



SAN MATEO COUNTY HEALTH

BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Services Act (MHSA) Innovation Project Plan

County Name: San Mateo

Date submitted:

Project Title: Co-location of Prevention Early Intervention Services in Low-Income Housing

Total amount requested: \$925,000 (\$750K services; \$100K admin; \$75K eval)

Duration of project: 3.9 years

Section 1: Innovations Regulations Requirement Categories

GENERAL REQUIREMENT:

An Innovative Project must be defined by one of the following general criteria:

- Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention**
- Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

PRIMARY PURPOSE:

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement.

- Increases access to mental health services to underserved groups**
- Increases the quality of mental health services, including measured outcomes
- Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- Increases access to mental health services, including but not limited to, services provided through permanent supportive housing





Section 2: Project Overview

PRIMARY PROBLEM:

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

Young Adults and Mental Health

According to the National Institute of Mental Health, young adults (18-25 years) have the highest prevalence of mental illness, including severe mental illness.¹ However, young adults with mental illness receive mental health treatment at a lower rate than adults. Young adults also have higher rates of co-occurring mental illness and substance use disorders. In 2018:

- About one in four young adults aged 18 to 25 (26.3%) had any mental illness in the past year and 7.7% had a serious mental illness;
- 7.2% of young adults had co-occurring mental illness and substance use disorder.²

In San Mateo County, about 4.9% (413) of eligible Medi-Cal 18 to 20-year-old beneficiaries received specialty mental health services. Behavioral Health and Recovery Services, Youth to Adult Transition Program provides intensive mental health services to 18 to 25-year-olds eligible for Medi-Cal and with serious mental illness. The program receives referrals from Psychiatric Emergency Services (PES), inpatient hospitals, the youth and adult system of care and Children Protective Services. Annually the program serves 300 youth, which includes 225 youth who are admitted to psychiatric emergency services.

Transition into adulthood can be a stressful process as young people become more self-sufficient, independent and begin making decisions that can significantly shape their lives. This is an important period for both promoting linkages to behavioral health services, increasing protective factors and reducing risk factors and the negative consequences of untreated mental illness. Ensuring prevention and early intervention, prior to PES visits and hospitalizations, and meeting the behavioral health needs of this age group is an important priority for San Mateo County.

***Primary Problem: High rates of mental illness
amongst low-income young adults***

Low-income Youth

In San Mateo County, 29% of families are considered below poverty based on the California

¹ <https://www.nimh.nih.gov/health/statistics/mental-illness.shtml>

² Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS RTI International). Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health. <https://www.samhsa.gov/data/report/2018-nsduh-annual-national-report>



Self-Sufficiency Standard.³ More impactful is the fact that inequality continues to increase with the top-income families earning almost 15.8 times more than low-income families.⁴ Youth from low-income households are at a higher risk for mental health challenges. Among children living below 100% of the federal poverty level, more than 1 in 5 (22%) had a mental, behavioral, or developmental disorder.⁵

Research has shown not only that mental illness may lead to poverty and that poverty exacerbates mental illness but, more recently that poverty may contribute to the onset of mental illness. Families living in poverty face an increased risk of both community and individual trauma.⁶ These families are rarely successfully connected with the mental health services they need. This is exacerbated for youth from vulnerable cultural/ethnic families. Studies have found that youth of color experience higher levels of mental health difficulties due to racial discrimination, stigma, tendency to not engage in help-seeking behaviors and lack of culturally relevant support services. The most common racial or ethnic group living below the poverty line in San Mateo County is Hispanic.

There is a need for more upstream, innovative, comprehensive approaches to addressing behavioral health among young adults. Implementing multi-level interventions that reach high risk communities where they are, providing screening, resources and linkages in their homes and communities.

PROPOSED PROJECT

Describe the INN Project you are proposing.

A) Provide a brief narrative overview description of the proposed project.

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

Co-location of services in affordable housing complexes

By coordinating access to behavioral health and social services with affordable housing, low-income residents can have improved health outcomes and quality of life, including housing stability.⁷ The California Reducing Disparities Project (CRDP), an MHSA

³ The Census Bureau uses a federal poverty threshold based on a set income by family size to determine poverty.

⁴ Public Policy Institute of California, 2012-2014

⁵ Cree RA, Bitsko RH, Robinson LR, Holbrook JR, Danielson ML, Smith DS, Kaminski JW, Kenney MK, Peacock G. Health care, family, and community factors associated with mental, behavioral, and developmental disorders and poverty among children aged 2–8 years — United States, 2016. *MMWR*, 2018;67(5):1377-1383.

⁶ Collins, K, Connors, K, Donohue, A, Gardner, S, Goldblatt, E, Hayward, A, Kiser, L, Strieder, F, Thompson, E. 2010. Understanding the impact of trauma and urban poverty on family systems: Risks, resilience, and interventions. Baltimore, MD: Family Informed Trauma Treatment Center.

⁷ Carder, PC, Luhr, G, West, M, Morgan, B. 2016. Housing with Services Program Evaluation. Portland, OR: Institute on Aging, Portland State University.



Prevention and Early Intervention (PEI) State funded project and the largest investment in the nation to look into diverse community perspectives on mental health disparities, released the Strategic Plan to Reduce Mental Health Disparities in 2018. The strategic plan includes recommendation for increasing access to unserved, underserved and inappropriately served communities. Co-locating services in spaces where people are comfortable is the first strategy recommended as a first step in making services more available to those in need. It makes sense to build supports around the home setting. Affordable housing properties offer that ideal space to provide culturally and linguistically competent services to communities in need, which are often communities of color.

Affordable housing as a hub for services is described in four main models⁸:

- Health or social services are provided by an outside agency
- Services and amenities made available to everyone in a building complex by the housing organization
- Integrated supportive services on-site available to residents with special needs
- Services on-site available to residents and nearby community

These models have been widely researched in specific populations such as, the elderly, people living with mental illness or disabilities, and youth exiting the juvenile justice system and at risk of experiencing homelessness. Strategies are primarily focused on supportive and integrated services. In terms of prevention, the majority of program focus on environmental factors in the physical homes. There is no model targeting prevention and early interventions for young adults specifically and even those targeting high risk youth document that further research is needed to determine how to best serve youth between the ages of 18-25 in these settings.⁹

Prevention and Early Intervention for young adults

Despite the high need for mental health services, low-income youth are least likely to be connected with high-quality mental health care.¹⁰ There is a pressing need to develop promising strategies to ensure greater access to appropriate early intervention services among those with the highest risks for developing behavioral health disorders.

Specifically, programs that are client driven, culturally responsive, target individuals in their natural contexts and take a comprehensive approach that addresses relevant social determinants (e.g., housing or food insecurity) may be associated with increased engagement. The proposed program will target young adults at affordable housing properties and surrounding community. A behavioral health peer educator and a harm reduction specialist with experience in mental health and are culturally and linguistically competent to work with the community being served, including being affirming of

⁸ Butler, S, Cabello, M. Housing as a Hub for Health, Community Services, and Upward Mobility. Mar 2018. The Brookings Institution.

⁹ Bardine, Darla, et al., "Addressing the Intersections of Juvenile Justice Involvement and Youth Homelessness: Principles for Change," 2017. Coalition for Juvenile Justice.

¹⁰ Hodgkinson, S, Godoy, L, Beers, LS, Lewin, A (2017). Improving Mental Health Access for Low-Income Children and Families in the Primary Care Setting. *Pediatrics*. Jan; 139(1): e20151175.



LGBTQ individuals and able to foster a welcoming place for all, will provide:

- Preventative behavioral health and harm reduction workshops
- Peer support group(s)
- Social determinants of health and behavioral health screenings
- Referrals and linkages to resources for mental health and substance use
- Crisis support

If young adults could be provided behavioral health information, supports and be screened for mental illness early, there is a strong possibility that those young adults will increase their overall quality of life and lessen the impact that undiagnosed mental illness creates by preventing crises and connecting them to resources and treatment services.

Project implementation activities:

- Project startup - hire peer educator and harm reduction specialist(s), identify screening tools and referral resources, establish crisis protocols, etc.
- Establish advisory board for the project and conduct assessment (interviews/surveys) to determine relevant activities, workshop topics and outreach/incentive strategies for young adult engagement.
- Create “safe” settings and activities at housing properties for young adults to discuss amongst peers and engage in topics that are relevant to their every day stressors, needs and interests decreasing barriers and stigma related to accessing behavioral health services.
- Conduct Preventative and Harm Reduction Workshops and Peer Support Groups.
- Screen young adults for behavioral health issues and social determinants of health to provide appropriate linkages.
- Refer and provide warm hand-offs to connect the young adults to appropriate behavioral health services and supports.
- Once identified additional preventive interventions may be put in place to support and reduce identified stressors.

B) Identify which of the three project general requirements specified above [per CCR, Title 9, Sect. 3910(a)] the project will implement.

Increases access to mental health services to underserved groups



C) Briefly explain how you have determined that your selected approach is appropriate.

Based on a comprehensive review of published literature, web-based searches, the following were identified as key considerations for the project activities and approach:

1. **Early Intervention:** Poverty contributes to onset of behavioral health challenges, early intervention for low-income young adults is critical.
2. **Ease of access:** Co-locating services in spaces where young adults are comfortable will increase access and combat stigma.
3. **Comprehensive and culturally relevant approach:** Young adults are more likely to engage with programs that are client driven, culturally responsive and take a comprehensive approach that addresses relevant social determinants (e.g., housing or food insecurity).

These findings were used as supporting evidence for the proposed interventions and selected approach for this project. Appendix 1. Theory of Change illustrates the pathways between these five key considerations, the interventions or activities, expected outcomes, and learning objectives.

D) Estimate the number of individuals expected to be served annually and how you arrived at this number.

The project team will outreach to young adults living at affordable housing complexes.

The expected reach based on this data is as follows:

- 80 workshops offered at 10 affordable housing complexes
- 150 young adults participate in services provided on-site
 - 90% increased knowledge about behavioral health.
 - 90% reduced stigma
- 120 number of young adults screened
- 30% will be referred to social and/or behavioral health services
- 70% of young adults referred to behavioral health service will receive treatment
- 80% of the young adults who are found to have mental illness and receive treatment will report:
 - Increased understanding of their emotions
 - Increased understanding of mental illness



E) Describe the population to be served, including relevant demographic information (age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate).

In San Mateo County, 29% of families are considered below poverty based on the California Self-Sufficiency Standard. 8% of the White population live below the poverty line; compared to 20% of Latinos and 5% of Asians.

RESEARCH ON INN COMPONENT

A) What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

Co-location of services is a well-documented best practice particularly as it relates to co-locating services in schools and primary health care settings or co-locating various health and social services, and co-locating services in supportive housing for individuals living with mental illness. The key differences with the proposed project include:

- Co-locating prevention and early intervention services targeting young adults in affordable housing complexes.
- Integrating comprehensive approach that considers cultural relevance and addresses social determinants of health.

B) Describe the efforts made to investigate existing models or approaches close to what you’re proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.

Literature searches were conducted through the San Mateo Medical Center Inter-Library Loan system, Google Scholar and Google search engine. The subjects searched included: “co-location of mental health services;” “co-location of mental health services in affordable housing complexes;” “affordable housing as service hubs;” “young adults and mental health outcomes;” “mental health and low-income families.”

Gaps in the literature and practice	Proposed intervention
<p>A search for co-location of services in affordable housing revealed a gap in best practices for behavioral health prevention and early intervention for young adults. Most co-location of services target special populations (elderly, homeless youth, people living with mental illness or disabilities, etc.). Strategies are primarily focused on supportive and integrated direct services vs. prevention.</p>	<p>The proposed project will develop a best practice for: 1) targeting young adults 2) focus on prevention</p>



Links used to gather information:

- <https://housing.smcgov.org/>
- https://cpehn.org/sites/default/files/crdp_strategic_plan.pdf
- https://www.brookings.edu/wp-content/uploads/2018/03/es_20180315_housing-as-a-hub_final.pdf
- <http://juvjustice.org/sites/default/files/ckfinder/files/FINAL%20Principles%20-%20ns%20final.pdf>
- <https://www.pdx.edu/ioa/affordable-housing-with-services>
- <https://bainumfdn.org/blog/housing-service-hub-opportunities-challenges/>
- <https://www.schoolhealthcenters.org/wp-content/uploads/2015/09/CSHA-CDE-Youth-MH-Program-Engagement-091715.pdf>

LEARNING GOALS/PROJECT AIMS

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

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

Learning Goal #1

- Does co-location of behavioral health prevention and early intervention services in affordable housing complexes reach young adults at risk for mental illness?

Learning Goal #2

- Do culturally responsive services in affordable housing establish the trust and rapport needed to reduce stigma and engage young adults in wellness and behavioral health services?

Learning Goal #3

- Does a comprehensive approach that address social determinants lead to linkages that prevent more severe behavioral health challenges?



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

As stated, prior, the two key differences with the proposed project include:

- Co-locating prevention and early intervention services targeting young adults in affordable housing complexes. (*Learning Goal #1*)
- Integrating comprehensive approach that considers cultural relevance and addresses social determinants of health. (*Learning Goal #2 and #3*)

The learning goals are directly connected to the needs, strategies (including the approaches that are new in the proposed project) and outputs as depicted in Appendix 1. Theory of Change.

EVALUATION OR LEARNING PLAN

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. Specifically, please identify how each goal will be measured and the proposed data you intend on using.

An independent evaluation consultant will be contracted and monitored by the MHSA Manager in collaboration with the BHRS program monitor and the Aging and Adult Services program coordinator to formally evaluate the innovation project. The following depicts a rough evaluation plan given that the consultant will be hired after the project is approved.

Learning Goal #1

- Does co-location of behavioral health prevention and early intervention services in affordable housing complexes reach young adults at risk for mental illness?

The outputs for Learning Goal #1 could include:

- Number of workshops offered
- Number of young adults participating

Additionally, demographics of participants will be collected that include questions on youth risk for mental illness, protective factors, risk factors, etc.



Learning Goal #2

- Do culturally responsive services in affordable housing establish the trust and rapport needed to reduce stigma and engage young adults in wellness and behavioral health services?

The outputs for Learning Goal #2 could include:

- Increased knowledge about behavioral health
- Reduced stigma

Additionally, interviews with young adults engaged in conversations and focus groups with workshop participants can help us determine the level of trust and rapport that was established, the level of confidence in getting support services when/if needed, and satisfaction with the services provided.

Learning Goal #3

- Does a comprehensive approach that address social determinants lead to linkages that prevent more severe behavioral health challenges?

The outputs for Learning Goal #3 could include:

- Number of young adults screened
- Number referred to social and/or behavioral health services
- 70% of young adults referred to behavioral health service will receive treatment.
- 80% of the young adults who are found to have mental illness and receive treatment will report:
 - Increased understanding of their emotions
 - Increased understanding of mental illness.

Additionally, occasional interviews with young adults that were referred to services can help us determine whether the youth engaged in support, the level of satisfaction and outcomes of the referrals.



Section 3: Additional Information for Regulatory Requirements

CONTRACTING

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

All BHRS service agreements (contracts, MOU's) are monitored by a BHRS Manager that has the subject matter expertise. Contract monitors check-in at least monthly with service providers to review challenges, successes, troubleshoot and stay up-to-date on the progress of the project. Additionally, reporting deliverables are set in place in the agreements and linked to invoicing. Payments of services are contingent on the reporting. Evaluation contracts are monitored in a similar fashion by the MHSA Manager in collaboration with the assigned BHRS Manager.

COMMUNITY PROGRAM PLANNING

Please describe the County's Community Program Planning (CPP) process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community.

In San Mateo, the CPP process for Innovation Projects begins with the development of the MHSA Three -Year Plan. A comprehensive community needs assessment process determines the gaps, needs and priorities for services, which are used as the basis for the development of Innovation projects. Appendix 2 illustrates and describes the Three-Year Plan CPP process for San Mateo County.

Between February and March 2019, a broad solicitation of innovation ideas was launched. Both a flyer and an MHSA Innovation Idea Form were circulated through various means:

- Flyers are 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.smcbhrrsblog.org
- MHSA Innovation brainstorming sessions held with groups that requested it (Lived Experience Workgroup, MHSARC Older Adult Committee).



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The MHSAs Innovation Idea Form requested narrative on the proposed idea/project and information to ensure the idea meets the requirements for Innovation funding. Additionally, in San Mateo County we had the requirement that the idea address the MHSAs Three-Year Plan prioritized needs:

- Engagement and integration of older adults across services and prevention activities
- Culturally relevant outreach and service delivery
- Integration of peer/family supports across services and prevention activities
- Integration of co-occurring practices across services and prevention activities
- Engagement services for transition-age youth (mentoring, education, peer support)
- Broader housing options to support individuals across the continuum of care

We received 35 MHSAs Innovation Idea Forms, which speaks to the need for innovation in serving some of our most vulnerable communities' needs. All submitted ideas were pre-screened against the Innovation requirements, twenty-one were moved forward to an MHSAs Innovation Selection Committee. The committee was made up of diverse clients, family members, community service providers and staff. All projects were reviewed and prioritized by the committee and included an Impact/Effort assessment and scoring. Five proposed Innovation ideas moved forward to develop into full Innovation project proposals for approval by the Mental Health Oversight and Accountability Commission (MHSOAC).

On October 2, 2019, the MHSAs Steering Committee met to review the 5 project ideas and provide comment and considerations for the projects. The MHSARC voted to open the 30-day public comment period, all comments will be included in Appendix 3. [This section to be updated following the 30-day public comment process].

MHSAs GENERAL STANDARDS

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

A) Community Collaboration

The proposed project will require collaboration with youth to ensure the most culturally relevant engagement strategies are employed; with service providers to bring appropriate services to the young adults and allow for linkages and warm hand-offs; and the community at-large since service will be available to the surrounding community.

B) Cultural Competency

In order to deliver culturally responsive services, ideally a peer staff that's bilingual/bicultural Spanish speaking, with personal experience with mental health, to represent the low-income young adults being served. This will support trust-building and linkages.



C) Client/Family-Driven

As mentioned above, young adults will be driving the linkages made and development of any additional resources and interventions needed. The evaluation contractor will gather input on the evaluation questions and strategies, develop quarterly progress reports to share preliminary findings and gather input from an advisory group made up of young adults, clients and family members. The Mental Health Substance Abuse and Recovery Commission Older Adult Committee, which is made up of clients, family members and providers may be an ideal resource for this role.

D) Wellness, Recovery, and Resilience-Focused

Supporting wellness, recovery and resilience is accomplished through relationships and social networks, flexibility, respect and responsiveness, and taking a wholistic approach that considers overall health, stable housing, independence, etc. These principles are key to the strategies of the proposed project including hiring bilingual/bicultural peer mental health worker to conduct the outreach, focusing the outreach on trust building, conversations and a process that aims to creating safe spaces and reduce stigma and shame.

E) Integrated Service Experience for Clients and Families

A request for proposal process will select the service provider that will own the contract for these services. Pre-launch planning and ongoing collaboration will be critical to offering an integrated service experience for recipients. Staff will need to be well-informed on the full range of services at BHRS and the community and build relationships to ensure a coordinated referral and warm hand-off process.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

Explain how you plan to ensure that the Project evaluation is culturally competent and includes meaningful stakeholder participation.

As mentioned earlier, the evaluation contractor will engage an advisory group of diverse young adults, clients, family members and providers to gather input on the evaluation questions, strategies and on quarterly progress reports. Cultural and language demographics will be collected and analyzed as part of the quarterly reports to ensure equal access to services among racial/ethnic, cultural, and linguistic communities. The quarterly reports will be used to inform and adjust as needed the direction, outreach strategies and activities.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

Briefly describe how the County will decide whether it will continue with the INN project in its entirety or keep particular elements of the INN project without utilizing INN Funds following project completion. Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals upon project completion.



The advisory group will be engaged in the evaluation and adjustments of the project. In addition, the MHSA Steering Committee will be a venue for vetting next steps with diverse stakeholders. If the evaluation indicates that the proposed project is an effective means of increasing access to behavioral health services for at risk older adults and there is availability of Prevention and Early Intervention (PEI) funding, a proposal of continuation would be brought to the MHSA Steering Committee and the Mental Health and Substance Abuse Recovery Commission for approval and to a 30-day public comment process to secure ongoing PEI funding. Contractors will be asked to develop a sustainability plan as part of their project proposal.

COMMUNICATION AND DISSEMINATION PLAN

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

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

MHSA implementation is very much a part of BHRS' day-to-day business. Information is shared, and input collected with a diverse group of stakeholders, on an ongoing basis. All MHSA information is made available to stakeholders on the MHSA webpage, www.smchealth.org/bhrs/mhsa. The site includes a subscription feature to receive an email notification when the website is updated with MHSA developments, meetings and opportunities for input. This is currently at over 1,500 subscribers.

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

Opportunities to present at statewide conferences will also be sought.

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

- Housing as service hubs
- Co-location of behavioral health services in affordable housing
- Young adults and mental health
- Low-income young adult engagement in behavioral health services



TIMELINE

A) Specify the expected start date and end date of your INN Project

February 1, 2020 – December 31, 2023

B) Specify the total timeframe (duration) of the INN Project

3.9 years;

- 5 months of BHRS administrative project start-up through June 30, 2020
- 3 years of project implementation through June 30, 2023
- 6 months for final evaluation report due December 31, 2023

C) Include a project timeline that specifies key activities, milestones, and deliverables.

The timeline will be negotiated and finalized with the contracted partner agency and may change during implementation:

February 1, 2020 – June 30, 2020

- BHRS Administrative startup activities – RFP and contract negotiations

July 1, 2020 – September 30, 2020

- Project startup activities – hire peer educator and harm reduction specialist(s), identify screening tools and referral resources, establish crisis protocols, set up infrastructure for implementation/evaluation and referral system/resources, etc.
- Establish Young Adult advisory group
- Conduct assessment (interviews/surveys) to determine relevant activities, workshop topics and outreach/incentive strategies for young adult engagement.
- Evaluator to meet with, advisory group, agency and BHRS staff to discuss evaluation plan and tools

October 1, 2020 – December 31, 2020

- Onboarding of staff – training, relationship building, networking
- Determine schedule of workshops and activities based on needs assessment, finalize promotion materials, referral resources and screening tools
- Evaluation plan finalized including data collection and input tools

January 1, 2021 – June 30, 2021

- Outreach, workshops/activities, referrals and warm hand-offs begin
- Data tracking and collection begins
- First evaluation quarterly report January 1, 2021 – March 31, 2021 presented to advisory group for input, adjustments to strategies, tools and resources, based on operational learnings to-date and quantitative data available.
- Identify any additional preventive interventions that may be needed to support and reduce youth identified stressors.



July 1, 2021 – December 31, 2021

- Explore and finalize any recommendations for additional preventive interventions that may be needed to support and reduce identified stressors.
- Qualitative data collection begins (interviews, focus groups, etc.)
- Sustainability planning begins
- Continue outreach, workshops/activities, referrals and warm hand-offs
- Continue evaluation quarterly reports to request input and determine adjustments, as needed

January 1, 2022 – June 30, 2022

- Explore and finalize any recommendations related to additional preventive interventions that may be needed to support and reduce identified stressors.
- Continue sustainability planning
- Continue outreach, workshops/activities, referrals and warm hand-offs
- Continue evaluation activities and quarterly reports to request input and determine adjustments, as needed

July 1, 2022 – December 31, 2022

- Initial sustainability plan presented
- Engage MHSA Steering Committee and MHSARC on issue of continuation of the project with non-INN funds
- Determine if PEI dollars will be available to fund all or portions of the project
- Continue outreach, workshops/activities, referrals and warm hand-offs
- Continue evaluation activities and quarterly reports to request input and determine adjustments, as needed

January 1, 2023 – June 30, 2023

- Sustainability plan finalized
- Continue outreach, workshops/activities, referrals and warm hand-offs
- Continue evaluation activities and quarterly reports to request input and determine adjustments, as needed

July 1, 2023 – December 31, 2023

- Complete evaluation analysis and report
- Disseminate final findings and evaluation report



Section 4: INN Project Budget and Source of Expenditures

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

The next three sections identify how the MHSAs funds are being utilized:

- A) BUDGET NARRATIVE** (Specifics about how money is being spent for the development of this project)
- B) BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY** (Identification of expenses of the project by funding category and fiscal year)
- C) BUDGET CONTEXT** (if MHSAs funds are being leveraged with other funding sources)

BUDGET NARRATIVE

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project.

The total Innovation funding request for 3.9 years is \$925,000, which will be allocated out as follows: \$925,000 (\$750K services; \$100K admin; \$75K eval)

Service Contract: \$750,000	Evaluation (10%): \$75,000	Administration (15%): \$100,000
<ul style="list-style-type: none"> • \$250,000 for FY 20/21 • \$250,000 for FY 21/22 • \$250,000 for FY 22/23 	<ul style="list-style-type: none"> • \$30,000 for FY 20/21 • \$20,000 for FY 21/22 • \$20,000 for FY 22/23 • \$5,000 For FY 23/24 	<ul style="list-style-type: none"> • \$20,000 for FY 19/20 • \$30,000 for FY 20/21 • \$30,000 for FY 21/22 • \$20,000 for FY 22/23

Direct Costs will total \$750,000 over a three-year term and includes all contractor expenses related to delivering the services (salaries and benefits, program supplies, rent/utilities, mileage, transportation of clients, translation services, subcontracts for outreach, etc.).

Indirect Costs will total \$150,000

- \$75,000 for the evaluation contract with the final report will be due by December 31, 2024. The evaluation contract includes developing a plan, supporting data collection, data analysis and submitting annual reports to the MHSOAC.
- \$100,000 for for BHRS county business, contract monitoring, fiscal tracking, IT support, and oversight of the innovation project

Federal Financial Participation (FFP) there is no anticipated FFP.

Other Funding N/A



BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	TOTAL
1.	Salaries						
2.	Direct Costs						
3.	Indirect Costs	\$20,000	\$30,000	\$30,000	\$20,000		\$100,000
4.	Total Personnel Costs	\$20,000	\$30,000	\$30,000	\$20,000		\$100,000
OPERATING COSTS		FY xx/xx	FY xx/xx	FY xx/xx	FY xx/xx	FY xx/xx	TOTAL
5.	Direct Costs						
6.	Indirect Costs						
7.	Total Operating Costs						
NON RECURRING COSTS (equipment, technology)		FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	TOTAL
8.							
9.							
10.	Total Non-recurring costs						
CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)		FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	TOTAL
11.	Direct Costs		\$250,000	\$250,000	\$250,000		\$750,000
12.	Indirect Costs		\$30,000	\$20,000	\$20,000	\$5,000	\$75,000
13.	Total Consultant Costs		\$280,000	\$270,000	\$270,000	\$5,000	\$825,000
OTHER EXPENDITURES (please explain in budget narrative)		FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	TOTAL
14.							
15.							
16.	Total Other Expenditures						
BUDGET TOTALS							
Personnel (line 1)							
Direct Costs (add lines 2, 5 and 11 from above)			\$250,000	\$250,000	\$250,000		\$750,000
Indirect Costs (add lines 3, 6 and 12 from above)		\$20,000	\$60,000	\$50,000	\$40,000	\$5,000	\$175,000
Non-recurring costs (line 10)							
Other Expenditures (line 16)							
TOTAL INNOVATION BUDGET		\$20,000	\$246,000	\$246,000	\$231,000	\$12,000	\$925,000

*For a complete definition of direct and indirect costs, please use DHCS Information Notice 14-033. This notice aligns with the federal definition for direct/indirect costs.

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)

ADMINISTRATION:

A.	Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	TOTAL
		1.	Innovative MHSAs Funds	\$20,000	\$280,000	\$280,000	\$270,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	Total Proposed Administration	\$20,000	\$280,000	\$280,000	\$270,000		\$850,000

EVALUATION:

B.	Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	TOTAL
		1.	Innovative MHSAs Funds		\$30,000	\$20,000	\$20,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	Total Proposed Evaluation		\$30,000	\$20,000	\$20,000	\$5,000	\$75,000

TOTAL:

C.	Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	TOTAL
		1.	Innovative MHSAs Funds	\$20,000	\$310,000	\$300,000	\$290,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	Total Proposed Expenditures	\$20,000	\$310,000	\$300,000	\$290,000	\$5,000	\$925,000

*If "Other funding" is included, please explain.

Appendix 1. Theory of Change

Theory of Change

Primary Problem: High rates of mental illness amongst low-income young adults

Key Considerations (from the literature)

Early Intervention: Poverty contributes to onset of behavioral health challenges, early intervention for low-income young adults is critical.

Ease of access: Co-locating services in spaces where young adults are comfortable will increase access and combat stigma.

Comprehensive approach: Young adults may engage with programs that are client driven, culturally responsive and take a comprehensive approach that addresses relevant social determinants (e.g., housing or food insecurity).

Interventions

Co-location of Services

Prevention and early intervention (PEI) services will be provided on-site at affordable housing complexes.

- Preventative behavioral health and harm reduction workshops
- Peer support group(s)
- Social determinants and behavioral health screenings
- Referrals and linkages
- Crisis support

Culturally-relevant activities

Advisory board will identify culturally relevant activities for young adults that allow for peer discussion on every day stressors, needs and interests; decreasing barriers and stigma.

Screening and Referrals/Warm Hand-offs

Peer staff will link young adults to services and resources to support mental well-being .

Outcomes

PEI Services Provided

80 workshops offered at **10** affordable housing complexes

150 young adults participate in services provided on-site

- **90%** increased knowledge about behavioral health.
- **90%** reduced stigma

Screening and Linkages

120 young adults screened
30% will be referred to social and/or behavioral health svcs
70% of young adults referred to behavioral health service will receive treatment.

80% of the young adults who are found to have mental illness and receive treatment will report:

- Increased understanding of their emotions
- Increased understanding of mental illness.

Learning Objectives

Learning Goal #1

Does co-location of behavioral health prevention and early intervention services in affordable housing complexes reach young adults at risk for mental illness?

Learning Goal #2

Do culturally responsive services in affordable housing establish the trust and rapport needed to reduce stigma and engage young adults in wellness and behavioral health services?

Learning Goal #3

Does a comprehensive approach that address social determinants lead to linkages that prevent more severe behavioral health challenges?

MHSA INN Primary Purpose

Increased access to behavioral health services

**Appendix 2. Community Planning Process
for MHSA Three-Year Plan**

San Mateo County Mental Health Services Act

Three-Year Plan FY 2017-2020

Community Program planning (CPP) process

In December 2016, a comprehensive Community Program Planning (CPP) process to develop the MHSa Three-Year Plan was kicked off by our local mental health board, the Mental Health and Substance Use Recovery Commission (MHSARC). Planning was led by the MHSa Manager and the Director of BHRS along with the MHSARC and the MHSa Steering Committee.



A draft CPP process was presented to and vetted by the MHSARC. The MHSARC was asked for their input and comments on the process and what other stakeholder groups should we be reaching out to in each of the CPP Phases.

STAKEHOLDERS INVOLVED

Input was sought from twenty nine diverse groups and vulnerable populations to include perspectives of different backgrounds and interests including geographical, ethnic, cultural and

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social economic, providers and recipients of behavioral health care services and other sectors, clients and their family members. See the full list of input sessions below.

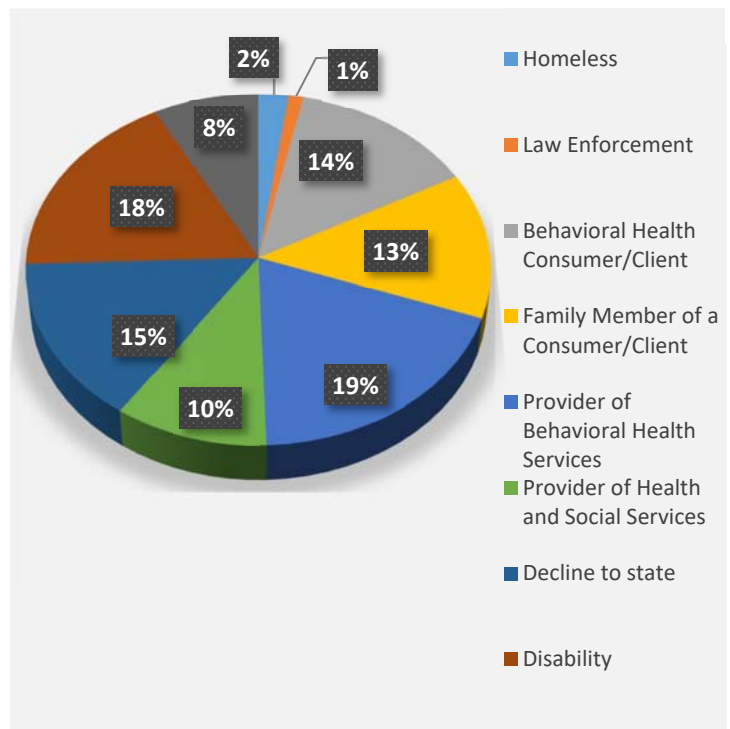
Additionally, a Pre-Launch session was held with clients/consumers hosted by the Peer Recovery Collaborative, a collaborative of peer-run agencies including California Clubhouse, Heart and Soul and Voice of Recovery. At this session information was presented and shared to help prepare clients/consumers for the CPP Launch session where they would be providing input and public comment. Discussion items included, 1) Background on MHSA; 2) What to expect at the CPP Launch session; and 2) How to prepare a public comment.

Extensive outreach was conducted to promote two key public meetings, the CPP Launch Session on March 13, 2017 and the CPP Prioritization Session on April 26, 2017. Flyers were made available in English, Spanish, Chinese, Tagalog, Tongan and Samoan. Stipends to consumers/clients and their family members, language interpretation, child care for families and refreshments were provided at each of these sessions.

Over 270 participated in the sessions, 156 demographic sheets were collected and of these 37% identified as clients/consumers and family members and 36 stipends were provided.

The majority of participants at these two public meetings (64%) represented central and south geographical areas of the county. There are institutional barriers to accessing and attending centrally located public meetings (trust, transportation, cultural and language, etc.). In an effort to account for this, two additional Community Prioritization Sessions were conducted in East Palo Alto and the Coastside. In the future, we will add a community session in the north part of the county as well.

Represented Groups



Input Sessions

Date	Stakeholder Group
12/7/16	MHSARC and MHSA Steering Committee (Input on CPP Process)
2/15/17	MHSARC Adult Committee
2/15/17	NAMI Board Meeting
2/16/17	Filipino Mental Health Initiative
2/21/17	Coastside Community Service Area
2/21/17	Northwest Community Service Area
3/1/17	MHSARC Older Adult Committee
3/2/17	Central Community Service Area
3/2/17	Peer Recovery Collaborative
3/3/17	Diversity and Equity Council
3/3/17	Northwest School-Based Mental Health Collaborative
3/7/17	Pacific Islander Initiative
3/7/17	Coastside School-Based Mental Health Collaborative
3/8/17	AOD Change Agents/CARE Committee
3/9/17	Peer Recovery Collaborative (Pre-Launch Session)
3/9/17	East Palo Alto Community Service Area
3/9/17	Central School Collaborative
3/13/17	MHSA Steering Committee (CPP Launch)
3/14/17	African American Community Initiative
3/16/17	Ravenswood School-Based Mental Health Collaborative
3/17/17	South Community Service Area and Child/Youth Committee
3/23/17	Chinese Health Initiative
3/23/17	Northeast School-Based Mental Health Collaborative
3/28/17	Latino Collaborative
4/10/17	Coastside Youth Advisory Committee
4/11/17	Spirituality Initiative
4/13/17	East Palo Alto (Community Prioritization Session)
4/18/17	Coastside (Community Prioritization Session)
4/19/17	MHSARC Child and Youth Committee
4/20/17	Native American Initiative
4/20/17	Contractor's Association
4/21/17	Latino Immigrant Parent Group
4/24/17	Veterans
4/25/17	TAY recipients of services
4/26/17	MHSA Steering Committee (CPP Prioritization)

PHASE 1. NEEDS ANALYSIS

To build off of the previous Community Program Planning (CPP) process in FY 2014/15, stakeholders including clients, family members, community partners and organizations were asked to think about current services as they relate to the gaps in services identified in FY 2014/15 (listed below), specific service categories and populations served to identify any additional gaps in services:

- Cultural humility and stigma
- Timely access
- Services for peers and families
- Services for adults and older adults
- Early intervention
- Services for children and TAY
- Co-occurring services
- Criminal justice involvement

For Phase I and the initial input sessions, stakeholders were asked the following questions, based on the priority gaps identified in previous years for continuity:

- From your perspective, do these MHSa services effectively [e.g. serve the cultural and linguistic needs of your target communities, address timely access for your target communities, serve the behavioral healthcare needs of clients and families, etc.]? What's working well? What improvements are needed?
Probes: Do these services address principles of wellness and recovery? stigma?
- Are current collaborations effective in reaching and serving target communities? What is working well? What's missing?

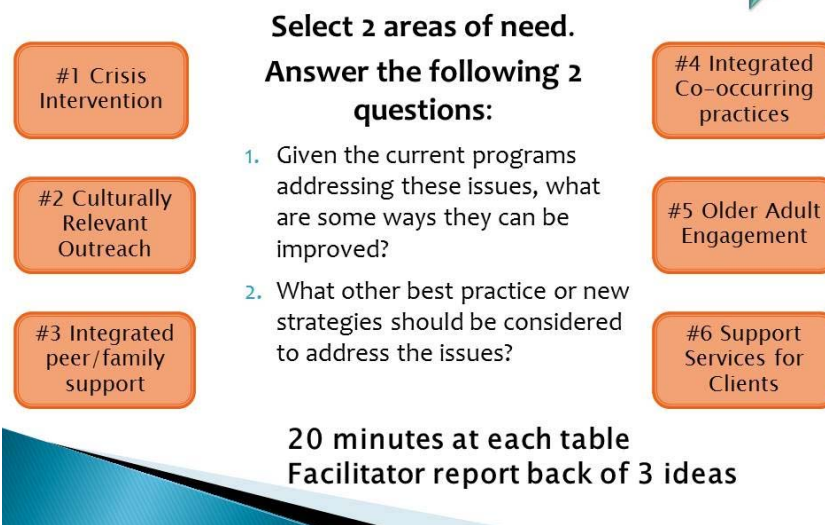
All comments received up to the date of the CPP Launch Session on March 13th were grouped into themes and presented at the CPP Launch. Additional input was sought regarding both the needs/service gaps and whether there were any voices (or communities) missing from the Needs Analysis phase. See Appendix 3, Needs Analysis Summary of Input, for the complete list of themes and comments received. The CPP Launch Session was a joint MHSARC and MHSa Steering Committee meeting and included a facilitated community input. Agenda items included 1) an MHSa Housing proposal for use of unencumbered housing funds 2) public comment from clients, families and community members on priority needs and gaps in mental health services, and 3) breakout groups to begin developing strategies to address the key needs/service gaps identified. About 120 clients, families, community members and stakeholders attended the CPP Launch Session. See Appendix 4 for all CPP Launch Session materials, handouts, minutes and attendance.

PHASE 2. STRATEGY DEVELOPMENT

The Strategy Development Phase was kicked off at the CPP Launch Session on March 13, 2017. Findings from the initial input sessions were shared at the CPP Launch Session including relevant strategy ideas.

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Phase 2. Strategy Development



While the above six need/gaps in services were identified, there was also an overarching theme that arose from the input sessions, which brought to surface common questions in MHSA planning: do we build upon existing MHSA-funded programs or do we create new programs? Input session participants identified the need to consider both. It has been 10 years since the inception of MHSA and most programs have not received additional resources (aside from Cost of Living increases to the contracts) to expand services and/or clients served, especially for those programs that are resulting in positive behavioral health outcomes.

Three key next steps for the CPP process were identified at the CPP Launch Session:

- Additional input sessions with vulnerable populations and key stakeholders identified.
- Additional strategy development sessions in isolated and higher need communities, in particular East Palo Alto and the Coastside/South Coast region.
- Follow up meetings with all MHSA-funded programs to identify priority program challenges, needs and possible strategies to address these.

PHASE 3. PLAN DEVELOPMENT

The final Phase of the CPP Process was kicked off at the CPP Prioritization Session on April 26, 2017. The meeting goals were three-fold:

1. Present strategy recommendations, results from the Community Input Sessions and prepared public comments in support of each recommendation.
2. Provide meeting participants the opportunity to bring forward any additional strategy recommendations and to prioritize the additional recommendations.
3. Prioritize across all strategies proposed (MHSA Steering Committee only) to help identify the recommendations to include in the MHSA Three-Year Plan.

Appendix 3. Public Comments

[To be updated following the 30-day public comment process]