the NMT approach with youth since 2012. To date, the number of studies evaluating the effectiveness of NMT are limited. However, some studies have found evidence of increased social-emotional development and improvements in problematic behavior in children receiving NMT (Barfield, Gaskill, Dobson, & Perry, 2012). In BHRS, among a sample of 10 youth receiving NMT assessments and interventions, all showed improved self-regulation, and two-thirds showed improvements in sensory integration, relational, and cognitive domain measures.

Application of NMT for Adults

Currently, NMT is most widely used with maltreated and traumatized children, and the use of NMT with adults is limited. However, there is a strong theoretical basis to predict that adult mental health consumers may also benefit from the NMT approach. As mentioned, NMT is built upon the premise that trauma can cause neurological damage and that sequential, neurodevelopmentally appropriate interventions can help improve coping skills and recovery outcomes.

A study of over 17,000 adults revealed a strong positive relationship between ACEs and the increased likelihood of behavioral health issues, suggesting disordered brain functioning in response to child trauma (Anda et al., 2006). In particular, adults who experienced four or more ACEs were 3.6 times more likely to be depressed, 2.4 times more likely to experience anxiety, 7.2 times more likely to suffer alcoholism, and 4.5 times more likely to use illicit drugs than adults with no ACEs (Anda et al., 2006). The relationship between trauma and mental health is further strengthened by the high prevalence of adult consumers with mental illness and/or substance use issues who also have experiences of trauma, approximately 40 to 80% (Missouri Institute of Mental Health, 2004). These findings suggest that interventions, such as NMT, that address the neurological impacts of trauma may be effective in helping consumers improve coping skills and achieve better recovery outcomes.

Despite the potential of using NMT with adults, there are also important differences between the adult and youth consumer populations that should be considered. In comparison to children, the extent of neurological damage is likely greater among adult mental health consumers who may suffer continued brain impairment beyond the effects of childhood trauma. For instance, many adult mental health consumers also have a history of long-term psychiatric medication usage as well as long-term substance abuse, both of which can further impair brain functioning.

In addition, initial studies of NMT have found the approach is most effective for children in safe, stable, and nurturing environments (Perry & Hambrick, 2008). However, many adult consumers may still be experiencing patterns of instability and trauma. One study found that nearly a third of mental health consumers had been victimized within the previous six months (Desmarais et al., 2014), while other studies found that consumers with serious mental illness are more than 10 times more likely to be homeless than the general population (Treatment Advocacy Center, 2016).

Nevertheless, the effectiveness of NMT in improving recovery outcomes in the adult population is unknown. As of yet, no outcome studies have been conducted to evaluate NMT in an adult population and NMT has not yet been formally implemented into an Adult System of Care. Given this opportunity and the preliminary success of NMT with youth, San Mateo BHRS has undertaken a project to adapt, pilot, and evaluate the application of the NMT approach to an adult population within the BHRS Adult System of Care.

San Mateo BHRS Adult NMT Pilot Project

NMT Providers

As mentioned previously, BHRS has been using the NMT approach with youth for the past five years. In that time, 10 BHRS providers have become certified NMT trainers. These NMT trainers cannot certify other providers in NMT; however, the trainers can provide consultation and teaching of NMT principles. In January 2017, 14 mental health clinicians began NMT training.[13] The clinicians work in a variety of settings within the BHRS Adult System of Care, including BHRS specialty mental health or regional clinics as well as programs targeted toward consumers re-entering the community following incarceration.

Target Population

The NMT providers will incorporate the NMT process into their clinical work, targeting three main populations of adult mental health consumers, including:

- General adult consumers receiving specialty mental health services,
- Transition age youth (TAY) consumers (ages 18-25), and
- Criminal justice-involved consumers re-entering the community following incarceration.

It is important to note that the three target populations likely have different experiences, needs, and coping skills and as a result, could respond to NMT differently. For example, TAY are still undergoing brain development and therefore may be more responsive to neurodevelopmental treatment approaches, such as NMT. The re-entry population may have different coping mechanisms than the general adult and TAY consumer populations, such as engaging in high risk behaviors that are more likely to lead to incarceration. In addition, for the re-entry population, the experience of incarceration could contribute to trauma.

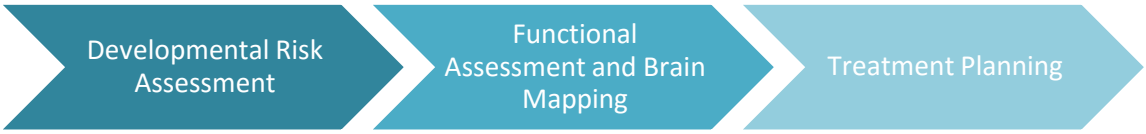
BHRS estimates that through the adult NMT pilot project, approximately 75 to 100 adult consumers will receive NMT-based services annually. Providers will refer existing BHRS consumers from their caseloads to NMT. Due to the novel nature of this pilot, clear selection criteria for adults referred to NMT have not yet been established. Although, adult consumers who will most benefit will likely have a history of crisis or trauma. Additionally, NMT is not intended for consumers diagnosed with serious psychotic disorders or who are currently cycling in and out of psychiatric hospitalization. As implementation progresses, BHRS will establish guidance in case selection with the support of NMT trainers and mentors.

[13]The formal training certification program takes place over one year, with trainees learning through a combination of readings, videos, webinars, and case-based trainings. Trainees begin implementing the NMT model with consumers shortly after the training commences and must conduct a minimum of 10 NMT assessments annually. In order to ensure fidelity to the NMT model, CTA requires that all certified NMT providers complete fidelity assessments twice annually, wherein the providers evaluate the same client data and inter-rater reliability scores are calculated.

NMT Process and Activities

The NMT approach helps clinicians identify the developmental strengths and challenges of each individual to help create an individualized treatment plan matching their unique developmental needs. As depicted in Figure 1, the NMT process consists of three main phases: 1) developmental risk assessment, 2) functional assessment and brain mapping, and 3) the development of individualized treatment recommendations. These phases are described in greater detail below. However, the elements of the NMT process and specific NMT-based services will likely be modified as the approach is adapted to the adult population.

Figure 6. Key phases of the NMT Process



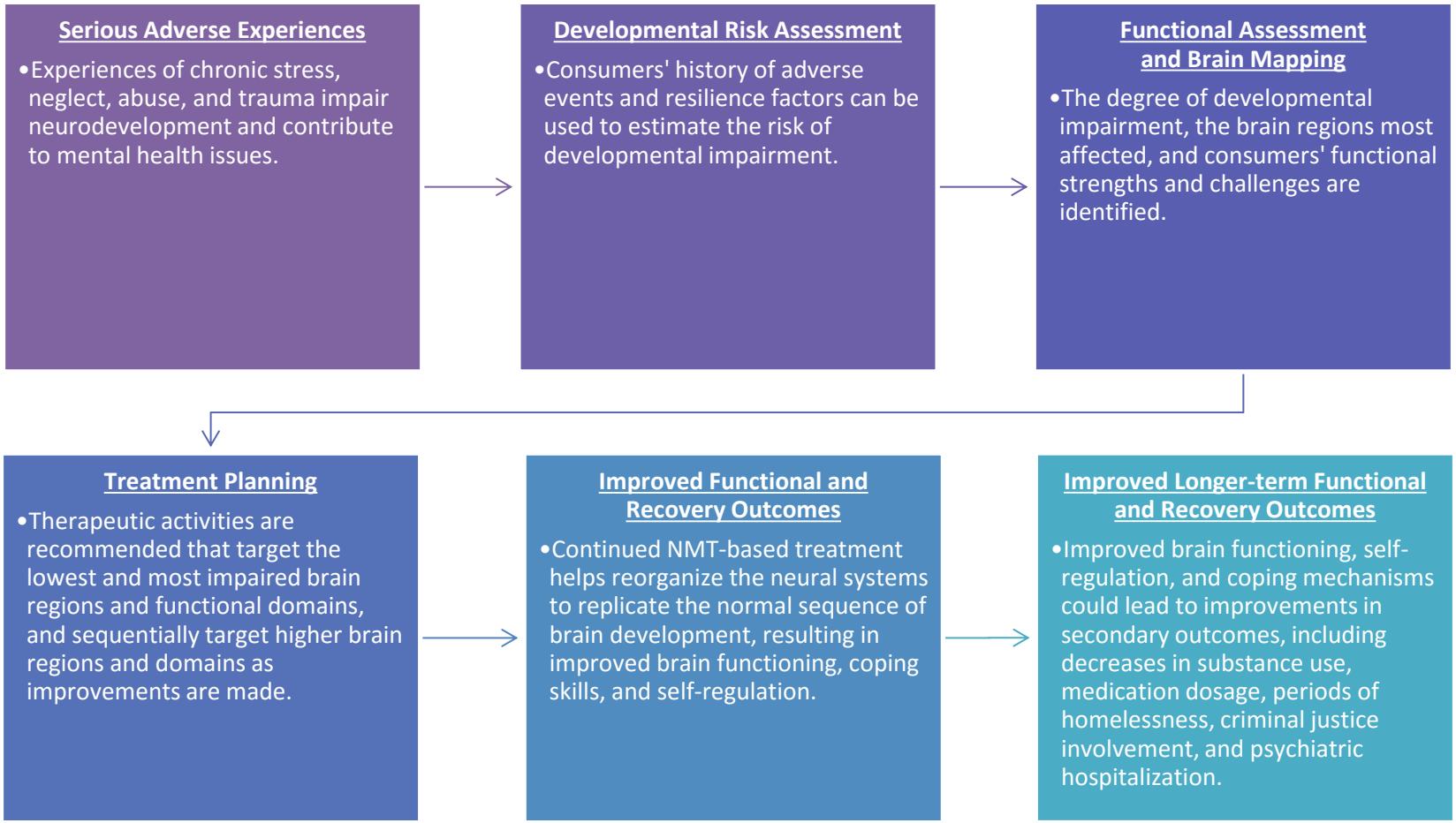
Developmental Risk Assessment. NMT-trained clinicians collect information pertaining to consumers' history of adverse experiences – including their timing, nature, and severity – as well as any protective factors to estimate the risk and timing of potential developmental impairment.

Functional Assessment and Brain Mapping. NMT-trained clinicians conduct an assessment various brain-mediated functions (e.g., heart rate, motor skills, short-term memory, speech and language, etc.) to develop a brain map identifying the brain regions most affected by developmental impairment. Through this "mapping" process, scores are calculated in four functional domains: 1) Sensory integration, 2) Self-regulation, 3) Relational, and 4) Cognitive. The functional domain values are then compared with age typical domain values to assess the degree of developmental impairment, identify the consumers' functional strengths and challenges, and track progress over time.

Treatment Planning. In the third phase of the NMT process, therapeutic activities are identified that address the consumers' needs in the four functional domains, first targeting the lowest brain regions with most severe impairment. For example, consumers with severely impaired self-regulation scores often have hyper-reactive response systems and may benefit from deep-breathing techniques and the use of weighted vests or blankets. Consumers impaired in the sensory integration domain may benefit from patterned, repetitive somatosensory activities such as drumming and yoga. Treatment may include a mix of activities that are tailored to each consumers' unique developmental needs and activity preferences.

Throughout treatment, functional assessment and brain mapping are performed at regular intervals to evaluate any changes in functional domains. As functional improvements are made, treatment recommendations are adapted, with therapeutic activities becoming more advanced and/or targeting higher brain regions. Ultimately, as NMT treatment progresses, it is expected that consumers will experience improved functional and recovery outcomes. The NMT process and outcomes pathway is summarized in Figure 7.

Figure 7. NMT Process and Outcomes Pathway



Evaluation Overview

Learning Goals and Evaluation Questions

BHRS developed two main learning goals for the NMT evaluation. The first learning goal pertains to the adaptation and implementation of the NMT approach in the adult consumer population, while the second learning goal pertains to the effectiveness and impact of the NMT approach in improving recovery outcomes. To further guide the NMT evaluation, RDA developed evaluation sub-questions associated with each learning goal. The learning goals and evaluation questions (EQ) are listed below.

Learning Goal 1: Can NMT, a neurobiology and trauma-informed approach, be adapted in a way that leads to better outcomes in recovery for BHRS adult consumers?

> **EQ 1.1.** How is the NMT approach being adapted to serve an adult population?
>
> **EQ 1.2.** Who is being served by the adult NMT project, what types of NMT-based services are consumers receiving, and with what duration and frequency?

Learning Goal 2: Are alternative therapeutic and treatment options, focused on changing the brain organization and function, effective in adult consumers' recovery?

> **EQ 2.1.** To what extent is the NMT approach supporting improvement in adult consumers' functional outcomes and overall recovery and wellbeing?
>
> **EQ 2.2.** To what extent is the experience of care with the NMT approach different from consumers' previous care experiences?

Evaluation Strategy

RDA will implement a mixed methods evaluation that is collaborative and emphasizes continuous quality improvement.

Mixed Methods. A mixed methods approach utilizes both qualitative and quantitative data to address the research questions. Utilizing mixed methods allows the evaluator to identify the correlation between program participation and outcomes and also identify the program strengths and challenges from the participants' perspective. This allows program staff to make adjustments to the program in real-time.

Collaborative. RDA conceptualizes its role as research partners rather than outside evaluators. In this approach, BHRS staff, service recipients, and other invested parties work collaboratively with evaluators to articulate program goals, develop outcome measures, and interpret and respond to evaluation findings.

Continuous Program Improvement. RDA will work with BHRS and its stakeholders to build capacity for evaluation and engage in ongoing continuous program improvement. Continuous program improvement

is a framework by which evaluation is not a one-time event, but an ongoing way of providing data for the program to use to strengthen program design and implementation.

Data Collection and Analysis

In order to develop a comprehensive understanding of program implementation and impact, BHRS and RDA identified a number of expected measurable outcomes including process outcomes, clinical outcomes, functional and recovery outcomes, and consumers' experience of care. Process outcomes will largely be descriptive, and will include documentation of any training and NMT implementation activities, the number of consumers served, and the types of services provided. Consumer-level outcomes, including clinical, functional, and recovery outcomes, will be evaluated before and during NMT treatment to assess the impact of NMT services.

During the first year, the evaluation will focus on collecting and analyzing process outcomes to assess NMT implementation, as well as collecting individual-level clinical, functional, and recovery baseline data. The second year will focus on measuring progress in NMT implementation and changes in clinical, functional, and recovery outcomes from baseline. Throughout both years, RDA will provide technical assistance to BHRS staff implementing the NMT intervention to support their ability to collect client data.

BHRS and RDA identified a number of data sources to collect outcome measures, including NMT metrics, the NMT treatment plan, Avatar electronic health records, the NMT consumer form, and focus groups with NMT providers and with NMT consumers. Table 3 lists the expected measurable outcomes as well as the data sources that will be used to collect each outcome measure. The data sources are described in greater detail below. In addition, Table 5 in Appendix I summarizes the data sources and information that will be used to address each learning goal and evaluation question, and Table 6 in Appendix II outlines the specific data requested.

Table 3. Expected Measurable Outcomes and Data Sources

Outcome Type	Outcome Measures	Data Sources
Process Outcomes	Clinician experience of NMT training and implementation	Provider Focus Group
	Number and demographics of consumers participating in NMT services	Avatar Electronic Health Records (EHR)
	Number and type of NMT services provided	NMT Treatment Plan
Clinical Outcomes	Changes in brain map values	NMT Database
	Changes in functional domain values	NMT Database
Shorter-term Functional and Recovery Outcomes	Changes in coping skills and self-regulation	Consumer & Provider Focus Groups
	Continued participation in NMT services	NMT Database
	Continued participation in BHRS outpatient services	Avatar EHR
Longer-term Functional and Recovery Outcomes	Changes in substance use	Avatar EHR
	Changes in medication dosage	NMT Consumer Form
	Changes in homelessness	NMT Consumer Form
	Changes in criminal justice involvement	NMT Consumer Form
	Changes in psychiatric hospitalization	Avatar EHR

Outcome Type	Outcome Measures	Data Sources
Experience of Care	Consumer experience of NMT services and perceived impact	Consumer Focus Group

Data Sources

NMT Metrics. RDA will work with CTA and BHRS to obtain NMT Metrics with which to measure clients' functional domain values. NMT metrics will be obtained from consumers' initial NMT brain mapping and at agreed upon intervals thereafter (e.g., every six months). The NMT functional domain values will be used to establish consumers' baseline functioning at service start and documenting any change that occurs over the course of service delivery. To the extent that adult age typical functional domain values are available, RDA will also compare BHRS consumers' functional domain scores to age typical values to assess the degree of impairment and progress toward age typical functioning.

NMT Treatment Plan. RDA will work with BHRS to obtain information from consumers' treatment plans at agreed upon intervals. The NMT Treatment Plans include information about the types of treatment or activities that are recommended, treatment received, and any progress notes. This information will be used to assess NMT treatment participation and adherence to the service plan.

Avatar Electronic Health Record Data. RDA will work with BHRS to obtain relevant consumer-level information from BHRS' electronic health record (EHR) system, Avatar. Information obtained from the EHR may include client demographic information, clinical diagnoses, BHRS mental health service utilization, and psychiatric hospitalization. EHR Data will be requested for the year prior to NMT enrollment as well as during NMT participation to assess any changes in mental health service utilization during NMT treatment.

NMT Consumer Form. RDA developed a NMT consumer form to capture additional consumer-level information that is not currently captured or not readily extractable from existing data sources. The NMT consumer form includes information regarding consumers' current psychiatric medication, substance use, housing and homelessness, and criminal justice system involvement (e.g., arrests and incarcerations). NMT providers will administer the consumer form during NMT assessments at agreed upon intervals (e.g., once a month). This information will be used to assess changes in longer-term functional and recovery-oriented outcomes throughout NMT participation (e.g., changes in the frequency or duration of incarcerations or arrests, frequency of substance use, and medication dosage). The NMT consumer form is available in Appendix III.

Focus Groups with Providers Trained in NMT. RDA will facilitate focus groups with BHRS Adult System of Care staff who were trained in the NMT model. During the first year of the evaluation, these focus groups will explore providers' experiences with the NMT training and initial application of the NMT model, including the quality and applicability of their training in NMT, successes and challenges in adapting the model for adult consumers, and the integration of the brain mapping and other elements of the NMT approach into their existing service delivery processes. During the second year of the evaluation, the focus groups with providers will assess how their experiences using the NMT approach have changed over time, any new successes or challenges that have emerged, and their perceptions of the impact of the NMT

approach on client wellbeing, including improvements in functional and recovery outcomes. The focus group protocol is available in Appendix IV.

Focus Groups with Clients Participating in NMT. During the second year of the evaluation, RDA will facilitate focus groups with adult BHRS clients who have received the NMT-based services. During the first year of the evaluation, the focus groups will ascertain clients' experiences with the NMT approach, how NMT services differ from other mental health services received, and consumers' perception of the impact of NMT on their own wellness and recovery. Before beginning the focus groups, the intention of the focus groups will be explained and informed consent will be obtained from all consumers. The focus group protocol is available in Appendix IV and the consent form is available in Appendix V.

Data Analysis

RDA will begin our analysis by organizing and cleaning the NMT and client-level data as well as information from the focus groups. To analyze the quantitative data we will conduct both descriptive and inferential statistics, as appropriate, to describe the outcomes as well as to identify changes over time. To assess process outcomes, descriptive statistics will primarily be used, while pre-post analyses will be used assess changes in clinical, functional, and recovery outcomes before and during NMT services.

Qualitative data will inform both the process and consumer outcomes. To evaluate qualitative data, focus group participants' responses will be transcribed so that participants' responses and reactions are appropriately captured. RDA will then thematically analyze responses from participants to identify any recurring themes and key takeaways from the focus groups. RDA will triangulate qualitative findings with quantitative findings to develop a complete picture of the extent to which the NMT goals have been achieved.

Reporting

On an annual basis, RDA will draft a report that provides a comprehensive understanding of the implementation and impact of the NMT project to date as well as comply with new MHSA INN regulations. The report will address the learning goals and evaluation questions, including an information about the progress of NMT implementation and related process outcomes, preliminary outcome measures, and recommendations for actionable program improvements.

Findings will be shared with relevant BHRS staff through a findings work session prior to drafting the report. This work session will give BHRS staff an opportunity to interpret and respond to findings as well as provide feedback. Following the work session, RDA will draft the annual report and send it to BHRS for review. RDA will then address and incorporate BHRS feedback, finalize the report, and send it to BHRS for submission to the Mental Health Services Oversight and Accountability Commission (MHSOAC). The final report will then be available for presentation to the MHSA Steering Committee and the Stakeholder Advisory Committee.

Timeline

The NMT evaluation is a two-year evaluation, beginning in January 2017 and running through December 2018. Table 4 below provides an outline of evaluation activities over the two year evaluation period, including the organization responsible for conducting each activity (i.e., RDA and/or BHRS). RDA understands that program needs develop and evolve, so RDA will be flexible in adapting the evaluation timeline to align with BHRS needs. RDA will confer with BHRS when creating any modifications to the evaluation timeline.

Table 4. NMT Evaluation Activities Timeline

Phase	Major Activities	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Year 1 (2017)	Project Kickoff Meeting (RDA & BHRS)	■											
	Evaluation Planning (RDA & BHRS)	■	■	■	■	■	■	■	■				
	Compile and Send NMT Consumer Data (BHRS)									■			
	Focus Groups: Service Providers and Consumers (RDA)										■		
	NMT Data Analysis (RDA)									■	■		
	Findings Work Session (RDA & BHRS)										■		
	Draft Annual Report (RDA)										■	■	
	Review Report and Provide Feedback (BHRS)												■
	Finalize Annual Report (RDA)												■
	Submit Annual Report to MHSOAC (BHRS)												X
Year 2 (2018)	Compile and Send NMT Consumer Data (BHRS)								■	■			
	Focus Groups: Service Providers and Consumers (RDA)									■	■		
	NMT Data Analysis (RDA)										■	■	
	Findings Work Session (RDA & BHRS)											■	
	Draft Annual Report (RDA)											■	■
	Review Report and Provide Feedback (BHRS)												■
	Finalize Annual Report (RDA)												■
	Submit Annual Report to MHSOAC (BHRS)												X
Ongoing	Regular Meetings and Communication (RDA and BHRS)	■	■	■	■	■	■	■	■	■	■	■	■
	Technical Assistance (RDA)	■	■	■	■	■	■	■	■	■	■	■	■

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Information Collected for Evaluation Questions

Table 5. Data Sources and the Evaluation Questions Addressed

Data Source	Information Collected	Learning Goal 1		Learning Goal 2	
		EQ 1.1	EQ 1.2	EQ 2.1	EQ 2.2
NMT Metrics	• Brain Map Values • Functional Domain Values			✓	
NMT Treatment Plan	• Recommended Treatment • Treatment Participation		✓	✓	
Avatar Electronic Health Records	• Demographic Information • Clinical Diagnosis • BHRS Mental Health Service Utilization • Psychiatric Hospitalization • Substance Use		✓	✓	
NMT Consumer Form	• Current Psychiatric Medication • Housing and Homelessness • Criminal Justice System Involvement (Arrests and Incarcerations)		✓	✓	
Focus Groups with NMT Providers	• Providers' experience with NMT training and implementation • Successes and challenges in adapting NMT to adults • Providers' perceived impact of NMT on consumers' recovery and wellbeing	✓	✓	✓	
Focus Groups with NMT Consumers	• Consumers' experience of NMT services and activities • Consumers' perceived impact of NMT on their recovery and wellbeing			✓	✓

NMT Data Request

Description: The table below lists the data requested for every adult consumer who was or is currently enrolled in BHRS NMT services as of the end of the given fiscal year (i.e., June 30th). Data for the previous fiscal year(s) will be requested once annually, in September. The asterisks (*) denote specific consumer data that is requested by the MHSOAC for the Annual Innovative Project Report.

Table 6. Data Requested for Adult NMT Consumers

Domain	Categories	Variables	Data Source	Time Period
Consumer Information	Identifying Information	Medical Record/Mental Health Number	Avatar Electronic Health Records	Most Recent Information
		Client Name		
	Demographic Information*	Date of Birth*		
		Gender*		
		Race*		
		Ethnicity*		
		Primary Language*		
		Sexual Orientation*		
		Veteran Status*		
	Physical or Mental Impairment*	Difficulty hearing, speaking, communicating*		
		Limited physical mobility*		
		Learning disability*		
		Chronic health conditions*		
		Other disabilities/health conditions*		
	Clinical Diagnoses	Primary diagnosis code		
		Primary diagnosis description		
		Secondary diagnosis code		
		Secondary diagnosis description		
		Substance use disorder diagnosis		
Psychiatric Medication Prescriptions	Identifying Information	Medical Record/Mental Health Number	Avatar Electronic Health Records – Order Connect	All Data during NMT Enrollment
		Client Name		
	Medication	Medication Name		
		Medication Dosage		
		Instructions for Use		
Substance Use, Housing, and Criminal Justice	Substance Use	Substances used	Avatar Electronic Health Records – NMT Consumer Form (to be added)	All Data during NMT Enrollment (Not yet collected)
		Substance use frequency		
		Substance use route of administration		
	Housing Status	Residence last night		
		Nights homeless in last month		
	Criminal Justice Involvement	Arrests in last month		
		Incarcerations in last month		
BHRS Mental Health and Substance Use Service Utilization	Identifying Information	Medical Record/Mental Health Number	Avatar Electronic Health Records	All Data during NMT Enrollment and Previous Year
		Client Name		
	Service Episode Information	Episode Number		
		Provider Organization/Level of Care (e.g., Outpatient, Adult Residential, etc.)		
		Program Name		
		Episode Opening Date		

Domain	Categories	Variables	Data Source	Time Period
		Episode Closing Date		
	Service Encounter Information	Service Code		
		Service Description		
		Date of Service		
		Service Length (minutes)		
Psychiatric Inpatient and Emergency Service Utilization – Service Episodes	Identifying Information	Medical Record/Mental Health Number	Billing/Claims Data	All Data during NMT Enrollment and Previous Year
		Client Name		
	Episode Information	Episode Number		
		Provider Organization/Level of Care (e.g., Psychiatric Emergency Services, Psychiatric Inpatient, etc.)		
		Program Name		
		Episode Admission Date		
		Episode Discharge Date		
		Service Length (days)		
NMT Assessments and Metrics	Identifying Information	Medical Record/Mental Health Number	CTA NMT Database	All Data during NMT Enrollment
		Client Name		
	Assessment Information	Assessment Date		
		Assessment Type (e.g., Initial assessment, Follow-up assessment)		
	NMT Metrics	Developmental History Values		
		Functional Brain Map Values		
		Functional Domain Values		
	NMT Treatment Plan	NMT Treatment Recommendations		

Adult NMT Consumer Form

Instructions: These questions are intended to provide information about adult NMT consumers' substance use, housing status, and criminal justice involvement. Please administer the questionnaire to consumers every six months during the NMT assessment. Please inform the consumers that this information will only be used to identify any changes throughout NMT participation, and there will be no repercussions for any illicit activity. Additionally, consumers can choose not to respond to any questions they feel uncomfortable answering.

1. a. In the past 30 days, did you use the following substances (if any)?

   b. If yes, how frequently did you use the substance and what was the primary route of administration?

Substance Type	Y/N	Frequency (check one)	Route (check one)
a. Alcohol	☐ Yes ☐ No ☐ Don't Know ☐ Refused to Answer	☐ Daily ☐ Several times a week ☐ Every weekend ☐ A few times a month ☐ Once ☐ Don't Know ☐ Refused to Answer	☐ Oral ☐ Nasal ☐ Smoking ☐ Injection ☐ Don't Know ☐ Refused to Answer
b. Cocaine/Crack	☐ Yes ☐ No ☐ Don't Know ☐ Refused to Answer	☐ Daily ☐ Several times a week ☐ Every weekend ☐ A few times a month ☐ Once ☐ Don't Know ☐ Refused to Answer	☐ Oral ☐ Nasal ☐ Smoking ☐ Injection ☐ Don't Know ☐ Refused to Answer
c. Hallucinogens (PCP, LSD, Mushrooms, Mescaline/Peyote)	☐ Yes	☐ Daily	☐ Oral

Substance Type	Y/N	Frequency (check one)	Route (check one)
	☐ No ☐ Don't Know ☐ Refused to Answer	☐ Several times a week ☐ Every weekend ☐ A few times a month ☐ Once ☐ Don't Know ☐ Refused to Answer	☐ Nasal ☐ Smoking ☐ Injection ☐ Don't Know ☐ Refused to Answer
d. MDMA (Ecstasy, Molly)	☐ Yes ☐ No ☐ Don't Know ☐ Refused to Answer	☐ Daily ☐ Several times a week ☐ Every weekend ☐ A few times a month ☐ Once ☐ Don't Know ☐ Refused to Answer	☐ Oral ☐ Nasal ☐ Smoking ☐ Injection ☐ Don't Know ☐ Refused to Answer
e. Methamphetamine or other Amphetamines	☐ Yes ☐ No ☐ Don't Know ☐ Refused to Answer	☐ Daily ☐ Several times a week ☐ Every weekend ☐ A few times a month ☐ Once ☐ Don't Know ☐ Refused to Answer	☐ Oral ☐ Nasal ☐ Smoking ☐ Injection ☐ Don't Know ☐ Refused to Answer
f. Synthetics (Spice, Flakka, Bath Salts)	☐ Yes ☐ No ☐ Don't Know ☐ Refused to Answer	☐ Daily ☐ Several times a week ☐ Every weekend ☐ A few times a month	☐ Oral ☐ Nasal ☐ Smoking ☐ Injection

Substance Type	Y/N	Frequency (check one)	Route (check one)
		☐ Once ☐ Don't Know ☐ Refused to Answer	☐ Don't Know ☐ Refused to Answer
g. Inhalants	☐ Yes ☐ No ☐ Don't Know ☐ Refused to Answer	☐ Daily ☐ Several times a week ☐ Every weekend ☐ A few times a month ☐ Once ☐ Don't Know ☐ Refused to Answer	☐ Oral ☐ Nasal ☐ Smoking ☐ Injection ☐ Don't Know ☐ Refused to Answer
h. Other Downers (Ketamine, GHB)	☐ Yes ☐ No ☐ Don't Know ☐ Refused to Answer	☐ Daily ☐ Several times a week ☐ Every weekend ☐ A few times a month ☐ Once ☐ Don't Know ☐ Refused to Answer	☐ Oral ☐ Nasal ☐ Smoking ☐ Injection ☐ Don't Know ☐ Refused to Answer
i. Other Prescription Drugs (Benzodiazepines, Barbiturates)	☐ Yes ☐ No ☐ Don't Know ☐ Refused to Answer	☐ Daily ☐ Several times a week ☐ Every weekend ☐ A few times a month ☐ Once ☐ Don't Know ☐ Refused to Answer	☐ Oral ☐ Nasal ☐ Smoking ☐ Injection ☐ Don't Know ☐ Refused to Answer

Substance Type	Y/N	Frequency (check one)	Route (check one)
j. Other: _____	☐ Yes ☐ No ☐ Don't Know ☐ Refused to Answer	☐ Daily ☐ Several times a week ☐ Every weekend ☐ A few times a month ☐ Once ☐ Don't Know ☐ Refused to Answer	☐ Oral ☐ Nasal ☐ Smoking ☐ Injection ☐ Don't Know ☐ Refused to Answer

2. Where did you sleep last night?

☐ Own house or apartment
☐ Family home
☐ Couch or someone else's home
☐ Transitional housing
☐ Emergency shelter
☐ Streets
☐ Other: _____
☐ Don't Know
☐ Refused to Answer

3. In the past 30 days, how many nights did you spend homeless, if any (e.g., on the streets, in a car, an emergency shelter, someone's couch or home without paying rent, etc.)?

# of Homeless Nights: _____ ☐ Don't Know ☐ Refused to Answer

4. In the past 30 days, how many times were you arrested, if at all?

# of Arrests: _____ ☐ Don't Know ☐ Refused to Answer

5. In the past 30 days, how many nights did you spend in jail/prison, if any?

# of Nights in Jail: _____ ☐ Don't Know ☐ Refused to Answer

NMT Provider Focus Group Protocol

Thank you for making time to join our focus group today. My name is _____ and this is _____. We are with a consulting firm from Oakland, California called Resource Development Associates (RDA) and we were hired by San Mateo Behavioral Health and Recovery Services (BHRS) to evaluate BHRS' implementation of the Neurosequential Model of Therapeutics (NMT) program within the Adult System of Care. As part of this evaluation, we will be conducting focus groups with staff members, as well as consumers, to better understand program processes and outcomes as well as the strengths and challenges of implementing NMT in the Adult System of Care. We're here to talk to you today about your experiences as NMT providers.

I will be facilitating this focus group and _____ is here to take notes. Please note that what you say in this focus group will remain anonymous, but we will be taking notes of the discussion. My role as the facilitator means that it is my job to ensure everyone has a chance to say what is on his or her mind in a respectful way. We have a few guidelines to help us do that. Please:

- Silence your cell phones
- There are no "wrong" or "right" opinions, please share your opinions honestly
- Engage in the conversation
- Listen to understand
- Be curious about others' opinions
- Limit "side conversations" or "cross talk" so that everyone can hear what is being said
- Your names will not be linked to any comments unless we specifically ask if we can use your comment as a quote

Does anyone have any questions before we begin?

Introductions

Before we get started I would like everyone to answer these two questions:

- What is your name?
- What is your position/role?

NMT Training

1. Please describe the NMT training you received.
    a. Where are you in your NMT training?
    b. What has been challenging about the training? Working well?
    c. What types of ongoing training and/or support do you receive?

NMT Referral/Recruitment

2. Could you describe the recruitment or referral process for the NMT?
    a. What is the consumer population that you are serving?
    b. How do you identify consumers that may benefit for NMT?
    c. What information do you provide to consumers about the NMT program?
    d. What about the referral and recruitment process is working well? What is not working well?

NMT Services

3. Could you describe the NMT assessment process?
    a. What is working well about the assessment process? What has been challenging?
    b. How do consumers respond to the NMT assessments?
    c. What information, if any, do you share with consumers?

4. Could describe the NMT services and activities?
    a. How often do you meet with consumers?
    b. How do you decide the treatment plan? What types of activities are included?
    c. How do you involve the consumer in the treatment planning?
    d. How do you involve family members or their social network in the treatment planning?
    e. How do NMT services differ from other mental health services you have provided?

5. Thinking about consumers who are doing well, what has been helpful in getting them to participate in NMT treatment or what has helped them in their recovery?
    a. What makes it difficult to get consumers to engage in treatment?
    b. What strategies do you use in those situations where the consumer is difficult to engage?

Overall Experience and Perspective

6. From your perspective, what has been working well about implementing NMT with the adult population? What has been challenging?
    a. What could be done to improve the NMT approach among the adult population?

7. From your perspective, how would you describe the impact of the NMT approach on consumers?
    a. Changes in coping mechanisms and self-regulation?
    b. Changes in other wellness and recovery outcomes?

8. Think about your team, what is something you are most proud of?

9. Is there anything else you would like to add?

Thank you for your time! We value your input and appreciate you sharing your experiences with us.

NMT Consumer Focus Group Protocol

Thank you for making the time to join our focus group today. My name is _____ and this is _____. We are with a consulting firm from Oakland, California called Resource Development Associates (RDA) and we were hired by San Mateo Behavioral Health and Recovery Services (BHRS) to evaluate BHRS' implementation of the Neurosequential Model of Therapeutics (NMT) program within the Adult System of Care. As part of this evaluation, we will are conducting focus groups with people who have participated in the NMT program to understand how the program is working and what people like you are experiencing.

I will be facilitating this focus group and _____ is here to take notes. Please note that what you say in this focus group will remain anonymous, but we will be taking notes of the discussion. My role as the facilitator means that it is my job to ensure everyone has a chance to say what is on his or her mind in a respectful way. We have a few guidelines to help us do that. Please:

- Silence your cell phones
- There are no "wrong" or "right" opinions, please share your opinions honestly
- Engage in the conversation
- Listen to understand
- Be curious about others' opinions
- Limit "side conversations" or "cross talk" so that everyone can hear what is being said
- Your names will not be linked to any comments unless we specifically ask if we can use your comment as a quote

Does anyone have any questions before we begin?

Introductions

Before we get started let's go around the room and have everyone share:

- Your name
- Where you're from

Referral Process

1. How did you learn about NMT?
    a. Who referred you?
    b. What type of information did you receive about NMT?
    c. Why did you decide to participate in NMT?

NMT Experience

2. How would you describe the NMT assessment (e.g., risk assessment, brain mapping, etc.)
    a. What kinds of questions do they ask you?
    b. Is there anything about the assessment that feels stressful?
    c. Is there anything the provider does to make it less stressful? Anything you do?
    d. What kinds of information about the assessment did the provider share with you?

3. How would you describe the NMT treatment you have received (e.g., yoga, drumming, art, etc)?
    a. What kinds of activities did the provider recommend? What kinds of activities are you doing?
    b. How did the provider decide the activities?
    c. How are you involved in planning NMT activities?
    d. How is your family involved in the NMT activities?
    e. How often do you participate in NMT activities?
    f. Have the activities been like what you thought they would be?
    g. How have NMT services differed from other mental health services you have received in the past?

4. How has NMT helped you?
    a. What do you like about the NMT program?
    b. What has been challenging?
    c. What has helped you continue to participate in the different activities?

Consumer Perceptions and Recommendations

5. What is the best part about NMT?

6. What is something you would do or change to make NMT better?

7. What is something you would add or include in the program, that isn't already happening?

8. What have been some of your accomplishments since starting NMT services?
    a. What has helped you achieve this?

9. Is there anything else you'd like to add that we haven't already talked about?

Thank you for your time! We really value your input and appreciate you sharing your experiences with us.

Focus Group Consent Form for NMT Consumers

Before we start the focus group, we want to make sure you understand what our questions are about and that you give us your informed consent to participate. Please take as much time as you need to review this form.

San Mateo Behavioral Health and Recovery Services (BHRS) has hired Resource Development Associates (RDA), a planning and evaluation organization in Oakland, to evaluate the implementation and impacts of the BHRS' Neurosequential Model of Therapeutics (NMT) program within the Adult System of Care. We are having group discussions with individuals such as yourselves to help BHRS better understand your experiences with NMT services.

Participating in this focus group is voluntary, and you may decide to stop participating at any point. We are interested in hearing about your experiences with NMT services, including the referral process, the types of NMT services and activities you participated in, how your experience with NMT differs from other services you have received, your relationships and interactions with the NMT providers, as well as any accomplishments you have experienced since beginning NMT services. We are also interested in hearing your suggestions about how you would improve NMT services.

We will not ask about your personal history, and you should only share what you feel comfortable sharing. The information you share will be kept private and anonymous. If you do not want to be part of the focus group, it will not affect any services or treatment you receive now or in the future.

If you have any questions about the focus group, please contact Roberta Chambers at (510) 984-1478 or rchambers@resourcevelopment.net

I understand that:

- *I am free to decide not to participate in the focus group*
- *I can change my mind at any time about participating*
- *I do not have to share any information that I do not feel comfortable sharing*
- *If I choose not to participate, it will not affect the treatment and services I receive*
- *My name will not be used as part of the information gathered during the focus group*

By signing this form, you are saying that you understand what the focus group is about, that you have been given the above information, and that you are agreeing to participate voluntarily.

_____

Print Name of Participant

_____

Signature of Participant DATE