MENTAL HEALTH SERVICES ACT

Three-Year Program and Expenditure Plan FY 20/21 through FY 22/23 & Annual Update FY 20/21

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

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*This section to be completed after Board of Supervisor adoption of the Three-Year Plan

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*This section to be completed after Board of Supervisor adoption of the Three-Year Plan

INTRODUCTION

INTRODUCTION TO SAN MATEO COUNTY

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

COUNTY OF SAN MATEO MISSION

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

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

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

BEHAVIORAL HEALTH AND RECOVERY SERVICES

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

The following statements were developed out of a dialogue involving consumers, family members, community members, staff and providers sharing their hopes for the Behavioral Health and Recovery Services (BHRS) Division.

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

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

Our Values

Person and Family Centered: We promote culturally responsive person-and-family centered recovery.

Potential: We are inspired by the individuals and families we serve, their achievements and potential for wellness and recovery

Power: The people, families and communities we serve and the members of our workforce guide the care we provide and shape policies and practices.

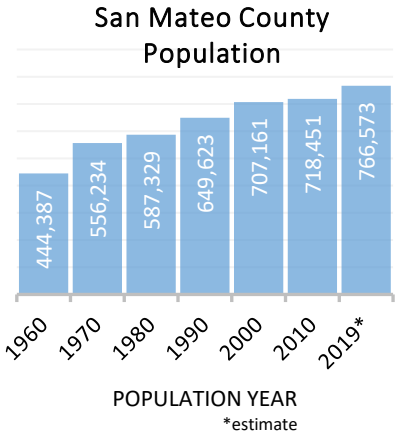
Partnerships: We can achieve our mission and progress towards our vision only through mutual and respectful partnerships that enhance our capabilities and build our capacity

Performance: We use proven practices, opportunities, and technologies to prevent and/or reduce the impacts of mental illness and additions and to promote the health of the individuals, families and communities we serve.

SAN MATEO COUNTY DEMOGRAPHICS

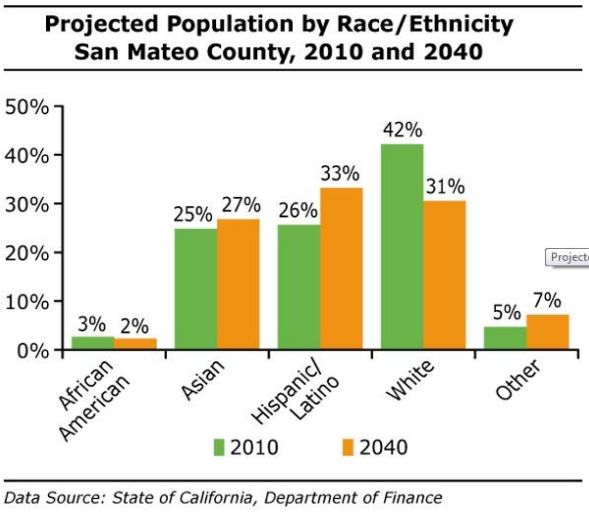
The estimated population of San Mateo County according to the U.S. Census Bureau is 766,573, a 6.7% jump over the 2010 Census. Daly City remains the most populous city followed by San Mateo and Redwood City.

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



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

By 2040, San Mateo County is projected to have a majority non-White population. The White population is projected to decrease by 11%. The Latino and Asian communities are projected to increase by 7% and 2%, respectively[1]. Additionally, the projected population by age group shows that residents 65 and older is projected to almost double.



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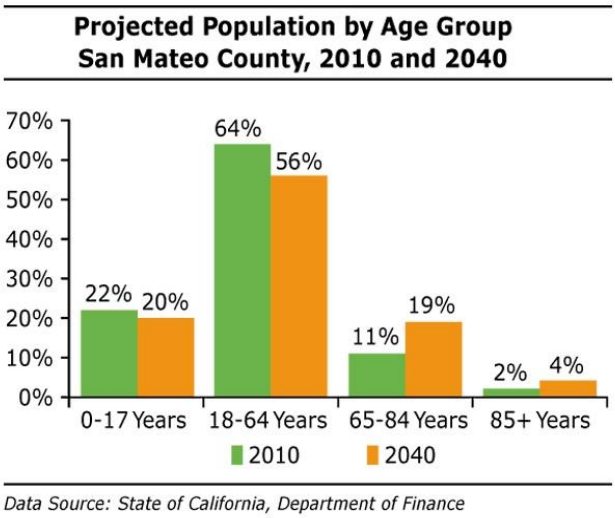


Data Source: State of California, Department of Finance

[1] sustainablesanmateo.org

MHSA BACKGROUND

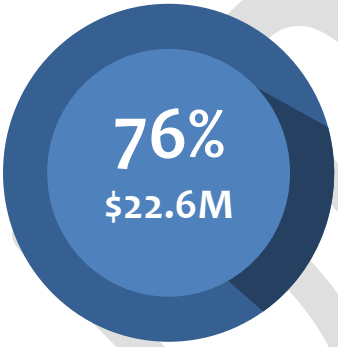
Proposition 63, the Mental Health Services Act (MHSA), was approved by California voters in November 2004 and provided dedicated funding for mental health services by imposing a 1% tax on personal income over $1 million dollars. San Mateo County received an annual average, in the last five years through Fiscal Year 2018-19, of about $29.7 million.

MHSA emphasizes transformation of the behavioral health system, improving the quality of life for individuals living with behavioral health issues and increasing access for marginalized communities. MHSA planning, implementation, and evaluation incorporates the following core values and standards:

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

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

Community Services & Supports (CSS)



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

Prevention & Early Intervention (PEI)

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

Innovation (INN)

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

COMMUNITY PROGRAM PLANNING

COMMUNITY PROGRAM PLANNING (CPP)

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 our Mental Health Board, is involved in all MHSA planning activities providing input, receiving regular updates as a standing agenda item on their monthly meetings, and making final recommendations to the San Mateo County Board of Supervisors (BoS) on all MHSA plans and updates.

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. All Commissioners of the MHSARC are 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 MHSA. In 2016, the MHSA Steering Committee was restructured to strengthen the representation of diverse stakeholders. MHSA Steering Committee guidelines were developed along with an application process. The MHSA Steering Committee Roles and Responsibilities, Committee Membership and the Application are available on the MHSA website, www.smchealth.org/MHSA. The MHSA Steering Committee makes recommendations to the planning and services development process and assures that MHSA planning reflects local diverse needs and priorities, contains the appropriate balance of services within available resources and meets the criteria and goals established. The meetings are open to the public and include opportunities for public comment. It is co-chaired by a member of the Board of Supervisors and by the Chair of the MHSARC and is comprised of over 30 community leaders representing the diverse San Mateo behavioral health constituents (clients, advocates, family members, community partners, County and CBO staff), and non-behavioral health constituencies (County leadership, Education, Healthcare and Criminal Justice among others).

MHSA Steering Committee Members

Stakeholder Group	Name	Title (if applicable)	Organization (if applicable)
Public	Sheila Brar	Chair	
Public	Donald Mattei	Co-Vice Chair	
Family Member	Patricia Way	Co-Vice Chair	
San Mateo County Dist 1	Dave Pine	Chair	Board of Supervisors, District 1
SMC District 1	Randy Torrijos	Staff to David Pine	
Client/Consumer	Jan Wongchuking	MHSARC Commissioner	
Family Member	Bill Nash	MHSARC Commissioner	
Family Member	Chris Rasmussen	MHSARC Commissioner	
Family Member	Jean Perry	MHSARC Commissioner	
Law Enforcement	Mark Duri	MHSARC Commissioner	
Public	Leticia Bido	MHSARC Commissioner	
Public	Yoko Ng	MHSARC Commissioner	
Public	Cherry Leung	MHSARC Commissioner	
Client/Consumer - Adults	Jairo Wilches	Program Coordinator	BHRS, OCFA
Client/Consumer - Adults	Michael Lim		
Client/Consumer - Adults	Michael S. Horgan	Program Coordinator	Heart & Soul, Inc.
Cultural Competence	Maria Lorente-Foresti	Director	BHRS, Office of Diversity & Equity
Cultural Competence	Kava Tulua	Executive Director	One East Palo Alto
Education	Mary McGrath	Administrator	San Mateo County Office of Educ
Family Member	Judith Schutzman		
Family Member	Juliana Fuerbringer		California Clubhouse
Other - Aging and Adult	Anna Sawamura	Prog Services Manager	SMC Health System, Aging & Adult
Other - Peer Support	Ray Mills	Executive Director	Voices of Recovery
Other - Peer Support	Stephanie Morales	Peer Support Worker	BHRS, OASIS
Provider of MH/SU Svcs	Adriana Furuzawa	Division Director	Family Service Agency
Provider of MH/SU Svcs	Cardum Harmon	Executive Director	Heart & Soul, Inc.
Provider of MH/SU Svcs	Chris Kernes	Managing Director	Health Right 360
Provider of MH/SU Svcs	Clarise Blanchard	Director	StarVista
Provider of MH/SU Svcs	Joann Watkins	Clinical Director	Puente de la Costa Sur
Provider of MH/SU Svcs	Melissa Platte	Executive Director	Mental Health Association
Provider of MH/SU Svcs	Michael Krechevsky	Family Support Specialist	Family Service Agency
Provider of Social Svcs	Mary Bier		North County Outreach Collaborative
Provider of Social Svcs	Rev. Chester McCall		East Palo Alto Partnership for Behavioral Health Outreach

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 Three-Year Program and Expenditure Plan FY 20/21 through FY 22/23 & Annual Update FY 20/21 was presented on June 3, 2020 to the MHSARC. The MHSARC voted to open a 30-day public comment period closing with a Public Hearing on July 1, 2020. The MHSARC voted *unanimously* to submit the plan to the Board of Supervisors. Please see Appendix 1 for the presentation materials and public comment received.]
**this section to be updated/confirmed after the vote to submit to the BoS*

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

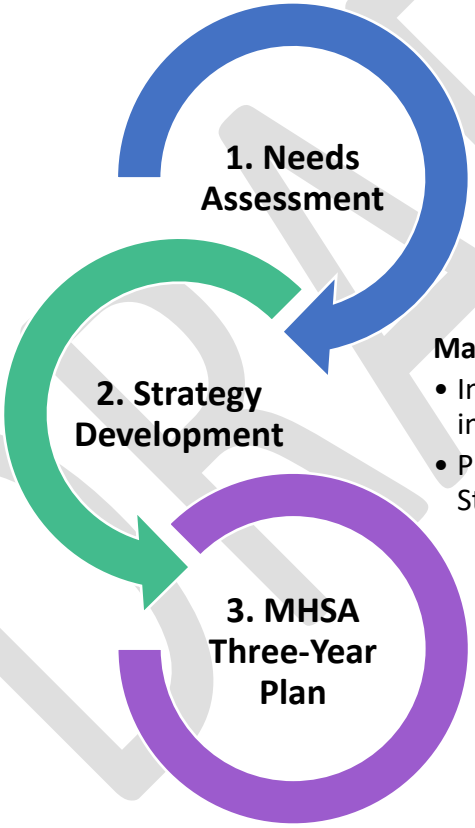
Various means are used to circulate information about the availability of the plan and request for public comment and include:

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

THREE-YEAR PLAN CPP PROCESS

The MHSA Three-Year is developed in collaboration with clients and families, community members, staff, community agencies and stakeholders. In December 2019, a comprehensive Community Program Planning (CPP) process to develop the MHSA Three-Year Plan commenced. 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 provided to the MHSARC on December 4, 2019 and followed up with a presentation on February 5, 2020. The MHSARC was asked for their input and comments on the process and what additional stakeholder groups we should reach out to.

CPP FRAMEWORK



Dec 2019 – Mar 2020
- Review of local plans, assessments, evals/reports
- Survey to prioritize needs

Mar – Apr 2020
- Input sessions and key interviews
- Prioritization by MHSA Steering Committee

May – Jun 2020
- MHSARC 30-Day Public Comment
- Board of Supervisors Adoption

The **Needs Assessment** phase of the CPP process included the following two steps:

1. **Review**: The following local plans, assessments, evaluations and reports were reviewed **to identify priority mental health and substance use needs across service sectors**.
    i. MHSA Annual Updates FY 2017-18 and 2018-19
    ii. BHRS Cultural Competence Plan
    iii. CA Reducing Health Disparities
    iv. AOD Strategic Prevention Plan
    v. County of San Mateo Substance Use Needs Assessment - 2019 Report
    vi. San Mateo County BHRS No Place Like Home Plan
    vii. 2013 Community Health Needs Assessment: Health and Quality of Life in San Mateo County
    viii. SMC Community Health & Needs Assessment 2019 - Major Findings
    ix. San Mateo County Childcare and Preschool Needs Assessment
    x. California's Public Mental Health Services: how are older adults being served?
    xi. Aging and Adult Service Needs Assessment
    xii. Probation Department County of San Mateo, Annual Report 2018
    xiii. Jail Needs Assessment for San Mateo County
    xiv. Supporting Transition-Aged Foster Youth
    xv. Juvenile Justice Coordinating Council (JJCC): Local Action Plan 2016-2020: Landscape of at-risk Youth & the services that support them
    xvi. SMC Veterans Needs Assessment: Report and Recommendations
    xvii. Agricultural Worker Housing Needs Assessment
    xviii. Health Care for the Homeless Farmworker Health Annual Report

2. **Prioritization:** The identified needs from the review of local plans and reports where included in an online survey that was distributed broadly to individuals living or working in San Mateo County, **to prioritize across the needs identified**. The survey asked respondents to rate the needs based on how important it is to address them over the next 3 years. There were 329 respondents, see Appendix 2 for the Needs Assessment summary of survey results.

    Preliminary survey results were presented to the MHSA Steering Committee on March 3, 2020 to gauge initial reactions and launch the Strategy Development phase of the CPP process. See Appendix 3 for the March 3rd MHSA Steering Committee materials and meeting notes.

The **Strategy Development** phase of the CPP process included the following two steps:

1. **Input:** 28 community input sessions and key interviews with diverse groups and vulnerable populations were conducted **to identify strategies to address the prioritized needs.** Participants brainstorm strategies in the areas of prevention, direct service and workforce training. See Appendix 4 for the Input Session materials and input received.

   Participants were asked the following questions:

   - Are there any program/service that are working well to address the need identified and would benefit from either expansion or enhancements?
   - Is there a new service or program that you would like to see considered to address the need identified?

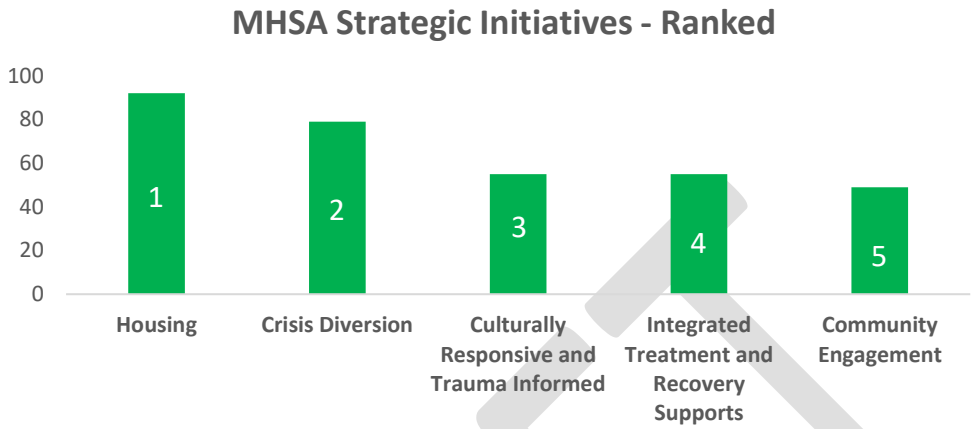
2. **Prioritization:** To support the prioritization of strategies, participants were also asked: Which strategy will have the most impact over the next three years?

Additionally, in an effort to offset the anticipated lack of new funding, due to COVID-19 pandemic and upcoming recession, a strategic approach to addressing the input received, was proposed to the MHSA Steering Committee. The 22 strategies prioritized through the input sessions were organized under 5 MHSA Strategic Initiatives with the intent to reallocate existing MHSA staff resources to engage stakeholders in planning to develop an adaptive strategy direction for these initiatives. The goal being to a) define a continuum of services, b) identify gaps at all levels of support or intensity in treatment, and c) articulate expected outcomes and identify the activities/strategies that will support a comprehensive continuum of services. This can be accomplished within the current budget and will give us valuable information we need to make informed decisions about funding and next steps once revenue increases.

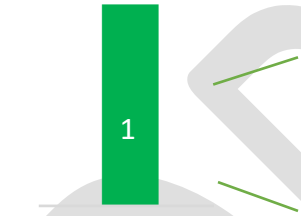
The 5 MHSA Strategic Initiatives and respective 22 strategies were presented to the MHSA Steering Committee on April 29, 2020. Pre-recorded public comments were included for each strategy area and an opportunity for additional public comments was provided. See Appendix 5 for the April 29th MHSA Steering Committee materials, notes and a full summary of the prioritization results. The MHSA Steering Committee members were asked the following two questions via an online survey to help both a) rank the 5 Strategic Initiatives and b) rate the 22 strategies.

MHSA Steering Committee - Summary of Prioritization Results

Housing was the MHSA Strategic Initiative that most Steering Committee members prioritized, followed by Crisis Diversion. See Appendix 5 for a full summary of the prioritization results.



Top two strategies prioritized for Housing and Crisis Diversion



1. Mental health workers providing on the field, mobile mental health assessments and treatment for homeless individuals and linkages to housing.
2. Trained/certified peers providing housing navigation, support services (e.g. independent living skills, accessing housing subsidies) to clients and training on the issue of homelessness to service providers (primary care physicians, mental health staff, police/first responders, etc.).

1. Trained/certified peers providing peer and family crisis support services to assist clients transition from psychiatric emergency services, hospitalization and incarceration, into the community.
2. Walk-in services for addressing immediate crisis needs in a less intensive setting than psychiatric emergency services.

The **MHSA Three-Year Plan** development includes the MHSA Steering Committee prioritized strategies as recommendations for funding when increases in revenues are available. The Three-Year Plan builds on previous planning processes and existing funded programs. Existing programs are monitored, evaluated and adjusted as needed during the implementation years and recommendations are made annually about continuing and/or ending a program. Any adjustments are presented to the MHSA Steering Committee and included in subsequent Annual Updates, which incorporates a 30-day public comment period.

All agencies funded to provide MHSA services go through a formal Request for Proposal (RFP) process to ensure an open and competitive process. The RFP's are posted on the BHRS RFP website, www.smchealth.org/rfps, which includes a subscription option to receive notifications.

The Three-Year Plan will be presented to the MHSARC for opening of a 30-day public comment, a public hearing and subsequently submitted to the Board of Supervisors for adoption.

STAKEHOLDERS INVOLVED

Extensive outreach was conducted to promote the two MHSA Steering Committee meetings and the Input Sessions. Flyers were made available in English, Spanish, Chinese, Tagalog, Tongan and Russian. Stipends to consumers/clients and their family members and language interpretation were provided at each of these sessions. Child care for families and refreshments were offered for the first in-person meeting, prior to switching to online due to COVID-19 pandemic.

Pre-sessions for both the MHSA Steering Committee meetings were held as an orientation for clients, family members and community members. At this session information was presented and shared to help prepare participants for the meetings and to provide input and public comment. Discussion items included, 1) Background on MHSA; 2) What to expect at the meetings; and 2) How to prepare a public comment.

Input included perspectives from clients and family members, communities across geographical, ethnic, cultural and social economic status, providers of behavioral health care services, social services and other sectors. The sessions were conducted through 14 existing collaboratives/initiatives, 8 committees/workgroups, 3 geographically-focused (Coastside, East Palo Alto and North County) and 3 stakeholder groups of transition-age youth, immigrant families and veterans. Because of the historical barriers to accessing and attending centrally located public meetings (mistrust, lack of transportation, cultural and language accessibility) three Community Prioritization Sessions were scheduled in North County, East Palo Alto and

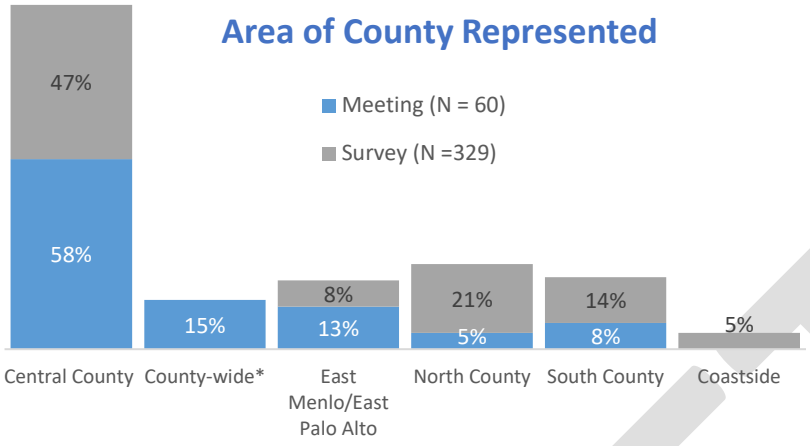
the Coastside. Yet, the majority of the meetings ended up being conducted via phone and video conferencing given the COVID-19 shelter-in-place orders.

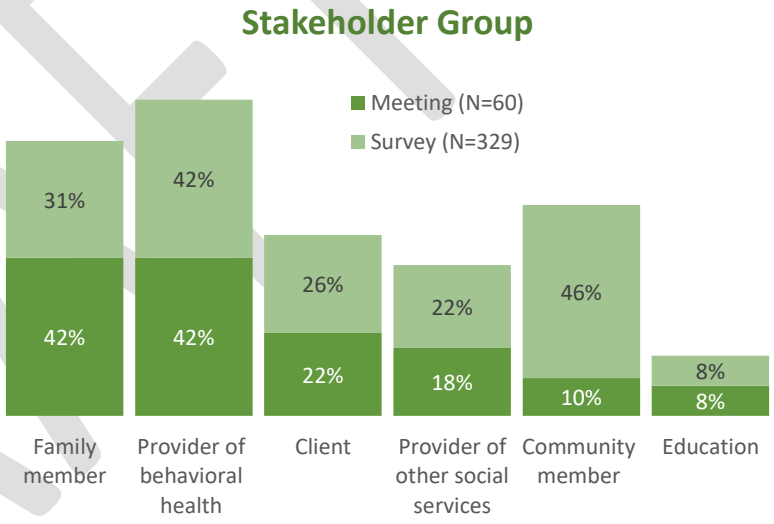
Over 400 individuals participated across the various means of providing input (surveys, input sessions, public comments). While we were unable to collect demographic data from all the Input Sessions, we know that 57 client and family member stipends were provided during various sessions as listed below, for a total amount of $1,425.

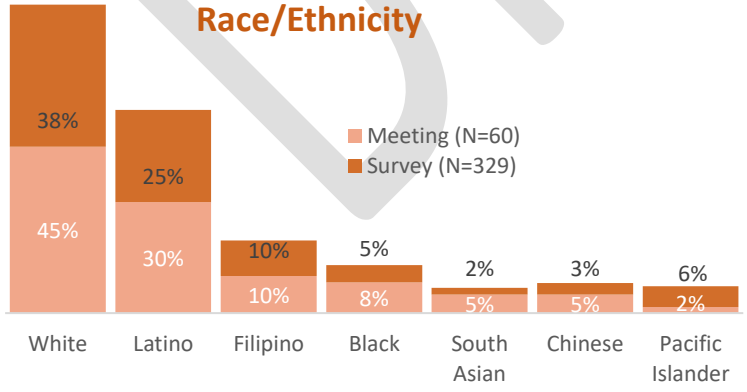
2020 MHSA Input Sessions Stipend Record Summary		
Input Session	**Date**	**# of Stipends Distributed**
Lived Experience Education Workgroup	3/3/2020	11
MHSA Strategy Launch	3/4/2020	15
African American Community Initiative	3/10/2020	3
Spirituality Initiative	3/10/2020	4
Latino Collaborative	3/24/2020	1
Chinese Health Initiative	4/3/2020	4
MHSA Strategy Prioritization	4/29/2020	19
Total		**57**

Demographics were collected for 329 survey respondents and 60 (of 88) participants via a Zoom Poll feature during the April 29th MHSA Steering Committee. Participants in each of these activities were not mutually exclusive and therefore demographics are summarized separately below. Attendance at input sessions and the meetings appeared to be slightly lower than the previous CPP process for the Three-Year Plan. Yet, because of the initial survey that was distributed to prioritize needs, there was almost double the number of participants overall.

Demographics of participants







Input Session conducted

Date	Stakeholder Group
3/3/20	Lived Experience Education Workgroup
3/4/20	MHSA Steering Committee- Strategy Launch
3/6/20	Diversity and Equity Council
3/6/20	Northwest School Collaborative
3/10/20	African American Community Initiative
3/10/20	Spirituality Initiative
3/10/20	Central School Collaborative
3/12/20	Housing Committee
3/18/20	MHSARC Child and Youth Committee
3/19/20	Coastside Collaborative
3/19/20	Native American Initiative
3/19/20	Contractors Association
3/24/20	Latino Collaborative
3/30/20	Peer Recovery Collaborative
4/1/20	MHSARC Older Adult Committee
4/2/20	AOD Treatment Providers Meeting
4/3/20	North County Outreach Collaborative
4/3/20	Chinese Health Initiative
4/7/20	Pacific Islander Initiative
4/8/20	Pride Initiative
4/09/20	East Palo Alto Behavioral Health Advisory Group
4/9/20	Filipino Mental Health Initiative
4/15/20	MHSARC Adult Committee
4/16/20	Northeast School Collaborative
4/20/20	South School Collaborative
12 individual interviews conducted:	
Immigrant Parents	
Transition Age Youth	
Veterans	

THREE-YEAR PLAN FUNDING PRIORITIES

FUNDING SUMMARY

An expenditure plan for the MHSA Three-Year Plan includes available unspent funds, estimated revenue, and reserve amounts. It includes the budgeted amount to be spent on MHSA Components and associated categories, as detailed below. See Appendix 6 for this Three-Year Plan's Funding Summary by component.

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% (51% of CSS must be allocated to FSP)	3 years
Prevention and Early Intervention (PEI)	Early Intervention Prevention Recognition of Signs of Mental Illness Stigma and Discrimination Access and Linkages	19% (51% of PEI must be allocated to program serving ages 0-25)	3 years
Innovations (INN)		5%	3 years

Counties received one-time allocations in three additional Components.

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

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

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

MHSA FUNDING PRINCIPLES

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

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

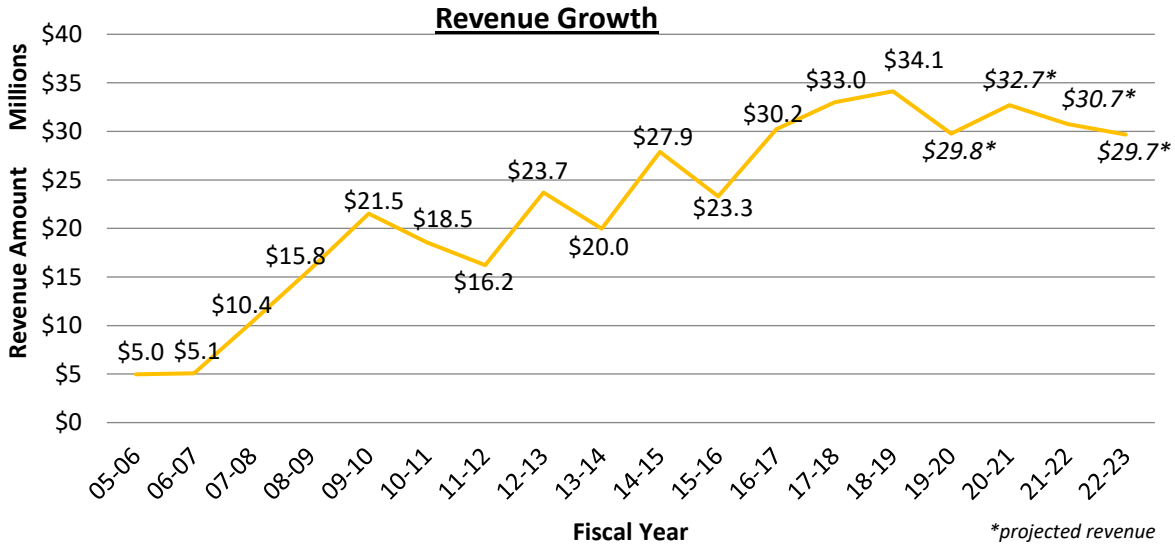
- ***Maintain MHSA required funding allocations***
- ***Sustain and strengthen existing MHSA programs*** - MHSA revenue should be prioritized to fully fund core services that fulfill the goals of MHSA and prevent any local or realignment dollars filling where MHSA should.
- ***Maximize revenue sources***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

ANNUAL REVENUE GROWTH

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. The average annual revenue for the last five years equals to about $29.7 million for San Mateo County.

Annual MHSA 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. The following chart shows annual revenue allocation for San Mateo County since inception. Below are factors that impacted the decreases and increases in revenues throughout the years:

- FY 05/06 and FY 06/07: funding included Community Services and Supports (CSS) only.
- FY 07/08 and FY 08/09: Prevention and Early Intervention (PEI) and Innovations (INN) dollars were released in those years, respectively.
- FY 10/11 and FY 11/12: the California recession of 2009 led to decreased revenues
- FY 12/13: Counties began receiving monthly MHSA allocations based on actual accrual of tax revenue (AB100), resulting in a "one time" allocation.
- FY 14/15: changes in the tax law that took effect on January 1, 2013, led to many taxpayers filing in December 2012 resulting in a "one time" increase.
- FY 19/20: "No Place Like Home" estimated cost for San Mateo County is $1.3 million, taken from revenue growth or "off the top." Additionally, there was an extension of filing of taxes to July 2020, due to COVID-19 pandemic.
- FY 20/21: projections include an "artificial" increase due to late filing of 19/20 taxes.
- FY 21/22 and 22/23: projected decreased revenue due to COVID-19 pandemic recession.



FUNDING CONSIDERATIONS

Impact of COVID-19 pandemic

Given the significant revenue decrease projections expected to continue through Fiscal Year (FY) 2022-23, it is unlikely that we will be able to fund any new programs or expansions during the implementation of this Three-Year Plan. Yet, priorities for funding were still developed with stakeholders which will, along with the MHSA Funding Principles, guide all funding decisions moving forward.

The COVID-19 pandemic has brought on a lot of challenges related to providing quality, timely and relevant services to clients as they shelter-in-place. Clients need technology devices to stay connected, receive telehealth services and communicate with their service providers. Providers in residential and other services are in need of flexible funds to purchase activities for clients (cards, games, arts and crafts, etc.) to keep them engaged. Other behavioral health funding streams (general County funds, realignment and local sales tax) for core behavioral health services are now in jeopardy. Additionally, there are three Innovation projects in San Mateo County that will need sustainability funding past FY 21/22.

As of July 1, 2019, there was about $5 million in unspent one-time funding available, given the $34.1 million revenue for FY 18/19 and expenditures totaling about $29 million. Based on stakeholder input for supports needed, this unspent one-time funding will be allocated to support COVID-related impacts in San Mateo County. Funding priorities for these monies where developed with feedback from stakeholders and included the following categories:

- Technology Supports and Other Client Support Needs
- Workforce Education and Training
- Stop Gaps for budget reduction impacts

The following community stakeholder groups were engaged in providing input:

- Contractor's Association – May 21, 2020
- Lived Experience Workgroup – June 1, 2020
- MHSARC Older Adult Committee – June 3, 2020
- MHSARC Adult Committee – June 17, 2020
- MHSARC Youth Committee – June 17, 2020

[On June 3, 2020, the MHSARC reviewed a preliminary plan for using unspent monies for COVID-related impacts, they subsequently voted to open the 30-day public comment period and on July 1, 2020 reviewed the public comments received, voted to close the 30-day public comment period and subsequently voted to submit the plan to the Board of Supervisors for approval. The plan including all public comments received is included in Appendix 1.]

**this section to be updated/confirmed once the public comment period closes*

Target Reserve

Counties are required to establish a **Prudent Reserve** to ensure the County programs will be able to serve clients should MHSA revenues drop. The California Department of Health Care Services (DHCS) Info Notice 19-017, released on March 20, 2019, established an MHSA Prudent Reserve level that does not exceed 33% of the average Community Services and Supports (CSS) revenue received in the preceding five years. For San Mateo County, this corresponds to $6.7 million. The Prudent Reserve can only be accessed when "revenues for the Mental Health Services Fund are below recent averages adjusted by changes in the state population and the California Consumer Price Index" subject to DHCS approval.

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

Reversion

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

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

AB 114 and a subsequent Senate Bill (SB) 192 allowed Counties to submit a plan by January 1, 2019 for expending funds by June 30, 3030 that were deemed reverted as of July 1, 2017. San Mateo County submitted plans for INN in the amount of $3,832,545 and WET in the amount of $423,610. The INN plan was approved for an extension. The WET funding was expended as proposed.

Unencumbered Housing Funds

On June 2, 2015, the release of unencumbered San Mateo County MHSA housing funds was approved by our Board of Supervisors following MHSA Steering Committee and MHSARC review and recommendation to approve. DHCS Info Notice 16-025 required Counties to complete *Ongoing Fund Release Authorization* for both existing and future unencumbered funds that may be received by CalHFA on behalf of the counties (e.g. funds that are no longer required by a housing project, accrued interest, and/or other funds receive on behalf of the counties. Funds will be released annually by May 1st. The *Ongoing Fund Release Authorization* was approved by our Board of Supervisors on April 7, 2020. Currently, San Mateo County has an estimated $104,066 in accrued interest and loan payments, which we expected to receive FY 19/20.

Counties must spend the housing funds to provide "housing assistance", which means rental assistance or capitalized operating subsidies; security deposits, utility deposits, or other move-in cost assistance; utility payments; moving cost assistance; and capital funding to build or rehabilitate housing for persons who are seriously mentally ill and homeless or at risk of homelessness. A community planning process will inform the use of the funds.

PRIORITY EXPANSIONS

MHSA priorities identified by stakeholders in the previous Three-Year Plan, that have not been implemented, remain top priorities moving forward.

Progress on previous MHSA Three-Year Plan Priority Expansions

Priority Expansions	**Cost** per Fiscal Year	**Implemented**
Expansion of supports for older adults	$130,000	**YES – Partial** Senior Peer Counseling
Field-based mental health and wellness services to expand access to Coastside	$450,000	**YES** Coastside Multi-Cultural Wellness Center
Expansion of Stigma Free San Mateo, Suicide Prevention and Student Mental Health efforts	$50,000	**YES** Suicide Prevention mini-grants and county-wide stigma survey
Youth mental health crisis support and prevention	$600,000	**In Progress**

Trauma-Informed Services training for 0-5 providers	$150,000	**YES** 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
Expansion of culturally responsive outreach strategies	$50,000	**YES** Chinese community outreach in North County + East Palo Alto and Coastside community collaboration facilitation

Youth Mobile Crisis Response Planning

In San Mateo County, we were able to implement all but one priority expansion from the previous Three-Year Plan, related to youth mental health crisis support and prevention. A Request for Proposal (RFP) for a Youth Mobile Crisis Response and Prevention program, was released in March 2019. Due to County-wide budget constraints, the RFP was put on hold in June 2019 and eventually withdrawn to ensure an integrated approach to youth crisis response.

This has given us an opportunity to augment the program planning and address some of the most prominent concerns related to improving coordination and efficiency versus implementing a free-standing crisis response program. Questions we are considering in planning include how the mobile crisis team integrates with other crisis response efforts, school crisis protocols, law enforcement and private insurances, given that over sixty percent of youth in San Mateo County are privately insured.

Starting in October 2019, the Youth Committee of our local mental health board, the Mental Health and Substance Use Commission (MHSARC) has been meeting monthly to plan an integrated youth crisis strategy, see Appendix 7 for the DRAFT youth crisis strategy concept.

Recently, due to COVID-19 pandemic, the project planning is on hold, and we expect to revisit and determine appropriate next steps in the fall 2020.

MHSA Three-Year Plan Priorities, Fiscal Year (FY) 2020-23

Given the significant revenue decrease projections through FY 2022-23, it is unlikely that we will be able to fund any new programs or expansions during the implementation of this Three-Year Plan. Moving into this new Three-Year Plan, the previously prioritized programs and expenditures will continue. As required, if there is a need to decrease, shift or update the Three-Year Plan in any way, a community planning process will be conducted including a 30-day public comment process and Board of Supervisor approval.

Previous fiscal priorities will continue:

- Ongoing MHSA program expenditures (See Appendix 6 for the funding summary)
- $12.5M Plan to Spend One-Time Funds (See page 55, Plan to Spend One-Time Funds)
- $17M target Operational Reserve; 50% of the highest annual revenue

New fiscal priorities included in this Three-Year Plan:

- $5M unspent from FY 2018-19 allocated to one-time COVID-19 related budget impacts
- $2M anticipated use of operational reserve to cover decreases in revenue and ongoing expenditures in FY 22-23.
- $5M for new MHSA Innovation programs (pending OAC approval) over the next three years

Fiscal priorities if revenues increase:

- Ongoing programs that will be funded temporarily with unspent monies through the $12.5M Plan to Spend One-Time Funds that
    - Innovation program sustainability
    - Workforce Education and Training loan repayment match
    - Peer certification/training and advocacy
- Priority expansion from Three-Year Plan program planning process
    - Mental health workers providing on the field, mobile mental health assessments and treatment for homeless individuals and linkages to housing.
    - Trained/certified peers providing peer and family crisis support services to assist clients transition from psychiatric emergency services, hospitalization and incarceration, into the community.

THREE-YEAR PLAN
PROGRAM PRIORITIES

THREE-YEAR PROGRAM PLAN FY 2017-2020

Welfare and Institutions Code Section (WIC) § 5847 states that county mental health programs shall prepare and submit a Three-Year Program and Expenditure Plan (Plan) that addresses each MHSA component and include expenditure projections. The San Mateo County MHSA Three-Year Plan aligns with the Behavioral Health and Recovery Services (BHRS) of the San Mateo County Health System's commitment a holistic view to the health and well-being of individuals; placing high value in care coordination, collaboration and integration, prevention and early intervention, data-driven interventions, cost control, quality improvement, and meaningful outcomes.

The following pages describe the MHSA Three-Year Plan programs and priorities developed taking specific priorities identified through stakeholder input from previous years, new priorities identified through this year's Community Program Planning process, and the fiscal projections for the next three years. Our multi-year approach facilitates stability, ensures a balanced approach when considering programmatic changes, and utilizes higher revenue years to cushion lower revenue years.

COMMUNITY SERVICE AND SUPPORTS (CSS)

CSS provides direct treatment and recovery services to individuals of all ages living with serious mental illness or emotional disturbance with a focus on un-served and underserved populations. CSS is the largest MHSA component, approximately 75-80% of MHSA funding. There are three different service categories; Full Service Partnerships (FSP), System Development (SD), and Outreach and Engagement (O&E). At least 51% of CSS funds must be spent on FSPs and focus on un-served and underserved populations.

FULL SERVICE PARTNERSHIP (FSP)

FSPs include 24 hours a day, 7 days a week services; peer supports; high staff to client ratios for intensive behavioral health treatment including medications; linkage to housing; supported education and employment; treatment for co-occurring disorders; skills-based interventions, among others. The target population for FSPs include, high risk children and youth who would otherwise be placed in a group home; seriously mentally ill and dually diagnosed adults including those eligible for diversion from criminal justice incarceration; incarcerated individuals; persons placed in locked facilities who can succeed in the community with intensive supports; and individuals with frequent emergency room visits, hospitalizations, and homelessness; and seriously mentally ill older adults at risk of or currently institutionalized who could live in a community setting with intensive supports.

The current CSS FSP component categories will continue through FY 2022-23, as follows:

Children and Youth Full Service Partnerships - helps our highest risk children and youth with serious emotional disorders remain in their communities and with their families or caregivers while attending school and reducing involvement in juvenile justice and child welfare. Integrated clinic-based FSP services for the Central/South Youth Clinic (outpatient), as well as the integrated FSP for intensive school-based services, school-based milieu services, and the non-public school setting, will continue. FSPs for children and youth will also serve youth placed in foster care temporarily outside of the County to support and stabilize youth in the foster home, support the foster family, and facilitate the return of the youth to San Mateo County.

The Children and Youth FSP slots were decreased a total of 35 slots across all programs below, due to decreased demand on services. FSP services (excluding out-of-county foster care) also experienced decreases in referrals from Human Services Agency and Probation. Since the decrease, there has been progress made with timeliness of engagement, units of service and providers seeming more willing to refer. The slots allotted will be revisited if programs begin to increase to near or at capacity.

Projected number of children and youth to be served through FSPs: 70

Program	*Cost*	*# to be served*
Out of County Foster Care Settings	$180,802	5
Integrated "SAYFE" FSP	$700,486	25
Comprehensive "Turning Point" FSP	$2,101,093	40

Transitional Age Youth (TAY) Full Service Partnerships - provides intensive community based supports and services to youth identified as having the "highest needs" who are between the ages of 16-25. Specialized services to TAY with serious emotional disorders are provided to assist them to remain in or return to their communities, support positive emancipation including transition from foster care and juvenile justice, secure, safe, and stable housing and achieve education and employment goals. TAY FSPs helps reduce involuntary hospitalizations, homelessness, and involvement in the juvenile justice system.

TAY FSPs will continue to provide enhanced supported education services to TAY with emotional and behavioral difficulties and/or substance use issues. Outreach activities engage TAY in educational or vocational activities for educational plans and employment. Housing services for TAY will provide housing subsidies and a small cluster of apartments. Teaching daily living skills, medication management, household safety/cleanliness, budgeting, and roommate negation skills are a part of the treatment and education of the youth.

Projected number of TAY to be served through FSPs: 50 Comprehensive FSPs (added 10 slots), 40 Enhanced Education, 20 Supported Housing

Program	*Cost*	*# to be served*
Comprehensive "Turning Point" FSP + Drop-In Centers	$2,101,093	40

Adult and Older Adult Full Service Partnerships – provides services specific to maximize social and daily living skills and facilitate use of in-home supportive agencies. Services are provided to our highest risk adults, highest risk older adults/medically fragile adults. The overall goal of the adult FSPs is to divert from the criminal justice system and/or acute and long-term institutional levels of care (locked facilities) seriously mentally ill and dually diagnosed individuals who can succeed in the community with sufficient structure and support. The goal of the FSP is to facilitate or offer "whatever it takes" to ensure that consumers remain in the least restrictive setting possible through the provision of a range of community-based services and supports delivered by a multidisciplinary team. A housing program provides FSP members stable housing by providing additional oversight and support to enable members who might otherwise be at risk of losing their housing to stay consistently housed. This also includes some supplementing of residential care facilities for clients who require this level of supervision and services.

Projected number of adults, older adults and medically fragile individuals to be served: 252 plus housing supports

Program	*Cost*	*# to be served*
Adult and Older Adult/Medically Fragile FSP	$3,500,009	207
Comprehensive FSP	$740,062	30
Assisted Outpatient Treatment "Laura's Law" FSP	$890,639	50
Lodge Integrated FSP	$127,367	15

HOUSING INITIATIVE

Housing supports can include various strategies including scattered site housing, augmented board and cares, room and boards, temporary shelter beds, transitional housing and permanent supportive housing, amongst other strategies. Additionally, a comprehensive continuum of services can include pre-housing engagement strategies such as drop-in centers, field services targeting the homeless, and linkages and peer support post-psychiatric emergency, hospitalization and incarceration. As described earlier, a strategic approach to address the input received during the community planning process, was proposed to the MHSA Steering Committee. The 22 strategies prioritized through the input sessions were organized under 5 MHSA Strategic Initiatives with the intent to reallocate existing MHSA staff resources to engage stakeholders in planning across the prioritized initiatives. Housing was the Strategic Initiative that most Steering Committee members prioritized. Beginning FY 2020-21, planning for this Housing initiative will include the following goals:

- Define a continuum of services for housing
- Identify gaps at all levels of support or intensity of housing needs
- Identify expected outcomes and activities/strategies that will support a comprehensive housing continuum for individuals with mental health challenges.

Augmented Board and Cares – provide a supported living environment for clients with severe mental illness (SMI). These placements are needed to afford SMI client's an opportunity to live in the community in a supported living environment. There is one BHRS staff that is the designated board and care liaison. This staff approves board and care referrals, completes assessments, oversees admissions and discharges to BHRS contracted B&C's.

B&C's serve adults with SMI that have completed a social rehabilitation program or are stepping down from a locked setting. They are psychiatrically stable, compliant with medications and in need of a supported living environment. Clients are Health Plan of San Mateo members, and either have Social Security Administration and/or General Assistance benefits.

The B&C provides three meals a day, medication management which includes storing and administration of medications. They regularly collaborate with the client's treatment team and conservator about client's progress, and/or issues that impact the client's placement.

Projected number of people served: 184

Program	*Cost*	*# to be served*
Augmented Board and Cares (various)	$3,497,585	184

GENERAL SYSTEM DEVELOPMENT (GSD)

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

OLDER ADULT SYSTEM OF CARE

Older adult system of care – to create integrated services for older adults to assure that there are sufficient supports to maintain the older adult population in their homes and community, in optimal health and sustaining independence and family/community connections.

Projected number of older adult consumers/clients served: 750

Program	*Cost*	*# to be served*
Older Adult System of Integrated Services (OASIS)	$764,660	50
Senior Peer Counseling (50%)	$171,696	350

CRIMINAL JUSTICE INTEGRATION

Criminal justice integration – to provide treatment and support services to seriously mentally ill non-violent offenders and divert from incarceration into community-based services.

Projected number of mentally ill non-violent offenders' consumers/clients served: 70

Program	*Cost*	*# to be served*
Pathways Court Mental Health Program + Housing	$435,520	50
Juvenile Girls Program (45%)	$89,375	20

CO-OCCURRING SERVICES

Co-occurring services – to support services for clients with co-occurring mental health and substance use disorders with additional bed days (for residential providers) or additional hours of service (for non-residential providers), or to enhance/supplement services provided to clients already in treatment. BHRS contracts with seven AOD providers and funds co-occurring staff to enhance services provided to co-occurring clients. Additionally, two clinical contractors provide co-occurring capacity development trainings, consultation for complex co-occurring clients and system transformation support for relevant programs.

Projected number of co-occurring consumers/clients served: 5,580

Program	*Cost*	*# to be served*
Co-Occurring Recovery Support Services	$164,653	5,000
Co-Occurring Contracts + Staff	$698,817	400
Coastside Multicultural Wellness - Co-Occurring Services	$55,000	180

PEER AND FAMILY PARTNERS SUPPORTS

Peer and family partner supports – to support employment of consumer/client and family partners with lived experience within the county behavioral health system of care, which recognizes the special contributions and perspectives of behavioral health consumers/family members and encourages the valuable role of peer support and case management.

Projected number of consumers/clients served through peer support strategies: 250

Program	*Cost*	*# to be served*
Peer Support Workers & Family Partners	$1,553,977	250

Wellness centers – to support wellness and recovery of clients and their families in the community. Provide opportunities for increased socialization, employment, education, resource sharing and self-advocacy.

Projected number of consumers/clients served through drop-in centers: 850

Program	*Cost*	*# to be served*
California Clubhouse	$334,214	200
Barbara A. Mouton Multicultural Wellness Center	$194,428	150
Coastside Multicultural Wellness Center	$355,000	500

OTHER SYSTEM DEVELOPMENT

Child Welfare – to support services for high risk children/youth referred through child welfare.

Projected number of high-risk children/youth served: 50

Program	*Cost*	*# to be served*
Child Welfare Partners	$495,377	50

Dual diagnosis, developmental disabilities services– to serve the special mental health needs of clients with developmental disabilities with comprehensive mental health treatment including medication management.

Projected number of mentally ill consumers/clients with developmental disabilities served: 150

Program	*Cost*	*# to be served*
Puente Clinic	$363,369	150

Evidence-based practices (EBP) – to support provision of evidence-based services throughout BHRS for youth and adult consumers/clients.

Projected number of consumers/clients served by EBP clinicians: 950

Program	*Cost*	*# to be served*
Evidence-Based Practice	$1,502,767	950

INFRASTRUCTURE STRATEGIES

Infrastructure- BHRS administration, information technology (IT), support staff, evaluation, and the Contractor's Association all support BHRS and network of care in the amount of $1,554,941.

OUTREACH AND ENGAGEMENT (O&E)

San Mateo's MHSA-funded Outreach and Engagement program strategy increase access and improves linkages to behavioral health services for underserved communities. Current programs under this component category will continue. BHRS has seen a consistent increase in representation of underserved communities in our system since these MHSA-funded strategies were deployed. Strategies include:

Pre-crisis response **-** provides outreach, engagement, assessment, crisis intervention, case management and support services to individuals who are experiencing severe emotional distress and their families/caretakers.

Projected number of people reached: 100

Program	*Cost*	*# to be served*
Family Assertive Support Team	$316,245	100

Primary care-based efforts **-** identifies and engages individuals presenting for healthcare services that have significant needs for behavioral health services.

Projected number of people reached: 400

Program	*Cost*	*# to be served*
Ravenswood Family Health Center (40%)	$16,900	160

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 INTERVENTIONS (AGES 0-25)

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

EARLY CHILDHOOD COMMUNITY PROGRAM

Early childhood community program – supports healthy social emotional development of children through community outreach, case management, parent education, mental health consultation, and child-parent psychotherapy services to families with young children.

Projected number of children and families with young children to be served: 120

Program	*Cost*	*# to be served*
Early Childhood Community Team (ECCT)	$425,450	120

COMMUNITY INTERVENTIONS FOR SCHOOL AGE AND TAY

School-age youth programs – will serve children and youth in grades K-12 either administered by a school or a community-based organization in cooperation with schools. This program provides population and group-based interventions to at-risk children and youth, such as substance abuse programs, drop-in centers, youth focused and other organizations operating in communities with a high proportion of underserved populations.

Projected number of school-age youth to be served: 350

Program	*Cost*	*# to be served*

Project SUCCESS	$305,771	200
Trauma-Informed Co-Occurring Services for Youth	$180,000	100
Teaching Pro-Social Skills	200,000	50

PEI AGES 0-25: EARLY CRISIS INTERVENTIONS

Crisis hotline and intervention – a free, confidential 24-hour, seven days a week crisis intervention hotline for San Mateo County residents provided by trained volunteer/staff. Provide peer phone counseling linkages to resources that may help.

Projected number calls to the crisis hotline: 12,000

Program	*Cost*	*# to be served*
Youth Crisis Response & Prevention	$333,691	12,000

EARLY INTERVENTION: EARLY CRISIS INTERVENTIONS

911 mental health assessment and referral **-** specially trained paramedic responds to law enforcement requests for individuals having a behavioral health emergency.

Projected number of calls to SMART: 2,500

Program	*Cost*	*# to be served*
San Mateo Mental Health and Referral Team (SMART)	$145,000	2,500

EARLY INTERVENTION: EARLY ONSET OF PSYCHOTIC DISORDERS

Prevention of early onset of psychotic disorders – to provide a comprehensive program of science-based early diagnosis, treatment, and rehabilitation services for psychotic disorders such as schizophrenia. This program aims to prevent the onset of full psychosis, and, in cases in which full psychosis has already occurred, seeks to remit the disease and to rehabilitate cognitive capacities damaged by the disease.

Projected number of clients with early psychosis to be served: 100

Program	*Cost*	*# to be served*
Early Psychosis Program – (re)MIND	$835,648	100

EARLY INTERVENTION: PRIMARY CARE AND BEHAVIORAL HEALTH INTEGRATION

Integration with primary care –identifies persons in need of behavioral health services in the primary care setting, connecting people to needed services. Strategies include system-wide co-

location of BHRS practitioners in primary care environments to facilitate referrals, perform assessments, and refer to appropriate behavioral health services.

Projected number of clients to be served at primary care settings: 1,000

Program	*Cost*	*# to be served*
Primary Care Interface	$1,069,057	1,000

PREVENTION: COMMUNITY OUTREACH, ENGAGEMENT AND CAPACITY BUILDING

Office of Diversity and Equity (ODE) programs –ODE advances health equity in behavioral health outcomes of marginalized communities throughout San Mateo County. ODE works to empower communities; influence policy and system changes; develop strategic and meaningful partnerships; and promote workforce development and transformation within the County's behavioral health service system. ODE has oversight of MHSA Administration, Workforce Education and Training, Prevention and Early Intervention (PEI) coordination and some PEI programming. The current PEI programs under ODE that will continue include culturally-relevant provider trainings, Health Equity Initiatives, Health Ambassador Programs for Adult and Youth, Storytelling, Mental Health First Aid for adults and youth and the Parent Project, which is currently funded by a local tax revenue, Measure K.

Projected number of people reached through the following core ODE programs: 2,580

Program	*Cost*	*# to be served*
Health Equity Initiatives	$148,390	2,500
Health Ambassador Program (Youth and Adult)	$262,200	80

Infrastructure- PEI and ODE administration and supplies, planning and evaluation expenditures total $863,776.

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS

Mental Health First Aid – to introduce participants to the unique risk factors and warning signs of mental health problems in adults, build understanding of the importance of early intervention, and teaches individuals how to help an individual in crisis or experiencing a mental health challenge. Youth MHFA is currently funded by a local tax revenue, Measure K.

Projected number of people reached through the following ODE program: 200

Program	*Cost*	*# to be served*
Adult Mental Health First Aid (MHFA)	$35,826	200

Outreach worker program (reallocating) – provides behavioral health outreach and engagement services to marginalized communities who may be in need of behavioral health services to link them to appropriate services. Outreach workers are from the target communities and bilingual/bicultural to provide culturally responsive education, awareness, empowerment and linkages.

Currently, ODE employs limited-term outreach workers focused on the Pacific Islander and LGBTQ+ community. These positions will end in the fall of 2020. Given challenges with hiring County permanent staff positions, the funding will be reallocated to community-based organizations with expertise in reaching marginalized communities. For example, starting FY 18/19, the funding for the part-time Chinese outreach worker was supplemented with the previous MHSA Three-Year Plan priority "Expansion of culturally responsive outreach strategies." The combined funding in the amount of $60,000 was integrated into the Request for Proposal (RFP) for the North County Outreach Collaborative with increased deliverables to reach and link the Chinese community to behavioral health services.

Program	*Cost*
Outreach Workers (through September 2020)	$227,136

Community outreach collaboratives – intended to facilitate a number of activities focused on community engagement, including outreach and education efforts aimed at decreasing stigma related to mental illness and substance abuse; increasing awareness of and access to behavioral health services; advocating for the expansion of local resources; gathering input for the development of MHSA-funded services; linking and referring residents to culturally and linguistically competent behavioral health, public health and social services; and providing input into the development of MHSA funded services and other BHRS program initiatives.

Projected number of people reached: 6,000

Program	*Cost*	*# to be served*
North County Outreach Collaborative	$227,136	4,500
East Palo Alto Partnership for Behavioral Health	$185,848	1,500

Coastside community engagement – to provide providing culturally-responsive outreach to the Coastside community. Primarily services are provided through outreach workers (promotores) with shared lived experience with the Coastside and familiarity with behavioral health resources to conduct outreach and engagement, provide referrals, warm hand-offs, mental health information, and education, collaborate with BHRS staff, and identify community-based entities, health and social service providers and other resources. Community engagement also includes ongoing community capacity building, including youth leadership development that focuses on advocacy and system change.

Projected number of consumers/clients served through the wellness center: 3,000

Program	*Cost*	*# to be served*
Coastside Multicultural Wellness – Community Engagement	$40,000	3,000

Older adult outreach – to create integrated services for older adults to assure that there are sufficient supports to maintain the older adult population in their homes and community, in optimal health and sustaining independence and family/community connections.

Projected number of older adult consumers/clients served: 350

Program	*Cost*	*# to be served*
Senior Peer Counseling (50%)	$171,696	350

Primary care-based efforts **-** identifies and engages individuals presenting for healthcare services that have significant needs for behavioral health services.

Projected number of people reached: 240

Program	*Cost*	*# to be served*
Ravenswood Family Health Center (60%)	$25,440	240

STIGMA AND DISCRIMINATION REDUCTION

Digital Storytelling & Photovoice **-** empowers community members to share their stories of recovery and wellness to heal and to address issues within their communities. Participants engage in workshops that help them create and share their stories in different forms. Beginning with a framing question, facilitators support participants to share their stories as Photovoices or Digital Stories.

Projected number of people reached: 50

Program	*Cost*	*# to be served*
Digital Storytelling & Photovoice	$56,289	50

Mental Health Awareness - is an initiative by San Mateo County's Behavioral Health and Recovery Services (BHRS) to eliminate stigma and end the discrimination against people with mental illness and substance use issues in San Mateo County.

Projected number of people reached: 3,000

Program	*Cost*	*# to be served*
Mental Health Awareness & Be the One Campaign	$113,522	3,000

SUICIDE PREVENTION

Suicide Prevention Initiative - For over three years, San Mateo County has convened a Suicide Prevention Committee that has examined ways to improve policies and systems to prevent suicide. The Committee is comprised of both BHRS staff and community members, and address issues such as community mental health education and awareness, gatekeeper trainings, and provider trainings on suicide ideation and intervention. Activities have included suicide prevention presentations at agencies and community meetings, partner meetings with the County Office of Education, and data updates.

Projected number of people reached: 1,000

Program	*Cost*	*# to be served*
Suicide Prevention Committee	$63,019	1,000

PEI STATEWIDE PROJECTS

California Behavioral Health Services Authority (CalBHSA) implements PEI Statewide Projects including Suicide Prevention, Stigma and Discrimination Reduction, and the Student Mental Health Initiative. CalBHSA is a Joint Powers Authority (JPA), formed July 2009 as solution to providing fiscal and administrative support in the delivery of mental health services. San Mateo County will continue to contribute 2% of PEI funding for sustainability of these projects.

INNOVATION (INN)

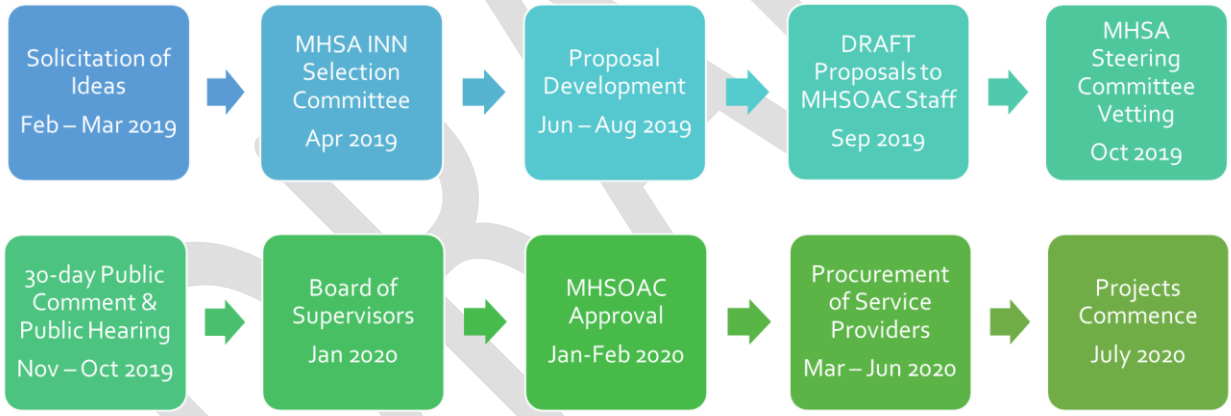
INN projects are designed and implemented for a defined time period (not more than 5 years) and evaluated to introduce a behavioral health practice or approach that is new; make a change to an existing practice, including application to a different population; apply a promising community-driven practice 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.

Utilizing MHSA funding for sustainability of INN Projects is part of the MHSA Three-Year Plan comprehensive Community Program Planning (CPP) process. Following are the current INN projects, the end date for INN funding and current sustainability plan given the anticipated decreases in revenue:

Innovation Project	Innovation Funding Ending	Sustainability Plan
Neurosequential Model of Therapeutics (NMT) in Adult System of Care	June 30, 2020	One-time funding through June 30, 2022
Health Ambassador Program for Youth	June 30, 2020	One-time funding through June 30, 2022
San Mateo County Pride Center	June 30, 2021	One-time funding through June 30, 2022
Help@Hand (Tech Suite)	Extended to June 30, 2023	To be determined

New Innovation Projects

On April 7, 2020, the San Mateo County Board of Supervisors (BoS) approved the 5 project ideas we submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) in February for approval. The MHSOAC review of the San Mateo County proposals has been placed on hold. The MHSOAC is prioritizing Counties that have funds subject to reversion as of June 30, 2020. San Mateo County is anticipating about $385,734 from FY 17/18 unallocated and subject to reversion. The MHSOAC has agreed to review one of our 5 projects to allow us the opportunity to lock in the FY 17/18 unallocated funds.



The 5 anticipated new INN projects are summarized below and the BoS approved versions were submitted with our most recent FY 19/20 Annual Update.

1. **Addiction Medicine Fellowship in a local community setting**
   Estimated Project Amount & Length: $663,125 / 4 years
   The proposed project is an accredited Addiction Medicine Fellowship sponsored by San Mateo County that is tailored to addressing the needs and priorities of the public sector including treating the most vulnerable communities with co-occurring substance use disorders, advancing equity on multiple levels and contributing to educational projects in clinical and community settings. This would also be the first Addiction Medicine Fellowship based in a local health safety net health system, serving as a model for California's 58 counties.

Annual projected number of participants served: 1,400

2. **Co-location of Prevention and Early Intervention Services in Low-Income Housing**
   Estimated Project Amount & Length: $925,000 / 4 years
   The proposed project will provide prevention and early intervention services including behavioral health resources, supports, screening, referrals and linkages to young adults, ages 18-25, on-site at affordable housing properties, minimizing stigma and reducing barriers to accessing behavioral health care.
   Annual projected number of young adults served: 150
3. **PIONEERS - College-Age Pacific Islander Mental Health**
   Estimated Project Amount & Length: $925,000 / 4 years
   The proposed project, Pacific Islanders Organizing, Nurturing, and Empowering Everyone to Rise and Serve (PIONEERS) provides a culturally relevant, college behavioral health program for NHPI youth that prioritizes the mental wellbeing of students and their respective communities through empowerment, leadership and advocacy.
   Annual projected number of NHPI youth served: 45 direct; 30 through community projects
4. **Older Adult Homelessness Prevention due to Economic Stress**
   Estimated Project Amount & Length: $750,000 / 4 years
   The proposed project will reach-out and engage isolated older adults who may be at risk of becoming homeless. Trust and safety will be established to reduce shame/stigma. Older adults will be screened for economic stress, behavioral health issues, and connected to homeless, housing and behavioral health resources for planning, and support, to prevent acute homelessness and to slow the growing older adult homeless population trend. The innovation will create a new partnership between Human Services Agency Center for Homelessness providers, Older American Act programs, Behavioral Health and Recovery Services, and Aging and Adult Services.
   Annual projected number of participants served through home visits: 340; 120 screened
5. **Social Enterprise Cultural and Wellness Café**
   Estimated Project Amount & Length: $2,625,000 / 5 years
   The proposed project is a cultural arts and wellness-focused social enterprise café that offers youth development and mental health programming on site. The social enterprise café will hire and train at-risk youth from Northern San Mateo County and serve as a culturally affirming space for Filipino/a/x youth and community. The social enterprise model has proven to be a more sustainable approach when it comes to stable and diversified funding streams. Most of the existing community organizations that offer some elements of the proposed project rely heavily on grant-writing and fundraising.
   Annual projected number of participants served: 2,000 unique visitors; 300 referrals; 150 receive behavioral health services; 90 participate in services; 40 in full programming

WORKFORCE EDUCATION & TRAINING (WET)

In Fiscal Year (FY) 2006-07 and FY 2007-08, San Mateo County Behavioral Health and Recovery Services (BHRS) received a one-time MHSA allocation in the amount of $3,437,600, for Workforce Education and Training (WET) strategies. A WET 10-Year Impact and Sustainability Report was released and presented to our local mental health board, the Mental Health and Substance Use Recovery Commission on February 7, 2018 recommending $500,000 per year to sustain the most effective and impactful elements of WET. The sustainability plan was approved and submitted as part of the FY 2017-20 MHSA Three Year Plan.

More recent developments include the following:

The Office of Statewide Health Planning and Development (OSHPD), in coordination with the California Behavioral Health Planning Council (CBHPC), is charged with the development of a WET Plan every five years to address the needs of the behavioral health workforce statewide. In February 2019, OSHPD released a 2020-2025 MHSA WET Five-Year Plan. Implementation of the Five-Year WET Plan will occur through a Regional Partnership framework. Regional Partnerships will be funded to implement strategies in pipeline development, undergraduate scholarships, education stipends, and educational loan repayments. San Mateo County will participate in the Bay Area Regional Partnership and has allocated a required match in the amount of $200,000 one-time monies approved through a community planning process and submitted in our FY 2019-20 MHSA Annual Update.

A San Mateo County MHSA Three-Year WET Plan, FY 2020-2023 has been developed to guide implementation of local strategies. The Three-Year WET Plan is in alignment with statewide priorities, builds off of the current plan and was developed in collaboration with stakeholders, providers and community partners, to identify areas of need, strengths, opportunities for improvement and recommendations for future funding. Following are the 4 key Priority Recommendations moving forward:

Priority Recommendation #1

Increase in one WET team position classification in order to adequately support the existing WET strategies. Moving forward, BHRS recommends the following workforce staffing structure:

- A WET Director: Provides oversight of the WET Program planning and implementation and related WET workgroups/committees including statewide representation; evaluation; facilitation of the Workforce Development and Education Committee (WDEC) and the Practice Evaluation Committee (evidence-based practices); and

participation in several BHRS Workgroups related to supporting BHRS strategic initiatives.

- A WET Community Program Specialist: Provides oversight of clinical and Office of Diversity ad Equity (ODE) internship programs, the Cultural Competency Stipend Internship Program and the Cultural Humility Training Cohort.
- A WET Community Program Specialist (new - previously an Office Specialist): Coordinates training/education needs, documentation, and evaluation for all WET Programs and trainings; administers the Learning Management System for all BHRS trainings including the new learning management system to support enhanced online training opportunities.

Priority Recommendation #2

Add a Supervising Peers training to support Peer Integration strategies to that lead to system transformation. The Supervising Peers training will be focused on developing the skills and knowledge needed to apply recovery-oriented, trauma-informed, and culturally relevant approaches to the supervision of peers and family support workers. The training will be followed with standardization of peer and family support workers' critical role in behavioral health care services.

Priority Recommendation #3

Provide ongoing funding for peer-led and focused trainings. The following trainings will be offered beginning FY 2020-21 utilizing $100,000 in one-time funding that has been approved through a community planning process and submitted in our FY 2019-20 MHSA Annual Update. Stakeholders have prioritized this across various strategies to be included in the MHSA Three-Year Plan's ongoing budget.

- *Peer Services Training.* Provide a standardized curriculum in San Mateo County to support peers in developing the ability, skills, knowledge, and values needed to deliver support services in behavioral health care settings (county, community-based, peer-run agencies, etc.). Training competencies will be drawn from established organizations and research on Peer Certification and training curricula development across the state and customized through a local San Mateo County stakeholder input process. Additional key values in San Mateo County that will be included are principles of recovery, trauma-informed care, cultural humility, and client empowerment.

- *Community Advocacy for Peers.* Training will be designed to empower clients and family members to advocate for themselves and their communities and to bring the powerful voices of those with lived experience to behavioral health decision-making spaces.

Training participants will develop skills related to giving public comment, effective advocacy, and understanding government organizational structures. Clients and family members will be provided initial support (e.g., completing applications/interviews if applicable) and list of local opportunities for participation in decision-making boards, commissions, committees, and other county bodies.

- *Documentation for Peer Workers.* This training will help participants develop the skills and knowledge needed for documentation including understanding billing codes and writing progress notes.

Priority Recommendation #4

Given stakeholder interest in a local educational loan forgiveness program, it is recommended that MHSA fund a local educational loan forgiveness program for hard-to-fill positions including bilingual and culturally/ethnically diverse clinical positions. While this was not prioritized by the MHSA Steering Committee as part of the FY 2020-23 MHSA Three-Year Plan, it was the highest priority for Workforce needs. The OSHPD Regional Partnerships may offer an opportunity to supplement a local San Mateo County educational loan forgiveness program but this is pending regional approval.

Please see Appendix 8 for the complete MHSA Three-Year WET Plan, which includes a description of ongoing workforce strategies and a summary of stakeholder input and prioritizations.

CAPITAL FACILITIES & TECHNOLOGY NEEDS (CFTN)

In the early implementation years of MHSA, 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.

Until recently, we had not allocated funding to CFTN. The Plan to Spend One -Time Available Funds includes CFTN priorities to renovate the following County-owned facilities, the South San Francisco Clinic, the East Palo Alto Clinic and Casia House and Cordilleras.

ANNUAL UPDATE
FY 2020-2021

ANNUAL UPDATE FY 2020-21

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.

San Mateo County submitted the most recent data for FY 2018-19 in the FY 2019-20 Annual Update. The Annual Update was approved by our local Board of Supervisors on April 7, 2020. Given we have no new program data to submit, this current Annual Update will focus on updates to MHSA implementation, expenditures and evaluation reports.

PLAN TO SPEND ONE-TIME FUNDS

In FY 2019-20 Annual Update, San Mateo County submitted a Plan to Spend Available One-Time Funds, included in Appendix 9 as a reference.

As of July 1, 2018, San Mateo County had $12.5 million unspent available one-time funding to advance MHSA program priorities ($3.9 of the $12.5 million must be spent in Prevention and Early Intervention projects). Funding priorities for the $12.5 million available one-time funds were developed in collaboration with stakeholders and presented to the MHSA Steering Committee. On November 6, 2019, the Mental Health and Substance Use Commission held a public hearing, closed the 30-day public comment period, reviewed the public comments, and subsequently voted to submit the plan to the Board of Supervisors for approval. The final Plan to Spend was submitted and approved by our Board of Supervisors on April 7, 2020 along with the FY 2019-20 Annual Update.

San Mateo County MHSA Reserve	
Unspent	$35.7M
Reserve Goal	-$16.5M
Obligated	-$6.7M
Available One-Time	$12.5 M

The Plan to Spend included a few priorities in FY 2019-20 as summarized below. Due to COVID-19 pandemic, many of the proposed expenditures are delayed to FY 20/21. We have made significant progress on developing a Comprehensive, Continuous, Integrated System of Care model for Full Service Partnerships through a multi-county FSP project facilitated by Third Sector consultants and CalMHSA administration. This project is a proposed 4.5 year Multi-County FSP Innovation Project between the following Counties: Fresno, Sacramento, San Mateo, San Bernardino, Siskiyou and Ventura. In San Mateo County we are not using MHSA INN funds for this project as this was better aligned with one-time priorities. We intend to use unspent MHSA CSS funds as designated and approved through the Plan to Spend Available One-Time Funding local community program planning process to meet a similar purpose and set of objectives as the Multi-County FSP Innovation Project. The Multi-County FSP Innovation Project are available in Appendix 10.

Priority	Item	FY 19/20	Implementation Updates
System Improvements - Core MHSA Services	Recovery oriented, co-occurring capacity of FSPs (Comprehensive, Continuous, Integrated System of Care model)	$500,000	San Mateo County joined a statewide, multi-county FSP project to develop and implement new data-driven strategies to better coordinate FSP service delivery, operations, data collection, and evaluation.
	MHSA PEI outcomes-oriented and data-informed improvements and planning	$100,000	Delayed to FY 20/21
	System Improvement Total	**$600,000**	
Technology for System Improvement	Network Adequacy Compliance	$100,000	Delayed to FY 20/21
	Documentation Training	$100,000	Completed
	Increase access-telepsychiatry/health	$30,000	Completed
	Technology Total	**$230,000**	
Capital Facilities	EPA Clinic	$700,000	Delayed to FY 20/21
	Casia House Renovations	$100,000	Delayed to FY 20/21

EVALUATION REPORTS

San Mateo County hires, independent contractors to provide annual evaluation reports for Full Service Partnerships, Innovation, and the Outreach Collaboratives. San Mateo County submitted the most recent implementation highlights for FY 2018-19 in the FY 2019-20 Annual Update that was approved by our local Board of Supervisors on April 7, 2020. Appendix 11, 12 and 13 includes the completed final evaluation reports as follows:

- Innovation - current INN projects in San Mateo County include: The San Mateo County Pride Center, the Neurosequential of Therapeutics (NMT) in an Adult System of Care, the Health Ambassador Program for Youth (HAP-Y) and most recently the Help@Hand (Tech Suite). Resource Development and Associates developed an evaluation plan for all four projects and has been collecting ongoing data for the first three. Help@Hand has not had a full year of implementation. See Appendix 11 for full FY 2017-18 INN Evaluation Reports including an implementation update for Help@Hand prepared by the California Mental Health Services Authority (CalMHSA) who is managing the statewide Help@Hand Collaborative.

- Full Service Partnerships (FSP) - American Institutes for Research (AIR) analyzes FSP data for youth, transition age youth and adults to understand how enrollment in the FSP is promoting resiliency and improved health outcomes of clients living with a mental illness. Appendix 12 includes the completed FSP Evaluation Report.

- Outreach Collaboratives - AIR also supports evaluation and analyses of the PEI Outreach Collaboratives. Appendix 13 includes the completed Outreach Collaborative Evaluation Report

PREVENTION AND EARLY INTERVENTION (PEI) EVALUATION REPORT

PEI EVALUATION REPORT

In June 2018, the PEI regulations were amended, and specific requirements were added that include indicators, data trackers, and requirement of an Annual PEI Report and a Three-Year PEI Evaluation Report.

Annual PEI Reports

San Mateo County has submitted Annual PEI Reports with each MHSA Annual Update. The most recent Annual PEI Report included data outcomes form FY 2018-19 and was submitted and approved by our local Board of Supervisors on April 7, 2020 along with the FY 2019-20 Annual Update.

Three-Year PEI Evaluation Report

Each County is also required to submit a Three-Year PEI Evaluation Report with the first report due by June 30, 2019 and covering data from FY 2016-17 and FY 2017-18. While, we had not submitted our first PEI Evaluation Report until now, we intend to submit these in a timely manner moving forward and have been taking steps since the new regulations were released in June 2018 to develop the infrastructure for meeting all the data collection requirements including:

- Hired a limited-term Community Health Planner in the fall of 2018 to support infrastructure development for PEI reporting. The three-year term for the Community Health Planner will end in the fall of 2021.
- Updated the annual reporting tool for all PEI programs and contractors to include all demographic and data reporting requirements.
- Ensured that all PEI programs addressed the required new categories and strategies from the updated PEI regulations including:
    - Create access to linkage and treatment
    - Timely access to mental health services for individuals and families from underserved populations
    - Non-stigmatizing and non-discriminatory
- Developed an evaluation framework for the Office of Diversity and Equity prevention programs including a comprehensive and community informed demographic form for all events, workshops and activities
- Allocated, through a local stakeholder planning process, $200,000 one-time available funds to develop a PEI database or centralized portal for data collection and we look forward to implementing this priority next fiscal year (FY) 2020-21.

Appendix 12 includes the complete **Three-Year PEI Evaluation Report**. Based on the findings of this report, below are some recommended action steps that are included in the report and will allow us to better comply with the new PEI regulations.

- **Contract an external evaluator:** Due to limited staffing capacity, an evaluator from an outside agency will be contracted to guide the PEI evaluation process, outcomes, and implementation of tools. They will work with the Community Health Planner to meet with contract monitors, contract agencies, establish and implement outcome metrics for each of the programs. The standardized outcome template will be changed to reflect specific data requirements. The outcome metrics will be developed with contractors, clients/family members as well as staff to ensure outcomes that they are representative of the work being done, that they fulfill the PEI requirements and are meaningful to the community. This will enable us to develop an evaluation plan that is culturally competent and includes the perspective of diverse people with lived experience.
- **Hold regular meetings with contract monitors:** These meetings will be held with each of the contract monitors to update and provide them with the new PEI regulations. It will enable us to gain understand as to their involvement with the contractor, familiarity with the data requirements and establish oversight procedures for data collection.
- **Hold egular meetings with PEI programs and contracted agencies:** These meetings will be held with each of the contractors regarding implementation, data collection and analysis. One of the recommendations from our previous evaluator was that contract agencies needed training on data collection. These preliminary meetings will serve to gauge the capacity of the agency, obtain feedback on outcome measures and tools proposed, creation of a PEI data base, and review of the new PEI guidelines as well as updated expectations and potential contract amendments.
- **Develop a PEI database**: Currently, data collection is not standardized. Many programs submit annual reports with quantitative data that changes from year to year based on their capacity/turn over and many outcomes are based on what the agencies deem to be meaningful at the time. With the standardization of outcome metrics and reporting, as well as a centralized data base, it will enable us to make data driven systems improvements, compare year to year outcomes and comply with PEI regulations.
- **Create formal protocols**: Formal written protocols are needed for PEI programs, these protocols would include communication of PEI requirements, clear expectations of what needs to be completed by each program, who is responsible for each task assigned, as well as timelines for all activities. These protocols would specify the expectations around data collection, the role of the contract monitors and reporting expectations, such as quarterly reports, and annual reports for programming.

APPENDIX 1 THREE-YEAR PLAN & ANNUAL UPDATE MATERIALS & PUBLIC COMMENTS

Mental Health Services Act (MHSA)

Three-Year Plan, Fiscal Year 2020-23

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health and Substance Use Recovery Commission
April 29, 2020

MHSA Overview

76% 

Community Services & Supports (CSS)

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

19% 

Prevention & Early Intervention (PEI)

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

5% 

Innovation (INN)

New approaches and community-driven best practices

Workforce Education and Training (WET)

Education, training and workforce development to increase capacity and diversity of the mental health workforce

Capital Facilities and Technology Needs (CFTN)

Buildings and technology used for the delivery of MHSA services to individuals and their families.

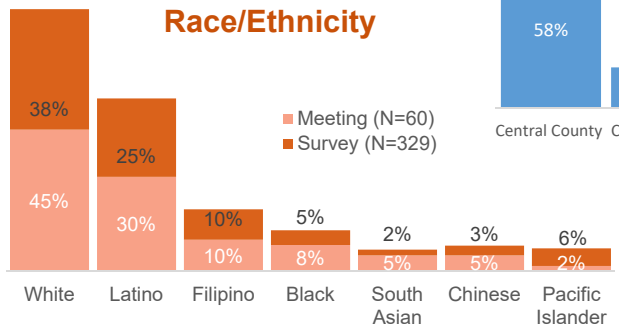
1% tax on personal income over $1 million
San Mateo County: $29.7M annual 5-year average through FY 18-19

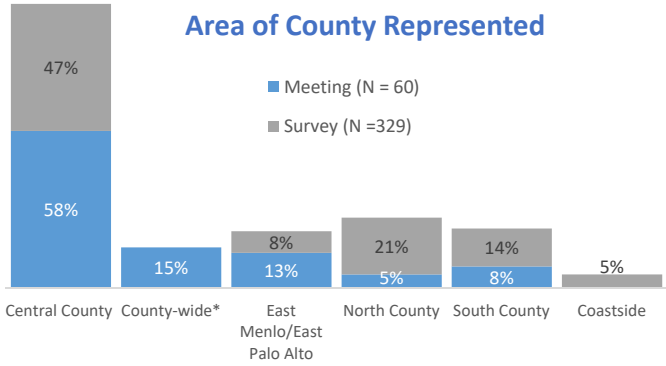
What's in a Three-Year Plan

1. Community Program Planning (CPP)
2. Revenue and Expenditure Projections
3. Ongoing Program Commitments
4. Strategic Priorities

Community Program Planning

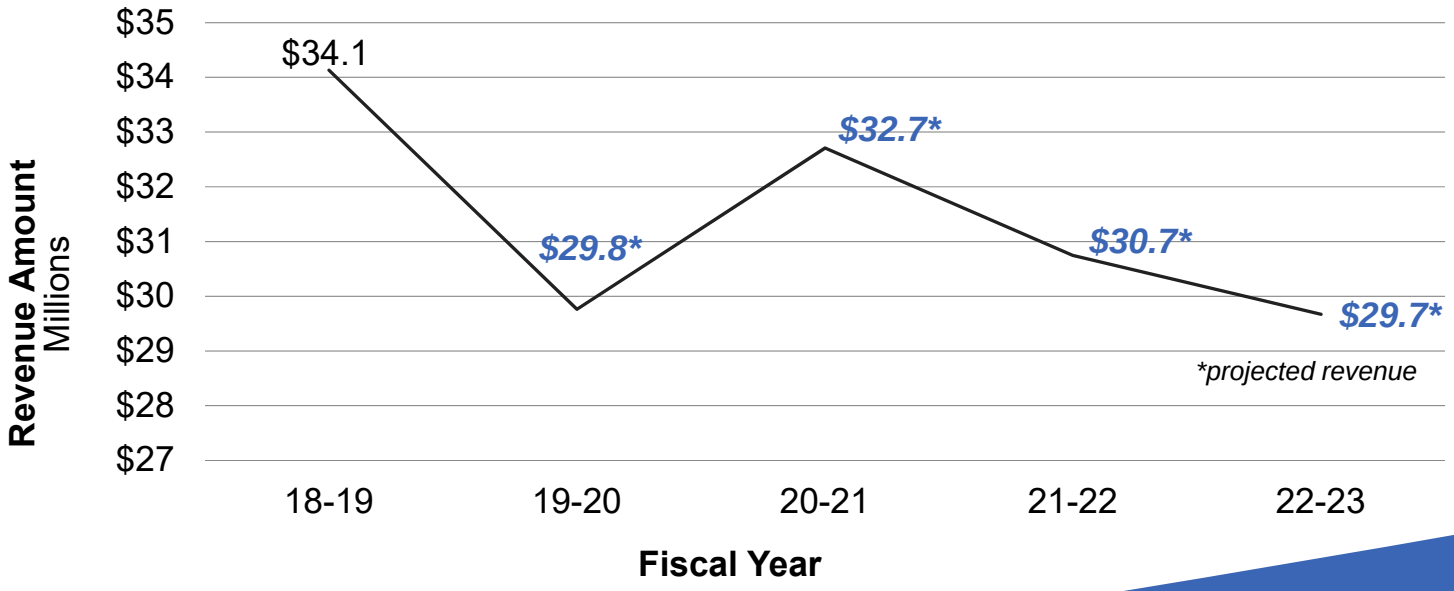
- 400+ individuals engaged via survey, input sessions and meetings
- Demographics collected for survey and April 29th meeting
  - 28 targeted and geographically-based input sessions conducted (not represented in the data)
  - 57 stipends to clients and family members were provided





Revenue Projections

- San Mateo County's MHSA Ongoing Expenditure Projection is $29,986,179



SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

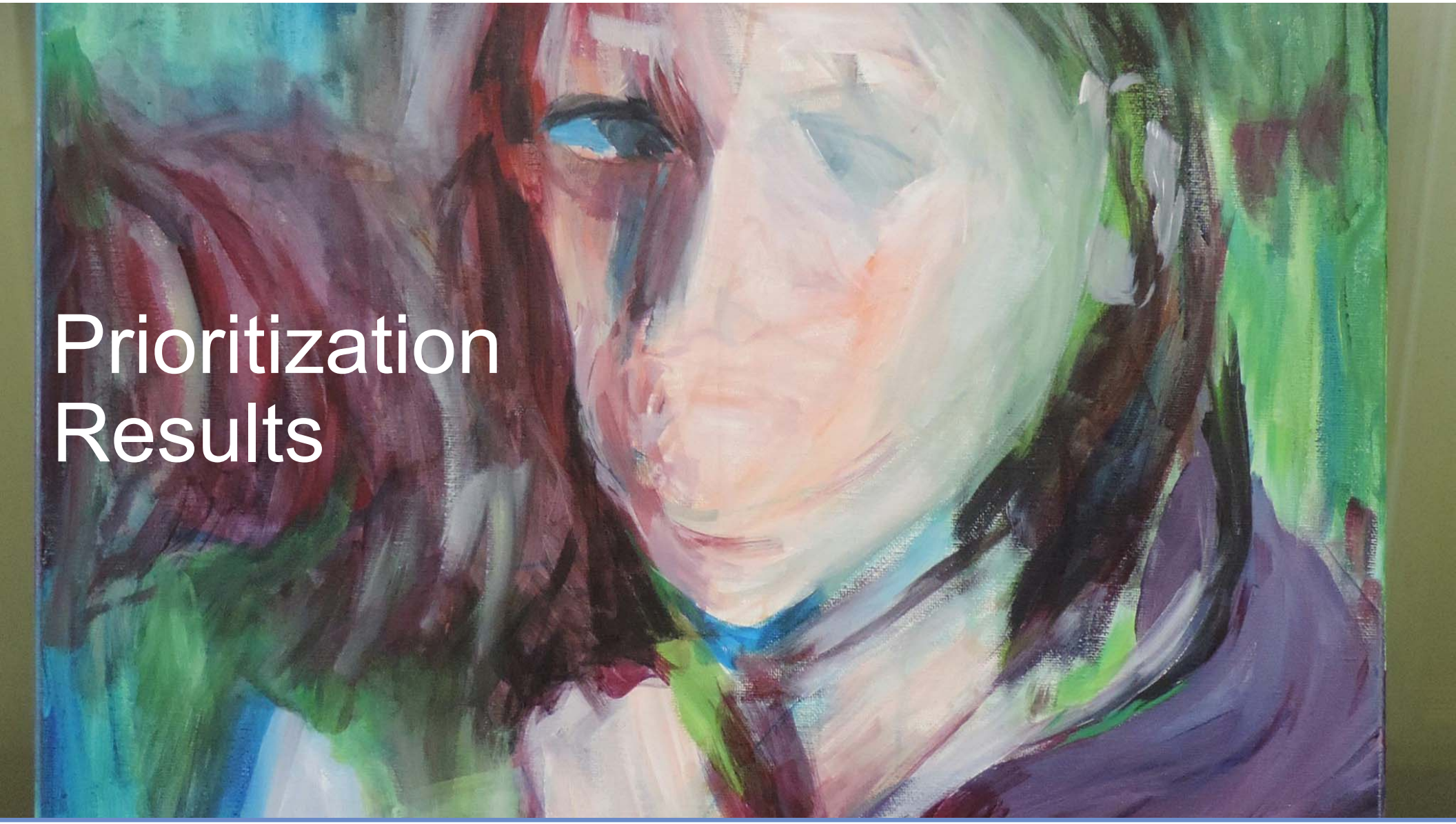
Expenditure Projections

- Current fiscal priorities
  - Ongoing: $30M
  - One-Time: $12.5M
  - Operational Reserve Goal: $17M
- New fiscal considerations (one-time)
  - $5M unspent from FY 2018-19 allocated to COVID-19 related impacts
  - - $2M from operational reserve in FY 22-23.
  - $5M in new MHSA Innovation programs (pending approval)

Plan to Spend $5M One-Time (COVID)

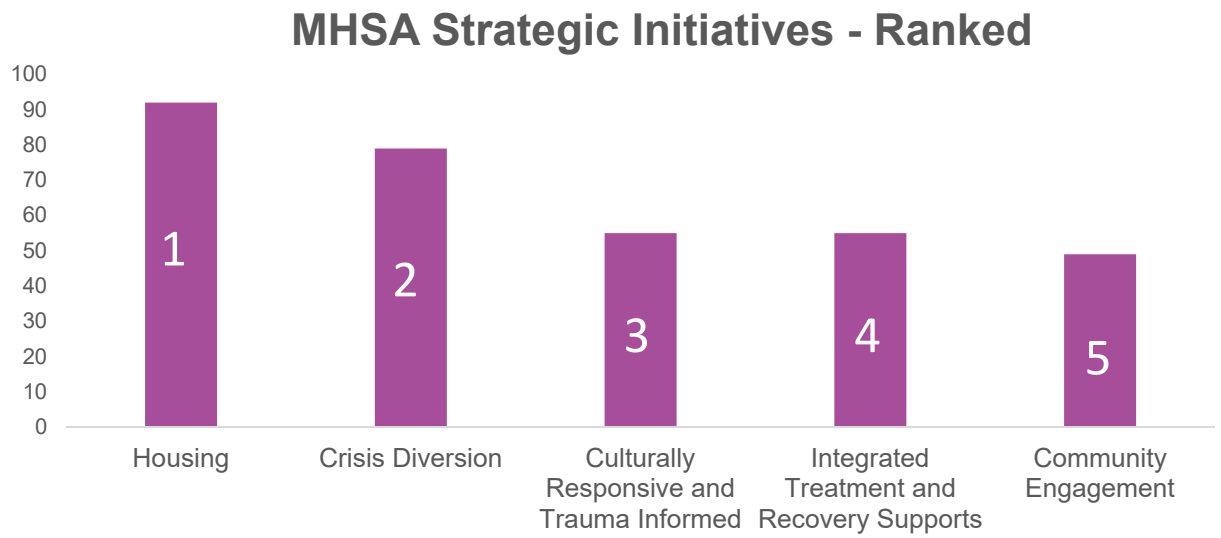
Priority	Item	Total Annual Cost	Notes
Technology Supports	Phones + Data Plan for BHRS Clients	$108,000	Cost is for data plan + free phones for BHRS clients ($360/unit; 300 units)
	Phones + Data Plan for Contractors	$270,000	Cost is for data plan + free phones for MHSA contractors ($360/unit; 750 units)
	Tablets + Data Plan	$46,000	Cost is for tablets + data plan for residential sites/B&C; for telehealth, staff, etc,($460/unit; 100 units)
	Technology Total	**$424,000**	**$424,000**
Workforce Needs	Workspace assessment and safety	$200,000	Safety assessment + measures (pexi glass, cubicle reconfiguration, other spaces, PPE)
	Workforce Needs Total	**$200,000**	**$200,000**
Clients supports	Client activities/needs	$50,000	For residential sites; card games, apps, food, supports
	Alternative Care Sites	$100,000	For residential clients that are COVID-19 positive and need to be quarantined
	Hotels for homeless	$200,000	Mass jail releases and reduction of shelter beds due to COVID
	Co-occurring detox facility	$200,000	Reduced beds due to physical distancing
	COVID Testing Program for high risk clients	$96,000	Regular 2x/week testing at Palm Ave Detox (25 tests/wk) will allow clietns to enter tx immediately and CYOC as needed; will allow MediCal billing
	Client Supports Total	**$846,000**	**$846,000**
Stop Gaps (ongoing programs)	Primary Care Interface	$1,337,972	
	Resource Management	$2,192,028	
	Stop Gaps Total	**$3,530,000**	**$3,530,000**
	TOTAL	**$5,000,000**	**$5,000,000**


Public
Comment



Prioritization Results

Strategic Priorities



SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Top 2 strategies for Housing Initiative

Strategy Recommendation	Priority Weighted Avg
Mental health workers providing on the field, mobile mental health assessments and treatment for homeless individuals and linkages to housing.	1.73
Trained/certified peers providing housing navigation, support services (e.g. independent living skills, accessing housing subsidies) to clients and training on the issue of homelessness to service providers (primary care physicians, mental health staff, police/first responders, etc.).	2.0

MHSARC Motion

1. Vote to open a 30-day Public Comment Period for the Mental Health Services Act (MSHA) Three-Year Program and Expenditure Plan FY 20/21 through FY 22/23 & Annual Update FY 20/21
2. Vote to open a 30-day Public Comment Period for the MHSA Plan to Spend $5 Million in One-Time Funds for COVID-19 related impacts

Next Steps

- MHSARC Pubic Hearing July 1st + vote to close 30-day public comment period
- Board of Supervisors Adoption

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Thank you!

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

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COVID Plan to Spend $5M One-time MHSA Funds
Fiscal Year 2020-21

Priority	Item	Total Annual Cost	Notes
Technology Supports	Phones + Data Plan for BHRS Clients	$108,000	Cost is for data plan + free phones for BHRS clients ($360/unit; 300 units)
	Phones + Data Plan for Contractors	$270,000	Cost is for data plan + free phones for MHSA contractors ($360/unit; 750 units)
	Tablets + Data Plan	$69,000	Cost is for tablets + data plan for residential sites/B&C; for telehealth, staff, etc. ($460/unit; 150 units)
	Technology Total	**$447,000**	**$447,000**
Workforce Needs	Workspace assessment and safety	$200,000	safety assessment + measures (pexi glass, cubicle reconf, PPE)
	Workforce Needs Total	**$200,000**	**$200,000**
Clients supports	Client activities/needs	$50,000	For residential sites; card games, apps, food, supports
	Alternative Care Sites	$100,000	For residential clients that are COVID-19 positive and need to be quarantined
	Hotels for homeless	$200,000	Mass jail releases and reduction of shelter beds due to COVID
	Co-occurring detox facility	$200,000	Reduced beds due to physical distancing
	COVID Testing Program for high risk clients	$96,000	Regular 2x/week testing at Palm Ave Detox (25 tests/wk) will allow clients to enter tx immediately and CYOC as needed; will allow for MediCal billing
	Client Supports Total	**$846,000**	**$846,000**
Stop Gaps (ongoing programs)	Primary Care Interface	$1,337,972	To support revenue reductions. This existing program includes mental health clinicians embedded in primary care clinics to provide brief intervention and linkages.
	Resource Management	$2,169,028	To support revenue reductions. This existing program provides case-management to hospitalized adults and residential settings and assertive outreach to homeless.
	Stop Gaps Total	**$3,507,000**	**$3,507,000**
	TOTAL	**$5,000,000**	**$5,000,000**

Public Comments Received – for Mental Health Substance Abuse and Recovery Commission (MHSARC) Review

➢ Plan to Spend $5M One-Time Funds on COVID related impacts

Comments	Response
Re: the Plan to Spend $5M One-Time Funds – COVID impacts Looking down the road, one hopes there will be planning and funding to re-integrate and house homeless people now housed in hotels. Now is the time to begin planning. That's the part I'm so concerned about.	We appreciate your comment. We agree with your recommendation to begin planning now for post-COVID housing needs. We will engage in a planning process with stakeholders to further develop the spectrum of strategies for the Housing Initiative with the goals of a) defining a continuum of services, b) identifying gaps at all levels of support or intensity in treatment, and c) articulating expected outcomes and identify the activities/strategies that will support a comprehensive continuum of services. Your feedback will be incorporated into that planning process, thank you.
My understanding is that there is state funding available for testing programs. Why are we using MHSA funds for testing programs?	The State funding available for testing does not cover staff. MHSA could be used to cover both clients and staff that would need to be tested in residential facilities. We also need to be able to bill Medi-Cal and private insurance. With the larger labs we have considered, they do bill Medi-Cal, bill private insurance. We would use MHSA funds only for the amounts that are not paid for by Medi-Cal and private insurance. We are also considering two labs that are fast but they don't bill, so we are looking at having the Health Plan bill for us since this is a physical health, not behavioral health issue.
LifeLine (aka "Obama Phones") can be acquired by clients for free with a low-cost data plan. It would save us monies to promote this service instead.	This is still an option for clients. Having a direct contract with T-Mobile/Sprint allows us to ensure that clients that do not have the funds to pay for even the low-cost option would have access to a phone and the data plan that is needed to participate in telehealth, recovery supports and stay connected when sheltering-in-place. A few other benefits include higher gigabytes to support doxy.me and other apps necessary for telehealth and the ability to pre-load (and digitally push) the necessary apps on the phones.

Phones & Date Plans for 300 Consumers

COMMENT: Although the phones are free and the data plan is a reasonable cost, I believe that there is no preparation or plan for how these phones and plans would be distributed, Most clients who cannot afford a phone qualify for a free Obama phone with has limited data.

How ad decision be made as to is "qualified" for one of the 300. How do you determine the individual has a dire need and cannot obtain a free phone and plan or makes too much to justify giving them a phone they can actually afford? What will the expectations of clients as to whether BHRS will continue after 3years to stop funding their phone? What of those clients who call foul when client a receives one, but client b does not? What if someone loses their phone? What if it gets broken? What expectations are clients going to have? If they were worthy a phone and plan in the first and lost it or broke through no fault of their own, do we then replace it at the cost of someone else not getting a phone? I think while well intentioned, the roll out and implementation of this plan is more in the "wouldn't it be nice to this and we can get free phones" instead of looking the reality of inequality in distribution, cries of unfairness and expectations that are not realistic.

As a peer worker, I will again speak to technological challenges. Many clients cannot voice a mail or email or text, much less navigate the web. Telephonic and Zoom instructions are often lost on those unfamiliar or overwhelmed with what to do and how to do it. What then, is the plan for tech support, education, and helping the consumer make the most out of the gift?

In my opinion, well while intentioned, consumer complaints about lack of communication are seldom linked to not having a phone. There are truly very few people in this day and age who do not qualify for a free phone and data plan or do not have a phone

Thank you so much for your feedback. We agree that having a well-thought out plan for distributing phones is necessary to ensure that clients who are most in need receive this support. We have significant input from clinicians and contractors alike that lack of technology supports (phones, tablets at residential facilities, and viable data plans) is a legitimate barrier to continuing the support groups, therapy and recovery service that were available prior to shelter-in-place orders for clients.

We are working closely with the Office of Consumer and Family Affairs to determine the best way of doing this and will finalize a distribution and management plan prior to purchasing of any data plans for the free phones provided through this federally subsidized program, which includes free replacement of lost, stolen, broken phones by T-Mobile/Sprint directly with no impact to the 300 data plans we are able to purchase with the funds.

Some things that will support the planning:

- Consultation with California Clubhouse and Heart & Soul given they have been able to implement as part of the MHSA Help@Hand project
- Training for peer workers, family partners and other staff that will be distributing phones to support clients with simple "how to…" download apps, use the phones, navigate the web, etc. The training will also include information on staying safe online, from the Help@Hand Digital Mental Health Literacy project for and by consumers.
- Development of a screener to ensure clients that need the phones and data plan have access to this program

available to them whether that be at home, in the shelter, board and care, etc.

If BHRS decided to use this large amount of money for something most can get free, I would suggest the distribution be tightly controlled by case managers who first attempt to enroll the client to receive an Obama phone. Additionally, case managers are more attuned to what the actual communication issues are with a consumer. For example, if in my household, I do not personally have my own cell phone, but there are other cell phones in the house or house phones for my use, do I deserve a phone and data plan, whereas someone else may have no communication means.

I would recommend the non-implementation of this program until how it will actually be run to insure inclusivity and fairness. My suggestion would be to take that money ad instead devote to a much larger problem then not having a phone, which is homelessness. I would further increase the hotels for the homeless as given the choice between a roof over your head or a phone, I believe most homeless people would opt for the roof.

Phones + Data Plan for BHRS Clients: $108,000

Most, if not all BHRS clients are under Public Assistance Program. As such, they qualify for a FREE Lifeline phone. A mentioned preference for the T-Mobile/Sprint phones was that they come with 8GigaBytes(GB) for apps to support telehealth. Assurance Wireless has been supplying Lifeline phones with 8GB for years.

Most telehealth appointments are conducted through a telephone call. There may be circumstance when it requires doxy.me. If so, I'm sure the MHSA Steering Committee would like to be educated on it's features.

What about loss or breakages? Carriers will replace them for a nominal fee of about $10. Phones are throwaway instruments now. It's more lucrative for Carriers to maintain the service.

Thank you for your comment. The free phones offered by T-Mobile/Sprint data plans come with 11 GB, offer a hotspot for internet access and we are working with T-Mobile/Sprint to ensure we receive devices that will support Doxy.me and other wellness apps. Doxy.me is the preferable method of providing telehealth given confidentiality; data shared through Doxy.me is encrypted and no patient info is stored. Feedback from clinicians has been that most appointments are currently done via the phone due to a small percentage of client preference but mostly not having adequate technology supports to use doxy.me.

We will also be working closely with the Office of Consumer Affairs to develop a plan for distributing phones to ensure that clients who are most in need receive this service (have not been able to access Lifeline phones due to cost prohibition or other barriers).

Similarly, BHRS clients would also qualify for the reduced home internet service for $10/month (equipment included) from Comcast, AT&T, etc. This program has also been around for years. 300 units will only cost $36,000/yr, for a cost savings of $72,000/yr (67%). <u>Phones + Data Plan for Contractors: $270,000</u> I don't quite recall the particulars for this line item. Is it because contractors need to conduct telehealth services that require internet access when they are not in the office/home? Please clarify.	The free phones with data plans for contractors is for the same reason BHRS is looking to provide this service to clients. Contractors have also expressed that the lack of technology supports is a legitimate barrier for clients and staff alike to be able to continue the support groups, therapy and recovery service that were available prior to shelter-in-place orders for clients.
Primary Care Interface & Resource Management: Both of these 2 line items cost over $3.5M which is 70% of the $5M. I've requested that these 2 items be unpacked so that the public would have better understanding of what these cover. The public can't really comment on something that they do not understand.	Thank you so much for this comment. While we have provided information during previous public meetings, it is important that this information is also included on the plan itself; thank you for this suggestion. We will update the plan to include this information. These two programs are existing programs. Given BHRS 30% expected revenue reductions, this $3.5M will allow us to fill a gap in funding and not have to make further reductions in existing programs. It is a one-time funding strategy, so we will need to continue to plan and make ongoing changes like collapsing programs and prioritizing reduced resources. The Adult Resource Management team provides case-management services for San Mateo County Residents who are hospitalized in public and private facilities, and for adults who are placed in Mental Health Residential settings and long-term treatment both in and out of county. The team also provides assertive outreach to homeless underserved residents. The Primary Care Interface Team is embedded in various Primary Care clinics throughout San Mateo County and provide brief mental health treatment along with linkages for clients that may need more intensive care.

I also agree that COVID funds would be best spent to train counselors in suicide prevention. I also think teenagers and young kids in turmoil as a result of Covid might benefit from counseling in the future. I would like very much to be put on the list of trainees...I REALLY want to help! Thank YOU!!!	Suicide prevention training is coordinated through the Office of Diversity and Equity via workforce, education and training team and various contracts for mental health first aid. I will follow up with the individual to find out more about the need and coordinate training. please contact Sylvia Tang at The MHSA Three-Year Plan includes a $600,000 allocation to youth mental health crisis response and prevention, which includes increase resources for training. The crisis response team is in the planning stages, please see Appendix 7 of the Three-Year Plan for the current draft concept. The MHSARC Youth Committee has been tasked with this effort. These planning meetings are held on the third Wednesday of every month at 4pm.

Public Comments Received – for MHSARC Review

➢ MHSA Three-Year Plan, Fiscal Year 2020-23

1. **Comment:** I am health care professional within behavioral health. Health professionals, not police officers (alone) should respond when people with mental health and developmental disabilities or with substance use disorders are in crisis or in a mental health crisis emergency. How does the MHSA address improving the relationship between city Police Departments and crisis services? I believe we should consider supporting and expanding San Mateo's Psychiatric Emergency Response Team (PERT) to allow mental health professionals respond with law enforcement and be available 24 hours per day. Currently, the PERT team, per the brochure, https://www.smchealth.org/sites/main/files/file-attachments/pertbrochure.pdf?1556207937, do not provide co-responders nor do they service all cities. They function as a secondary response and it is unclear whether they are adequately funded.

   Response: Thank you for your comment. BHRS agrees with your sentiments on the importance of collaboration with law enforcement to improve mental health crisis response. The MHSA Three-Year Plan includes a $600,000 allocation to youth mental health crisis response team that would be available across the County to support police response. The crisis response team is in the planning stages, please see Appendix 7 of the plan for the current draft concept. PERT serves unincorporated areas and mostly adult clients. As part of our BHRS commitment to collaboration with law enforcement, we will continue to support our current work of providing Crisis Intervention Team (CIT) training, a specialized police curriculum that aims to train law enforcement to safely respond to encounters with people with mental illness.

2. **Comment:** Ranked # 1 was the Housing Continuum with 5 strategy recommendations. (really important that it is so highly ranked): Is there any provision/possibility that would be considered a part of the housing continuum among the 5 recommendations that patients being discharged from SMMC's 3AB acute psychiatric unit could access? That vital hospital unit has been impacted with patients that have no adequate efficacious therapeutic step-down place to be discharged to for continued care. These patients are generally BHRS clients....or future BHRS clients. They need a much higher level of care than the typical Board and Care.....a robust step-down place! Where can they be housed/cared for appropriately? They aren't acute but still very ill and in need of considerable care. As you probably know, the Commission at our January retreat made it our highest priority to maintain the number of licensed acute beds on 3AB vs. decreasing about half the beds. Patients who are no longer acute impact the acute beds because they have no place to go....this must be remedied.

   Response: Yes, there is still opportunity to include this and other gaps/needs. We will engage in a planning process with stakeholders to further develop the spectrum of strategies for the Housing Initiative with the goals of a) defining a continuum of services, b) identifying gaps at all levels of support or intensity in treatment, and c) articulating expected outcomes and identify the activities/strategies that will support a comprehensive continuum of services. Your feedback will be incorporated into that planning process, thank you.

Comment (cont'd): Ranked # 2 Crisis Diversion: Trained/certified peers providing peer and family crisis support services to assist clients transition from PES, hospital and incarceration into the community: Question: Doesn't the HOPE program already do most of this? Can it be enhanced, expanded?

Walk-in services for addressing immediate crisis needs in a less intensive setting than PES: Question: Couldn't the already existing Serenity House be the place for this? I believe that was what advocates originally proposed Serenity House to be.

Response: Yes, the HOPE program could be expanded. It was included as a strategy because stakeholder input identified this as an area needing additional support. Expansion of current services would absolutely be the way to approach this. When we begin planning for these services, your feedback will be incorporated into that planning process.

Yes, Serenity House could be an option. When we begin planning for these services, your feedback will be incorporated into that planning process.

3. **Comment:** Rank1 Housing: "Transitional housing that is designed for and specializes in the needs of transition age youth (16-25 years) with serious mental health challenges. "Transitional housing should be addressed for Transition Age Youth (TAY) even if their mental health (MH) challenges are not serious. Homelessness for this group directly affects the worsening of their MH. This affects all sorts of developments in their lives, most importantly, their academic ability. When (not if) than happens, it robs them the ability to develop into the best versions of themselves. Protecting our youth is the best insurance against future issues. It is the "low hanging fruit", the best return on our investment, and is the right thing to do. Additionally, I'd like to see a requirement of input from the TAY group on the development of this plan.

   Rank2 Crisis Diversion: In the previous MHSA planning cycle, a crisis management program for youth was approved. For various reasons, it has been delayed. Our County Office of Education (COE) has made a number of presentations the MHSA Steering Committee, the Children & Youth Services Committee, and others on the urgency of addressing this issue. Even a previous year's county Civil Grand Jury agrees with the urgency when they did a study on Teen Suicidality. The COE implemented a Post-vention procedure to help the community deal with the after affects of suicide. Let's make the investment today on Prevention, to eliminate the need for Post-vention.

   Rank3 Culturally Responsive and Trauma-Informed Systems: The 4 strategies listed are great. However, are we being culturally responsive to our Youth? Do we actively solicit input from our Youth? We have the Health Ambassador Program for Youth (HAP-Y) that educates them on MH topics. We provide input to their brains, but rarely prompt for an output. In the services we provide, I see Clinicians determining what's best for our Youth. But can we really say we fully understand their current stressors. The Youth "culture" has discernible shifts roughly every 5years, and it affects areas in fostering situations, poverty, schooling, substance use, etc. Look at the current times we live in. Does not the voices of our Youth today put a certain clarity on age old issues? To be fully culturally responsive & trauma-informed, I request that we invest in developing Youth leadership voices on MH. Perhaps a new Health Equity Initiative under the Office of Diversity & Equity, and charter them to address the Youth MH challenges of the day.

Response: Thank you so much for your comments across the top three prioritized initiatives, Housing, Crisis Diversion and Culturally Responsive and Trauma-Informed Systems. We appreciate your sentiments regarding prioritizing investments in youth strategies to prevent exacerbated mental health issues in the future. Your input will be incorporated into that planning processes for these initiatives when they being. The Youth Crisis Response and Prevention planning will continue as a priority through the MHSARC Youth Committee and we fully agree with your recommendation to include youth voice into our planning. The Office of Diversity and Equity is working closely with the Health Ambassador Program for Youth to begin connecting youth leaders to these opportunities.

4. **Comment:** Youth Crisis Response Team - County Council has been fielding a lot of questions from school boards and other regarding police response to a student's psychiatric issue (Suicide ideation, depression and anxiety/panic attacks). A lot of school districts are looking at ending contracts with the School Resource Officers due to the racial unrest in the county and the commitment for equity and to be more trauma Informed about the way the handle student mental health issues. If they no longer have SRO's it makes it difficult to 5150 a student that needs to be 5150'd. Often times parents won't take the children to PES for numerous reason (Stigma, costs, not believing the child, not wanting government involvement) and then the school needs to call the police to either take the student or call the police to have them go to the home for a welfare check since the parent's didn't take them. With schools doing distance learning, and continuing to do it next year, it puts the police as the only resource to check on a student at their house, since counselors cannot see them face to face.

   A lot of this seems to be able to be solved by the Youth Crisis Response Team (YCRT). Pediatric Psych beds are costly, and we only see about 2.5 kids a day county wide at PES, most of which never get sent to the hospital. We could avoid the need for this with the YCRT, they would act as triage and allow the student to be safe at home. Depending on the district the student is in the YCRT could even have Care Solace find them a provider for further treatment.

   School budgets are being cut, at a time where more mental health issues are going to come up. We will see huge fallout from this if we don't put into place what is needed. The priority #2 being Crisis Diversion, that is exactly what YCRT is. It diverts 0-25 year olds from PES and Jail, by giving the skills/safety plan and connecting them to care. In the adult population there seems to already be so many programs that assist in the aftercare from PES, 3AB or Jail. But unless you have Medi-cal as a youth there is nothing helping you when you leave PES or the hospital. The YCRT could be that for the non-medi-cal kids, which you know is the majority of this county and the majority of the student that need help, need treatment, don't get it, then become BHRS school based clients, or become YSC clients, or end up at IPRC needing residential placement at the expense of probation or school districts. I would really like to get a group together to figure out how to move YCRT to the top of the list, especially with how schools are starting back up in the fall. Kids are going to be home more, but parents will be at work. We need YCRT now.

   Response: Thank you so much for your comment and providing additional current context that is impacting school and law enforcement response to mental health crisis. We appreciate and agree with your sentiments that the planning and implementation of the Youth Crisis Response

Team must remain a priority. The planning for a Youth Crisis Response program was delayed due to needing to shift to COVID-19 response across all key stakeholders including schools, law enforcement and behavioral health providers. With facilitation support from the MHSA Manager and the BHRS Deputy Director of Youth Services, the MHSARC Youth Committee has been tasked with this effort. Appendix 7 of the MHSA Three-Year Plan has the current draft concept. These planning meetings are held on the third Wednesday of every month at 4pm, I will add you to the meeting notification.

5. **Comment:** Fiscal Priorities if Revenues Increase **-** Trained/certified peers providing peer and family crisis support to assist clients' transitions from psychiatric emergency, hospitalization, and incarceration into the community. Funding Stream: 0

   It seems inconceivable to me that this is only prioritized as an "if revenues increase". These individuals are among our most fragile mental health clients and it is proven that peer to peer support and encouragement, providing resources, facilitating, and simply listening are rated amongst mental health clients as extremely influential in their recovery. The identification of this high-risk population and services can lead to positive outcomes whereas the failure to provide such services can result in repeated mental health crises, recidivism, and recurrent hospitalizations.

   Response: Thank you so much for your comments. We appreciate and value your thoughts and suggestions. Yes, peer services to clients transitioning from psychiatric emergency, hospitalization, and incarceration is an important priority and was undeniably prioritized by the MHSA Steering Committee. Due to COVID-19 pandemic and subsequent recession, we anticipate reductions in funding over the next three years. To be able to fund a new direct treatment program, without new revenue, would require reallocation and funding cuts to another direct treatment program for clients. The MHSA legislation requires that 19% of funds be allocated to the important work of prevention and early intervention, including stigma discrimination and mental health awareness activities. Therefore, we cannot move monies from prevention to fund more direct treatment.

   As of January 1, 2018, under the Whole Person Care funding, Heart & Soul, Voice of Recovery, California Clubhouse and National Alliance for Mental Illness were contracted to provide the HOPE program which utilizes peer mentors and family partners to support individuals transitioning from locked facilities and other settings to the community. If MHSA funding becomes available, expansion of current services would be prioritized. In addition to the vital work that the aforementioned providers are doing, BHRS works diligently to connect individuals to our services or those of partnering agencies. We agree that this work is critical and will continue to work to strengthen these connections between those that need support and those that are providing care.

   Comment (cont'd): Digital Storytelling and Photo Voice - Funding Stream: 50 people served at the cost of $56,289

The cost per individual served, with only 50 clients served, equates to $1,125.78. Given our dire needs in direct services, I feel a portion of this funding should be diverted to serve a great number of individuals with direct services that will have a greater overall impact. While I applaud Photo Voice and Digital Storytelling, the service of the mental health community would be far greater impacted by shifting half of this budget, or $28,144.45 to direct services aimed at helping the much larger community in need. I would transfer this money to the unfunded peer outreach program discussed in item one. While photovoice and digital story telling may impact the individual participating in learning to tell their story in this medium, the reality of our county is that not many clients utilize the; websites and online information provided by BHRS as is currently exists. I think a clear choice needs to be made between saving lives and benefitting consumers, especially, as argued above those most at risk rather than an expensive program aimed at a much smaller group. Our world is topsy turvy right now and without support I believe many of the consumers will not thrive. We are already large increases in substance abuse among co-occurring clients, elevated depression, isolation, feelings of hopelessness and failure to have a viable support network. We also have in place the Lived Experience Academy which teaches storytelling, NAMI provides similar training as does of Voices of Recovery. While this is not inclusive of video and the digital medium, I feel its far reaching effects are far outweighed by the one on one support of a fragile client.

Suicide Prevention and Be The One Campaign - Funding Stream: $113,522 with a projected 3000 people served

While Suicide Prevention was one of the top choices for funding in the BHRS focus groups, I question whether a "Campaign" particularly given our lack of diverse online zoom meetings and training will come no where to close to reaching 3000 people. Further, I would like to know what definition of "serve" you are using in the capacity to project this number. I am certainly not advocating for this campaign not to be funded, as the recognition, empowerment, and education of individuals to identify and take appropriate steps is a must needed tool.

However, in addition to this training, which is also offered through Mental Health First Aid, and Wellness programs in the county, one cry I heard over and over was the lack of support upon transition out of hospitalization and no follow up leaving consumers at risk for a second attempt. The per person costs of the current budget at 300 served is $37.84. Reducing the Served pool to 2, 225, frees up $29,328 which could be utilized in direct services to those in suicidal crisis, following attempts, and allocating more money to aftercare. We heard in the focus groups of individuals who received a small amount of after-care but then, in their opinion, were abandoned. Since life is out most commodity and BHRS owes of a duty of care to this fragile population, in my opinion, action steps to help insure no further attempts as in a state of abandonment and neglect we lose lives. I believe this almost 30,00, a small reduction in the overall allotted funds, will still live the campaign with $84,194 dollars.

I will again reiterate the lack of consumer participation online as seen in BHRS own survey asking what is important to the client. Many clients do not know how to set up email much less have the savvy to zoom for a Be the One Workshop.

Response: MHSA legislation requires that 19% of funds be allocated to prevention and early intervention, including stigma discrimination and mental health awareness and suicide prevention activities. We cannot move monies from prevention to fund direct treatment. We do appreciate your recommendation and due diligence in identifying funding for much needed direct services to clients transitioning from psychiatric emergency, hospitalization, and incarceration. We will continue to work with the MHSA Steering Committee and stakeholders to bring your perspective into the Housing strategic planning process, which includes the recommendation to connect peers to homeless engagement activities.

More specifically, in terms of the $56,289, this funds 50% of a program coordinator position in BHRS that oversees Digital Storytelling, Photo Voice and other stigma reduction work under the Office of Diversity and Equity. The impact of this storytelling program is beyond the 50 clients that have participated directly in workshops to share their stories of recovery and wellness to heal and to address issues within their communities. The impact of this program has been well documented in the MHSA annual reports and includes topics related to recovery in jails, substance use and suicide, spirituality in recovery and housing.

Storytelling is used not only to support the recovery of the 50 clients but to reduce stigma, bring awareness, education and advocacy on important topics countywide, impacting thousands. These are some of the limitations with reporting quantitative data and why we include qualitative impact in all MHSA annual reports. As one example, housing advocacy using storytelling led to the mapping of the housing system to identify the most effective advocacy points which included leaders of homeless shelters (or those who make decisions about the shelters and landlords (to challenge the stigma about people who are formerly unhoused or struggle with substance abuse to be risky or 'bad' tenants).

The $113,522 funds a full-time position that oversee Mental Health Awareness activities, Mental Health First Aid contracts, Suicide Prevention activities and the Be the One Campaign. The campaign is only a small portion of the activities to bring recognition and education around mental health, stigma and discrimination reduction. 3,000 is an estimated number of people reached via the many activities (workshops, online marketing, educational series) during Mental Health Awareness Month, Suicide Prevention Week and Be the One Campaign. We will continue to work with the Office of Consumer and Family Affairs strengthen the supports to clients given the challenges you bring up related to online participation in these sorts of activities.

6. **Comment:** Our NAMI National 5 year plan identifies 3 critical areas where we feel we can have the greatest possible impact in the lives of the individuals and families we serve: Getting people help earlier;

   ensuring people have access to the best possible care; and diverting people with mental health conditions away from the criminal justice system. All of these align closely with MHSA's stated goals.

   NAMI can provide training and support to both peers and family members to help implement Children & Youth and TAY full service partnerships. NAMI's mission of support, education and

advocacy in targeting young people and their families is in keeping with these goals. We can partner with you in these prevention and early intervention efforts.

Intervening early with the youngest population involves providing education and support (now virtually) for parents, caregivers and other family members along with addressing the issues of the young person experiencing mental health difficulties. Having been conceived and developed by families 45 years ago, NAMI's existing programs uniquely focus on the family as the primary support system.

Our growing outreach efforts targeting schools, businesses, and other community resources provide a forum for beginning a dialogue about mental illness, addressing stigma and myths about these illnesses, and advocacy for change. Our efforts to train and work closely with law enforcement and health professionals engaged in early crisis intervention can be effective in diverting people from the criminal justice system and getting appropriate and effective treatments from day one.

No one should face mental illness alone, and our community will be most effective when we partner to address our common goals and priorities, together.

Response: Thank you so much for your public comment on behalf of NAMI SMC.

We appreciate the opportunity for partnership and agree with your sentiments regarding the importance of intervening early and training peers and family members to support FSPs. This work is definitely a big lift and we appreciate NAMI's partnerships and outreach efforts to-date. We look forward to growing our collaborative efforts with agencies like NAMI.

I will be sharing your comment with the MHSA Steering Committee and the Mental Health and the Substance Abuse and Recovery Commission (MHSARC) for review. Your comment will be included with the Three-Year Plan as an attachment and submitted to the Board of Supervisor and the State.

COMMISSION ON DISABILITIES

June 25, 2020

Doris Estremera, MHSA Manager
Mental Health and Substance Abuse Recovery Commission (MHSARC)
310 Harbor Blvd, Bldg E
Belmont, CA 94002

To the members of the Mental Health and Substance Abuse Recovery Commission,

The San Mateo County Commission on Disabilities (CoD) would like to submit the following public comments as suggestions and changes for the Mental Health Services Act 3-Year Plan Update, which many County residents with disabilities and/or aging related issues rely on:

1. There should be representatives from the disabilities community on the MHSA Steering Committee, so we request that if applications are not received from a range of persons with disabilities or any liaison agencies or organizations (such as the Center for Independence of Individuals with Disabilities) that the MHSA Director take affirmative steps to seek such representatives to serve on the Steering Committee.
2. We request that the innovation funds and related projects and ideas be shared with the CoD as they are being considered, as well as the protocols for submissions, as this may be a wonderful opportunity for collaboration between BHRS and the often unfunded, innovative projects of the CoD's various Committees, which frequently have a connection or co-occurrence with mental health.
3. We request that actions/resources/training be prioritized in the furtherance of fostering cultural sensitivity to the disabilities community, in partnership with the work of the CoD, as well as of the Office of Diversity and Equity, the Health Equity Initiative, and the NEW Office of Equity and Social Justice.
4. There was a high need for focus on youth mental health crisis supports, including for children (pre-adolescent/Age 12 and below) diagnosed with psychiatric disabilities, pre-COVID-19. There have been recent statements from BHRS (6/3/20 Commission Meeting) that since schools are not currently in session, this priority was being delayed. Now, with the effects of COVID-19, this is not the time to delay such focus. It has become even more important with the anxiety, depression, and mental health impacts on families and children.
5. The County should prioritize supports for children with mental health and psychiatric disabilities and their families, by:
    a. Having pediatric psychiatric ER beds in San Mateo County (which are currently nonexistent) so that families will not be displaced out-of-county in the middle of psychiatric crises that require children to be put on 5150 holds;
    b. Providing more readily accessible psychiatric crisis supports for children, rather than the default to call 911, which is not always safe for children given the variance of officer responses to sometimes atypical responses of persons with disabilities to their authority; and
    c. Assisting schools with early mental health supports for children through a much stronger partnership with the SMCOE and local School Districts to support their identification and service to children through Educationally Related Mental Health Services (ERMHS), consistent with AB 114 (2011). These supports are lacking in many respects (as many schools and staff often do not

understand their role and responsibility concerting mental health supports for their young students), resulting in delayed or nonexistent services. For instance, most families are unaware of the opportunity for Districts to make ERMHS referrals to the SELPA or through the County's Clinics for consideration in obtaining access to the BHRS-contracted Full-Service Partnerships (such as the Youth/Family FSP at Edgewood Center), and better attention, training, understanding of the available resources would likely result in a significant decrease in extreme crisis events for children and families throughout San Mateo County.

The Commission on Disabilities requests that these suggestions and changes be strongly considered in the plan's update. We hope this will result in creating additional opportunities for the two Commissions to partner in making positive improvements in the quality of life for our residents in the County.

Sincerely,

San Mateo County Commission on Disabilities

Robert G. Hall, President
San Mateo County Commission on Disabilities (CoD)

Chelsea Bonini, Chair
CoD Youth and Family Committee

Cc: Honorable Carole Groom, Member, San Mateo County Board of Supervisors
Lisa Mancini, Director, Aging and Adult Services

Response to Letter from the Commission on Disabilities

Thank you to the Commission on Disabilities (CoD) for taking the time to write this letter and provide such important feedback for the MHSA Three-Year Plan. I have cc'd the relevant BHRS Directors in this email who may also provide additional response and relevant action items.

Additionally, I will be sharing your letter with the MHSA Steering Committee and the Mental Health and the Substance Abuse and Recovery Commission (MHSARC) to discuss any relevant changes to the MHSA Three-Year Plan, at the next MHSARC meeting on July 1st. The letter and the response will be included with the Three-Year Plan as an attachment and submitted to the State as formal public comment.

Regarding the specific recommendations, I wanted to take the time to formally respond to some of your comments. Again, the MHSARC, Directors and other stakeholders may also provide additional recommendations.

1. I appreciate the feedback regarding stakeholder engagement as this is directly related to my role as the MHSA Manager. I will commit to taking more affirmative steps as you pointed out to ensure there is representation from the disabilities community. Having diverse stakeholder engagement is something that is very important to BHRS and I've always held MHSA in San Mateo County to a high standard of ensuring diverse voices are represented. I will make sure the disabilities community continuous to be heard and appreciate you reaching out and holding us accountable.

2. Throughout the year, we conduct broad outreach and communications to inform stakeholders about innovation funds and other planning and funding opportunities as they present. The last innovation funding cycle resulted in over 35 proposals being submitted for consideration across diverse agencies and interests. I will commit to ensuring announcements are forwarded to CoD at all times to support and improve ongoing representation. I also encourage folks to subscribe to the MHSA list serve if you haven't already, www.smchealth.org/MHSA. I provide regular announcements and information via this MHSA website and list serve.

3. Thank you for your important perspective on fostering cultural sensitivity to the disabilities community. The Director of the Office of Diversity and Equity, who also oversees the Diversity and Equity Council and the Health Equity Initiative, has direct oversight of MHSA community and stakeholder engagement and prevention and early intervention. We look forward to partnering with the CoD to ensure cultural sensitivity work moving forward includes the disabilities community.

4. Youth crisis prevention and response continues to be a priority for BHRS, MHSA Stakeholders and the MHSARC. The planning for a Youth Crisis Response program was delayed due to needing to shift to COVID-19 response across all key stakeholders including schools, law enforcement and behavioral health providers. We appreciate and agree with your sentiments that the planning and implementation of these efforts must remain a priority. With facilitation support from the MHSA Manager and the BHRS Deputy Director of Youth Services, the MHSARC Youth Committee has been tasked with this effort. Appendix 7 of the MHSA Three-Year Plan has the current draft concept. These planning meetings are held on the third Wednesday of every month at 4pm and open to anyone who wants to join. To be added to the email list for the MHSARC Youth Committee, please contact Nicola Freeman at nfreeman@smcgov.org.

5. Thank you so much for this feedback regarding children with mental health and psychiatric disabilities. I will be bringing this forward to the MHSARC, our BHRS Director and the Deputy Director of Youth Services for further comments. The Youth Crisis Response program mentioned above is a way to address the community response along with law enforcement to ensure a more sensitive and appropriate response to children with disabilities. As part of our BHRS commitment to collaboration with law enforcement, we will also continue to support our current work of providing Crisis Intervention Team (CIT) training, a specialized police curriculum that aims to train law enforcement to safely respond to encounters with people with mental illness.

   With regards to your comment on assisting schools with early mental health supports, The Children and Youth System of Care (CYSOC) committee, is an inter-agency collaboration between BHRS, SMCOE, Probation, Human Services Agency/Children and Family Services and the Special Education Local Plan Area (SELPA) District that meets monthly to coordinate prevention, early intervention and treatment capacity so that children and youth have the best opportunity to succeed in school and achieve optimal mental health. Your feedback will be forwarded to the group and I have included the BHRS Deputy Director of Youth Services in this email to facilitate that dialogue.

Again, huge appreciation to the Commission on Disabilities for taking the time to provide such thoughtful feedback. BHRS looks forward to facilitating increased partnerships in this important work.

SOLUTIONS for Supportive Homes
1161 Granada Street
Belmont, CA 94002

June 30, 2020

Doris Estremera, MHSA Manager
Mental Health and Substance Abuse Recovery Commission (MHSARC)
310 Harbor Blvd, Bldg E
Belmont, CA 94002

Response to 30 Day Open Public Comment to MHSA 3 year Plan, 20-23

To the MHSA Commission:

Solutions for Supportive Homes strongly recommends language in the MHSA 3 year plan that names discrepancies or problems, links strategies to the problems and describes outcome or goals of intervention/strategies. A clear statement of priority of funding is needed. The Plan needs to reflect a change in both delivery of services and a change in services.

- We are not satisfied with reiteration of past plans.
- We are not satisfied with the results of past plans.
- The lack of change in response to direct community stakeholder request is disheartening.
- We are not satisfied with a promise of involvement as stakeholders in future planning.

Urgent issues span the whole continuum of care, including, most markedly, the housing continuum. There is a need for **Supported Housing**, and a clear definition of Supported Housing.

- The first point of scarcity is about to be exacerbated: limited acute psychiatric beds. Because of scarcity of stepdown care, clients remain on 3AB beyond the acute stage of their illness. Clients needing acute psychiatric care experience extended traumatic stays in PES. We strongly recommend conducting needed structural modifications to 3AB and resuming present bed count.
- Clients need different levels of and types of support during recovery. Contractors providing Full Service Partnership care need to be adequately funded to do so. Intermediate levels of care need to be available for non-FSP clients.
- BHRS and its contractors, with MHSA support, need to make movement toward a level of staffing with the range of needed professionals, including

peers, and appropriate intervals of reassessment, to make the care congruent with client needs.

- All programing needs to be based on recovery-oriented, whole person, evidence based practices. This support needs to be brought to where the client is. Consider providing higher intensity services by BHRS/contractor staff in settings such as board and cares, as well as already "supported" settings when client need increases.
- On-site support in housing is needed for both assistance in independent living skills and acting as liaison to the individual's support services or emergency services as needs arise.
- Current client/support staff ratios are inadequate for real-time benefit.
- Finally, it is not realistic or fair to prioritize services away from clients whose family and community are currently providing sufficient support to keep the client out of PES or incarceration, but not prosper. An actual strength (family and community support) ends up hindering recovery in the present system.

In closing, there are several models of supportive homes: multi-unit buildings with on-site health and social services, shared cooperative houses, groups of units set aside in large affordable housing developments linked to local health and social service, tiny home villages and mini therapeutic communities with on-site employment opportunities. These are strategies that not only prevent homelessness, they can be life-saving and ultimately cost saving.

No single investment of MHSA funds can do more good than investment in quality supportive homes. Please help make supportive homes a reality.

Submitted by

SOLUTIONS for Supportive Homes
Inclusive living environments for adults with mental health and cognitive disabilities

Carolyn Shepard – J092048@aol.com, (650) 595-5635

Melinda Henning	Joan Dower-Wilson	Tanya Frank
Karen Shea	Linder Allen	Dorothy Christian
Helene Zimmerman	Jean Perry	Jem Quesinberry
Mary Beaudry	Fara Presto Chan	Michael Lim

Response to Letter from SOLUTIONS for Supportive Homes

Dear Carolyn,

Thank you so much for taking the time to submit a thoughtful public comment on behalf of SOLUTIONS for Supportive Homes for the MHSA Three-Year Plan. The MHSA Steering Committee, the Mental Health and Substance Use Recovery Commission and stakeholders agree with your sentiments regarding the urgency of having a continuum of care in relation housing services. Housing was the initiative prioritized in the MHSA Three-Year Plan for strategic planning investment. While the MHSA Three-Year Plan is not this strategic plan, it is intended to identify gaps in services, identify potential solutions and strategies and prioritize these strategies for funding as it becomes available.

We engaged over 400 individuals in this process via online surveys (329 respondents) and 28 targeted and geographically-based input sessions. Through this process we distributed 57 stipends to clients and family members that participated in providing input. Having diverse stakeholder participation is something that is very important to BHRS and we've held MHSA in San Mateo County to a high standard of ensuring diverse voices are represented. I can assure you that stakeholders will be involved in the strategic planning for a continuum of housing services. Your feedback will be incorporated into that planning process and I look forward to working with SOLUTIONS for Supportive Homes on this effort.

In the meantime, I will be sharing your comments with the MHSA Steering Committee and the Mental Health and the Substance Abuse and Recovery Commission (MHSARC) for review and consideration of changes to the Three-Year Plan. Your comment will be included with the Three-Year Plan as an attachment and submitted to the Board of Supervisors and the State Mental Health Services Oversight Commission and the Department of Health Care Services as formal public comment.

Thank you again for taking the time to submit this very important perspective!

July 20, 2020

Doris Estremera, MHSA Manager
Mental Health and Substance Abuse Recovery Commission (MHSARC)
310 Harbor Blvd, Bldg E
Belmont, CA 94002

To the members of the Mental Health and Substance Abuse Recovery Commission,

The MHSA Commission is designed to play an important role in crafting how BHRS and our county approach the complex challenges of serving our citizens who struggle with a wide range of challenges, including those related to mental health and substance addiction.

We have noticed over the years that while community input has evolved, the basic tools used by the county to address these complex needs have remained the same. There have been positive improvements, especially including peer and family support team members. However, the basic "business model" used to work with non-profit community-based organizations and the community in general has stayed the same.

We believe that this basic model is unable to provide stable, sustainable services over the lifetime of needs experienced by our citizens. Our non-profits are tied to three-year county-funded contracts that typically don't provide sufficient funding to fully support a team of well trained, experienced care providers who are paid enough to live in our county. And of course the county budget is tied to the macro-economic tides impacting the state budget and the federal budget.

The most experienced team members are often syphoned off into county or other programs – or other counties - that can provide a more livable wage and benefits. The constant turnover is hard on clients, their families, and the remaining team members. Even the non-profits themselves are challenged to sustain their presence in our county because of the cost of office space and living.

The structure of the county contracts can leave little room to integrate "lessons learned" and can stifle synergy between groups.

Some of our most effective non-profit services, such as Edgewood's Transition Age Youth program, provide an array of holistic well-being supports and services that don't typically exist in the "for-profit" arena. Our county is home to many high-income citizens whose families would benefit from these services, and who probably don't even know they exist.

We would like to urge BHRS and the county Board of Supervisors to explore directly how our diverse community can collaborate to create new business models for

integrated care, and new funding models beyond the basic "ask the county and a few donors to pay for it" approach.

Think of it as working toward a sustainable ecosystem that will support and nurture the long-term evolution and survival of truly effective, integrated care for our citizens.

San Mateo County is home to a large number of companies, including non-profits, that were created around novel business models. We have a well-established biomedical industry that evolved from a hardy band of startups back in the early 1980s. We have a thriving and diverse population of companies exploiting information technology and engineering. We have companies that have merged several new areas together in unexpected ways to create better approaches to the challenges we all face.

We have many entrepreneurs who are experienced in looking beyond the usual way of doing business. And many of these people are directly impacted by mental health/substance addiction challenges - in their own families and close friends or affecting key employees in their companies.

The huge impact on quality of life and costs has caught the attention of companies that employ large workforces. These companies are highly motivated to find ways to bring better health care to their employees.

We challenge BHRS and the county Board of Supervisors to proactively pursue collaborations to explore creating new business approaches that can couple the impressive experience and knowledge existing in many non-profits with the entrepreneurial ideas and networks existing in our county's private and corporate citizens.

Sincerely,

Cynthia Robbins-Roth*
Jean Perry Verley**

*CRR came to the Bay Area in 1981 as a research scientist at Genentech. She worked in business development before becoming an industry consultant and journalist/founding editor of BioVenture View, BioWorld, and BioPeople Magazine.

Following a serious accident, CRR and her family gained first-hand experience in searching for effective mental health and family supports in San Mateo county, and dealing with the huge impact of serious illness. CRR worked as a Family Partner and manager at Edgewood Center for 11 years before retiring.

**JPV came to the Bay Area in 1978 as a graduate student at UCSF. During her career as an Advanced Practice Nurse she provided direct care in community clinics and contributed to translational research in women's health.

During her unintentional career as a family member with lived experience, she and her family have benefitted from Full Partnership Services from Edgewood Center for Children and Families, NAMI support and educational services and BHRS's Lived Experience Education Workgroup.

Cc: Scott Gilman, director, San Mateo County Behavioral Health, San Mateo County Board of Supervisors

Response to Letter

Dear Jean and Cynthia,
Thank you so much for providing such a thoughtful public comment about the current County business-model used to work with agencies to provide high quality, stable and sustainable behavioral health services and the recommendation to considering doing things differently, especially given the entrepreneurial resources in San Mateo County.

I will be sharing your comment with the MHSA Steering Committee and the Mental Health and the Substance Abuse and Recovery Commission (MHSARC) for review and consideration. Your comment will also be included with the Three-Year Plan as an attachment and submitted to the Board of Supervisors and the State Mental Health Services Oversight Commission and the Department of Health Care Services as formal public comment.

Thank you again for taking the time to submit this very important perspective!

APPENDIX 2 CPP NEEDS ASSESSMENT SUMMARY OF SURVEY RESULTS

Q1. Over the next 3 years, how important is it to address the following issues impacting Children/Youth/Transition Age Youth struggling with mental health and substance use in San Mateo County.

Answered: 323 Skipped: 6

	1=ABSOLUTELY ESSENTIAL	2=VERY IMPORTANT	TOTAL
Mental Health Crisis Supports	72.19% 231	21.88% 70	320
Suicide/Suicide Ideation	73.19% 232	18.93% 60	317
Homelessness/Unstable Housing	69.59% 222	23.51% 75	319
Complex Cases/Concurrent Issues (mental illness, trauma, substance use, poor health)	62.97% 199	28.16% 89	316
Trauma (Community, Intergenerational)	62.78% 199	27.76% 88	317
Depression	58.65% 183	30.77% 96	312
Co-Occurring Diagnosis (Both Mental Health and Substance Use)	58.04% 184	30.28% 96	317
Transition-Age Youth Specific Services (short-term housing, drop-in, engagement)	47.47% 150	35.44% 112	316
Family Conflict/Stress	43.31% 136	40.45% 127	314
Social/Community Connectedness	41.27% 130	37.78% 119	315
Chronic Absenteeism/School Drop Outs	38.91% 121	34.08% 106	311
Juvenile Justice Involvement	36.77% 114	38.39% 119	310
Continuity of Services After Age 0-5	41.04% 126	31.27% 96	307
Services for those without a formal diagnosis	33.44% 105	39.81% 125	314
Employment	29.58% 92	31.83% 99	311

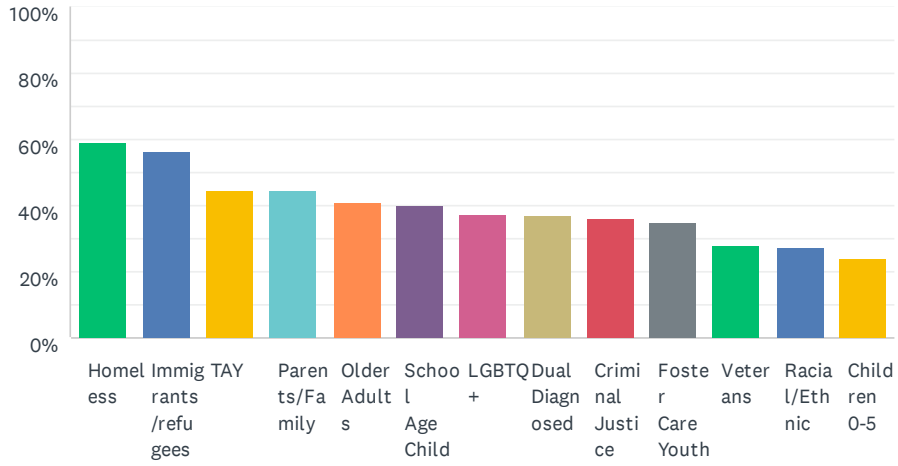
Q2. Over the next 3 years, how important is it to address the following issues impacting Adult/Older Adults struggling with mental health and substance use in San Mateo County.

Answered: 323 Skipped: 6

	1=ABSOLUTELY ESSENTIAL	2=VERY IMPORTANT	TOTAL
Mental Health Crisis	70.22% 224	22.26% 71	319
Homelessness/Housing	70.53% 225	21.63% 69	319
Complex Cases/Concurrent Issues (mental illness, trauma, substance use, poor health)	62.89% 200	28.30% 90	318
Trauma	60.13% 190	28.16% 89	316
Suicide/Suicidal Ideation	61.27% 193	25.40% 80	315
Co-occurring Diagnosis (Both Mental Health and Substance Use Issues)	58.13% 186	29.38% 94	320
Domestic Violence	57.28% 181	28.80% 91	316
Residential Care/In-home Care	45.11% 143	37.54% 119	317
Parenting/Family Stress Support Services	46.69% 148	35.96% 114	317
Incarceration of Mentally Ill Adults	39.75% 126	45.43% 144	317
Chronic Health Issues	40.58% 127	38.66% 121	313
Social isolation	37.22% 118	38.49% 122	317
Employment/Supported Employment	32.81% 104	41.01% 130	317
Supported Education	26.60% 83	36.22% 113	312

Q3. Are there any populations or groups of people struggling with mental health and substance use issues whom you believe are not being adequately served? Please check all that apply.

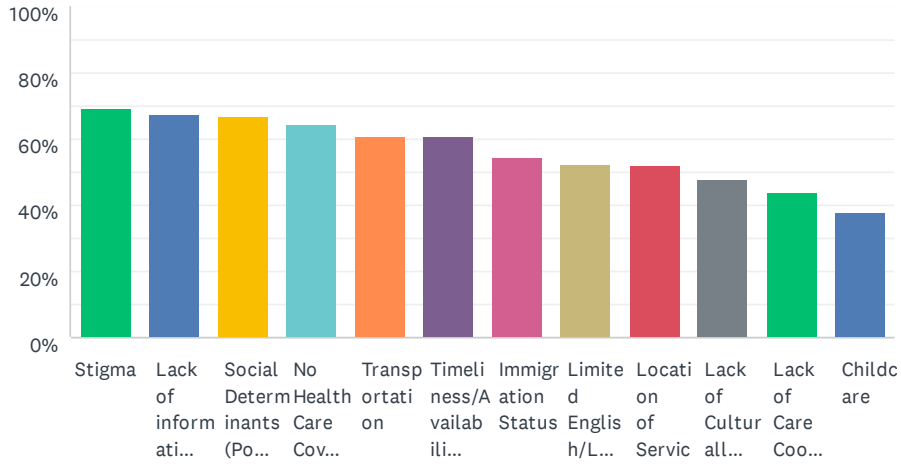
Answered: 319 Skipped: 10



ANSWER CHOICES	RESPONSES	
Homeless	59.25%	189
Immigrants/refugees	56.74%	181
TAY	44.51%	142
Parents/Family	44.51%	142
Older Adults	40.75%	130
School Age Children	40.13%	128
LGBTQ+	37.30%	119
Dual Diagnosed	36.99%	118
Criminal Justice	36.05%	115
Foster Care Youth	35.11%	112
Veterans	27.90%	89
Racial/Ethnic	27.27%	87
Children 0-5	23.82%	76
Total Respondents: 319		

Q4. What makes it difficult for individuals and their families to receive mental health and substance use services? Please check all that apply.

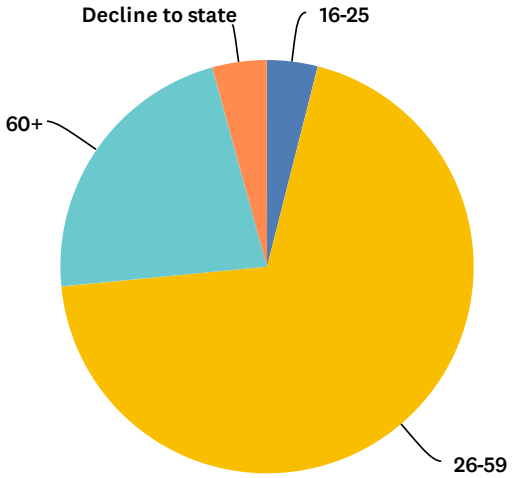
Answered: 328 Skipped: 1



ANSWER CHOICES	RESPONSES	
Stigma	69.51%	228
Lack of information/awareness	67.68%	222
Social Determinants (Poverty, Unemployment, Housing)	67.07%	220
No Health Care Coverage	64.33%	211
Transportation	60.98%	200
Timeliness/Availability of Services	60.98%	200
Immigration Status	54.57%	179
Limited English/Language Barriers	52.44%	172
Location of Services	52.13%	171
Lack of Culturally Competent Providers	48.17%	158
Lack of Care Coordination	43.90%	144
Childcare	38.11%	125
Total Respondents: 328		

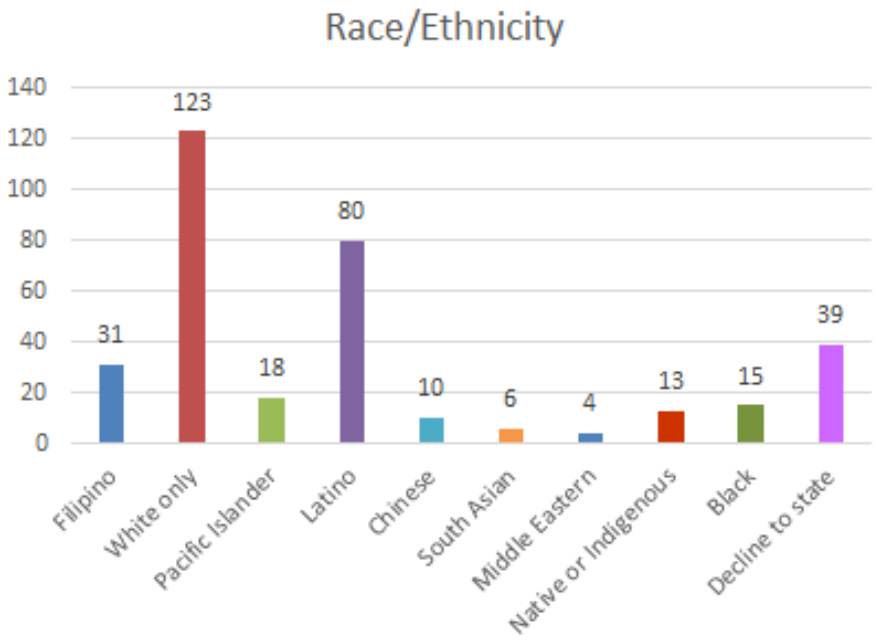
Q6 Please tell us about yourself. My Age group is:

Answered: 328 Skipped: 1



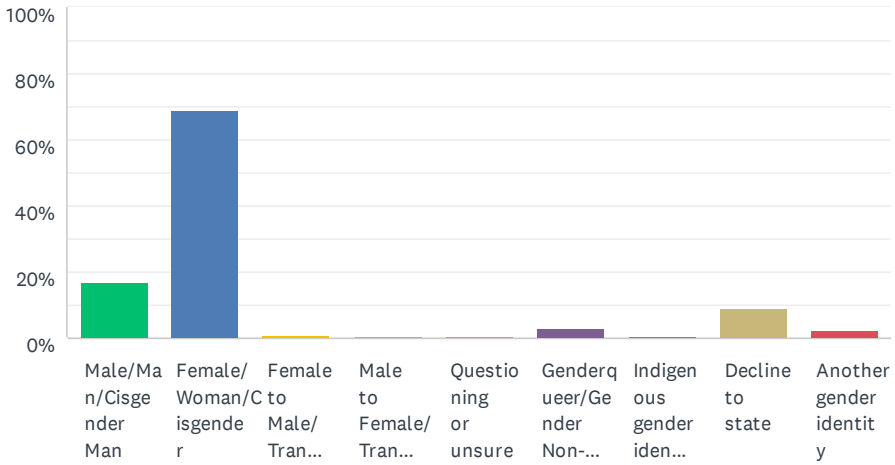
Q7 & Q8. Race/Ethnicity Combined

Answered: 321 Skipped: 8



Q9 Gender Identity (select ALL that apply)

Answered: 322 Skipped: 7



Q10 Are you a Veteran?

Answered: 324 Skipped: 5

ANSWER CHOICES	RESPONSES	
Yes	0.93%	3
No	94.75%	307
Decline to state	4.32%	14
TOTAL		324

Q11. Do you represent any of the following groups? (select ALL that apply)

Answered: 317 Skipped: 12

ANSWER CHOICES	RESPONSES	
Behavioral health consumer/client	25.87%	82
Family member of consumer/client	30.60%	97
Provider of behavioral health services	42.27%	134
Provider of health and social services	22.08%	70
Law enforcement	0.95%	3
Homeless	2.21%	7
Student	7.57%	24
Community member	46.37%	147
Decline to state	7.26%	23
Another group	11.04%	35
Total Respondents: 317		

Q12 What city do you live in OR work in San Mateo County? Please select ONLY one city that you want to represent for your responses to this survey.

Answered: 329 Skipped: 0

ANSWER CHOICES	RESPONSES	
Atherton	0.00%	0
Belmont	3.04%	10
Brisbane	0.30%	1
Burlingame	1.52%	5
Colma	0.30%	1
Daly City	10.33%	34
East Palo Alto	8.21%	27
El Granada	0.30%	1
Foster City	1.82%	6
Half Moon Bay	4.56%	15
Hillborough	0.30%	1
La Honda	0.00%	0
Menlo Park	2.13%	7
Millbrae	0.30%	1
Pacifica	3.95%	13
Pescadero	0.30%	1
Redwood City	13.68%	45
San Bruno	5.47%	18
San Carlos	3.65%	12
San Mateo	27.66%	91
South San Francisco	5.47%	18
Decline to state	5.17%	17
Total Respondents: 329		

APPENDIX 3 STRATEGY LAUNCH MHSA STEERING COMMITTEE & PUBLIC COMMENTS

Be the one to help

Mental Health Service Act (MHSA) Three-Year Plan

Open to the public! Join advocates, providers, clients and family members to provide input on the next 3 years of MHSA funding.

The MHSA Three-Year Plan is developed in collaboration with clients and families, community members, staff, community agencies and stakeholders. It includes priorities for future funding, program expansions and/or improvements and expenditure projections.

Meeting objectives include:

- Provide input and prioritize behavioral health needs
- Develop and prioritize strategies for the next three years
- Review and provide input into available one-time funding

✓ Stipends are available for clients/family members
✓ Language interpretation is provided if needed*

**Please contact Tania Perez at (650) 573-5047 or tsperez@smcgov.org 1 week in advance of the meeting(s) to reserve language/childcare services.*

MHSA Steering Committee Meetings

1) MHSA Needs Prioritization

Wednesday, March 4, 2020
3:30 pm – 4:00 pm (MHSARC)
4:00 pm – 5:30 pm (MHSA)*

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

**The March meeting is combined with the Mental Health Substance Abuse and Recovery Commission (MHSARC), both meetings are open to the public.*

2) MHSA Strategy Prioritization

Wednesday, April 29, 2020
4:30 pm – 6:00 pm

Zoom Meeting: https://zoom.us/j/125761698
Dial in: +1 669 900 6833 / Meeting ID: 125 761 698

Contact:

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

The Mental Health Services Act (MHSA) provides a dedicated source of funding in California for mental health services by imposing a 1% tax on personal income over $1 million.

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Services Act (MHSA) Steering Committee

Wednesday, March 4, 2020 / 4:00 – 5:30 PM
County Health Campus, Room 100, 225 37th Ave. San Mateo, CA 94403

AGENDA

1. **Welcome** — 5 min

2. **MHSA Background** — 15 min
   - MHSA Steering Committee Restructure
   - MHSA Three-Year Plan
   - Community Program Planning

3. **Needs Assessment – Preliminary Results** — 25 min
   - Reactions? Does this resonate?

4. **Strategy Development Launch - Breakout Activity** — 40 min
   - Select 1 area of need you would like to focus on and answer the following questions:
     1. Are there any program/service that are working well to address the need identified and would benefit from either expansion or enhancements?
     2. Is there a new service or program that you would like to see considered to address the need identified?
     3. If you were to select one (1) strategy from those identified in the above two questions, which do you believe would have the biggest impact in San Mateo County. (dots)

5. **Adjourn**

Next MHSA Three-Year Planning Meeting
Strategy Prioritization

April 29, 2019 from 4:30pm – 6:30pm

Veterans Memorial Building, Redwood Room
1455 Madison Ave, Redwood City, CA

Mental Health Services Act (MHSA)

Three-Year Planning

MHSA Steering Committee

March 3, 2019 / 4pm – 5:30pm

www.smchealth.org/mhsa

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Agenda

1. Welcome
2. MHSA Background
   - Steering Committee
   - Community Program Planning
3. Needs Assessment – Preliminary Results
4. Strategy Development Launch – Breakout Activity
5. Adjourn

MHSA – Prop 63 (2004)

1% tax on personal income over $1 M

$29.7M annual 5-year average for San Mateo County through FY 18-19

76% 

Community Services & Supports (CSS)

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

19% 

Prevention & Early Intervention (PEI)

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

5% 

Innovation (INN)

New approaches and community-driven best practices

Workforce Education and Training (WET)*

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

Capital Facilities and Technology Needs (CFTN)*

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

*Up to 20% of the average 5-year CSS revenue can be allocated annually to WET, CFTN and prudent reserve.

MHSA Steering Committee

- **Makes recommendations during planning and implementation, prioritizes services**
- **Meets 2x/yr + add'l meeting during three-year planning**
- **All commissioners + application process for broader diverse participation**
  - At least 50% represent clients/families
  - At least 50% marginalized cultural/ethnic groups
  - Maximum 2 member from any one agency + stakeholder seats

⇒ **Proposing a restructure – more to come!**

- Quarterly meetings to meet the increased demands on MHSA
- Smaller group of MHSA "experts" to promote meaningful engagement
- 1-2 Commissioner liaison(s) to allow for more focused participation
- Focused, time-limited strategy groups to maximize special interests and subject matter expertise

What's in a Three-Year Plan

- Current program descriptions and outcomes
- Priorities for future funding (if increased revenues)
  - Program expansions and/or improvements
  - Addressing gaps in services
- Expenditure projections

Community Program Planning (CPP)

Need Assessment Phase

- **Reviewed 15 local plans, assessments, reports**
  - ⇒ **Survey to help prioritize**
    - 1,600+ MHSA subscribers and email networks
    - Blog, Social Media, Nextdoor postings
    - Flyers at libraries, clinics
    - BHRS employees
    - Collaboratives, groups, meetings
    - Social Media
    - Community colleges
    - City communication officers
- **Strategy Development Phase launches today!**

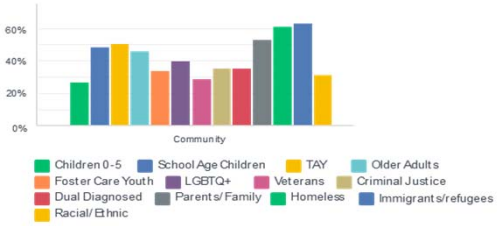
Preliminary Survey Results

- **Survey closes on March 20th**
- **176 responses to-date**
  - 80 BHRS employees
  - 96 broader community
    - 46% identify as client/family member
    - 40% identify as providers (behavioral/social services)
    - 58% white / 74% ages 26-59, 20% 60+
- **Top priorities to-date across all age groups**
  1. Homelessness/Housing
  2. Mental Health Crisis Supports
  3. Suicide/Suicide Ideation
  4. Trauma

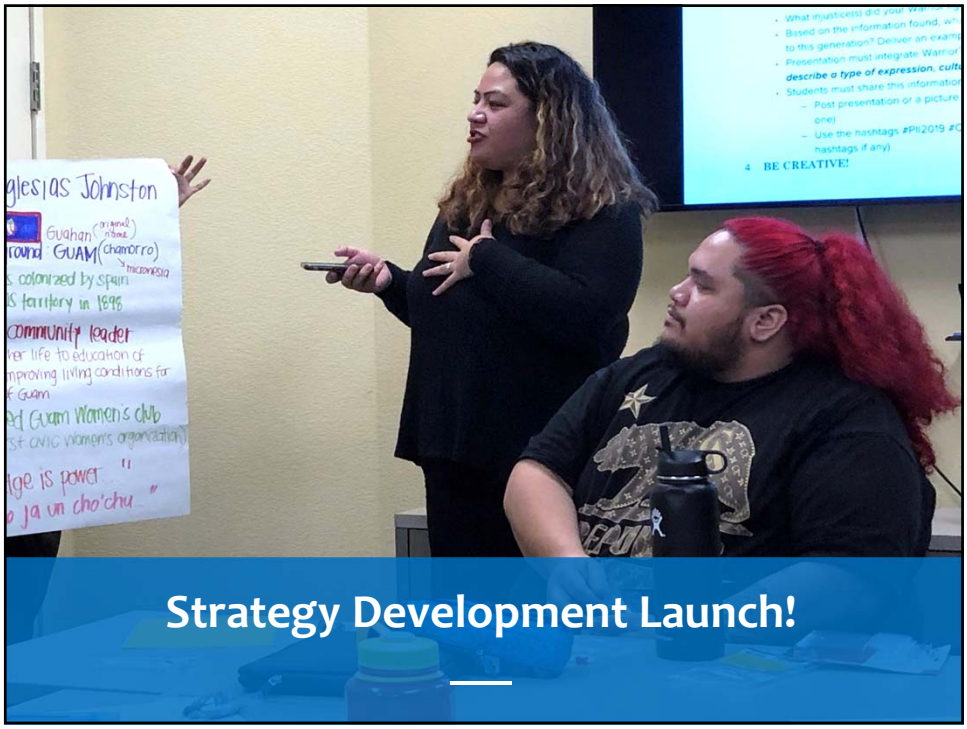
  *BHRS employees - Co-occurring and Complex Cases

Preliminary Survey Results

- **Priority populations**
  - Immigrants, Homeless, Parents/Families
  - School Age Children, Transition-Age Youth, Older Adults



- **Barriers to accessing services**
  - Healthcare Coverage, Stigma, Social Determinants, Immigration Status, Lack of Information
  - BHRS employees - Transportation



Strategy Development Launch!

Breakout Activity

1. **Breakout into groups based on top needs (select one)**
   - Homelessness/Housing
   - Mental Health Crisis Supports
   - Suicide/Suicide Ideation
   - Trauma
2. **Brainstorm the following questions:**
   - Are there any program/service that are working well to address the need identified and would benefit from either expansion or enhancements?
   - Is there a new service or program that you would like to see considered to address the need identified?
3. **Prioritize strategies**

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
BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Services Act (MHSA) Steering Committee

Wednesday, March 4, 2020 / 4:00 – 5:30 PM
County Health Campus, Room 100, 225 37th Ave. San Mateo, CA 94403

AGENDA/MINUES

- Welcome 5 min
- Scott Gilman:
  - Governor speech about MHSA priorities
  - "If you don't spend it then we'll spend it for you" (Prudent Reserve/Risk Reserve)
  - Not at risk of lapsing money back to the state
  - Analysis to make sure that we're in line where the governor thinks we should be ~22%
    - Assess to see whether to put more money in the prudent reserve
  - Elective officials circuit
    - Bill to reform MHSA dollars
    - Homelessness: making sure that money is used correctly instead of building more apartments to fix the issue
  - Next month: release of a fact sheet and flagging the governor's priorities with our legislative priorities

- MHSA Background 15 min
- MHSA Steering Committee Restructure
  - 2 meetings are not enough with jampacked information
    - How can we make this more meaningful?
    - Proposing quarterly meetings
      - MHSA experts
      - 1 or 2 commission liaisons
      - A lot more involved and be a spokesperson to pass to the board
      - Focus-time limited strategy groups
        - Example: Youth Crisis strategy development
    - Bringing this topic back as a proposal in the fall to open it up for comments
  - Question: Are applications available?

        - Applications are on the website through smchealth.org/mhsa or email Doris for further questions
- MHSA Three-Year Plan
    - Will include current program commitments that remains as the status quo
    - Implementation phase
        - Annual evaluations, reporting, adjust, or end a program
    - Identify priorities, gaps, what's working well that could benefit from an enhancement to help address the needs
    - Present the findings and vote on April 29 meeting
        - Includes expenditure projections
    - How fast?
        - depends on the revenue
            - Revenue: 34 million
            - Projection: 32 million
    - How do we get the money?
        - Through RFP
- Community Program Planning
    - Needs assessment phase
        - Assessments and report findings developed into a survey that includes the needs of the communities to help prioritize the themes
            - Includes how important each theme is
            - Survey ends 03/20
        - Question: Can we post this survey on our personal platforms?
            - Yes, you can share it.
    - Preliminary results
        - Survey (sent separately to BHRS employees)
            - 80 BHRS employees
            - Needs
                - Co-occurring and complex cases
                - Can tie with workforce education
        - 96 from broader community

    - 46% client or family member
        - Individuals identified as a client also prioritized co-occurring and complex cases as a need
    - 40% provider
    - 58% White
    - 74% Ages 26 to 59
- Needs of youth and adults (data are the same)
    - Homelessness & housing
    - Mental health crisis supports
    - Suicide/suicide ideation
    - Trauma
- Question: Is language included in the survey?
    - We did not include language. We wanted to keep the survey short. The survey is only available in English, but we will host input sessions that will include different languages
- Question: You mentioned that this survey is new. What was the thinking behind this?
    - We wanted the in-person time to focus on strategy development.
- Populations experiencing mental health/substance use issues that aren't adequately served
    - Immigrant
    - Refugees
    - Homeless
    - Parents and families
    - Age groups
        - School age
        - Transition age
        - Older adults
    - Similar oh both BHRS and community survey data
- What makes it difficult to access services? (Question from survey)

- Healthcare coverage
  - Not really a lack of coverage, but limited coverage especially from private insurances
- Stigma
- Social determinants of health
  - Poverty, employment, education
- Immigration status
- BHRS employees
  - Transportation

- Strategy development phase
  - Use the results from the survey to know the priority populations that we need to address as we think about the topics that are important

1. Needs Assessment – Preliminary Results 25 min

2. Strategy Development Launch - Breakout Activity 40 min
   - Notes attached
   - Select 1 area of need you would like to focus on and answer the following questions:
     1. Are there any program/service that are working well to address the need identified and would benefit from either expansion or enhancements?
     2. Is there a new service or program that you would like to see considered to address the need identified?
     3. If you were to select one (1) strategy from those identified in the above two questions, which do you believe would have the biggest impact in San Mateo County. (dots)

3. Adjourn

Next MHSA Three-Year Planning Meeting
Strategy Prioritization

April 29, 2019 from 4:30pm – 6:30pm

Veterans Memorial Building, Redwood Room
1455 Madison Ave, Redwood City, CA

MHSA Three-Year Plan Community Program Planning (CPP)

MHSA Steering Committee Meeting (3/4/20)
Strategy Development Launch - Breakout Activity Notes

1. Are there any program/service that are working well to address the need identified and would benefit from either expansion or enhancements?
2. Is there a new service or program that you would like to see considered to address the need identified?
3. Strategy categories:
    - Prevention
    - Direct service
    - Workforce Education and Training

Homelessness/Housing

Prevention:

- Permanent supportive housing
- Change restrictions that you cannot live with family in supported housing- enhancement of services (1)
- Cedar St. housing- Support in case of change in status – challenging living with neighbors in crisis, monitoring and intervention- enhancement
- Creating more single-family affordable housing (Tiny Homes)
- Samaritan house- help with rent and deposit- expansion
- Support core agencies that help financially and teach financial health-expansion
- Inclusionary housing with onsite support (developmentally disabled, and paid staff to live in housing)
- Creating community for the recently housed- teach them daily living skills
- RAMP- Re-entry- enhancement
- Barrier removal for those that have been previously incarcerated

Direct Service:

- Mobile MH services (1)
- Safe parking programs linked to core services (1)
- Drop-in centers, programs for those recently released from rehab/correctional facilities
    - Navigation centers- case management but also a place to look for jobs, training on daily living, a place to shower, provide hygiene products
- Intentional Outreach- Education to Police
- St. Vincent De Paul- Drop in center or womens center
- Transitional housing- less restrictive housing, study to see variety of environments/structures (1)
- Rehab housing- Transition them out, health supportive environment (co-ocurring)

- Fund a study to understand why we have such high attrition (end services early for substance use)
- 5 year program for housing that includes job training until person is able to support themselves

Workforce and Education:

- Expand workforce mobile van
- Training and Education specific to homeless population for mental health staff, police, homeless service provides, first responders trained by those with lived experience (3)
- CIT training (1)
- More peers! Mental health, outreach, case managers- all providing cores services and getting paid
- Train primary care physicians not comfortable asking about homelessness
- Screening for SDOH by primary care providers
- Schools- train teachers on identifying homelessness
- Train students (psych, MSW, MFT) on the issue and how to provide services

<u>Trauma</u>

Prevention:

- Womens group (HEI Structure) (1)
- Generation support (ACES) direct or indirect trauma at early age within school system: school clinicians' partnership with orgs work with both parents and child (0-5) include art therapy (1)
- Helping new parents ex: pre 3 directly to clients into home to establish a healthy routine
- WRAP- 3x a week after residential services and sometimes afterwards to give referrals and pipeline to leadership opportunities (HAP)
- Work closer with human trafficking efforts to support trauma services

Direct Service Strategy:

- Trauma informed therapists (or specialty) listed or info provided by ACCESS
- More support during early stages of recovery services (residential) LMFTs trauma groups at residential treatment
- 24/7 availability of MH services at all residential services
- Male services (CORA) relationships abuse including those in name of support

Workforce Strategy:

- LEA work/Healing process
- Trauma Informed care (SDA process)- workforce that is trained (ACE scores) including front line staff (ACCESS) (2)
    - Trained in trauma
    - Cultural/socio-economic trauma
- Photovoice for broaden pop ex: military transition
- Peer Support

Suicide/Suicidal Ideation

Prevention:

- Outreach to schools Junior high 6-7-8: Public education about suicide (4)
- Peer support
- Community Inclusion (WRAP, cognitive behavioral therapy, trauma informed, psycho emotional training)
- Anti-Bullying Program
- Screenings
- WRAP/Wellness tools/ psycho emotional training
- Using social media responsibly
- Weeklong school event (WRAP, anti bullying, social media)
- Public education for olderr adults and other groups
- SRS screening

Direct Service:

- School: Peer to peer training
- Strategy of case management
- Warmline: Children and Adults
- Wellness center for connectivity; drop-in center (1)
- Starvista language access; more training for crisis hotline
- Pride Center- more wellness programs

Workforce:

- Peer support for clinicians
- Harm reduction training
- Educating on trauma informed language (1)
- Cultural competency/different cultures define suicide differently

Mental Health Crisis

Prevention:

- Existing- WRAP- Expand it, more trainers, more classes to all BHRS clients (1)
    - Include in treatment plan
    - Customize to AOD, MH, Trauma, psychosis
- New: MH relapse prevention: include wellness to recovery in treatment plan
    - Other supports even after exiting treatment
- Increase access to CBT/DBT interventions
- Peer support available after business hours and weekends (3)
- 24/7 crisis warm line (1)

- Duplicate respite homes in other location (1)
- Expanding family access to crisis prevention tools/resources

Direct Service:

- Crisis services by peers at the peer lead programs (5)
    - By trained peers such as NAMI Peer Pal
- 24/7 warm line

Workforce:

- Training peer and family members as crisis responders: EBPs, de-escalation practices (1)
- Community training, expanding training for parents scale as the Parent Project curriculum (2)
- Train AOD provers to recognize MH issues better, make better referrals for co-occurring
- Create structured trainings for family/peers to respond to crisis (5)

Sea la persona que ayude

Plan de tres años de la Ley de servicios de salud mental (MHSA)

¡Abierta al público! Participe con los abogados, proveedores, clientes y miembros de familia para proporcionar sus opiniones sobre los próximos tres años de financiamiento de la MHSA.

El plan de tres años de la Ley de servicios de salud mental (Mental Health Services Act, MHSA) se lleva a cabo en colaboración con los clientes y las familias, los miembros de la comunidad, el personal, las agencias comunitarias y los accionistas. Se abordarán las prioridades para los financiamientos a futuro, los programas de expansión o mejoramiento y la proyección de gastos.

Los objetivos de las reuniones incluyen:

- dar opiniones y prioridad a las necesidades de salud del comportamiento
- elaborar y priorizar estrategias para los próximos tres años
- evaluar y dar opiniones para el financiamiento único disponible

- ✓ Hay retribuciones disponibles para clientes o miembros de familia.
- ✓ Se proporcionará interpretación de idiomas conforme sea necesario.*

**Comuníquese con Tania Perez al (650) 573-5047 o a tsperez@smcgov.org para reservar los servicios de idiomas o cuidado infantil.*

¡Marquen sus calendarios!

1) La MHSA necesita establecer una prioridad.
   Miércoles 4 de marzo de 2020
   De 3:30pm a 4:00pm (MHSARC)
   De 4:00pm a 5:30pm (MHSA)*

   County Health Campus, sala n.º 100
   225 37th Ave. San Mateo, CA

   **La reunión de marzo se hará con la participación de la Comisión para la Salud Mental, el Abuso de Sustancias y la Rehabilitación (Mental Health Substance Abuse and Recovery Commission, MHSARC); ambas reuniones están abiertas al público.*

2) Se debe establecer una prioridad sobre la estrategia de la MHSA.
   Miércoles 29 de abril de 2020
   De 4:30pm a 6:00pm

   Zoom Meeting: https://zoom.us/j/125761698
   Dial in: +1 669 900 6833 / Meeting ID: 125 761 698

Comuníquese con:
Doris Estremera, gerente de la MHSA
(650) 573-2889 ♦ mhsa@smcgov.org
www.smchealth.org/MHSA

La Ley de servicios de salud mental (MHSA) brinda una fuente dedicada de financiamiento en California para los servicios de salud mental al aplicar un impuesto del 1 % en los ingresos personales de más de $1 millón.

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

助人為樂

《心理健康服務法》(MHSA)
三年計畫

向公眾開放！ 加入倡導者、提供者、客戶和家庭成員，為MHSA的未來三年經費提供意見。

《心理健康服務法》(Mental Health Services Act, MHSA)三年計畫是與客戶和家庭、社區成員、員工、社區機構和利益相關者合作制定。其包括未來經費、計畫擴展和/或改進以及支出預測的優先事項。

會議目的包括：

- 提供意見並確定行為健康需求的優先順序
- 制定並確定未來三年策略的優先順序
- 審查可用的單次經費並提供意見

✓ 客戶/家庭成員可獲得固定津貼
✓ 如有需要可提供語言翻譯服務*

***請在致電** (650) 573-5047與Tania Perez聯絡，或發送電子郵件至tsperez@smcgov.org，**以預訂語言**。

在日曆上做上標記！

1) MHSA需求的優先順序

2020年3月4日，週三
下午3:30至下午4:00 (MHSARC)
下午4:00 至下午5:30 (MHSA)*

County Health Campus，100室
225 37th Ave. San Mateo, CA

*« 三月份會議與心理健康和物質濫用康復委員會 *(Mental Health & Substance Abuse Recovery Commission, MHSARC)* 聯合舉辦，這兩場會議均向公眾開放»。

2) MHSA策略優先順序

2020年4月29日，週三
下午4:30至晚上6:00

Zoom Meeting: https://zoom.us/j/125761698
Dial in: +1 669 900 6833 / **Meeting ID:** 125 761 698

聯絡人：
Doris Estremera，MHSA經理
(650) 573-2889 ♦ mhsa@smcgov.org
www.smchealth.org/MHSA

《心理健康服務法》(MHSA) 對個人收入在$1,000,000以上的人士徵收1%的稅，作為在加州提供心理健康服務的經費。

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Ikaw ang tumulong

Batas sa Serbisyo sa Kalusugan ng Pag-iisip (MHSA) Tatlong Taong Plano

Bukas sa publiko! Sumali sa mga tagapagtaguyod, provider, kliyente at miyembro ng pamilya sa pagbibigay ng input sa susunod na 3 taon ng pagpopondo ng MHSA.

Binuo ang Tatlong Taong Plano ng MHSA sa pakikipagtulungan ng mga kliyente at pamilya, miyembro ng komunidad, kawani, ahensya ng komunidad at stakeholder. Kabilang dito ang mga priyoridad para sa pagpopondo sa hinaharap, pagpapalawak ng programa at/o mga pagpapahusay at pagpaplano ng gastusin.

Kabilang sa mga layunin ng pulong ang:

- Magbigay ng input at gawing priyoridad ang mga pangangailangan sa kalusugan ng pag-uugali
- Gumawa at gawing priyoridad ang mga diskarte para sa susunod na tatlong taon
- Suriin at magbigay ng input sa available na isang beses na pagpopondo

✓ May available na mga bayad para sa mga kliyente/miyembro ng pamilya
✓ Nagbibigay ng pagsasaling-wika kung kailangan*

**mangyaring makipag-ugnayan kay Tania Perez sa (650) 573-5047 o tsperez@smcgov.org, upang magpareserba ng mga serbisyo sa wika.*

Markahan ang Inyong Mga!

1) Nangangailangan ng Pagsasapriyoridad ang MHSA

Miyerkules, Marso 4, 2020
3:30 pm – 4:00 pm (MHSARC)
4:00 pm – 5:30 pm (MHSA)*

County Health Campus, Kwarto 100
225 37th Ave. San Mateo, CA

**Isinama ang pulong sa Marso sa Komisyon ng Pag-abuso sa Paggamit ng Substance at Pagpapagaling ng Kalusugan sa Pag-iisip (Mental Health Substance Abuse and Recovery Commission, MHSARC), bukas sa publiko ang dalawang pulong.*

2) Pagsasapriyoridad ng Diskarte ng MHSA

Miyerkules, Abril 29, 2020
4:30 pm – 6:00 pm

Zoom Meeting: https://zoom.us/j/125761698
Dial in: +1 669 900 6833 / Meeting ID: 125 761 698

Makipag-ugnayan kay:

Doris Estremera, Tagapamahala ng MHSA
(650) 573-2889 ♦ mhsa@smcgov.org
www.smchealth.org/MHSA

Nagbibigay ang Mental Health Services Act (MHSA) ng nakalaang pinagkukunan ng pondo sa California para sa mga serbisyo sa kalusugan ng pag-iisip sa pamamagitan ng pagpapataw ng 1% buwis sa personal na kita na lampas sa $1 milyon.

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Tokoni Mai ki he Ngāue´ ni

Palani Ta'u-Tolu ki he Ngāue 'a e Lao 'o e Tokoni Mo'ui Faka'atamai (MHSA)

'Atā ki he kakai´! Kau mo e kau taukapo, toketā, kinautolu 'oku nau faka'aonga'i 'a e ngāue ni pea mo ha mēmipa 'o e fāmili, ke tānaki mai ha ngaahi fokotu'utu'u ki he fakapa'anga ta'u 3 'a e MHSA.

Ko e palani ta'u-tolu 'a e Lao 'o e Tokoni Mo'ui Faka'atamai (Mental Health Services Act, MHSA) ne fa'u 'i ha fengāue'aki pea mo kinautolu 'oku nau faka'aonga'i 'a e ngāue ni mo honau ngaahi fāmili, mēmipa 'o e komiuniti, kau ngāue, pea mo e kautaha he komiuniti pea mo e kau pulé. 'Oku kau ai ha fokotu'utu'u ki ha ngaahi me'a mahu'inga fakapa'anga ki he kaha'u, fakalahi ha polokalama pea/mo ha fakatupulaki, pea mo e fakatetu'a ki ha ngaahi fakamole.

Ngaahi taumu'a 'o e Fakataha´:

- Tokoni ki he ngaahi fokotu'utu'u 'o e ngaue´ ke fakamahu'inga'i 'a e ngaahi fiema'u ki he mo'ui lelei fakae'atamai´
- Fa'u pea fakahokohoko ha ngaahi palani ki he ta'u tolu ka hoko mai
- Vakai'i mo fokotu'utu'u ki ha ngaahi faingamalie fakapa'anga 'oku toki hū tā taaitaha mai

✓ 'Oku 'i ai 'a e ki'i tokoni fakapa'anga ke fakahounga'i'aki 'a kinautolu 'oku nau lava mai

✓ 'E lava ke ma'u atu ha fakatonu lea kapau 'e fiema'u*

**kataki 'o fetu'utaki kia Tania Perez he (650) 573-5047 pe ko tsperez@smcgov.org, ke ta'ofi ha fakatonulea tokoni.*

Maaka'i Ho Tohi Mahina!

1) MHSA Fakamu'omu'a 'a e Ngaahi Fiema'u

Pulelulu, Ma'asi 4, 2020
3:30 pm – 4:00 pm (MHSARC)
4:00 pm – 5:30 pm (MHSA)*

County Health Campus, Loki 100
225 37th Ave. San Mateo, CA

**Ko e fakataha 'i Ma'asi 'oku fakataha'i ia mo e fakataha 'a e Komisoni ki he Mental Health, Substance Abuse and Recovery Commision (MHSARC), ko e ongo fakataha 'oku 'atā pe ki he kakai.*

2) MHSA Fakamu'omu'a 'a e Ngaahi Founga Ngāue

Pulelulu, 'Epeleli 29, 2020
4:30 pm – 6:00 pm

Zoom Meeting: https://zoom.us/j/125761698
Dial in: +1 669 900 6833 / **Meeting ID:** 125 761 698

Fetu'utaki kia:
Doris Estremera, Pule MHSA
(650) 573-2889 ♦ mhsa@smcgov.org
www.smchealth.org/MHSA

Ko e Lao Tokoni Mo'ui Faka'atamai ((MHSA) 'oku ma'u ai ha fakamanava ki ha pa'anga 'i Kalefonia ki he tokoni mo'ui faka'atamai pea 'oku to'o ia mei ha 1% 'o ha tukuhau 'a kinautolu 'oku laka hake he $1 miliona 'enau vāhenga.´

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Вы можете помочь

Закон о службах психического здоровья (MHSA): трехлетний план

Каждый может принять участие! Присоединяйтесь к активистам, поставщикам услуг, клиентам и членам их семей, чтобы внести свой вклад в разработку программ, финансируемых с помощью MHSA, на следующие 3 года.

Трехлетний план для Закона о службах психического здоровья (Mental Health Service Act, MHSA), разрабатывается в сотрудничестве с клиентами и их семьями, членами сообщества, персоналом, местными организациями и другими заинтересованными лицами. В этом плане описаны приоритетные сферы для будущего финансирования, расширения и/или улучшения программ, а также прогнозируемые расходы.

Цели собрания

- Принять участие в определении потребностей в сфере психического здоровья и определить их приоритетность.
- Разработать стратегии и определить их приоритетность на следующие три года.
- Рассмотреть имеющиеся программы с единоразовым финансированием и принять участие в их разработке.

✓ Клиенты/члены их семей могут получить пособия.
✓ При необходимости предоставляются услуги переводчика*.

** Чтобы заказать* услуги за перевода, *свяжитесь с Tania Perez по номеру (650) 573-5047 или электронной почте* tsperez@smcgov.org..

Запишите в календарь!

1) Определение приоритетности потребностей для программ, финансируемых с помощью MHSA

4 марта 2020 г., среда
15:30–16:00 (MHSARC)
16:00–17:30 (MHSA)*

County Health Campus, офис 100
225 37th Ave. San Mateo, CA

** Собрание в марте совмещено с заседанием Комиссии по вопросам нарушения психического здоровья и реабилитации после злоупотребления психоактивными веществами (Mental Health Substance Abuse and Recovery Commission, MHSARC). Обе встречи открыты для публики.*

2) Определение приоритетности стратегий для программ, финансируемых с помощью MHSA

29 апреля 2020 г., среда
16:00–18:00

Zoom Meeting: https://zoom.us/j/125761698
Dial in: +1 669 900 6833 / **Meeting ID:** 125 761 698

Контактная информация:
Дорис Эстремера (Doris Estremera), менеджер MHSA
(650) 573-2889 ♦ mhsa@smcgov.org
www.smchealth.org/MHSA

Закон MHSA устанавливает налог размером 1 % на доходы физических лиц, превышающие 1 млн долларов США. Этот налог служит источником целевого финансирования служб психического здоровья в штате Калифорния.

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

APPENDIX 4 CPP INPUT SESSION MATERIALS AND SUMMARY OF INPUT RECEIVED

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Services Act (MHSA) Three-Year Plan, Fiscal Years 2020-2023

2020 Input Sessions – updated for COVID-19 response precautions

San Mateo County promotes collaboration with clients/consumers, families, communities, providers and advocates in all phases of the Community Program Planning (CPP) process for the development of the Mental Health Services Act (MHSA) Three-Year Plan. The MHSA Three-Year Plan includes priorities for future funding, program expansions and improvements, and expenditure projections.

The following are scheduled input sessions to-date. ***Please check the MHSA website regularly for updates to this schedule, www.smchealth.org/mhsa***. All sessions will be provided with MHSA background information and an overview of the CPP process. If language interpretation is needed, please contact Tania Perez at (650) 573-5047 or tsperez@smcgov.org, one (1) week in advance of the input session.

Stakeholder Group	Date	Time	Conference Call Line information
Collaboratives:			
Coastside Collaborative	3/19/20	3pm	Join Zoom Meeting: https://zoom.us/j/932719034?pwd=SlhxMG8xOGEyN2NRMFJBVGFLcmdjdz09 Meeting ID: 932 719 034 / Password: 772634 Dial in: +1 669 900 6833
East Palo Alto Behavioral Health Advisory Group	4/09/20	1pm	Zoom Meeting: https://zoom.us/j/705724833 Dial in: +1 669 900 6833 / Meeting ID: 705 724 833
North County Outreach Collaborative	4/3/20	1pm	Zoom Meeting: https://zoom.us/j/458216012 Dial in: +1 669 900 6833 / Meeting ID: 458 216 012
Peer Recovery Collaborative	3/30/20	3:30pm	Zoom Meeting: https://zoom.us/j/589250449 Dial in: +1 669 900 6833 / Meeting ID: 589 250 449
Health Equity Initiatives:			
African American Community Initiative	3/10/20	10:30am	650-761-6481 / Conference ID: 829 179 974#
Chinese Health Initiative	4/3/20	1:30pm	650-724-9799 / Meeting ID: 596 325 2478
Diversity and Equity Council	3/6/20	11am	1-888-636-3807 / Access code: 566983#
Filipino Mental Health Initiative	4/9/20	5pm	Zoom Meeting: https://zoom.us/j/7266572587
Latino Collaborative	3/24/20	3:30pm	1-866-390-1828 / Access code: 110549 #
Native American Initiative	3/19/20	8:30am	1-888-636-3807 / Access code: 566983 #
Pacific Islander Initiative	4/7/20	11am	650-761-6481 / Conference ID: 796 938 978#
Pride Initiative	4/8/20	4:30pm	650-761-6481 / Conference ID: 896 455 514#
Spirituality Initiative	3/10/20	12:30pm	650-761-6481 / Conference ID: 692 060 877#
Mental Health Services Act (MHSA) Steering Committee:			
MHSA Need Prioritization*	3/4/20	3:30pm	225 37th Ave, Room 100, San Mateo
Pre-session orientation	3/4/20	2pm	225 37th Ave, Room 100, San Mateo
MHSA Strategy Prioritization*	4/29/20	4:30pm	Zoom Meeting: https://zoom.us/j/125761698 Dial in: +1 669 900 6833 / Meeting ID: 125 761 698
Pre-session orientation	4/21/20	3pm	Zoom Meeting: https://zoom.us/j/807397618 Dial in: +1 669 900 6833 / Meeting ID: 807 397 618

Mental Health and Substance Abuse Recovery Commission (MHSARC):			
MHSARC Adult Committee	4/15/20	10:30am	1-866-390-1858 / Access Code: 110549
MHSARC Child and Youth Committee	3/18/20	4pm	1-866-390-1828 / Access Code: 110549
MHSARC Older Adult Committee	4/1/20	11am	650-761-6481 / Conference ID: 951 811 463#
Other Stakeholder Groups			
AOD Treatment Providers Meeting	TBD		Closed session
Contractors Association	3/19/20	9am	Closed session
Housing Committee	3/12/20	9am	650-761-6481 / Conference ID: 696 039 67#
Immigrant Parent Group	3/18/20	6pm	Key interviews
Lived Experience Education Workgroup	3/3/20	3:30pm	2000 Alameda de las Pulgas, Room 201, San Mateo
Transition Age Youth	N/A	N/A	Key Interviews
Veterans	N/A	N/A	Key Interviews
School Mental Health Collaboratives:			
Central School Collaborative	3/10/20	2pm	Cancelled
Coastside School Collaborative			Not Available
Northeast School Collaborative	4/16/20	8:30am	Zoom Meeting: https://smcoe.zoom.us/j/227763223 Dial in: +1 669 900 9128 / Meeting ID: 227 763 223
Northwest School Collaborative	3/6/20	8:30am	Jefferson Elementary School District Office, 101 Lincoln Ave, Daly City
South School Collaborative	4/20/20	10:30am	Zoom Meeting: https://smcoe.zoom.us/j/165241650 Dial in: +1 669 900 9128 / Meeting ID: 165 241 650

*There are two MHSA Steering Committee meetings, March 4th and April 29th (as highlighted above) that are focused on prioritizing the needs and strategies for the MHSA Three-Year Plan. Meetings are open to the public. For these MHSA Steering Committee meetings: stipends will be made available for clients and family members and language interpretation will be provided if needed. Please contact Tania Perez at (650) 573-5047 or tsperez@smcgov.org, one (1) week in advance of the meeting(s) to reserve language services.

Mental Health Services Act (MHSA)

FY 19-20 Three-Year Plan

Community Program Planning Process

www.smchealth.org/mhsa

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MHSA – Prop 63 (2004)

1% tax on personal income over $1 M

$29.7M annual 5-year average for San Mateo County through FY 18-19

76%

Community Services & Supports (CSS)

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

19%

Prevention & Early Intervention (PEI)

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

5%

Innovation (INN)

New approaches and community-driven best practices

Workforce Education and Training (WET)*

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

Capital Facilities and Technology Needs (CFTN)*

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

*Up to 20% of the average 5-year CSS revenue can be allocated annually to WET, CFTN and prudent reserve.

MHSA Three-Year Plan

What's in a Three-Year Plan

- Current program descriptions and outcomes
- Priorities for future funding (if increased revenues)
- Program expansions and/or improvements
- Expenditure projections

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 OASIS and Senior Peer Counseling expansions
	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	YES Suicide Prevention mini-grants and Stigma survey
	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

Community Program Planning (CPP)

- Reviewed 20+ local plans, assessments, reports for prioritized needs and strategies
- Survey to prioritize needs

Please take our survey!

Closes 3/20/20

https://www.surveymonkey.com/r/MHSA2020

Need Prioritization – Survey Results

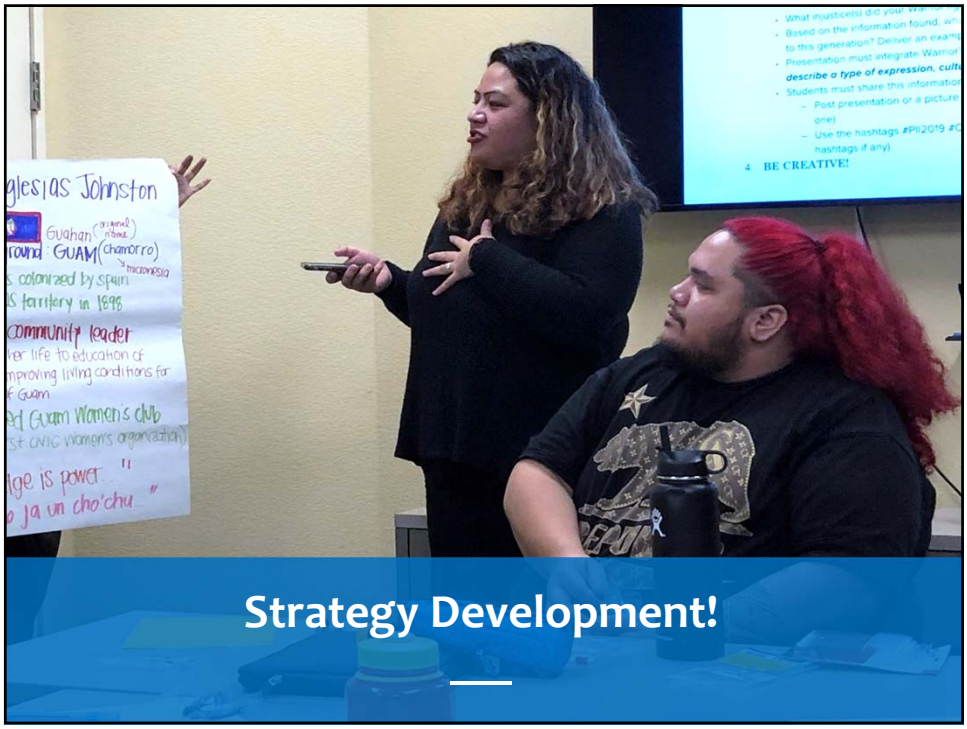
- **Top Priorities for Children/Youth/TAY**
  - Mental Health Crisis
  - Suicide/Suicidal Ideation
  - Homelessness/Housing
  - Trauma
- **Top Priorities for Adults/Older Adults**
  - Homelessness/Housing
  - Mental Health Crisis
  - Trauma
  - Complex Cases

Need Prioritization – Survey Results

- **Priority populations**
  - Top 3: Immigrants, Homeless, Transition-Age Youth
  - Others: Parents/Families, School Age Children, Older Adults
- **Barriers to accessing services**
  - Top 3: Stigma, Lack of Information, Social Determinants
  - Others: Healthcare Coverage, Timeliness/Availability of Services

Need Prioritization

- Which need would you like to help develop strategies for today? Select one
  - Children/Youth/Transition Age Youth Needs
  - Adults/Older Adults Needs
    - Other Priority Populations
    - Barriers to Care



Strategy Development!

Strategy Development

- Are there any program/service that are working well to address the need identified and would benefit from either expansion or enhancements?
- Is there a new service or program that you would like to see considered to address the need identified?
- Strategy categories:
  - Prevention
  - Direct service
  - Workforce Education and Training

Strategy Prioritization

- Which strategy do you feel will have the most impact over the next three years? Select one.

Thank you!

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

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Strategy Development – All Input Session Notes

Prioritized Needs	Stakeholder Groups

Youth/Children/Transition Age Youth:
1. Mental Health Crisis
2. Suicide/Suicidal Ideation
3. Homelessness/Housing
4. Trauma
 	
Adults/Older Adults:
1. Homelessness/Housing
2. Mental Health Crisis
3. Trauma
4. Complex Cases
 	
Priority populations:
1. Immigrants
2. Homeless
3. Transition-Age Youth
 	
Barriers to accessing services:
1. Stigma
2. Lack of Information
3. Social Determinants
	• AOD Treatment Providers
	• Contractor Association
	• Housing Operations and Policy (HOP) Committee
	• Peer Recovery Collaborative (PRC)
	• Lived Experience Education Workgroup (LEEW)
	• Immigrant Parents/Families
	• Transition Age Youth (TAY)
	• Veterans
	• Coastside Collaborative
	• East Palo Alto Community Service Area (EPA CSA)
	• North County Outreach Collaborative (NCOC)
	• Diversity and Equity Council (DEC)
	• Health Equity Initiatives (HEI)
	  ○ African American Community Initiative (AACI)
	  ○ Chinese Health Initiative (CHI)
	  ○ Filipino Mental Health Initiative (FMHI)
	  ○ Latino Collaborative (LC)
	  ○ Native and Indigenous People Initiative (NIPI)
	  ○ Pacific Islander Initiative (PII)
	  ○ PRIDE Initiative (PRIDE)
	  ○ Spirituality Initiative (SI)
	• MHSARC Older Adult
	• MHSARC Adult Committee
	• MHSARC Child and Youth Committee
	• Northwest School Based Mental Health Collaborative
	• Northeast School Based Mental Health Collaborative Ravenswood/South School Collaborative

Prioritized Need	Strategies - Direct Service (black), Prevention (green) and Workforce Education and Training (aqua)	Prioritized Strategy Ideas
Mental Health Crisis	**Chinese Health Initiative** • Agencies providing peer support, support services for clients and welcoming environments - MHA Friendship, Caminar, Clubhouse • Vocational Rehab Services including job coaching - Caminar • Comprehensive health/social care for elderly- On Lok Self-Help (1) • PERT program, CIT monthly meetings • Enhanced crisis intervention – Star Vista • Suicide prevention hotline - StarVista (2) • Health initiative for youth focused on addressing stressors, developing leadership (3) • MANA for Chinese community • Culturally/linguistically appropriate services across all services (1) • Suicide prevention efforts - Suicide Prevention Committee • Youth leadership efforts – Mills/CHI, HAP-Y • Anti-stigma advocacy • Client and family member support groups and education – NAMI (4)	Increased client and family member support groups and educational workshops
	Steering Committee Break out Groups • Crisis services by peers- trained peers such as NAMI peer pal (5) • WRAP expansion, more trainers, more classes, included in treatment plan, customize to AOD, MH, Trauma (1) • MH relapse prevention, supports after treatment, include wellness in treatment plan • Peer support after business hours and weekends (3) • Respite homes in more locations (1) • Warm line 24/7 (1) • Expanding family access to crisis prevention tools/resources • Community training, training for parents – Parent Project (2) • Increase access to CBT/DBT • Train peer and family as crisis responders, de-escalation practices (1)	Crisis support services provided by trained peers across a continuum of crisis diversion services (warm-line, emergency department and hospital diversion and ongoing supports)

	• Train AOD providers to recognize MH issues better • Create structured trainings for family/peers for crisis (5)	
Mental Health Crisis (cont'd)	**Lived Experience Education Workgroup** • More post-acute beds – Cordilleras • More transitional/supportive housing • Peer respite center – Serenity House criteria is too restrictive* • More Board and Cares • Pre-crisis – walk-ins for emergency situations • Same day service is not happening as intended, delayed appointments, PES turns people away, message that don't matter • Supportive services and communities – aging caregivers will need supports for SMI children, prevent housing loss, support relapse* • Supports for frail older adults • Substance use residential to support reintegration, day treatment for AOD/MH – prevents recidivism/relapse • Youth crisis response - FAST • Peer Support services for millennials - are isolated and suffer from depression • Community drop-in center for mental health days • Expand EAP for those in the workforce • Trauma-informed care training to prevent re-traumatization*	WET: Trauma-informed care training to prevent re-traumatization
	Filipino Mental Health Initiative • Non-police community response for crisis, accompanied by social workers, differential response, crisis stabilization unit expand SMART, train police (1) • Screening for mental health and services for children/adults with special needs • Psychoeducation and outreach for marginalized groups and communities (3) • Increased staffing capacity in the HEIs • Expansion of psychological first aid for all providers, contractors • Psychoeducation for the crisis hotline and when folks should call • More EAP supports for providers	Increase the capacity of culturally focused collaboratives to provide ongoing, consistent support groups, education and outreach for marginalized communities.

	• Psychoeducation/resiliency for unemployed folks due to COVID19 • LGBTQ+ (SOGI) training for police officers, providers, teachers, parents	
Mental Health Crisis (cont'd)	**Pride Initiative** • Satellite sites with co-location of services (6) • Medical and mental health services specific to LGBTQ services, misgendered, treated aggressively, long intense training, LGBTQ+ affirming professionals sprinkled in the system (2) • Police being trained on mental health first aid, special unit, also a unit that is non police emergency response (3) • LGBTQ+ family services for heads of households • More concerted effort to provide LGBTQ+ services for parents (1)	Satellite mental health clinics across San Mateo County co-located with community and social service agencies
	Native Indigenous People Initiative • Co-occurring groups for folks with substance use issues, creating affinity groups • Domestic violence groups and psychoeducation • Suicide prevention for youth- MHFA, tailored for Native and Indigenous folks • Wellness prevention- support groups for mothers with incentives where they learn wellness practices including digital storytelling • Sweat lodge in the phoenix gardens • Partner with NMT to provide clinical training in working with youth and adults - integrate MH treatment in a culturally appropriate way and link to direct service (2) • Trainings on traditional healing practices, trauma informed, culturally appropriate	WET: NMT clinical training to support working with youth and adults in a culturally responsive manner
Ideas from Strategic Plans Reviewed	California's Public Mental Health Services: how are older adults being served? • Peer services and social support groups for older adults • "One-Stop Shopping" Services – co-locating mental health and substance use services in aging services locations and primary care locations	

Suicide/Suicidal Ideation	**Steering Committee Break out Groups** • Peer to peer training in schools • Case management • Warmline • Wellness center for connectivity (1) • Pride Center- more wellness programs • Outreach to schools, Junior High - Public education about suicide (4) • Peer support • Anti-bullying program • Screenings • WRAP/ wellness tools • Public education for older adults • SRS screening • Community inclusion training (WRAP, CBT, Trauma Informed, Psycho-emotional training) potentially week-long event • Peer support training for clinicians • Harm reduction training • Educating on trauma informed language (1) • Cultural competency/ different cultures define suicide differently	School-based peer outreach, suicide education and prevention services
	South School Collaborative • School based counseling services (6) • Co-locating mental health/substance use services at community centers • Family resource centers with therapists on site, parent supports, case management, link families to core services, referrals, trainings, cafecitos • Mental health and substance use prevention and psycho education for parents and students (7) - Kognito, Sandy Hook Promise • Youth mental health awareness and leadership development as ambassadors of mental health -HAP-Y • Universal Screeners • Youth mobile crisis (6) • ASIST, QPR, YMHFA trainings for school personnel	

Homelessness/ Housing	**Housing Operations and Policy Committee (Adults/Older Adults)** • Clinical staff on the field providing mental health assessments and treatment -Homeless Engagement and Linkages (HEAL) program (1) • Incentives for sustainability of board and care homes (subsidies, support renovations/upgrades) (2) • Mental health clinicians at Core Service Agencies during coordinated entry assessment - Samaritan House program • Increase housing supportive services (rental subsidies, rep pay services) • Permanent supportive housing development (brick and mortar) (1) • Trauma-informed de-escalating training for providers • Increase AOD certified counselors and case managers	Incentives for sustainability of board and care homes (subsidies, support renovations/upgrades)
	MHSARC Youth Committee (Transition Age Youth) • Mobile mental health workers on the field providing mental health assessments and treatment (HEAL program) (5) • Ongoing support groups on maintaining housing, resource navigation, WRAP, HSA economic self-sufficiency programs and other housing supports (South County housing group) at Drop-In Center, Clubhouse day for TAY, and other spaces for TAY (1) • TAY peer support worker at Adult Clinics to provide linkages/support • Training for Adult services staff on what questions to ask, how to work with TAY, establish relationships	Mobile mental health workers on the field providing mental health assessments and treatment
	Coastside Collaborative (Adults) • Expand funding for rental assistance services provided by various agencies on the Coast (ALAS, Coastside Hope, Puente, St. Vincent) • MediCal insurance and housing strategies for undocumented (1) • More affordable housing (brick and mortar) • Employment support services for the homeless (Abundance Grace) • Entrepreneurship workshops/training for immigrant community (Renaissance in EPA, Rancho San Bernardino Co-Op) to develop self-sufficiency (4) • Expand local educational opportunities (computer, English, tutors for non-native speakers)	Entrepreneurship workshops/training for immigrant community

Homelessness/ Housing (cont'd)	**Peer Recovery Collaborative (Adults)** • Transitional program/halfway house for supporting individuals when released from hospitalization, emergency services and incarceration (1) • Housing for women and children out of treatment (5) • Peer liaisons supporting individuals to maintain housing, and other independent living skills (6) • BHRS housing support program for second chances (30-day grace period) before being evicted for drugs • Promote additional housing options and community integration, roommate options where ppl open up their homes – Hip Housing • DOH getting involved with property manager (1) • Supported employment, career advancement opportunities and supports for peers (13)	Supported employment and career advancement opportunities and supports for peers
	Diversity and Equity Committee • Advocates for those facing eviction due to MH (case management) • Emergency rental assistance expansion • Expansion of shelter services- strengthen the sober living environments (SLE) to permanent housing relationship • Tuff sheds/Tiny homes investment • Expansion to TAY housing • Change requirement that MH housing is just for singles and not families (1) • Collaboration with HIP housing to create a housing steam that gets folks into homes, frees up shelter spaces and homeless into shelters • Co-location of social workers and MH providers in housing as well as occupational therapists to teach daily living skills • Caseworkers in shelters to reduce recidivism • IMAT connection to parole through referrals • Integration of peers to workforce and other providers with lived experience (3)	Street outreach workers (peers) as system navigators, providing warm handoffs, WRAP groups for housing

	• System transformation for those coming out of jail- currently have no shelter, no access to food stamps and other resources • PES training to make right referrals for aftercare • Revisit the SLE structure- very restrictive • Peer to peer program to help with housing • Require a higher percentage of apartments in new developments to be affordable housing • Expansion of ODE stigma program to address homelessness • Insurance navigators for Medi-cal enrollment of homeless folks • Street outreach including system navigators, warm handoffs, WRAP for housing, peer outreach (5) • Youth HEI • Training first responders, jail guards, police on mental health • Training on the types of homelessness, and how to ask questions and connect to resources	
Homelessness/ Housing (cont'd)	**Spirituality Initiative** • Subsidized housing, shared housing with subsidy • California Clubhouse expansion • Heart and Soul expansion of seeing though stigma and increase storytelling program of how folks overcame homelessness • Peer support workers used more thoughtfully as system navigators, enhancement of program and responsibilities (3) • Expansion of VOR program for recently released from jail • Case managers- to make sure for recently housed bills are paid, can alert someone if they have a crisis etc. • More doctors, look at ratio of patients to doctors • Increase the number of groups being offered • Street outreach- bringing outreach materials, and bringing people in for warm handoffs (1) • County partnering with faith communities to house individuals (1) • Groups on spirituality for workforce and clients • Training for clinicians on homelessness and working with this population	Peer support workers used more thoughtfully as system navigators, enhancement of program and responsibilities

Homelessness/ Housing (cont'd)	**Steering Committee Break out session** • Permanent supportive housing • Change restrictions of no living with family in supported housing (1) • Cedar St. Housing- enhance support offered as there are changes of status among those living with mental health • Create more single-family affordable housing • Inclusionary housing with onsite support (developmentally disabled) • Samaritan house- expand help with rent and deposit • Mobile MH services (1) • Support core agencies to teach financial health • St. Vincent De Paul Women's center- enhancement • Transitional housing- less restrictive housing, study variety of environments/structures (1) • Rehab housing transition, healthy supportive env for co-occurring • Drop-in centers, programs for those recently released from rehab/correctional facilities- navigation centers, case management, job training, place to shower, hygiene products • More peers, mental health, outreach, case managers- all providing core services and being paid accordingly • RAMP re-entry enhancement of program • Barrier removal for those previously incarcerated • Safe parking programs linked to core services (1) • Intentional outreach- Education for police • Study to understand why we have such a high attrition rate (end services early for substance use) • 5-year program for housing that includes job training • Screening for SDOH by providers • Training on issue of homelessness and how to provide/refer to appropriate services-for schools, primary care, students (psych, MSW, MFT), staff, police, homeless providers, first responders. (3) • Trained by those with lived experience • CIT training	Training by peers on the issue of homelessness and how to provide/refer to appropriate services – for schools, primary care physicians, students (psych, MSW, MFT), mental health staff, police, homeless service providers, first responders

Ideas from Strategic Plans Reviewed	2013 Community Health Needs Assessment • Affordable housing policy Agricultural Worker Housing Needs Assessment • Creation of new housing units that are affordable • Subsidized housing paid for by the county	
Trauma	African American Community Initiative • More support groups (NAMI, VOICES) • Sister Circles- for women who are experiencing trauma • Mediation of traumatized victims of crime- restorative justice • Panel discussion involving the police department to address racism as trauma • Partnership with community programs for young people and faith-based organizations to address trauma • Groups and workshops for young black males, education and empowerment to learn historical trauma • Trainings for providers, first responders and police officers on the intersection of trauma and racism historically as well as racism as trauma • Expansion of WRAP programming • Eye movement desensitization reprocessing (EMDR) as a therapeutic intervention and training • LGBTQ+ trauma informed training • Expand the GARE trainings for all workforce and all departments • Trainings for teachers to respond to traumatized students, restorative justice practices	Trainings for providers, first responders and police officers on the intersection of trauma and racism historically as well as racism as trauma
	Northwest School Collaborative • Support with unaccompanied minors turning 18 • Family resource center • Full system support that includes: culturally appropriate programming, lawyers, case management, stipend programs for career exploration and technological careers • Partnering with community-based services during breaks • Educational trainings for trauma screenings	Hub of family resources that includes culturally appropriate programming, legal resources, case management, stipend programs for career exploration and technological careers

	• Increase TAY services housing • Inclusivity trainings • Therapy- ALAS wrap around model with cultural component • Academics- wrap around with academia, one on one tutors, accredited mentorships • Restorative justice • System navigators for parents • Somatic- pleasing activities and experiences • Trauma-informed curriculum • SAL and PAL • Collaboration between BHRS, CPS and probation • Trauma informed system 101- available for all staff, hire substitute teachers to deliver training • Support group for teachers • First responder trauma care	
Trauma (cont'd)	Northeast School Collaborative • Need resources for families, in-home supports for families (5) • Need trauma informed summer program to support kids outside of school • Youth Court programming pilot - prevention, leadership, catching youth early • Afterschool activities (arts, sports, etc.) and programming that are trauma-informed and support children with social emotional or behavioral issues and trauma • StarVista needs more mental health clinicians to support counseling services in the summer • Mobile crisis team for youth can outreach to homes and schools in a safe way and partner with law enforcement for an appropriate response (3) • Domestic violence – supports for school personnel on their role as mandated reporters and their response	Family-focused resources and supports for families
	Steering Committee Break out session • Work closer with human trafficking efforts to support trauma services	

	• Trauma informed therapists listed, and info provided by ACCESS • More support during early stages of recovery services LMFT trauma groups at residential treatment • 24/7 availability of MH services at all residential services • Male services (CORA) relationship abuse • LEA work/Healing process • Peer support • WRAP- 3x a week after residential services • Women's group - HEI (1) • Generational support (ACES) direct or indirect trauma at early age within school system (1) • Helping new parents establish a healthy routine • Photovoice for broader population • Clinical referrals to pipeline to leadership (HAP) • Trauma informed care (SDA process)- workforce that is trained (ACE) including frontline staff (ACCESS) (2)	WET: Trauma informed systems training for all BHRS staff
Trauma (cont'd)	Pacific Islander Initiative • Homelessness and changing community service areas, making services more inclusive not area based • Friendship line expansion to languages to include PI languages • Ngatuvi- A pop up senior center, gather and socialize over food- expansion to other large PI populations including EPA • Central place for money, community advisory board that makes decisions on funding • Making the outreach worker positions permanent • Prevention and wrap around strategy: Culturally appropriate, oral history project, heal and paint, workshops, pipeline to direct services from community events (4) • Building trust with law enforcement • Workshops for community on finding funding, how to write a grant • HEI Co-Chairs as job positions	Prevention, outreach and engagement services for the NHPI community that leads to linkages and warm-handoff to BHRS services

	• Trainings to providers around PI communities, systemic not anthropological, with a historical context	
Complex Cases	Contractors Association (Adults/Older Adults) • Court ordered assisted outpatient treatment (currently not court-ordered in San Mateo County) (2) • Multi-disciplinary teams across behavioral and social service sectors to discuss and support complex cases (3) • Same day access to residential treatment (2) • Strengthen continuum of care services for clients that includes transition supports • Sobering centers • Specialized training for providers (personality disorders, setting boundaries) (1) • Retention strategies for residential counselors (stipends, increase pay rate, resiliency and self-care supports, etc.) (3)	Multi-disciplinary teams across behavioral and social service sectors to discuss and support complex cases WET: Retention strategies for residential counselors (stipends, increase pay rate, resiliency and self-care supports, etc.)
	AOD Treatment Providers (Adults) • Enhanced outpatient recovery engagement strategies for clients with complex needs - specialized case management, incentives, etc. (2) • Expanded care navigators to provide integrated care management including housing resources and other supported services • Enhanced support services focused on high Emergency Department users - housing supports, linkages (1) • More Sober Living Environment (SLE) beds to support long-term recovery • After-care services for clients out of residential treatment to provide ongoing case management supports (2) • Ongoing intensive case management for co-occurring clients with serious mental illness served by regional clinics (1) • Full scope Dialectical Behavior Therapy (DBT) program focused on high-risk, tough-to-treat patients with complex needs.	Enhanced outpatient recovery engagement strategies for clients with complex needs - specialized case management, incentives, etc. After-care services for clients out of residential treatment to provide ongoing case management supports
	Latino Collaborative	Co-location of mental health services in immigration service settings/CBOs

	• Peer to peer support as system navigators, and expansion of family partners and health ambassador program (1) • Senior peer counseling- expansion, because of long waits • Support for older adults who have an adult child with mental health challenges • Tele-heath: less restrictions, as a contractor can't bill for telehealth, diminish barriers (2) • Support technology services • Co-location of services for immigrant services and mental health (3) Photovoice and storytelling workshop • Embed mental health in primary care settings • Standardized needs assessment for targeted case management (2) • Communication campaign- frame stigma, racism, discrimination in MH • Coaching for advocacy, education (1) • Training for those who work at senior centers to refer other places • Culturally sensitive trainings for staff, to be better able to serve diverse clients • Spirituality training for staff and clinical providers	
	MHSARC Older Adult Committee • Whole person level strategies at both behavioral health and primary care entry points with peer support - Total Wellness services (2) • An outreach team of trained peer workers to provide MH101-type trainings to non-behavioral health providers (3) • Supportive housing services to help stabilize clients • Addressing anxiety and isolation is a way to prevent complex cases, connect older adults when not tech savvy, phone lines (warm line) • Older adult, non-behavioral health providers (contractors, community-based agencies) need the skills to address clients with complex needs • Psych testing for clinicians to ensure proper diagnosis of dementia vs. mental health issue - Ron Robinson	Outreach team of trained peer workers to provide MH101-type trainings to non-behavioral health providers
	MHSARC Adult Committee	

	• Trauma is a chronic issue, need more case management supports • Technology for peers to support engagement (smartphones, tablets) and technology education • FSPs need more resources and training to work with difficult to engage clients and specifically, providers including training and support on burnout and high turnover, resilience	
Other Priority Areas		
Parenting/Family Stress Support	North County Outreach Collaborative • Co-location of services at senior centers • Parent and family wellness and supports - expansion of journey to empowerment, includes; safe space for community for culturally specific programming, family liaison, connection to parent project, family outings, financial wellness and family resources (4) • Ngatuvai- older adult program for low impact movement and socializing for isolated folks • Training on telehealth and how to do family sessions and group sessions • Training on how to stay connected with community online including linking to emergency resources, education, easing anxiety	Parent and family wellness and support services to engage and link families in the northern region of the county to BHRS services.
Priority population: Latino Immigrant Parents	Health Ambassador Program Participants (Key Stakeholder Interviews) • Therapeutic Behavioral Services expansion - Cappuccino program in South San Francisco • Edgewood- services are hard to get, but they have a great program • Services for folks with sexual trauma- therapy and groups (2) • Trauma-informed support and/or treatment for cannabis/alcohol use before it gateways into other severe drugs and residential treatment (4) • Classes for adults- social emotional regulation workshops/classes for parents to express their feelings, process trauma and gain tools integrated with meditation and yoga (3) • Parent classes for children of LGBTQ+ youth • Need more culturally relevant classes in Spanish through the county (3) • WRAP, ASIST • Vaping and drugs in schools- workshops and classes for prevention (2) • Art therapy at the schools	Trauma-informed support and/or treatment for cannabis/alcohol use before it gateways into other severe drugs and residential treatment

	• Communication strategy to advertise the classes • Use social media, Facebook • Train the police so that they can work with youth experiencing mental health crisis as well as a class for adults where police present and there is a shared dialogue or a non-police response to mental health crisis	
Priority Population: Transition Age Youth	Canyon Oaks TAY (Key Stakeholder Interviews): • Strategy around prevention of drugs and alcohol and treatment • Expansion of WRAP services, and linked to services as they leave residential care like Y-tec and Edgewood • Establishing a connection between the youth and services months before they leave so that they are inclined to stay in services • Housing options for TAY, current options have a lot of adults • In school treatment, mobile services that we can provide in schools this way we keep them home in their communities, in school • More AOD services, more prevention and treatment with a youth model • Case managers that parent the kids, instead of letting them choose, they do not have the ability to make the right choices without guidance, they are not adults • Services for LGBTQ+ youth, including housing since many cannot go home • Comprehensive TAY workgroup that follows this population and their outcomes • Use all contracting agencies, housing, DCS • Look at the quality of services being offered to the youth, contract monitoring more closely and looking at outcomes • Train staff in how to work with youth, and how to empower the youth and also show the youth they are in their corner as someone who cares about them as a parent would	School-based and mobile services for youth to support behavioral health needs in their communities.
	• More support towards family including youth and family parent groups to create a support network and understanding, how they can do this together • More support staff rather than therapists • After care and support services after leaving canyon oaks	Family-focused support groups and therapy to support transition age youth with behavioral health challenges

	• Training and community building with police, neighbors, community members around discrimination of youth of color being racially profiled • Flexibility with school schedules, understanding from teachers if students work and learning about their family context • Job training and job support programs to help youth apply to jobs • Host events asking for youth to come together, programs like the boys and girls club, have staff that can relate to youth • Art therapy	
Ideas from Strategic Plans Reviewed	Supporting Transition Aged Foster Youth • Increase awareness of local resources and facilitate connections to services and supports • Extending eligibility for services and financial resources to students aged 21+ instead of 18 • Knowledgeable staff providing specialized support Creating Results with Youth & their Families Local Action Plan 2016-2020 Landscape of at-risk youth & the services that support them • Trauma recovery services - directly addressing complex trauma and youth's recovery through individual or group therapy • Creating trauma-informed systems of care targeting direct service providers • Appropriate mental health services including Cognitive Behavioral Therapy (CBT) and Problem Solving Therapy • Address substance use in youth through evidence-based approaches - Adolescent Community Reinforcement Approach (A-CRA), Motivational Enhancement Theory & Motivational Interviewing, Familias Unidas Preventative Intervention for Latinx adolescents • Juvenile Drug Courts; community-based approach which requires a team that understands the challenges experienced by the youth	
Priority Population: Veterans	Key Stakeholder Interviews • Case worker for every veteran, once a veteran gets in touch with VRO they are screened on SDOH and checked in on every 6 months to check	

	mental health and physical health and make referrals and connected to job pipelines • Services for military sexual trauma which goes unrecognized • Communication campaign that shows the services and facilities available to veterans • Strong connections with employers and self-sufficiency groups as well as a job training program • Training the workforce on working with veterans; partner with the VA and research organizations	Case workers for veterans to support their behavioral health, physical health and social service needs
Ideas from Strategic Plans Reviewed:	SMC Veterans Needs Assessment: Report and Recommendations • Homeless prevention for those at risk for losing housing, and permanent supportive housing for those with highest needs • Identifying veterans and providing culturally competent services in public and private health care settings • Veterans treatment courts - Screening for previous military service • Service model: patient-centered, family oriented, wellness health promotion oriented • Partnerships: establish a partnership with the county veteran services office to assist with assessment of benefits eligibility	

APPENDIX 5 STRATEGY PRIORITIZATION RESULTS & PUBLIC COMMENTS

Mental Health Services Act (MHSA)

Three-Year Plan Strategy Prioritization

April 29, 2020

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Logistics

- Interpretation - Spanish
- Stipends for clients and family members participating
- Meeting is being recorded
- Participants are muted, chat and share screen are disabled
- Participation during Q&A and Public Comment
  - “Raise Hand” button
  - Host will unmute one participant at a time
  - 1-2 minutes maximum
- Other opportunities for public comment

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Agenda

- MHSA Overview
- COVID-19 Impact on MHSA
- Community Program Planning
- New MHSA Strategic Initiatives
  - Q&A
- Proposed Strategies
  - Public Comment
- Next Steps

MHSA Overview

76% **Community Services & Supports (CSS)**
Direct treatment and recovery services for serious mental illness or serious emotional disturbance

19% **Prevention & Early Intervention (PEI)**
Interventions prior to the onset of mental illness and early onset of psychotic disorders

5% **Innovation (INN)**
New approaches and community-driven best practices

Workforce Education and Training (WET)
Education, training and workforce development to increase capacity and diversity of the mental health workforce

Capital Facilities and Technology Needs (CFTN)
Buildings and technology used for the delivery of MHSA services to individuals and their families.

1% tax on personal income over $1 million
San Mateo County: $29.7M annual 5-year average through FY 18-19

COVID-19 Impact on MHSA

- Revenue impact
- Opportunity to strengthen current areas of work
- Potential flexibilities
- One-time funding from fiscal year 2018-19 to allocate to COVID-19 impacts
  - June 3rd - Mental Health and Substance Abuse Commission for input and opening of a 30-day public comment

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MHSA Principles & Core Values

- Focus on wellness, recovery and resilience
- Cultural and linguistic responsiveness
- Consumer/client and family-driven services
- Integrated service experience
- Community collaboration

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MHSA Planning Requirements

- Three-Year Plan & Annual Updates
- Community Program Planning Process
  - MHSA Steering Committee
  - Stakeholder Input
  - 30-Day Public Comment Period

What's in a 3-year Plan

Current Program Outcomes

Strategic Priorities

Expenditure Projections

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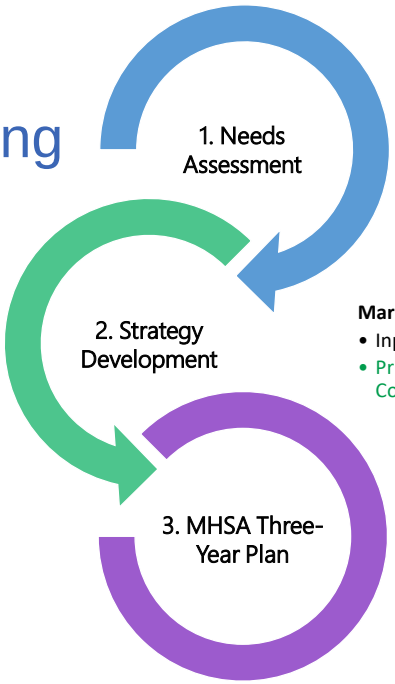
Community Program Planning



Dec 2019 – Mar 2020
- Review of local plans, assessments, evals/reports
- Survey to prioritize needs

Mar – Apr 2020
- Input sessions and key interviews
- Prioritization by MHSA Steering Committee

May – Jun 2020
- MHSARC 30-Day Public Comment
- Board of Supervisors Adoption

Update on CPP Process

- 21 local plans, assessments, data reports
- 329 survey responses

- 28 stakeholder group input sessions
  - 14 collaboratives/initiatives
  - 8 committees/workgroups
  - 3 stakeholder groups interviewed (transition-age youth, immigrant families, veterans) – 12
  - 3 geographically-focused sessions (Coast, East Palo Alto, North County)
- Subject matter experts, strategic plans

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New MHSA Strategic Initiatives

Prioritized Needs

- Homelessness/Housing
- Mental Health Crisis
- Suicide/Suicidal Ideation
- Trauma
- Complex Cases

MHSA Initiatives

1. Housing
2. Crisis Diversion
3. Culturally Responsive and Trauma-Informed Systems
4. Community Engagement
5. Integrated Treatment and Recovery Supports

Housing Continuum - example

Pre- Housing Engagement: Drop-In Centers / Field Services / Post- Psychiatric Emergency Services, Hospitalization, Incarceration

Housing Continuum for Individuals with Mental Illness

** Based on Luke-Dorf Inc and Washington County, Oregon*

REHABILITATION CENTER
- Locked
- 24/7 Staffing
- Most restrictive
- Ideal for highly symptomatic

RESIDENTIAL TREATMENT
- Unlocked
- 24/7 Staffing
- Stabilization and skills building
- Ideal for individuals out of higher level of care

RESIDENTIAL CARE "BOARD & CARE"
- Unlocked
- 24/7 Staffing
- Skill building and long-term stability
- Ideal for support with basic needs

TRANSITIONAL
- Independent units
- Staffing on-site
- Intensive support services on-site
- Ideal for stable individuals needing support

SUPPORTIVE
- Independent integrated housing
- Support service staffing on-site
- Ideal for individuals who are able to manage their needs

MORE STRUCTURED INTENSIVE CARE ← → **LESS STRUCTURED SUPPORTS**

Prioritization Process

- MHSA Steering Committee members will:
  1. Rank the new MHSA Initiatives to determine primary focus of MHSA resources and planning over the next three years.
  2. Prioritize across all strategies to determine other areas of impact necessary to meet MHSA legislative requirements and overall goals.
- Via online survey following this meeting and due May 8th

Fiscal Year 2017-20 Priority Expansions Remain a Priority

Priority Expansions	Implemented
Expansion of supports for older adults *	YES OASIS and Senior Peer Counseling expansions
Mobile mental health and wellness services to expand access to Coastside	YES Coastside Multicultural Wellness Program
Expansion of culturally responsive outreach strategies	YES NCOC Chinese Community Outreach
Expansion of Stigma Free San Mateo, Suicide Prevention and Student Mental Health efforts*	YES Suicide prevention mini-grants and stigma survey
Youth mental health crisis support and prevention	In Progress
After-care services for early psychosis treatment	YES PREP/BEAM After Care Services

Recommended Strategies

Community Services & Supports / Prevention Early Intervention

MHSA Initiative	Strategy Recommendation
Housing Continuum	1. Drop-in center for homeless with behavioral health challenges in East Palo Alto to include comprehensive services across sectors (co-occurring substance use services, case management, linkages, etc.).
	2. Incentives for sustainability of residential care facilities or board and care homes (subsidies, renovations, etc.).
	3. Mental health workers providing on the field, mobile mental health assessments and treatment for homeless individuals and linkages to housing.
	4. Transitional housing that is designed for and specializes in the needs of transition age youth (16-25 years) with serious mental health challenges.
	5. Trained/certified peers providing housing navigation, support services (e.g. independent living skills, accessing housing subsidies) to clients and training on the issue of homelessness to service providers (primary care physicians, mental health staff, police and first responders, etc.).

Public Comment #1 / Public Comment #2 /Public Comment #3

Recommended Strategies

Community Services & Supports / Prevention Early Intervention

MHSA Initiative	Strategy Recommendation
Crisis Diversion	6. Trained/certified peers providing peer and family crisis support services to assist clients transition from psychiatric emergency services, hospitalization and incarceration, into the community.
	7. Walk-in services for addressing immediate crisis needs in a less intensive setting than psychiatric emergency services.
	8. School-based, youth-led outreach, suicide education and prevention services.
	9. Suicide support services, education and outreach targeted to underserved communities (people of color, low income, and LGBTQ+, monolingual), including adding language capacity for crisis line(s).

Public Comment

Recommended Strategies

Community Services & Supports / Prevention Early Intervention

MHSA Initiative	Strategy Recommendation
Culturally Responsive and Trauma-Informed Systems	10. Educational loan forgiveness and/or financial assistance programs to support recruitment and retention of hard-to-fill positions including bilingual and culturally/ethnically diverse clinical positions.
	11. Mental health services co-located in community settings addressing core needs of marginalized communities (core service agencies, immigration service settings, etc.).
	12. Training for providers across service sectors (human services, probation, law enforcement, education, etc.) on the intersection of trauma and racism.
	13. Trained/certified peers providing trauma-informed and culturally responsive mental health 101 training for community-based service providers (senior centers, libraries, core service agencies, etc.).

Public Comment

Recommended Strategies

Community Services & Supports / Prevention Early Intervention

MHSA Initiative	Strategy Recommendation
Community Engagement	14. Culturally-focused outreach and engagement collaboratives to provide ongoing support groups, navigation and linkages, education and outreach for marginalized communities.
	15. Evidence-based youth empowerment models that work with youth to identify mental health and substance use issues to address as community leaders.
	16. Home-based early intervention services for families with young children, including case management, parent education, and parent support groups with an emphasis on wrap-around services to provide support on multiple levels and increasing collaboration between providers.
	17. Parent and family-focused wellness and support services (domestic violence, trauma, rape, healing) to engage and link families in the northern region of the county to behavioral health services.
	18. School-based resources to provide support groups, therapy and educational workshops for families.

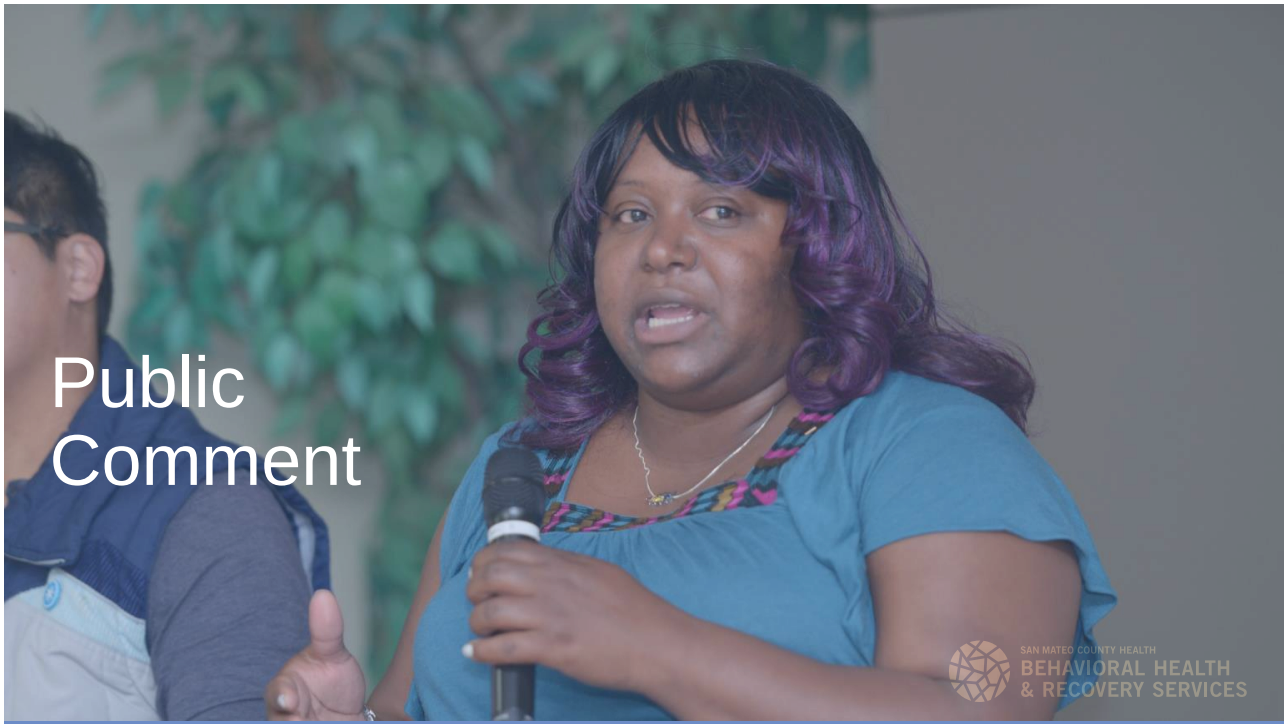
Public Comment (Spanish)-Transcript (English) #1 / Public Comment #2

Recommended Strategies

Community Services & Supports / Prevention Early Intervention

MHSA Initiative	Strategy Recommendation
Integrated Treatment and Recovery Supports	19. After-care services for clients out of residential treatment with complex needs to provide ongoing specialized case management including outpatient recovery engagement strategies (e.g. incentives to engage).
	20. Supported employment programs based on recovery-oriented, evidence-based practices.
	21. Trained/certified peers providing system navigation and resources, psychosocial rehabilitation, wellness coaching and other wellness and recovery support services.
	22. Early treatment and supports for youth and families as it relates to increased cannabis and alcohol use among youth.

Public Comment (Spanish)-Transcript (English)



3. MHSA Three-Year Plan Development

Next Steps

- Online survey for **MHSA Steering Committee** to prioritize Initiatives and Strategies
- Three-Year Plan draft to the **MHSARC** in June 3rd for opening of 30-day public comment period

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Thank you!

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Doris Estremera, MHSA Manager
650-573-2889 **T**
mhsa@smchealth.org
smchealth.org/MHSA

*To receive a client/family member stipend for your participation in this meeting, please remain online.

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Mental Health Services Act (MHSA) Steering Committee Meeting
Three-Year Plan Strategy Prioritization

Wednesday, April 29, 2020 / 4:30 – 6:00 PM
Zoom Meeting: https://zoom.us/j/125761698
Dial in: +1 669 900 6833 / Meeting ID: 125 761 698

MEETING MINUTES

1. Welcome
   - Doris Estremera, MHSA Manager
   - Supervisor Dave Pine, San Mateo County Board of Supervisors
   - Scott Gilman, BHRS Director

   - Logistics
     - Offering interpretation in Spanish.
     - Providing stipends for clients and family members of clients that are participating today. To receive a stipend, please remain online after the meeting ends and we will collect your information.
     - The meeting is being recorded. Participants are muted, and your chat and share screen are disabled to prevent background noise and disruptions. You can chat with the hosts only.
     - Participants will "Raise Hand" during the Q&A and Public Comment portions of the meeting and will be unmuted one participant at a time.
     - Questions and public comments can also be submitted via email mhsa@smcgov.org. Additionally, there will be a 30-day public comment period once the draft MHSA 3-Year Plan is published likely in June.
     - The Mental Health and Substance Use Recovery Commission will vote to open the 30-day public comment during their June 3rd meeting.

   - Interconnectedness
     "Being concerned about other people is especially relevant in today's world. If we consider the complex inter-connected ness of our modern lives, how we depend on others and others depend on us, our outlook will change. We'll begin to see 'others' not as somehow distant from us, but as people we are in touch with, people close to us; we will no longer feel indifferent to them." - Dalai Lama:

2. MHSA Overview & Community Program Planning (CPP) Process
   - MHSA Overview
     - Prop 63 (2004) 1% tax on personal income over a million dollars, "millionaire's tax"

  - 76% to direct treatment and recovery supports for individuals with serious mental illness and children with serious emotional disturbance, system integration work
  - 19% to prevention and early intervention prior to onset of mental illness; includes stigma reduction, mental health awareness, suicide prevention and school-based strategies; also early onset of psychosis.
  - 5% innovation to test out new approaches
  - Can also allocate funding to workforce, education and training and to capital facilities and technology needs
- Community Program Planning Process
  - Pandemic has had incredible impact on all BHRS operations
  - Everyone is welcome to contact Scott Gilman's office if they have any questions
  - Working with state to relax on various regulations to allow for more telehealth (e.g. billing regulations and other types of regulations)
  - Recognize need to see people face to face no matter what
  - Doing everything we could do to help our partners (SMMC) and other emergency services to prepare for surge
  - CBOS have been doing a great job to keep in regular contact with consumers
  - Peers helping delivering food
  - New providers don't have access to infectious control and trying to connect them with technology and resources
  - Physical distancing in residential agencies
  - Accessing personal protective equipment has been a huge issue
  - Adjusting evidence-based practices to fit more with virtual modes
  - Learning best practices for telehealth
  - Extended shelter in place through May 31, 2020
  - Mental health, substance use and domestic violence issues – this is our time
  - 100% money we operate on are based on tax dollars
    - Potential reductions
    - Not as many millionaires
    - Hiring freeze
    - Reduced revenue
  - MHSA Funding
    - June 3rd MHSARC – one-time funding proposal for COVID impacts
    - May stay stable this coming fiscal year and potentially an artificial boost due to delayed filing of taxes
    - Expecting a significant decrease beginning fiscal year 2022
- MHSA Principles & Core Values
  - Focus on wellness, recovery and resilience
  - Cultural and linguistic responsiveness
  - Consumer/client and family-driven services

  - Integrated service experience
  - Community collaboration
- MHSA Planning Requirements
  - MHSA manager required to submit 3-year plan and annual updates, which includes any changes to the 3-year plan and program outcomes
  - Required to do a community program planning process, which includes the MHSA Steering Committee, community input (this meeting is an example of this) and 30-day public comment process for updates/changes to the plan.
  - The Steering committee has an application process that is available on the MHSA website, www.smchealth.org/MHSA
- Community Program Planning – three phases
  - Needs Assessment – review of local plans/assessments/reports and a survey to prioritize needs
  - Strategy Development – input sessions and MHSA Steering Committee prioritization of strategies
  - Development of the MHSA 3 Year Plan – will be posted for 30-day public comment followed by adoption by the Board of Supervisors
- Update on CPP Process Plan
  - 21 local plans, assessments, data reports reviewed to identify behavioral health needs across sectors (criminal justice system, substance use prevention, 0-5 services, cultural competency, aging and adult services, agricultural workers, foster youth, etc.); this informed the development of the survey
  - 329 survey responses - prioritized top behavioral health needs
  - 28 stakeholder group input sessions – focused on strategy development
  - Subject matter experts supported strategy wording

- New MHSA Strategic Initiatives
  - During the strategy development phase, as we collected a myriad of recommendations it became clear that there are a lot of opportunities to focus on a system approach and what a continuum of services would look like across these focus areas.
  - Traditionally, we fund services across a spectrum of issues and we have legislation that requires % allocations and even areas of focus. MHSA has been stretched out thinly. There are pros and cons to this. MHSA has been able to be highly leveraged supporting many areas of need. The cons: it is very difficult to measure the overall impact of MHSA and especially on any specific goals and outcomes. Yet, that's the expectation. It's a lot of money and we should be able to impact broad level outcomes.
  - While we can't do anything immediately about the legislative requirements and the continued pull and demands on MHSA funding to focus on various issues. We believe that the framework we are proposing will allow us to

focus our internal resources in an Initiative area and also provide what is needed for meet the legislative requirements across a spectrum of services.
    - We can dedicate resources to do more strategic planning around a specific area; define what a continuum of services would entail; identify gaps; and develop logic models to illustrate expected outcomes and the specific process/activities that will get us there. The initiative areas we are proposing based on the input we received are:
        - Housing
        - Crisis Diversion
        - Culturally Responsive and Trauma-Informed Systems
        - Community Engagement
        - Integrated Treatment and Recovery Supports
    - Housing Continuum example (from Washington County, Oregon)
    - The Steering Committee will rank the 5 initiatives AND prioritize across all 22 strategies via a survey that will be emailed out after the meeting and due by May 8, 2020.
    - The priorities will be included in the 3-year plan, which will be posted for 30-day public comment
    - The youth crisis support strategy from the previous plan will remain a priority in the new 3-year plan

- Question & Answer (Q&A)*
    - Loyd: Regarding mental health and homeless, many homeless don't go into mental health centers. How do we engage homeless in drop-in center?
    - Response: If we are able to prioritize drop-in center strategies for homeless, we will make sure to engage communities in this level of detail prior to implementation. For example, a Coastside Wellness Program was prioritized last three-year plan. As a next step, we went to the community and engaged them in conversations about what it would take for them to come to a wellness center, what does it need to have, what would outreach look like. This was all prior to releasing an RFP for funding. We would do a similar process for a homeless drop in center.

    - Ellen Darnell: Excited for mental health substance abuse coalition to be formed. I lived in mental health county housing. Many people are returning to their addictions. Will there be any consumers on that commission?
    - Response: A mental health and substance use commission already exists, the Mental Health and Substance Abuse Recovery Commission. It is our local county board. There is an application process to join the commission and it does include consumers/clients and family members seats that are required to be filled.

- Alan Cochran: What are we going to do about continuing to form relationships with like /minded agencies – NAMI San Mateo County? I don't want to lose that connection with HOPE program. Further that partnerships.
- Response: Collaboration is a core value of MHSA. We will always do what we can to allow agencies to participate in project planning. For agencies to receive funding, we have a bidding process that follows any project planning.

- Carol Gosho: Can you explain who decides how you get from 100+ ideas to 22 ideas? Who decides what those 22 are?
- Response: We ran input sessions and engaged community members in strategy development. During the input sessions we asked the question, if you had to select one out of all these great ideas that would have the biggest impact over the next three years, what would it be? This initial prioritization happened during the input sessions We also looked across all the ideas for things that may have come up often but, not necessarily prioritized. All the strategy ideas and prioritization will be posted.

- Stephanie Morales: One of the expansion programs you showed was implemented already – supports for older adults, OASIS. Why is the position only 3 years, is it because it is a three-year plan?
- Response: The OASIS expansion included an additional mental health counselor, the decision to make it a limited-term three-year position is a County hiring decision, it is not due to the revenue or three-year plan. The other expansion was for the senior peer counseling program.

- Erica Horn: Will the meeting be recorded, and will it be shared?
- Response: Yes, and yes. The meeting will be posted on the MHSA website, www.scmhealth.org

- Michael Lim: The new slide on the slide deck referred to one-time funding. How big is the funding? Is it from revertible funds or back up funds? COVID-19 funding.
- Answer: Yes, the updated slide deck is on the website now. At the end of fiscal year 2018-2019, we had unspent dollars of about $5.7 million. The proposal is to dedicate these unspent funds to support with the impact of COVID-19. We will bring a proposal to the commission during the June 3rd meeting for input and 30-day public comment process.

3. Proposed Strategies
   - 22 strategies across the 5 proposed MHSA Initiatives were reviewed including prepared public comments to provide a voice to the are of focus being proposed. All strategies and recorded public comments have been included in the presentation

slide deck and will be made available on the MHSA website, www.smchealth.org/MHSA.

4. Public Comment*
   - Public comments were recorded and will be posted on the MHSA website, www.smchealth.org/MHSA. The transcriptions will be included in the Three-Year Plan.

5. Next Steps
   - Online survey for MHSA Steering Committee to prioritize Initiatives and Strategies
   - Phase 3 – Three Year Plan Development
     - Three-Year Plan draft to the MHSARC in June 3rd for opening of 30-day public comment period

6. Adjourn

Mark Your Calendars!

MHSA Three-Year Plan – Opening of 30-day public comment period
Mental Health and Substance Use Recovery Commission (MHSARC)
June 3, 2019 from 3:30pm – 5:00pm

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

ATTENDANCE

There were up to 88 participants (at 5:38pm) logged in to the Zoom app; below is a list of attendee names as recorded from Zoom, some call-in numbers and names were unidentifiable.

MHSA Steering Committee

1. Adriana Furuzawa
2. Alan Cochran
3. Cardum Harmon - Heart & Soul
4. Chris Kernes
5. Chris Rasmussen
6. Clarise Blanchard
7. Supervisor Dave Pine (MHSARC)/ Randy Torrijos (Staff to Dave Pine)
8. Jairo Wilches
9. Jan Wongchuking (MHSARC)
10. Jean Perry (MHSARC)
11. Judy Schuztman
12. Juliana Fuerbringer
13. Kava Tulua
14. Leti Bido (MHSARC)
15. Maria Lorente-Foresti
16. Mark Duri (MHSARC)
17. Mary Bier
18. Michael Lim
19. Mike Krechevsky
20. Pat Way (MHSARC)
21. Sheila Brar (MHSARC)
22. Stephanie Morales
23. William Chester McCall

Community Participants

1. Adriana Romo
2. Amaal
3. Angelica Za…
4. Aurora Pena
5. Azzam Shahzad
6. Brenda Nunez
7. Carol Gosho
8. Carolyn Shepperd
9. Carson Cook

Staff & Supports

Doris Estremera (MHSA Manager, Host)
Scott Gilman, BHRS Director
Chantae Rochester, Executive Assistant
Tania Perez (MHSA Support, Co-Host)
Frances Lobos (Co-Host)
Leon Quintero (Spanish Interpreter #2)
Michelle Blanchard (Spanish Interpreter #1)

Other BHRS Staff

1. Angela Quiroz
2. Camille Hicale
3. Charo Martinez
4. Claudia Saggese
5. Edith Cabuslay
6. Erica Britton
7. Jessica Tieu
8. Lee Harrison
9. Matt Boyle
10. Yolanda Ramirez

10. ccardenas
11. Chelsea Bonini
12. Christian
13. Christopher Hoover
14. Don -VRS
15. Donna Rutherford
16. Ellen Darnell
17. Erica Horn
18. Gloria Flores-Garcia
19. Haelee
20. Helene
21. Jan Cohen
22. John Butler
23. Jose Nunez
24. Lanjean Vecchione
25. Liana Garza
26. Linder Allen
27. Lloyd
28. Lourdes Briseno
29. Luiz Vizcardo
30. Lupita
31. Maria Cuellar
32. Marina Kravtsova
33. Mark
34. Marlenne
35. Melinda Henning
36. Mike D
37. Priscilla Hurt
38. Rev Mary Frazier
39. Stephanie Weisner
40. Valerie Abea-Bor
41. Westley

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

MHSA Three-Year Plan FY 20/21 to FY 22/23

MHSA Steering Committee Prioritization Results

In an effort to offset the anticipated lack of new funding, due to COVID-19 pandemic and upcoming recession, a strategic approach to addressing the input collected during the CPP process was proposed to the MHSA Steering Committee on April 29, 2020. Twenty two strategies that were prioritized by stakeholders were organized under five MHSA Strategic Initiatives with the intent to reallocate existing MHSA staff resources to engage stakeholders in planning to develop an adaptive strategy direction for these initiatives. This can be accomplished within the current budget and will give us valuable information we need to make informed decisions about funding and next steps once revenue increases. Following the MHSA Steering Committee, members were asked via an online survey to both a) rank the 5 Strategic Initiatives and b) rate the 22 strategies. The results of this vote are summarized below listed in order of priority:

MHSA Initiative	Strategy Recommendation Green = Prevention and Early Intervention strategy	Priority - Weighted Avg
Rank 1: Housing Continuum	Mental health workers providing on the field, mobile mental health assessments and treatment for homeless individuals and linkages to housing.	1.73
	Trained/certified peers providing housing navigation, support services (e.g. independent living skills, accessing housing subsidies) to clients and training on the issue of homelessness to service providers (primary care physicians, mental health staff, police/first responders, etc.).	2.0
	Transitional housing that is designed for and specializes in the needs of transition age youth (16-25 years) with serious mental health challenges.	2.05
	Incentives for sustainability of residential care facilities or board and care homes (subsidies, renovations, etc.).	2.27
	Drop-in center for homeless with behavioral health challenges in East Palo Alto to include comprehensive services across sectors (co-occurring substance use services, case management, linkages, etc.).	2.41

MHSA Initiative	Strategy Recommendation Green = Prevention and Early Intervention strategy	Priority - Weighted Avg
Rank 2: Crisis Diversion	Trained/certified peers providing peer and family crisis support services to assist clients transition from psychiatric emergency services, hospitalization and incarceration, into the community.	1.90
	Walk-in services for addressing immediate crisis needs in a less intensive setting than psychiatric emergency services.	1.95
	Suicide support services, education and outreach targeted to underserved communities (people of color, low income, and LGBTQ+, monolingual), including adding language capacity for crisis line(s).	2.09
	School-based, youth-led outreach, suicide education and prevention services.	2.32

MHSA Initiative	Strategy Recommendation Green = Prevention and Early Intervention strategy Purple = Workforce Education and Training strategy	Priority - Weighted Avg
Rank 3: Culturally Responsive and Trauma-Informed Systems	Trained/certified peers providing trauma-informed and culturally responsive mental health 101 training for community-based service providers (senior centers, libraries, core service agencies, etc.).	2.18
	Training for providers across service sectors (human services, probation, law enforcement, education, etc.) on the intersection of trauma and racism.	2.27
	Mental health services co-located in community settings addressing core needs of marginalized communities (core service agencies, immigration service settings, etc.)	2.45
	Educational loan forgiveness and/or financial assistance programs to support recruitment and retention of hard-to-fill positions including bilingual and culturally/ethnically diverse clinical positions.	2.82

MHSA Initiative	Strategy Recommendation Green = Prevention and Early Intervention strategy	Priority - Weighted Avg
Rank 4: Integrated Treatment and Recovery Supports	After-care services for clients out of residential treatment with complex needs to provide ongoing specialized case management including outpatient recovery engagement strategies (e.g. incentives to engage).	2.09
	Trained/certified peers providing system navigation and resources, psychosocial rehabilitation, wellness coaching and other wellness and recovery support services.	2.23
	Supported employment programs based on recovery-oriented, evidence-based practices	2.45
	Early treatment and supports for youth and families as it relates to increased cannabis and alcohol use among youth.	2.55

MHSA Initiative	Strategy Recommendation Green = Prevention and Early Intervention strategy	Priority - Weighted Avg
Rank 5: Community Engagement	Parent and family-focused wellness and support services (domestic violence, trauma, rape, healing) to engage and link families in the northern region of the county to behavioral health services.	2.18
	School-based resources to provide support groups, therapy and educational workshops for families.	2.23
	Evidence-based youth empowerment models that work with youth to identify mental health and substance use issues to address as community leaders.	2.32
	Home-based early intervention services for families with young children, including case management, parent education, and parent support groups with an emphasis on wrap-around services to provide support on multiple levels and increasing collaboration between providers.	2.36
	Culturally-focused outreach and engagement collaboratives to provide ongoing support groups, navigation and linkages, education and outreach for marginalized communities.	2.41

APPENDIX 6 MHSA THREE-YEAR PLAN FUNDING SUMMARY

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: San Mateo

Date: 6/25/20

	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 2020/21 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	29,222,019	6,854,548	5,752,273	0	2,255,000	
2. Estimated New FY 2020/21 Funding	24,858,053	6,214,513	1,635,398			
3. Transfer in FY 2020/21a/	(1,980,000)			830,000	1,150,000	
4. Access Local Prudent Reserve in FY 2020/21						0
5. Estimated Available Funding for FY 2020/21	52,100,072	13,069,061	7,387,671	830,000	3,405,000	
B. Estimated FY 2020/21 MHSA Expenditures	28,014,073	7,552,846	3,761,882	830,000	2,702,000	
C. Estimated FY 2021/22 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	24,085,999	5,516,215	3,625,789	0	703,000	
2. Estimated New FY 2021/22 Funding	23,366,569	5,841,642	1,537,274			
3. Transfer in FY 2021/22a/	(830,000)			830,000		
4. Access Local Prudent Reserve in FY 2021/22						0
5. Estimated Available Funding for FY 2021/22	46,622,568	11,357,857	5,163,063	830,000	703,000	
D. Estimated FY 2021/22 Expenditures	26,905,497	8,907,846	3,054,124	830,000	703,000	
E. Estimated FY2022/23 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	19,717,071	2,450,011	2,108,939	0	0	
2. Estimated New FY2022/23 Funding	22,548,739	5,637,185	1,483,470			
3. Transfer in FY2022/23[a/]	(500,000)			500,000		
4. Access Local Prudent Reserve in FY2022/23						0
5. Estimated Available Funding for FY2022/23	41,765,810	8,087,196	3,592,409	500,000	0	
F. Estimated FY2022/23 Expenditures	24,320,497	7,712,846	2,572,658	500,000	0	
G. Estimated FY2022/23 Unspent Fund Balance	17,445,313	374,350	1,019,751	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2020	600,000
2. Contributions to the Local Prudent Reserve in FY 2020/21	0
3. Distributions from the Local Prudent Reserve in FY 2020/21	0
4. Estimated Local Prudent Reserve Balance on June 30, 2021	600,000
5. Contributions to the Local Prudent Reserve in FY 2021/22	0
6. Distributions from the Local Prudent Reserve in FY 2021/22	0
7. Estimated Local Prudent Reserve Balance on June 30, 2022	600,000
8. Contributions to the Local Prudent Reserve in FY 2016/17	0
9. Distributions from the Local Prudent Reserve in FY 2016/17	0
10. Estimated Local Prudent Reserve Balance on June 30, 2017	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 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: San Mateo Date: 6/25/20

	Fiscal Year 2020/21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Early Childhood Community Team	442,468	442,468				
2. Community Interventions for School Age and TAY	835,771	835,771				
3. Community Outreach, Engagement and Capacity Building	527,505	527,505				
4. Trauma-Informed Systems (One-Time Spend Plan)	100,000	100,000				
5. Peer Engagement (One-Time Spend Plan)	80,000	80,000				
6. Health Ambassador Program for Youth (One-Time Spend Plan)	250,000	250,000				
7.	0					
8.	0					
PEI Programs - Early Intervention						
1. Early Onset of Psychotic Disorders	835,648	835,648				
2. Early Crisis Interventions	487,039	487,039				
4. Primary Care/Behavioral Health Integration (One-Time Spend Plan)	1,337,972	1,337,972				
5. Crisis Coordination (One-Time Spend Plan)	150,000	150,000				
PEI Programs - Outreach for Increasing Recognition of Early Signs of MI						
1. Mental Health First Aid	70,300	70,300				
2. Mental Health 101 for Organizations (One-Time Spend Plan)	60,000	60,000				
PEI Programs - Access and Linkage to Treatment						
1. Outreach Worker Program	57,898	57,898				
2. Outreach Collaboratives	412,984	412,984				
3. Coastside Community Engagement	90,000	90,000				
4. Older Adult Outreach	171,696	171,696				
5. Primary Care-Based Efforts	25,440	25,440				
PEI Programs - Stigma and Discrimination Reduction						
1. Digital Storytelling & Photovoice	328,080	328,080				
2. Mental Health Awareness	157,196	157,196				
PEI Programs - Suicide Prevention						
1. Sucide Prevention Inititive	157,196	157,196				
PEI Evaluation - One-Time						
1. PEI Outcomes-Oriented Data Planning (One-Time Spend Plan)	150,000	150,000				
PEI Administration + Evaluation	702,356	702,356				
PEI Assigned - CalMHSA	123,297	123,297				
Total PEI Program Estimated Expenditures	7,552,846	7,552,846	0	0	0	0

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: San Mateo Date: 6/25/20

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Early Childhood Community Team	442,468	442,468				
2. Community Interventions for School Age and TAY	835,771	835,771				
3. Community Outreach, Engagement and Capacity Building	527,505	527,505				
4. Trauma-Informed Systems (One-Time Spend Plan)	100,000	100,000				
5. Peer Engagement (One-Time Spend Plan)	80,000	80,000				
6. Health Ambassador Program for Youth (One-Time Spend Plan)	250,000	250,000				
7. Help@Hand Expansion (One-Time Spend Plan)	300,000	300,000				
8. Pride Center (One-Time Spend Plan)	455,000	455,000				
PEI Programs - Early Intervention						
1. Early Onset of Psychotic Disorders	835,648	835,648				
2. Early Crisis Interventions	487,039	487,039				
3. Expansion - Crisis Intervention	650,000	650,000				
4. Primary Care/Behavioral Health Integration (One-Time Spend Plan)	1,337,972	1,337,972				
5. Crisis Coordination (One-Time Spend Plan)		150,000				
PEI Programs - Outreach for Increasing Recognition of Early Signs of MI						
1. Mental Health First Aid	70,300	70,300				
2. Mental Health 101 for Organizations (One-Time Spend Plan)	60,000	60,000				
PEI Programs - Access and Linkage to Treatment						
1. Outreach Collaboratives	57,898	57,898				
2. Coastside Community Engagement	412,984	412,984				
3. Older Adult Outreach	90,000	90,000				
4. Primary Care-Based Efforts	171,696	171,696				
5.	25,440	25,440				
PEI Programs - Stigma and Discrimination Reduction	0					
1. Digital Storytelling & Photovoice	328,080	328,080				
2. Mental Health Awareness	157,196	157,196				
PEI Programs - Suicide Prevention	0					
1. Sucide Prevention Inititive	157,196	157,196				
PEI Evaluation - One-Time						
1. PEI Outcomes-Oriented Data Planning	100,000	100,000				
PEI Administration + Evaluation	702,356	702,356				
PEI Assigned Funds - CalMHSA	123,297	123,297				
Total PEI Program Estimated Expenditures	8,757,846	8,907,846	0	0	0	0

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: San Mateo Date: 6/25/20

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Early Childhood Community Team	442,468	442,468				
2. Community Interventions for School Age and TAY	835,771	835,771				
3. Community Outreach, Engagement and Capacity Building	527,505	527,505				
4. Help@Hand Expansion (One-Time Spend Plan)	300,000	300,000				
5.	0					
6.	0					
7.	0					
8.	0					
PEI Programs - Early Intervention						
1. Early Onset of Psychotic Disorders	835,648	835,648				
2. Early Crisis Interventions	487,039	487,039				
3. Expansion - Crisis Intervention	650,000	650,000				
4. Primary Care/Behavioral Health Integration	1,337,972	1,337,972				
5.	0					
PEI Programs - Outreach for Increasing Recognition of Early Signs of MI						
1. Mental Health First Aid	70,300	70,300				
2.	0					
PEI Programs - Access and Linkage to Treatment						
1. Outreach Collaboratives	57,898	57,898				
2. Coastside Community Engagement	412,984	412,984				
3. Older Adult Outreach	90,000	90,000				
4. Primary Care-Based Efforts	171,696	171,696				
5.	25,440	25,440				
PEI Programs - Stigma and Discrimination Reduction						
1. Digital Storytelling & Photovoice	328,080	328,080				
2. Mental Health Awareness	157,196	157,196				
PEI Programs - Suicide Prevention						
1. Sucide Prevention Inititive	157,196	157,196				
PEI Administration + Evaluation	702,356	702,356				
PEI Assigned Funds - CalMHSA	123,297	123,297				
Total PEI Program Estimated Expenditures	7,712,846	7,712,846	0	0	0	0

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Mateo Date: 6/25/20

	Fiscal Year 2020/21					
	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 FSP	2,851,579	2,851,579				
2. Transition Age Youth FSP	2,708,754	2,708,754				
3. Adults and Older Adults FSP	5,258,077	5,258,077				
4. Housing Initiative	3,497,585	3,497,585				
5. FSP/BHRS Clinic Restructure (One-Time Spend Plan)	2,500,000	2,500,000				
6. Recovery Oriented, Co-Occurring Capacity (One-Time Spend Plan)	500,000	500,000				
7. Ongoing CalHFA Unencumbered Housing	104,066	$104,066				
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. Older Adult System of Care	1,107,802	936,356	171,446			
2. Criminal Justice Integration	588,477	524,895	63,582			
3. Co-Occurring Services	970,488	863,470	107,018			
4. Other System Development	2,927,921	2,361,513	566,408			
5. Peer and Family Supports	2,912,754	2,442,619	470,135			
6. Infrastructure Strategies	1,096,103	1,096,103				
7. Outreach and Engagement	333,205	333,205				
8. Capacity Building for Board and Care (One-Time Spend Plan)	40,000	40,000				
9. Supported Employment (One-Time Spend Plan)	400,000	400,000				
10. COVID-19 Supports (One-Time Spend Plan)	1,046,000	1,046,000				
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration + Evaluation	549,851	549,851				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	29,392,662	28,014,073	1,378,589	0	0	0
FSP Programs as Percent of Total	62.2%					

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Mateo Date: 6/25/20

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Children and Youth FSP	2,851,579	2,851,579				
2. Transition Age Youth FSP	2,708,754	2,708,754				
3. Adults and Older Adults FSP	5,258,077	5,258,077				
4. Housing Initiative	3,497,585	3,497,585				
5. FSP/BHRS Clinic Restructure (One-Time Spend Plan)	1,500,000	1,500,000				
6. Recovery Oriented, Co-Occurring Capacity (One-Time Spend Plan)	250,000	250,000				
7. Ongoing CalHFA Unencumbered Housing	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					
Non-FSP Programs						
1. Older Adult System of Care	1,107,802	936,356	171,446			
2. Criminal Justice Initiative	588,477	524,895	63,582			
3. Co-Occurring Services	970,488	863,470	107,018			
4. Other System Development	2,927,921	2,361,513	566,408			
5. Peer and Family Supports	2,912,754	2,442,619	470,135			
6. Infrastructure Strategies	1,096,103	1,096,103				
7. Outreach and Engagement	333,205	333,205				
8. Recovery Oriented, Co-Occurring Capacity (One-Time Spend Plan)	250,000	250,000				
9. Capacity Building for Board and Care (One-Time Spend Plan)	40,000	40,000				
10. Supported Employment (One-Time Spend Plan)	300,000	300,000				
11. Pride Center (One-Time Spend Plan)	245,000	245,000				
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	1,446,341	1,446,341				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	28,284,086	26,905,497	1,378,589	0	0	0
FSP Programs as Percent of Total	59.7%					

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Mateo Date: 6/25/20

	Fiscal Year 2022/23					
	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 FSP	2,851,579	2,851,579				
2. Transition Age Youth FSP	2,708,754	2,708,754				
3. Adults and Older Adults FSP	5,258,077	5,258,077				
4. Housing Initiative	3,497,585	3,497,585				
5. Ongoing CalHFA Unencumbered Housing	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. Older Adult System of Care	1,107,802	936,356	171,446			
2. Criminal Justice Initiative	588,477	524,895	63,582			
3. Co-Occurring Services	970,488	863,470	107,018			
4. Other System Development	2,927,921	2,361,513	566,408			
5. Peer and Family Supports	2,912,754	2,442,619	470,135			
6. Infrastructure Strategies	1,096,103	1,096,103				
7. Outreach and Engagement	333,205	333,205				
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	1,446,341	1,446,341				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	25,699,086	24,320,497	1,378,589	0	0	0
FSP Programs as Percent of Total	58.9%					

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: San Mateo Date: 6/25/20

	Fiscal Year 2020/21					
	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. San Mateo County Pride Center	810,000	810,000				
2. Help@Hand (Tech Suite)	1,476,069	1,476,069				
3. Addiction Medicine Fellowship (pending approval)	199,813	199,813				
4. Co-location of PEI Services in Low-Income Housing (pending approval)	330,000	330,000				
5. PIONEERS - College-Age Pacific Islander Mental Health (pending approval)	330,000	330,000				
6. Older Adult Homelessness Prevention due to Economic Stress (pending approval)	261,000	261,000				
7. Social Enterprise Cultural and Wellness Café (pending approval)	355,000	355,000				
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	3,761,882	3,761,882	0	0	0	0

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: San Mateo Date: 6/25/20

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Help@Hand (Tech Suite)	1,214,749	1,214,749				
2. Addiction Medicine Fellowship (pending approval)	253,375	253,375				
3. Co-location of PEI Services in Low-Income Housing (pending approval)	300,000	300,000				
4. PIONEERS - College-Age Pacific Islander Mental Health (pending approval)	300,000	300,000				
5. Older Adult Homelessness Prevention due to Economic Stress (pending approval)	246,000	246,000				
6. Social Enterprise Cultural and Wellness Café (pending approval)	740,000	740,000				
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	0					
Total INN Program Estimated Expenditures	3,054,124	3,054,124	0	0	0	0

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: San Mateo Date: 6/25/20

	Fiscal Year 2022/23					
	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. Help@Hand (Tech Suite)	816,721	816,721				
2. Addiction Medicine Fellowship (pending approval)	204,937	204,937				
3. Co-location of PEI Services in Low-Income Housing (pending approval)	290,000	290,000				
4. PIONEERS - College-Age Pacific Islander Mental Health (pending approval)	290,000	290,000				
5. Older Adult Homelessness Prevention due to Economic Stress (pending approval)	231,000	231,000				
6. Social Enterprise Cultural and Wellness Café (pending approval)	740,000	740,000				
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	0					
Total INN Program Estimated Expenditures	2,572,658	2,572,658	0	0	0	0

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: San Mateo Date: 6/25/20

	Fiscal Year 2020/21					
	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/Technical Assistance	145,400	145,400				
2. Mental Health Career Pathways	0					
3. Residency/Internship	0					
4. Financial Incentive	94,600	94,600				
WET (One-Time Spend Plan)	0					
1. Online Training Capacity	76,000	76,000				
2. Workforce Capacity (EMDR, DBT, Self Care)	80,000	80,000				
3. Peer Certification and Training	50,000	50,000				
4. Workforce Strategies (OSHPD match)	124,000	124,000				
5.	0					
WET Administration	260,000	260,000				
Total WET Program Estimated Expenditures	830,000	830,000	0	0	0	0

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: San Mateo Date: 6/25/20

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training/Technical Assistance	145,400	145,400				
2. Mental Health Career Pathways	0					
3. Residency/Internship	0					
4. Financial Incentive	94,600	94,600				
WET (One-Time Spend Plan)	0					
1. Online Training Capacity	76,000	76,000				
2. Workforce Capacity (EMDR, DBT, Self Care)	80,000	80,000				
3. Peer Certification and Training	50,000	50,000				
4. Workforce Strategies (OSHPD match)	124,000	124,000				
5.	0					
WET Administration	260,000	260,000				
Total WET Program Estimated Expenditures	830,000	830,000	0	0	0	0

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: San Mateo Date: 6/25/20

	Fiscal Year 2022/23					
	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/Technical Assistance	145,400	145,400				
2. Mental Health Career Pathways	0					
3. Residency/Internship	0					
4. Financial Incentive	94,600	94,600				
WET (One-Time Spend Plan)	0					
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
WET Administration	260,000	260,000				
Total WET Program Estimated Expenditures	500,000	500,000	0	0	0	0

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: San Mateo Date: 6/25/20

	Fiscal Year 2020/21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects (One-Time Spend Plan)						
1. SSF Clinic	500,000	500,000				
2. EPA Clinic	700,000	700,000				
3. Casia House Renovations	100,000	100,000				
4. Cordilleras	500,000	500,000				
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects (One-Time Spend Plan)						
11. Electronic Health Care Record Add-Ons	425,000	425,000				
12. Telepsychiatry	30,000	30,000				
13. Technology Supports for Clients	447,000	447,000				
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	2,702,000	2,702,000	0	0	0	0

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: San Mateo Date: 6/25/20

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Cordilleras	500,000	500,000				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. Electronic Health Care Record Add-Ons	173,000	173,000				
12. Telepsychiatry	30,000	30,000				
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	703,000	703,000	0	0	0	0

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: San Mateo Date: 6/25/20

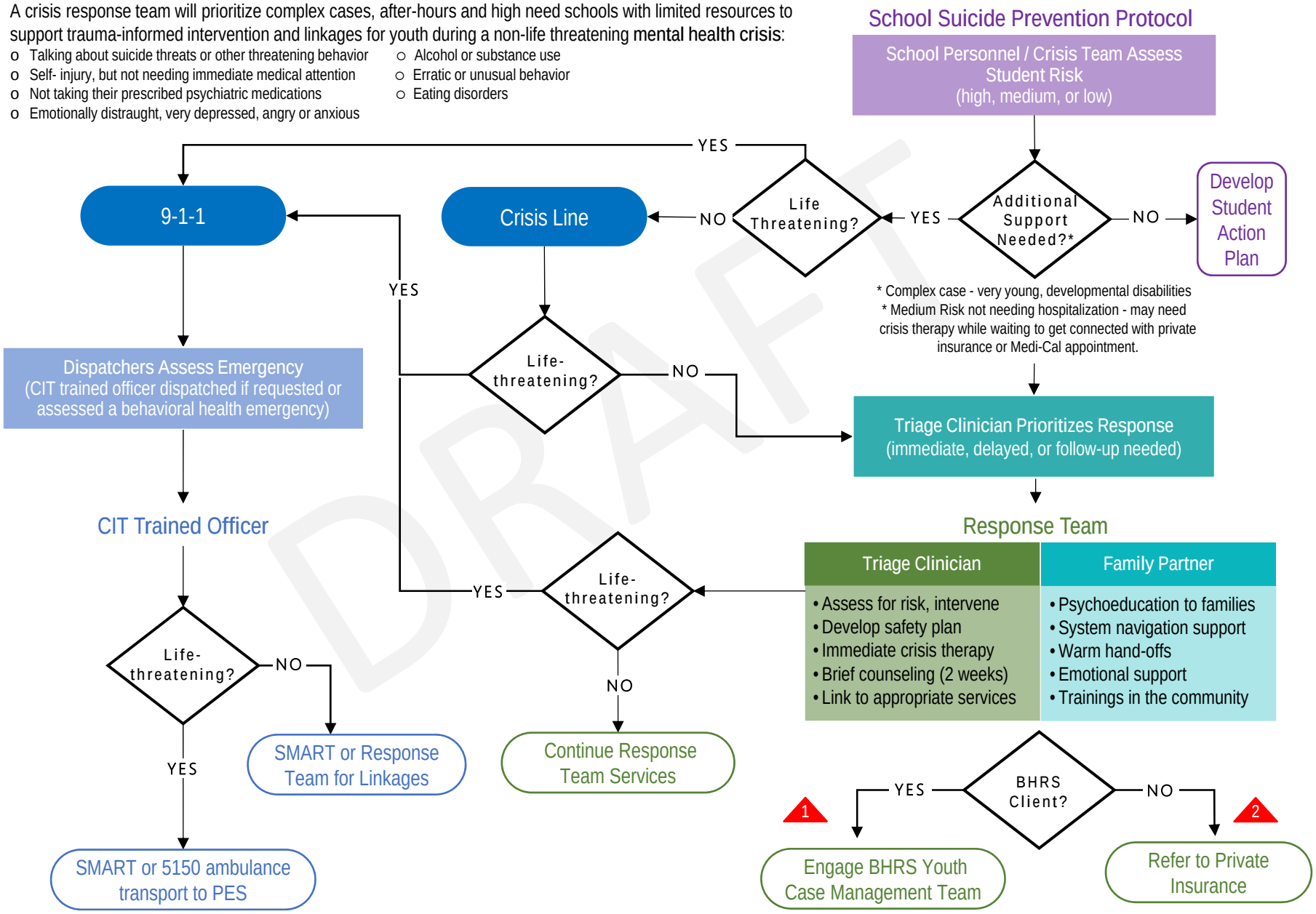
	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	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 7 DRAFT YOUTH CRISIS STRATEGY DEVELOPMENT

Youth Crisis Strategy Development – Flow Chart

A crisis response team will prioritize complex cases, after-hours and high need schools with limited resources to support trauma-informed intervention and linkages for youth during a non-life threatening **mental health crisis**:

- Talking about suicide threats or other threatening behavior
- Self- injury, but not needing immediate medical attention
- Not taking their prescribed psychiatric medications
- Emotionally distraught, very depressed, angry or anxious
- Alcohol or substance use
- Erratic or unusual behavior
- Eating disorders



Updated: 3/18/2020

Youth Crisis Response Strategy Development – Program Characteristics

Program Component	Considerations/Notes
Response Team(s)	• Made up of Triage Clinician and Family Partner • Two (2) overlapping response teams • Oversight BY and integrated with BHRS Youth Case Management Team
Hours of Operation	• Mon – Fri, 9am to 9pm / Sat – Sun, 11am to 11pm • Triage Clinician available after-hours for assessment and next-day deployment scheduling as needed.
Access Points	Crisis Hotline • Will need to establish protocols with existing crisis hotline (StarVista) • Hotline volunteers/clinician(?) will assess for safety status. If no need to dispatch 9-1-1 then dispatch Response Team. Schools • School personnel have suicide risk assessment (part of the Suicide Prevention Protocol) that can help determine level of risk to call 9-1-1 or the Crisis Hotline • Direct access to Response Team? General Public/ Community programs (non-direct service) • Can call 9-1-1 or the crisis hotline Law Enforcement, Jails, MH Clinics • Can contact PSC for SMART. Direct access to Response Team? • Direct access to Response Team?
Response Team Dispatch	• Triage Clinician assess calls to determine dispatch based on location/case load o Immediate Response (45 min) to location o Delayed Response (within 4 hours) o Follow-up appointment (within 24 hours)
Service Locations	Any location where youth may be in crisis? • Schools – review suicide risk protocol, coordinate efforts • Home – need safety protocols • Community Organizations
Staffing	Triage Clinician • Continued contact for 8-12 weeks is too long, referral/warm hand-off should be at 2 weeks • Must have appropriate training and experience (3-5 years working with high risk youth) • Very familiar with San Mateo County system resources Family/Peer Partner • Individual with lived experience as clients and/or family members • Family Partner preferably member of the community that speaks a threshold language • Youth Peer Partner will be young adult age (21-28 years old) Supervisor Interns

APPENDIX 8 THREE-YEAR WORKFORCE EDUCATION AND TRAINING (WET) PLAN

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

MHSA Three-Year Workforce Education and Training (WET) Plan, FY 2020-2023

Introduction

The Mental Health Services Act (MHSA) was approved by California voters in November 2004 and provided dedicated funding for mental health services by imposing a 1% tax on personal income over $1 million dollars. MHSA emphasizes transformation of the mental health system while improving the quality of life for individuals living with mental illness. In Fiscal Year (FY) 2006-07 and FY 2007-08, San Mateo County Behavioral Health and Recovery Services (BHRS) received a one-time MHSA allocation in the amount of $3,437,600, for Workforce Education and Training (WET) strategies. A WET 10-Year Impact and Sustainability Report was released and presented to our local mental health board, the Mental Health and Substance Use Recovery Commission on February 7, 2018 recommending $500,000 per year to sustain the most effective and impactful elements of WET. The sustainability plan was approved and submitted as part of the FY 2017-20 MHSA Three Year Plan.

Statewide, the Office of Statewide Health Planning and Development (OSHPD), in coordination with the California Behavioral Health Planning Council (CBHPC), is charged with the development of a WET Plan every five years to address the needs of the behavioral health workforce. Implementation of OSHPD's Five-Year WET Plan will occur through a Regional Partnership framework. The Regional Partnerships will be funded to implement strategies in pipeline development, undergraduate scholarships, education stipends, and educational loan repayments through a framework that engages Regional Partnerships. San Mateo County will participate in the Bay Area Regional Partnership and has allocated a required match in the amount of $200,000 one-time monies approved through a community planning process and submitted in our FY 2019-20 MHSA Annual Update.

This MHSA Three-Year WET Plan will guide implementation of WET strategies and activities for the 2020-2023 MHSA cycle. This plan is in alignment with statewide priorities, builds on the current plan developed in collaboration with stakeholders, providers and community partners, and identifies areas of need, strengths, and opportunities for improvement.

Stakeholder Participation Summary

WET Plan development was guided by a stakeholder engagement process that targeted diverse groups of San Mateo County Behavioral Health and Recovery Services (BHRS) staff and contract agency staff (including peer and family positions), and community stakeholders. The input process included key informant interviews, online surveys for BHRS staff and individuals with lived experience, small remote focus group discussions conducted through the Zoom platform, and input discussion groups targeting a variety of different stakeholder groups. BHRS directly gathered input from stakeholder groups as part of its broader three-year MHSA community planning process. BHRS contracted an independent consulting firm, Resource Development Associates (RDA), to conduct staff focus groups, design and administer the online surveys, and summarize stakeholder needs and recommendations. The chart below lists the forums through which information was collected.

Table 1. Stakeholder Data Collection Activities

Forum Type	Stakeholder Group
Input Sessions	• African American Community Initiative • AOD Treatment Providers • Chinese Health Initiative • Coastside Collaborative • Contractors Association • Diversity and Equity Committee • East Palo Alto Service Area • Filipino Mental Health Initiative • Housing Operations and Policy Committee • Latino Collaborative • Lived Experience Education Workgroup • MHSARC Adult Committee • MHSARC Older Adult Committee • MHSARC Youth Committee • Native American Indigenous People Initiative • North County Outreach Collaborative • Northeast School Collaborative • Northwest School Collaborative • Pacific Island Initiative • Peer Recovery Collaborative • Pride Initiative • South School Collaborative • Spirituality Initiative • Steering Committee Breakout Groups
Key Stakeholder Interviews	• Canyon Oaks Staff and Youth Participants • Health Ambassadors • Veterans

Forum Type	Stakeholder Group
Focus Groups (conducted by RDA)	• BHRS Providers (2) • Workforce Development and Education Committee
Surveys	• BHRS Provider Survey o 43 participants ▪ 53.5% Direct Service/Clinical ▪ 16.3% Clinical Supervisor/Unit Chief ▪ 11.6% Administrative ▪ 9.3% Peer/Lived Experience Worker ▪ 4.7% Manager/Senior-Level Administrator ▪ 2.3% Community Program Planning and Coordination ▪ 2.3% Other • BHRS Survey for People with Lived Experiences o 27 participants

Stakeholder Results

RDA analyzed the results of online surveys, focus groups, and stakeholder input discussions to understand stakeholders' needs and recommendations related to workforce training and development. Through these data collection activities, stakeholders indicated the need to continue to implement and build upon existing WET strategies included in the County's prior WET Plan. Stakeholders identified several priority areas where expanded investment may also increase the capacity of San Mateo County's behavioral health workforce to meet the needs of its diverse communities. Stakeholders highlighted the importance of the following overarching strategies across the four WET components: 1) increasing awareness, accessibility, and impact of trainings for community members and BHRS staff; 2) developing the behavioral health career pipeline through proactive engagement with educational institutions and community organizations and groups; and 3) providing career navigation support to existing staff and people with lived experience. A comprehensive breakdown of findings from stakeholder discussions and surveys is presented in Appendix A.

MHSA WET Components, Strategies & Priority Recommendations

Component: Workforce Staffing Support

Summary of Stakeholder Findings

During stakeholder input discussions, participants frequently shared their appreciation for the WET team's current efforts while calling for a continued strengthening and expansion of programming including increased training offerings and internal career navigation support. Participants also noted a need to increase staff awareness of existing training opportunities, employee support services, and available education and licensing reimbursement opportunities.

WET Strategies

BHRS WET programming provides education/training and workforce development opportunities to San Mateo County behavioral health staff, contractors, providers, clients/consumers and family members. The WET programming also works in partnership with other BHRS strategic initiatives including:

- Developing an inclusive, equitable organization culture and environment;
- Promoting cultural humility and racial equity;
- Developing best practices for the treatment of co-occurring mental health and substance use conditions;
- Building a comprehensive suicide prevention program;
- Honoring lived experience in employment;
- Creating trauma-informed systems of care; and
- Decreasing stigma.

WET operates under the Office of Diversity and Equity (ODE) and is supervised by the ODE Director. This organizational structure enhances the focus of WET to embed cultural humility, as well as to support the core values of MHSA and allows for a systemic approach to workforce strategies. The WET Team currently includes three positions: the WET Director, a Community Program Specialist, and an Office Specialist.

Priority Recommendation #1

Moving forward, BHRS recommends the following workforce staffing structure:

- A WET Director: Provides oversight of the WET Program planning and implementation and related WET workgroups/committees including statewide representation; evaluation; facilitation of the Workforce Development and Education Committee (WDEC) and the Practice Evaluation Committee (evidence-based practices); and participation in several BHRS Workgroups related to supporting BHRS strategic initiatives.
- A WET Community Program Specialist: Provides oversight of clinical and Office of Diversity ad Equity (ODE) internship programs, the Cultural Competency Stipend Internship Program and the Cultural Humility Training Cohort.
- A WET Community Program Specialist: Coordinates training/education needs, documentation, and evaluation for all WET Programs and trainings; administers the Learning Management System for all BHRS trainings including the new learning management system to support enhanced online training opportunities.

As the San Mateo County population continues to grow and diversify and client needs are becoming more complex, a workforce that is culturally humble, provides client/family-driven mental health services, and adheres to the values of wellness, recovery, and resilience is critical. The demands on the staffing for the WET program have increased in scope and scale. WET supported 98 trainings in FY 2018-19, triple the

average number of trainings in previous years. Prior to the COVID-19 pandemic, WET staff were implementing improved technologies to provide increased online and webinar-style trainings, which has now been elevated by the shelter-in-place orders. The WET Team will require an increase in one position's classification in order to: adequately support the existing WET strategies; respond to stakeholder recommendations to continue to strengthen and expand WET programming; build infrastructure to implement new technologies; maintain a well-organized, effective, consistent workforce program; and conduct reporting and evaluation of BHRS training activities.

Component: Training for System Transformation

Summary of Stakeholder Findings

During stakeholder engagement activities, participants shared a desire to expand opportunities for clinical and non-clinical staff to attend County-provided/funded trainings by increasing the frequency of training offerings and/or by increasing training accessibility (e.g., remote participation). Participants also recommended providing ongoing follow-up and training refreshers (in individual and group settings/supervision) and ongoing consultation on training concepts to ensure learnings are successfully applied in practice.

BHRS staff members, community providers, and individuals with lived experience highlighted the importance of trainings in trauma-informed care and cultural humility/responsiveness**.** They indicated these training areas as priorities for all levels of clinical and non-clinical staff, emphasizing that these training areas promote supportive, communicative, and inclusive working environments for staff within the BHRS network of services.

WET Strategies

To support BHRS providers in successfully applying learnings in practice, WET will offer training refreshers and ongoing consultation on training concepts. WET will continue and expand its practice of offering foundational-level courses followed by advanced-level learning opportunities with specific focus on the application of the training concepts to specific communities or settings. Also, WET will provide technical assistance to staff and providers for implementation. For example, WET provides a foundational-level Motivational Interviewing training, which is followed by smaller coaching sessions where providers can present cases to trainers for consultation.

In addition, WET, in collaboration with the BHRS Quality Improvement Committee, expanded the accessibility of its training program by adding BHRS contracted providers to the Learning Management System to remove stated barriers to registration for trainings and documentation of contract requirements. The WET Team launched a virtual-based service to increase the amount of online-based training and education. These services will continue as priorities for BHRS.

Having a wide breadth of trainings is key to building staff capacity to provide modalities and services that are effectively tailored to the County's array of racial, ethnic, and linguistic communities. The WET team supports a systemic transformation approach. In order to transform systems, training begins with foundational knowledge and extends to specialized topics. Trainings initiate dialogue, personal impacts, and the beginning of organizational culture shifts. WET goes beyond providing training topics and works collaboratively with BHRS teams to ensure adequate policies and procedures, evidence-based practice, leadership accountability, and intentional linkages to quality improvement goals advance genuine system transformation. Cultural humility, recovery, trauma-informed care, standards of care, co-occurring and other integrated care, and lived experience integration are all areas of focus for BHRS system transformation. These will continue as priorities for BHRS as described below.

Cultural Humility

Four hours of cultural humility-related training are required for all staff on an annual basis as per an ODE-sponsored policy: Cultural Humility, Equity and Inclusion Framework; Implementation of CLAS Standards. Trainings are intended to increase understanding of health inequities in the community; provide instruction in culturally and linguistically responsive services; and to increase access, capacity, and understanding by partnering with community groups and resources. BHRS makes educational and training activities consumers, family members, providers, and those working and living in the community. In addition, staff who have direct client contact are required to complete the Working Effectively with Interpreters training upon hire and at minimum a refresher option every three years.

The Health Equity Initiatives work with the WET team to create and support trainings to address special populations and appropriately serve marginalized communities, examples include:

- Native American Mental Health: Historical Trauma and Healing Practices
- Working with Filipino Youth
- Transgender 101: Creating an Inclusive Community

Trauma-Informed Care

Trauma-informed care is a system-wide orientation that takes into consideration the pervasive impact of trauma by implementing training, practices, and policies that contribute to a safer environment for healing and recovery. BHRS has an active trauma learning collaborative (TLC) dedicated to improving the behavioral health system and the resource-sharing across programs and communities. Additionally, many of the TLC members are trained to teach Trauma 101. The WET Program has presented trainings that target specific populations and providers in our efforts to move toward a trauma-informed system including the following:

- Introduction to Trauma Informed Care in a Clinic Setting
- Mindfulness for Trauma impacted Youth

- Providers Vicarious Trauma and Toxic Stress: Cumulative Impact of Supporting Oppressed Communities

Standard of Care

Multiple Evidence-Based, Community-Defined, and Promising Practice trainings occur over the course of the year. A 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. A Practice Evaluation Committee reviews proposal for interventions. Examples include:

- *Functional Family Therapy* is a family-based intervention with youth in the criminal justice system focused on family and consumer strengths to help youth gain control of their behavior.
- *Trauma-Focused Cognitive Behavioral Therapy* is a model that integrates cognitive and behavioral interventions with traditional child abuse therapies and focuses on enhancement of interpersonal trust and empowerment.
- *Dialectical Behavior Therapy* is a psychotherapy that focuses on addressing negative cognitions and intense emotions by practicing skill development to effectively deal with distress.

Co-occurring and Other Integrated Care

BHRS is a recovery-oriented system of care. Specifically, many of our programs and interventions are characterized by SAMSHA's guiding principles of recovery. The focus of the recovery-oriented trainings is to provide education with attention to substance use disorder (SUD) providers and the unique needs of populations impacted by SUD. The WET team partners with Alcohol and Other Drug (AOD) staff to offer several training opportunities that support both providers and people with SUD lived experience. WET also provides courses on Relapse Prevention and Motivational Interviewing. Additionally, the WET Program administers continuing education for providers with SUD certification.

Peer Integration

Integrating individuals with lived experience in all aspects of behavioral health care is discussed in the next section, Training for/by Consumers and Family Members.

Priority Recommendation #2

An additional component of Peer Integration strategies that can support system transformation is training for Supervising Peers focused on developing the skills and knowledge needed to apply recovery-oriented, trauma-informed, and culturally relevant approaches to the supervision of peers and family support workers. The training will be followed with standardization of peer and family support workers' critical role in behavioral health care services.

Component: Training for/by Clients and Family Members

Summary of Stakeholder Findings

During stakeholder engagement activities, participants voiced the importance of empowering individuals and families with lived experience within the BHRS continuum of services, expanding culturally responsive community messaging, and facilitating ongoing knowledge exchanges that destigmatize mental illness and draw on cultural understandings of healing. Similar to findings related to staff training, participants emphasized the importance of trauma-informed care and cultural responsiveness as training areas for individuals with lived-experience.

WET Strategies

This WET component is focused on creating pathways for clients and family members with lived experience to participate in the behavioral health workforce. Clients and family members receive training by peers focused on knowledge and skills in the area of stigma reduction, advocacy, and empowerment to inspire participants to share their stories as a means to both advocate and support their recovery, reduce shame, isolation and increase confidence. The Office of Consumer and Family Affairs (OCFA), a team of diverse consumers and family members with lived experience, will have oversight of this component.

- *Lived Experience Academy (LEA).* 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. Graduates of the LEA are eligible to join the Speakers' Bureau and receive an incentive to present their stories with behavioral health staff and community members at trainings and community events.
- *Other peer-led trainings*. This includes Recovery and Peer Support 101, Inspired at Work trainings for BHRS Peer Support Workers/Family Partners, Wellness Recovery Action Plans, etc.

Priority Recommendation #3

During various MHSA input processes including this process, clients/consumers and family members and peer workforce have voiced the need for ongoing, sustained trainings focused on developing the skills to work effectively in the behavioral health workforce, advocate effectively during public meetings, and develop the infrastructure within BHRS to support peer staff development and growth.

As a starting point, the following trainings will be offered beginning FY 2020-21 utilizing $100,000 in one-time funding has been approved through a community planning process and submitted in our FY 2019-20 MHSA Annual Update. Moving forward, the recommendation is to fund this ongoing and stakeholders

have prioritized this across various other strategies to be included in the MHSA Three-Year Plan's ongoing budget.

- *Peer Services Training.* Provide a standardized curriculum in San Mateo County to support peers in developing the ability, skills, knowledge, and values needed to deliver support services in behavioral health care settings (county, community-based, peer-run agencies, etc.). Training competencies will be drawn from established organizations and research on Peer Certification and training curricula development across the state and customized through a local San Mateo County stakeholder input process. Additional key values in San Mateo County that will be included are principles of recovery, trauma-informed care, cultural humility, and client empowerment.

- *Community Advocacy for Peers.* Training will be designed to empower clients and family members to advocate for themselves and their communities and to bring the powerful voices of those with lived experience to behavioral health decision-making spaces. Training participants will develop skills related to giving public comment, effective advocacy, and understanding government organizational structures. Clients and family members will be provided initial support (e.g., completing applications/interviews if applicable) and list of local opportunities for participation in decision-making boards, commissions, committees, and other county bodies.

- *Documentation for Peer Workers.* This training will help participants develop the skills and knowledge needed for documentation including understanding billing codes and writing progress notes.

Component: Behavioral Health Career Pathways Programs

Summary of Stakeholder Findings

Stakeholders recommended promoting and expanding education pathways and career advancement opportunities for clinical and non-clinical staff through early career outreach, career mentorship, and financial incentives. Focus groups and surveys responses particularly indicated the importance of proactive engagement strategies during all phases of the behavioral health career pathway. Participants recommended increasing the pipeline of bilingual and culturally/ethnically diverse clinical positions by targeting transition age youth (TAY) with career outreach at high schools, universities, and community groups. For recruitment of a diverse clinical and non-clinical workforce, participants recommended conducting outreach to bilingual individuals in community locations; providing additional incentives through robust employee wellness benefits; and continuing to offer and expand upon existing scholarship and financial incentives. BHRS stakeholders also highlighted the importance of career guidance and support for current employees (especially for those in short-term positions) to ensure awareness of available resources offered by the County and State for educational advancement, certifications, and licensure.

WET Strategies

Given the limited capacity of WET staff and to ensure appropriate outreach and programming for pipeline development and recruitment strategies, the WET Director will participate in the OSHPD Regional Partnerships to leverage regional efforts, which will be funded by OSHPD. As mentioned earlier, San Mateo County has allocated the required match to participate in the program.

The Behavioral Health Career Pathways Program aims to recruit, hire, support, and retain diverse staff in behavioral health careers. The following are ongoing strategies that are supported by stakeholder feedback and will continue:

- *Internship Programs including BHRS Clinical Internships.* BHRS partners and contracts with graduate schools in the Bay Area to provide education, training, and clinical practice for their students at various behavioral health worksites in the county to provide training opportunities for psychology interns, masters-level trainees, alcohol and drug certificate program students, and psychiatric residents each year. Students are welcome to attend any of the five didactic training seminars throughout the county. There are bi-monthly psychiatric grand rounds that are open to all staff and students. Regular in-service training and specialized staff training are also available for students to attend. In recent years, additional skills training was added to the internships in the following areas: wellness and recovery; crisis response, suicide and trauma; cultural humility; integrated care; and co-occurring mental health and substance use disorders.
- *BHRS New Hire Orientation.* The BHRS New-Hire Orientation consists of a series of three sessions that take place over the course of a few months after a new employee is hired. The goal of the orientation is to help new staff learn mandated requirements, understand how BHRS works and connects to other agencies and departments, meet and learn from BHRS managers, explore the possibilities for career advancement, and feel invested in and supported by BHRS as an organization.
- *BHRS Mentorship Program.* BHRS Mentoring serves to help staff build professional competencies, develop leadership skills, support career advancement, and prevent job burn-out. The mentoring process provides a wealth of accumulated knowledge and wisdom, as well as professional stimulation and growth. It is also an opportunity to contribute to the development of the workforce. The mentoring program is designed to address many levels of needs, including sharing of experience, information, and skills development. Program goals include the following:
    - Develop knowledge, skills, and attitudes of effective leaders;
    - Develop confidence and interpersonal skills;
    - Raise issues, tackle challenges, nurture growth;
    - Provide a professional role model;
    - Obtain professional support;
    - Foster long-term development;
    - Gain appreciation of management and leadership issues;

- Develop appreciation of respective roles, and their rewards and challenges;
- Provide an opportunity to reflect on one's assumptions and beliefs;
- Expand professional networks;
- Build networks with variations in functions, position, demographics;
- Provide mutual benefit through exchange of information;
- Advance people of diverse backgrounds to leadership levels, and/or retain them in the workforce; and
- Enhance employee engagement, job satisfaction and contribution.

Additionally, to respond to stakeholder request to increase awareness of available resources offered by the County and State for educational advancement, certifications, and licensure, the WET team will collaborate with the BHRS Human Resources team to create greater understanding during the County orientation process and the BHRS New Hire Orientation meetings. In addition, the WET team will produce content with information about WET-associated trainings and support for BHRS communications.

Component: Financial Incentives

Summary of Findings

Through surveys and stakeholder input discussions, stakeholders rated educational loan forgiveness programs as the top strategy to support the recruitment and retention of a diverse workforce. Educational loan repayment assistance and support with costs related to certifications and licensure were also indicated as essential incentives for career advancement among those already employed by the County and its network of providers. Stakeholders frequently recommended increasing providers' awareness and understanding of existing loan forgiveness and available education reimbursement programs during early career outreach efforts and in existing recruitment strategies.

WET Strategies

The following are ongoing strategies that are supported by stakeholder feedback and will continue.

- *Cultural Competence Stipend Internship Program (CSIP).* Selected interns receive a $5,000 stipend as part of our Cultural Competency Stipend Internship Program (CCSIP) for their contributions to improving the cultural competence and cultural humility of our system of care. Up to 10 trainees are selected based on their bicultural/bilingual capabilities, with preference given to those who identify or have experience working with special populations. CCSIP interns are required to interact with and learn from members of the Health Equity Initiatives and other systems-change initiatives.
- *Lived Experience Scholarship.* The scholarship provides up to $500 for clients/consumers or family members to pursue their academic goals toward a clinical, administrative, or management career in behavioral health. Applicants must be current or former BHRS clients/consumers or family

members, residents of San Mateo County, and registered for at least six units in a vocational, 2-year college, 4-year college, credential, or graduate program.

Priority Recommendation #4

Given stakeholder interest in a local educational loan forgiveness program, it is recommended that MHSA fund a local educational loan forgiveness program for hard-to-fill positions including bilingual and culturally/ethnically diverse clinical positions. The OSHPD Regional Partnerships may offer an opportunity to supplement a local San Mateo County educational loan forgiveness program, but this is pending regional approval.

Appendix A: Stakeholder Input Findings: San Mateo County Workforce Education and Training (WET) Plan

RDA prepared the following summary of stakeholder findings based on a synthesis of data collection activities (stakeholder input discussions and key informant interviews, focus groups, and online surveys).

Staff Recruitment

Challenges and Needs

- Overall, respondents to the Provider Survey viewed their **clinics and programs as "somewhat able" to recruit the staff** necessary to meet the community's needs. This perception aligned with the focus group results.

- Participants shared the perception **that recruitment and retention of qualified personnel for short-term/temporary positions is a challenge**. They shared that experienced and/or qualified candidates are likely disincentivized from accepting these type of positions due to the lack of long-term security.

- Participants shared that there is a broad **need to increase linguistic and ethnic/cultural diversity** of the behavioral health workforce to adequately serve the county's communities. Specifically, participants noted:
    - More **Spanish-speaking clinicians are needed.**
    - There is **inadequate representation of people of color**, specifically African Americans, in clinical and staff positions clinics and locations that serve people of color (e.g., the clinic that serves justice-involved youth). This can be a barrier to engaging hard-to-engage groups.
- In some parts of the county, limited visibility and interaction with BHRS outside of direct services **limits exposure to the behavioral health field** for youth and available employment opportunities for eligible community members.

Strategies

- The majority of respondents to the Provider Survey indicated that all of the listed recruitment strategies for a diverse workforce were important, including early career outreach, scholarships, stipends, and loan forgiveness programs. However, **educational loan forgiveness programs** were rated as the top priority most frequently.

- Participants recommended increasing the pipeline of bilingual and culturally/ethnically diverse clinical positions through **expansion of targeted relationships** w**ith high schools, universities, and community groups**. Example strategies included:
    - Cultivate relationship with Santa Clara University's Bilingual MFT program track to establish internship pipeline.
    - Engage relevant student groups at local colleges to increase awareness of behavioral health field and learning pathways.
    - Conduct assemblies and participate in career fairs at local high schools.
- Participants recommended raising awareness of currently available peer personnel and lived experience positions for bilingual community members through **preferred, accessible means of communication**. Example strategies included:
    - Physical job postings in community locations (grocery stores, commerce centers, community events).
    - Build/leverage relationships with community gatekeepers and elders to increase "word-of-mouth" communications and to raise awareness of existing opportunities.

Staff Retention & Career Advancement

Challenges and Needs

- Most providers who responded to the survey viewed their **programs/clinics as able to retain staff "somewhat" or "to a great extent."** These results appeared more positive than the perception shared by focus group participants.
- Most providers who responded to the survey rated **their programs/clinics as "somewhat" able to successfully support individuals to advance their careers in the behavioral health workforce**.
- Participants in focus groups indicated that there is **inconsistent awareness and utilization** of education reimbursement and loan forgiveness opportunities across the County.
- Participants also reported **difficulty in utilizing education reimbursement programs** due to a challenging application processes that include what they view as "excessive" documentation of classes and hours, and limited eligibility for reimbursement.
- **Hiring for short-term/temporary positions** means that qualified and committed staff positions (clinical and nonclinical) are frequently lost, despite ongoing community need for their services and contributions. Short-term clinician positions can be especially detrimental to clients as a therapeutic relationship, developed over time, is lost.

- Participants shared a perception that San Mateo County **salaries and benefits are lacking** when compared to neighboring counties. Given the current cost of living and rising housing costs, participants noted that there is **greater incentive to work for neighboring counties**.
- Participants shared the **importance of a healthy and supportive work environment** to support staff retention and prevent burnout. While many cited having supervisors and colleagues that effectively contribute to their experience of a healthy, vibrant workplace that keeps them at their job, some participants reported unhealthy work environments attributed directly to supervisors' behavior or lack of ability to manage conflict and team dynamics.

Strategies

- Providers viewed all of the survey retention strategies listed, including fellowships and licensure support, as important.
    - *Among staff considering licensure or already licensed*, **educational loan repayment assistance** and **financial incentives for those who remain in the workforce** were rated as the top priority most frequently.
    - *Among staff not considering licensure*, **financial incentives for career advancement** and **scholarships for certificate programs for individuals with lived experience** were rated as the top priority most frequently.
- Participants recommended **keeping qualified staff who are in limited-term positions (interns, extra-help, part-time) in the County pipeline**. Example strategies included:
    - Establish an internal Career Navigator position (or assign related responsibilities to an existing staff) to engage departing staff about other opportunities, vacancies within the County and contracted provider network.
    - Proactively engage limited-term staff sooner about their departure dates and additional opportunities that may be available within the County.
- Participants recommended **increasing awareness and understanding of available loan forgiveness and education reimbursement programs** among current County employees and featuring these incentives more prominently in recruitment efforts/materials. Example strategies included:
    - Establish a point person within BHRS to explain loan forgiveness and educational incentive programs and application processes.
    - Increase supervisors' awareness of available loan forgiveness and education reimbursement opportunities to relay information for staff and provide support.
- Participants recommended providing **benefits comparable to other counties** to support quality of life and wellbeing. Example strategies included:

  - Discounted gym memberships, increased PTO, greater flexibility of work hours.
  - For those with lived experiences, current and past trauma, and secondary trauma, offer additional mental health support beyond limited number of EAP counseling sessions and more flexible PTO.

- Participants recommended **promoting and expanding education pathways and career advancement opportunities** for clinical and non-clinical staff through financial incentives and career mentorship. Example strategies included:
  - Expand career counseling and supervisor and peer support especially for those with lived experience.
  - Expand grant opportunities for continued education/employment in peer counseling for those with lived experiences.
  - Provide stipends that cover all of the hours that clinical interns are providing services.
- Participants recommended **promoting healthy, inclusive work environments through continued skill development for supervisors.**
  - Provide supervisors or any other staff management positions with more training and skill development relating to **group dynamics, conflict/resolution, and cultural competency**.
- Input session participants highlighted the need to focus on **self-care and resilience** among providers who serve clients with complex needs.
  - Stakeholders recommended expanding **Employee Assistance Programs** (EAP) for providers, especially those with lived experiences.

Pursuing Licensure as a Social Worker

- **Challenges**
  - **Difficulty acquiring supervision hours** due to lack of availability of licensed supervisors within the BHRS able to take on the extra time commitment.
  - **High expenses associated with licensure** including cost of outside supervision.
  - **Lack of consistent awareness** of what County will offer to support licensure.
- **Example Strategies**
  - Provide **incentives for qualified/licensed staff to provide supervision** and/or account for the time burden this has on their workload.
  - Create a **database of available licensed supervisors** within the BHRS system to support faster linkages with those needing supervision to prevent loss of unlogged hours toward licensure.

- Expand **opportunities for financial reimbursement of outside supervision costs** (if needed), trainings and test expenses (exam cost, test-taking tools, PTO to study)
- **Offer mentorships with other LCSWs** to provide guidance with licensure process; group supervision; didactic training.
- Offer **free law and ethics courses** that cover licensure and required CE requirements.

Staff Training

Challenges and Needs

- Most providers who responded to the survey viewed staff in their clinic/program as having the necessary training to meet the needs of the county's diverse population **"somewhat"** or **"to a great extent."**
- Clinical staff generally indicated a desire for more opportunities for **advanced training and certifications** in specific treatment modalities (e.g., EMDR, trauma informed EBPs, DBT) with ongoing consultation/follow-up to ensure retention and application.
    - Some participants requested additional opportunities to attend trainings outside of the County. This might include reimbursement for training cost and/or compensation for time spent in training.
- Participants noted a need **to increase awareness and frequency of County-provided/funded training offerings**.
- Input session participants raised a need for greater awareness of mental health among non-mental health providers, including **teachers, first responders, and police**.

Strategies

- Participants recommended expanding opportunities for clinical and non-clinical staff to attend County-provided/funded trainings by **increasing frequency of offerings and/or by increasing training accessibility** (i.e. remote participation/online trainings). Example strategy:
    - Send newsletters more frequently to behavioral health care workforce informing them of online resources, and upcoming training opportunities.
- Participants recommended providing **ongoing follow-up and training refreshers** (in individual and group settings/supervision) **and ongoing consultation** on training concepts to ensure learnings are successfully applied to practice.
- Participants recommended **expanding evaluation of training outcomes** to ensure desired impacts.

- Participants recommended providing **more trainings from a lived experience perspective** and **ensuring a culturally competent approach to providing training platforms for selected trainers.**
- Increase breadth of **cultural competency training** for any/all staff that may engage with clients and community members.
- Increase **mental health and trauma-informed trainings** for non-mental health providers that may engage with clients and community members, including schoolteachers, first responders, police, and alcohol and other drug providers.

Recommended Training Areas

Foundational Knowledge

- Provider survey respondents indicated **"trauma-Informed care" and "cultural humility/responsiveness"** most frequently as the top foundational knowledge training priority.

Trainings for Mental Health Providers

- Providers viewed **trauma-informed care** and **assessing/treating suicide risk/harm** as a top training priority for staff who have direct contact with client/consumers.
- Individuals with lived experiences viewed **creating a welcoming environment** for clients and their families as a top training need for providers.

Trainings for Individuals with Lived Experience

- Individuals with lived experiences viewed **trauma-informed care** training as a top priority for both themselves and their provider.
- Individuals viewed their own top training needs as **managing depression and anxiety** and **self/community advocacy**.
- Stakeholders recommended training peers and family in **crisis response and de-escalation practices.**

Trainings for Supervisors

- Providers viewed **creating safety and trust among teams** and **how to give and receive feedback in a culturally sensitive/responsive way** as top training needs for managers and supervisors.

Trainings for Administrative Staff

- Providers viewed **engagement and welcoming** as a top training need for administrative staff.

Detailed Summary of Training Recommendations

The table below collects and categorizes training areas and topics that survey and focus group/input session respondents recommended.

Recommended Training Area	Recommended Training Topics
Trauma-informed evidence-based modalities	• EMDR; TFCBT; CPP; DBT; trauma CBT; NMT; EFT Cognitive Processing Therapy; Touchpoints
Cultural competency/humility	• Historical trauma trainings • Racial equity • Spirituality • Traditional healing practices
Trainings to enhance cultural understanding, competencies, and recommended approaches for working with distinct ethnic/cultural/linguistic groups	• African Americans, Pacific Islanders, Hispanic/Latino, Chicanos, Russians • Indigenous communities (specifically on coast side and in San Mateo)
Trainings to enhance understanding, competencies, and modalities recommended for distinct population groups	• LGBTQ (SOGI: Sexual Orientation/Gender Identity) • Older adults • People with physical disabilities • Undocumented individuals and justice-involved individuals o Implications of involvement in justice system and mental health system on immigration status. • Religious minorities (Muslims, Mormons, Jehovah's Witnesses) • Refugees and those fleeing violence/oppression in other countries • Low income • Homeless/Housing insecure • Veterans
Targeted trainings that focus on specific mental health populations and presenting issues	• Substance-use disorder; Persons in or want to be in recovery • Harm reduction training • Eating disorders • Autism Spectrum Disorder • OCD • Dual diagnosis / Co-occurring (including MI/SA, MI/IDD, MI/PH) • Borderline personality disorder • Self-harming behaviors • AOD • Dissociative Disorders

Recommended Training Area	Recommended Training Topics
Targeted trainings that focus on needs children and TAY	● Teen Psychosis ● Youth and their families - family therapy modalities ● Undocumented individuals; Individuals in justice system ● Domestic violence
Mental health laws and billing	● Basic knowledge of mental health and AOD billing practices ● public insurance and other benefit programs and how they affect the care provided within BHRS and its CBOs ● Laws and Ethics (more than once a year training as some laws and regulations change on bi-monthly basis)
Professional development	● Positive engagement with fellow employees ● Didactic trainings ● Motivational interviewing ● Combating mental health stigma ● Fundamental neurological aspect of mental illness ● New software and applications (especially tele-health technology with COVID-19) ● Peer support training ● Psychological testing for clinicians to ensure proper diagnosis of dementia vs. mental health issues
Other	● Trauma-informed de-escalating training ● Strategies to integrate peer support into treatment and recovery ● Available programs/resources: ○ WRAP, IPS, and NAMI Family-to-Family and Provider classes

APPENDIX 9 PLAN TO SPEND ONE-TIME AVAILABLE FUNDS

3-Year Plan to Spend $12.5M Available One-time Funds

*$3.9M must be spent in Prevention and Early Intervention (PEI)

Priority	Item	FY 19/20	FY 20/21	FY 21/22	Grand Total
System Improvements - Core MHSA Services	Recovery oriented, co-occurring capacity	$500,000	$250,000	$250,000	
	Full Service Partnerships/Clinic restructuring		$2,500,000	$1,500,000	
	MHSA PEI data-informed improvements	$100,000	$50,000	$50,000	
	Trauma-informed systems (BHRS, HSA, CJ, etc)		$100,000	$100,000	
	System Improvement Total	**$600,000**	**$2,900,000**	**$1,900,000**	**$5,400,000**
Technology for System Improvement	Network Adequacy Compliance	$100,000			
	Improve productivity	$100,000	$225,000	$173,000	
	Increase access-telepsychiatry/health	$30,000	$30,000	$30,000	
	Technology Total	**$230,000**	**$255,000**	**$203,000**	**$688,000**
Workforce and Community Education and Training	Workforce Capacity Development		$206,000	$98,000	
	Community Education		$180,000	$180,000	
	Crisis Coordination		$150,000	$150,000	
	Supported Employment		$400,000	$300,000	
	Workforce pipeline and retention		$124,000	$124,000	
	Education and Training Total	**$0**	**$1,060,000**	**$852,000**	**$1,912,000**
Capital Facilities (must be County-owned)	SSF Clinic		$500,000		
	EPA Clinic	$700,000			
	Casia House Renovations	$100,000			
	Cordilleras		$500,000	$500,000	
	Capital Facility Improvements Total	**$800,000**	**$1,000,000**	**$500,000**	**$2,300,000**
Stop Gaps (ongoing programs)	Pride Center			$700,000	
	HAP-Y		$250,000	$250,000	
	NMT- Adults		$200,000	$200,000	
	Tech Suite		$300,000	$300,000	
	Stop Gaps Total		**$750,000**	**$1,450,000**	**$2,200,000**
TOTALS		$1,630,000	$5,965,000	$4,905,000	**$12,500,000**

APPENDIX 10 MULTI-COUNTY FSP INNOVATION PROJECT

INNOVATION PROJECT PLAN

Participating Counties: Fresno[1]; Sacramento; San Mateo[2]; San Bernardino; Siskiyou; Ventura

Project Title: Multi-County Full Service Partnership (FSP) Innovation Project

Duration of Project: January 1, 2020 through June 30, 2024 (4.5 years)

Section 1: Innovation Regulations Requirements Categories

General Requirement: An Innovative Project must be defined by one of the following general criteria. The proposed project:

X 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. The proposed project:

☐ Increases access to mental health services to underserved groups

X Increases the quality of mental health services, including measured outcomes

X 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

[1] Fresno County has already submitted an Innovation Project plan to the MHSOAC detailing its plans to participate in this project; this plan was approved by the MHSOAC in June 2019.

[2] San Mateo County does not have MHSA INN funds available to commit to this project, but instead intends to use unspent MHSA CSS funds to participate in the goals and activities of this project, alongside other counties. These are one-time funds that have been designated and approved through a local community program planning process to meet a similar purpose and set of objectives as the Multi-County FSP Innovation Project. San Mateo County is not submitting a proposal to use INN funds but intends to participate in the broader effort and, thus, is included here and in the Multi-County FSP Innovation Project plan.

Section 2: Project Overview

Primary Challenge

Since the creation of the Mental Health Services Act (MHSA) in 2004, California has made significant strides in improving the lives of those most in need across the state. In particular, Full Service Partnerships (FSP) support people with the most severe and often co-occurring mental health needs. These MHSA-funded FSP programs are designed to apply a "whatever it takes" approach to serving and partnering with individuals living with severe mental illness. In many counties, FSP programs are effectively improving life outcomes and staff can point to success stories, highlighting dedicated staff and programs tailored to specific cultural groups and ages.

Despite the positive impact of FSP, the program has yet to reach its full potential. Many Californians with serious mental illness still struggle to achieve fuller, more independent lives and achieve the outcomes that MHSA prioritizes (i.e., reduced criminal justice involvement, incarceration, unnecessary hospitalizations, in-patient stays, and homelessness).

Counties and FSP providers have identified two barriers to improving and delivering on the "whatever it takes" promise of FSP:

The first is a *lack of information* about which components of FSP programs deliver the greatest impact. To date, several counties have strived to establish FSP programs to address specific populations and specific underserved regions, but data collection has been limited or inconsistently implemented. Additionally, there have been few coordinated efforts or comprehensive analyses of this data. This has resulted in an approach to program development that is, in its most noble of intent, driven by a desire to serve the community, but based often only on a best guess as to what will be effective. Counties desire a more data-driven approach to program development and continuous improvement, one rooted in shared metrics that paints a more complete picture of how FSP clients are faring on an ongoing basis, is closely aligned with clients' needs and goals, and allows comparison across programs, providers, and geographies. As one participating county (San Bernardino) described during an early planning meeting for this project, "Community members, FSP staff, and clinicians have identified an opportunity for data collection [and metrics] to be better integrated with assessment and therapeutic activities." These metrics might move beyond the current state-required elements and allow the actionable use of data for more effective learning and ongoing program refinement. Several counties and their provider staff, for example, indicate that FSP data is collected for state-mandated compliance and does not inform decision-making or service quality improvements. In addition, data is collected within one system, typically by FSP providers; however, meaningful FSP outcomes are designed to be measured with cross-agency data (such as health care, criminal justice, etc.), meaning many counties are reliant on self-reported progress toward outcomes rather than verified sources.

The second barrier is *inconsistent FSP implementation*. FSP's "whatever it takes" spirit has allowed necessary flexibility to adapt the FSP model for a wide variety of populations and unique local contexts. At the same time, this flexibility inhibits meaningful comparison and a unified standard of care across the state. During early planning conversations for this project, several counties indicated the need to improve how their county collects and uses FSP program data, particularly as it relates to creating

consistent and meaningful criteria for eligibility, referral, and graduation. As one participating county (San Bernardino) described, "consumers have expressed interest in a standardized format for eligibility criteria and [seek] consistency in services that are offered and/or provided." While some variation to account for local context is to be expected, standardizing these processes using data, evidence, and best practices from across California offers the promise of significant performance improvements and better client outcomes.

To-date, several initiatives have worked on related challenges but have not identified solutions that are directly applicable to this dual-natured problem, or they have not attempted to apply solutions in a statewide context. Specifically:

- While Los Angeles (LA) County's Department of Mental Health has attempted to address these two primary challenges via their FSP transformation pilot, it remains to be seen whether the metrics, strategies, and data-driven continuous improvement approach is directly applicable to other California counties, or whether their solutions need further customization and refinement in order to be used as a statewide model. Through this Multi-County FSP Innovation Project, counties will also seek to compare and leverage needs and solutions from Los Angeles County, determining how their metrics and processes can be adapted to be relevant to California counties of all geographies and sizes.

- In 2011 and 2014, the Mental Health Services Oversight and Accountability Commission (MHSOAC) supported two efforts[3] that, at a high level, worked to develop priority indicators of both consumer- and system-level mental health outcomes through leveraging existing data, develop templates and reports that would improve understanding of FSP impact on these outcomes, and identify gaps and redundancies in existing county data collection and system indicators. However, these efforts did not work to implement these changes in a collective, consistent multi-county manner, nor did they focus on additional FSP elements such as eligibility and graduation criteria. This effort also did not focus on creating actionable continuous improvement strategies that would improve the quality and consistency of FSP programs.

Proposed Project

This project responds to the aforementioned challenges by reframing FSP programs around meaningful outcomes and the partner (client) experience. This Multi-County FSP Innovation Project represents an innovative opportunity for a diverse group of participating counties (Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura) to develop and implement new data-driven strategies to better coordinate FSP service delivery, operations, data collection, and evaluation.

The MHSOAC has supported Third Sector in leading counties through the process of developing and implementing this Multi-County FSP Innovation Project, as well as in facilitating a broader statewide exchange of collective learning and shared opportunities for improving FSP programs. A San Francisco-based nonprofit, Third Sector has helped behavioral and mental health programs nationwide create an

[3] The 2011 effort was undertaken by the UCLA Center for Healthier Children, Families, and Communities and EMT Associates. The 2014 effort was undertaken by the UCLA Center for Healthier Children, Families, and Communities and Trylon.

improved focus on outcomes, guiding government agencies through the process of implementing and sustaining outcomes-oriented, data-driven services focused on improved meaningful life outcomes. *Section 4: INN Project Budget and Source of Expenditures* below further describes Third Sector's experience and approach to transitioning social services programs to an outcomes orientation. Third Sector will act as the overall project lead and project manager, developing recommendations and customized strategies, leading working group calls and collaborating with each participating county to meaningfully elevate stakeholder voice, while ensuring the project remains on schedule and adjusting responsively to any challenges.

Through participation in this Multi-County FSP Innovation Project, participating counties will implement new data-informed strategies to program design and continuous improvement for their FSP programs, supported by county-specific implementation and evaluation technical assistance. Staff will examine what matters in improving individual wellness and recovery and take a data-informed approach to program design, evaluation, and continuous improvement, leading to more effective and responsive FSP programs. The overall purpose and goals of the Multi-County FSP Innovation Project are to:

1. **Improve how counties define and track priority outcomes** and related performance measures, as well as counties' ability to apply these measures consistently across FSP programs
2. **Develop new and/or strengthen existing processes for continuous improvement** with the goals of improving outcomes, fostering shared learning and accountability, supporting meaningful program comparison, and effectively using qualitative and quantitative data to inform potential FSP program modifications
3. **Develop a clear strategy for how outcomes and performance measures can best be tracked and streamlined** through various state-level and county-specific reporting tools
4. **Develop a shared understanding and more consistent interpretation of the core FSP components** across counties, creating a common FSP framework that both reflects service design best practices and is adaptive to local context
5. **Increase the clarity and consistency of enrollment criteria, referral, and graduation processes** through the development and dissemination of clear tools and guidelines intended for county, providers, and referral partners

Collaboration with a Statewide FSP Outcomes-Driven FSP Learning Community: In addition to the county-specific implementation technical assistance (TA) proposed in this Innovation Project, counties participating in this Innovation Project have co-developed and will participate in a concurrent, statewide Outcomes-Driven FSP Learning Community that Third Sector is leading with funding from the MHSOAC. County MHSA and FSP staff, FSP providers, FSP clients, and other community stakeholders will engage in an interactive learning process that includes hearing and sharing lived experiences and developing tools to elevate FSP participant voice. Third Sector will synthesize and disseminate learnings between counties participating in this Innovation Plan and the Outcomes-Driven FSP Learning Community, helping each group build upon the work of the other, and develop a set of recommendations for any state-level changes to FSP requirements and/or data collection practices that are supported by a broad coalition of participating California counties.

Rationale for Using the Proposed Approach

Over the past several months, a broad group of counties (beyond the six counties participating in this Innovation Project) and Third Sector have convened to further unpack these challenges in a collective setting. Specifically, counties and Third Sector have collaborated in several virtual and in-person convenings to develop (i) an initial baseline understanding of counties' current FSP programs, including unique assets and challenges as it relates to defining and measuring important FSP client outcomes; data collection, data sharing, and data use; FSP services and population guidelines; and ongoing FSP performance management and continuous improvement processes, and (ii) an initial, shared plan for implementing outcomes-focused FSP improvements. Counties have expressed interest in developing a consistent and understandable framework for data collection and reporting across counties that better encourages actionable analysis of outcomes data and helps counties track the adoption of evidence-based practices.

The activities and goals proposed by this project are directly informed by these efforts and designed to respond to common challenges, capacity needs, and shared opportunities for FSP program improvements cited by counties.

This approach is also inspired by Los Angeles County Department of Mental Health's (LACDMH) journey to similarly focus their FSP programs on meaningful outcomes. This Innovation Project will build off LACDMH's early successes, implement adjusted strategies and approaches that are appropriate for a statewide context, and facilitate broader statewide exchange of collective learning and shared opportunities for improving FSP programs.

Number and Description of Population(s) Served

This project focuses on transforming the data and processes counties use to manage their FSP programs to improve performance at scale; it does not entail direct services for FSP clients. Accordingly, we have not estimated the number of individuals that will be served or identified specific subpopulations of focus. This project will build outcomes-focused approaches across a variety of age-specific and population-specific FSP programs statewide, exploring and identifying key commonalities and relevant differences by population of focus, and building a flexible, scalable set of strategies that can be further implemented statewide.

Research on the Innovative Component

This Innovation Project presents a new opportunity and innovative practice for participating counties in several ways:

1. Systems-Level Changes to Accelerate Performance

Instead of piloting a new FSP service or intervention, this project will reduce barriers that prevent counties from leveraging data and evidence to deliver better outcomes in FSP programs. While piloting and testing new service interventions remains a key tool for driving mental health services innovation, far too often promising innovations are expected to take root in systems that lack the infrastructure or capacity to support them—leading to suboptimal replication, challenges disseminating learnings, or failure to scale. This Innovation Project seeks to address those structural barriers by accelerating counties' ongoing efforts to use data and shared outcome goals to continuously improve their FSP programs, and do so in a manner that centers on increasing statewide learning.

2. County-Driven Origins with Statewide Impacts

This project also represents an opportunity for counties to drive state progress on reporting requirements, data collection, and data use. Many counties have individually struggled to track FSP client outcomes and make meaningful use of the existing data, but have to-date approached this problem alone. Recognizing these gaps and the power of a collective effort, counties themselves took the initiative to form this project as a response to their individual FSP program challenges and after hearing reflections on Los Angeles County Department of Mental Health's FSP transformation.

The county-driven origins of this project, paired with support from the MHSOAC, present a unique opportunity for participating counties to both (i) pursue county-specific implementation efforts that will drive lasting improvements within their *individual* FSP programs, and (ii) exchange learnings from these implementation efforts with other counties via a structured Outcomes-Driven FSP Learning Community designed to help increase *statewide* consensus on core FSP components and develop shared recommendations for state-level changes to FSP data requirements and guidelines.

3. Introducing New Practices for Encouraging Continuous Improvement and Learning

This project proposes to introduce new data-driven practices for managing FSP programs that center on improving clients' experiences and life outcomes and aim to increase consistency in how FSP programs are administered within and *across* different counties. It aims to develop and pilot continuous improvement processes and actionable data use strategies that are tailored to each participating county's specific context, and to generate new learning and shared consensus around FSP program and performance management best practices, alongside other participating counties. For example, a county may implement a new data dashboard that helps better illustrate client utilization of emergency services over time. This dashboard could be used to understand the relationship between an incoming client's needs, FSP services delivered, and changes in emergency services utilization over time. With this newly clarified data, county staff and/or providers would be able to understand and collaboratively discuss how different clients' needs should determine the services they receive, based on the historical success of other, similar clients.

4. Building on Individual County Progress to Create a Statewide Innovative Vision

This project will build on the continuous improvement tools and learnings emerging from Third Sector's existing work with the Los Angeles County Department of Mental Health's (LACDMH) FSP

transformation, which centered on understanding and improving core FSP outcomes across all age groups, inclusive of improving stable housing, reducing emergency services utilization, and reducing criminal justice involvement. LACDMH's FSP transformation efforts have led to the development of new continuous improvement-focused "Learning Collaboratives" (regular meetings for providers and LACDMH to review outcomes data and discuss new service approaches), have surfaced new learnings and questions (e.g., how to define and measure positive FSP life outcomes like "meaningful use of time"), and have better standardized FSP programs via clarified enrollment and graduation criteria. This project presents an opportunity to deeply explore these learnings and tools at a statewide level in a collaborative manner, bringing counties together to explore and identify which FSP changes and innovations that LACDMH pursued (or purposefully did not pursue) might be most relevant and applicable across counties and, importantly, what modifications are necessary to implement these learnings at a state-level. More specifically, counties will explore how these changes may need to be adopted to meet the needs of counties with a variety of different attributes (e.g., smaller counties, more rural counties, counties with fewer program staff, counties with fewer contracted FSP programs, counties with different ethnic and racial makeups), balancing the desire for increased consistency with the spirit of meeting local context and needs.

5. Building Upon Existing Data-Focused Multi-County Collaborations

In addition, this project differs from existing, data-focused multi-county Innovation Projects in its focus on *implementing and applying* data insights to refine current learning and continuous improvement practices within FSP programs.

Four California counties are currently participating in an FSP "classification" pilot study sponsored by the MHSOAC and in partnership with the Mental Health Data Alliance. Through surveys of specific programs, this "classification" pilot seeks to identify specific components of FSP programs that are associated with high-value outcomes, namely early exits. The "classification" study can create and already has produced valuable learning on how counties can define outcomes like early exit and what FSP program characteristics map to a specified outcome. Moreover, it is an important demonstration of the value of collecting, maintaining, and sharing descriptive information about FSP program profiles that counties can correlate to FSP client outcomes.

However, the "classification" pilot does not propose to support counties in *applying* such learnings to their FSP programs, or in creating sustainable data feedback loops that leverage existing data to drive more real-time, continuous program improvements. Additionally, as a pilot, it is limited to the four participating counties and to a select few FSP programs and types (TAY, Adult, and Older Adult). Counties participating in this Multi-County FSP Innovation Project may look at the entire range of FSP services (including Child). Finally, this project will regularly connect with a larger group of counties than the scope of the "classification" pilot allows, leveraging the statewide Outcomes-Driven FSP Learning Community that is open to all counties (beyond the six counties contributing funds in this Innovation Project proposal) and that will encourage broader statewide input and collaboration.

In 2011, the UCLA Center for Healthier Children, Families, and Communities and EMT Associates, with support from the MHSOAC, developed templates and reports on statewide and county-specific data that would improve understanding of MHSA's impact, as well as evaluated existing statewide data on FSP

impact. While this effort worked to identify current data collection practices and develop data templates, it did not suggest new outcomes domains, data collection, or metrics. Moreover, this effort did not focus on creating actionable continuous improvement strategies that would improve the quality and consistency of FSP programs and services.

Similarly, in 2014, the UCLA Center for Healthier Children, Families, and Communities and Trylon, with support from the MHSOAC, reviewed existing data to develop priority indicators of both consumer- and system-level mental health outcomes and understand trends and movement in these indicators over time. This effort also identified gaps and redundancies in existing county data collection and system indicators. However, it did not attempt to *implement* new and consistent outcomes and metrics across multiple counties, nor did it develop regular continuous improvement processes that would leverage these specific measures in an action-oriented, data-informed manner.

This Innovation Project will go beyond both the 2011 and 2014 UCLA-led projects by focusing on both the implementation of new data collection and data use strategies, improving consistency and clarity of program guidelines (especially those around cultural or other specific types of services, eligibility, and graduation), and better understanding the connection between FSP services and outcomes. In this manner, this proposed Multi-County FSP Innovation Project proposes a new approach by expanding the extent to which counties attempt to align and create consistency.

5. *Proposing Changes to State-level FSP Data Requirements*

Building from the above, this project also intends to surface specific data collection and data use elements that counties can use to track their FSP outcome goals in a more streamlined, consistent fashion that can be feasibly applied across the state. Through this project, counties will develop a more cohesive vision around which data elements and metrics are most relevant and recommend changes to statewide FSP data requirements that better prioritize and streamline their use. Ultimately, these recommendations will aim to better support counties in understanding who FSP serves, what services it provides, and which outcomes clients ultimately achieve.

Stakeholder Input

Through individual discussions and group convenings, Third Sector and participating counties have discussed several strategies to ensure that the Multi-County FSP Innovation Project aligns with each county's goals, including priorities expressed in stakeholder forums. The Appendix includes more detail about each county's specific stakeholder needs, how this project addresses these needs, and how community planning processes in each county have impacted the overall project vision.

To date, Third Sector has supported counties in sharing the project with local stakeholders by providing summary materials (i.e. project descriptions and talking points) and answers to frequently asked questions. These materials were requested by counties and designed to be accessible to a broad audience. Counties such as Sacramento and San Bernardino have already used and adapted these for community planning meetings, soliciting feedback that has helped to inform this plan. Currently, all participating counties have shared this project as a part of their three-year plan, annual update, or standalone proposal for public comment and county Board of Supervisors' review.

Furthermore, this project intends to engage county stakeholders—including program participants, frontline staff, and other key community partners—throughout its duration. In the implementation stage, engagement activities may include consulting and soliciting feedback from stakeholders when defining the outcome goals, metrics, service components, and referral and graduation criteria. Counties may choose to do this through focus groups, interviews, and working group discussions. Counties may also invite participants or community representatives to participate in statewide Outcomes-Driven FSP Learning Community events. Since the community planning process is ongoing, stakeholders will continue to receive updates and provide input in future county meetings that are open to the public. Additional description of these activities can be found in the *Work Plan and Timeline* section below.

Learning Goals and Project Aims

This project expects to contribute new learnings and capacities for participating counties throughout the county-specific TA and evaluation activities involved. Specifically, this project will seek to assess two types of impacts: (A) the overall impact and influence of the project activities and intended changes to current FSP practices and program administration ("systems-level impacts"), and (B) the overall improvements for FSP client outcomes ("client-level impacts"). These two types of measures will help determine whether the practices developed by this project simplify and improve the usefulness of data collection and management and cross-county collaboration, and whether these practices support the project's ultimate goal of improving FSP client outcomes. Guiding evaluation questions that this project aims to explore include, but are not limited to, the following, as divided by each type of impact:

A) Systems-Level Impacts

Systems-level impacts will be assessed both within each county to understand local administration changes, as well as across counties to assess the impact of the multi-county, collaborative approach. Guiding evaluation questions to understand changes to individual county FSP administration are:

1. What was the process that each participating county and Third Sector took to identify and refine FSP program practices?
2. What changes to counties' original FSP program practices were made and piloted?
3. Compared to current FSP program practices, do practices developed by this project streamline, simplify, and/or improve the overall usefulness of data collection and reporting for FSP programs?
4. Has this project improved how data is shared and used to inform discussions within each county on FSP program performance and strategies for continuous improvement?
5. How have staff learnings through participation in this FSP-focused project led to shared learning across other programs and services within each participating county?

Beyond the above county-level learning goals, the project also aims to understand the value of a collaborative, multi-county approach via understanding the level of county collaboration, the quality of it, and its ultimate impact. Guiding evaluation questions to assess the collaborative nature of this project include, but are not limited to:

6. What was the process that participating counties and Third Sector took to create and sustain a collaborative, multi-county approach?

7. What concrete, transferrable learnings, tools, and/or recommendations for state-level change have resulted from the Outcomes-Driven FSP Learning Community and collective group of participating counties?
8. Which types of collaboration forums and topics have yielded the greatest value for county participants?

B) Client-Level Impacts

9. What impacts has this project and related changes created for clients' outcomes and clients' experiences in FSP?

Evaluation and Learning Plan

This project will include two types of learning and evaluation.

First, Third Sector and the counties will pursue a number of evaluation and data analysis activities throughout the duration of the project (as described in the *Work Plan and Timeline* section below) to better understand and measure current FSP outcomes and identify appropriate strategies for improving these outcomes.

Second, Third Sector and the California Mental Health Services Authority ("CalMHSA") will support counties in identifying, procuring, and establishing an ongoing governance structure for partnering with a third-party evaluator. This third-party evaluator ("evaluator") will provide an independent assessment of the project's impacts and meaningfully assess the above learning goals via an evaluation. These efforts will support counties in articulating a meaningful, data-informed impact story to share across the state about the specific actions pursued through this project and the resulting learnings.

Counties have expressed a desire to prioritize onboarding this evaluator in the early stages of the project. The counties have emphasized the importance of having this partner involved in any initial efforts to approximate counties' baseline FSP practices and performance, as well as provide appropriate time to execute any data-sharing agreements required for the evaluator to gather and assess outcomes data across each of the participating counties. Currently, counties have identified RAND Corporation as a potential evaluation partner, given that RAND has previously partnered with counties through CalMHSA and brings previous experience evaluating FSP programs in LA County. Participating counties, Third Sector,[4] and CalMHSA are currently taking steps to contract and onboard this evaluation partner.

A description and example measures for each of the nine evaluation questions follows below. Counties, with support from Third Sector and the evaluator, will develop and finalize these measures after contracting with the evaluator. The evaluation plan will include a timeline for defined deliverables and will crystallize these evaluation questions, outcome measures, data-sharing requirements and resulting evaluation activities. Evaluation planning activities will also include developing and confirming a strategy

[4] Third Sector will support counties in identifying and onboarding an evaluation partner, developing an ongoing governance structure for collaborating with the evaluator, and finalizing outcome measures and required data collection strategies through Third Sector's TA period (i.e., through November 2021). Third Sector does not plan to have an ongoing role in the Evaluation period (December 2021 through June 2024).

for each county to gather and collect data consistently, both for the purposes of creating a baseline understanding of current FSP program practices and performance, as well as for gathering data required for the evaluation.

The table below proposes potential qualitative and quantitative measures to assess both systems-level and client-level impacts. As described above, these system-level impacts will assess the positive value and changes experienced by participating counties and community stakeholders. These systems-level measures will be tracked during and following the initial 23-month implementation TA period, and directly answer guiding evaluation questions 1-8 above. Additionally, this project proposes to measure overall improvements in FSP client outcomes that may occur during the project timeframe (client-level impacts), to better understand evaluation question 9 above.

Example Measures	*Example Data Source*	*Relevant Evaluation Questions*
Systems-Level Impacts		
Policy changes that a county, the Department of Health Care Services (DHCS), or the MHSOAC implemented as a result of the project	Qualitative interviews of participating counties, state agencies	2, 5, 7
New FSP service approach as a result of the project	Qualitativequalitative interviews of participating counties, observational data from local FSP programs	2, 4, 5, 7
New data sharing mechanisms and/or agreements created to support ongoing evaluation, feedback, and analysis of disparities	Qualitativequalitative interviews of participating counties	3, 4, 7
Improvements or changes to FSP continuous improvement practices	Qualitative interviews of participating counties	2, 3, 4, 5, 7
New FSP metrics or data elements measured in each county	Qualitative interviews of participating counties	2, 3, 4, 5, 7
FSP metrics or data elements removed by each county due to lack of relevance or usefulness	Qualitative interviews of participating counties	2, 3, 4, 5, 7

	Example Measures	*Example Data Source*	*Relevant Evaluation Questions*
	Overall staff and clinician satisfaction with quality and impact of outcome measures selected, changes to data collection practices and service guidelines	Survey and/or qualitative interviews of participating counties	2, 3, 4, 8
	Increased confidence from staff and clinicians that measures tracked are meaningful for participants and/or are regularly reviewed and used to inform programs	Survey and/or qualitative interviews of participating counties	3, 4, 8
	Increased understanding across providers and/or county staff of how priority outcomes are defined and the corresponding data collection and reporting requirements	Survey and/or qualitative interviews of participating counties and local staff	3, 4, 8
Client- and Program Level Impacts			
	Changes in cross-system outcomes, such as:		
	Increased percentage of housing-insecure FSP clients connected with housing supports	Self-report via existing outcomes collections systems; data from local housing agencies	9
	Decreased recidivism for justice-involved FSP clients	Self-report via existing outcomes collections systems; data from local jails, and state prisons	9
	Decreased use of emergency psychiatric facilities	Self-report via existing outcomes collections systems; billing records from local hospitals via the county Mental Health Plan	9
	Increased percentage of clients engaging in recreational activities, employment, and/or other forms of meaningful use of time	Self-report via existing outcomes collections systems; additional	9

	Example Measures	*Example Data Source*	*Relevant Evaluation Questions*
		new state and local data sharing agreements targeting tax and employment data	
	Increased percentage of clients graduating FSP successfully	Enrollment and retention data from county FSP providers	9
	Increased program graduation rates for clients due to increased capacity (i.e., exits because clients are stable and re-integrated into the community)	Enrollment and retention data from county FSP providers	9
	Additional client-level outcomes, such as:		
	Reduced FSP outcome disparities (i.e. disparities by race, ethnicity, and language)	Comparison of pre- and post-outcomes on existing outcomes collections systems	9
	Timely access to programs and services aligned with individuals' long-term goals	FSP provider services and billing records	9
	Decreased utilization of crisis services in counties (e.g., emergency rooms, mental health, justice) due to increased emphasis on prevention and wellbeing	Data from county hospitals, jails, FSP providers	9

Note that the time period for observing and evaluating changes in outcomes and metrics may end sooner (e.g., end of 2023), so as to provide sufficient time for the evaluator to measure and synthesize evaluation findings and to share this information with counties. Third Sector, the evaluator, and participating counties will determine the exact measures and an appropriate evaluation methodology for assessing client-level impacts during the project.

Participating counties will identify and finalize these measures, data sources, and associated learning goals during the first year of the project, memorialized in a shared evaluation plan, with advisory support from Third Sector and the evaluator. As mentioned above, it will be beneficial to the overall project and the project's evaluation plan to identify and partner with an evaluator prior to finalizing the specific learning metrics, given the complex and systems-level nature of these changes. While the

measures listed above are preliminary ideas and priorities identified by participating counties, Third Sector, the evaluator, and the counties will work to refine these measures in the first year of this project.

The evaluation plan will include a timeline for defined deliverables and will crystallize these evaluation questions, outcome measures, data-sharing requirements and resulting evaluation activities. Third Sector, participating counties, and the evaluator will also carefully consider and discuss strategies for mitigating possible unintended consequences when designing the evaluation and selecting measures to be tracked (e.g., any perverse incentives to graduate clients from FSP before they are ready). During the first year of the project, the evaluator and Third Sector will also support counties in identifying the appropriate method and steps to develop an accurate baseline of these measures.

See the *Budget Narrative* section below for additional detail on the evaluation activities.

Section 3: Additional Information for Regulatory Requirements

Contracting

Participating counties intend to contract with a technical assistance provider to support counties with project implementation activities. As described above in the *Proposed Project* section, the MHSOAC has supported Third Sector (a San Francisco-based nonprofit) in leading counties through the process of developing and implementing this Innovation Project, as well as in facilitating a broader statewide exchange of collective learning and shared opportunities for improving FSP programs. Third Sector will act as the overall project lead and project manager, developing recommendations and customized strategies, leading working group calls and collaborating with each county to meaningfully elevate stakeholder voice, while ensuring the project remains on schedule and responding to any challenges.

Participating counties will also identify and contract with an evaluation partner during the first year of the project. The evaluation partner will support counties in designing and implementing a shared strategy for assessing the project impact.

Counties plan to contract with Third Sector and the evaluation partner through the existing Joint Powers Agreement (JPA) viaCalMHSA. The JPA sets forward specific governance standards to guide county relationships with one another, Third Sector, and the evaluator and ensure appropriate regulatory compliance. CalMHSA will also develop participation agreements with each participating county that will further memorialize these standards and CalMHSA's specific role and responsibilities in providing fiscal and contract management support to the counties. As further detailed in Section 4, counties intend to use a portion of the Multi-County FSP Innovation Project budget to pay CalMHSA for this support.

Community Program Planning

The Appendix to the Innovation Plan includes more detail about each participating county's specific stakeholder needs, how this project addresses these needs, and what the overall community planning process has involved in each county. Since the community planning process is ongoing, stakeholders will continue to receive updates and provide input throughout the duration of this project, including participation via specific focus group and stakeholder interview activities outlined in the project work plan.

Alignment with Mental Health Services Act General Standards

This project meets MHSA General Standards in the following ways:

- It is a **multi-county collaboration** between Fresno, Ventura, Sacramento, Siskiyou, San Bernardino, and San Mateo to address FSP program challenges and opportunities
- It is **client-driven**, as it seeks to reframe FSP programs around meaningful outcomes for the individual, centering on holistic client **wellness and recovery**
- It seeks to create a coordinated approach to program design and service delivery, leading to an **integrated service experience for clients and family**

- It will establish a shared understanding of the core components of FSP programs and create a common framework that reflects best practices while adapting for local context and **cultural competency**
- **Diverse stakeholders** will be meaningfully engaged throughout the development and implementation of the project

Cultural Competence and Stakeholder Involvement in Evaluation

This project intends to engage each county's stakeholders (i.e., program participants, frontline staff, other key community partners) throughout its duration, including in evaluation activities. Example engagement activities may include, but are not limited to:

- Asking for input from FSP provider staff, clients or client representatives, partner agencies, and other stakeholders (via focus groups, interviews, surveys, and/or working group discussions) as counties identify and define outcome goals, develop meaningful metrics for tracking these goals over time, identify key FSP service components, and surface opportunities to clarify and streamline referral and graduation criteria
- Sharing and reviewing data gathered and analyzed throughout this project—including in the Evaluation period—with community members to gather additional input and insight in interpreting trends
- Inviting clients and/or client representatives to participate in statewide Outcomes-Driven FSP Learning Community events
- Soliciting qualitative feedback from stakeholders on how this project has helped (or hindered) FSP service delivery in each county and opportunities for further improvement
- Sharing learnings and regular updates from this project with stakeholders at MHSA community planning meetings and county-specific stakeholder committees

Innovation Project Sustainability and Continuity of Care

This Innovation Project does not propose to provide direct services to FSP clients. Each contractor (Third Sector; the third-party evaluator; CalMHSA) will operate in an advisory or administrative capacity and will not provide services to FSP clients. Throughout project implementation, participating counties will ensure continuity of FSP services, without disruption as result of this project.

Participating counties are strongly interested in sustaining any learnings, practices, and/or new statewide collaborative structures developed through this Innovation Project that demonstrate effectiveness in meeting the project goals. The Multi-County FSP Innovation Project work plan includes dedicated time and resources for sustainability planning among counties and Third Sector throughout each phase of the project. During the first two phases of the Implementation TA period (Landscape Assessment and Implementation), Third Sector will work closely with each participating county to ensure sustainability and transition considerations are identified and prioritized in developing new strategies for implementation, and that, by the conclusion of the project, county staff have the capacity to continue any such new strategies and practices piloted through this project.

In addition, the final two months of the Implementation TA period provide additional time and dedicated focus for sustainability planning, whereby Third Sector will work with participating counties to

understand the success of the changes to-date and finalize strategies to sustain and build on these new data-driven approaches. Participating counties may also partner with other counties to elevate project implementation successes in order to champion broad understanding, support, and continued resources for outcomes-focused, data-driven mental health and social services. These plans are further described below in the *Work Plan and Timeline* section). Counties will also use findings from the evaluation to identify which specific practices or changes were most effective for achieving the different client- and systems-level impacts that the project will measure, prioritizing these for continuation in future years.

Similarly, while Third Sector will organize and facilitate the statewide Outcomes-Driven FSP Learning Community in 2020, the counties and Third Sector intend for the Learning Community to be largely county-driven and county-led. The counties and Third Sector will gather feedback on the efficacy of the Learning Community at various points throughout the first year of the project (2020) and will develop a plan for continuing prioritized activities in an ongoing fashion, whether through county-led facilitation, ongoing Third Sector support, and/or another strategy. The counties and Third Sector welcome and hope to solicit the MHSOAC's input in these conversations.

Data Use and Protection

Third Sector does not intend to request, collect, or hold client-level Personally Identifiable Information (PII) and/or Protected Health Information (PHI) during this Innovation Project. Participating counties may only provide Third Sector with de-identified and/or aggregate data related to their FSP programs. Any such de-identified and/or aggregate data provided will be stored electronically within secure file-sharing systems and made available only to employees with a valid need to access.

Should the third-party evaluator require access to individual level data and/or PII/PHI, CalMHSA, the evaluator and counties will take steps to ensure appropriate data protections are put in place and necessary data use agreements are established.

Communication and Dissemination Plan

Throughout the ideation and development of this Innovation Project, Third Sector has maintained ongoing conversation with the MHSOAC to share updates on county convenings, submit contract deliverables, solicit feedback about project decisions, discuss areas of further collaboration, and generally ensure alignment of interests, goals, and expectations. As the project progresses and moves into a phase of county-specific landscaping and implementation TA, Third Sector will continue to share regular updates, questions, and deliverables with Commission staff. These updates may include summaries of common challenges that participating counties experience on their FSP programs, from state-level data collection and reporting to performance management and continuous improvement practices. Based on these common challenges, participating counties intend to develop a set of shared recommendations for changes to state-level data requirements. Through the statewide Outcomes-Driven FSP Learning Community, these recommendations will be co-created and informed by counties across the state. Third Sector will share regular updates on Learning Community workshops and may invite Commission staff to attend select events. Additionally, Third Sector and the counties will collaborate with the MHSOAC to determine if and when presentations to the Commission may be valuable for further disseminating project learnings.

As the implementation phase of work comes to a close, Third Sector will work with participating counties to develop a plan for sustaining new outcomes-focused, data-driven strategies. This will include developing a communication plan for sharing project activities, accomplishments, and takeaways with the MHSOAC and DHCS. Third Sector will share counties' recommended revisions to state data requirements, and it will initiate discussions about opportunities for the MHSOAC and DHCS to streamline and clarify guidelines and requirements, supporting more effective and responsive FSP programs. Third Sector will also share insights about the process itself, from Innovation Plan development to implementation TA, and reflect on the successes and challenges of these efforts, promoting a discussion about the sustainability and scalability of future Innovation Projects.

Work Plan and Timeline

Project Activities and Deliverables and Timeline

The Multi-County FSP Innovation Project will begin in January 2020 and end in June 2024 for a total project duration of 4.5 years. The project will be divided into two periods: an Implementation TA period and an Evaluation period. Throughout project implementation, counties will ensure continuity of FSP services.

In the first 23-month Implementation TA period, Third Sector will work directly with each participating county to understand each county's local FSP context and provide targeted, county-specific assistance in implementing outcomes-focused improvements. Third Sector will leverage a combination of regular (weekly to biweekly) virtual meetings or calls with counties' core project staff, regular site visits and in-person working groups, and in-person stakeholder meetings, in order to advance the project objectives. These efforts will build on learnings and tools developed in Third Sector's work with the Los Angeles County Department of Mental Health, as well as Third Sector's previous partnerships with other California and national behavioral health, human services, justice, and housing agencies. Each county will receive dedicated technical support with a combination of activities and deliverables tailored for their unique county context, while also having access to shared resources and tools applicable across all FSP programs and counties.

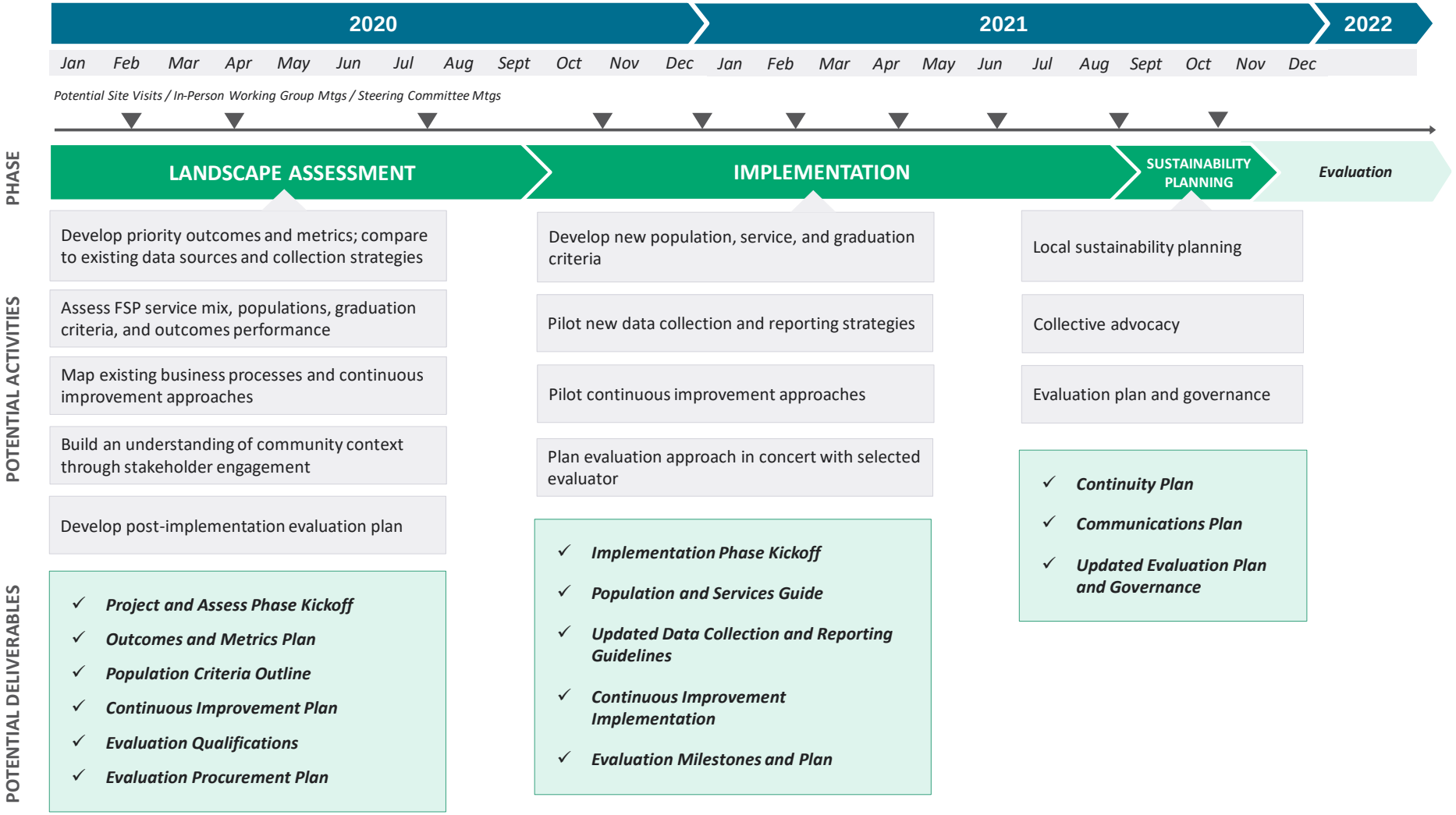
This Implementation TA period will be divided into three discrete phases (Landscape Assessment; Implementation; Sustainability Planning). The activities and deliverables outlined below are illustrative, as exact phase dates, content, and sequencing of deliverables will depend on each county's needs and goals. County staff and Third Sector will collaborate over the next several months to identify each county's most priority activities and goals and to create a unique scope of work to meet these needs. See ***Figure 1*** below for an illustrative Implementation TA work plan and timeline by phase.

In the second period of the project, participating counties will pursue an evaluation, conducted by a third-party evaluator, with the goal of assessing the impacts and learning that this project produces.[5]

[5] Note that this evaluator will also be a part of the Implementation TA period, given the importance of having this partner involved in any initial efforts to approximate counties' baseline FSP practices and performance, as well as to provide appropriate time to execute any data use agreements required for the evaluator to gather and assess outcomes data across each of the participating counties. Additional details on the timeline and plan for onboarding an evaluation partner follow in the sections below.

This Evaluation Period and the overall Multi-County FSP Innovation Project will conclude at the end of June 2024.

***Figure 1**: Illustrative Implementation TA Work Plan*



Phase 1: Landscape Assessment

The Landscape Assessment phase will act as a ramp-up period and an opportunity for Third Sector to learn about each county's context in further detail, including local community assets, resources, and opportunities, existing FSP program practices, and performance on existing outcomes measures. Building off of templates from national mental and behavioral health projects, Third Sector will customize deliverables and activities for each county's local FSP context. During this phase, Third Sector will work with county staff to lead working groups and interviews, analyze county data, and facilitate meetings with local stakeholders to identify opportunities for improvement. County staff will share data and documents with Third Sector and provide guidance on local priorities and past experiences. Other example activities may include conducting logic models and root cause analyses to create consensus around desired FSP outcomes, reviewing current outcomes and performance data to understand trends, and gathering qualitative data about the client journey and staff challenges. By the end of this phase, each participating county will have an understanding of the current state of its FSP programs, customized recommendations to create a more data-driven, outcomes-oriented FSP program, and a realistic work plan for piloting new improvements during the Implementation phase.

Third Sector will produce a selection of the following illustrative deliverables, as appropriate for each county's unique context and needs:

- *Outcomes and Metrics Plan:* Recommended improved FSP outcomes and metrics to understand model fidelity and client success, including recommended areas of commonality, alignment, and consistency across counties
- *Population to Program Map:* A map of current FSP sub-populations, FSP programs, and community need, to illuminate any potential gaps or opportunities
- *Population Criteria Outline:* Recommended changes to population eligibility criteria, service requirements, and graduation criteria
- *Current State to Opportunity Map*: A map of metrics and existing data sources, including identification of any gaps and opportunities for improved linkages and continuity (e.g., auto-population of fields, removal of duplicate metrics, linking services or billing data to understand trends, opportunities to use additional administrative data sources to validate self-reported data)
- *Outcomes Performance Assessment*: An assessment of provider and clinic performance against preliminary performance targets, leveraging existing data and metrics
- *Process Map*: A process map identifying current continuous improvement and data-sharing processes and opportunities for improvement
- *Implementation Plan:* An implementation plan for new continuous improvement processes, both internal (i.e., creating improved feedback loops and coordination between county data, funding, and clinical or program teams) and external (i.e., creating improved feedback loops between county teams and contracted providers)

During this phase, Third Sector and the counties will develop a set of qualifications and work plan for procuring a third-party evaluator. Example evaluator-led activities and deliverables include:

- Recommended evaluation methodology (e.g., randomized control trial, quasi-experimental method, etc.)
- Work plan for executing any required data-use agreements and/or Institutional Review Board (IRB) approvals that may be necessary to implement the evaluation
- Evaluation plan that identifies specific outcomes, metrics, data sources and timeline for measuring client- and systems-level impacts
- Final impact report

Counties will select an evaluator based upon the qualifications and work plan described above. Following procurement and/or onboarding as appropriate, Third Sector, counties, and the evaluator will develop a scope of work detailing the exact deliverables and activities that the evaluator will lead as part of the evaluation, and any associated planning and preparing (e.g. validation of baseline FSP practices and performance) that should occur during the Implementation phase.

Phase 2: Implementation

Third Sector will provide individualized guidance and support to each county through the Phase 2 Implementation process, piloting new strategies that were developed during Phase 1. Understanding limitations on staff capacity, Third Sector will support county staff by preparing materials, analyzing and benchmarking performance data, helping execute on data-sharing agreements, and leading working group or project governance meetings. County staff will assist with local and internal coordination in order to meet project milestones. Additional activities in Phase 2 may include the following: improving coordination across county agencies to create a human-centered approach to client handoffs and transfers, completing data feedback loops, and developing new referral approaches for equitable access across client FSP populations. As a result of this phase, county staff will have piloted and begun implementing new outcomes-oriented, data-driven strategies.

With Third Sector's implementation support, participating counties may achieve a selection of the following deliverables in Phase 2:

- *Referral Strategies*: Piloted strategies to improve coordination with referral partners and the flow of clients through the system
- *Population and Services Guide*: New and/or revised population guidelines, service requirements, and graduation criteria
- *Updated Data Collection and Reporting Guidelines*: Streamlined data reporting and submission requirements
- *Data Dashboards:* User-friendly data dashboards displaying performance against priority FSP metrics
- *Continuous Improvement Process Implementation:* Piloted continuous improvement and business processes to create clear data feedback loops to improve services and outcomes
- *Staff Training:* Staff trained on continuous improvement best practices
- *FSP Framework:* Synthesized learnings and recommendations for the FSP framework that counties and Third Sector can share with the broader statewide Outcomes-Driven FSP Learning Community for further refinement

- *FSP Outcomes and Metrics Advocacy Packet:* Recommendations on improved FSP outcomes, metrics, and data collection and sharing practices for use in conversations and advocacy in stakeholder forums and with policy makers.

Phase 3: Sustainability Planning

Throughout Phases 1 and 2, Third Sector will work closely with each participating to ensure sustainability and transition considerations are identified and prioritized during implementation, and that, by the conclusion of the project, county staff have the capacity to continue any new strategies and practices piloted through this project. Phase 3 will provide additional time and dedicated focus for sustainability planning, whereby Third Sector will work with participating counties to understand the success of the changes to-date and finalize strategies to sustain and build on these new data-driven approaches. Participating counties may also partner with other counties to elevate project implementation successes in order to champion broad understanding, support, and continued resources for outcomes-focused, data-driven mental health and social services. Specific Phase 3 activities may include articulating lessons learned, applying lessons learned to other mental health and social service efforts, creating ongoing county work plans, and developing an FSP impact story. As a result of Phase 3, each participating county will have a clear path forward to continue building on the accomplishments of the project.

Third Sector will produce a selection of the following deliverables for each county:

- *Project Case Study:* A project case study highlighting the specific implementation approach, concrete changes, and lessons learned
- *Continuity Plan*: A continuity plan that identifies specific activities, timelines and resources required to continue to implement additional outcomes-oriented, data-driven approaches
- *Project Toolkit:* A project toolkit articulating the specific approaches and strategies that were successful in the local FSP transformation for use in similarly shifting other mental health and related services to an outcomes orientation
- *Communications Plan:* A communications strategy articulating communications activities, timelines, and messaging
- *Project Takeaways*: Summary documents articulating major takeaways for educating statewide stakeholders on the value of the new approach
- *Evaluation Work Plan and Governance:* An evaluation work plan to assist the counties and the evaluation partner in project managing the Evaluation period

Expected Outcomes

At the end of this project, each participating county will have clearly defined FSP outcome goals that relate to program and beneficiary priorities, well-defined performance measures to track progress towards these outcome goals, and a clarified strategy for tracking and sharing outcomes data to support meaningful comparison, learning, and evaluation. The specific implementation activities may vary based on the results of each county's landscape assessment, but may include the following: piloting new referral processes, updating service guidelines and graduation criteria, using qualitative and quantitative data to identify program gaps, sharing data across providers, agencies, and counties, streamlining data

practices, improving data-reporting formats, implementing data-driven continuous improvement processes, and recommending changes to state-level data requirements.

Section 4: INN Project Budget and Source of Expenditures

Overview of Project Budget and Sources of Expenditures: All Counties

The total proposed budget supporting six counties in pursuing this Innovation Project is approximately $4.85M over 4.5-years. This includes project expenditures for four different primary purposes: Third Sector implementation TA ($2.87M), fiscal and contract management through CalMHSA ($.314M), third-party evaluation ($0.596M), as well as additional expenditures for county-specific needs ("County-Specific Costs") ($1.07M).

All costs will be funded using county MHSA Innovation funds, with the exception of San Mateo County which will contribute available one-time CSS funding. Counties will contribute varying levels of funding towards a collective pool of resources that will support the project expenditures (excluding County-Specific Costs, which counties will manage and administer directly). This pooled funding approach will streamline counties' funding contributions and drawdowns, reduce individual project overhead, and increase coordination across counties in the use of these funds. See *Figure 2* below for the estimated total sources and uses of the project budget over the 4.5-year project duration across all six participating counties. The Appendix includes additional detail on each county's specific contributions and planned expenditures.

Budget Narrative for Shared Project Costs

Consultant Costs and Contracts: Each county is contributing funding to a shared pool of resources that will support the different contractor and consultant costs associated with the project. These costs include support from Third Sector (implementation TA), CalMHSA (fiscal and contract management), and the third-party evaluator (evaluation). These consultants and contractors will operate across the group of participating counties, in addition to supporting each individual county with its own unique support needs.

The total amount of consultant and contractor costs is approximately $3.78M across all six counties over the 4.5 year timeline. A description of each of these three cost categories follows below.

Third Sector Costs

As described in the *Project Activities and Deliverables* section above, Third Sector will lead counties through individualized implementation TA over a 23-month timeframe (January 2020 through November 2021). The total budget for Third Sector's TA across all six counties is $2.87M over the full 23-month TA period. These costs will fund Third Sector teams who will provide a wide range of dedicated technical assistance services and subject matter experience to each individual county, as they pursue the goals of this Innovation Plan. Third Sector staff will leverage regular site visits to each county, in addition to leading weekly to biweekly virtual meetings with different working groups, developing recommendations for the project Steering Committee, and supporting county staff throughout each of the three implementation TA phases.

Based in San Francisco and Boston, Third Sector is one of the leading implementers of outcomes-oriented strategies in America. Third Sector has supported over 20 communities to redirect over $800M in public funds to data-informed, outcomes-oriented services and programs. Third Sector's experience includes working with the Los Angeles County Department of Mental Health to align over $350M in annual MHSA FSP and PEI funding and services with the achievement of meaningful life outcomes for well over 25,000 Angelenos; transforming $81M in recurring mental health services in King County, WA to include new performance reporting and continuous improvement processes that enable the county and providers to better track each providers' monthly performance relative to others and against specific, county-wide performance goals; and advising the County of Santa Clara in the development of a six-year, $32M outcomes-oriented contract intended to support individuals with serious mental illness and complex needs through the provision of community-based behavioral health services.

CalMHSA Costs

Six counties (San Mateo, Sacramento, San Bernardino, Ventura, Siskiyou, and Fresno) have selected to contract using the existing Joint Powers Agreement (JPA) via CalMHSA. CalMHSA will act as the fiscal and contract manager for this shared pool of resources through the existing JPA. The JPA sets forward specific governance standards to guide county relationships with one another, Third Sector, and the evaluator. CalMHSA will develop participation agreements with each participating county that will further memorialize these standards and CalMHSA's specific role and responsibilities in providing fiscal and contract management support to the counties.

CalMHSA charges an estimated 9% for its services. Rates are based on the specific activities and responsibilities CalMHSA assumes. The total estimated cost of CalMHSA's services across all six counties, assuming a 9% rate, are $.314M over the total duration of the project.

Evaluation Costs

Third Sector and the counties will determine the appropriate procurement approach and qualifications for a third-party evaluator during the first nine months of the project. Counties have expressed a desire to prioritize onboarding an evaluator in the early stages of the project. Currently, counties have identified RAND Corporation as a potential evaluation partner, as RAND has previously partnered with counties through CalMHSA and brings previous experience evaluating FSP programs in Los Angeles County. Once selected, counties intend to contract with the evaluator via the JPA administered through CalMHSA. Third Sector and CalMHSA will support counties in determining the appropriate statement of work, budget, and funding plan for the third-party evaluator.

The current budget projects a total evaluation cost of approximately $.596M. The evaluator will be responsible for developing a formal evaluation plan, conducting evaluation activities, and producing an evaluation report. Estimated costs assume that the counties, Third Sector, and the to-be-determined third-party evaluator will collaborate to develop a uniform evaluation approach and set of performance metrics, with corresponding metric definitions that can be applied consistently across all counties. Costs are estimates and subject to change. Additional charges, such as academic overhead rates and/or the costs for completing any required data sharing agreements, may apply. If any additional information

emerges that will increase costs beyond the initially budgeted amounts, the counties, CalMHSA and Third Sector will work in partnership with the MHSOAC to identify appropriate additional funding.

Budget Narrative for County-Specific Costs

The remaining project costs are intended to support additional, county-specific expenditures. Counties will fund these costs directly, rather than through a pooled funding approach. A summary of the total $1.07M in County-Specific Costs across all six counties follows below. The Appendix includes additional detail of each county's specific expenditures within these categories:

Personnel Costs

Total personnel costs (county staff salaries, benefits) for all counties are approximately $844,000 over 4.5 years and across six counties. Each county's appendix, attached, details the specific personnel that this will support.

Operating Costs

Total operating costs for counties are approximately $233,000 over 4.5 years and across six counties. Operating costs support anticipated travel costs for each county and requisite county-specific administrative costs. Each county's appendix, attached, details their specific operating costs.

Non-Recurring Costs

This project will not require any technology, equipment, or other forms of non-recurring costs.

FIGURE 2: BUDGET BY FUNDING SOURCE AND FISCAL YEAR							
EXPENDITURES							
Personnel Costs (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
1	Salaries	$116,271	$181,117	$187,502	$137,735	$128,071	$750,696
2	Direct Costs	$15,454	$26,614	$27,945	$10,323	$4,700	$85,036
3	Indirect Costs	$1,409	$2,856	$2,999	$624	$624	$8,512
4	Total Personnel Costs	$133,134	$210,587	$218,446	$148,682	$133,395	$844,244
Operating Costs (travel, hotel)		**FY 19/20**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**
5	Direct Costs	$20,390	$24,390	$24,390	$24,390	$12,390	$105,950
6	Indirect Costs	$9,785	$29,293	$29,293	$29,293	$29,294	$126,958
7	Total Operating Costs	$30,175	$53,683	$53,683	$53,683	$41,684	$232,908
Non-Recurring Costs (technology, equipment)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
8	Direct Costs	$0	$0	$0	$0	$0	$0
9	Indirect Costs	$0	$0	$0	$0	$0	$0
10	Total Non-Recurring Costs	$0	$0	$0	$0	$0	$0
Consultant Costs/Contracts (training, facilitation, evaluation)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
11a	Direct Costs (Third Sector)	$487,424	$1,515,954	$681,278	$186,000	$0	$2,870,655
11b	Direct Costs (CalMHSA)	$34,502	$197,029	$72,085	$6,564	$4,687	$314,866
11c	Direct Costs (3rd Party Evaluator)	$10,417	$101,649	$101,649	$196,649	$186,232	$596,596
12	Indirect Costs	$0	$0	$0	$0	$0	$0
13	Total Consultant Costs	$532,343	$1,814,632	$855,012	$389,213	$190,919	$3,782,117
Other Expenditures (explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
14	Program/Project Cost	$0	$0	$0	$0	$0	$0
15		$0	$0	$0	$0	$0	$0
16	Total Other Expenditures	$0	$0	$0	$0	$0	$0
BUDGET TOTALS							
Personnel		$133,134	$210,587	$218,446	$148,682	$133,395	$844,244
Direct Costs		$552,733	$1,839,022	$879,402	$413,603	$203,309	$3,888,067
Indirect Costs		$9,785	$29,293	$29,293	$29,293	$29,294	$126,958
Total Innovation Project Budget		**$695,652**	**$2,078,902**	**$1,127,141**	**$591,578**	**$365,998**	**$4,859,269**

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 MHSA Funds	$621,032	$1,617,209	$899,869	$393,991	$178,828	$3,710,929
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*	$64,203	$360,044	$125,623	$938	$938	$551,744
6.	**Total Proposed Administration**	**$685,235**	**$1,977,253**	**$1,025,492**	**$394,929**	**$179,766**	**$4,262,673**
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 MHSA Funds	$10,417	$52,085	$52,085	$147,085	$136,668	$398,340
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*	$0	$49,564	$49,564	$49,564	$49,564	$198,256
6.	**Total Proposed Evaluation**	**$10,417**	**$101,649**	**$101,649**	**$196,649**	**$186,232**	**$596,596**
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 MHSA Funds	$631,449	$1,669,294	$951,954	$541,076	$315,496	$4,109,269
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*	$64,203	$409,608	$175,187	$50,502	$50,502	$750,000
6.	**Total Proposed Expenditures**	**$695,652**	**$2,078,902**	**$1,127,141**	**$591,578**	**$365,998**	**$4,859,269**
*If "Other funding" is included, please explain.							

*San Mateo County does not have MHSA INN funds available to commit to this project, but instead intends to use unspent MHSA CSS funds to participate in the goals and activities of this project, alongside other counties.. Estimated amounts are provided in the table above. These are one-time funds that have been designated and approved through a local community program planning process to meet a similar purpose and set of objectives as the Multi-County FSP Innovation Project. San Mateo County is not submitting a proposal to use INN funds but is committed to participating in the broader effort and, thus, is included here and in the Multi-County FSP Innovation Project plan.

Innovation Plan Appendix

Appendix Overview

The following appendix contains specific details on the local context, local community planning process (including local review dates), and budget details for four of the six counties participating in the Multi-County FSP Innovation Project:

1. Sacramento County
2. San Bernardino County
3. Siskiyou County
4. Ventura County

The other two participating counties, Fresno County and San Mateo County, are not included in this appendix for the following reasons:

5. Fresno County has already submitted an Innovation Project plan to the MHSOAC detailing its plans to participate in this project. This plan was approved by the MHSOAC.
6. San Mateo County does not have MHSA INN funds available to commit to this project, but instead intends to use unspent MHSA CSS funds to participate in the goals and activities of this project, alongside other counties. These are one-time funds that have been designated and approved through a local community program planning process to meet a similar purpose and set of objectives as the Multi-County FSP Innovation Project. San Mateo County is not submitting a proposal to use INN funds but is participating in the broader effort and thus is included here.

Budget summaries for both Fresno and San Mateo, however, are included for additional reference regarding the total budget across all counties.

Each county appendix describes the county-specific local need for this Multi-County FSP Innovation Project. Though there are slight differences among participating counties' in terms of highest priority and/or specificity of local need, the response to this local need will be similar among counties through the execution of the Innovation Plan.

Through this Innovation Project proposal, participating counties seek to engage in a statewide initiative seeking to increase counties' collective capacity to gather and use data to better design, implement, and manage FSP services. The key priorities outlined in the Multi-County FSP Innovation Project plan (i.e., improve how counties define and track priority outcomes, develop processes for continuous improvement, develop a clear strategy for tracking outcomes and performance measures, updating and disseminating clear FSP service guidelines, improving enrollment and referral process implementation consistency) will allow each participating county to address current challenges and center FSP programs and services around meaningful outcomes for participants. More specifically, participating in this project and aligning with the identified priorities will enable participating counties to:

- Develop a clear strategy for how outcome goals and performance metrics can best be tracked using existing state and/or county-required tools to support meaningful comparison, learning, and evaluation
- Explore how appropriate goals and metrics may vary based on population (e.g., age, acuity, etc.)
- Update and disseminate clear FSP service guidelines using a common FSP framework that reflects clinical best practices
- Create or strengthen mechanisms for sharing best practices and fostering cross-provider learning
- Improve existing FSP performance management practices (i.e., when and how often program data and progress towards goals is discussed, what data is included and in what format, how next steps and program modifications are identified)

This project will also provide participating counties the opportunity to share and exchange knowledge with other counties through the statewide Outcomes-Driven FSP Learning Community. This learning will not only contribute to improved participant outcomes and program efficiency, but may also help facilitate statewide changes to data requirements.

In addition to outlining county-specific local need and community planning processes, each county appendix outlines a budget narrative and county budget request by fiscal year, with detail on specific budget categories.

Appendix: Sacramento County

County Contact and Specific Dates

- Primary County Contact: Julie Leung; leungj@saccounty.net; (916) 875-4044
- Date Proposal was posted for 30-day Public Review: November 18, 2019
- Date of Local Mental Health Board hearing: December 18, 2019
- Date of Board of Supervisors (BOS) approval: January 14, 2020

Description of the Local Need

Sacramento County has eight (8) FSP programs serving over 2,100 individuals annually. Each FSP serves a specific age range or focuses on a specific life domain. While a majority of the FSP programs serve transition-aged youth (18+), adults and older adults, one FSP serves older adults only, another one serves TAY only, and two serve all ages. Further, one serves Asian-Pacific Islanders, one serves pre-adjudicated youth and TAY, and two support individuals experiencing or at risk of homelessness. A new FSP serving TAY (18+), adults and older adults will be added to Sacramento County's FSP service array this fiscal year. This new FSP will utilize the evidence-based Strengths case management model.

While FSP programs provide the opportunity to better serve specific age and cultural groups who need a higher level of care, Sacramento County seeks to establish consistent FSP service guidelines, evaluate outcomes, and disseminate best practices across all FSP programs. Community members, staff, and clinicians have identified opportunities to strengthen the connection between client outcome goals and actual services received and provided by FSP programs. Providers and county department staff do not share a consistent, clear understanding of FSP service guidelines, and providers and peer agencies do not currently have a forum to meet regularly and share learnings and best practices or discuss opportunities. Overall, stakeholders would like to see FSP data used in an effective, responsive way that informs decision-making and improves service quality. Additionally, county staff would like to update inconsistent or outdated standards for referral, enrollment, and graduation.

Description of the Response to Local Need

Through this Innovation proposal, Sacramento County seeks to participate in the statewide initiative for the purpose of increasing counties' collective capacity to gather and use data to better design, implement, and manage FSP services. The key priorities outlined in the Innovation Plan (i.e., improve how counties define and track priority outcomes, develop processes for continuous improvement, develop a clear strategy for tracking outcomes and performance measures, updating and disseminating clear FSP service guidelines, improving enrollment and referral process implementation consistency) will allow Sacramento County to address current challenges and center FSP programs and services around meaningful outcomes for participants. More specifically, participating in this project and aligning with the identified priorities will enable Sacramento County to:

- Develop a clear strategy for how outcome goals and performance metrics can best be tracked using existing state and/or county-required tools to support meaningful comparison, learning, and evaluation

- Explore how appropriate goals and metrics may vary based on population (e.g., age, acuity, life domain example: homelessness, unemployment, etc.)
- Update and disseminate clear FSP service guidelines using a common FSP framework that reflects clinical best practices
- Create or strengthen mechanisms for sharing best practices and fostering cross-provider learning
- Improve existing FSP performance management practices (i.e., when and how often program data and progress towards goals is discussed, what data is included and in what format, how next steps and program modifications are identified)

In addition, this project will provide Sacramento County the opportunity to share and exchange knowledge with other counties through the statewide Outcomes-Driven FSP Learning Community. This learning will not only contribute to improved participant outcomes and program efficiency, but may also help facilitate statewide changes to data requirements.

Description of the Local Community Planning Process

The community planning process includes participation from the Sacramento County Mental Health Steering Act (MHSA) Steering Committee, Mental Health Board, Board of Supervisors, community based organizations, consumers and family members and community members. The community planning process helps the county determine where to focus resources and effectively utilize MHSA funds in order to meet the needs of the community. Since this process is ongoing, stakeholders will continue to receive updates and provide input in future meetings.

The Multi-County FSP Innovation Project was introduced to stakeholders at the May 16, 2019 Mental Health Services Act Steering Committee meeting. Further, at the October 17, 2019 MHSA Steering Committee meeting, the Multi-County FSP Innovation Project was presented and discussed. The Steering Committee voted in full support of Sacramento County Division of Behavioral Health Services, opting into this project with Innovation funding.

At the October 17, 2019 MHSA Steering Committee meeting, 24 committee members were in attendance and 17 public members attended. The MHSA Steering Committee is comprised of one primary member and one alternate from the following groups: Sacramento County Mental Health Board; Sacramento County's Behavioral Health Director; three (3) Service Providers (Child, Adult, and Older Adult); Law Enforcement; Adult Protective Services/Senior and Adult Services; Education; Department of Human Assistance; Alcohol and Drug Services; Cultural Competence; Child Welfare; Primary Health; Public Health; Juvenile Court; Probation; Veterans; two (2) Transition Age Youth (TAY) Consumers; two (2) Adult Consumers; two (2) Older Adult Consumers; two (2) Family Members/Caregivers of Children age 0 – 17; two (2) Family Members/Caregivers of Adults age 18 – 59; two (2) Family Members/Caregivers of Older Adults age 60+; and one (1) Consumer At-large. Some members of the committee have volunteered to represent other multiple stakeholder interests including Veterans and Faith-based/Spirituality.

The Multi-County FSP Innovation Project was posted as an attachment to the MHSA Fiscal Year 2019-20 Annual Update from November 18 through December 18, 2019. The Mental Health Board conducted a Public Hearing on December 18, 2019, beginning at 6.00 p.m. at the Grantland L. Johnson Center for

Health and Human Services located at 7001A East Parkway, Sacramento, California 95823. No public comments regarding this Innovation Project were received. The plan was presented for Board of Supervisors approval on January 14, 2020.

County Budget Narrative

Sacramento County will contribute up to $500,000 over the 4.5-year project period to support this statewide project. As of this time, Sacramento County intends to use MHSA Innovation funding subject to reversion at the end of FY19-20 for the entirety of this contribution.

As detailed below, Sacramento County will pool funding with other counties to support consultant and contracting costs. This $500,000 will support project management and technical assistance (e.g. Third Sector's technical assistance in project implementation), fiscal intermediary costs, and evaluation.

Budget and Funding Contribution by Fiscal Year and Specific Budget Category

BUDGET BY FUNDING SOURCE AND FISCAL YEAR							
EXPENDITURES							
Personnel Costs (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
1	Salaries	$0	$0	$0	$0	$0	$0
2	Direct Costs	$0	$0	$0	$0	$0	
3	Indirect Costs	$0	$0	$0	$0	$0	
4	Total Personnel Costs	$0	$0	$0	$0	$0	$0
Operating Costs (travel, hotel)		**FY 19/20**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**
5	Direct Costs	$0	$0	$0	$0	$0	$0
6	Indirect Costs	$0	$0	$0	$0	$0	$0
7	Total Operating Costs	$0	$0	$0	$0	$0	$0
Non-Recurring Costs (technology, equipment)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
8	Direct Costs	$0	$0	$0	$0	$0	$0
9	Indirect Costs	$0	$0	$0	$0	$0	$0
10	Total Non-Recurring Costs	$0	$0	$0	$0	$0	$0
Consultant Costs/Contracts (training, facilitation, evaluation)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
11a	Direct Costs (Third Sector)	$48,594	$269,134	$91,990	$0	$0	$409,718
11b	Direct Costs (CalMHSA)	$5,252	$30,341	$11,147	$938	$936	$48,614
11c	Direct Costs (Evaluator)	$-	$10,417	$10,417	$10,417	$10,417	$41,668
12	Indirect Costs	$0	$0	$0	$0	$0	$0

13	Total Consultant Costs	$53,846	$309,892	$113,554	$11,355	$11,353	$500,000
Other Expenditures (explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
14	Program/Project Cost	$0	$0	$0	$0	$0	$0
15		$0	$0	$0	$0	$0	$0
16	Total Other Expenditures	$0	$0	$0	$0	$0	$0
BUDGET TOTALS							
Personnel		$0	$0	$0	$0	$0	$0
Direct Costs		$53,846	$309,892	$113,554	$11,355	$11,353	$500,000
Indirect Costs		$0	$0	$0	$0	$0	$0
Total Individual County Innovation Budget*		$53,846	$309,892	$113,554	$11,355	$11,353	$500,000
CONTRIBUTION TOTALS							
Individual County Contribution		$54,849	$312,943	$114,455	$8,876	$8,876	$500,000
Additional Funding for County-Specific Project Costs		$0	$0	$0	$0	$0	$0
Total County Funding Contribution		$54,849	$312,943	$114,455	$8,876	$8,876	$500,000

Appendix: San Bernardino County

County Contact and Specific Dates

- Primary County Contacts: Francesca Michaels Francesca.michaels@dbh.sbcounty.gov, 909-252-4018; Karen Cervantes, kcervantes@dbh.sbcounty.gov, 909-252-4068
- Date Proposal was posted for 30-day Public Review: November 27, 2019
- Date of Local Mental Health Board hearing: January 2, 2020
- Calendared date to appear before Board of Supervisors: June 9, 2020

Description of the Local Need

San Bernardino County Department of Behavioral Health is dedicated to including diverse consumers, family members, stakeholders, and community members in the planning and implementation of MHSA programs and services. The community planning process helps the county determine where to focus resources and effectively utilize MHSA funds in order to meet the needs of county residents. It empowers community members to generate ideas, contribute to decision making, and partner with the county to improve behavioral health outcomes for all San Bernardino County residents. San Bernardino is committed to incorporating best practices in the planning processes that allow consumer and stakeholder partners to participate in meaningful discussions around critical behavioral health issues. Since the community planning process is ongoing, stakeholders will continue to receive updates and provide input in future meetings.

San Bernardino County has eight (8) FSP programs serving an estimated three thousand-four hundred-fifty-eight (3,458) individuals annually. Two (2) of these assist underserved children and youth living with serious emotional disturbance; one (1) serves Transitional Age Youth (TAY); four (4) serve adults with serious mental illness, and one (1) program specifically focuses on older adult populations. In addition to San Bernardino County FSP programs targeting specific age ranges, the programs are designed to serve unique populations such as those experiencing homelessness, who may be involved in criminal or juvenile justice, individuals transitioning from institutional care facilities, and high frequency users of emergency psychiatric services and hospitalizations, however all programs provide full wraparound services to the consumer. The specificity and number of these FSP programs are both an asset and a challenge. While they enable our county to better serve specific age, cultural, and geographic groups, our county stakeholders express the desire to establish consistency in FSP service guidelines or disseminate best practices across county regions, programs, or while transferring FSP services from one county to another. San Bernardino County intends to focus this project on Adult Full Service Partnership programs.

Through public forums, community members have identified the need for consistency in FSP services across regions, programs, and counties to better serve and stabilize consumers moving from one geographic region or program to another. Consumers have also expressed interest in a standardized format for eligibility criteria and consistency in services that are offered and/or provided. Community members, FSP staff, and clinicians have also identified an opportunity for data collection to be better integrated with assessment and therapeutic activities.

Description of the Response to Local Need

Through this Innovation proposal, San Bernardino County seeks to participate in the statewide initiative seeking to increase counties' collective capacity to gather and use data to better design, implement, and manage Adult FSP programs and services. The key priorities outlined in the Innovation Plan (i.e., improve how counties define and track priority outcomes, develop processes for continuous improvement, develop a clear strategy for tracking outcomes and performance measures, updating and disseminating clear FSP service guidelines, improving enrollment and referral process implementation consistency) will allow San Bernardino County to address current challenges and center FSP programs and services around meaningful outcomes for participants. Specifically, participating in this project and aligning with the identified priorities will enable San Bernardino County to:

- Develop a clear strategy for how outcome goals and performance metrics can best be tracked using existing state and/or county-required tools to support meaningful comparison, learning, and evaluation
- Explore how appropriate goals and metrics may vary based on population (e.g., age, acuity, etc.)
- Update and disseminate clear FSP service guidelines using a common FSP framework that reflects clinical best practices
- Create or strengthen mechanisms for sharing best practices and fostering cross-provider learning
- Improve existing FSP performance management practices (i.e., when and how often program data and progress towards goals is discussed, what data is included and in what format, how next steps and program modifications are identified

In addition, this project will provide San Bernardino County the opportunity to share and exchange knowledge with other counties through the statewide Outcomes-Driven FSP Learning Community. This learning will not only contribute to improved participant outcomes and program efficiency, but may also help facilitate statewide changes to data requirements.

Description of the Local Community Planning Process

The community planning process helps the county determine where to focus resources and effectively utilize MHSA funds in order to meet the needs of county residents. The community planning process includes participation from adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests including the Board of Supervisors, and the Behavioral Health Commission. Since the community planning process is ongoing, stakeholders will continue to receive updates and provide input in future meetings.

The project was shared with stakeholders during the following:

- Community Advisory Policy Committee (CPAC), July 18, 2019
- Asian Pacific Islander Awareness Subcommittee, September 13, 2019
- Santa Fe Social Club, September 16, 2019
- African American Awareness Subcommittee, September 16, 2019

- Yucca Valley One Stop TAY Center, September 16, 2019
- Native American Awareness Subcommittee, September 17, 2019
- Transitional Age Youth (TAY) Subcommittee, September 18, 2019
- Serenity Clubhouse, September 19, 2019
- Co-Occurring and Substance Abuse Subcommittee, September 19, 2019
- Consumer and Family Member Awareness Subcommittee, September 23, 2019
- Central Valley FUN Clubhouse, September 24, 2019
- Ontario One Stop TAY Center, September 25, 2019
- Latino Awareness Subcommittee, September 26, 2019
- Older Adult Awareness Subcommittee, September 26, 2019
- A Place to Go Clubhouse, September 26, 2019
- Amazing Place Clubhouse, September 27, 2019
- Victorville One Stop TAY Center, September 27, 2019
- 2nd and 4th District Advisory Committee, October 10, 2019
- Disability Awareness Subcommittee, October 15, 2019
- 1st District Advisory Committee, October 16, 2019
- Community Advisory Policy Committee, October 17, 2019
- LGBTQ Awareness Subcommittee, October 22, 2019
- Women Awareness Subcommittee, October 23, 2019

Stakeholder feedback received was in favor of the Multi-County FSP Innovation Project with **96% of stakeholders in support** of the project, 4% neutral, and 0% opposed. A draft plan will be publicly posted for a 30-day comment period tentatively beginning on November 27, 2019. No feedback was received. The Plan was presented before the San Bernardino County Behavioral Health Commission on January 2, 2020. San Bernardino County will request Board of Supervisors review and final approval in February or March of 2020 (following the MHSOAC's review and approval process).

County Budget Narrative

San Bernardino County requests to contribute a total of $979,634 in MHSA Innovation funds to support this project over the 4.5-year project duration. This funding is not currently subject to reversion. A portion of these funds ($386,222) will cover San Bernardino County-specific expenditures, while the remainder ($593,412) will go towards the shared pool of resources that counties will use to cover shared project costs (i.e. Third Sector TA; CalMHSA; third-party evaluation):

- ***Personnel Costs:*** Costs in this category include salaries and benefits for the time spent by .10 of the Innovation Program Manager as well .5 of the Program Specialist II who will be the lead on this project. Salaries and benefits include a 3% increase to allow for cost of living increases each year. Based on current rates for administrative costs, San Bernardino County will allocate $349,272 for 4.5 years of personnel costs.
- ***Operating Costs:*** Costs in this category include travel and administrative costs that will be incurred by staff traveling to meetings for this project. Additional operating costs anticipated include printing materials for community stakeholder meetings, meeting space costs, as well as incentives to encourage stakeholder participation is consistent and ongoing. San Bernardino County anticipates

operating costs, including travel, up to $36,950 over the 4.5 years, or $7,390 per year, which may vary based on the number of staff traveling and the number of in-person meetings. Costs will also vary on the number of additional stakeholder meetings held.

- ***Consultant Costs:*** The remaining amount, $588,778, will support project management and technical assistance (e.g. Third Sector's technical assistance in project implementation), fiscal intermediary costs (CalMHSA), and evaluation. The evaluation total for San Bernardino County's contribution is $41,668 or 4% of the allocated budget.

The budget totals includes 36% of the budget for personnel costs with the remaining 64% going to direct costs associated with the project including county operating costs and the consultant costs. Note that all of San Bernardino's funding contributions would come from MHSA Innovation funding. See the below tables for an estimated breakdown of budget expenditures and requested funds by fiscal year.

Budget and Funding Contribution by Fiscal Year and Specific Budget Category

BUDGET BY FUNDING SOURCE AND FISCAL YEAR							
EXPENDITURES							
Personnel Costs (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
1	Salaries	$65,787	$67,760	$69,794	$71,887	$74,044	$349,272
2	Direct Costs	$0	$0	$0	$0	$0	$0
3	Indirect Costs	$0	$0	$0	$0	$0	$0
4	Total Personnel Costs	$65,787	$67,760	$69,794	$71,887	$74,044	$349,272
Operating Costs (travel, hotel)		**FY 19/20**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**
5	Direct Costs	$7,390	$7,390	$7,390	$7,390	$7,390	$36,950
6	Indirect Costs	$0	$0	$0	$0	$0	$0
7	Total Operating Costs	$7,390	$7,390	$7,390	$7,390	$7,390	$36,950
Non-Recurring Costs (technology, equipment)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
8	Direct Costs	$0	$0	$0	$0	$0	$0
9	Indirect Costs	$0	$0	$0	$0	$0	$0
10	Total Non-Recurring Costs	$0	$0	$0	$0	$0	$0
Consultant Costs/Contracts (training, facilitation, evaluation)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
11a	Direct Costs (Third Sector)	$58,353	$326,706	$113,435	$0	$0	$498,494
11b	Direct Costs (CalMHSA)	$5,850	$33,338	$12,188	$938	$938	$53,250
11c	Direct Costs (Evaluator)	$0	$10,417	$10,417	$10,417	$10,417	$41,668

12	Indirect Costs	$0	$0	$0	$0	$0	$0
13	Total Consultant Costs	$64,203	$370,461	$136,040	$11,355	$11,355	$593,412
Other Expenditures (explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
14	Program/Project Cost	$0	$0	$0	$0	$0	$0
15		$0	$0	$0	$0	$0	$0
16	Total Other Expenditures	$0	$0	$0	$0	$0	$0
EXPENDITURE TOTALS							
Personnel		$65,787	$67,760	$69,794	$71,887	$74,044	$349,272
Direct Costs		$71,593	$377,851	$143,430	$18,745	$18,745	$630,362
Indirect Costs		$0	$0	$0	$0	$0	$0
Total Individual County Innovation Budget*		$137,380	$445,611	$213,224	$90,632	$92,789	$979,634
CONTRIBUTION TOTALS							
Individual County Contribution		$64,203	$370,461	$136,040	$11,355	$11,355	$593,412
Additional Funding for County-Specific Project Costs		$73,177	$75,150	$77,184	$79,277	$81,434	$386,222
Total County Funding Contribution		$137,380	$445,611	$213,224	$90,632	$92,789	$979,634

Appendix: Siskiyou County

County Contact and Specific Dates

The primary contact for Siskiyou County is:

Camy Rightmier
Email: crightmier@co.siskiyou.ca.us
Tel: 530-841-4281

Siskiyou County's local review dates are listed in the table below. More detail on Siskiyou's stakeholder engagement process can be found in the "Local Community Planning Process" section.

Local Review Process	Date
Innovation Plan posted for 30-day Public Review	December 10, 2019
Local Mental Health Board Hearing	January 21, 2020
Board of Supervisors (BOS) approval	February 4, 2020

Description of Local Need

Siskiyou County operates two FSP programs, a Children's System of Care (CSOC) and an Adult System of Care (ASOC) program that combined serve approximately 230 individuals annually. Program eligibility is determined by diagnosis and risk factors pursuant to the MHSA regulations for FSP criteria. Each Partner is assigned a clinician and case manager that work in the appropriate system of care as determined by the Partner's age. FSP programs may also receive psychiatric services and/or peer support services upon referral by the primary service provider. Many Partners also receive services through the county Wellness Center.

Due to the specificity and flexibility of the FSP program, the county has encountered difficulty developing consistent FSP service guidelines, evaluating outcomes, and disseminating best practices. Siskiyou County utilizes the Data Collection Reporting (DCR) database developed by the State to track outcomes, however, this tool has not been useful with regard to informing treatment or promoting quality improvements.

Community stakeholders have consistently identified the need for clear, consistent and reliable data and outcomes to assist programs in identifying goals, measuring success and pinpointing areas that may need improvement. Throughout numerous focus groups where outcomes have been shared, the Department has recognized that consumers are not interested in the measurement of progress, rather they are solely focused on the amelioration of the problem. Therefore, Siskiyou County Behavioral Health rarely receives feedback on outcome data and is evaluating the program in order to find a meaningful way in which to share the data that will encourage collaborative feedback.

Conversations with Siskiyou County FSP staff and clinicians have revealed that outcome goals and metrics are not regularly reassessed or informed by community input, nor are they well-connected to actual services received and provided by FSP programs. There is not a shared, clear understanding of FSP service guidelines among providers and county department staff, and interpretation and implementation of these guidelines varies widely. Data is collected for compliance and does not inform decision-making or service quality improvements, and data is collected within one system, with limited knowledge of cross-agency outcomes. Further, standards for referral, enrollment, and graduation are inconsistent, outdated, or non-existent.

Response to Local Need

Through this Innovation proposal, Siskiyou County Behavioral Health seeks to participate in the statewide initiative to increase counties' collective capacity to gather and use data to better design, implement, and manage FSP services. The key priorities outlined in the Innovation Plan will allow Siskiyou County Behavioral Health to address current challenges and center FSP programs and services around meaningful outcomes for participants. More specifically, participating in this project and aligning with the identified priorities will enable the department to:

1. Develop a clear strategy for how outcome goals and performance metrics can best be tracked using existing state and/or county-required tools to support meaningful comparison, learning, and evaluation.
2. Explore how appropriate goals and metrics may vary based on population.
3. Update and disseminate clear FSP service guidelines using a common FSP framework that reflects clinical best practices.
4. Create or strengthen mechanisms for sharing best practices and fostering cross-provider learning.
5. Improve existing FSP performance management practices (i.e., when and how often program data and progress towards goals is discussed, what data is included and in what format, how next steps and program modifications are identified).

In addition, this project will provide Siskiyou County Behavioral Health the opportunity to share and exchange knowledge with other counties through the statewide Outcomes-Driven FSP Learning Community.

Local Community Planning Process

The community planning process helps Siskiyou County determine where to focus resources and effectively utilize MHSA funds in order to meet the needs of county residents. The community planning process includes participation from the Board of Supervisors, Behavioral Health Board, providers, consumers, community members and partners. Since the community planning process is ongoing, stakeholders will continue to receive updates and provide input in future meetings.

The project was shared in stakeholder groups in March 2019, where the proposed use of Innovation funds was well-received. A draft plan was posted for a 30-day comment period beginning on December 10, 2019. No comments were received during the public comment period. Siskiyou presented this plan

at a public hearing with the local mental health board on January 21, 2020. Siskiyou County submitted a final plan (incorporating any additional feedback received) to its Board of Supervisors for review and approval on February 4, 2020.

County Budget Narrative

Siskiyou County will contribute up to $700,000 of MHSA Innovation Funds over the 4.5-year project period to support this statewide project. As of this time, Siskiyou County does not intend to use funding subject to reversion for this contribution. As detailed below, Siskiyou County will pool most of this funding with other counties to support consultant and contracting costs, with a small portion of Siskiyou County's funding also set aside for county staff travel and administrative costs:

- *County Travel and Administrative Costs*: Siskiyou County anticipates travel costs up to $16,000 over the 4.5 years, or approximately $3,500 per year, which may vary based on the number of staff traveling and the number of in-person convenings. Including estimated administrative costs, Siskiyou County will allocate approximately $178,000 for 4.5 years of personnel costs.
- *Shared Project Costs*: The remaining amount, $506,000, will support project management and technical assistance (e.g. Third Sector's technical assistance in project implementation), fiscal intermediary costs, and third-party evaluation support

Siskiyou County Budget Request and Expenditures by Fiscal Year

BUDGET BY FUNDING SOURCE AND FISCAL YEAR							
EXPENDITURES							
Personnel Costs (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
1	Salaries	$17,578	$35,616	$37,396	$7,771	$7,771	$106,132
2	Direct Costs	$10,597	$21,514	$22,590	$4,700	$4,700	$64,101
3	Indirect Costs	$1,409	$2,856	$2,999	$624	$624	$8,512
4	Total Personnel Costs	$29,584	$59,986	$62,985	$13,095	$13,095	$178,745
Operating Costs (travel, hotel)		**FY 19/20**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**Total**
5	Direct Costs	$2,000	$4,000	$4,000	$4,000	$2,000	$16,000
6	Indirect Costs	$0	$0	$0	$0	$0	$0
7	Total Operating Costs	$2,000	$4,000	$4,000	$4,000	$2,000	$16,000
Non-Recurring Costs (technology, equipment)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
8	Direct Costs	$0	$0	$0	$0	$0	$0
9	Indirect Costs	$0	$0	$0	$0	$0	$0
10	Total Non-Recurring Costs	$0	$0	$0	$0	$0	$0

Consultant Costs/Contracts (training, facilitation, evaluation)		FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
11a	Direct Costs (Third Sector)*	$58,353	$100,000	$61,983	$0	$0	$220,336
11b	Direct Costs (CalMHSA)	$5,850	$33,338	$12,188	$938	$938	$53,252
11c	Direct Costs (Evaluator)	$0	$10,417	$10,417	$105,417	$105,417	$231,668
12	Indirect Costs	$0	$0	$0	$0	$0	$0
13	Total Consultant Costs	$64,203	$143,755	$84,588	$106,355	$106,355	$505,256
Other Expenditures (explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
14	Program/Project Cost	$0	$0	$0	$0	$0	$0
15		$0	$0	$0	$0	$0	$0
16	Total Other Expenditures	$0	$0	$0	$0	$0	$0
EXPENDITURE TOTALS							
Personnel		$29,584	$59,986	$62,985	$13,095	$13,095	$178,745
Direct Costs		$64,203	$143,755	$84,588	$106,355	$106,355	$505,256
Indirect Costs		$2,000	$4,000	$4,000	$4,000	$2,000	$16,000
Total Individual County Innovation Budget*		$95,787	$207,741	$151,573	$123,450	$121,450	$700,001
CONTRIBUTION TOTALS							
Individual County Contribution		$64,203	$143,755	$84,588	$106,355	$106,355	$505,256
Additional Funding for County-Specific Project Costs		$31,584	$63,986	$66,985	$17,095	$15,095	$194,745
Total County Funding Contribution		$95,787	$207,741	$151,573	$123,450	$121,450	$700,001

* Third Sector will provide additional support and capacity to Siskiyou County, beyond the amount Siskiyou is able to contribute using county Innovation dollars alone. This is intended to support the objectives of Third Sector's contract with the Commission, i.e. that this Multi-County FSP Innovation Project make effort to support and provide meaningful capacity to counties with limited financial resources to participate in the project.

Appendix: Ventura County

County Contact and Specific Dates

The primary contacts for Ventura County are:

Kiran Sahota
Email: kiran.sahota@ventura.org
Tel: (805) 981-2262

Hilary Carson
Email: hilary.carson@ventura.org
Tel: (805) 981-8496

Ventura County's local review dates are listed in the table below. More detail on Ventura's stakeholder engagement process can be found in the "Local Community Planning Process" section.

Local Review Process	Date
Innovation Plan posted for 30-day Public Review	December 17, 2019
Local Mental Health Board Hearing	January 27, 2020
Board of Supervisors (BOS) approval	March 10, 2020

Description of Local Need

Ventura County has 7 FSP programs serving 619 individuals in the 2018/19 fiscal year. Each of these programs has a specific focus, yet they overlap in the age groupings as compared to age groupings as prescribed by MHSA regulations. One (1) of these serves juveniles currently on probation, 1 of these programs serves transition age youth, 4 serve adults age 18 years and older, and another serves older adults. The majority of these programs focus on individuals who are currently experiencing or at risk of experiencing incarceration, substance abuse, or homelessness. Eligibility is determined by the following factors: experience or at risk of incarceration, substance abuse, homelessness, hospitalization, or removal from the home, as well as the individual's age and a case manager or clinician recommendation.

The specificity and number of these FSP programs is both an asset and a challenge. While they enable our county to better serve specific age, cultural, and geographical groups, our county often struggles to establish consistent FSP service guidelines, evaluate outcomes, or disseminate best practices.

A common, recurring theme at community engagement gatherings has resonated toward offering more concentrated care for the seriously and persistently mentally ill homeless population. Along this line, Ventura County conducted a Mental Health Needs Assessment recently that indicated a need to address issues of homelessness and dual diagnosis as priority populations. Ventura County FSP services are fewer for those under 18 years of age and with respect to ethnicity. There has been consistent communication in Santa Paula and Oxnard community meetings to stress the need to increase services in breadth and depth to the Latinx community. A more cohesive suite of services for step up and step

down crisis aversion. To this end, Ventura County has opened up two Crisis Stabilization Units in the past two years however the feedback continues to be that there is need for more to be done.

Conversations with Ventura County FSP staff and clinicians have revealed that outcome goals and metrics are not regularly reassessed or informed by community input, nor are they well-connected to actual services received and provided by FSP programs. There is not a shared, clear understanding of FSP service guidelines among providers and county department staff—interpretation and implementation of these guidelines varies widely. Further, there is not a standard documented model of care designed for each FSP age grouping (Youth, TAY, Adult, Older Adult). FSP has a different meaning and objectives within each group, but is not formally documented. As age categories are further documented, identifying the idiosyncratic challenges particular to each target group due to the needs being very different.

Staff and clinicians have also indicated that data is collected for state mandated compliance and does not inform decision-making or service quality improvements. In addition, data is collected within one system, but outcomes are designed to be measured with cross-agency data collection systems (such as health care, criminal justice, etc.) meaning many counties are reliant on self-reported progress toward outcomes rather than verified sources. Providers and peer agencies do not have a forum to meet regularly and share learnings and best practices or discuss opportunities. Standards for referral, enrollment, and graduation are inconsistent or outdated. Finally, there is a need for more clarity in the understanding of FSP funding allowances. The “whatever it takes” category is especially open to interpretation and there’s no standard across counties to compare approved expenditures or to know what resources are available through FSP funds

Response to Local Need

Through this Innovation proposal, Ventura County seeks to participate in the statewide initiative to increase counties’ collective capacity to gather and use data to better design, implement, and manage FSP services. The key priorities outlined in the Innovation Plan will allow Ventura County Behavioral Health to address current challenges and center FSP programs and services around meaningful outcomes for participants. More specifically, participating in this project and aligning with the identified priorities will enable the department to:

1. Develop a clear strategy for how outcome goals and performance metrics can best be tracked using existing state and/or county-required tools to support meaningful comparison, learning, and evaluation.
2. Explore how appropriate goals and metrics may vary based on population.
3. Update and disseminate clear FSP service guidelines using a common FSP framework that reflects clinical best practices.
4. Create or strengthen mechanisms for sharing best practices and fostering cross-provider learning.
5. Improve existing FSP performance management practices (i.e., when and how often program data and progress towards goals is discussed, what data is included and in what format, how next steps and program modifications are identified).

In addition, this project will provide Ventura County Behavioral Health the opportunity to share and exchange knowledge with other counties through the statewide Outcomes-Driven FSP Learning Community.

Local Community Planning Process

The community planning process helps Ventura County determine where to focus resources and effectively utilize MHSA funds in order to meet the needs of county residents. The community planning process includes participation from the Board of Supervisors, Behavioral Health Advisory Board, providers, and community members. Since the community planning process is ongoing, stakeholders will continue to receive updates and provide input in future meetings.

The project was shared in the following Behavioral Health Advisory Board subcommittee meetings:

- Adult Committee on Thursday, November 7, 2019
- Executive Meeting on Tuesday, November 12, 2019
- Prevention Committee on Tuesday, November 12, 2019
- Youth & Family Committee on Wednesday, November 13, 2019
- TAY Committee on Thursday, November 21, 2019
- General Meeting on Monday, November 18, 2019

This project was shared as a part of the 3 year-plan update in the section of proposed use of Innovation funds. A more detailed draft plan proposal was posted for a 30-day public comment period beginning on December 16, 2019. The Behavioral Health Advisory Board held a public hearing on the proposed plan on January 27, 2020. The plan will be revised based on any feedback received, after which it is scheduled to go before the Ventura County Board of Supervisors for review and final approval on March 10, 2020.

County Budget Narrative

Ventura County will contribute $979,634 using MHSA Innovation funds over the 4.5-year project period to support this statewide project. As of this time, Ventura County intends to use funding subject to reversion at the end of FY 19-20 for the entirety of this contribution.

As detailed below, Ventura County will pool most of this funding with other counties to support consultant and contracting costs, with a small portion of Ventura County's funding also set aside for county staff travel and administrative costs:

- *County Travel and Administrative Costs:* Ventura County anticipates travel costs up to $13,000 over the 4 years, or $3,000 per year, which may vary based on the number of staff traveling and the number of in-person convening's. Based on current rates for administrative costs, Ventura County will allocate $296,801 for 4 years of personnel costs. The following positions have been allocated at a few hours annually over the next few years in order to achieve the project goals of system change.
    - Senior Project Manager
    - Program Administrator
    - Quality Assurance Administrator

- Electronic Health Record System Coordinator
- Behavioral Health Clinician

- *Shared Project Costs:* The remaining amount, $593,412 will support project management and technical assistance (e.g., Third Sector's technical assistance in project implementation), fiscal intermediary costs, and evaluation.

County Budget Request by Fiscal Year

The table below depicts Ventura County's year-over-year contribution to the Multi-County FSP Innovation Project.

County Budget Request and Expenditures by Fiscal Year and Budget Category

BUDGET BY FUNDING SOURCE AND FISCAL YEAR							
EXPENDITURES							
Personnel Costs (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
1	Salaries	$21,531	$65,797	$67,771	$44,909	$46,256	$246,264
2	Direct Costs						
3	Indirect Costs						
4	Total Personnel Costs	$21,531	$65,797	$67,771	$44,909	$46,256	$246,264
Operating Costs (travel, hotel)		**FY 19/20**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**
5	Direct Costs	$1,000	$3,000	$3,000	$3,000	$3,000	$13,000
6	Indirect Costs	$9,785	$29,293	$29,293	$29,293	$29,294	$126,958
7	Total Operating Costs	$10,785	$32,293	$32,293	$32,293	$32,294	$139,958
Non-Recurring Costs (technology, equipment)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
8	Direct Costs	$0	$0	$0	$0	$0	$0
9	Indirect Costs	$0	$0	$0	$0	$0	$0
10	Total Non-Recurring Costs	$0	$0	$0	$0	$0	$0
Consultant Costs/Contracts (training, facilitation, evaluation)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
11a	Direct Costs (Third Sector)	$58,353	$326,706	$113,435	$0	$0	$498,494
11b	Direct Costs (CalMHSA)	$5,850	$33,338	$12,188	$938	$938	$53,250
11c	Direct Costs (Evaluator)	$0	$10,417	$10,417	$10,417	$10,417	$41,668
12	Indirect Costs	$0	$0	$0	$0	$0	$0
13	Total Consultant Costs	$64,203	$370,461	$136,040	$11,355	$11,355	$593,412

Other Expenditures (explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
14	Program/Project Cost	$0	$0	$0	$0	$0	$0
15		$0	$0	$0	$0	$0	$0
16	Total Other Expenditures	$0	$0	$0	$0	$0	$0
EXPENDITURE TOTALS							
Personnel		$21,531	$65,797	$67,771	$44,909	$46,256	$246,264
Direct Costs		$65,203	$373,461	$139,040	$14,355	$14,355	$606,412
Indirect Costs		$9,785	$29,293	$29,293	$29,293	$29,294	$126,958
Total Individual County Innovation Budget*		$96,519	$468,551	$236,104	$88,557	$89,905	$979,634
CONTRIBUTION TOTALS							
Individual County Contribution		$64,203	$370,461	$136,040	$11,355	$11,355	$593,412
Additional Funding for County-Specific Project Costs		$32,316	$98,090	$100,064	$77,202	$78,550	$386,222
Total County Funding Contribution		$96,519	$468,551	$236,104	$88,557	$89,905	$979,634

Appendix: Fresno County Budget Tables

As mentioned above, Fresno County submitted an Innovation Project proposal to the MHSOAC in June 2019, detailing Fresno's participation in this project. This plan has been approved by the commission and thus. Additional appendix detail on local need is not included here as this information is more comprehensively outlined in Fresno's Innovation Plan proposal.

A summary of Fresno's approved budget follows below. Note that the approved Fresno County budget includes costs for Third Sector, CalMHSA and the third-party evaluation in a single total under "Other Project Expenditures"), approximately $840,000 total over the 4.5 years.

COUNTY BUDGET REQUEST BY YEAR						
	FY 19/20	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
Fresno County Funding Contribution	$237,500	$237,500	$237,500	$237,500	$0	$950,000

BUDGET BY FUNDING SOURCE AND FISCAL YEAR							
EXPENDITURES							
Personnel Costs (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
1	Salaries	$11,375	$11,944	$12,541	$13,168	$0	$49,028
2	Direct Costs	$4,857	$5,100	$5,355	$5,623	$0	$20,935
3	Indirect Costs	$0	$0	$0	$0	$0	$0
4	Total Personnel Costs	$16,232	$17,044	$17,896	$18,791	$0	$69,963
Operating Costs (travel, hotel)		**FY 19/20**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**
5	Direct Costs	$10,000	$10,000	$10,000	$10,000	$0	$40,000
6	Indirect Costs	$0	$0	$0	$0	$0	$0
7	Total Operating Costs	$10,000	$10,000	$10,000	$10,000	$0	$40,000
Non-Recurring Costs (technology, equipment)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
8	Direct Costs	$0	$0	$0	$0	$0	$0
9	Indirect Costs	$0	$0	$0	$0	$0	$0
10	Total Non-Recurring Costs	$0	$0	$0	$0	$0	$0
Consultant Costs/Contracts (training, facilitation, evaluation)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
11	Direct Costs	$0	$0	$0	$0	$0	$0
12	Indirect Costs	$0	$0	$0	$0	$0	$0
13	Total Consultant Costs	$0	$0	$0	$0	$0	$0

Other Expenditures (explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
14	Program/Project Cost	$221,685	$210,456	$209,604	$198,292	$0	$840,037
15		$0	$0	$0	$0	$0	$0
16	Total Other Expenditures	$221,685	$210,456	$209,604	$198,292	$0	$840,037
BUDGET TOTALS							
Personnel		$11,375	$11,944	$12,541	$13,168	$0	$49,028
Direct Costs		$14,857	$15,100	$15,355	$15,623	$0	$60,935
Indirect Costs		$221,685	$210,456	$209,604	$198,292	$0	$840,037
Total Individual County Innovation Budget*		$247,917	$237,500	$237,500	$227,083	$0	$950,000

Appendix: San Mateo County Budget Tables

As noted above, San Mateo County does not have MHSA INN funds available to commit to this project, but instead intends to use unspent MHSA CSS funds to participate in the goals and activities of this project, alongside other counties. These are one-time funds that have been designated and approved through a local Community Program Planning (CPP) process to meet a similar purpose and set of objectives as the Multi-County FSP Innovation Project.

Local Community Planning Process

On October 2, 2019, the San Mateo County MHSA Steering Committee reviewed a "Plan to Spend" one-time available funds, developed from input received through the following:

- The previous MHSA Three-Year Plan CPP process - 32 community input sessions
- Behavioral Health and Recovery Services budget planning - 3 stakeholder meetings
- Additional targeted input sessions to further involve community-based agencies, peers, clients and family members in the development of the Plan to Spend including:
    - MHSARC Older Adult Committee – June 5, 2019
    - MHSARC Adult Committee – June 19, 2019
    - MHSARC Youth Committee – June 19, 2019
    - Contractor's Association – June 20, 2019
    - Office of Consumer and Family Affairs/Lived Experience Workgroup – July 2, 2019
    - Peer Recovery Collaborative – August 26, 2019

The Plan to Spend included $500,000 to better align San Mateo'sSan Mateo's FSP programming with BHRS goals/values and improve data collection and reporting. The proposed Multi-County FSP Innovation Project was brought forward as the means to accomplish this goal. San Mateo's local mental health board, the Mental Health and Substance Abuse and Recovery Commission (MHSARC), reviewed the Plan to Spend and on November 6, 2019 held a public hearing, reviewed comments received and voted to close the 30-day public comment period. The Plan to Spend was subsequently approved by the San Mateo County Board of Supervisors on April 7, 2020. The Plan to Spend also included $250,000 for any ongoing needs related to FSP program improvements. San Mateo has brought forward the proposed Multi-County FSP Innovation Project as the means to accomplish this longer-term goal. The update to the Plan to Spend will be included in the current San Mateo County FY 2020-2023 Three-Year Plan and Annual Update, which will be brought to the San Mateo County Board of Supervisors for approval, likely in August 2020. San Mateo is not submitting a proposal to use INN funds. Detailed appendix information is thus not included below, though a summary of San Mateo's intended funding amounts and expenditures follows below. Note that, like other counties, these amounts are subject to change and further local input and approval.

COUNTY BUDGET REQUEST BY YEAR						
	FY 19/20	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
San Mateo County Funding Contribution	$500,000	$250,000	$0	$0	$0	$750,000

BUDGET BY FUNDING SOURCE AND FISCAL YEAR							
EXPENDITURES							
Personnel Costs (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
1	Salaries	$0	$0	$0	$0	$0	$0
2	Direct Costs	$0	$0	$0	$0	$0	$0
3	Indirect Costs	$0	$0	$0	$0	$0	$0
4	Total Personnel Costs	$0	$0	$0	$0	$0	$0
Operating Costs (travel, hotel)		**FY 19/20**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**
5	Direct Costs	$0	$0	$0	$0	$0	$0
6	Indirect Costs	$0	$0	$0	$0	$0	$0
7	Total Operating Costs	$0	$0	$0	$0	$0	$0
Non-Recurring Costs (technology, equipment)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
8	Direct Costs	$0	$0	$0	$0	$0	$0
9	Indirect Costs	$0	$0	$0	$0	$0	$0
10	Total Non-Recurring Costs	$0	$0	$0	$0	$0	$0
Consultant Costs/Contracts (training, facilitation, evaluation)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
11a	Direct Costs (Third Sector)	$58,353	$326,706	$113,435	$0	$0	$498,494
11b	Direct Costs (CalMHSA)	$5,850	$33,338	$12,188	$938	$938	$53,250
11c	Direct Costs (Evaluator)	$0	$49,564	$49,564	$49,564	$49,564	$198,256
12	Indirect Costs	$0	$0	$0	$0	$0	$0
13	Total Consultant Costs	$64,203	$409,608	$175,187	$50,502	$50,502	$750,000
Other Expenditures (explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**Total**
14	Program/Project Cost	$0	$0	$0	$0	$0	$0
15		$0	$0	$0	$0	$0	$0
16	Total Other Expenditures	$0	$0	$0	$0	$0	$0
BUDGET TOTALS							
Personnel		$0	$0	$0	$0	$0	$0
Direct Costs		$64,203	$409,608	$175,187	$50,502	$50,502	$750,000
Indirect Costs		$0	$0	$0	$0	$0	$0
Total Individual County Budget*		$64,203	$409,608	$175,187	$50,502	$50,502	$750,000

APPENDIX 11 INNOVATION EVALUATION REPORTS, FY 2018-19

San Mateo County Pride Center
Fiscal Year 2018-19 Evaluation Report

A Mental Health Services Act Innovation Project

Prepared by:

Resource Development Associates

December 2019

Table of Contents

Introduction

Project Overview and Learning Goals

The San Mateo County Pride Center is an Innovation (INN) program under the Mental Health Services Act (MHSA) that is funded by the San Mateo County Behavioral Health Recovery Services (BHRS) department. The San Mateo County Pride Center (Pride Center or the Center) is a formal collaboration of four partner organizations: StarVista, Peninsula Family Services, Adolescent Counseling Services, and Daly City Partnership.

- **MHSA INN Project Category:** Introduces a new mental health practice or approach.
- **MHSA Primary Purpose:** 1) Promote interagency *collaboration* related to mental health services, supports, or outcomes and 2) Increase *access* to mental health services to underserved groups.
- **Project Innovation**: While it is not new to have an LGBTQ center providing social services, there is no model of a coordinated approach across mental health, social and psycho-educational services for this marginalized community.

The Mental Health Services Oversight and Accountability Commission (MHSOAC) approved the project on July 28, 2016, and BHRS began implementation in September 2016. The Pride Center opened to the public on June 1, 2017. The following report provides findings from the third year of implementing the San Mateo County Pride Center, from July 1, 2018 to June 30, 2019.[1]

In accordance with the requirements for MHSA INN programs, BHRS selected two Learning Goals—Collaboration and Access—as priorities to guide the development of the Pride Center. As Figure 1 demonstrates, BHRS sought to explore how this innovative model of coordinated service delivery and community engagement could enhance access to mental health services within underserved LGBTQ+ populations, particularly for individuals at high risk for, or with, acute mental health challenges. In turn, the program domains of Collaboration and Access are areas in which the Pride Center might serve as a model to expand of mental health services for LGBTQ+ individuals in other regions.

Figure 1: San Mateo County Pride Center Learning Goals

Learning Goal 1 (Collaboration)	Learning Goal 2 (Access)
• Does a coordinated approach improve service delivery for LGBTQ+ individuals at high risk for or with moderate to severe mental health challenges?	• Does the Pride Center improve access to behavioral health services for LGBTQ+ individuals at high risk for or with moderate or severe mental health challenges?

[1] Because the first year of implementation was devoted to planning, development, and startup of the Pride Center, this report sometimes refers to this third year of the program as the "second year of operations." That is, the Pride Center itself has been open to the public for two years, while the Innovation program has been active for 3 years.

Project Need

Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and other (LGBTQ+) individuals commonly experience depression, anxiety, suicidal thoughts, substance abuse, homelessness, social isolation, bullying, harassment, and discrimination. LGBTQ+ individuals are at higher risk of mental health issues compared to non-LGBTQ+ individuals given that they face multiple levels of stress, including subtle or covert homophobia, biphobia, and transphobia.[2] Across the United States, a majority (70%) of LGBTQ+ students report having experienced harassment at school because of their sexual orientation and/or gender identity, and suicide is the second leading cause of death for LGBTQ+ youth ages 10-24.[3]

These nationwide trends are no less evident in San Mateo County. According to the San Mateo County LGBTQ Commission's 2018 countywide survey of 546 LGBTQ+ residents and employees, nearly half of adult respondents (44%) identified a time in the past 12 months when they felt like they needed to see a professional for concerns about their mental health, emotions, or substance use. At the same time, 62% of adult respondents felt that there are not enough local health professionals adequately trained to care for people who are LGBT, and fewer than half (43%) felt their mental health care provider had the expertise to care for their needs. Among LGBTQ+ youth who responded to the survey, three-quarters (74%) reported that they had considered harming themselves in the past 12 months, and two-thirds (65%) did not know where to access LGBTQ+ friendly health care.[4]

In this context, BHRS developed the San Mateo County Pride Center as a coordinated behavioral health services center to address the need for culturally specific programs and mental health services for the LGBTQ+ community. The establishment of the Pride Center also fulfills the MHSA principle to promote interagency collaboration and increase access to mental health services for underserved groups.

Project Description and Timeline

As a coordinated service hub that meets the multiple needs of high-risk LGBTQ+ individuals, the Pride Center offers services in four components:

1. *Social and Community Activities*: The Pride Center aims to outreach, engage, reduce isolation, educate, and provide support to high-risk LGBTQ+ individuals through peer-based models of wellness and recovery that include educational and stigma reduction activities.
2. *Clinical Services*: The Pride Center provides mental health services focusing on individuals at high risk of or already with moderate to severe mental health challenges.
3. *Resource Services*: The Pride Center serves as a hub for local, county, and national LGBTQ+ resources, including the creation of an online and social media presence. Pride Center staff host

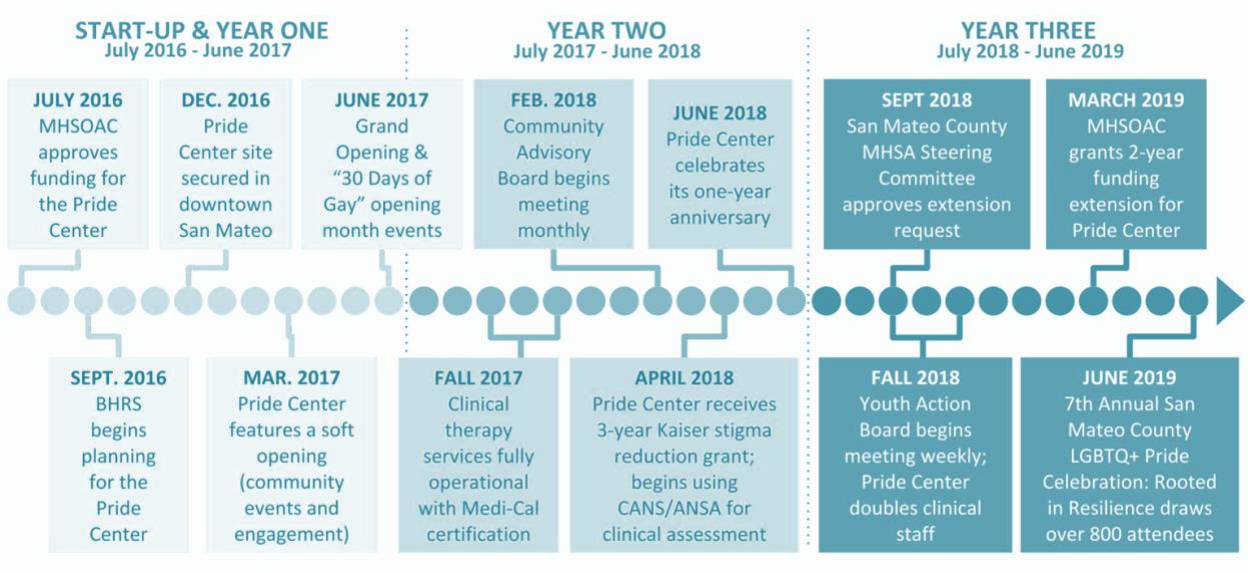
[2] King, M., Semlyen, J., Tai, S. S., Killaspy, H., Osborn, D., Popelyuk, D., & Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self-harm in lesbian, gay and bisexual people. BMC Psychiatry, 8:70
[3] GLSEN, *2017 National School Climate Survey*; The Trevor Project, "Facts About Suicide." <<https://www.thetrevorproject.org/resources/preventing-suicide/facts-about-suicide/>>
[4] San Mateo County LGBTQ Commission, "Survey Results of San Mateo County LGBTQ+ Residents and Employees," 2018 ed.

year-round trainings and educational events for youth, local public and private sector employees, community service providers, and other community members. Common topics include understanding sexual orientation and gender identity, surveying common LGBTQ+ issues and mental health challenges, and learning how to provide culturally affirmative services to LGBTQ+ clients.

Project Timeline

Figure 2 illustrates some of the key activities that have occurred since the Pride Center first became an MHSA Innovation project in July 2016.

Figure 2: Pride Center Project Timeline

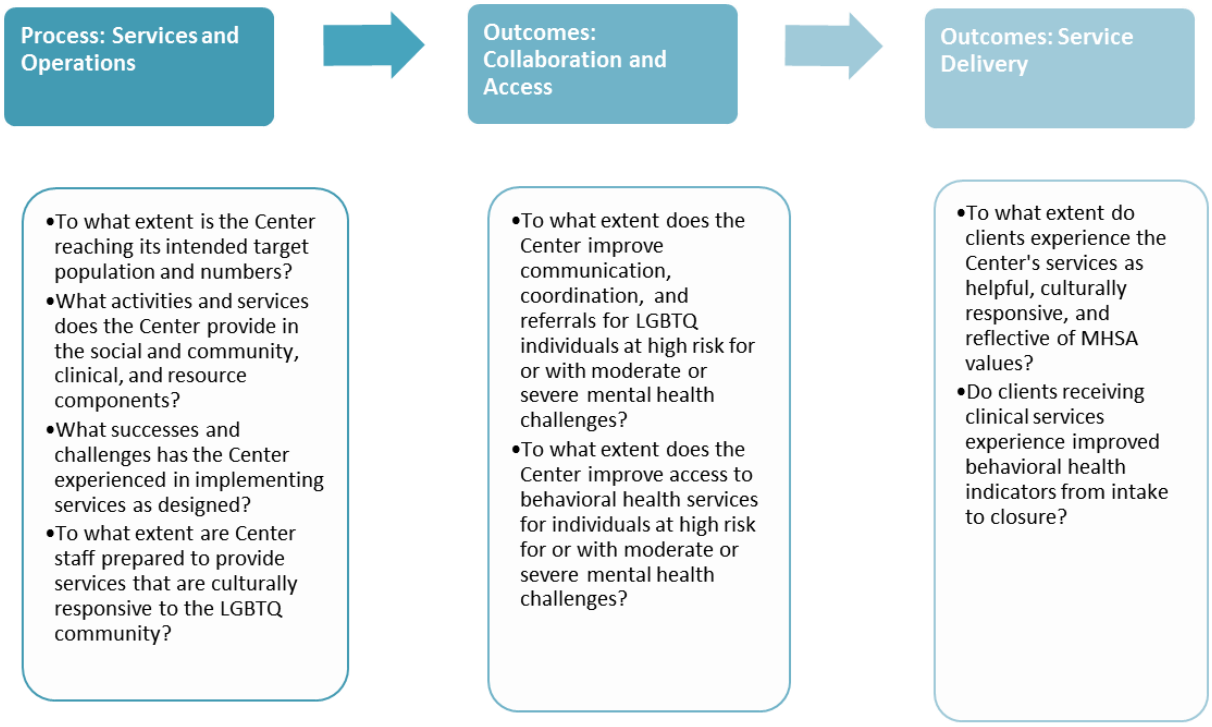


Evaluation Overview

In 2017, BHRS contracted Resource Development Associates (RDA) to conduct the evaluation of the Pride Center implementation and outcomes. RDA collaborated with BHRS staff, Center leadership staff, and Center partners to develop data collection tools measure program and service outcomes. In order to maximize RDA's role as research partners and fulfill MHSA Innovation evaluation principles, this evaluation uses a collaborative approach throughout, including Pride Center staff and partners in operationalizing the evaluation goals into measurable outcomes and interpreting and responding to evaluation findings.

BHRS seeks to learn how the Pride Center enhances access to culturally responsive services, increases collaboration among providers, and, as a result, improves service delivery for LGBTQ+ individuals at high risk for or with moderate to severe mental health challenges. To guide the evaluation, RDA and BHRS have developed evaluation questions in three categories (see Figure 3). 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 3. Evaluation Domains and Questions



Evaluation Methods

RDA developed a mixed methods evaluation that incorporates both process and outcome evaluation components.

- A **mixed methods** approach allows the evaluation to track quantitative measures of service delivery and outcomes, while also gathering qualitative input on how and why activities and outcomes occurred. Using multiple sources to explore the evaluation questions also enables comparison and corroboration of findings across data sources.
- The **process evaluation** component explores the extent to which the Pride Center has been implemented as planned, as well as the strengths and challenges the county has experienced in implementation. The process evaluation considers the perspective of various stakeholders, including Pride Center staff and participants alike. Evaluating the implementation of Pride Center activities and services enables BHRS, Pride Center leadership staff, and Center partners to make real-time adjustments that may improve the operations and outcomes of the Center.
- The **outcome evaluation** component assesses the extent to which the Pride Center—through its collaborative approach to service delivery—improves access to services and client-level behavioral health outcomes.

Data Collection

In line with RDA's mixed methods approach, this evaluation includes both quantitative and qualitative tools to measure indicators in three domains: Center services and operations, the Center's Learning Goals (Collaboration and Access to Services), and service delivery outcomes. Below we describe the measures that the evaluation will use along with the data collection methods that we will use to measure each of the indicators. Please see Appendix A for a detailed data collection plan.

Collaboration Survey

As collaboration is the core innovative element of this MHSA INN project, it was crucial for the evaluation team to operationalize the concept of collaboration so that it could be measured over time. RDA researched validated survey tools intended to measure collaboration among a team of service providers, including both management-level staff (who may not work directly with clients) and direct service staff. RDA and BHRS selected the Assessment of Interprofessional Team Collaboration Scale II (AITCS-II), developed by Dr. Carole Orchard.[5]

AITCS-II is a diagnostic instrument that is designed to measure the interpersonal dynamics and teamwork among health services coworkers. It consists of 23 statements, representing three elements that are considered to be key to interprofessional collaborative practice: 1) Partnership, 2) Cooperation, and 3)

[5] Orchard, C. A., King, G. A., Khalili, H. and Bezzina, M. B. (2012), Assessment of Interprofessional Team Collaboration Scale (AITCS): Development and testing of the instrument. J. Contin. Educ. Health Prof., 32: 58–67. doi:10.1002/chp.21123

Coordination. Respondents indicate their general level of agreement with each statement on a 5-point Likert scale that ranges from 1 (Never) to 5 (Always). The survey takes approximately 10 minutes to complete. To facilitate survey administration, RDA transferred the survey onto the online 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 RDA's online version of the AITCS-II.

Attendance and Demographic Reporting

To document the Pride Center's service population, Center staff and RDA collaborated to create a protocol for monitoring the number and characteristics of individuals who participate in onsite programs and services. Because the Pride Center provides an array of services with varying degrees of participation—including drop-in services, one-time community events, ongoing peer support groups, and clinical services—it was important to define what constitutes *meaningful* participation at the Pride Center for the purposes of collecting and reporting demographic data to the MHSOAC.

The Pride Center serves marginalized individuals who may be hesitant to provide personal information on paper, even anonymously. Asking new attendees to fill out an extensive demographic form could feel unwelcoming to individuals who have experienced fear, stigma, and trauma related to their LGBTQ+ identity or other life circumstances. In order to maintain a welcoming environment, Center staff determined that individuals who attend the Center *more than once*, as well as any clients receiving clinical services, would be considered meaningful participants and would be asked to complete a demographic form. To capture the total number of individuals served, the Pride Center decided to also track attendance through a sign-in sheet that captures basic personal information, but does not include the full range of demographic variables listed in the updated INN regulations.

The demographic form was designed to capture all elements required by the MHSOAC. The Pride Center and its partners decided to add additional categories to the questions regarding sexual orientation and gender identity in order to include a wider spectrum of LGBTQ+ identities. These revisions were aligned with BHRS's initiative to revise Sexual Orientation 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. In the summer of 2019, the Pride Center staff and RDA made a few additional changes to some of the demographic categories: rewording some of the options for sexual orientation and gender identity, streamlining the options for ethnicity, adding a separate question about intersex identity, and revising the options for housing status to align better with commonplace categories in homelessness services systems.

RDA developed an online format of the demographic survey using a HIPAA-compliant version of Survey Gizmo, which Pride Center staff used to input data for paper surveys through the end of 2018. Starting in January 2019, the Pride Center began collecting participant demographic data in Efforts to Outcomes (ETO), StarVista's client management database. The current version of the demographic questions is included in Appendix C.

Participant Experience Survey

RDA developed a survey to gauge Pride Center participants' experiences and approval of the Center's onsite programs, staff members, mental health services, and community space. The survey is designed to be administered annually at a point in time to as many participants as possible, through both paper and online formats. The survey includes 13 statements that invite respondents to indicate their level of agreement with each statement on a four-level Likert scale (Disagree, Somewhat Disagree, Somewhat Agree, Agree). In addition, the survey asks the number of times participants have visited the Pride Center and contains an optional demographic section. RDA developed an online format of the demographic survey using a HIPAA-compliant version of Survey Gizmo. Paper surveys were entered into the online form. The Participant Experience Survey is included in Appendix D.

Clinical Assessment and Survey Data

This program year marks the first time that the evaluation analyzes Pride Center data on clinical services utilization and patient assessments. There are four main data sources in this subset for all participants who accessed clinical services between July 1, 2018 and June 30, 2019:

1. **Type of service and average durations of treatment.** This data indicates the type of service (individual, couple, family, or group) and the average number of months clients were enrolled in clinical services.
2. **Demographic data for participants.** Analyzing the demographic background of clinical participants allows for a comparison with the demographics of all Pride Center participants.
3. **Baseline results from the Child and Adolescent Needs and Strengths (CANS) and Adult Needs and Strengths Assessment (ANSA)**. The CANS and ANSA are open domain tools for use in multiple individual-serving systems that address the needs and strengths of individuals, adolescents, and their families. San Mateo County BHRS has designated the CANS as the required tool for its contracted providers. The Pride Center standardized the use of the CANS and ANSA for all clinical clients during the 2018-2019 program year, and trained staff to conduct the assessment and enter the data into ETO. Staff administer the assessment at intake, at regular follow-up intervals, and at discharge to gauge clients' progress during their time in clinical services. For this program year, the evaluation team is only analyzing intake data as a baseline, as there is only a small number of follow-up assessments completed to date. The CANS and ANSA are included in Appendix E.
4. **Baseline results from a brief mental health self-assessment.** This short, three-question survey that the Pride Center developed in consultation with RDA asks participants about their mental health, anxiety levels, and emotional wellbeing over the past 30 days:
    - How would you rate your mental health in the last 30 days? (Poor/Fair/Good/Excellent)
    - How would you rate your ability to cope with stress in the last 30 days? (Poor/Fair/Good/Excellent)
    - I have benefited from the services that I am receiving or participating in at the Pride Center. (Strongly Disagree, Disagree, Neutral, Agree, Strongly Agree)

    By administering the survey alongside the more comprehensive CANS and ANSA assessments, Pride Center staff have a quick method to gauge changes in patients' wellness over time.

Focus Groups with Pride Center Participants, Staff, and Community Advisory Board

RDA conducted four focus groups with Pride Center participants—one each with youth and older adults, and two with adult participants—to gather in-depth information from individuals who accessed clinical services and participated in Center programs and events. With feedback from BHRS and the Pride Center Director, the evaluation team developed a semi-structured focus group guide to learn from participants about their experiences with programs onsite, to what extent the Pride Center facilitates access to services for LGBTQ+ individuals, and any suggestions for improvement. In addition, RDA held two other focus groups: one with Pride Center staff (minus the Program Director), and one with the Community Advisory Board. These focus groups offered insight into the Pride Center's operations, including the extent to which staff members have been able to collaborate with each other, the CAB, and the partner organizations.

Key Informant Interviews with Partner Organizational Staff

In October 2019, the evaluation team conducted separate phone interviews with staff members from StarVista and Peninsula Family Services to gain insight into the roles and responsibilities of partner organizations vis-à-vis the Pride Center, the kinds of regular support that the partner organizations provide, and staff's perspectives on the Pride Center's major successes and challenges.

Measures and Data Sources

Table 1 indicates the key measures and data sources the evaluation uses to assess outreach and implementation, collaboration and access to services, and service delivery outcomes.

Table 1. Evaluation Measures and Data Sources

Outreach and Implementation of Services	Data Sources
Number of individuals reached	• 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 Group with Staff • Quarterly progress reports
Successes and challenges of implementing services as designed	• Focus Group with Staff • Interviews with Center Leadership and partners • Focus Group with Community Advisory Board (CAB) • Regular communications with Pride Center leadership and staff
Cultural responsiveness of services	• Focus Groups with Participants • Focus Group with Staff • Participant Experience Survey

Collaboration and Access to Services	Data Sources
Effectiveness of communication, coordination, and referrals for LGBTQ+ individuals with moderate to severe mental health challenges	• Focus Group with Staff • 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	• Clinical Service Data • Participant Experience Survey • Focus Groups with Participants

Data Analysis

To analyze the quantitative data from demographic forms and the collaboration survey, RDA examined frequencies, averages, and ranges. To analyze qualitative data, RDA transcribed focus group and interview participants' responses to appropriately capture the responses and reactions of participants. RDA thematically analyzed responses from participants to identify commonalities and differences in participant experiences.

Implementation Update

Changes to Innovation Project during Reporting Period

In March 2019, the Mental Health Services Oversight and Accountability Commission (MHSOAC) approved a two-year funding extension for the Pride Center as an MHSA Innovation Program. The MHSOAC unanimously approved the extension request, following a panel presentation to the Commission. Nearly fifty Pride Center participants traveled to Sacramento to demonstrate their support, and celebrate in the success.

Pride Center staff worked closely with BHRS, RDA, and community partner to build a case for the extension. Center staff and supporters successfully made the case that two additional years of MHSA funding would help the Center strengthen its internal and countywide collaboration efforts, measure clients' clinical outcomes, and develop a set of best practices for others to replicate the Pride Center's service delivery model.

Key Accomplishments

Services, Programs, and Community Presence

In its second year of operations, the Pride Center continued to operate many of the programs, services, and events that Center staff and participants launched during the first year. These ongoing activities include:

- *Providing psychotherapy services for individuals, groups, couples, and families.* Staff provided clinical services to 88 individuals during the program year. Pride Center clinicians employ a range of different modalities, including cognitive and dialectical behavioral therapy (CBT and DBT), mindfulness-based therapy, emotionally focused couples' therapy, narrative therapy, play therapy, and expressive arts therapy.

- *Providing case management services*. A dedicated case manager supports participants in accessing supportive resources and coordinating services. These services include both weekly drop-in hours and long-term case management

- *Operating the Center as a "one-stop shop" and resource hub for LGBTQ+ community members.* The Pride Center continues to host an LBGTQ+ resource library, and provides community members with free amenities like clothing, toiletries, makeup products, shoes, bags, safer sex products, and chest binders (gender-affirming items used by the transgender, genderqueer, and nonbinary community). In addition, Pride Center staff help to field participants' ad hoc needs and requests for support.

- *Hosting multiple peer support groups* (PSGs). PSGs active during the program year include:
    - Coffee Break (Ages 50+)
    - Gay Men's Group (Ages 18+)

- Grown Folks (Ages 18-30)
- LGBTQ+ Youth Group (ages 10-17)
- Polyamory Peer Power (Ages 18+)
- Queer Trans People of Color "QTPOC" Group hosted in East Palo Alto (Ages 18+)
- Queer Woxmn's Group (Ages 18+)
- Sunshine Series (Ages 50+)
- Trans Group (Ages 18+)

- *Operating Youth Programs, for participants ages 10 to 25*. The Youth Group meets on a weekly basis, and regularly draws one to two dozen participants. Over the program year, 53 unique individuals participated in the Youth Group. Other Youth Programs include Grown Folks, a smaller group for participates between the ages of 18 and 30; coordination of Gender and Sexuality Alliance (GSA) student organizations across campuses; and regular outreach to high schools across the county. The Pride Center also partnered with Outlet to host the third annual Queer Youth Prom in the spring of 2019, which drew youth from 12 different high schools and raised around $7,000. The Pride Center has contracted with the Cupertino Union School District to offer a multipart program at Kennedy Middle School, which includes two therapy groups for students with mental health care needs, a bilingual discussion and training session for parents, an educational assembly for all students, and SOGI trainings for school staff.

- *Operating Older Adult Programs, for people ages 50 and older who live or work in San Mateo County*. A total of 88 unique individuals participated during the program year. Programs and activities for older adults include a weekly Mindfulness Meditation, a monthly lunch, a monthly book club, and a quarterly Senior Affordable Housing Workshop. For the second year in a row, older adult participants also shared their life stories for the Oral History Legacy Project, a student research project for the “Queer Identities” class at Notre Dame de Namur University.

- *Running many different educational events, social activities, and community-based programs at the Center throughout the year*. These events include regular film screenings, speakers’ events and discussions, meals and coffee breaks, informational sessions, and events cosponsored with other organizations and companies. In addition, during the 2018-19 program year, Pride Center staff continued to host periodic activities begun in the first year of public operations:

    - The Center continues to host quarterly intergenerational meals, which bring together participants of all ages to share food and build community.

    - For the second year in a row, the Center coordinated the “In Bloom” project. During the 2018 Transgender Day of Visibility, staff hosted a photograph shoot featuring transgender and gender nonconforming participants. The goals of “In Bloom” include supporting participants’ self esteem, increasing the visibility of non-cisgender community members, decreasing participants’ social isolation, and shifting the broader community’s perceptions and understanding of gender identity. "In Bloom" photos were used in a Pride

Center social media outreach campaign and also displayed as part of an art installation at a prominent local coffee shop (Philz in Burlingame).

- *Training public agencies and private organizations on matters of sexual orientation and gender identity, both at the Pride Center and throughout the county*. Staff regularly conduct trainings for service providers, public employees, youth, and many other community members throughout the county. The most common training module involves core information about SOGI and LGBTQ+ inclusion. Staff also conducted trainings on transgender rights, trans-inclusive policies, gender pronouns, and cultural humility. Between January and June 2019, Pride Center staff trained 966 people across 37 separate trainings across the county. While precise data are unavailable for the first half of the program year, Pride Center staff estimate that they hosted around 50 trainings for over 1,500 people over the entire year.

- *Conducting year-round outreach across San Mateo County.* Pride Center staff regularly attempt to establish new partnerships with clinical providers, community organizations, schools, and other key stakeholders across the county. Staff members make educational presentations, staff tables at health fairs and other informational events, and participate in other community gatherings. Outreach serves multiple purposes: establishing referral pathways with other service providers, building a greater community presence, informing the broader public about the Center, SOGI, and LGBTQ+ issues, and engaging potential participants, particularly youths and older adults.

- *Partnering with other LGBTQ+ inclusive county events and programs*. The Center continues to serve as a meeting space for the San Mateo County PRIDE Initiative and the LGBTQ Commission. In addition, Pride Center staff regularly collaborate with these community partners to host educational and social events. Among the Center's collaborative efforts this program year included:
    - The first Youth Advocacy and Support Summit (YAASS) for LGBTQ+ high school students and allies in San Mateo County, which the Youth Program Coordinator helped to plan;
    - A youth speakers' panel for the Transgender Day of Remembrance, in partnership with the county's Office of Equity and Diversity, the LGBTQ Commission, and Communities Overcoming Relationship Abuse;
    - A Youth Pride Night for young people in the North Bay, in collaboration with the Daly City Youth Health Center;
    - The first-ever Family Pride Day at the San Mateo County Fair, which represented a new partnership between the Center and the County Fair

Center staff expanded programming for, and about, LGBTQ+ people of color. Among the Pride Center's long-term goals has been increasing participation among nonwhite community members, and ensuring that its services and programs are culturally affirmative. In February 2019, the Pride Center held its quarterly Intergenerational Dinner in honor of Black History Month, featuring a trivia competition about Black LGBTQ+ social movements. During the following Pride Month, Pride Center staff partnered with the county's African American Community Initiative to host an educational event, "Black Queer Identities: An

Introduction to Black LGBTQ+ Identities and Culture." While participation fluctuated over the program year, Pride Center staff also continued to support Noches de Cumbia, a peer group for Latinx LGBTQ+ participants. The Pride Center's Peer Support Worker also started a new Queer Trans People of Color "QTPOC" peer group hosted at the Barbara A. Mouton Multicultural Wellness Center in East Palo Alto. These events affirmed the Center's commitment to exploring and accommodating *intersectional* notions of identity and belonging (e.g., identifying with multiple marginalized communities, as an LGBTQ+ person and as a person of color).

The Pride Center launched its Youth Action Board in the fall of 2018. The YAB meets on a weekly basis, and provides a space for students from different schools to convene, discuss LGBTQ+ issues, and coordinate student activities across campuses. The YAB is intended to provide a space for youth to develop their leadership skills and explore new avenues for LGBTQ+ community advocacy. A total of 13 students attended a YAB meeting during the program year, though a minority of those students have participated on a weekly basis.

The Pride Center initiated a name change workshop. The Pride Center began its monthly Legal Name and Gender Change Workshop to support transgender, genderqueer, and nonbinary individuals in July 2018. As the only local center providing this type of workshop on a monthly basis, the name change workshop has grown to be a sought-after service that has gained widespread recognition and referrals. In FY 2018-19, the clinic served 55 unique individuals from San Mateo County. Beyond San Mateo County, the clinic also served individuals from counties including Alameda, Contra Costa, Marin, San Francisco, Santa Clara, San Joaquin, and San Diego.

Infrastructure and Capacity Building

The Pride Center expanded its clinical policies and procedures to improve service delivery. With an established clinical program in place and additional clinical staff, the Pride Center was able to implement a number of workflow improvements. The Center's Clinical Coordinator oversaw the streamlining of the Center's waitlist procedures for prospective clinical patients, which helped reduce the time it took for staff to do initial follow-ups and phone screenings with clients, and the time it takes to bring in clients for assessment and intake. In addition, Center staff standardized the referral forms for other providers to use when directing their clients to the Pride Center.

Pride Center staff implemented a new standardized assessment procedure for clinical services participants. All clinical patients take two surveys at intake and during periodic follow-ups: a short screener about their current mental health and emotional wellbeing; and either the Adult Needs and Strengths Assessment (ANSA) or the Child and Adolescent Needs and Strengths (CANS), based on their age. CANS and ANSA are validated mental health surveys that help providers and patients develop care plans based on patients' core strengths and skills. Put together, these survey tools will help Pride Center staff to track clinical services and better gauge clients' progress and growth over time.

The Pride Center strengthened its data capacity by integrating with StarVista's database. During the 2018-2019 program year, Pride Center staff transferred their data tracking practices from Google Spreadsheets to ETO, StarVista's client management data system. Despite the challenges of training staff to use the new system, ETO has provided palpable benefits. For one, the database offers a safer and securer way to store clinical patients' protected health information, and maintain compliance with HIPAA regulations. ETO also offers a more stable way for staff to maintain updated numbers on their community engagement efforts, and allows the Pride Center to maintain its own participant demographic data instead of relying on SurveyGizmo.

The Community Advisory Board (CAB) expanded its roles and responsibilities. In its first full year of existence, the CAB was able to build out some key duties for its members. For instance, the CAB assigned various members to support individual staff members, as one strategy to reduce staff workloads and lessen the chance for burnout. CAB members also continue to explore potential funding sources and avenues for sustainability; support the Youth Action Board; and help to plan Center events, such as the Adult Prom.

The Pride Center grew capacity and experience in grantwriting and development over the program year, strengthening the Center's efforts to build a larger base of donations. During the program year, the Pride Center's Grant Writer and Development Associate participated in a fellowship through the American Fundraising Professionals, which provided professional skill-building in donor development and fundraising strategy. The Development Associate also worked with StarVista's Development staff to create a corporate sponsorship package for future fundraising events and efforts.

The Pride Center recruited new staff members, both to replace outgoing staff and to expand the number of employees. During the third quarter of 2018, the Center added three new clinicians, doubling the number of clinical staff. During the second quarter of 2019, the Center hired a Community Outreach Coordinator to replace an outgoing staff member. As well, the Center brought on a participant from the Senior Community Service Employment Program (SCSEP), who helps out with administrative and outreach activities on a part-time basis. SCSEP provides on-the-job training opportunities for low-income seniors. In addition, multiple existing staff members stepped into new roles and responsibilities: the Case Manager was promoted to Lead Case Manager and Clinical Data Coordinator, the Lead Mental Health Clinician became the Clinical Coordinator, and the Peer Support Worker assumed the role of Training and Peer Group Coordinator.

Consumer Population

Numbers Served

All Participants

During FY 2018-19, nearly 3,000 people accessed Pride Center programs, trainings, and services. This includes 1,213 unique individuals who completed a sign-in sheet onsite, and 1,526 people who participated in a training held by Pride Center staff. The total number of people is larger than the sum of these two, as Pride Center staff were unable to tally the number of unique individuals (ages 18 and older) who attended a peer group, or who were members of other programs (such as PFLAG or Alcoholics Anonymous) who convened at the Pride Center. In addition, the Pride Center engaged many thousands more individuals through dozens of outreach efforts throughout the year. As of the end of the fiscal year, 1,280 users had accessed the Pride Center website and the Pride Center had 868 Instagram followers, 848 Facebook followers, and 200 Twitter followers.

Clinical Services

During the program year, 88 people accessed psychotherapy services. As of June 30, 2019, 34 unique individuals were actively receiving clinical services. Among all participants who accessed therapy during the program year, the average duration of service was six and a half months. Among participants who had completed clinical services, the average duration of service was five months.

Participant Background

All Participants

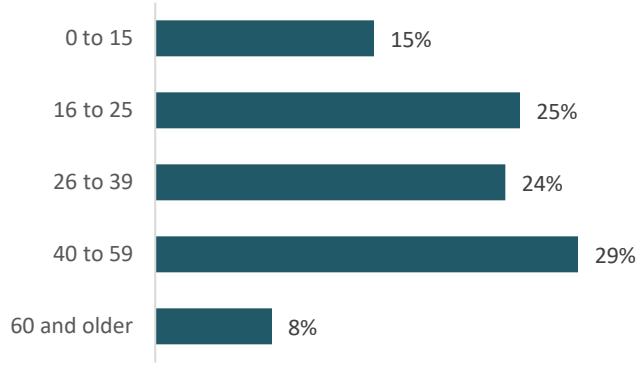
In FY2018-19, only *new participants* were asked to complete the Pride Center Participant Demographic Survey. Participants who visited the Pride Center during FY2018-19 and had already completed a demographic form in a previous year are not included in the FY2018-19 demographic calculations. Table 2 below includes a comparison of new participants in FY2018-19 to all participants from the Pride Center opening through June 30, 2019.

During FY2018-19, a total of 201 new participants completed the demographic survey. The results are summarized below and presented in full in Appendix F.[6]

[6] *Note on reporting:* To comply with HIPAA requirements and protect the confidentiality of participating individuals, this report only presents data for response categories with at least five responses. Where fewer than five responses were received, some categories have been combined.

Age: The majority of participants (78%) reported being between the ages of 16 and 59. Eight percent were 60 or older, and 15% were 15 or younger. See Figure 4 for the full range of participants' ages.

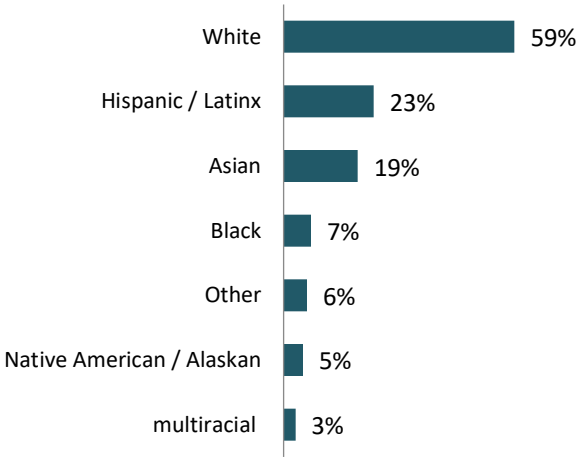
Figure 4: Center Participants by Age in FY2018-19 (n=199)



Language: Nearly all participants (96%) reported speaking English in their households. Other responses included Spanish, Cantonese, Tagalog and other languages.

Race: Slightly more than half of participants (59%) identified as white (48% identified as white only). This was followed by participants who identified as Hispanic or Latino/a/x (23%) and Asian or Asian American (19%). In total, 52% of participants identified as either multiracial or people of color (See Figure 5).

Figure 5: Pride Center Participants by Race in FY2018-19 (n=193)
note: participants could select multiple answers



When comparing the race of Pride Center participants to the population of San Mateo County in 2018, the Pride Center saw a slightly higher percentage of white participants (39% of the county, vs. 48% of participants who identified as only white) and a smaller percentage of Asian participants (30% of the county, vs. 19% of Pride Center participants). One-quarter (24%) of county residents are Hispanic or Latino/a/x, which is consistent with Latinx representation at the Pride Center (23%). Black, Native American, and Hawaiian or Pacific Islander participants and American Indian were also represented at rates somewhat comparable to the population of San Mateo County (3%, 2%, and 1% of county residents, respectively).[7]

Ethnicity: For participants in Year Three, the most commonly identified ethnicity was European. Latinx participants most commonly identified as Mexican or Chicano/a/x. Among Asian American participants, the most common ethnicities were Filipino/a/x and Chinese, with other participants identifying as South Asian, Japanese, Vietnamese, or other Southeast Asian ethnicities. Smaller proportions of the participants identified as African, Middle Eastern, Salvadoran or South American.

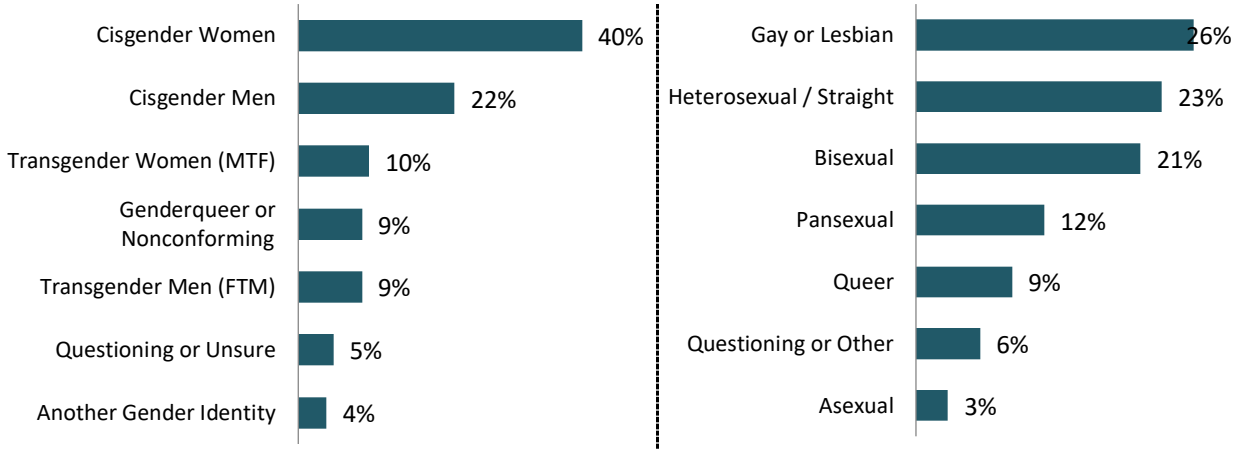
[7] "U.S. Census Bureau Quick Facts: San Mateo County, California," *U.S. Census Bureau website*. <<https://www.census.gov/quickfacts/sanmateocountycalifornia>>

Sex: Fifty-nine percent of participants responded that they were female at birth, and 40% responded that they were male at birth. Other participants identified as intersex at birth or declined to respond.

Gender Identity: In all, 62% of participants identified as cisgender: 40% percent identified as cisgender women and 22% identified as cisgender men. Nineteen percent of participants identified as either transgender men or women, and nine percent identified as genderqueer or gender non-conforming. The remainder of respondents identified as another gender identity, or as questioning or unsure of their gender identity. See Figure 6 for the full range of responses.

Sexual Orientation: Gay and lesbian individuals accounted for 26% of survey responses, and 23% of the participants identified as heterosexual or straight.[8] Twenty-one percent identified as bisexual, 12% identified as pansexual, and 9% identified as queer. The remaining participants reported that they were asexual, questioning, or identified with another sexual orientation. Figure 6 shows the full range of responses for participants' sexual orientations.

Figure 6: Participants by Gender Identity (Left) and Sexual Orientation (Right) in FY2018-19 (n=186)



[8] The high proportion of respondents who identified as straight or heterosexual is likely due to multiple factors: Pride Center staff originally administered the demographic survey to service providers who attended onsite trainings (but stopped doing so in the middle of the year); parents of LBGTQ+ youth visit the Center to access resources or attend parenting classes and peer groups, and some of these parents have completed the survey; a number of the Pride Center's transgender participants identify as heterosexual; because the Pride Center does not turn away people who are not LGBTQ+, it is possible some straight people accessed drop-in services.

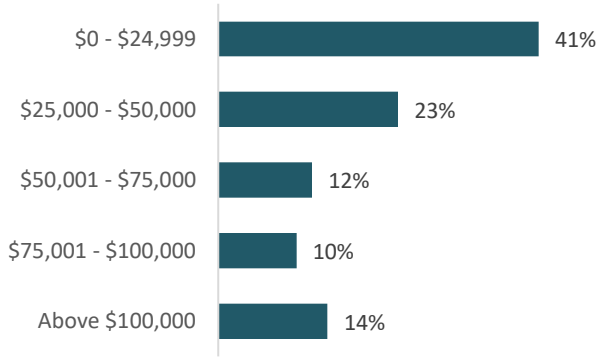
Disability Status: Two-thirds of participants (67%) reported having no disabilities or health conditions. Of those that reported some type of disability, the most commonly reported were other health problems (13%), limited physical mobility (6%), and learning disabilities (6%).

Education:[9] As a whole, adult Pride Center participants are highly educated. Among respondents, most of the participants had either earned their bachelor's degree (24%) or a graduate degree (17%). Twenty-three percent reported having some college education. The remaining respondents had an associate's degree, a vocational or trade certification, a high school diploma or GED, or less than a high school diploma.

Employment: Less than half of participants (38%) reported having full-time employment, with 17% reporting part-time employment and 24% identifying as students. Ten percent of participants were unemployed and looking at the time of the survey, and 6% were retired. The remaining participants were unemployed and not looking for a job.

Income: As Figure 7 shows, the Pride Center draws adult participants across the socioeconomic spectrum. Among survey respondents ages 26 or older, most are considered Extremely Low Income (less than $33,850) or Very Low Income (less than 56,450) for San Mateo County, based on 2019 US Department of Housing and Urban Development (HUD) income levels.[10]

Figure 7: Adult Participants by Personal Income (n=139)



Housing: Over three-quarters of participants ages 26 and older (77%) reported having stable housing, and an additional 12% reported that they were staying with family or friends. The remaining respondents reported that they were homeless, living in a shelter or transitional housing, or had another form of housing.

Veteran Status: Over 96% of adult participants reported that they were not armed forces veterans.

[9] Adult participants aged 25 and younger are not included because the Pride Center's demographic survey includes an age category between 16 and 25, which would include current high school students as well.
[10] 2019 San Mateo County Income Limits as determined by HUD. Retrieved from https://housing.smcgov.org/sites/housing.smcgov.org/files/AFFORD2019x_0.pdf

Demographic Comparison

In order to understand participant demographic trends, the table below highlights key differences and similarities between FY2018-19 participants and A) participants receiving clinical services in FY2018-19, and B) all participants from the Pride Center opening through FY2018-19. The comparison shows that among *clinical service participants,* higher proportions were children or transition age youth, transgender or gender nonconforming, and Latinx. Among *new participants*, higher proportions were children, male, and transgender women.

Table 2. Demographic Comparison to FY2018-19 Participants

Category	A. Clinical Participants FY2018-19	B. Pride Center Opening through FY2018-19
Age	Compared to all FY2018-19 participants, a **higher** percentage of clinical participants were age 25 or under.	Compared to participants across all years, a **slightly higher** percentage of new participants in FY2018-19 were children ages 0-15.
Race	Compared to all FY2018-19 participants, a **higher** percentage of clinical participants identified as Latinx/o/a, and a **lower** percentage identified as White.	Overall, the racial breakdown was generally the same for new FY2018-19 participants and participants across all years.
Sex at Birth	Compared to all FY2018-19 participants, a **higher** percentage of clinical participants reported that they were assigned male at birth.	Compared to participants across all years, a **slightly higher** percentage of new participants in FY2018-19 reported that they were assigned male at birth.
Sexual Orientation	Compared to all FY2018-19 participants, a **higher** percentage of clinical participants identified as pansexual and a **lower** percentage identified as heterosexual.	Compared to participants across all years, **slightly lower** percentages of new participants in FY2018-19 identified as gay/lesbian or as heterosexual, and **slightly higher** percentages identified as bisexual or pansexual.
Gender Identity	Compared to all FY2018-19 participants, a **slightly higher** percentage identified as gender nonconforming.	Compared to participants across all years, a **slightly higher** percentage of new participants in FY2018-19 identified as transgender women, while a **slightly lower** percentage identified as cisgender women.

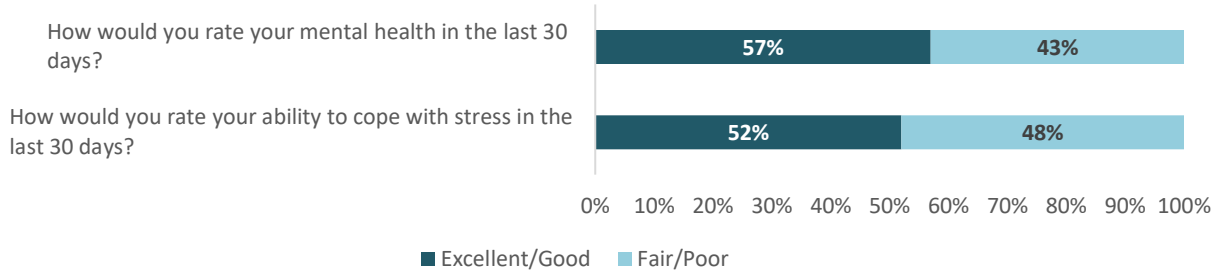
Clinical Services Baseline Data

The FY2018-19 report contains baseline clinical data. Subsequent years will examine changes from baseline to follow-up for clinical participants.

Client Self-Assessment

The Client Self-Assessment asks clinical participants to rate how they felt about their mental health and their ability to cope with stress in the last 30 days. At intake, respondents to the survey were almost evenly split between positive and negative assessments of their mental health and stress levels in the last 30 days (see Figure 8). For both self-assessment questions, “good” was the most common response, followed by “fair.” “Excellent” was the least common response.

Figure 8. Participants Initial Screening Experiences in FY 2018-19 (n=28)



Client Strengths and Needs

Table 3 summarizes the results of the assessments administered to clinical service participants—the CANS for children, and the ANSA for adults. The table below presents the strengths that most frequently emerged for each age group, as well as the needs that most frequently emerged in the "actionable" range (described as a rating of 2 or 3 on a scale of 0-3). As noted in the table, some of the needs and strengths domains received equal responses and are therefore listed as the same rank.

Table 3. Top Need and Strength Domains for Clinical Participants at Intake

CHILD AND ADOLESCENT NEEDS AND STRENGTHS

RANK	STRENGTHS	RANK	NEEDS
1	Family Strengths	1	Anxiety
2	Relationship Permanence	2	Family Functioning
2	Resiliency	2	Cultural Stress
3	Optimism	3	Physical/Medical
3	Educational setting	3	Depression
3	Natural Supports	3	Involvement with Care

ADULT NEEDS AND STRENGTHS ASSESSMENT

RANK	STRENGTHS	RANK	NEEDS
1	Resiliency	1	Anxiety
2	Resourcefulness	2	Family Relationships
3	Optimism	3	Depression
3	Vocational	4	Social Functioning
4	Job History	5	Adjustment to Trauma

Progress Toward Learning Goals

This section discusses the progress that the San Mateo County Pride Center has made toward achieving its two learning goals. A summary of key findings is presented below, followed by a detailed discussion of each learning goal.

Learning Goal 1: Impact of Coordinated Service Delivery Model

Staff Coordination and Collaboration. Strong collaboration among staff has led to improved coordination of services for clinical and case management clients. The collaborative approach of Pride Center staff helps participants feel welcome, supported, and empowered.

Collaboration with External Partners. Beyond internal coordination, the Pride Center has become a key part of a larger network of providers advancing LGBTQ+ inclusion, equality, and empowerment in San Mateo County and beyond.

Collaborative Organizational Model. The Pride Center has continued to build and refine a collaborative organizational model. The Pride Center is working to define the appropriate level of oversight and involvement of the partner agencies. Pride Center staff continue to face heavy workloads with only modest resources, which increases the risk of staff burnout and turnover.

Learning Goal 2: Improved Access to Mental Health Services

Access to Culturally Responsive Psychotherapy. Participants continued to cite the importance and quality of the Pride Center's culturally affirmative mental health services, and most clinical participants strongly agreed or agreed that they have benefited from services offered to them at the Pride Center.

Community as Protective Factor. The Pride Center demonstrates how having a safe space to build community can be a significant protective factor for LGBTQ+ residents. Many participants feel that the Pride Center is a therapeutic experience, including many community members who do not use the Pride Center for formal clinical services.

Services for Marginalized Groups. The Pride Center prioritizes its mental health services for members of underserved and marginalized communities, including youth and older adults. The Pride Center has made progress in fostering a welcoming and inclusive environment for LGBTQ+ people of color, and this remains a priority for continued efforts.

Access and Inclusion in County Mental Health System. Increased awareness and integration of the Pride Center in the San Mateo County behavioral health system has improved access to inclusive and responsive mental health services.

Unmet Need. Space and staff capacity constraints limit the Pride Center's ability to address the needs of all LGBTQ+ community members with moderate to severe mental health challenges.

Learning Goal 1: Impact of Coordinated Service Delivery Model

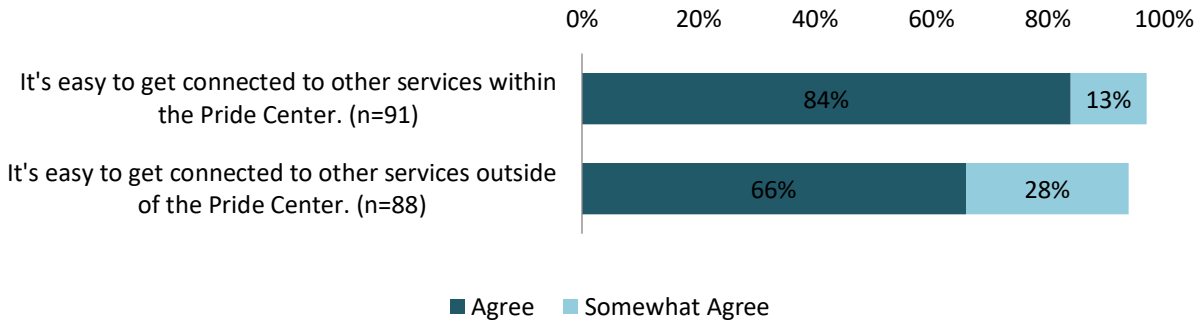
Staff Coordination and Collaboration

Strong collaboration among staff has led to improved coordination of services for clinical and case management clients. The Pride Center's clinical programs emphasize the importance of preventive care for all clients: not just treating acute symptoms that are currently presenting, but setting up clinical clients for long-term wellness by developing care plans, building resilience, and providing patients with psychoeducational resources. Pride Center staff continue to collaborate with each other to serve clients and facilitate linkages to services within and outside of the Pride Center. The clinical team and Case Manager often work together to establish care plans for client. Pride Center staff have instated multiple new policies and procedures for clinical programs, which have improved the referral, waitlist, and intake and assessment process for new clients. All of these developments required close collaboration between staff members: ensuring that staff were familiar with new workflows, training staff in survey administration and database entry, and coordinating contact with a single client between multiple team members.

> *"Staff have dynamic collaborations working with case management, mental health; [in a] one-stop-shop, we can do warm handoffs, introduce [clients] to someone on staff, bring them in gently to a new environment—it's really cool."*
>
> –Pride Center Staff

On the Staff Collaboration Survey, the highest ratings continued to be in the "Partnership" domain, which encompasses staff coordination with each other and with participants to develop a care plan (see Appendix F for full results of the Staff Collaboration Survey). Participants corroborated staff members' observations that this team-based approach to service delivery has enhanced participants' wellbeing. As noted in Figure 9 below, 97% of respondents to the Participant Experience Survey either fully or somewhat agreed that it was easy to connect to other services within the Pride Center, which points to staff members' ability to facilitate those service linkages.

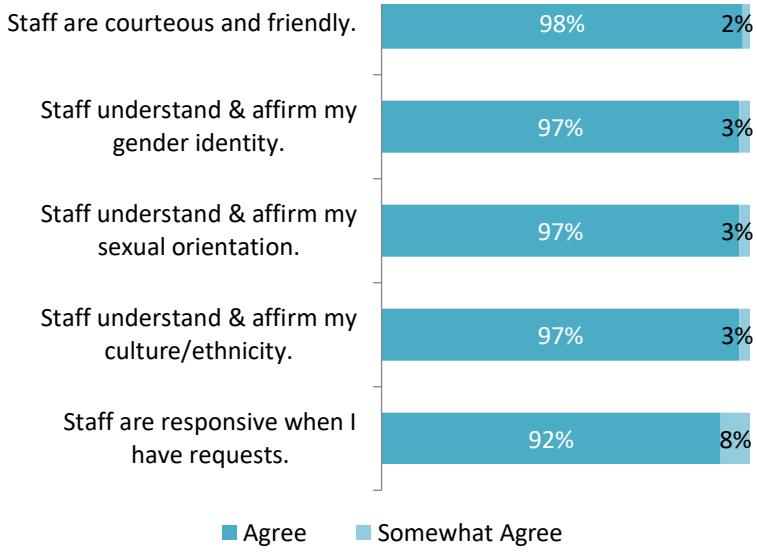
Figure 9: Participant Approval of Service Linkages at the Pride Center in FY2018-19
Source: Participant Experience Survey



Similar to last year's findings, survey respondents found it easier to connect to other services *within* the Center than *outside* the Center: about two-thirds (66%) agreed that it was easy to connect to other services outside of the Center. This finding can be interpreted in two ways: on one hand, it points to the inherent ease of access in a one-stop-shop model; on the other hand, it may suggest an area for improvement in linking participants from the Pride Center with outside agencies.

The collaborative approach of Pride Center staff helps participants feel welcome, supported, and empowered. Staff members' skills in working together help to create overwhelmingly positive participant experiences. Many participants praise staff for being welcoming and supportive at all points of contact, from the front desk to chance encounters within the Center to community outreach events. The Participant Experience Survey items that received the highest ratings were all related to participants' impressions of Pride Center staff (see Figure 10).

Figure 10: Participant Experience Survey Results, Percentage of Respondents who Agree with Statements About Staff (n=92)



Collaboration with External Partners

Beyond internal coordination, the Pride Center has become a key part of a larger network of providers advancing LGBTQ+ inclusion, equality, and empowerment in San Mateo County and beyond. The Pride Center's year-round outreach efforts and organizational partnerships have helped Center staff to build a large, countywide network in just two years of program operations. The Center's early successes have bolstered its reputation in the county as an authoritative source on LGBTQ+ inclusion, community building, and mental health care. Moreover, Pride Center staff continue to build on their network by advancing new partnerships and joint initiatives. In addition, Pride Center staff engaged with LGBTQ+ inclusive service providers and other stakeholders in venues beyond the county. For instance, in 2019 the Center's Program Director was invited to speak at a statewide LBGTQ+ convening, to talk about the Pride Center and the prospects of replicating its service delivery model in other communities.

Pride Center staff continue to train hundreds of county staff members about SOGI and LGBTQ+ inclusion. Among these trainings were sessions specifically for BHRS staff and Probation staff. The Center has also helped to advance symbolic support for LGBTQ+ community members within local government, such as participating in the raising of LGBTQ+ flags at city and county government buildings during Pride Month. In turn, local officials, including a County Supervisor, have demonstrated consistent support for the Pride Center as an important community institution.

Collaborative Organizational Model

The Pride Center has continued to build and refine a collaborative organizational model. The Pride Center is working to define the appropriate level of oversight and involvement of the partner agencies in its collaborative organizational model. The partner organizations continue to serve in an oversight and advisory role to Center leadership. Management from the four partner organizations meet on a monthly basis to discuss key administrative and financial matters, plan for upcoming programs and events, explore development and sustainability opportunities, and address emergent problems. Based on feedback from staff and partners, there is not yet a shared vision of the intended roles and responsibilities of the partner agencies. In general, Pride Center staff seek a greater level of direct support than they currently receive. Pride Center staff noted that they would benefit from more strategic direction, professional development, and program planning guidance from the partner organizations' leadership, which could improve efficiency when developing new programs and policies for the Center.

Pride Center staff continue to face heavy workloads with only modest resources, which increases the risk of staff burnout and turnover. Staff members continue to receive modest compensation for high-volume, demanding work. While staff maintain high-quality services and a welcoming environment at the Pride Center, many face challenges of making relatively low salaries as professionals in a region with very high costs of living. In addition, urgent capacity needs have led some staff members to step into coordinating or managerial roles that they had felt unprepared to do. However, some staff have also struggled to find adequate support when taking on these responsibilities.

Learning Goal 2: Improved Access to Mental Health Services

Access to Culturally Responsive Psychotherapy

Participants continue to cite the importance and quality of the Pride Center's culturally affirmative mental health services. Participants receiving therapy services emphasized that having a LGBTQ+ therapist has supported their mental health treatment. With LGBTQ+ therapists who understand participants' lived experiences, participants feel more understood and supported compared to previous experience with non-LGBTQ+ therapists. Similar to last year's findings, focus group participants noted that they struggled to find adequate mental health care locally beforehand, and had faced issues when their providers were not trained to work with LGBTQ+ clients. On the clinical self-assessment survey, most clinical participants strongly agreed or agreed that they have benefited from services offered to them at the Pride Center.

> *"When I decided to transition, I came here for counseling…. The clinical services here are great. [Gender] transitions are scary, so it's great to come here—where people remember your pronouns, your name. My home situation isn't validating, so having a place that is safe helps me continue to transition when otherwise I might not have and would still suffer from the mental health issues that I was going through."*
>
> –Focus Group Participant

The Pride Center's clinical services have been a beacon for transgender, genderqueer, and nonbinary individuals. Several participants shared experiences of Pride Center therapists remembering their correct pronouns and offering support through their gender transition. One transgender participant noted that while she could have accessed mental health services through private insurance, she chose to seek therapy at the Pride Center because of the Center's expertise in gender identity.

Community as Protective Factor

The Pride Center demonstrates how having a safe space to build community can be a significant protective factor for LGBTQ+ residents. Many participants feel that the Pride Center is a therapeutic experience, including many community members who do not use the Pride Center for formal clinical services. Although only 27% of participants who took the Participant Experience Survey in June 2019 indicated that they received therapy from the Pride Center, 85% of respondents agreed that the services they receive at the Pride Center have improved their mental health (nearly all respondents either agreed or somewhat agreed with this statement).

Several participants also described the sense of community that the Pride Center provided, and how those feelings of belonging helped to boost their confidence, morale, or general emotional wellbeing. Focus group participants described many features that helped to ground the Pride Center in a sense of community: the warmth and support of staff members at all points of contact, the familial environment, the intergenerational meals and social events, and the accessibility of the Center for regular visitors. Others described how the Center's visibility on El Camino Real, and the Center's prominence in San Mateo County, was a source of pride and self-esteem. Results from the Participant Experience Survey follow this trend. Among respondents who had been to the Center at least once before, 86% agreed that the Pride Center gives them a sense of community, and 96% either agreed or somewhat agreed.

> *"The staff here are very accepting; they accept who I am. I come here with my partner; they treat us like family. I feel connected with them, even though I don't come here often, I know that they're here."*
>
> –Focus Group Participant

In other words, while only a fraction of respondents uses formal therapy services at the Pride Center, virtually all participants can benefit from the inclusive and supportive community space that the Center offers on a daily basis. We can think of this sense of community as a *protective factor*: something that helps LGBTQ+ community members and their allies build resilience and reduce the risk of experiencing mental health challenges.

The Pride Center has cultivated a devoted community of regular participants, many of whom are frequent visitors and/or have been long-term participants. Among the 93 individuals who completed the Participant Experience Survey in June 2019, just under half (49%) had been coming to the Pride Center for a year or more, and nearly one-quarter (23%) had been participants since the Pride Center opened in 2017. Furthermore, 40% of respondents noted that they attend the Pride Center at least once a week,

and an additional 30% attend at least once a month. In addition, several participants have joined the evaluation team's focus groups for two years in a row. These participants are among those who have reiterated how the Pride Center offers a safe and inclusive community environment, and a sense of belonging.

> *"I remember living in the County without the Pride Center existing—it felt like I was alone, very alone…. Just knowing the Pride Center is here in my community makes me feel more comfortable. The fact that it's supported by the County, the Board of Supervisors, I feel more welcome in this county, more comfortable to be who I am. It's empowering."*
>
> –Focus Group Participant

Figure 11: Participant Experience Survey Respondents, by Frequency of Visits to the Pride Center (n=93)

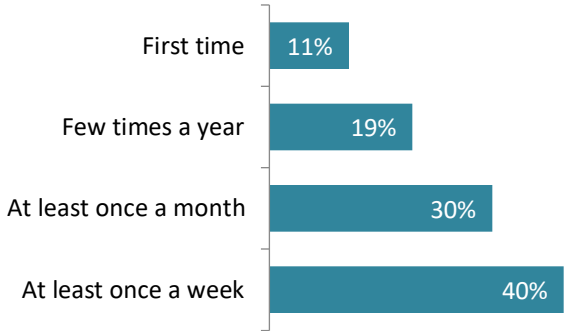
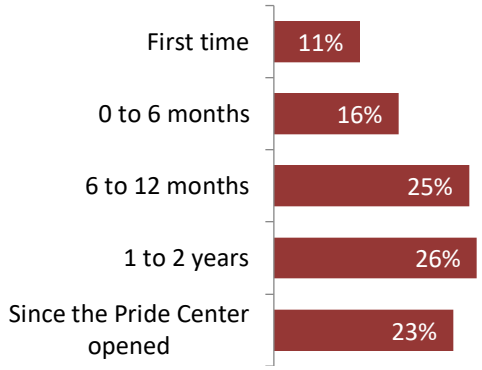


Figure 12: Participant Experience Survey Respondents, by How Long They Have Been Visiting (n=93)



Services for Marginalized Groups

The Pride Center prioritizes its mental health services for members of underserved and marginalized communities, including youth and older adults. In developing policies and procedures for its clinical programs, Pride Center staff ensured that their services would be consistent with their commitment to inclusivity, equity, and social justice. When clinical staff have the capacity to see new clients or take people off the waitlist, they prioritize participants who represent marginalized identities within the larger LGBTQ+ community: non-heterosexual and non-cisgender individuals, genderqueer and gender nonconforming people, people of color, low-income individuals, and survivors or victims of abuse, among others. The Center also offers low-fee or pro bono services for undocumented individuals and people with financial hardships. During the program year, 65% of clinical patients identified as people of color or as multiracial, and 30% identified as genderqueer, gender nonconforming, or transgender.

In addition, the Pride Center has emphasized clinical services for its younger clients with moderate to severe mental health challenges. This decision derives from the understanding that the earlier a person receives care for mental illness or trauma, the more likely they will achieve long-term wellness. During the program year, 49% of clinical participants were under the age of 26.

> *"I found out about the Pride Center from my school therapist. I talked to her about my sexuality and how I feel about it, she recommended the peer groups for me. Since I've started coming, I feel happy and I'm accepting myself more."*
>
> –Focus Group Participant

The Pride Center has built capacity to provide services to Spanish-speaking participants, and has witnessed a significant rise in Spanish-speaking community members seeking mental health services. The Center's primary Spanish-speaking clinician worked with fellow staff members and clinicians from the partner organizations to develop a network of referrals for monolingual Spanish-speaking clients. The same clinician hosts a Bilingual Consultation Group in partnership with a staff member from the Felton Institute, which provides guidance to bilingual providers around sexual orientation, gender identity, and LGBTQ+ issues.

The Pride Center has made progress in fostering a welcoming and inclusive environment for LGBTQ+ people of color, and this remains a priority for continued efforts. The Pride Center has continued to offer dedicated programming for people of color, including launching several new events and peer groups. In some cases, it has been a challenge to encourage regular and repeated participation in such events. For instance, during the program year, the Pride Center retired Noches de Cumbia, a peer group for Latinx adult participants, due to minimal attendance. Staff capacity issues and resource constrains have also limited the Center's ability to outreach to or serve non-English speaking participants. In some cases, only one staff member speaks a non-English language, which places the onus on them to support members of that language community. Staff members have also had to translate forms that were not offered in participants' primary languages, which takes considerable time and effort. Nonetheless, it should be emphasized that Pride Center staff remain committed to serving LBGTQ+ community members of color, and being an inclusive space for their families and allies of color.

> *"My experience has been a little rocky. The first year I tried coming, it was hard, because it was a predominantly white space and didn't feel okay, as a queer person of color in a white space. I tried coming to support groups and there was someone who made me feel uncomfortable, that I wasn't affirmed…*
>
> *Throughout the years the Pride Center has been evolving, there's been other queer people of color here, and spaces for queer people of color. Not just queer people or people of color, but both—I don't have to choose."*
>
> –Focus Group Participant

Access and Inclusion in County Mental Health System

Increased awareness and integration of the Pride Center in the San Mateo County behavioral health system has improved access to inclusive and responsive mental health services. Because the Pride Center has filled a crucial gap in mental health services, and has undertaken a wide array of activities and services, the Center has quickly become an established organization within San Mateo County's network of mental health care. During FY18-19, staff expanded their outreach to other mental health providers throughout the county, while also improving their internal coordination and management of clinical services. These changes resulted in an upsurge in referrals from schools and other agencies, while also expanding their capacity to accommodate and serve clinical patients. Beyond its direct service to LGBTQ+ community members, the Pride Center has taken a leading role in advancing LGBTQ+ inclusivity and cultural humility within the county's mental health and social services systems as a whole. In particular, the Pride Center has helped to support other organizations through its extensive training program.

Unmet Need

Space and staff capacity constraints limit the Pride Center's ability to address the needs of all LGBTQ+ community members with moderate to severe mental health challenges. Because the Center provides clinical services alongside daily onsite activities, as well as general support and resources for drop-in guests, it can be a challenge to accommodate the range of participant needs in such a small location. The limited number of private rooms is a challenge for the expansion of clinical services, case management, or any other activities that require privacy for participants.

- **Clinical Services**: Pride Center staff noted a significant increase in sliding-scale referrals for clinical services at the end of the program year, which resulted in many of those referrals being waitlisted. With minimal capacity to see Medi-Cal clients, and no ability to see Medicare clients, the Pride Center is limited in its ability to provide mental health services to low-income and older adult participants. The Pride Center has faced setbacks in its clinical capacity due to changing regulations dictating whether clinical trainees can see Medi-Cal patients. Two predoctoral trainees joined the clinical staff in August 2019, but due to recent regulatory changes for doctoral students, these trainees will only be able to see clients on a sliding scale. Several Pride Center participants reflected that they experienced delays in accessing clinical services due to having Medi-Cal or not having insurance.
- **Case Management** Because the Pride Center has only one case manager, the capacity to offer case management services is limited. As such, Center staff prioritize these services for participants with more critical and/or complex needs.

Staff members' heavy workloads can sometimes impede participants' timely access to staff. While participants overwhelmingly praise Pride Center staff for their work, some focus group participants noted that they had occasionally experienced difficulties in reaching

> *"Sometimes staff—as wonderful as they are—their plates are so full."*
>
> –Focus Group Participant

staff members. The focus group participants who brought up these challenges were nonetheless forgiving. They had come to attend Pride Center services or events on a regular basis, and had many positive experiences with staff members otherwise. In general, the Pride Center's devoted participants who joined the focus groups were well aware of staff members' intense work commitments, and demonstrated care and concern for staff members' wellbeing. However, this limited capacity could prevent timely communication with potential new participants who are making their first effort to contact staff.

Moreover, staff members' limited capacity is likely constraining their ability to run a more extensive volunteer program, which in turn could help to ease some of their responsibilities. With so many devoted and regular participants, the Center has a community where many people are willing to help out in some way. However, the Pride Center does not currently have the staff resources necessary to coordinate such a program.

The Pride Center's physical location, layout, and hours continue to restrict access for some community members, those who live further away from downtown San Mateo, and participants with disabilities or physical limitations. San Mateo is a geographically large county, and has few east-west transportation routes that connect the smaller coastal communities to the metropolitan areas on the eastside. Although the Pride Center is centrally located within the county, in downtown San Mateo, participants (and potential participants) who live further away may find it challenging to access services or visit the Center on a regular basis. This is especially true for participants who rely on public transit, participants with limited physical mobility, or participants who suffer from agoraphobia (fear of leaving the house).

In addition, the physical layout of the Pride Center itself can be a challenge for some older adult participants and disabled participants. As mentioned above, one of the main meeting rooms lies at the top of a steep flight of stairs, making it inaccessible to some participants. This problem of inaccessibility for disabled clients has also invalidated a potential solution to the Center's space issues. A second-story office in the same building became vacant during the program year, but without an elevator the space would not be compliant with the Americans with Disabilities Act.

Finally, some participants cannot attend Pride Center activities or receive clinical services, because their work hours overlap with the Pride Center's regular hours of operation. For instance, some older adult participants with jobs have had difficulty attending activities run by Older Adult Programs, many of which are held during the daytime.

Recommendations

Based on the evaluation findings, below are recommendations to support the Pride Center's operations and programming.

Operations and Governance

Facilitate discussions between Pride Center staff, partner organizational representatives, and Community Advisory Board (CAB) members, to establish a mutual understanding of roles and responsibilities. It is clear that there are differences in perspective regarding the desired roles of the partner organizations. It is important that all parties can make space for creating shared expectations of each party's primary roles and responsibilities, and their accountability and obligations to each other.

Explore areas where partner organization staff and CAB members can provide additional organizational development support for Pride Center staff. Pride Center staff have developed organizational policies, practices, and procedures for the Pride Center, for which the partner organizations might already have a template or model in place. To maximize staff time for program and service delivery, the partner organizations should work together to establish a process for reviewing the Pride Center's organizational development needs and identifying how the partner organizations could support through technical assistance or guidance.

Explore additional strategies to reduce staff members' workload, such as providing support to develop a participant volunteer program. Staff members' workloads are unsustainable, and the CAB and partner organizations should continue to find ways to alleviate some of staff's responsibilities. For instance, additional support could help staff members launch a full-fledged volunteer program, which could help lighten staff workloads once the program is up and running.

Programs and Services

Collaborate with other providers to fill gaps in services for the LGBTQ+ community. Given that the Pride Center has been operating at or above full capacity, there are opportunities to leverage the partnerships that the Pride Center has cultivated to address unmet needs within the LGBTQ+ community. These partnerships include not only the Pride Center's organizational partners (StarVista, Peninsula Family Services, Adolescent Counseling Services, and Daly City Partnership), but also the many providers of clinical and social services that the Pride Center has trained in LGBTQ+ cultural sensitivity. The Pride Center should work with these partners to create referral systems and establish new services to expand culturally appropriate mental health and social services for the LGBTQ+ community. Unmet service needs include:

- **Activities for adult participants on evenings and weekends.** Multiple participants noted that they had trouble attending Pride Center events during or soon after regular business hours, because of work or the time it takes to commute from work to the Center. This is especially true for older adults who are still working, as the majority of Older Adult Programs occur during weekdays.
- **Clinical services that meet the needs of clients with Serious Mental Illness (SMI).** Given its organizational structure, regulations surrounding Medi-Cal and Medicare billing, and staff

capacity, the Pride Center is only able to serve a fraction of the LGBTQ+ SMI community. In order to create a sustainable system of LGBTQ+ affirming mental health services, it will be necessary to coordinate with outside providers to help meet this need. The Pride Center could leverage and enhance its training model for providers to include learning collaboratives and ongoing consultation. In this way, providers could participate in continuous learning and support to provide responsive services for LGBTQ+ clients.

- **Group therapy services to accommodate additional clinical participants and provide group therapeutic support.** Group therapy would both expand capacity to serve more clients and offer an additional therapeutic modality that may be supportive for some LGBTQ+ clients with mental health needs.
- **Programs for LGBTQ+ families.** Some participants expressed a desire that the Pride Center build out additional programming for LGBTQ+ parents and their children, or families with children who identify as LGBTQ+. Family-oriented events would help to draw out additional community members, and in general provide visibility and acceptance around different kinds of families within the LGBTQ+ community.

Conclusion

The 2018-19 fiscal year marked the second full year of operation of the San Mateo County Pride Center. In this short time, the Pride Center has established a wide array of clinical services and community-oriented programs and has become a crucial community resource. The Pride Center has not only filled a critical gap in local mental health care services; it has also demonstrated the benefit of its unprecedented model of coordinated service delivery. The Center allows participants to access mental health services with LGBTQ+ therapists, which for many participants is a welcome departure from their previous difficulties in finding mental health care providers both knowledgeable and respectful of their sexual orientation and gender identity. In addition, the Pride Center offers a safe space for community members who often experience discrimination or social isolation to gather. Through community outreach and workplace trainings, the Pride Center has built the skills of non-LGBTQ+ providers to better serve their LGBTQ+ clients and students and helped build awareness of the Center across San Mateo County.

The process of building a collaborative model has highlighted the importance of—and challenges with—developing a shared vision of roles and responsibilities among all partners, containing the scope and volume of services to fit staff capacity, addressing barriers to providing low-cost mental health care services, and preventing staff burnout. In March 2019, the Pride Center received approval to extend the innovation study period through June 2021. Having two additional years to evaluate how the Pride Center's collaborative model influences access to services and client outcomes will support the County in documenting a replicable best practice model that can benefit behavioral health services statewide and nationally.

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	**Participant Demographic Form**	All participants with a minimum of 2 visits	Center administration staff	Paper form	On individual basis	Center staff enter into ETO database
	Participant Experience 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 into ETO database
	Clinical Services: CANS and ANSA	Any person who receives clinical services	Clinician	Paper form	At intake, at 6-month follow-up, and at discharge	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
2019 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: _____ **What city do you live in?** _____

What is your primary reason for visiting the Pride Center? (Please pick one.) ❑ Clinical/social services ❑ Peer groups or social activities ❑ Organizational meetings ❑ Education/ trainings

1. What is your age category?

- ❑ 0-15
- ❑ 16-25
- ❑ 26-39
- ❑ 40-59
- ❑ Age 60 and above
- ❑ Decline to answer

2. What is your preferred or primary language? (Mark one.)

- ❑ English
- ❑ Cantonese
- ❑ Mandarin
- ❑ Spanish
- ❑ Tagalog
- ❑ Vietnamese
- ❑ American Sign Language
- ❑ Another: _____
- ❑ Decline to answer

3. How do you define your race? (Mark all that apply.)

- ❑ American Indian / Native Alaskan
- ❑ Asian / Asian American
- ❑ Black / African American
- ❑ Hispanic / Latinx/a/o
- ❑ Native Hawaiian / Pacific Islander
- ❑ White / Caucasian
- ❑ Another race: _____
- ❑ Decline to answer

4. How do you define your ethnicity? (Mark all that apply.)

- ❑ African: _____
- ❑ Cambodian
- ❑ Caribbean: _____
- ❑ Chinese
- ❑ Central American: _____
- ❑ Eastern European: _____
- ❑ European: _____
- ❑ Filipinx/a/o
- ❑ Indigenous Nation: _____
- ❑ Japanese
- ❑ Korean
- ❑ Mexican / Chicanx/a/o
- ❑ Middle Eastern: _____
- ❑ Pacific Islander: _____
- ❑ Puerto Rican
- ❑ South American: _____
- ❑ Vietnamese
- ❑ Another ethnicity: _____
- ❑ Decline to answer

5. What is your assigned sex at birth?

- ❑ Male
- ❑ Female
- ❑ Another sex: _____
- ❑ Decline to answer

6. Do you identify as intersex?

❑ Yes ❑ No ❑ Decline to answer

Please turn the page over to continue.

Prepared by RESOURCE DEVELOPMENT ASSOCIATES Updated: June 26, 2019 | 1

7. What is your current gender identity? (Mark all that apply.)

- ❑ Cisgender Man / Man
- ❑ Cisgender Woman / Woman
- ❑ Genderqueer / Gender nonconforming / Neither exclusively male nor female
- ❑ Indigenous gender identity: _____
- ❑ Questioning or unsure of gender identity
- ❑ Trans Man / Transgender Male / Trans-masculine / Female-to-Male (FTM) / Man
- ❑ Trans Woman / Transgender Female / Trans-feminine / Male-to-Female (MTF) / Woman
- ❑ Another gender identity: _____
- ❑ Decline to answer

8. How do you identify your sexual orientation? (Mark all that apply.)

- ❑ Asexual
- ❑ Bisexual
- ❑ Gay or Lesbian
- ❑ Heterosexual or Straight
- ❑ Indigenous sexual orientation: _____
- ❑ Pansexual
- ❑ Queer
- ❑ Questioning or unsure of sexual orientation
- ❑ Another sexual orientation: _____
- ❑ Decline to answer

9. What is your current employment status?

- ❑ Full time employment
- ❑ Part time employment
- ❑ Retired
- ❑ Student
- ❑ Unable to work due to disability or illness
- ❑ Unemployed and looking for work
- ❑ Unemployed and not looking for work
- ❑ Decline to answer

10. 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.

- ❑ Mental health condition: _____
- ❑ Chronic health condition
- ❑ Dementia
- ❑ Developmental disability
- ❑ Difficulty hearing or having speech understood
- ❑ Difficulty seeing
- ❑ Learning disability
- ❑ Limited physical mobility
- ❑ Another challenges with communication: _____
- ❑ Another disability or condition: _____
- ❑ None of the above
- ❑ Decline to answer

11. What is your current housing status?

- ❑ Stable housing (renter, owner, or living permanently with friends or family)
- ❑ Homeless and unsheltered (staying in a place not meant for habitation)
- ❑ Renting with a subsidy, voucher, or supportive services (e.g., Permanent Supportive Housing)
- ❑ Staying in an emergency shelter or transitional housing program
- ❑ Temporarily staying with friends or family
- ❑ Another housing status: _____
- ❑ Decline to answer

Complete questions 12 & 13 only if you are 18 or older.

12. What is your individual annual income?

- ❑ 0 - $24,999
- ❑ $25,000 - $50,000
- ❑ $50,001 - $75,000
- ❑ $75,001 - $100,000
- ❑ Above $100,000
- ❑ Decline to answer

13. Are you a veteran?

- ❑ Yes
- ❑ No
- ❑ Decline to answer

Thank you for taking the time to complete this survey!

Appendix D: Participant Experience Survey

San Mateo County Pride Center Participant Experience Survey

For office use:
Form #_____

Welcome to the Participant Experience Survey! The purpose of this 5-minute survey is to hear from you about the services you have received and/or programs you've participated in at the San Mateo County Pride Center. The information you provide will help improve our services and programs to better meet the needs of community members. All of your answers will be anonymous.

We appreciate you taking the time to share your experience with us!

1. How many times have you visited the Pride Center?

❑ 1 time ❑ 2 to 5 times ❑ More than 5 times

2. Please mark the services you have participated in at the Pride Center. (*Check all that apply.*)

❑ Case Management
❑ Community Meetings
❑ Connection to Resources
❑ Education / Training
❑ Drop-In Center
❑ Therapy services
❑ Social Activities / Events
❑ Peer Group:_____
❑ Other: _____

3. Please rate your interactions with the Pride Center's staff.	Disagree	Somewhat Disagree	Somewhat Agree	Agree
Staff are courteous and friendly.	❑	❑	❑	❑
Staff are responsive when I have requests.	❑	❑	❑	❑
Staff understand & affirm my sexual orientation.	❑	❑	❑	❑
Staff understand & affirm my gender identity.	❑	❑	❑	❑
Staff understand & affirm my culture/ethnicity.	❑	❑	❑	❑

(NOTE: "Staff" refers to any professional who provides services/programming.)

4. Please rate your experiences with the facility.	Disagree	Somewhat Disagree	Somewhat Agree	Agree
The Pride Center is a welcoming & safe environment.	❑	❑	❑	❑
The Pride Center gives me a sense of community.	❑	❑	❑	❑
The Pride Center is in a convenient location.	❑	❑	❑	❑
The hours of the Pride Center work with my schedule.	❑	❑	❑	❑

5. Please rate your experiences with the services provided at the Pride Center.	Disagree	Somewhat Disagree	Somewhat Agree	Agree
It's easy to get connected to other services within the Pride Center.	❑	❑	❑	❑
It's easy to get connected to other services outside of the Pride Center.	❑	❑	❑	❑
The Pride Center staff include me in deciding what services are best for me.	❑	❑	❑	❑
The services that I am receiving at the Pride Center are improving my mental health.	❑	❑	❑	❑

[TURN PAGE OVER TO CONTINUE]

6. Please note any other services/programs to which the Pride Center has connected you. (OPTIONAL)

7. Please share any positive or negative experiences you have had with the Pride Center. (OPTIONAL)

Your Background

The following questions are optional and will help us know more about who responded to our survey.

A) What is your age category?

❑ 0 – 15 ❑ 16 – 25 ❑ 26 – 39 ❑ 40 – 59 ❑ 60 & above ❑ Decline to Answer

B) With which race/ethnicity do you identify? (*Check all that apply*.)

❑ American Indian / Native Alaskan
❑ Asian / Asian American
❑ Black / African American
❑ Hispanic / Latino/a / Latinx
❑ Native Hawaiian / Pacific Islander
❑ White
❑ Other: _____
❑ Decline to Answer

C) What is your assigned sex at birth?

❑ Female ❑ Male ❑ Intersex ❑ Decline to Answer

D) What is your current gender identity?

❑ Cisgender Man
❑ Cisgender Woman
❑ Genderqueer / Gender Nonconforming / Neither exclusively male nor female
❑ Questioning or Unsure of Gender Identity
❑ Female-to-Male (FTM) / Transgender Male / Trans Man / Trans-masculine / Man
❑ Male-to-Female (MTF) / Transgender Woman / Trans Woman / Trans-feminine / Woman
❑ Indigenous gender identity: _____
❑ Other gender identity: _____
❑ Decline to answer

E) How do you identify your sexual orientation?

❑ Gay or Lesbian
❑ Heterosexual or Straight
❑ Bisexual
❑ Questioning / Unsure
❑ Queer
❑ Pansexual
❑ Asexual
❑ Decline to Answer
❑ Indigenous sexual orientation: _____
❑ Other sexual orientation: _____

Appendix E: CANS and ANSA Instruments

ADULT NEEDS AND STRENGTHS ASSESSMENT(ANSA)					STANDARD VERSION 2.0
Individual's Name:		DOB:	Gender:	Race/Ethnicity:	
Caregiver(s):		Form Status:	Initial	Subsequent / Annual / Discharge	
		Case Name:			
		Case Number:			
Assessor:		Date of Assessment:	m m d d y y		

FUNCTIONING				
0=no evidence	1=history, suspicion			
2= action needed	3= disabling, dangerous, immediate action			
	0	1	2	3
Family Relationships	○	○	○	○
Physical/Medical	○	○	○	○
Employment Functioning	○	○	○	○
Social Functioning	○	○	○	○
Recreational	○	○	○	○
Developmental/intellectual	○	○	○	○
Sexual Development	○	○	○	○
Living Skills	○	○	○	○
Residential Stability	○	○	○	○
Legal	○	○	○	○
Sleep	○	○	○	○
Self-Care	○	○	○	○
Medication Compliance	○	○	○	○
Transportation	○	○	○	○
Living Situation	○	○	○	○
School	○	○	○	○

STRENGTHS				
**Please note only for the Strengths section 3 is "no evidence"*				
0=Centerpiece strength	1=Useful strength			
2=Identified strength	3=No evidence			
	0	1	2	3
Family Strengths	○	○	○	○
Interpersonal/Social Connectedness	○	○	○	○
Optimism	○	○	○	○
Educational Setting	○	○	○	○
Job History	○	○	○	○
Talents and interests	○	○	○	○
Spiritual/Religious	○	○	○	○
Community Connection	○	○	○	○
Natural Supports	○	○	○	○
Resilience	○	○	○	○
Resourcefulness	○	○	○	○
Volunteering	○	○	○	○
Vocational	○	○	○	○

CULTURAL FACTORS				
0=no evidence	1=history, suspicion			
2= action needed	3= disabling, dangerous, immediate action			
	0	1	2	3
Language	○	○	○	○
Cultural Identity	○	○	○	○
Traditions and Rituals	○	○	○	○
Cultural Stress	○	○	○	○

BEHAVIORAL/EMOTIONAL NEEDS				
0=no evidence	1=history, suspicion			
2= action needed	3= disabling, dangerous, immediate action			
	0	1	2	3
Psychosis (Thought Disorder)	○	○	○	○
Impulse Control	○	○	○	○
Depression	○	○	○	○
Anxiety	○	○	○	○
Interpersonal Problems	○	○	○	○
Antisocial Behavior	○	○	○	○
Adjustment to Trauma	○	○	○	○
Anger Control	○	○	○	○
Substance Abuse	○	○	○	○
Eating Disturbances	○	○	○	○

RISK BEHAVIORS				
0=no evidence	1=history, suspicion			
2= action needed	3= disabling, dangerous, immediate action			
	0	1	2	3
Suicide Risk	○	○	○	○
Non-Suicidal Self-Injurious Behavior	○	○	○	○
Other Self-Harm (Recklessness)	○	○	○	○
Exploitation	○	○	○	○
Danger to Others	○	○	○	○
Gambling	○	○	○	○
Sexual Aggression	○	○	○	○
Criminal Behavior	○	○	○	○

CAREGIVER RESOURCES & NEEDS (OPTIONAL)				
0=no evidence	1=history, suspicion			
2= action needed	3= disabling, dangerous, immediate action			
	0	1	2	3
Physical/Behavioral Health	○	○	○	○
Involvement in Care	○	○	○	○
Knowledge	○	○	○	○
Social Resources	○	○	○	○
Family Stress	○	○	○	○
Safety	○	○	○	○
Organization	○	○	○	○
Residential Stability	○	○	○	○
Substance Use	○	○	○	○
Developmental	○	○	○	○

Standard ANSA 2.0 March 10, 2017,

CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS)				STANDARD CANS COMPREHENSIVE
Child's Name:		DOB:	Gender:	Race/Ethnicity:
Caregiver(s):		Form Status:	Initial / Subsequent / Annual / Discharge	
		Case Name:		
		Case Number:		
Assessor:		Date of Assessment:	m m d d y y	

LIFE DOMAIN FUNCTIONING

0=no evidence; 1=history or suspicion; 2=interferes with functioning; action needed; 3=disabling, dangerous; immediate or intensive action needed

	0	1	2	3
Family Functioning	○	○	○	○
Living Situation	○	○	○	○
Social Functioning	○	○	○	○
Recreational	○	○	○	○
Developmental/Intellectual[1]	○	○	○	○
Job Functioning	○	○	○	○
Legal	○	○	○	○
Medical/Physical	○	○	○	○
Sexual Development	○	○	○	○
Sleep	○	○	○	○
School Behavior	○	○	○	○
School Attendance	○	○	○	○
School Achievement	○	○	○	○
Decision-Making	○	○	○	○

STRENGTHS DOMAIN

0=Centerpiece strength; 1=Useful strength; 2=Identified strength; 3=No evidence

	0	1	2	3
Family Strengths	○	○	○	○
Interpersonal	○	○	○	○
Optimism	○	○	○	○
Educational Setting	○	○	○	○
Vocational	○	○	○	○
Talents/Interests	○	○	○	○
Spiritual/Religious	○	○	○	○
Community Life	○	○	○	○
Relationship Permanence	○	○	○	○
Resiliency	○	○	○	○
Resourcefulness	○	○	○	○
Cultural Identity	○	○	○	○
Natural Supports	○	○	○	○

CULTURAL FACTORS

0=no evidence; 1=history or suspicion; 2=interferes with functioning; action needed; 3=disabling, dangerous; immediate or intensive action needed

	0	1	2	3
Language	○	○	○	○
Traditions and Rituals	○	○	○	○
Cultural Stress	○	○	○	○

CAREGIVER RESOURCES AND NEEDS

0=no evidence; 1=history or suspicion; 2=interferes with functioning; action needed; 3=disabling, dangerous; immediate or intensive action needed

	0	1	2	3
Supervision	○	○	○	○
Involvement with Care	○	○	○	○
Knowledge	○	○	○	○
Organization	○	○	○	○
Social Resources	○	○	○	○
Residential Stability	○	○	○	○
Medical/Physical	○	○	○	○
Mental Health	○	○	○	○
Substance Use	○	○	○	○
Developmental	○	○	○	○
Safety	○	○	○	○

CHILD BEHAVIORAL/EMOTIONAL NEEDS

0=no evidence; 1=history or suspicion; 2=interferes with functioning; action needed; 3=disabling, dangerous; immediate or intensive action needed

	0	1	2	3
Psychosis (Thought Disorder)	○	○	○	○
Impulsivity/Hyperactivity	○	○	○	○
Depression	○	○	○	○
Anxiety	○	○	○	○
Oppositional	○	○	○	○
Conduct	○	○	○	○
Adjustment to Trauma[2]	○	○	○	○
Attachment Difficulties	○	○	○	○
Anger Control	○	○	○	○
Substance Use[3]	○	○	○	○

RISK BEHAVIORS

0=no evidence; 1=history or suspicion; 2=interferes with functioning; action needed; 3=disabling, dangerous; immediate or intensive action needed

	0	1	2	3
Suicide Risk	○	○	○	○
Non-Suicidal Self-Injurious Behavior	○	○	○	○
Other Self-Harm (Recklessness)	○	○	○	○
Danger to Others[4]	○	○	○	○
Sexual Aggression[5]	○	○	○	○
Runaway[6]	○	○	○	○
Delinquent Behavior[7]	○	○	○	○
Fire Setting[9]	○	○	○	○
Intentional Misbehavior	○	○	○	○

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INDIVIDUAL ASSESSMENT MODULES (rate if indicated on prior sheets)	[1]Developmental Disabilities Module
	[2]Trauma Module
	[3]Substance Use Module
	[4]Violence Module
	[5] Sexually Aggressive Behaviors Module
	[6]Runaway Module
	[7]Juvenile Justice Module
	[8]Decision Making Module
	[9]Fire Setting Module

DEVELOPMENTAL DISABILITIES MODULE

0=no evidence 1=history or suspicion
2=interferes with functioning; action needed 3=disabling, dangerous; immediate or intensive action needed

	0	1	2	3
Cognitive	○	○	○	○
Communication	○	○	○	○
Developmental	○	○	○	○
Self-Care/Daily Living Skills	○	○	○	○

TRAUMA MODULE

No=no evidence of Trauma Yes=Evidence of Trauma

	No	Yes
Sexual Abuse	○	○
Physical Abuse	○	○
Neglect	○	○
Emotional Abuse	○	○
Medical Trauma	○	○
Natural or Manmade Disaster	○	○
Witness to Family Violence	○	○
Witness to Community/School Violence	○	○
Victim/Witness to Criminal Activity	○	○
War/Terrorism Affected	○	○
Disruptions in Caregiving/Attachment Losses	○	○
Parental Criminal Behavior	○	○

If the youth has been sexually abused:

	0	1	2	3
Emotional Closeness to Perpetrator	○	○	○	○
Frequency of Abuse	○	○	○	○
Duration	○	○	○	○
Force	○	○	○	○
Reaction to Disclosure	○	○	○	○

Traumatic Stress Symptoms:

	0	1	2	3
Emotional/Physical Dysregulation	○	○	○	○
Intrusions/Re-Experiencing	○	○	○	○
Hyperarousal	○	○	○	○
Traumatic Grief/Separation	○	○	○	○
Numbing	○	○	○	○
Dissociation	○	○	○	○
Avoidance	○	○	○	○

SUBSTANCE USE MODULE

0=no evidence 1=history or suspicion
2=interferes with functioning; action needed 3=disabling, dangerous; immediate or intensive action needed

	0	1	2	3
Severity of Use	○	○	○	○
Duration of Use	○	○	○	○
Stage of Recovery	○	○	○	○
Peer Influences	○	○	○	○
Parental Influences	○	○	○	○
Environmental Influences	○	○	○	○

VIOLENCE MODULE

0=no evidence 1=history or suspicion
2=interferes with functioning; action needed 3=disabling, dangerous; immediate or intensive action needed

	0	1	2	3
Historical risk factors:				
History of Physical Abuse	○	○	○	○
History of Violence	○	○	○	○
Witness to Domestic Abuse	○	○	○	○
Witness to Environmental Violence	○	○	○	○
Emotional/Behavioral Risks:				
Bullying	○	○	○	○
Frustration Management	○	○	○	○
Hostility	○	○	○	○
Paranoid Thinking	○	○	○	○
Secondary Gains from Anger	○	○	○	○
Violent Thinking	○	○	○	○
Resiliency Factors:				
Aware of Violence Potential	○	○	○	○
Response to Consequences	○	○	○	○
Commitment to Self-Control	○	○	○	○
Treatment Involvement	○	○	○	○

SEXUALLY AGGRESSIVE BEHAVIORS MODULE				
0=no evidence 2=interferes with functioning; action needed	1=history or suspicion 3=disabling, dangerous; immediate or intensive action needed			
	0	1	2	3
Relationship	○	○	○	○
Physical Force/Threat	○	○	○	○
Planning	○	○	○	○
Age Differential	○	○	○	○
Type of Sex Act	○	○	○	○
Response to Accusation	○	○	○	○
Temporal Consistency	○	○	○	○
History of Sexual Abusive Behavior	○	○	○	○
Severity of Sexual Abuse	○	○	○	○
Prior Treatment	○	○	○	○

RUNAWAY MODULE				
0=no evidence 2=interferes with functioning; action needed	1=history or suspicion 3=disabling, dangerous; immediate or intensive action needed			
	0	1	2	3
Frequency of Running	○	○	○	○
Consistency of Destination	○	○	○	○
Safety of Destination	○	○	○	○
Involvement in Illegal Acts	○	○	○	○
Likelihood of Return on Own	○	○	○	○
Involvement of Others	○	○	○	○
Realistic Expectations	○	○	○	○
Planning	○	○	○	○

9 - JUVENILE JUSTICE MODULE				
0=no evidence 2=interferes with functioning; action needed	1=history or suspicion 3=disabling, dangerous; immediate or intensive action needed			
	0	1	2	3
History	○	○	○	○
Seriousness	○	○	○	○
Planning	○	○	○	○
Community Safety	○	○	○	○
Peer Influences	○	○	○	○
Parental Criminal Behavior	○	○	○	○
Environmental Influences	○	○	○	○

FIRE SETTING MODULE				
0=no evidence 2=interferes with functioning; action needed	1=history or suspicion 3=disabling, dangerous; immediate or intensive action needed			
	0	1	2	3
History	○	○	○	○
Seriousness	○	○	○	○
Planning	○	○	○	○
Use of Accelerants	○	○	○	○
Intention to Harm	○	○	○	○
Community Safety	○	○	○	○
Response to Accusation	○	○	○	○
Remorse				
Likelihood of Future Fire Setting				

Appendix F. Data Tables

Demographic Data

To comply with HIPAA requirements and protect the confidentiality of participating individuals, the tables below only present data for response categories with at least five responses. Where fewer than five responses were received, some categories have been combined. RDA was unable to create a table displaying demographic data on preferred language due to most responses having fewer than five responses. The tables below reflect demographic data from: 1) Fiscal Year 2018-19 and 2) the opening of the Pride Center through Fiscal Year 2018-19, reflected in the tables as "all time periods."

Table 1. Participants served by age

Age	2018-19 (n=199)		All time periods (n= 631)	
	Count	Percent	Count	Percent
0-15	29	15%	55	9%
16-25	50	25%	178	28%
26-39	47	24%	175	28%
40-59	58	29%	168	27%
Age 60 and above	15	8%	55	9%

Table 2. Participants served by race[11]

Race	2018-19 (n=193)		All time periods (n=625)	
	Count	Percent	Count	Percent
White or Caucasian	113	59%	350	56%
Hispanic or Latino/a/x	44	23%	147	24%
Asian or Asian American	36	19%	127	20%
Black or African American	13	7%	33	5%
Native American or Native Alaskan	9	5%	21	3%
Other	8	4%	31	5%
Native Hawaiian or Pacific Islander	4	2%	19	3%

[11] Some participants are counted more than once, as they could mark all categories that apply

Table 3. Participants served by ethnicity[12]

Ethnicity	2018-19 (n= 159)		All time periods (n=523)	
	Count	Percent	Count	Percent
European	55	35%	178	34%
Mexican, Mexican American, or Chicano/a/x	33	21%	89	17%
Other[13]	22	14%	55	11%
Filipino/a/x	18	11%	59	11%
Other Asian ethnicity (Japanese, Korean, Vietnamese, Cambodian, South Asian)	17	11%	43	8%
Chinese	13	8%	40	8%
Eastern European	8	5%	31	6%
African	7	4%	25	5%
Salvadoran	7	4%	16	3%
South American	6	4%	27	5%
Middle Eastern	-	-	15	3%
Central American	-	-	11	2%
Puerto Rican	-	-	10	2%
Caribbean	-	-	6	1%

Table 4. Participants served by sex at birth

Sex	2018-19 (n=193)		All time periods (n=601)	
	Count	Percent	Count	Percent
Female	114	59%	390	65%
Male	78	40%	209	35%

[12] Some participants are counted more than once, as they could mark all categories that apply
[13] Categories with fewer than five responses are reflected in the Other category

Table 5. Participants served by gender identity

Gender identity	2018-19 (n=181)		All time periods (n=549)	
	Count	Percent	Count	Percent
Cisgender Woman	73	40%	249	45%
Cisgender Man	39	22%	141	26%
Male-to-Female (MTF) / Transgender Woman / Trans Woman / Trans-feminine / Woman	18	10%	29	5%
Genderqueer / Gender nonconforming / Neither exclusively male nor female	17	9%	55	10%
Female-to-Male (FTM) / Transgender Male / Trans Man / Trans-masculine / Man	17	9%	34	6%
Questioning or unsure of gender identity	9	5%	17	3%
Another gender identity	7	4%	18	3%

Table 6. Participants served by sexual orientation

Sexual orientation	2018-19 (n=186)		All time periods (n=591)	
	Count	Percent	Count	Percent
Gay or Lesbian	49	26%	187	32%
Heterosexual or Straight	42	23%	166	28%
Bisexual	39	21%	81	14%
Pansexual	22	12%	42	7%
Queer	17	9%	68	12%
Questioning or unsure of sexual orientation	9	5%	17	3%
Asexual	5	3%	20	3%

Table 7. Participants served by disability status (some participants are counted more than once, as they could mark all categories that apply)

Disability Status	2018-19 (n=163)		All time periods (n=534)	
	Count	Percent	Count	Percent
None	109	67%	375	70%
Other ailments	22	13%	61	11%
Chronic health problems	14	9%	36	7%
Learning disability	10	6%	27	5%
Limited physical mobility	10	6%	20	4%
Difficulty seeing	7	4%	27	5%
Difficulty hearing	-	-	19	4%
Other communication challenges	-	-	8	1%

Table 8. Participants served by level of education

Level of Education	2018-19 (n=188)		All time periods (n=600)	
	Count	Percent	Count	Percent
Less than a high school diploma	28	15%	65	11%
High school diploma or GED	15	8%	44	7%
Some college	43	23%	102	17%
Vocational or trade certificate	7	4%	17	3%
Associate's degree	18	10%	34	6%
Bachelor's degree	45	24%	186	31%
Graduate degree	32	17%	152	25%

Table 9. Participants served (aged 26 and older) by income

Income	2018-19 (n=139)		All time periods (n=444)	
	Count	Percent	Count	Percent
0-$24,999	57	41%	162	36%
$25,000-$50,000	32	23%	94	21%
$50,001-$75,000	17	12%	70	16%
$75,001-$100,00	14	10%	53	12%
Above $100,000	19	14%	65	15%

Table 10. Participants served by employment status

Employment Status	2018-19 (n=186)		All time periods (n=584)	
	Count	Percent	Count	Percent
Full-time employment	71	38%	260	45%
Student	44	24%	123	21%
Part-time employment	31	17%	91	16%
Unemployed and looking for work	19	10%	48	8%
Retired	12	6%	35	6%
Unemployed, not looking for work	9	5%	27	5%

Table 11. Participants served (aged 26 and older) by housing status

Housing status	2018-19 (n=188)		All time periods (n=585)	
	Count	Percent	Count	Percent
I have stable housing	144	77%	465	79%
I am staying with friends or family	23	12%	68	12%
Other housing status; I am living in a shelter or transitional housing; I am homeless	10	5%	12	2%
Other	10	5%	32	5%
Homeless/Unsheltered	5	3%	8	1%

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	**13**	0	0	0	1	12
b. listen to the wishes of their patients when determining the process of care chosen by the team	**12**	0	0	0	2	10
c. meet and discuss patient care on a regular basis	**12**	0	0	0	3	9
d. coordinate health and social services (e.g. financial, occupation, housing, connections with community, spiritual) based upon patient care needs	**13**	0	0	0	4	9
e. use consistent communication with the team to discuss patient care	**13**	0	0	0	4	9
f. are involved in goal setting for each patient	**12**	0	1	4	2	5
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	**12**	0	0	0	3	9
h. work with the patient and their relatives in adjusting care plans	**11**	0	0	1	5	5

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	2	6	4
b. respect and trust each other	**12**	0	0	1	6	5
c. are open and honest with each other	**12**	0	0	1	8	3
d. make changes to their team functioning based on reflective reviews	**12**	0	2	2	4	4
e. strive to achieve mutually satisfying resolution for differences of opinions	**12**	0	0	3	3	6
f. understand the boundaries of what each other can do	**12**	0	0	0	9	3
g. understand that there are shared knowledge and skills between health providers on the team	**12**	0	0	0	1	11
h. establish a sense of trust among the team members	**12**	0	0	1	7	4

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	1	2	4	5
b. equally (equitably) divide agreed upon goals amongst the team	**12**	0	0	4	6	2
c. encourage and support open communication, including the patients and their relatives during team meetings	**10**	0	0	1	1	8
d. use an agreed upon process to resolve conflicts	**12**	1	4	0	5	2
e. support the leader for the team varying depending on the needs of our patients	**11**	0	0	1	8	2
f. together select the leader for our team	**10**	0	1	3	5	1
g. openly support inclusion of the patient in our team meetings	**9**	0	2	2	4	1

San Mateo County Adult NMT Pilot Fiscal Year 2018-19 Evaluation Report

A Mental Health Services Act Innovation Project

Prepared by:

Resource Development Associates

December 2019

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Introduction

Project Overview and Learning Goals

San Mateo Behavioral Health and Recovery Services (BHRS) implemented the Neurosequential Model of Therapeutics© (NMT) within the Adult System of Care as part of the three-year Mental Health Services Act (MHSA) Innovation (INN) plan. The MHSA INN project category and primary purpose of the NMT pilot project are as follows:

- **MHSA INN Project Category:** Makes a change to an existing mental health practice that has not yet been demonstrated to be effective.
- **MHSA Primary Purpose:** Increase quality of mental health services, including measurable outcomes.
- **Project Innovation:** While NMT has been integrated into a variety of settings serving infants through young adults, there is no literature or research of NMT in a strictly adult setting or population. BHRS intends to adapt, pilot, and evaluate the application of the NMT approach to an adult population with a history of trauma. This expansion to and evaluation of NMT in an adult system of care is the first of its kind.

The Mental Health Services Oversight and Accountability Commission (MHSOAC) approved the project on July 28, 2016 and BHRS began implementation in September 2016. In 2017, BHRS contracted Resource Development Associates (RDA) to evaluate the adult NMT pilot project. This report provides findings from the third year of NMT implementation—July 1, 2018 to June 30, 2019—in the BHRS Adult System of Care.

BHRS developed two learning goals to guide the NMT pilot and assess the extent to which the program is meeting its intended MHSA objectives—to increase the quality of services and consumer outcomes. The learning goals are outlined in Figure 1 below. The first learning goal pertains to the adaptation and implementation of the NMT approach in the adult consumer population, while the second learning goal pertains to the effectiveness and impact of the NMT approach in improving recovery outcomes.

Figure 1. NMT Pilot Project Learning Goals

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?

Project Need

Through the MHSA Community Planning Process in San Mateo, BHRS and community stakeholders identified the need to provide alternative treatment options to broaden and deepen the focus on trauma

informed care and provide better outcomes in recovery for adult BHRS consumers. To address this need, BHRS proposed implementing the NMT approach within the BHRS Adult System of Care. NMT is an innovative approach to treating trauma that is grounded in neurodevelopment and neurobiology. Subsequent sections provide a more in-depth description of NMT and its application to adults.

NMT Background

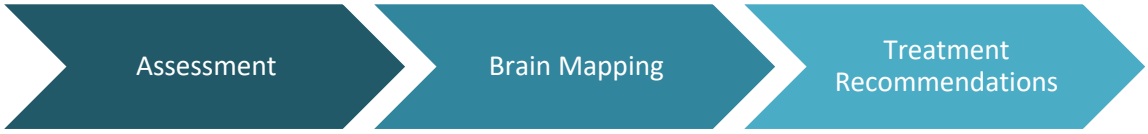
The Child Trauma Academy (CTA) developed NMT as an alternative approach to addressing trauma, typically used with children, that is grounded in neurodevelopment and neurobiology. NMT is not a single therapeutic technique or intervention. Rather, NMT uses assessments to guide the selection and sequence of a set of highly individualized therapeutic interventions (e.g., therapeutic massage, drumming, yoga, expressive arts, etc.) that best match each NMT consumer's unique strengths and neurodevelopmental needs.[1]

NMT is guided by the principle that trauma during brain development can lead to dysfunctional organization of neural networks and impaired neurodevelopment. The selected set of therapeutic interventions intends to help change and reorganize the neural systems to replicate the normal sequence of brain and functional development. Selected interventions first target the lowest, most abnormally functioning parts of the brain. Then, as consumers experience functional improvements, interventions are selected that target the next, higher brain region. The sequence of interventions aims to help consumers better cope, self-regulate, and progress in their recovery.

NMT Processes and Activities

As depicted in Figure 2, the NMT process consists of three main phases: 1) assessment, 2) brain mapping, and 3) the development of individualized treatment recommendations. These phases are briefly described below.

Figure 2. Key phases of the NMT Process



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

[1]Perry, B.D. & Hambrick, E. (2008) The Neurosequential Model of Therapeutics. *Reclaiming Children and Youth*, *17*(3), 38-43.

developmental impairment. Through this "mapping" process, scores are calculated in four functional domains: 1) Sensory integration, 2) Self-regulation, 3) Relational, and 4) Cognitive. The functional domain values are compared with age typical domain values to assess the degree of developmental impairment and identify the consumer's functional strengths and challenges.

Treatment Recommendations. Therapeutic interventions are identified that address the consumer's needs in the four functional domains, first targeting the lowest brain regions with most severe impairment. Throughout treatment, assessments and brain mapping are performed at regular intervals to evaluate any changes in functional domains, and treatment recommendations are adapted as appropriate.

NMT Training

CTA offers two levels of training: the Phase I NMT Certification training, and the Phase II "Train-the-Trainer" training for providers already certified in NMT. The NMT training model, for both Phase I and Phase II trainings, relies on a case conference or group supervision approach with intensive self-study. To conduct their self-study, providers receive a detailed training syllabus with a variety of web-based training materials and resources—including videos, lectures, recordings, readings, and case studies—allowing providers to work through the content at their own pace.

Providers must also participate in a monthly meeting, or case conference, wherein providers discuss real-life cases. These group discussions are the foundation for supervision of NMT implementation, provide opportunities for clinicians to refine their knowledge and skills, and allow for fidelity monitoring. Throughout the course of the training, trainees are also expected to conduct NMT assessments and interventions.

Certified NMT providers must then complete fidelity assessments annually, wherein providers evaluate the same client data and inter-rater reliability scores are calculated. NMT training is designed to be completed over the course of approximately one year, although the self-directed nature of the training allows the training to be extended as needed.

The Phase I and Phase II training structure is briefly described below:

- **Phase I training**: The Phase I training providers attend an initial in-person training that teaches the core principles of NMT. After this initial training, providers begin conducting their self-study and implementing NMT, often with the support of an NMT mentor. Throughout the training, trainees also participate in NMT study groups and learning communities. To graduate the training, providers must complete at least 10 NMT assessments.
- **Phase II training:** The Phase II training to prepare NMT clinicians to become NMT trainers or mentors. The structure and format of the Phase II training is similar to Phase I, and includes a combination of self-study, monthly meetings, and conducting NMT assessments. However, the Phase II training examines NMT principles in greater depth. Like the Phase I training, Phase II clinicians must conduct at least 10 NMT assessments. By the end of the Phase II training, providers are expected to be able to lead the core principles training and mentor providers in the Phase I training.

Application of NMT to Adults

Since its development, NMT has been most widely used with children who experienced maltreatment and/or trauma, and BHRS has been using the NMT approach with children since 2012. However, the use of NMT with adults is limited. Given the high prevalence of trauma among adult behavioral health consumers and the relationship between childhood trauma and behavioral health issues in adulthood, there is a strong theoretical basis to predict that adult mental health consumers could benefit from the NMT approach.[2,3]

Nevertheless, NMT's effectiveness in the adult population is unknown. As mentioned, NMT has not been formally implemented into an adult system of care, and no outcome studies have been conducted to evaluate NMT in an adult population. BHRS is adapting, piloting, and evaluating the application of the NMT approach to an adult population with hopes of increasing the quality of mental health services and improving recovery outcomes for adult mental health consumers with a history of trauma.

Project Description and Timeline

BHRS NMT Pilot Project

NMT Providers

As mentioned, BHRS has been using the NMT approach with youth since 2012. Prior to beginning the NMT adult pilot, 30 clinical staff in the BHRS Child and Youth System of Care and 10 clinical staff from community-based partner agencies received training through CTA. In addition, 10 BHRS providers became certified NMT trainers, and certify other providers in NMT through the CTA training. These trainers serve as mentors to NMT trainees and teach NMT principles and provide consultation to other providers. To expand NMT to the adult population, BHRS began training providers within the Adult System of Care in January 2017. The providers work in a variety of settings, including BHRS specialty mental health or regional clinics and programs serving consumers re-entering the community following incarceration.

Target Population

BHRS estimates that the adult NMT pilot project will serve approximately 75 to 100 adult consumers annually once the BHRS providers in the Adult System of Care are fully trained. Providers refer existing BHRS consumers from their caseloads to NMT, targeting three adult mental health populations:

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[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.

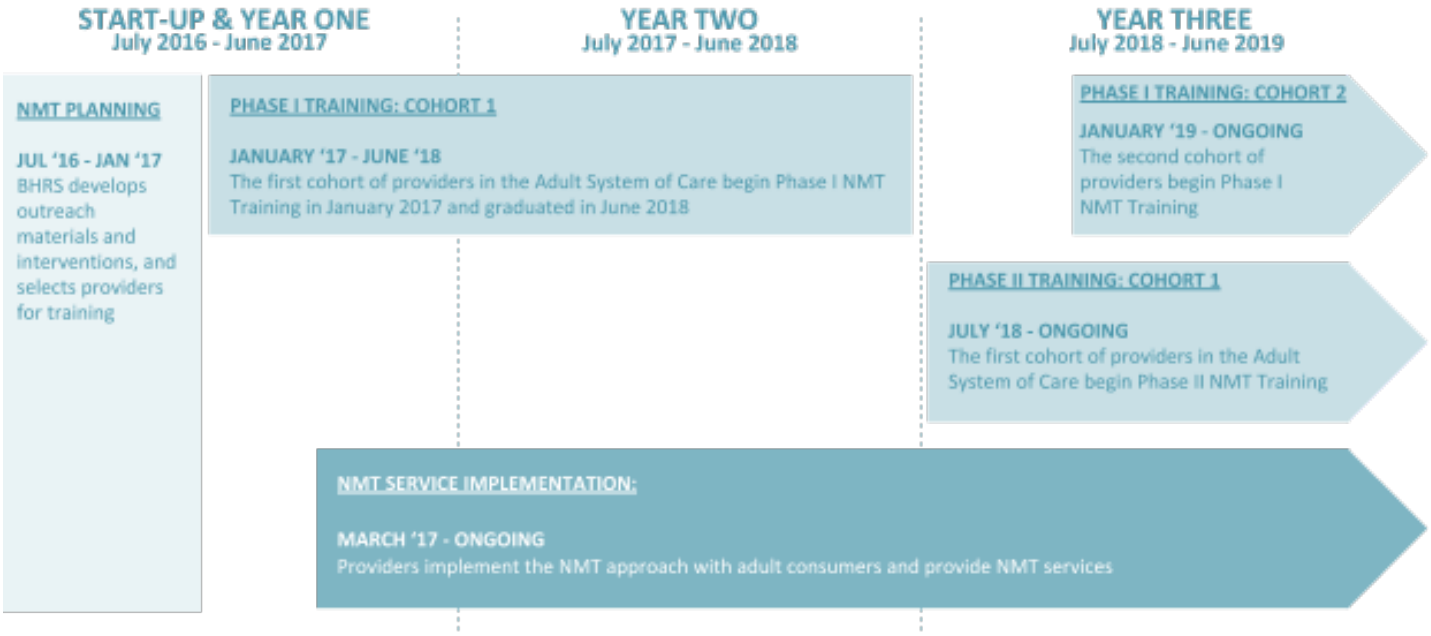
- General adult consumers (ages 26+) receiving specialty mental health services;
- Transition age youth (TAY) consumers (ages 16-25); and
- Criminal justice-involved consumers re-entering the community following incarceration.

The three target populations likely have different experiences, needs, and coping skills and, as a result, could respond to NMT differently. For example, TAY are still undergoing brain development and therefore may be more responsive to neurodevelopmental treatment approaches such as NMT. In addition, the re-entry population might have different coping mechanisms than the general adult and TAY consumer populations, such as engaging in high-risk behaviors that might lead to incarceration. For the re-entry population, the experience of incarceration could also further contribute to trauma.

Implementation Timeline

Figure 3 illustrates the key activities that have taken place since NMT implementation began in July 2016.

Figure 3. NMT Implementation Timeline



Evaluation Overview

As mentioned, BHRS contracted RDA to evaluate the pilot and support project learning. In order to maximize RDA's role as research partners, RDA collaborated with BHRS and CTA when planning the evaluation—including identifying evaluation goals, validating the theory of change for NMT specific to the adult population, identifying the types of variables that may support or complicate outcomes in adults, and developing data collection tools to measure program implementation and consumer outcomes.

To guide the NMT evaluation, RDA developed evaluation sub-questions associated with each learning goal. The evaluation questions (EQ) are listed below. To the extent possible, the evaluation 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.

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?

In this third year of the NMT implementation, the evaluation examines both Learning Goals to: 1) identify how NMT implementation has progressed as the program has matured and 2) examine preliminary changes in consumers' functional and recovery outcomes as consumers participate in NMT.

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, how BHRS is adapting the NMT approach for the adult population, and preliminary consumer outcomes. This report includes information about NMT implementation as well as preliminary consumer outcomes for adults who were open to NMT services during the evaluation period—July 1, 2018 to June 30, 2019, fiscal year 2018-2019 (FY18-19).

RDA worked closely with BHRS to identify and obtain appropriate outcome measures and data sources to address the evaluation questions. Table 1 outlines the outcome data available for this report as well as the respective data sources.[4]

Quantitative data: RDA collected quantitative data about NMT consumers from two main sources: 1) BHRS's Electronic Health Record (EHR) system, Avatar, and 2) the NMT Database operated by CTA, which includes brain map and functional domain scores and recommended NMT interventions.

Qualitative data: RDA also collected qualitative data through discussions with BHRS NMT providers and NMT consumers. RDA conducted two focus groups with NMT providers on August 6, 2019—including one group with a new cohort of BHRS providers participating in the Phase I training (7 participants) and one group with BHRS providers participating in the Phase II NMT "Train-the-Trainer" training. Additionally, on August 29, 2019 RDA conducted two separate discussions with NMT consumers (total of 3 participants).

Focus groups with BHRS providers centered on providers' experience of NMT training, how they are adapting the NMT approach with the adult population, and implementation successes and challenges. Discussions with consumers focused on their experience with NMT services, how NMT services differ from other mental health services received, and the perceived impacts of NMT on their wellness and recovery.

Table 1. Measurable Outcomes and Data Sources

Outcome Type	Outcome Measures	Data Sources
Process Outcomes	Number of consumers participating in NMT services	Electronic Health Records
	Characteristics of NMT consumers	Electronic Health Records
	Provider experience of NMT training and NMT implementation with the adult population	Provider Focus Groups
	Types of recommended NMT interventions	Consumer and Provider Focus Groups and NMT Database
Consumer Outcomes	Changes in brain map and functional domain scores	NMT Database
	Perceived impact of NMT services on consumer functional and recovery outcomes	Consumer and Provider Focus Groups
	Consumer experience of NMT services	Consumer Focus Group

[4]The Data Collection and Analysis section of the Appendix includes the types of additional outcome data expected to be available in later reports.

Data Analysis

To analyze the quantitative data (e.g., consumer characteristics and service utilization), RDA used descriptive statistics to examine frequencies and ranges. When the sample size was large enough, RDA also explored differences in outcomes across different sub-populations (e.g., adults, TAY, criminal justice involved adults, etc.) To analyze qualitative data, RDA transcribed focus group participants' responses to appropriately capture the responses and reactions of participants. RDA then thematically analyzed responses from participants to identify commonalities and differences in participant experiences.

Implementation Update

Changes to Innovation Project during Reporting Period

There were no changes to the NMT pilot project during the 2018-2019 fiscal year.

Key Implementation Updates and Accomplishments

In FY18-19, BHRS began training two new cohorts of providers within the adult system of care, including NMT certification training (Phase I) and NMT Train-the-Trainer training (Phase II). Phase I training began in January 2019 with 16 total providers—including six providers from the Adult System of Care. This was the second cohort of providers in the Adult System of Care to participate in the Phase I training. Phase II training began in July 2018 and includes five providers from the Adult System of Care. Before participating in Phase II training, providers must first complete the Phase I training. As the first cohort of adult providers completed the Phase I training in FY17-18, this was the first cohort to participate in the Phase II training.

As more providers are certified or begin NMT training, the volume of adult consumers participating in NMT services continues to grow. During Year 3 of the pilot, 77 consumers were enrolled in NMT services, compared to 40 in year 2 and 20 in year 1. Additionally, as the pilot progresses, providers have been able to complete more follow-up assessments to assess changes in functional outcomes. As of the end of Year 3, follow-up assessments were available for 28 consumers, compared to 11 consumers during Year 2.

BHRS created and filled a Mental Health Program Specialist position to support NMT training and the NMT pilot. As NMT continues to expand within the BHRS systems of care, the Mental Health Program Specialist role has been instrumental in supporting the organization and coordination of the NMT program. The Mental Health Program Specialist is a certified NMT clinician and trainer within BHRS and has acted as a resource and mentor for NMT trainees.

BHRS continued to expand the NMT resources and interventions available to consumers in the Adult System of Care. During the third year of pilot, BHRS continued to implement new interventions—such as offering the "Art of Yoga" therapeutic yoga sessions for NMT consumers at the North County clinic. BHRS also equipped all NMT providers with a basket of sensory tools (e.g., fidget spinners, stress balls, play doh, sensory brushes, pipe cleaners, etc.). Providers can request specific resources or interventions to best meet their client's needs (e.g., rocking chair, weighted blankets, coloring books, sketch pads, etc.). In addition to providing resources directly for interventions, NMT providers also received training in implementing sensory profiles to better understand consumers' sensory preferences and behaviors. This information can then be used to further inform appropriate therapeutic strategies and interventions.

NMT Consumer Profile

The following section describes the consumer population that participated in NMT services during FY18-19, including demographic information, behavioral health diagnoses, behavioral health service utilization, and baseline NMT assessment information.

Demographic Information

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 16-25) receiving mental health services, and criminal justice-involved consumers re-entering the community following incarceration.

During FY18-19, 77 adult consumers received NMT services, all of whom reflect the intended target population. Overall, the average age of consumers was 34, with ages ranging from 17 to 70. Most consumers (n=56, 72%) were adults ages 26 and older, while 21 consumers (27%) were TAY. In addition, at least 28 consumers (36%) were also part of the re-entry population, almost all of whom were adults.[5]

Figure 4. NMT Consumer Population, N=77

Table 2 describes the demographic characteristics of the NMT consumers.[6] For some characteristics, information was unknown or not reported for all consumers. As a result, the total number of consumers may be less than 77. The number of consumers for whom information is available is reported in the table.

Two-thirds of consumers reported they were female (n=49, 64%) and one-third reported they were male (n=28, 36%); no consumers reported a different sex.[7] Although the largest racial group was White (n=24, 34%), approximately a quarter of consumers each reported they were two or more races (n=18, 25%) or reported their race as Other (n=19, 27%). A smaller proportion of consumers reported their race as Black or African American (n=5, 7%) or Asian/Pacific Islander (n=5, 7%). Nearly half of consumers also reported

[5]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).
[6]In accordance with HIPAA, demographic categories comprised of fewer than five consumers were aggregated to protect consumer privacy.
[7]Information regarding gender identity was not available for this report.

their ethnicity as Hispanic/Latino (n=31, 44%). Race was unknown or unreported for six consumers, and ethnicity was not reported for seven consumers.

The majority of consumers (n=67, 87%) reporting speaking English only, while 9% of consumers reported speaking Spanish (n=7), and 4% reported another language (n=3). Most consumers reported they were heterosexual (n=51, 81%), while 17% (n=11) reported they were another sexual orientation, and one consumer declined to state their sexual orientation. Sexual orientation was unknown or unreported for 14 consumers. Nearly half of consumers (n=37, 48%) had a known disability. Of these consumers, nearly all (95%, n=35) reported a chronic health condition, while 16% (n=6) had an intellectual or developmental disability. No consumers reported that they were a veteran.

Table 2. Demographic Characteristics of Consumers

Characteristic	Consumers	% of Total
Gender (N=77)		
Female	49	64%
Male	28	36%
Race (N=71)		
White	24	34%
Black or African American	5	7%
Asian/Pacific Islander	5	7%
Other Race	19	27%
Two or More Races	18	25%
Ethnicity (N=70)		
Hispanic/Latino	31	44%
Not Hispanic/Latino	39	56%
Primary Language (N=77)		
English	67	87%
Spanish	7	9%
Other	3	4%
Sexual Orientation (N=63)		
Heterosexual	51	81%
LGBTQ+[8]	11	17%
Declined to State	1	2%
Disability (N=77)		
Any Disability	37	48%
No Known Disability	40	52%

Behavioral Health Diagnoses

Consumers who participated in NMT had a variety of mental health diagnoses. Typically, the majority of adult consumers receiving specialty mental health services within adult systems of care have been diagnosed with a psychotic disorder (e.g., schizophrenia or schizoaffective disorder) or a mood disorder (e.g., bipolar or major depressive disorders). However, as shown in Figure 5, the NMT population served

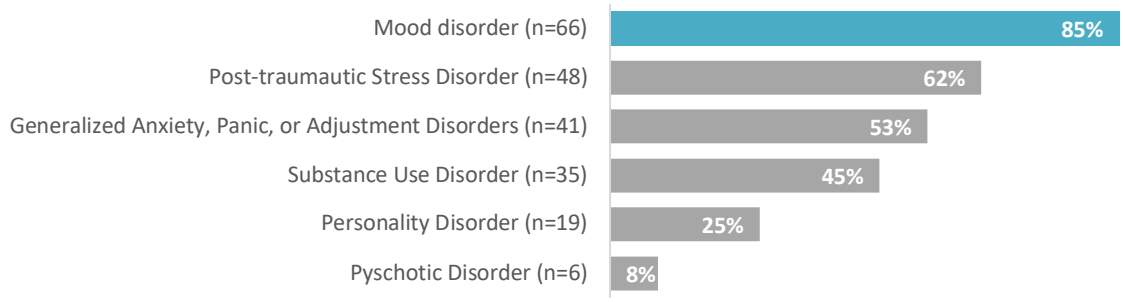
[8]LGBTQ+ refers to lesbian, gay, bisexual, transgender, questioning or gender queer, intersex, asexual, or other sexual orientations.

during FY18-19 had a wider variety of behavioral health diagnoses. Consumers may have more than one behavioral health diagnosis; as a result, percentages add to greater than 100%.

The most common diagnosis was a mood disorder; 85% (n=66) of consumers were diagnosed with a depressive or bipolar disorder. Of those, most were diagnosed with a major depressive disorder while a smaller subset were diagnosed with bipolar disorder or an unspecified mood disorder. Nearly two-thirds of consumers (62%, n=48) were diagnosed with a posttraumatic stress disorder (PTSD), and half (53%, n=41) were diagnosed with a generalized anxiety, panic, or adjustment disorder. Only 8% of consumers (n=6) were diagnosed with a psychotic disorder. In addition to these mental health diagnoses, 25% (n=19) also had a diagnosed personality disorder.

Substance use is also prevalent among the population served, wherein nearly half of consumers (n=35, 45%) have a documented co-occurring substance use disorder. Of these consumers, most reported using several substances, while some were diagnosed with specific cannabis, alcohol, opioid, stimulant, or other substance use disorders. Most consumers with documented substance use disorders were also part of the criminal justice re-entry population.

Figure 5. Behavioral Health Diagnoses of NMT Consumers, N=77



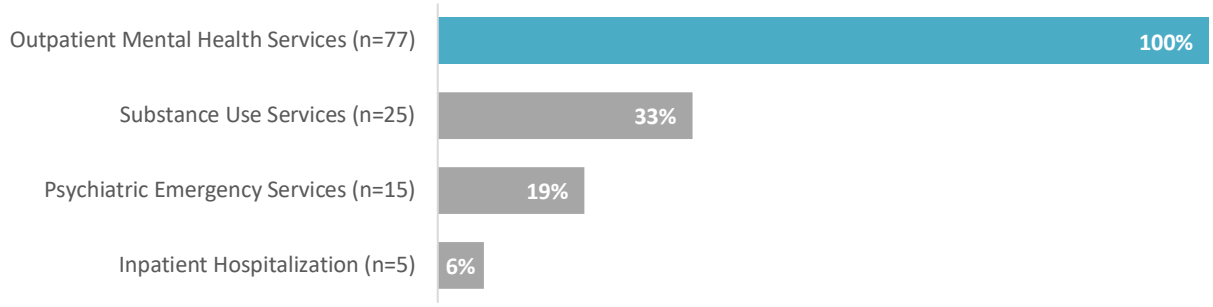
The breadth of diagnoses aligns with some of the diagnostic challenges that arise when working with individuals who have experienced significant trauma. Adults who have experienced trauma often have a more complex clinical presentation, frequently characterized by symptoms of anxiety, depression, and other mood fluctuations as well as substance misuse. Symptoms reflective of trauma may not clearly align to any one diagnosis within the existing diagnostic classification systems (e.g., DSM-IV TR or DSM-V). The relatively high prevalence of documented personality disorders may also be indicative of pervasive childhood trauma.

Behavioral Health Service Utilization

All consumers who received NMT services were enrolled in and receiving outpatient mental health services, which aligns with the model of integrating NMT within existing mental health services rather than creating a stand-alone program. In addition to outpatient mental health services, one-third of consumers (n=25, 33%) also participated in outpatient and/or residential substance use services. Of these consumers, five also participated in detoxification services in the year prior to enrollment. Additionally,

19% of consumers (n=15) experienced a mental health crisis that required psychiatric emergency services, and 6% of consumers experienced inpatient hospitalizations in the year prior to enrollment.

Figure 6. Behavioral Health Service Utilization, N=77



Baseline NMT Assessments

Baseline Brain Map and Functional Domain Scores

As mentioned previously, NMT-trained providers enter assessment data into a web-based tool designed by CTA that uses the assessment data to generate a brain map illustrating the brain regions most likely to be affected by developmental impairment. Through this mapping process, scores are calculated in four functional domains: 1) Sensory integration, 2) Self-regulation, 3) Relational, and 4) Cognitive. The brain map and functional domain values can then be compared with age typical values to assess the degree of developmental impairment and identify the consumer's functional strengths and challenges.

These functional domains are defined as follows:

- **Sensory Integration** refers to a set of functions that integrate, process, store, and act on sensory input from outside (e.g., visual, auditory) and inside (e.g., metabolic) the body.
- **Self-Regulation** refers to a broad set of functions that modulate and regulate the activity of other key systems in other parts of the body and brain, such somatosensory and emotional regulation.
- **Relational** refers to the complex set of relationship-related functions such as bonding, attachment, attunement, reward, empathy, and related emotional functions.
- **Cognitive** refers to the myriad functions involved in complex sensory processing, speech, language, abstract cognition, reading, future planning, perspective-taking, moral reasoning, and similar cognitive capabilities.

As of the end of the reporting period, baseline assessment data were completed and available for 72 consumers. Of these 72 consumers, 71% were adults (n=51) and 29% were TAY (n=21). Additionally, 39% (n=28) were part of the reentry population. For each consumer, functional domain values were compared with age typical values to calculate the percent of age typical functional domain score. A score of 100% indicates normal functioning with respect to a person's age. A score lower than 100% indicates some degree of impairment, wherein lower scores correspond to greater impairment. For example, a functional domain score of 70% indicates greater impairment than a value of 80%. The average baseline scores for the total brain map and each of the functional domains are illustrated in Figure 7.

Consumers' average baseline brain map score was 76%. However, the values ranged widely from 29% (indicating a high degree of impairment) to 100% (indicating normal functioning). Consumers appeared to have relatively high functioning in the sensory integration and cognitive domains at baseline, while baseline functioning in the self-regulation and relational domains tended to be slightly lower. For both the sensory integration score and cognitive domains, the average score was 81% (sensory integration range: 38% to 100%, cognitive range: 15% to 100%). In comparison, for both self-regulation and relational domains, the average score was 71% (self-regulation range: 35% to 100%, relational range: 27% to 100%). Overall, there were not significant differences in baseline scores and the level of recommended interventions between adults and TAY.

Figure 7. Average Baseline Brain Map and Functional Domain Scores, N=72

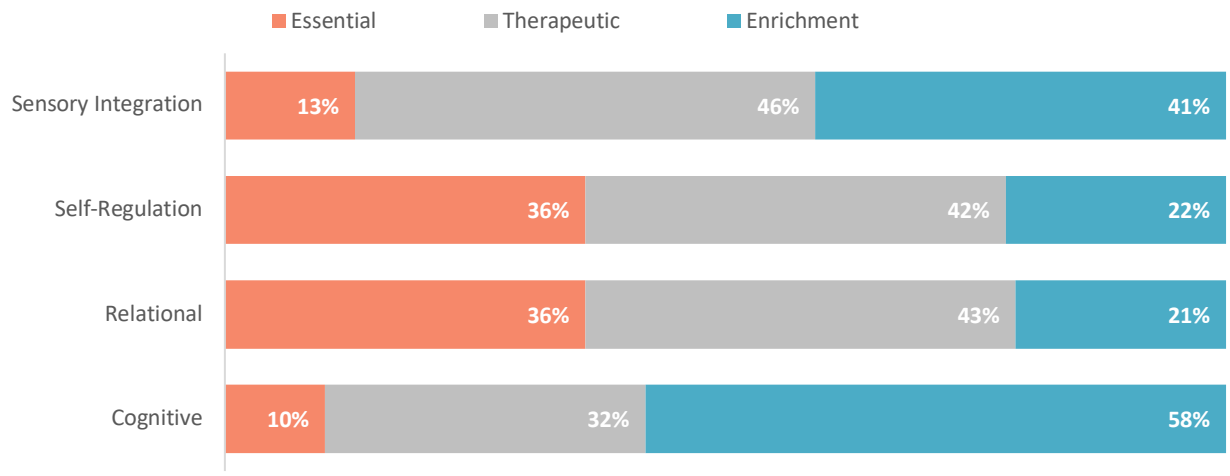
Level of NMT Recommended Interventions

As discussed, brain map and functional domain scores are used to highlight the consumers' functional strengths and needs. This information can then be used to develop broad recommendations for the types and intensity of NMT interventions that consumers should receive to promote growth and recovery. To guide treatment planning, CTA developed cut-off scores to indicate whether interventions targeting each of the functional domain areas are recommended as essential, therapeutic, or enrichment. These recommendation categories, or levels, are described in greater detail below:

- **Essential:** Functional domain score is **<65%** of age typical. At the essential level, activities are considered crucial for future growth in the given domain. If functioning in the essential area is not increased, the individual will lack the foundation for future growth and development in this and other areas.
- **Therapeutic:** Functional domain score is **65-85%** of age typical. At the therapeutic level, activities are aimed at building strength and growth in the particular area. Therapeutic activities are viewed as important for continued growth and development.
- **Enrichment:** Functional domain score is **>85%** of age typical. At the enrichment level, activities provide positive, valuable experiences that continue to build capacity in the given area.

The recommended level of interventions reflect the relatively high functioning of consumers in the cognitive and sensory integration domains, compared to the self-regulation and relational domains (Figure 8)**.** In both the sensory integration and cognitive domains, interventions for approximately half of consumers were recommended as enrichment, whereas interventions were recommended as essential for only 10% of consumers. In comparison, for the self-regulation and relational domains, only 20% of consumers had interventions recommended as essential while over 30% had interventions recommended as essential.

Figure 8. NMT Recommendation Categories across Functional Domains, N=72



Differences Across Target Populations

Overall, there were no significant differences between adults and TAY in the baseline functional domain scores and the recommended level of NMT interventions. Although, adults appeared to have a slightly wider range in functional domain scores. Additionally, baseline values were similar among adults in the re-entry population and adults who were not criminal justice involved. Baseline functional domain scores and baseline recommended level of interventions information for each of the target populations is available in Appendix I.

Progress Toward Learning Goals

Summary of Key Findings

This section discusses the progress that the BHRS NMT Pilot has made toward achieving its two learning goals. A summary of key findings is presented below, followed by a detailed discussion of each learning goal.

Learning Goal 1: NMT Implementation and Adaptation

NMT Capacity in Adult System of Care. BHRS continues to expand NMT capacity throughout the Adult System of Care as more providers are being trained and more consumers are receiving NMT services. BHRS is selecting NMT trainees to fill gaps in adult outpatient clinics and programs. However, some providers are experiencing challenges in getting buy-in for NMT among providers in their clinic or program who are not NMT-certified.

NMT Training Support. BHRS is building upon lessons learned and has implemented a number of strategies to better prepare and support providers through the intensive NMT training. These improvements are helping providers stay motivated and continue with training. However, the training is still time intensive and providers continue to face challenges balancing NMT training with caseload and productivity demands.

Adaptations to Adults. Although NMT assessments continue to take longer and are more complex with adults than children, NMT providers are becoming increasingly adept at adapting the NMT approach to adults. As providers are becoming more confident in the NMT approach and assessment process, providers continue to implement NMT with a broader adult population.

Provider Skill Development. The NMT training is increasing providers' knowledge and ability to respond to consumers with a history of trauma. Learning the NMT approach also helps providers bring creativity to their work and appears to be sharpening providers' clinical skills. In some cases, the opportunity for skill development and creativity in their clinical work is encouraging providers to stay at BHRS.

Learning Goal 2: NMT Outcomes

Improved Consumer Functional Domain Scores. Consumers appear to be benefitting from NMT services, as indicated by increases in functional domain scores. However, the magnitude of change varies widely across consumers, and preliminary data demonstrate greater and more consistent improvement among transition age youth compared to adults.

Improved Consumer Recovery and Experience of Care. NMT appears to be enhancing the consumer experience of care and helping consumers progress in their recovery. Prior to NMT, most consumers had only engaged in more traditional approaches to treatment. Consumers appreciated the individualized approach of NMT, the alternative interventions, and working with providers in a new way. For some consumers, the NMT approach may make it easier to engage in therapy.

Trauma-Informed Approach to Care. NMT training and implementation continues to support NMT clinicians—and, in turn, other providers who work with NMT clinicians—to implement a more trauma-informed approach to care with their caseloads and in their clinics overall.

Learning Goal 1: NMT Implementation and Adaptation

The following section describes key successes and challenges in implementing and adapting NMT to the adult population. The section includes discussion of the selection of providers in the adult system of care, NMT training, the NMT assessment process, and NMT interventions.

NMT Provider Selection

BHRS is selecting providers to fill NMT gaps throughout the Adult System of Care. Both the NMT Phase I and Phase II trainings are voluntary and available to BHRS master's level clinicians, although staff must apply to participate in the training. As providers' interest in NMT has grown, BHRS received a greater volume of applications from providers in both the Adult and Children's Systems of Care. When selecting providers to participate, BHRS aimed to fill gaps in the system of care and prioritized clinics or programs that did not have any or had only one NMT-certified clinician.

Providers are participating in NMT training to strengthen their ability to serve consumers with a history of trauma. As mentioned, five providers in the Adult System of Care began the NMT Phase II "Train-the-Trainer" training in July 2018, while six providers began the Phase I training in January 2019. Providers received information about NMT and the NMT training opportunity from supervisors, team members, and a training announcement circulated by BHRS. Several providers shared that they chose to apply to the Phase I training after learning more about the impact of trauma on neurodevelopment and the NMT approach in the six core principles training. Other providers were already familiar with the NMT approach—either from attending other trainings or conferences where NMT was discussed or working with other NMT-trained clinicians—and were eager to participate in the training themselves.

> *There were three people going through training program [at my clinic], and they would come back and share what they were learning and the changes and progress they were making…I also heard NMT referenced through other trainings I was part of. When the opportunity came to do the training myself, I was on board.*
>
> – NMT Provider

Providers participating in the Phase II training wanted to deepen their understanding of NMT principles learned in the Phase I training. In some cases, providers completed the Phase I training several years earlier and wanted to refresh and strengthen their training. Others had just completed the Phase I training and wanted to continue to build upon the foundations and skills learned to strengthen their own abilities as well as educate others on NMT principles.

NMT Training

BHRS has implemented a number of strategies to support providers to stay on track with the intensive NMT training obligations. NMT trainings require significant time and dedication. Providers from the first cohort of trainees in the Adult System of Care shared that the training was more demanding and time consuming than expected. They added that translating NMT tools from the child to adult population intensified the time spent during training. Additionally, providers noted that the training website is difficult to navigate, posing impediments to accessing the self-study materials.

> *[My mentor] provides a lot of positive feedback, modeling a lot of what we are learning. She's attentive and doesn't seem to miss a thing which helps me feel more engaged. It's like going through school again, but when you're engaged and you see progress and you see changes in your clients, then it feels worth it.*
>
> – NMT Provider

To address some of these challenges, BHRS implemented several strategies to better support trainees, including:

1) **Setting clearer expectations about NMT training demands.** During the training outreach and selection process, BHRS was clear with potential trainees as well as supervisors about the NMT training requirements to help ensure providers and their supervisors better understood the demands prior to beginning the training.
2) **Compiling and organizing training materials for providers.** Each month the BHRS' Mental Health Program Specialist for the NMT program creates a zip file with all of the self-study materials along with a checklist or instructions for training activities and expectations for that month. Providers shared that these emails help keep providers organized, motivated, and engaged.
3) **Providing greater mentorship throughout the training.** Although providers in the first cohort were assigned mentors toward the end of the training period, BHRS ensured that every trainee in the current cohort was assigned a mentor at the beginning of the training. Mentors work with trainees on a biweekly or monthly basis (depending on the trainee's needs) to help trainees better understand and integrate NMT principles. This often includes reviewing and discussing self-study materials, reviewing cases, co-leading or supporting trainees during assessments and intervention planning. Several providers noted that the mentorship was the most helpful aspect of the training.
4) **Granting trainees compensatory time for NMT training and self-study.** To help ease the burden of participating in NMT training on top of existing work and caseloads, BHRS has granted all trainees four hours of compensatory time (i.e., comp time) each week. This time is intended to help trainees set aside time for self-study and other training requirements.

Sufficient time to complete training requirements remains a challenge for trainees. Overall, the strategies mentioned have been immensely helpful to better support and retain providers throughout the training, and BHRS noted far fewer providers have dropped out compared to previous years. However, having sufficient time to complete training requirements remains a challenge for providers.

> *Time is a challenge in general, and the productivity index is a pressure as well. Yeah, we can use comp time, but I still need to reach a level of productivity.*
>
> – NMT Provider

For both the Phase I and Phase II training, the allocated comp time may not be enough at the beginning of the training when providers are familiarizing themselves with the materials and/or may be learning NMT principles for the first time. Additionally, it appears that the approval of comp time is inconsistent across sites and supervisors, and providers are sometimes unsure of when to use or how to submit comp time. Phase II providers shared that they need time to practice teaching and presenting on NMT modules but are unclear if comp time can be used. Several trainees shared that even with comp time, they still feel pressure to meet productivity targets and end up needing to work additional hours to keep up with the training. As a result, some providers may fall behind on training requirements.

The NMT training is increasing providers' knowledge and ability to respond to consumers with a history of trauma. Overall, providers found the NMT training useful and interesting and enjoyed learning about the neurobiology and impact of trauma. For many of the providers, the NMT training is providing an opportunity for more advanced training in brain development and neuropsychology related to trauma. For Phase I trainees in particular, their increased knowledge and understanding about the impact of trauma is helping them better understand the behaviors and presentation of consumers. For Phase II trainees, the training is helping them understand NMT principles more deeply. Phase II providers are improving their ability to identify and integrate appropriate interventions (particularly the use of sensory tools) into therapy, as well as apply and explain NMT principles to consumers and other providers.

Learning the NMT approach helps some providers bring creativity to their clinical work, which may also support provider retention at BHRS. NMT enables providers to "think outside the box" when identifying interventions to best meet each consumer's unique needs. In some cases, providers shared that the ability to be creative in their clinical work as a result of NMT keeps them at BHRS. NMT trainers and supervisors also observed these changes among providers and noted that the training appears to be sharpening providers' clinical skills. Given these benefits, several providers shared that all clinicians should receive some training in the NMT principles and the impact of trauma on neurodevelopment in order to improve service delivery to the entire adult consumer population.

NMT Assessment Process

Providers are implementing strategies to streamline the assessment process. The NMT assessment process is fairly intensive and includes a number of detailed questions to understand a consumer's developmental history and past experiences of trauma. For all new NMT trainees—in both adult and youth systems of care—it takes time for providers to learn and gain comfort with the assessment tool. Providers in adult systems may also have a steeper learning curve as they do not regularly conduct developmental histories with adult consumers with the level of detail required for the NMT assessment.

As NMT trainees first learn the assessment questions and process, they often administer the assessment in a direct way, going question by question. This approach takes longer and may trigger or risk re-traumatizing consumers—particularly adults—who are not accustomed to these types of questions. As providers progress through the training and become more confident with the assessment tool, they typically learn and implement strategies to make the assessment process smoother and minimize the risk of re-traumatization. These strategies include:

> *At first, I tried to run the NMT assessment like a regular BHRS assessment, and I realized some of the questions are really intense for adults that are going through a lot of trauma. Now, I give clients lots of space to talk, and I don't put a limit on the number of sessions to complete the assessment. My mentor has given me many tips on how to go through the assessment.*
>
> – NMT Provider

1) **Explaining the process and providing some psychoeducation to consumers** to help them understand why the providers are asking about their childhood and adolescence;
2) **Asking broader questions or combining** questions to make the assessment more conversational, less burdensome, and less-time consuming and to reduce the risk of re-traumatization;
3) **Breaking up the assessment over multiple visits** if the consumer had reactions to the questions or struggled to focus long enough to complete the assessment;
4) **Reaching out to additional respondents who may have information about the consumer**, such as another provider who is familiar with the consumer's history
5) **Examining existing health records** for clients who have been open to BHRS to learn more about the consumer's history; and
6) **Closing an assessment session with mindfulness exercises, meditation, or other interventions** to help soothe or stabilize consumers after discussing difficult topics.

For the second cohort of providers in the Phase I training, mentors are helping to shorten the assessment learning curve and are helping trainees learn and implement some of the strategies more quickly. In addition to discussing the assessment process with trainees, mentors also often conduct the first assessments with trainees. During these co-assessments, mentors model these strategies or give feedback to trainees about how to make the assessment process easier.

Consumers who participated in the focus group acknowledged that the assessment process can feel long but appreciated when providers broke it up over multiple sessions. Some consumers also enjoyed learning

about NMT and how it works but found the NMT language and materials to be complicated and difficult to understand. These consumers shared that it could be helpful to have more accessible materials to explain the NMT approach and process to a non-clinical audience.

Assessments continue to be more time consuming and challenging to complete with the adult population compared to children. Although providers are implementing different strategies to make the assessment process less burdensome, providers noted that implementing NMT assessments with adults continues to be more time consuming and challenging than with children. As noted in previous reports, some reasons the assessment process is often longer for adults are:

> *It is easier to complete an NMT metric with children than adults. It's geared toward kids and it's a much shorter history. They take a lot more time to do with adults and it's definitely an investment, 3-4 sessions for an assessment at least. For adult clinicians, 10 metrics might be too much.*
>
> – NMT Provider

- With adults, the NMT assessment collects information for a consumers' entire developmental history—fetal stages through adulthood. In contrast, the assessment is shorter for children as it only collects information through the child's current developmental stage.
- The assessments can be more time consuming for adults if consumers cannot recall information, and/or if consumers need to take breaks or stop the assessment if it brings up difficult experiences.
- Compared to children, adult consumers may have fewer collateral contacts that the providers or consumers can work with in order to fill in information gaps of the assessment.
- Adult consumers may be less likely to regularly participate in NMT services due to the severity of mental illness, substance use, homelessness, incarceration, etc.

Given these challenges, providers are experiencing difficulty completing assessments if consumers stop regularly attending mental health service appointments or become incarcerated, hospitalized, or otherwise unavailable to continue. With the complexity of adult cases and the time it takes to complete, some providers noted that the Phase I training requirement of 10 completed assessments may be too demanding in the adult population.

Although completing the assessments can still be a challenge, NMT providers often begin implementing the NMT approach with consumers before the assessment is completed. Providers have found that implementing NMT interventions can help consumers better understand the underlying principles and builds buy-in for continuing the assessment process. When engaging in NMT interventions, consumers may also feel more comfortable sharing information that then informs the assessment.

Providers are continuing to expand NMT selection criteria to include consumers with greater mental health needs. In the earlier stages of NMT training, providers were often conservative in determining which consumers to refer to NMT. Providers were mindful of the risk of the assessment process and effectiveness of interventions based upon consumers' level of functioning, coping skills, and ability to self-

regulate as well as providers' experience with the assessment tool. At the beginning of the pilot, several providers mentioned that they typically only referred higher functioning consumers.

As providers gain more experience and confidence with NMT and the assessment process, providers' perception of the adult population that may benefit from NMT is evolving, and providers' selection criteria is expanding. Providers still consider the risks of engaging in the assessment with the potential benefits of NMT and strive to build rapport with consumers before beginning the assessment process. However, providers feel that the most important selection criteria for NMT are:

> *Those that are actively psychotic are really difficult to do in person. It's not as linear or black and white, but you can often get answers just being with them and building rapport. You can also provide what you think the NMT intervention is first, rather than waiting for the assessment to be complete.*
>
> – NMT Provider

- Consumer has a history of trauma;
- Consumer is willing to participate in NMT and regularly attends appointments; and
- Consumer is stable enough to recall information and provide realistic responses.

As NMT continues to expand throughout the BHRS System of Care, providers are also identifying other populations that may benefit from NMT—such as parents of children in the Youth System of Care, mothers experiencing post-partum depression, and individuals with more severe mental health needs who are receiving services at residential placements. Providers mentioned that it can still be challenging to conduct assessments with individuals who are actively abusing substances, are experiencing psychosis, or have developmental disabilities as this may influence consumers' ability or willingness to respond to assessment questions and/or regularly participate in NMT services. However, if it is apparent that the individual could benefit from NMT services, providers are still implementing the NMT approach and interventions with these clients even if a formal assessment cannot be completed.

NMT Interventions

> *[My provider] has a box of squishy things, as well as a sand tray. [The interventions] offer a different way to express yourself, rather than talking it out.*
>
> – NMT Consumer

Providers are continuing to implement a breadth of NMT interventions, tailoring activities to each consumer's specific interests and needs. The assessment recommendations serve to guide the types of interventions that consumers may need and that providers should prioritize. However, the specific interventions that providers select are tailored to what each individual is interested in and willing to do. Compared to the Youth System of Care, the Adult System of Care is more heavily focused on medication management and talk therapy. As a result, adults are typically unaccustomed to participating in the types of alternative interventions recommended by NMT. Providers found that compared to children, some adults may be less willing to try new and different types of activities.

With adults, providers often try to introduce interventions that may be more familiar—such as deep breathing, counting, going for walks, and mindfulness exercises. Every NMT provider also has a basket of

sensory tools in their office (e.g., fidget spinners, stress balls, play doh, sensory brushes, pipe cleaners, etc.) that are available for consumers to use. Providers noted that these tools can often serve as a conversation starter and are a good mechanism to communicate NMT principles.

Providers also try to learn about consumers' hobbies and interests and will suggest or encourage activities that align with the recommended interventions. As providers build rapport with consumers and learn more about their specific goals and needs, they may suggest new or additional activities that consumers may enjoy or benefit from—such as yoga, massage therapy, animal assisted therapy, drumming, or spinning clay. In some cases, consumers also suggest new activities they would like to try. Consumers reported appreciated having a variety of activities to choose from and tools to use to best meet their needs in different situations. This flexible and individualized approach helps consumers feel supported and engaged and increases the likelihood that they will implement the interventions independently.

Support and resources from BHRS help providers implement the various NMT interventions. Some providers shared that they are used to purchasing materials or tools for their offices out-of-pocket. With the NMT pilot, providers are able to request tools and resources for the NMT interventions through County funds, which has helped providers expand the interventions available to better meet each consumer's unique interests and needs. Nevertheless, some providers noted that insufficient space or poor office configuration can still be a constraint for effectively implementing some NMT interventions. Additionally, some providers noted that it can be challenging to find instructors or providers to lead some NMT interventions if they are group (rather than individual) activities—such as yoga or gardening—due to providers' workload constraints.

> *We have funds to support NMT interventions, like getting a rocking chair for one of our clients. This is the first time I've gotten supplies with County support.*
>
> – NMT Provider

Learning Goal 2: NMT Outcomes

The following section describes individual-level outcomes of adult consumers who participated in NMT services—including changes in assessment scores and recovery outcomes—as well as larger systems-level changes in providers' approach to care as a result of NMT implementation in the adult system.

Changes in Brain Map and Functional Domain Scores

At the time of this report, follow-up assessment data were available for 28 consumers. Providers conduct follow-up NMT assessments with consumers to evaluate consumers' progress as well as update consumers' treatment plans if necessary. On average, there were 12 months between the baseline and most recent follow-up assessments, although the time interval ranged from 4 to nearly 2.5 years.

Among consumers with follow-up assessments, 16 were adults (57%) and 12 were TAY (43%). Additionally, seven consumers were part of the reentry population, all of whom are adults. The evaluation examined changes in assessment scores overall, as well as across sub-populations—including a comparison of adults to TAY, and a comparison of reentry and non-reentry adults. However, given the small number of individuals with follow-up data available, assessment findings should be considered exploratory.

The relatively small number of individuals with follow-up assessments and the varying length of time between assessments may partially reflect the challenges in completing assessments and inconsistent participation in services among the adult population. In some cases, programs are designed to be short-term and consumers may graduate or move on to other services before a follow-up assessment is completed. As the program continues to mature and greater numbers of consumers are served for longer periods, more follow-up assessments will be available.

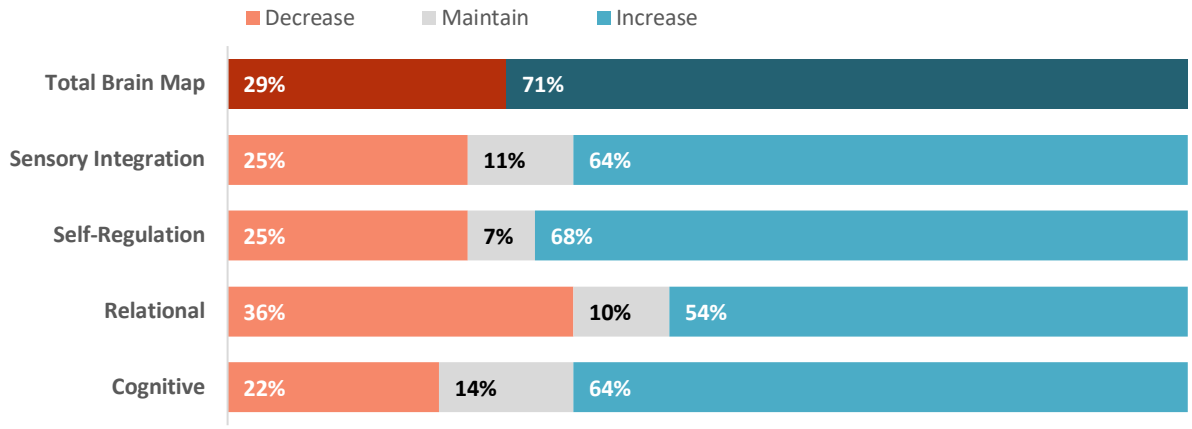
For the 28 consumers with follow-up data available for this report, baseline and follow-up assessment data were examined to identify changes in consumers' brain map and functional domain scores as consumers participated in NMT services. Brain map and functional domain changes are defined as follows:

- **Increase:** any positive change in a score from baseline to follow-up (follow-up – baseline > 0),
- **Decrease:** any negative change in scores from baseline to follow-up (follow-up – baseline < 0).
- **Maintain:** no change in the score from baseline to follow-up (follow-up – baseline = 0)

In general, increases in brain map values suggest improvement (progress toward age typical functioning), while decreases in brain map values suggest further impairment (movement away from age typical functioning).

Although the magnitude of change varies, most consumers are showing increases in their assessment scores, suggesting functional improvements. As shown in Figure 9, 71% of consumers (n=20) showed increases in their total brain map scores, while 29% (n=8) showed a decrease. Across the sensory integration, self-regulation, and cognitive domains, approximately two-thirds of consumers showed increases in domain scores, while a quarter showed decreases. Slightly fewer consumers (54%) showed increases in the relational domain, while one-third showed decreases. Across all functional domains, roughly 10% of consumers showed no change in scores.[9]

Figure 9. Percentage of Consumers with Increased and Decreased Assessment Scores from Baseline to Follow-up, N=28



[9]Although consumers may not have showed changes in one or more of the functional domain scores from baseline to follow-up (i.e., scores were maintained), all consumers showed some change (i.e., increase or decrease) in their overall brain map scores.

Overall, the average change in consumers' brain map and functional domain values was +3% to +5%, depending on the specific domain (Table 3). Trends in functional domain values are similar to those seen among consumers in the previous year.

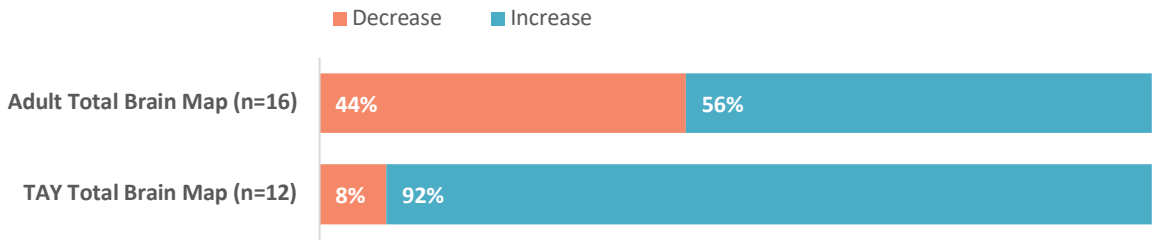
Table 3. Average Change in Assessment Scores from Baseline to Follow-Up, N=28

	Average Change in Scores	Range of Change in Scores
Total Brain Map	**+4%**	**-13% to +23%**
Sensory Integration	+4%	-7% to +25%
Self-Regulation	+5%	-11% to +29%
Relational	+4%	-13% to +28%
Cognitive	+3%	-26% to +24%

Providers noted that consumers who had particularly large increases in assessment scores responded particularly well to the selected NMT interventions and consistently engaged in NMT services. These consumers regularly engaged in the recommended activities and/or practiced various self-soothing or calming techniques on a day-to-day basis. However, in other cases, providers noted that some consumers showed great progress in their recovery, but the change in assessment scores was minor. In contrast, providers noted that individuals who showed decreases in assessment scores tended not to engage regularly in NMT services and may have had more active substance use and/or psychosis.

Compared to adults, TAY demonstrated greater and more consistent improvement in functional domain scores from baseline to follow-up. As mentioned, differences in the change in functional domain scores were examined across sub-populations. Overall, there were no significant differences between adults who were and were not part of the reentry population. However, significant differences emerged across the adult (n=16) and TAY population (n=12). Nearly all TAY showed improvements in their total brain map scores, compared to approximately half of adults (Figure 10). On average, the magnitude of change in assessment scores also tended to be larger among TAY. Among TAY, brain map scores increased by an average of 9% (range: -1% to +23%), while brain map scores increased by an average of 1% among adults (range -13% to +23). These trends continued across each of the functional domains, wherein more TAY had increased scores and the change in scores was larger compared to adults. Additional data regarding changes in functional domain scores across subpopulations is available in Appendix II.

Figure 10. Percentage of Adults and TAY with Increased and Decreased Brain Map Scores from Baseline to Follow-up, N=28



The larger and more consistent increases among TAY may reflect greater neuroplasticity among TAY compared to adults as they are still undergoing brain development. Additionally, TAY were also less likely

to have co-occurring substance use disorders and/or psychotic disorders, as may also have fewer years of heavy psychiatric medication. All of these factors may help TAY more consistently engage in and be more responsive to NMT interventions compared to adults. Differences in NMT effectiveness across sub-populations will continue to be explored as more consumers participate in NMT services and receive follow-up assessments.

Changes in functional scores may also be reflective of providers' as well as consumers' increasing experience and comfort with NMT and the assessment process. Providers observed that consumers may be more forthcoming about their history or experiences as they build rapport with providers and begin to see the benefits of NMT. As a result, more accurate information may be available for follow-up assessments, which could change assessment scores. Additionally, providers generally completed baseline assessments earlier in their NMT training, whereas follow-up assessments were completed later when providers had more practice and training. As providers gain more experience with the assessments, they may also score criteria slightly differently.

NMT Consumer Recovery and Experience of Care

NMT services appear to be helping consumers progress in their recovery. Aside from changes in assessment scores, all focus group participants (including providers and consumers) could point to benefits consumers experienced as a result of participating in NMT interventions. As in previous years, consumers frequently discussed how the NMT interventions helped them feel less anxious, more relaxed, and more in control. Concentrating on an activity—such as coloring or origami—helped consumers "get out of their head," while techniques such as deep breathing, meditation, yoga, or the use of sensory tools helped consumers stay centered and calm. As one consumer shared, "If there's something on my mind and I do origami, my focus is on the origami. After I'm done with the origami, the stuff I was worried about isn't too much to worry about anymore."

> *Evaluating situations and making better choices has been a significant improvement. Now I think about options to handle a situation, rather than just reacting to a negative stimulus. Now, I also think about the association of things. I think I would have handled issues with my family differently before. Now I have empathy and think about how they got to be that way.*
>
> – NMT Consumer

In several cases, consumers felt NMT was helping improve their quality of life and shared that they had a renewed interest in hobbies, reaching their goals, and spending time with family or friends. Other changes noted by consumers and providers included better communication, improved ability to manage anger or stress, and being better equipped to recognize and manage triggers. In previous years, other consumers reported that the NMT-based techniques and activities were helping consumers decrease substance use as well as reduce or avoid medication to cope with depression and anxiety.

For some consumers, the assessment process and NMT interventions appear to be helping them process their experiences to develop better insight and understand the impact that trauma has had on their current behaviors as well as behaviors of others. Consumers talked about how the interventions create a

safe space for them to address and rewrite their history. Providers also shared that some consumers are beginning to use NMT and trauma-informed language when discussing their experiences and recovery.

> *[NMT interventions] like the sand tray, or sketching, or writing offer a different way to express yourself, rather than talking it out.*
>
> – NMT Consumer

NMT offers an alternative approach to treatment that many consumers had never experienced. For some consumers, the NMT approach makes it easier for consumers to engage in therapy. As in previous years, consumers shared that NMT felt different from other mental health services they had received. In many cases, consumers were accustomed to more traditional talk therapy, which often left them feeling emotional and fatigued after sessions. In other cases, consumers talked about how other services they had received felt "one size fits all" and that previous providers did not try to get to know or understand them as individuals. In contrast, NMT-based activities made consumers feel "refreshed" and "light".

Several consumers observed that it was easier for them to discuss their feelings and trauma when engaging in the activities and that it helped them feel safe. Consumers also shared that providers' willingness to engage consumers in individualized activities such as drawing, coloring, and meditating helps build rapport and trust. Several consumers mentioned that no other providers have worked with them in this way before and that with NMT they look forward to their next sessions. As mentioned previously, in several cases, NMT consumers also implement NMT interventions on their own in between sessions.

Provider Approach to Care

> *Since I've been in a leadership role [at my clinic], NMT has been a constant part of agenda. At least once a month, I'm presenting on something on NMT and trauma-informed care…We want to get to a point where [non-NMT trained] supervisors can tell when a person needs a metric.*
>
> – NMT Provider

NMT implementation may be helping clinics and programs be more trauma-informed. As mentioned above, providers reported that being trained in NMT and the neurodevelopmental impacts of trauma is changing the way they approach care with all consumers. Additionally, providing NMT services in the Adult System of Care appears to be supporting non-NMT providers to employ a more trauma-informed approach when working with both NMT and non-NMT clients.

The NMT assessment process typically provides more comprehensive information about consumers' history and helps identify types of interventions that the consumer responds well to. This information is then often used to inform the way other non-NMT providers work with the client. In one instance, NMT metrics and sensory interventions with consumers in residential placements have been integral in helping non-NMT providers better understand consumers' behaviors and triggers. Additionally, the NMT clinicians have been able to offer recommendations for therapeutic strategies or interventions that the non-NMT providers can implement that are likely to be effective with the clients.

NMT-trained providers are increasingly receiving requests from non-NMT providers to conduct assessments with consumers on the non-NMT providers' caseloads, including both adults and the parents of children on their caseloads. Additionally, as the NMT adult pilot progresses, BHRS is receiving a greater volume of requests for the core principles training throughout the Adult System of Care. These findings suggest that training providers in the adult system of care in NMT principles may support adult clinics and programs in being more trauma-informed and trauma-capable organizations overall.

In some cases, NMT clinicians mentioned that other providers within their clinics or programs are not always as open or receptive to NMT. In particular, providers observed that non-NMT clinicians who have worked in the mental health system for a long time may see NMT as an intervention that will come and go, or may see NMT as too time intensive. In other cases, NMT providers work on interdisciplinary teams or with non-BHRS providers who do not have as much training in trauma-informed approaches and who may be more dismissive of NMT.

> *What we're learning is that adults are interfacing with a lot of different parts of our system. We still need more trauma-informed training across BHRS and those providers and agencies we work with.*
>
> – NMT Provider

Providers noted that having a supervisor who is trained in or supportive of NMT can make it easier to implement NMT more widely within a clinic or program. During case conferencing, supervisors can recommend that a consumer on a non-NMT provider's caseload receive an NMT assessment based upon the consumer's presentation and history of trauma. In contrast, NMT clinicians in non-supervisory roles and/or in larger teams sometimes feel they have less authority and can only suggest NMT to their fellow colleagues. NMT providers are hopeful that with the increasing exposure to NMT in the Adult System of Care, more providers will be receptive to and request NMT for their clients.

Recommendations

Based on the evaluation findings, below are recommendations to support NMT Adult Pilot implementation.

Continue to be intentional in trainee selection to fill NMT gaps in the BHRS Adult System of Care. To continue expanding NMT services and buy-in within the Adult System of Care, BHRS should continue prioritizing training providers at sites or programs where there are no or only one NMT trained clinician. Additionally, BHRS may wish to consider recruiting or selecting more trainees in supervisory or leadership roles to help facilitate wider adoption of NMT within the program.

Continue exploring and implementing strategies to help alleviate the time burden of NMT training. Several providers noted that finding time for NMT training activities can still be a challenge and compensatory time is used or granted inconsistently. BHRS may wish to consider providing a refresher to supervisors and trainees to clarify when, how, and for what training activities compensatory time can be applied. Additionally, BHRS may wish to consider allowing more comp time at the beginning of training when the learning curve may be steepest for trainees and NMT activities may take longer.

Consider developing more accessible, non-clinical NMT materials for consumers and their family members to help explain NMT principles and the approach. Some consumers shared that NMT materials explaining the NMT approach can be complicated and difficult to understand. Creating educational and outreach materials that use more accessible language could facilitate more interest and buy-in for NMT among consumers and family members.

Identify opportunities to disseminate findings from the NMT adult pilot. The NMT adult pilot is now in the third year of implementation, during which time BHRS has identified a number of strategies to successfully adapt the NMT to an adult population and expand NMT within an Adult System of Care. Additionally, preliminary findings are demonstrating positive outcomes among the adult population. The lessons learned by BHRS through the adult NMT pilot may be useful to other counties, systems of care, or partner agencies that are interested in NMT specifically or wish to implement or learn about alternative, trauma-informed approaches. To support this shared learning, BHRS may wish to identify opportunities to disseminate the evaluation findings—including lessons learned, success factors, and outcomes—more widely. This could include delivering findings presentations; drafting a white paper or brief document of key takeaways; and/or synthesizing lessons learned and successful implementation strategies to help guide and support others who may be interested in implementing NMT in an adult population.

Conclusion

The 2018-2019 fiscal year marked the third year of NMT implementation in the BHRS Adult System of Care. During this time, BHRS continued to expand NMT capacity throughout the Adult System. BHRS began the first "NMT Train-the-Trainer" training and the second NMT certification training with providers in the adult system of care. Providers were intentionally selected to fill gaps in NMT services across adult clinics and programs. As more providers are being trained in NMT across BHRS adult programs, the volume of adult consumers receiving NMT services continues to grow. In FY18-19, 77 consumers were enrolled in NMT services. Additionally, BHRS continues to better equip clinics and programs with NMT resources to expand the NMT interventions available to adult consumers.

BHRS built upon lessons learned during the first two years of the pilot and is becoming increasingly adept at adapting the NMT approach to adults. BHRS implemented a number of strategies to better support providers throughout the intensive NMT training. In particular, greater one-on-one mentorship throughout the training process has been instrumental in supporting providers to learn NMT principles and streamline the assessment process. Consumers also appear to be benefitting from NMT implementation, and for some, the NMT approach may make it easier for consumers to engage in therapy. Although follow-up assessment data were limited, preliminary data suggest that consumers are improving across all functional domains. TAY appear to be responding particularly well to NMT and showed greater and more consistent improvements in functional domain scores compared to adults. Consumers and providers also cited improvements in consumers' coping mechanisms and overall quality of life.

Additionally, NMT implementation is strengthening trained providers ability to serve consumers with a history of trauma and shows promise in supporting the adoption of trauma-informed practices and treatment options in the BHRS Adult System of Care overall. 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. In particular, BHRS and RDA will focus on understanding how NMT can continue to be expanded and sustained within the BHRS Adult System of Care. RDA will also continue to collect consumer-level data to examine changes in consumer outcomes overall and across sub-populations.

Appendix I. Baseline NMT Assessments Across Target Populations

Adults compared to TAY

Table 4. Average Baseline Functional Domain Scores among Adults and TAY (N=72)

Functional Domain	Adult (N=51) Average Score (Range)	TAY (N=21) Average Score (Range)
Total Brain Map	**76% (28 to 96%)**	**76% (55 to 99%)**
Sensory Integration	82% (38 to 100%)	79% (51 to 100%)
Self-Regulation	71% (35 to 94%)	73% (45 to 100%)
Relational	70% (27 to 96%)	73% (49 to 100%)
Cognitive	82% (15 to 100%)	80% (61 to 99%)

No significant differences were found across groups using t-test.

Table 5. Baseline Recommended Intervention Level among Adults and TAY (N=72)

Functional Domain	Recommended Intervention Level	Adult (N=51) % of Consumers	TAY (N=21) % of Consumers
Sensory Integration	Essential	14%	10%
	Therapeutic	39%	62%
	Enrichment	47%	29%
Self-Regulation	Essential	37%	33%
	Therapeutic	39%	48%
	Enrichment	24%	19%
Relational	Essential	41%	24%
	Therapeutic	37%	57%
	Enrichment	22%	19%
Cognitive	Essential	8%	14%
	Therapeutic	31%	33%
	Enrichment	61%	52%

No significant differences were found across groups using chi-square.

Non-Reentry compared to Reentry Adults

Table 6. Average Baseline Functional Domain Scores among Non-Reentry and Reentry Adults (N=51)

Functional Domain	Adult: Non-Reentry (N=27) Average Score (Range)	Adult: Reentry (N=24) Average Score (Range)
Total Brain Map	**75% (40 to 85%)**	**78% (28 to 96%)**
Sensory Integration	79% (51 to 100%)	85% (38 to 100%)
Self-Regulation	68% (39 to 94%)	74% (35 to 94%)
Relational	70% (36 to 96%)	70% (27 to 93%)
Cognitive	82% (22 to 97%)	81% (15 to 100%)

No significant differences were found across groups using t-test.

Table 7. Baseline Recommended Intervention Level among Non-Reentry and Reentry Adults (N=51)

Functional Domain	Recommended Intervention Level	Adult: Non-Reentry (N=27) % of Consumers	Adult: Reentry (N=24) % of Consumers
Sensory Integration	Essential	14%	11%
	Therapeutic	50%	39%
	Enrichment	36%	50%
Self-Regulation	Essential	41%	29%
	Therapeutic	41%	43%
	Enrichment	18%	29%
Relational	Essential	34%	39%
	Therapeutic	48%	36%
	Enrichment	18%	25%
Cognitive	Essential	5%	18%
	Therapeutic	36%	25%
	Enrichment	59%	57%

No significant differences were found across groups using chi-square.

Appendix II. Changes in NMT Scores Across Target Populations

Adults compared to TAY

Table 8. Type of Change in Functional Domain Scores among Adults and TAY (N=28)

Functional Domain	Change in Scores	Adult (N=16) % of Consumers	TAY (N=12) % of Consumers
Total Brain Map*	**Decrease**	**44%**	**8%**
	Maintain	**-**	**-**
	Increase	**56%**	**92%**
Sensory Integration*	Decrease	38%	8%
	Maintain	19%	-
	Increase	44%	92%
Self-Regulation*	Decrease	44%	-
	Maintain	13%	-
	Increase	44%	100%
Relational*	Decrease	50%	17%
	Maintain	19%	-
	Increase	31%	83%
Cognitive	Decrease	31%	8%
	Maintain	19%	8%
	Increase	50%	83%

*Indicates significant difference between populations using a chi-square test, p-value<0.05.

Table 9. Average Change in Functional Domain Scores among Adults and TAY (N=28)

Functional Domain	Adult (N=16) Average Change (Range)	TAY (N=12) Average Change (Range)
Total Brain Map*	**1% (-13 to +23%)**	**9% (-1 to +23%)**
Sensory Integration	2% (-7 to +25%)	6% (-1 to +22%)
Self-Regulation*	1% (-11 to +28%)	11% (+1 to 30%)
Relational*	0% (-13 to +26%)	10% (-3 to 28%)
Cognitive*	0% (-26 to +11%)	7% (-2 to 24%)

*Indicates significant difference between populations using a t-test, p-value<0.05.

Non-Reentry compared to Reentry Adults

Table 10. Type of Change in Functional Domain Scores among Adults and TAY (N=28)

Functional Domain	Change in Scores	Adult: Non-Reentry (N=9) % of Consumers	Adult: Reentry (N=7) % of Consumers
Total Brain Map	**Decrease**	**44%**	**8%**
	Maintain	**-**	**-**
	Increase	**56%**	**92%**
Sensory Integration	Decrease	38%	8%
	Maintain	19%	-
	Increase	44%	92%
Self-Regulation	Decrease	44%	-
	Maintain	13%	-
	Increase	44%	100%
Relational	Decrease	50%	17%
	Maintain	19%	-
	Increase	31%	83%
Cognitive	Decrease	31%	8%
	Maintain	19%	8%
	Increase	50%	83%

No significant differences were found across groups using chi-square.

Table 11. Average Change in Functional Domain Scores among Non-Reentry and Reentry Adults (N=16)

Functional Domain	Adult: Not Reentry (N=9) Average Change (Range)	Adult: Reentry (N=7) Average Change (Range)
Total Brain Map	**1% (-13 to +23%)**	**1% (-2 to +7%)**
Sensory Integration	5% (-7 to +25%)	0% (-5 to +3%)
Self-Regulation	6% (-11 to +30%)	2% (-8 to +10%)
Relational	6% (-13 to +28%)	0% (-10 to +9%)
Cognitive	4% (-26 to +24%)	1% (-2 to +6%)

No significant differences were found across groups using t-test.

San Mateo County
Health Ambassador Program–Youth
Fiscal Year 2018-19 Evaluation Report

A Mental Health Services Act Innovation Project

Prepared by:

Resource Development Associates

December 2019

Contents

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The youth ambassadors are the heart and soul of this program. BHRS, StarVista, and the evaluation team all deeply admire and appreciate their commitment to the health and wellbeing of young people in San Mateo County. A special thanks to StarVista and the following individuals from HAP-Y Cohorts 4, 5, and 6, whose participation was invaluable to this effort:

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Figure 1: HAP-Y Graduates, Cohorts 4 through 6


EASTSIDE
STAR VISTA
HEALTH AMBASSADOR PROGRAM FOR YOUTH


THE CRUCIBLE
SF PRIDE

Introduction

Project Overview and Learning Goals

The Health Ambassador Program-Youth (HAP-Y) is an Innovation (INN) program under the Mental Health Services Act (MHSA). San Mateo County Behavioral Health Recovery Services (BHRS) funds HAP-Y. StarVista, a nonprofit mental health organization based in San Mateo County, administers the program.

- **MHSA INN Project Category:** Makes a change to an existing mental health practice that has not yet proven to be effective.
- **MHSA Primary Purpose:** Increase access to mental health services.
- **Project Innovation:** HAP-Y serves as a youth-led initiative where young adults serve as mental health ambassadors to promote awareness of mental health, reduce mental health stigma, and increase access to mental health services among young people. The HAP-Y Innovation project is the first to offer formal evaluation of a program designed for youth peer educators.

In accordance with the requirements for MHSA INN programs, BHRS selected three Learning Goals as priorities for the HAP-Y program. Figure 2 introduces these Learning Goals.

Figure 2: HAP-Y Learning Goals

Learning Goal 1	Learning Goal 2	Learning Goal 3
• To what extent does participating in HAP-Y build the youth ambassadors' capacity to serve as mental health advocates?	• How does HAP-Y increase mental health knowledge and decrease mental health stigma?	• How does HAP-Y increase youth access to mental health services?

The Mental Health Services Oversight and Accountability Commission (MHSOAC) approved the project on July 28, 2016, and BHRS contracted with StarVista in December 2016. In 2017, BHRS selected Resource Development Associates (RDA) to serve as the evaluation team for three MHSA Innovation Projects, including HAP-Y.

This report provides findings from the third year of HAP-Y implementation (July 1, 2018 – June 30, 2019). This reporting timeframe includes the fourth, fifth, and six cohorts of youth ambassadors.

Project Need

Participants in San Mateo County's MHSA Community Planning Process (CPP) raised the need for programs that increase access to mental health services for youth and young adults. Young people, especially transition-age youth (TAY, between 16 and 24 years old), commonly experience many different

challenges in the move to adulthood. Many TAY must navigate adult challenges without having yet mastered the tools and cognitive maturity required of adults.[1] At the same time, mental health systems frequently underserve TAY. Given this discrepancy between identified needs and current resources, some CPP participants urged county officials to adapt the existing Health Ambassador Program (HAP) for youths.

According to the 2015-16 California Healthy Kids Survey,

29%

of 11th graders in San Mateo County had experienced chronic feelings of sadness or hopelessness in the past 12 months, and

13%

had considered suicide in the past 12 months.

HAP is a program created through San Mateo County's Office of Diversity and Equity, and currently operates out of BHRS. Through HAP, adult participants with lived experiences of mental health challenges undergo training to enhance their skills and knowledge about behavioral health. HAP participants serve as community liaisons and advocates, conducting outreach, speaking at community events, and teaching psychoeducational classes. The CPP participants who called for a youth version of HAP recognized that informed youth could take more proactive roles as community leaders, promote mental health and wellbeing among their peers, families and communities, help to reduce stigma around mental health, and facilitate other young people's access to mental health services.

Project Description

HAP-Y engages, trains, and empowers TAY as youth ambassadors, who promote awareness of mental health, educate their peers about mental health resources, and increase the likelihood that young people in San Mateo County are knowledgeable and comfortable enough to seek out mental health services. Each cohort of youth ambassadors undergoes a 14-week psychoeducational training program designed to enhance their knowledge of mental health, communicative best practices, and advocacy skills. Following the training program, the ambassadors engage in outreach and peer education activities in school- and community-based venues. Most ambassadors conduct their presentations with high school students in classroom settings, but HAP-Y participants are also welcome to complete their presentations by speaking on discussion panels or serving in other public speaking roles.

StarVista, which provides counseling, prevention, early intervention, and education services for San Mateo County residents, serves as the lead agency for HAP-Y. For over 30 years, StarVista has offered mental health services and resources to more than 40,000 people from diverse communities throughout San Mateo County. StarVista was selected through a Request for Proposal (RFP) process to implement and manage the HAP-Y project, including program administration, participant recruitment, and data collection efforts.

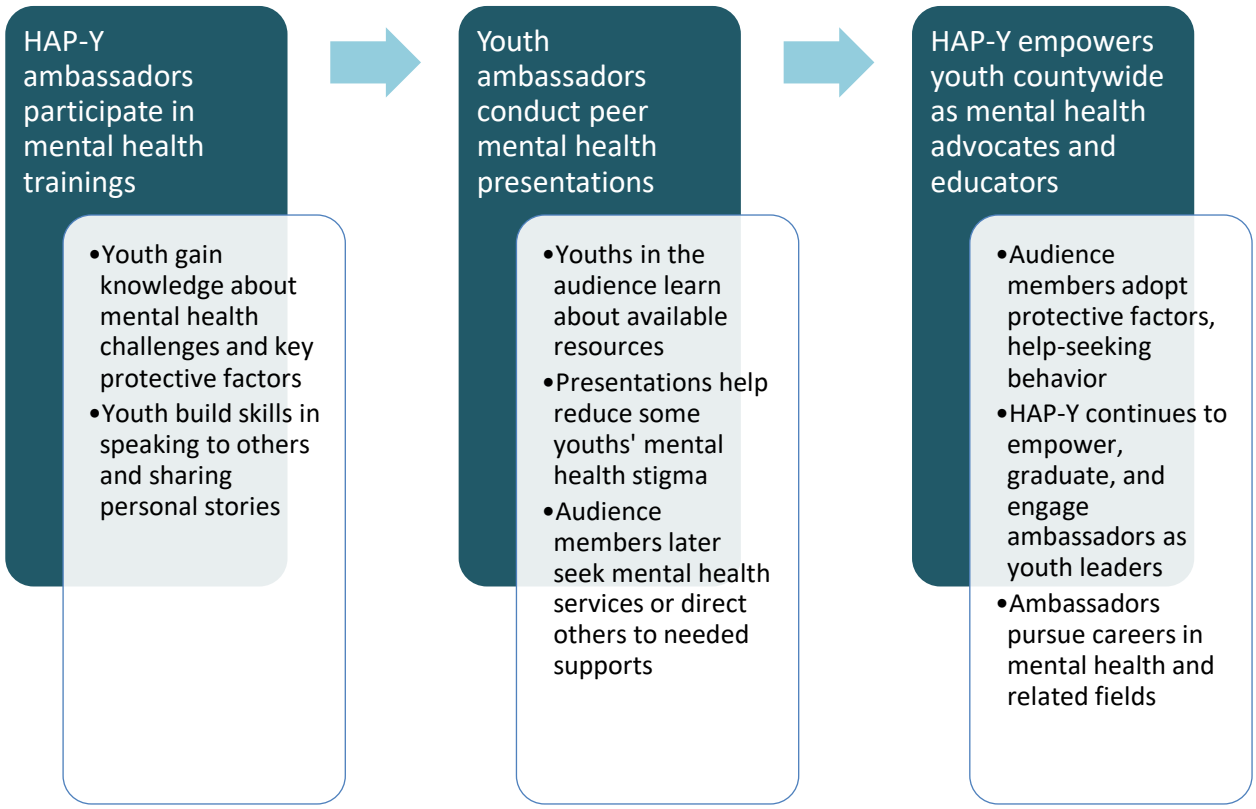
[1] Wilens, T., Rosenbaum, J. (2013) Transition Aged Youth: A New Frontier in Child and Adolescent Psychiatry. Child and Adolescent Psychiatry, 52:9. M.

StarVista staff are responsible for providing training, collaborating with outside agencies to provide additional training, and arranging and supporting public presentations for Youth Ambassadors. StarVista also provides transportation and stipends for youth to attend the trainings. Throughout the duration of the program, StarVista staff also engage youth to remain involved and attentive.

HAP-Y Theory of Change

As is illustrated in the Theory of Change below, HAP-Y is intended to educate and empower youth ambassadors, inform young people across the county, and enhance the county's mental health system in its ability to serve youth. The program design expects that youth audiences are more likely to access mental health services and resources when receiving the information from peers. StarVista staff work closely with the ambassadors to cultivate their knowledge of mental health, their public presentation skills, and their capacity to serve as community advocates. As such, HAP-Y is designed to create lasting change for individuals who directly engage with the program, while improving mental health access among young people in the community at large.

Figure 3: HAP-Y Theory of Change



HAP-Y Program Model

1. StarVista conducts outreach for HAP-Y through schools, community-based organizations, social media platforms, and general outreach in the community.
2. Youth who show interest in HAP-Y participation are asked to submit an application and go through a formal interview process conducted by StarVista staff. StarVista's key criteria for selecting ambassadors include youth who have lived experiences with mental health challenges, as well as youth who can commit to the full training program. StarVista staff also convene different cohorts in different parts of the county, to ensure a wider geographic and demographic representation of youth ambassadors.
3. Cohorts receive 14 weeks of training and have three months following their training to conduct a minimum of three community presentations. StarVista partners with youth to identify a location and support the training by either co-presenting or providing individual preparation support.

See Appendices A and B for the HAP-Y youth application and StarVista youth interview protocol.

HAP-Y Training Curriculum

Over the 14-week training program, StarVista staff present and coordinate an array of different mental health and suicide prevention trainings for the youth ambassadors. Together, these trainings prepare participants to:

- Present psychoeducational information to youths in school- and community-based settings;
- Facilitate discussions about mental health care, suicide, and mental health challenges;
- Provide their peers and loved ones with mental health resources;
- Encourage others to seek formal support for mental health challenges; and
- Build confidence and grow their skills in leadership, advocacy, and public speaking.

For the 2018-2019 program year, StarVista staff guided youth ambassadors through six different training modules. Four of these programs carried over from the previous year, while the other two were new additions to the training curriculum. Table 1 includes the full slate of training components.

Table 1: Programs in the HAP-Y Training Curriculum[2]

RETURNING COMPONENTS	**NAMI Family to Family*** • 12-session educational program for relatives and friends of people living with mental illness • Focus on how to support someone with mental illness, empathize with people who struggle with mental health challenges, and maintain one's own wellbeing as a caregiver • Includes comprehensive information on major mental illness, and skills training in problem solving, effective communication, and handling crises
	Wellness Action Recovery Plan (WRAP)* • Self-designed prevention and wellness practice adaptable to many different circumstances • Trains people to recognize the wellness resources in their life, create daily plans for wellness, recognize one's major stressors and early warning signs, and plan for crisis events
	Question, Persuade, Refer (QPR)* • Approach to communicating and supporting people who may be at risk for suicide • Trains people to recognize the warning signs of suicidal ideation, practice active listening, encourage someone at risk to seek help, and help connect them to formal support • Intended as an emergency mental health intervention, not a replacement for clinical services
	Linking Education and Awareness for Depression and Suicide (LEADS)* • Mental health awareness and suicide prevention curriculum designed for high school students • Intended to increase students' knowledge of depression and suicide, correct misconceptions about depression and suicide, increase awareness of suicide prevention resources, and improve students' comfortability with help-seeking behaviors
NEW COMPONENTS	**LGBTQ 101** • Overview of terminology and concepts related to gender identity, sexual orientation, and LGBTQ+ community members • Emphasis on the importance of culturally affirmative and respectful language • Intended to improve understanding about the linkages between anti-LGBTQ+ discrimination and heightened risk for mental health challenges among LGBTQ+ community members
	Photovoice • Qualitative method for community-based participatory research • Ambassadors select photographs that serve as the basis for personal storytelling • Designed to empower community members who are marginalized or underprivileged, by elevating personal stories that can build support for social and systemic change • The Photovoice module replaced an earlier training series around storytelling

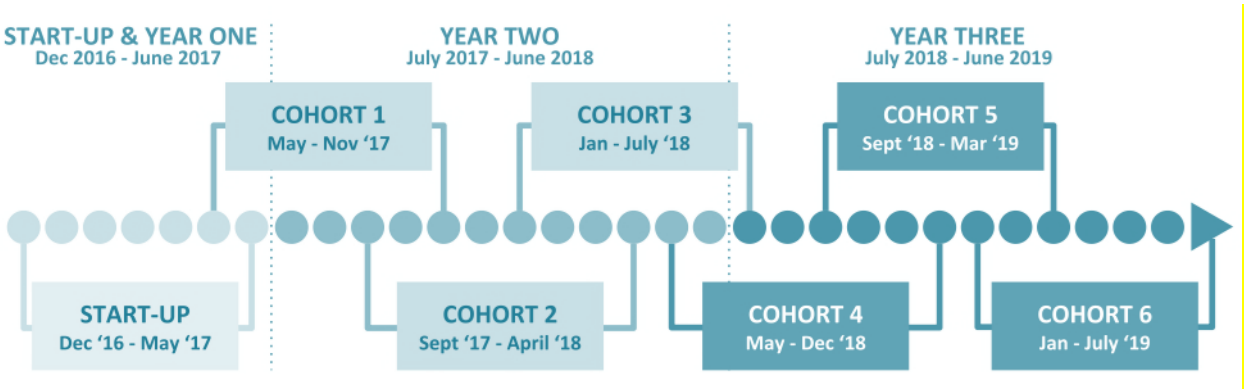
Listed in the National Registry of Evidence-based Practices and Policies

[2] External trainers led the NAMI Family to Family and WRAP trainings, and StarVista staff facilitated the remaining programs.

Implementation Timeline

Figure 4 illustrates the timeline of key activities that HAP-Y has completed in the past three years of the program. For each of the six cohorts, the first half of the program was devoted to the 14-week training program, and the second half to the ambassadors' presentations.

Figure 4: Timeline of Key HAP-Y Activities since Project Launch



Evaluation Overview

In 2017, BHRS contracted Resource Development Associates (RDA) to carry out the evaluation of HAP-Y's implementation and program outcomes. RDA is an Oakland-based public systems consulting firm that has conducted evaluations of MHSA Innovation Projects in multiple counties throughout California.

The HAP-Y evaluation has many purposes, including:

- Helping BHRS track the progress of the program;
- Measuring the impact of program activities;
- Providing data and analyses to inform further decision-making;
- Offering recommendations for program improvement;
- Generating knowledge about effective practices in mental health peer education; and
- Documenting the program for potential future replication in other jurisdictions.

HAP-Y's three Learning Goals, introduced in the previous section, provide the core framework for the evaluation. The following section of this document will explore the key evaluation findings in response to the questions presented in the three Learning Goals.

There are two major components to the evaluation:

- The **process evaluation** concerns the implementation of HAP-Y: the extent to which the program has operated according to plan, any challenges with implementation, and any major changes to

program operations. Lessons from the process evaluation enable BHRS and StarVista to make real-time adjustments that could improve program delivery.

- The **outcome evaluation** component assesses the extent to which HAP-Y activities produce the intended outcomes as outlined in the Learning Goals: building the leadership capacity of youth ambassadors, enhancing youth knowledge and decreasing mental health stigma, and increasing youth access to mental health services.

RDA worked with StarVista and BHRS to launch the HAP-Y evaluation using a **Participatory Action Research** (PAR) framework. During the first year of the program, HAP-Y youth ambassadors were instrumental in the development of the evaluation plan, and helped to design some of the major evaluation tools. StarVista staff, with support from RDA, introduce each new cohort to the importance of program evaluation during the training sessions. Youth ambassadors continue to serve a critical role in the evaluation process: they conduct data collection with their peer education audiences, and offer their insight and reflections to the evaluation team at the end of their time with the program.

Evaluation Methods

In order to assess HAP-Y's progress towards these Learning Goals, the evaluation team uses a **mixed-methods approach** to program evaluation. This approach includes tracking quantitative measures of impact from the educational presentations, as well as qualitative assessments of youth ambassadors' experiences and the program's major successes and challenges. Using multiple methods also enables a more robust comparison of findings across the different data sources.

The HAP-Y evaluation includes five main types of data collection, which are briefly described below. These methods have not changed significantly since last year's evaluation.

Demographic Reporting

The MHSOAC mandates that MHSA Innovation Projects collect data on the demographic backgrounds of program participants, and has a required list of demographic categories that the survey process must include. HAP-Y ambassadors complete a demographic survey at the start of the training program, which a StarVista staff member subsequently uploads onto a HIPAA-compliant version of SurveyGizmo. Beyond the MHSOAC requirements, the demographic survey includes an expanded list of options for sexual orientation and gender identity (SOGI), in order to accommodate a wider range of youth who identify as LGBTQ+. With these revisions, the demographic survey aligned with BHRS' agency-wide initiative to revise its SOGI questions on health intake forms. For a copy of the demographic survey, please see Appendix C.

HAP-Y Self-Determination Survey (Pre/Post)

RDA developed the Self-Determination Survey for the youth ambassadors, who take the same survey at the start of the program and after completing their time with the program. The survey, which is anonymous, requires the ambassadors to assess their skills and beliefs in three domains: mental health advocacy, leadership, and teamwork. Administering the survey at the start and end of the program ("pre" and "post" tests) helps to track how, on average, ambassadors' self-perceptions change over the course of their time with HAP-Y. As with the demographic survey, ambassadors complete a paper copy of the Self-Determination Survey, which StarVista staff then input into SurveyGizmo. For a copy of the Self-Determination Survey, please see Appendix D.

Audience Survey

To assess the impact of the ambassadors' peer mental health presentations, a group of youth ambassadors worked with RDA to develop the Audience Survey in the first year of HAP-Y. The ambassadors administer the survey to their audience members following the presentation. This survey uses a "post-pre" format: it asks audience members to recall their knowledge and beliefs about mental health before attending the presentation, and compare it to their knowledge after having witnessed the presentation. In addition, the Audience Survey includes an option for respondents to leave their contact information if they are experiencing mental health challenges and want follow-up contact from StarVista.

Cohorts 4, 5, and 6 continued to use the Audience Survey that former ambassadors had designed. Program alumni were also instrumental in recommending slight modifications to a few of the survey questions, which the evaluation team implemented between Cohorts 5 and 6. Subsequent sections describe these changes in detail. For a copy of the Audience Survey, please see Appendix E.

Focus Groups with Current and Former Youth Ambassadors

RDA conducted four focus groups with youth ambassadors for this evaluation period: both a "pre" and "post" focus group with Cohort 4, a "post" focus group with Cohort 6, and a reunion focus group that brought together alumni from all six cohorts to date. The evaluation team did not conduct a focus group with participants specifically from Cohort 5, although several Cohort 5 alumni participated in the reunion focus group. These in-person discussions enabled the evaluation team to gather in-depth information from HAP-Y's participants, and provide the ambassadors a space to reflect on their experiences following the end of the program. For a copy of the focus group questions, please see Appendix F.

Interviews with StarVista Staff

The evaluation team conducted an interview with a StarVista program manager to gather their perspectives on the HAP-Y implementation process, major program successes and challenges, and other observations from the 2018-2019 program year. For a copy of the focus group questions, please see Appendix G.

Data Analysis

To analyze the quantitative data from the Audience Surveys and Self-Determination Surveys, RDA examined frequencies, averages, and ranges of survey responses. To analyze qualitative data, RDA transcribed focus group and interview participants' responses, and analyzed these transcripts to identify major themes, significant outliers, and notable perspectives across participants' experiences. The open-ended answers on the Audience Surveys were also subject to a similar thematic analysis, to locate any trends in audience members' reactions. RDA then synthesized these quantitative and qualitative analyses in accordance with the three Learning Goals that guide the evaluation plan.

Data Limitations

Small sample sizes for "Post" Self-Determination Surveys. Logistical difficulties prevented the administration of the Self-Determination Survey to Cohorts 4 and 5 at the close of their respective programs. In order to collect "Post" survey data for these two cohorts, StarVista staff contacted former ambassadors from these cohorts to complete the survey online via SurveyGizmo, as well as members of Cohort 6 who could not attend the post-program focus group. While some former ambassadors have maintained contact with StarVista, however, others have been harder to reach after the end of the program. As such, the number of ambassadors from Cohorts 4 through 6 who completed the "post" survey (16) is fewer than half of the number who completed the "pre" survey (37). When looking at pre-post

response comparisons, it is important to keep in mind that some of the ambassadors represented in the "pre" group did not complete a "post" survey.

Difficulty of surveying audience members in non-school settings. As explained in later sections, HAP-Y ambassadors participated in a greater number of presentations, speakers' panels, and other events in community-based settings outside of school. However, ambassadors were often able to administer the Audience Survey in these settings, especially when StarVista was not the planner or organizer of the event. As such, the number of Audience Surveys necessarily is an undercount of the total number of people the HAP-Y ambassadors reached during their peer education efforts.

Ambiguous or confusing wording for some Audience Survey questions. The data from last year suggested that following the presentations, attendees were more likely to report feeling uncomfortable discussing mental health challenges, and more likely to believe that people with mental health challenges were unstable. These results appeared counterintuitive, as HAP-Y is a program designed to normalize open discussions about mental health challenges. In response, the evaluation team worked with StarVista and a group of former HAP-Y participants to revise the wording to these questions. In February 2019, StarVista staff presented these unexpected survey results to program alumni. These alumni discussed revisions to the audience survey, and recommended rewording these two questions to match the positive framing of the rest of the survey. Cohort 6 was the first group of ambassadors to use the new survey. The results of Cohort 6's Audience Surveys are more aligned with program expectations—that audience members would feel *more* comfortable talking about mental health, and be more likely to believe that people with mental health challenges can lead healthy lives. The differences in survey results between Cohorts 4/5 and Cohort 6 suggests that the previous wording may have skewed the results.

This year, the data analysis revealed that another survey question may have garnered unintended results. The survey asks audience members to check off any issues they have experienced in trying to access mental health care, but leaves no box or option to indicate that the survey-taker has never attempted to access mental health care. As such, it is possible that people in this position would have marked one of the answers, "I did not qualify for services," understanding that to mean that they did not qualify because they did not need any services. It is thus unclear whether the number of people who indicated that they had experienced this challenge with eligibility is an accurate headcount. This survey question will be changed for future cohorts.

Implementation Update

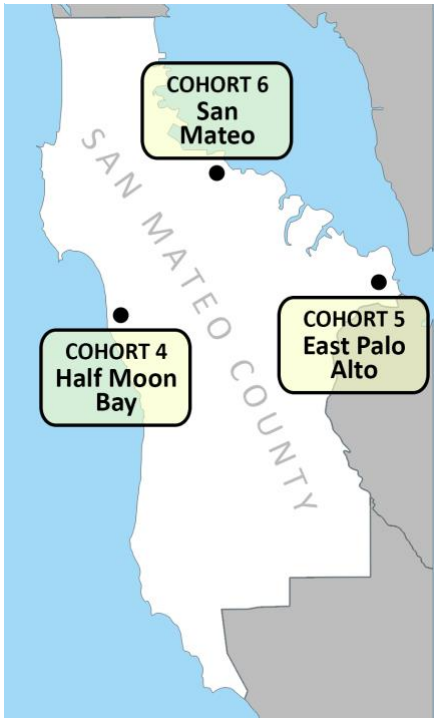
Changes to Innovation Project During Reporting Period

In FY18-19, the California Mental Health Services Oversight and Accountability Commission (MHSOAC) approved Behavioral Health and Recovery Services' request for a one year, no-cost extension for HAP-Y. With the extension, HAP-Y will run through the 2019–2020 fiscal year. This extension year will support the training and peer education activities for the seventh, eighth, and ninth cohorts.

Key Accomplishments

StarVista continued to expand HAP-Y into different areas of San Mateo County, ensuring a wider geographic representation of young people. For the second year of ambassador presentations, StarVista aimed to recruit students from parts of San Mateo County that had not been represented among the first three cohorts. This strategy would help to ensure a wider geographic representation of youths trained to be ambassadors, as well as young people whom the ambassadors engage in their presentations.

Figure 5: Targeted Recruitment Areas for Cohorts 4, 5, and 6



Cohorts 4 and 5 represented new areas for program expansion, centered in Half Moon Bay and East Palo Alto, respectively (see Figure 5).[3] Half Moon Bay is farther away from the county's major transportation routes, and is thus more isolated from other areas of the county. In turn, East Palo Alto residents are predominantly working-class people of color.

StarVista's emphasis on geographic diversity also overlapped with a goal of incorporating youth from historically marginalized communities. Cohorts 4 and 5 both had a majority of Latina/o/x youths, several of whom noted the cultural and social barriers in their families that made mental health a taboo topic. Multiple members of Cohort 6, which was centered in San Mateo, learned about HAP-Y through their participation in LGBTQ+ student organizations or the San Mateo County Pride Center.[4]

Ambassadors in Cohorts 4, 5, and 6 presented and spoke to over a thousand young people in a variety of school-based and community-based venues. As Table 2 and Table 3 show, the ambassadors from Cohorts 4, 5, and 6 completed a total of 89 presentations during their time with HAP-Y. In all, 1,331 people completed Audience Surveys after attending one of the presentations. It should be noted that this figure

[3] Presentations for Cohorts 1 through 3 were largely centered in the northern and eastern areas of the county: Pacifica, San Bruno, Menlo Park, San Mateo, and Redwood City, e.g.
[4] The Pride Center is another MHSA Innovation Project.

represents an undercount of people to whom the HAP-Y ambassadors presented, as some ambassadors participated in community-based presentations where it was not possible to administer the survey.

Table 2: Number of Ambassadors, Presentations, and Audience Surveys Completed for Cohorts 4–6

Cohort	HAP-Y Training Participants*	Youth Completing Presentations	Presentations	Audience Surveys
4	14	11	30	594
5	7	5	18	278
6	13	8	41	459
TOTAL	**34**	**24**	**89**	**1,331**

**Number of youth who completed an anonymous demographic survey during training*

Table 3: Presentation Dates and Presentation Locations for Cohorts 4–6

Cohort	Presentation Dates	Presentation Locations (Partial List)
4	**9/19/2018 – 12/10/2018**	• Half Moon Bay High School • Half Moon Bay Library • College of San Mateo's Middle College • Family & friends • Skyline Middle College
5	**12/19/2018 – 3/18/2019**	• Aragon High School • Burlingame High School • Eastside College Preparatory School • Skyline College • Woodside High School
6	**4/12/2019 – 7/24/2019**	• Aragon High School • Burlingame High School • El Camino High School • Hillsdale High School • Mill High School • Redwood Continuation High School • Sequoia High School

HAP-Y's emphasis on countywide geographic representation means that students from a wide range of schools and communities have been able to participate in the presentations. Many HAP-Y ambassadors conduct their presentations at their own schools, or schools in their communities of residence. Because StarVista recruits cohorts in different geographic regions of San Mateo County, the school-based presentations are also geographically dispersed. This broad approach is particularly important in the context of San Mateo County, which has areas that are physically harder to reach and with less robust social service infrastructures than the more densely populated areas of the county. A wide geographic representation also means that the ambassadors' presentations are more likely to reach students from diverse socioeconomic and racial backgrounds.

Ambassadors participated in an array of presentations outside of high schools, which helped to spread peer mental health education and knowledge of HAP-Y in other venues. As ambassadors had the freedom to choose where to conduct their presentations, several program participants opted to conduct their mental health peer education outreach to youth in other venues. For instance, some individual participants presented to members of a youth Bible study group, to library patrons, and to members of a local Police Athletic League. Some members of Cohort 6 were able to synchronize their presentations with community events for Mental Health Awareness Month in May 2019, such as serving as panelists for a discussion about the suicide prevention documentary *The S Word.* Other ambassadors opted to conduct their presentations with middle school students, out of a conviction that this information was necessary for youth earlier than high school age. In all, these other presentation venues ensured that a wider range of youth would receive information about mental health resources, and learn more about common misconceptions regarding mental health and suicide.

StarVista staff recruited HAP-Y alumni to participate in additional peer education and speaking opportunities. Some former HAP-Y program participants have maintained contact with StarVista staff, and during this program year StarVista began soliciting HAP-Y alumni to continue serving as panelists or speaking at community events when the opportunity arises. Because StarVista is well established in San Mateo County, the staff in charge of HAP-Y were able to redirect opportunities discovered through other StarVista programs and present them to former ambassadors. In another case, organizers of a nearby Asian American Pacific Islander youth mental health conference reached out to StarVista specifically looking for a representative of HAP-Y to speak at the event. That is, there has been a gradual increase in community members' recognition of HAP-Y as a local youth mental health initiative, which stands to increase with each successive community-facing speaking opportunity.

StarVista made additional improvements to the HAP-Y training curriculum. As mentioned in the Introduction, StarVista staff made two changes to the training program for this year's ambassadors. The previous module on storytelling was replaced with Photovoice, a similar program that uses photography to enhance the ambassadors' personal storytelling skills. In addition, StarVista added a workshop on LGBTQ 101, to educate ambassadors on the diversity of gender identities and sexual orientations, as well as the elevated risk of mental health challenges that many LGBTQ+ people face due to forms of discrimination, alienation, or mistreatment.

Implementation Lessons

HAP-Y ambassadors find the interactive and activity-based trainings, such as WRAP and Photovoice, most meaningful. When asked to recall the most impactful and memorable parts of the training program, multiple ambassadors specifically mentioned the Wellness Recovery Action Plan and Photovoice sessions. Ambassadors cited WRAP as a useful tool to manage their own stress and map out strategies for self-care and wellbeing. In turn, the Photovoice activities were particularly important in bringing cohort members together, as the ambassadors demonstrated trust and vulnerability with one another in sharing personal stories. As a whole, ambassadors appreciated the interactive components of the trainings: those involving actionable skills and strategies, and those that encouraged community-building between cohort members. On the other hand, some ambassadors found it harder to absorb all the information from the

lecture-based trainings. As with last year, ambassadors have suggested that the NAMI Family to Family training be replaced with a mental health curriculum with more interactive components, such as NAMI's Peer to Peer training module.

HAP-Y ambassadors have been key in making changes to the training curriculum and evaluation tools. HAP-Y not only provides youth ambassadors with rigorous training on mental health advocacy; the program also helps empower its participants to improve the experience of future HAP-Y cohorts. As StarVista staff note, HAP-Y ambassadors have been vocal in sharing their feedback about the training program. In turn, StarVista staff have incorporated the ambassadors' concerns and considerations in making updates to the training program. In response to ambassadors' input, staff are currently exploring the possibility of switching out NAMI Family to Family for a more youth-friendly curriculum, and are looking into adding a training component of cultural humility and cultural awareness. As well, the youth ambassadors have been instrumental in updating the data collection and evaluation tools. As mentioned earlier, former program participants helped to revise the wording of a few Audience Survey questions when the preliminary survey results included some unexpected, if not counterintuitive, outcomes.

Strong rapport between the StarVista program staff and the ambassadors enhances the ambassadors' overall experience of the program. Multiple ambassadors cited the guidance and support from StarVista staff as one of the highlights of the program. These youth valued the mentor-mentee relationship that they were able to build with program staff, beyond a strictly supervisory role. Youth participants also praised the staff's ability to balance the training and educational aspects of the program with a focus on self-care. Since the trainings covered difficult topics, and the presentations could be intimidating, youth participants appreciated the space and time to tend to their personal safety and wellbeing.

Consumer Population Served

Youth Ambassador Demographics

Between Cohorts 4, 5, and 6, 34 youth ambassadors completed a demographic survey. Similar to last year (Cohorts 1, 2, and 3), youth of color comprised the majority of program participants. However, Latina/o/x participants made up a larger proportion of all ambassadors (68% this year vs. 50% last year), as did participants of Mexican descent (59% vs. 35%), participants still in high school (94% vs. 68%), and participants who identified as cisgender women (88% vs. 59%). Conversely, participation among Asian American youth and cisgender male youth fell compared to last year's cohorts.

The full demographic results across this year's cohorts are presented below.

Table 4: HAP-Y Ambassador Demographics for Cohorts 4, 5, and 6 (n=34)

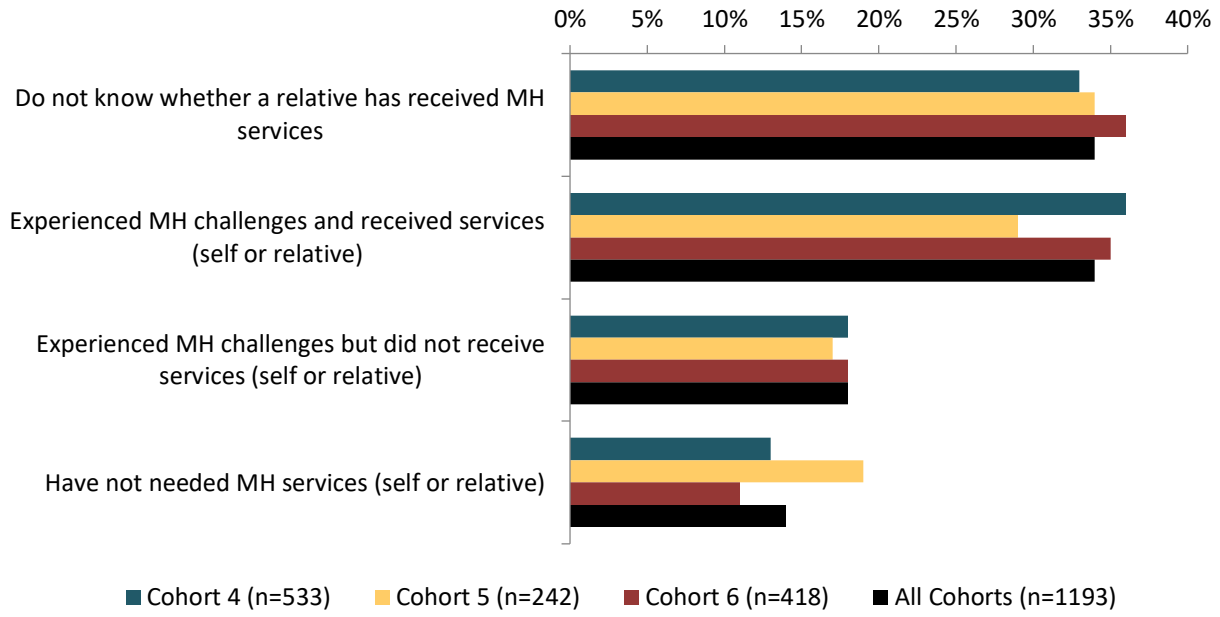
Age: 100% of ambassadors were 24 or younger at the time of survey, with nearly all participants between the ages of 16 and 24.	**Language:** Almost all (94%) of ambassadors listed English as their primary language, or listed English along with another language.
Race: About two-thirds (68%) of participants identified as Latinx, and 26% identified as white. Most of Cohorts 4 and 5 were Latinx, and a slight majority of Cohort 6 participants were white.	**Ethnicity:** A majority of ambassadors (59%) were Mexican/Mexican American/Chicanx, including nearly all of Cohorts 4 and 5. No more than three youth identified with any other ethnicity.
Sex at Birth: 88% of ambassadors indicated that they were female at birth. Others were male at birth or declined to answer.	**Gender Identity:** Nearly all ambassadors (88%) identified as cisgender women at the time of survey, including all 14 members of Cohort 4.
Sexual Orientation: About two-thirds (68%) of ambassadors identified as heterosexual or straight, and 18% identified as bisexual.	**Education:** Nearly all (94%) of participants were in high school at the time of survey, including all members of Cohorts 4 and 5.
Health Conditions: 62% of ambassadors reported having no major health issues. The most common reported condition was difficulty seeing (18%).	**Employment:** At the time, three-quarters of youth (76%) reported as students, and 29% had a part-time job. A few selected both categories.
Housing Status: All ambassadors indicated that they have stable housing, or are living with friends or family members.	**Income:** Only seven ambassadors answered this question; all seven respondents reported an annual income of $50,000 or less.

Note: To comply with HIPAA requirements and to protect the confidentiality of participants, the demographic analysis below only lists categories where there were at least five responses. Some categories have been combined in cases where there were fewer than five responses.

HAP-Y Audience Members & Lived Experiences

Across Cohorts 4, 5, and 6, 1,331 people who attended a HAP-Y ambassador's presentation completed an Audience Survey. While this anonymous survey does not solicit any demographic information from respondents, one question concerns the audience member's personal or familial experience with mental health challenges and mental health services. As Figure 6 shows, audience responses to this question were generally consistent across all three cohorts.

Figure 6: Audience Members' Prior History of Mental Health Challenges and Mental Health Services, Organized by Cohort



A majority of audience members have some personal experience with mental health challenges. Across all three cohorts, 52% of survey respondents indicated that either they or a family member had experienced mental health challenges. Among that subset of respondents, one-third had not received any mental health services in response.

Over one-third of audience members (34%) do not know whether any family members have received mental health services before. This proportion was more than twice the percentage of audience members who responded that neither they nor any family members had ever accessed mental health services (14%). The fact that so many audience members were uncertain about their family's mental health histories suggests that mental health challenges and mental health care may not have been a common topic of discussion at home for these students. Because they are designed to reduce audience members' stigma, HAP-Y presentations could help encourage some youth to speak up about mental health within family settings.

Progress Toward Learning Goals

This section presents the key evaluation findings for HAP-Y cohorts 4, 5, and 6, separated by the three Learning Goals. A summary of key findings is included below.

Learning Goal 1: Building Youth Capacity

Mental Health Knowledge and Tools. Participating in HAP-Y provides ambassadors with concrete tools and knowledge to support their own mental health and wellbeing, as well as help their peers and loved ones.

Confidence to Speak About Mental Health. Many HAP-Y ambassadors gain the self-assurance to speak up about difficult matters, and/or challenge other people's misconceptions about mental health.

Community as a Protective Factor. HAP-Y helps reduce the isolation that some ambassadors feel, especially those with lived experiences of depression or other mental health challenges.

Mental Health Career Pathways. For many ambassadors, participating in HAP-Y affirms their desire to pursue a career in the mental health field, or to integrate mental health concerns into their other career aspirations.

Learning Goal 2: Enhancing Mental Health Knowledge & Decreasing Stigma

Knowledge about Mental Health and Resources. Most audience members found the HAP-Y presentations useful and expressed high levels of satisfaction with both the presentation and the presenters. Following the presentation, nearly all audience members reported that they knew where to access help for their mental health struggles.

Addressing Stigma. HAP-Y presentations appear to decrease audience members' stigma around mental health. At the same time, it is still likely that stigma remains an issue for some audience members.

Mixed Levels of Engagement in Presentations. Students' interest in, and engagement with, the presentations varied between different classrooms, schools, and venues.

Learning Goal 3: Increasing Youth Access to Mental Health Services

Access to Resources. Many HAP-Y audience members indicated that the presentation had provided them with resources they could use in the future to seek support for themselves, family members, and/or friends.

Long-Term Ripple Effects. Youth ambassadors continue to share their knowledge about mental health resources following their participation in the program, which increases the likelihood that other youths will seek support for their own mental health challenges.

Learning Goal 1: Building Youth Capacity

Mental Health Knowledge and Tools

Participating in HAP-Y provides ambassadors with concrete tools and knowledge to support their own mental health and wellbeing, as well as help their peers and loved ones. Because many HAP-Y ambassadors have lived experiences of mental health challenges, the program is well suited to help these participants build resilience and practice self-care. For example, several participants noted how they had found the training on Wellness Recovery Action Plans (WRAPs) useful for the wider stresses in their own lives. One former ambassador noted that they had created a WRAP when working on their college applications, as they had found the experience to be incredibly burdensome. Several ambassadors also appreciated the emphasis on self-care during the training sessions, which covered difficult and sensitive topics. This focus on emotional self-awareness had made ambassadors more cognizant of their own stress levels and the need to advocate for their own wellbeing on a regular basis.

> *"For me, [participating in HAP-Y] helped break the stigma at home. My stepdad is not open-minded about mental health. We would talk about it at the dinner table. He had something happen to him and he realized that mental health was affecting him. My mom and I were able to get him help."*
>
> –Ambassador from Cohort 4

In addition, several ambassadors noted that they had joined the program because they had family members or friends with mental health challenges, and wanted to learn how to support their loved ones more effectively. This was especially important for ambassadors whose families carry a lot of stigma or misunderstanding around mental health, and families whose cultural practices have historically disregarded clinical mental health services.

After participating in HAP-Y, youth ambassadors have the skills to assess how many different factors in their communities contribute positively and/or negatively to residents' mental health. Former youth ambassadors who participated in the HAP-Y alumni focus group worked in small groups to identify major risk factors and protective factors for mental health in their peer circles and communities. The alumni's collaborative efforts revealed a sophisticated, multidimensional analysis of what community elements can worsen residents' mental health, and what can help residents cope with stress, heal from trauma, or build resilience. All of the small groups named risk factors and protective factors at multiple social scales of analysis, from personal and interpersonal factors (such how people discuss mental health) to structural and institutional factors (such as public policy, monetary resources, or systemic inequalities). Table 5 contains a summary of HAP-Y alumni responses in this activity. While these analytical skills are not solely attributable to what the alumni learned or experienced through HAP-Y, many alumni asserted that participating in HAP-Y had been crucial in developing their understanding about both mental health challenges and mental health resources.

Table 5: Notes from HAP-Y Alumni Activity (Brainstorming Local Risk Factors and Protective Factors)

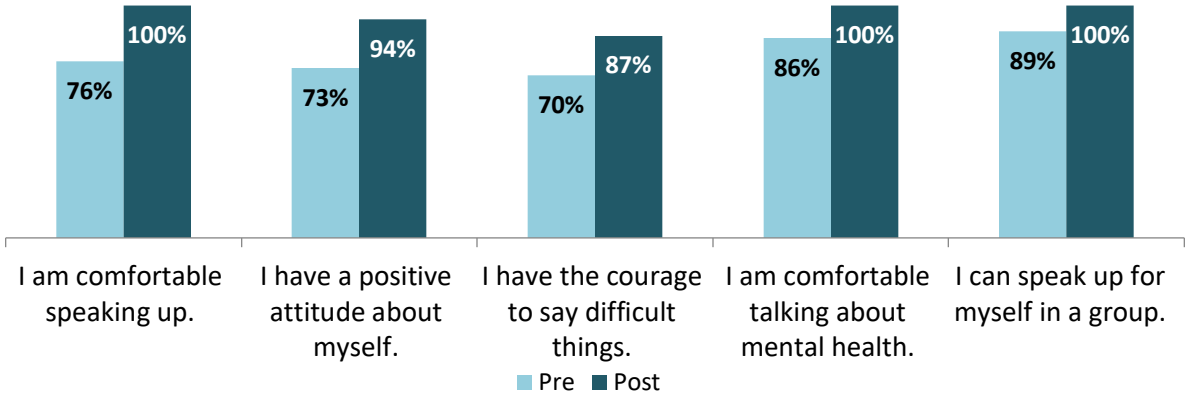
	Risk Factors	Protective Factors
Individual/Interpersonal Factors	• Academic stress and school pressures • Alcohol and/or drug use • Bullying and cyberbullying • Disabilities or other health conditions • Discriminatory behaviors (based on racism, sexism, homophobia, etc.) • Family members with mental health challenges • Major life changes (e.g. loss of a loved one) • Misinformation about mental health • Personal or familial beliefs about mental health and suicide • Social media pressures • Unhealthy relationships (family, friendships, dating)	• Having a crisis plan • Having a mentor • Help-seeking behavior • Hobbies and outlets for self-expression (art, music, journaling, etc.) • Positive outlook and self-esteem • Resilience and coping skills • Strong support systems and positive relationships with others • Therapy
Community-level Factors	• Absence of easy-to-access information about mental health • Community climate/environment (such as societal patterns of stigma around mental health) • Faith-based communities that disregard or dismiss mental health care • School climates that reinforce student stress about academic performance	• Community-based mental health outreach, events, and programming • Community mental health and service providers, like StarVIsta • Community support systems • Crisis hotlines and online chatrooms • Faith-based communities that support and advocate for mental health care • Health classes in schools • Peer education programs like HAP-Y • Spaces where marginalized or vulnerable community members can gather
Structural Factors	• Discriminatory policies and practices • Financial stressors, such as high costs of living, housing prices, or low income • Gaps in local mental health resources or access to mental health care • Healthcare insurers that does not cover mental health care	• Access to quality mental health resources for all community members • Inclusive and nondiscriminatory policies and practices • Public mental health agencies, like BHRS • Standardized mental heath curricula in schools, and resources for school-based mental health services and supports

Confidence to Speak About Mental Health

Many HAP-Y ambassadors gain the self-assurance to speak up about difficult matters, and/or challenge other people's misconceptions about mental health. As Figure 7 shows, HAP-Y participants reported some of the highest gains on the Self-Determination Survey for questions about confidence, self-esteem, and comfort with advocacy. About three-quarters (73%) of participants reported having a positive attitude about themselves at the start of the program, which rose to nearly all (94%) of respondents after the program ended. The percentage of respondents who have the courage to say difficult things similarly rose from 70% to 88%. By the end of their participation, 100% of respondents indicated that they felt comfortable speaking up, an increase from 76% upon starting HAP-Y.

Figure 7: Largest Pre-Post Gains on the Self-Determination Survey, Cohorts 4–6

(Percentage of ambassadors who responded "mostly true" or "very true")



Ambassadors became more confident in their presentation skills over the course of multiple presentations. During their first presentation(s), the ambassadors discovered where they needed to do additional preparation and adjusted for their subsequent peer education engagements. In addition, several ambassadors recalled that their first presentations helped them to overcome their initial fright: they realized that the experience was not as daunting as they had anticipated, or they received positive feedback from audience members who spoke with them afterwards. (It is also important to read the Audience Survey results in this context, as it is possible that some survey respondents would respond more positively to ambassadors who were conducting their second or third presentation as opposed to their first attempt.)

> *"[HAP-Y] got me thinking more about mental health in my everyday life, the words we use, and how that can influence stigma. [It] made me nudge my friends when they say stigmatizing things, and also, how to address when people casually say, 'I want to kill myself, this work is so hard.'"*
>
> –Former HAP-Y Ambassador

These increased levels of confidence help HAP-Y alumni to keep advocating for the importance of mental health awareness even after they complete their presentations. Several ambassadors noted

that by the end of the program, they felt knowledgeable and confident enough to challenge their friends and relatives who have misconceptions about mental health, or who say things that could be taken as insensitive. Importantly, these ambassadors also noted the importance of having empathy when challenging others: the goal was not to belittle the other person, but to share helpful knowledge and prevent the spread of potentially harmful beliefs.

Community as a Protective Factor

HAP-Y helps reduce the isolation that some ambassadors feel, especially those with lived experiences of depression or other mental health challenges. StarVista staff and HAP-Y participants both note that cohorts often become close-knit over the course of the program, and that many ambassadors develop close bonds with one another. Some ambassadors have not had the opportunity to discuss their own mental health challenges with peers, and discover through HAP-Y that they are not the only ones around them experiencing those struggles. In addition, several of the training sessions invite ambassadors to share difficult life experiences with one another, and that shared vulnerability helps to build deeper bonds of trust, respect, and appreciation.

HAP-Y cohorts could serve as a community for youths who had no other outlets to discuss mental health with others in a comfortable setting. For instance, StarVista staff suggested that Cohort 4 was the largest to date in part because it was centered in the coastal area of Half Moon Bay, further removed from the county's urbanized areas and major transportation routes. Many of the ambassadors who made up that cohort were looking for a safe space to convene with their peers, and to seek mutual support for the issues that they had been dealing with in their own lives.

"[HAP-Y] introduced me to amazing people. It made me feel like I'm not alone. You can feel the authenticity with this group…[being here] makes me feel comfortable in my own skin."	*"[My favorite part was] the sense of caring and community that HAP-Y brought…for a while I thought nobody cared, but it turned out that everybody cared."*
–Ambassador from Cohort 4	–Former HAP-Y Ambassador

Mental Health Career Pathways

For many ambassadors, participating in HAP-Y affirms their desire to pursue a career in the mental health field, or to integrate mental health concerns into their other career aspirations. While BHRS and StarVista did not plan for this as a program goal, many HAP-Y participants exit the program with goals to pursue careers as mental health practitioners, social workers, service providers, or similar professions. Some of these ambassadors start the program with some interest in a career in mental health, which strengthens over the course of the program; others find a newfound passion in HAP-Y that they wish to keep pursuing afterwards. HAP-Y participants with other professional aspirations still acknowledge the importance of HAP-Y in shaping their future goals, noting the importance of mental health awareness and

education for teachers, artists, scientists, policymakers, and advocates. Simply put, many former HAP-Y participants acknowledge how important the program has been in helping them better understand themselves and what they want to do in life.

> *"I want to go into something in mental health or the medical field. HAP-Y made me realize I'm passionate about this and I can relate with people who are going through things."*
>
> –Ambassador from Cohort 6

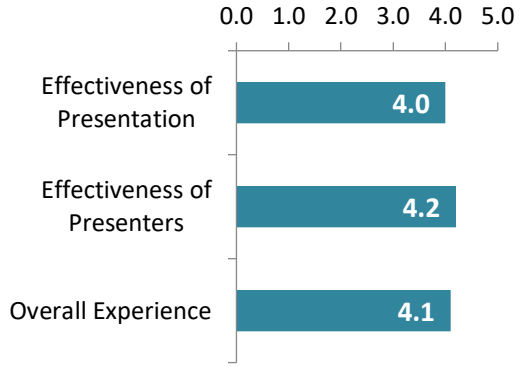
> *"Because of HAP-Y, I also joined the StarVista teen chatline and continue to assist those with crises."*
>
> –Former HAP-Y Ambassador

Learning Goal 2: Enhancing Mental Health Knowledge and Decreasing Stigma

Knowledge about Mental Health and Resources

Most audience members found the HAP-Y presentations useful and expressed high levels of satisfaction with both the presentation and the presenters. Across all three cohorts, 78% of audience members indicated that they had found the presentation useful, versus 10% of survey respondents who did not find the presentation useful. (The remaining respondents declined to answer the question.) As Figure 8 shows, the audience members deemed the effectiveness of both the presentation and presenters as "very good," with average reviews of 4.0 and 4.2 out of 5, respectively.

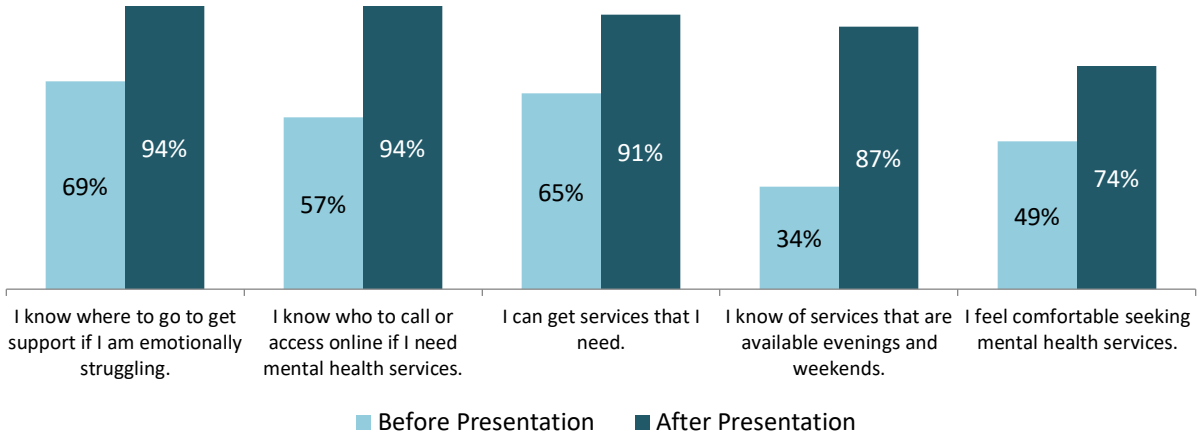
Figure 8: Audience Survey Respondents' Satisfaction with HAP-Y Presentations, Cohorts 4–6 (n=1,137; Score out of 5)



Those who found the presentation to be a positive experience offered a variety of reasons. Many of these explanations mirror common positive feedback from last year's presentations: students thought the issue was important in general, felt better equipped to help people in their lives, learned unexpected things about mental health and suicide, and felt less alone in dealing with their own mental health challenges. In turn, most of the audience members who did not find the presentation useful expressed that they already knew the information presented, or wanted the presentation to cover additional or different topics. That is, few audience members denied the fundamental importance of the topic matter, even if they had other objections.

Following the presentation, nearly all audience members reported that they knew where to access help for their mental health struggles. The HAP-Y presentations provide concrete information about mental health resources available to young people in San Mateo County, including crisis hotlines and StarVista's peer-run online chatroom for youth. As Figure 9 shows, prior to the presentation, about two-thirds of audience members knew how to find mental health supports, and slightly more than one-half knew where to find phone- or online-based services. Following the presentation, over 90% of audience members indicated that they now knew about these resources. Over the course of the presentation, the number of audience members who were aware of services on weekends and evenings more than doubled, from 34% to 87%.

Figure 9: Percentage of Audience Members who Responded "Mostly True" or "Very True," Cohorts 4-6 (n=1,331)



Many audience members indicated a desire to know more about mental health following the presentation. Multiple Audience Survey responses listed additional topics related to mental health that they wished the presentation had covered, or that they wanted to explore further. For instance, many survey responses expressed curiosity in learning more about the link between depression and anxiety; several other respondents wanted to know more about the environmental and physiological factors behind depression. While the HAP-Y presentations are necessarily limited in time and scope, it is nonetheless a positive sign that these peer education efforts compel some students to want to know more about mental health and related matters.

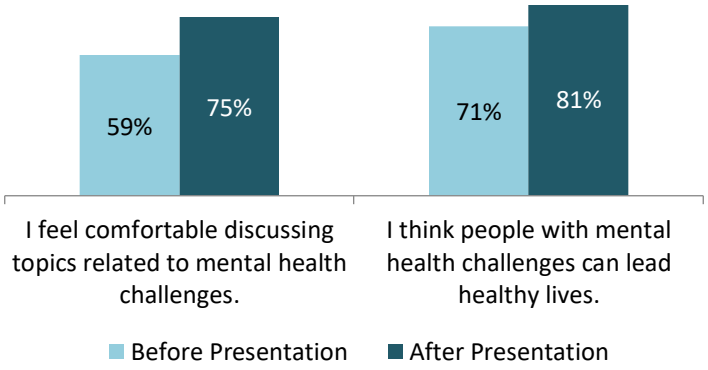
Audience Survey respondents indicated they wanted more information on:

- *What happens when you call a crisis hotline*
- *StarVista's programs and services*
- *Common risk factors for suicidal thoughts*
- *Anxiety and other mental health challenges*
- *Suicidal behavior vs. other forms of self-harm*
- *Where to access affordable mental health services*
- *Opportunities to volunteer or get involved*

Addressing Stigma

HAP-Y presentations appear to decrease audience members' stigma around mental health. Audience members reported that after attending the presentation, they would feel more comfortable talking about mental health, and be more likely to believe that people with mental health challenges can lead healthy lives (see Figure 10). Several audience members wrote in the open-ended comments that by learning more about mental health and mental illness, they are more informed and less likely to pass judgment on individuals who may be struggling with mental health challenges.

Figure 10: Audience Survey Responses After Changes in Wording (Cohort 6, n=459)
[% answering "Mostly True" or "Very True"]



> *"[I learned] not to be so judgmental of people with mental illnesses."*
>
> –Audience Member for Cohort 6

At the same time, it is still likely that stigma remains an issue for some audience members. As Figure 9 above demonstrates, after the presentation nearly all audience members reported that they knew where to get support for mental health challenges. However, slightly fewer audience members indicated that they felt *comfortable* seeking mental health resources (74%), even if audience members' comfort levels rose on average over the course of the presentation. Cohort 6 audience results similarly show that three-quarters of audience members felt comfortable discussing mental health challenges following the presentation. While these figures represent a sizeable majority of audience members, it is still noteworthy that more audience members felt knowledgeable about available mental health resources than those that would find it easy to access these resources, or even talk about mental health. These data suggest that stigma around mental health remains a challenge for some students in San Mateo County, including those who otherwise found the presentation to be informative.

Mixed Levels of Engagement in Presentations

Students' interest in, and engagement with, the presentations varied between different classrooms, schools, and venues. HAP-Y ambassadors across multiple cohorts reported witnessing a wide array of responses among students in their audience. Some ambassadors recalled students personally thanking them after the presentations; others remembered that many audience members seemed uninterested or restless during the presentations; others experienced both attentive and inattentive audiences. While Audience Survey data indicate overall high levels of satisfaction and appreciation among attendees, it is nonetheless likely that some audience members did take the presentation less seriously than their peers did.

> *"I remember sitting there freshman year [during a mental health lesson] and no one really cared…The culture [can be troubling] at my school. I feel like no matter what we do, it's like teenagers…not taking it seriously."*
>
> –Ambassador from Cohort 6

HAP-Y ambassadors offered nuanced assessments of these varied levels of audience engagement. Some participants suggested that they had more success presenting to student clubs, such as health and wellness clubs or LBGTQ+ organizations, whose members are self-selected and who may be more receptive to the topic matter. Many ambassadors presented to freshmen classes, and some of these ambassadors expressed concern that some audience members may not yet have the maturity or life experiences to see the presentation as important.

Learning Goal 3: Increasing Youth Access to Mental Health Services

Access to Resources

Many HAP-Y audience members indicated that the presentation had provided them with resources they could use in the future to seek support for themselves, family members, and/or friends. As mentioned in the previous section, many Audience Survey respondents who expressed their approval noted that they appreciated how ambassadors shared specific resources that were easy and free to access, such as crisis hotline numbers and the peer-run youth chatroom. These resources could serve as points of entry for youth to seek out longer-term mental health services.

> *"[The presentation had] good starting-level ways for everyone to try to help, [and provided] informational resources."*
>
> –Audience member from Cohort 4

> *"I have depression and [the presentation] allowed me to feel like I wasn't alone. I also learned about more services I can access."*
>
> –Audience member from Cohort 6

A small portion of Audience Survey respondents indicated that they were experiencing a mental health challenge, and requested individual follow-up support from StarVista. StarVista staff noted that most students who do leave their contact information ultimately do not respond to StarVista's efforts to contact them. Moreover, StarVista has not tracked the completion rate of follow up contacts, or whether a follow up call results in the student being connected to mental health supports. As such, it is difficult to gauge accurately how many of these survey requests result in access to formal services.

Long-Term Ripple Effects

Youth ambassadors continue to share their knowledge about mental health resources following their participation in the program, which increases the likelihood that other youths will seek support for their own mental health challenges. As indicated in the findings for the first Learning Goal, many former ambassadors found their time in HAP-Y to be enriching, or even transformative. Many program alumni continue to serve as mental health advocates in informal and formal roles alike. StarVista staff maintain contact with many alumni across the former cohorts, and have recruited former ambassadors to speak on discussion panels or share their experiences in other venues. With a growing number of alumni interested in participating in additional mental health-related activities, HAP-Y may have a greater *indirect* role in helping more youth learn where to find mental health resources, or encouraging them to seek mental health services for themselves or others.

> *"In the community, [HAP-Y works] bit by bit, or [it has] a ripple effect. Hopefully, you teach others [after participating in the program]."*
>
> –Ambassador from Cohort 6

Systemic Barriers

There are larger structural barriers in San Mateo County's mental health system that could impede audience members' efforts to seek clinical services after the presentation. While ambassador presentations inform audience members about available resources and encourage help-seeking behavior, HAP-Y alone cannot resolve other systemic issues that prevent people from accessing care. Among respondents who reported that they had previously attempted to access mental health services:

- 79 people stated that it had taken too long to be seen after having a crisis;
- 62 could not find services that fit their schedule;
- 42 could not find any appointments at all; and
- 31 people noted that there were not enough services to meet their needs.

While 251 respondents reported having no trouble accessing services, it is likely that some youth who seek mental health access following the HAP-Y presentations will encounter some of these barriers.

In addition, students' access to or knowledge of on-campus mental health resources can vary across schools. Ambassadors from Cohort 6, who attended several high schools in and around San Mateo, noted that mental health resources were not consistent across different schools, nor were students' awareness of available resources. While some ambassadors praised their schools for having a sufficient number of mental health counselors and widely publicizing student mental health resources, other ambassadors observed that their schools have comparative fewer clinical staff, or had done a poorer job of raising student awareness about the mental health supports available on campus. Because many students might first seek help for mental health through their schools, this inconsistency in accessibility and awareness could prevent some youth from accessing needed services in a timely fashion.

> *"[At my school] we have counselors and wellness groups, [but] these are not publicized and no one knows about them."*
>
> –Ambassador from Cohort 6

Recommendations

Cultivate opportunities to involve HAP-Y youth in decision-making related to mental health. Current and former HAP-Y ambassadors are excellent candidates to serve in leadership roles in mental health decision-making spaces. Similar to the County's Health Ambassador Program for adults, HAP-Y should also explore partnerships with BHRS to connect HAP-Y youth with opportunities to join County steering committees and commissions. For example, youth could join the Mental Health and Substance Abuse Recovery Commission or one of the Office of Diversity and Equity's Health Equity Initiatives.

Integrate education on mental health careers as part of the training program. Although expanding mental health career pathways was not an original aim of the HAP-Y program, HAP-Y has helped several ambassadors consider or reinforce their decision to pursue a career in mental health. Because of this trend, HAP-Y should look for ways to include additional information about mental health professions and career tracks during the trainings. This could include presentations or question-and-answer sessions with StarVista clinicians or other invited guests, especially later in the trainings when ambassadors have a foundation of knowledge about mental health.

Continue to explore additional updates to the training program, such as adding NAMI Peer to Peer and/or a unit on cultural humility. HAP-Y staff have demonstrated their receptiveness to ambassadors' feedback about what training components they found less engaging, such as NAMI Family to Family's lecture-based format. Because StarVista's contract with BHRS includes the NAMI Family to Family curriculum, it is worth exploring whether StarVista could use another evidence-based program that is better suited for a youth audience. In addition, staff have expressed interest in implementing a training on cultural humility: as HAP-Y outreach and recruitment has emphasized reaching youth in communities of color, it would be useful for ambassadors to build capacity in understanding how sociocultural trends and structural inequalities shape community perspectives on mental health.

Strategize with ambassadors about the best venues for their presentations. During this program year, multiple ambassadors noted that some of their audiences seemed less engaged, especially freshmen classes. At the same time, it is important that ambassadors reach out to youth who may not have been exposed to this information beforehand. It will help for StarVista staff to relay some of these past challenges to ambassadors who are getting ready to do their presentations, and to work with ambassadors to brainstorm classes, student clubs, and community-based venues where youth are most likely to be receptive to the materials.

Track follow-up contact attempts in StarVista's data system. As mentioned, StarVista does not have a mechanism to keep track of follow-ups for people who requested via the Audience Survey that StarVista contact them regarding a mental health challenge. Tracking that information could help to connect individuals to needed services more quickly, and could also provide valuable data on HAP-Y outcomes. For instance, keeping track of case notes from an initial screening call could provide more insight into which youth are more inclined to reach out for help after attending an ambassador's presentation.

Conclusion

This evaluation presents two major takeaways from the 2018-2019 program year for HAP-Y.

1. HAP-Y's deepest and most significant impact is the empowerment of its youth ambassadors.

Youth who have served as HAP-Y ambassadors are nearly unanimous in reflecting on the program as an enriching and meaningful experience. HAP-Y provides its ambassadors with a platform to strengthen multiple skillsets: participants gain extensive knowledge on mental health challenges and mental health care; receive guidance and experience in public speaking, community advocacy, and peer leadership; and grow their communication and active listening skills. Many ambassadors have lived experiences with mental health challenges, and HAP-Y has helped to reduce feelings of isolation and stigma among ambassadors who find out that they're not alone in these struggles.

Perhaps most importantly, participants' capacity to spread awareness and help others does not end once their presentations are complete. HAP-Y provides its ambassadors with lasting skills development, and after two years of program operations StarVista has graduated six cohorts of youth who can continue to serve as peer educators and advocates. It is also clear that HAP-Y motivates or affirms many ambassadors' decisions to pursue a career in mental health. In short, the depth and breadth of experience that ambassadors gain is one of HAP-Y's most palpable achievements.

2. It is difficult to isolate HAP-Y's specific role in increasing youth access to mental health services.

HAP-Y ambassadors, in both formal and informal settings, spread valuable knowledge about mental health challenges and easily accessible mental health resources. Even though only a small fraction of audience members requests a follow up contact from StarVista, it stands to reason that HAP-Y's presence has had a positive effect on the number of youth who call a crisis hotline, visit StarVista's online chatroom, or seek clinical services. However, there is no mechanism to quantify these outcomes. Some audience members may immediately try to access these resources, while others could take time before needing to draw upon this knowledge.

HAP-Y has played an important role in presenting many local youth with accessible, age-appropriate information about mental health, and has spread awareness about easy-to-access mental health supports. However, insofar as HAP-Y does not require a direct handoff or connection to therapy services, there are necessarily other factors at play in someone's decision to seek clinical services. It is helpful to think of HAP-Y as a valuable component in a broader mental health system for young people in San Mateo County. HAP-Y's long-term success is contingent on the ability of that broader system to serve young people from all communities and backgrounds.

Appendix A: HAP-Y Application

STAR VISTA

Health Ambassador Program for Youth

DESCRIPTION:
Health Ambassador Program-Youth (HAP-Y) is a new program established by StarVista. We are looking for youth health ambassadors who are passionate about serving communities that have been affected by mental health challenges, interested in raising awareness, and increase access to behavioral health services. Interested youth will participate in trainings focusing on mental wellness. After completion of training, Health Ambassadors will be community agents ready to help others in the community through information sharing or providing referrals when appropriate. Stipend of up to $700 will be provided for youth who complete the training program. Public transportation passes and child care are available upon request. **People who have family, communities or they themselves have been affected by mental health challenges are highly encouraged to participate.**

REQUIREMENTS:
Be between the ages of 16 to 24.
Able to commit to 70+ hours of training.
Participation in community events.

GENERAL RESPONSIBILITIES:
Training

Participate in the entire training program. Training will be focused on topics of mental wellness. Some of the trainings cover the common challenges in mental wellness, learning the signs and risks of suicide, suicide prevention, and information on access to mental health services. Snacks and light refreshments will be provided at each training.

Community Involvement

After completing required training, health ambassadors will have the opportunity to represent HAP-Y in community events such as health fairs, outreach events, and trainings. Opportunities to receive pay will be available.

PLEASE EMAIL APPLICATION TO: hapy@star-vista.org
OR
PLEASE MAIL APPLICATION TO:

StarVista Crisis Center, Attn: HAP-Y
610 Elm Street, Suite 212
San Carlos, CA 94070

Please submit applications by 12/14. Selected applicants will be contacted for interview. Any applications received after this date will be considered for the next round.

PERSONAL INFORMATION:

NAME:

DATE OF BIRTH: **AGE:**

GENDER IDENTITY:

ADDRESS:

PHONE NUMBER:

EMAIL ADDRESS:

DO YOU PREFER TO BE CONTACTED BY PHONE, TEXT OR EMAIL?

SCHOOL (IF APPLICABLE):

NOTE: PARENTAL PERMISSION REQUIRED FOR PARTICIPATION FOR THOSE UNDER 18.

BACKGROUND INFORMATION:

1. List any jobs or extracurricular activities that you are currently involved in or participated in previously.

Job/Activity	Description of involvement	How long have you been or were you involved?

1. What language(s) other than English do you speak? Would you need interpretation services to participate in the program?

2. Our next training program will be in San Mateo, Does this location work for you? If no, please enter most convenient location for you.

3. What qualities do you possess that will make you successful as a Health Ambassador?

4. How have you, your family, or your community been affected by mental health and behavioral health challenges?

5. How does becoming a health ambassador fit with your personal and professional goals?

Appendix B: StarVista HAP-Y Interview Protocol

Start by describing the program (combination of trainings and outreach)

Applicant Name:	**Interviewer:**

1. Tell us a little about yourself and why you are interested in participating in a program focusing on mental health?

2. What is something you hope to get out of participating in this program?

3. How do you feel about representing the program at community events like health fairs or in classroom presentations?

4. Tell us about a time you worked in a team: what were some challenges and what were some things that made is successful?

5. How do you think this will fit with your other commitments? How will you manage your time?

6. Our meetings would be in the afternoon starting at 4:30 starting in September lasting for 13 weeks. Do you expect any challenges to regular participation in the program? (For example: do you have transportation, any scheduling conflicts? Will you need vouchers?)

7. If you are under 18, have you discussed this program with your parents? Are they supportive? Would it be ok for us to contact them?

8. How did you hear about the program?

9. What do you think are your strengths and areas you are working to improve?

10. Why do you think it's important for young people to learn more about mental health?

11. Think about a teacher you liked, what made them effective?

12. What are you most proud of?

13. How would your friends describe you? (If more experienced, how would your supervisor describe you)?

14. What 3 words would you choose to describe yourself?

Appendix C: HAP-Y Demographic Form

Thank you for joining the Health Ambassador Program for Youth. This form will help us understand who is attending the trainings and part of the program. The questions are voluntary. Thank you for your time!

Team Member First and Last Initial & DOB:	
Zip code:	

1. What is your age category?

- ☐ 0-15
- ☐ 16-25
- ☐ 26-39
- ☐ 40-59
- ☐ Age 60 and above
- ☐ Decline to answer

2. What is your preferred language?

- ☐ English
- ☐ Spanish
- ☐ Mandarin
- ☐ Cantonese
- ☐ Russian
- ☐ Vietnamese
- ☐ Tagalog
- ☐ Hindi
- ☐ Farsi
- ☐ American Sign Language
- ☐ Other:_____
- ☐ Decline to answer

3. How do you define your race?
(check all that apply)

- ☐ American Indian/Native Alaskan
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino/a/x
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White/Caucasian
- ☐ Other:_____
- ☐ Decline to answer

4. How do you define your ethnicity?
(check all that apply)

Hispanic Ethnicity:

- ☐ Caribbean
- ☐ Central American:_____
- ☐ Mexican/Mexican-American/Chicano/a/x
- ☐ Puerto Rican
- ☐ El Salvadorian
- ☐ South American:_____

Non-Hispanic Ethnicity:

- ☐ African
- ☐ Asian Indian/South Asian
- ☐ Cambodian
- ☐ Chinese
- ☐ Eastern European
- ☐ European
- ☐ Filipino
- ☐ Middle Eastern
- ☐ Vietnamese
- ☐ Japanese
- ☐ Korean
- ☐ Other:_____
- ☐ Decline to answer

5. What is your assigned sex at birth?

- ☐ Male
- ☐ Female
- ☐ Intersex
- ☐ Decline to answer

6. What is your current gender identity?

- ☐ Cisgender Man
- ☐ Cisgender Woman
- ☐ Trans Man
- ☐ Trans Woman
- ☐ Genderqueer
- ☐ Two-Spirited
- ☐ Questioning or unsure of gender identity
- ☐ Another gender identity:_____
- ☐ Decline to answer

7. How do you identify your sexual orientation?

- ☐ Gay or Lesbian
- ☐ Heterosexual or Straight
- ☐ Bisexual
- ☐ Questioning or unsure of sexual orientation
- ☐ Queer
- ☐ Pansexual
- ☐ Asexual
- ☐ Two-Spirited
- ☐ Another sexual orientation:_____
- ☐ Decline to answer

8. Do you have any of the following disabilities or health conditions? *(check all that apply)*

A disability is defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness.

- ☐ Difficulty seeing
- ☐ Difficulty hearing, or having speech understood
- ☐ Other communication challenges:_____
- ☐ Limited physical mobility
- ☐ Learning disability
- ☐ Developmental disability
- ☐ Dementia
- ☐ Chronic health condition
- ☐ Other disability or health condition:_____
- ☐ None
- ☐ Decline to answer

9. What is your highest level of education?

- ☐ Less than high school diploma
- ☐ High school diploma or GED
- ☐ Some college
- ☐ Vocational or trade certificate
- ☐ Associate's Degree
- ☐ Bachelor's Degree
- ☐ Graduate Degree
- ☐ Decline to answer

10. What is your current employment status?

- ☐ Full time employment
- ☐ Part time employment
- ☐ Unemployed and looking for work
- ☐ Unemployed and not looking for work
- ☐ Retired
- ☐ Student
- ☐ Decline to answer

11. What is your current housing status?

- ☐ I have stable housing
- ☐ I am staying with friends or family
- ☐ I am living in a shelter or transitional housing
- ☐ I am homeless
- ☐ Other housing status:_____
- ☐ Decline to answer

Complete questions 12 &13 if you are 18 years old and over

12. What is your individual annual income?

- ☐ 0-$24,999
- ☐ $25,000- $50,000
- ☐ $50,001- $75,000
- ☐ $75,001- $100,000
- ☐ Above $100,000
- ☐ Decline to answer

13. Are you a veteran?

- ☐ Yes, I am a veteran
- ☐ No, I am not a veteran
- ☐ Decline to answer

Appendix D: HAP-Y Self-Determination Survey 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 E: Health Ambassador Program Youth Audience survey

Thank you for listening to our presentation today! Please use the scale below to rate your level of knowledge before and after the presentation:

1 = No 2 = Sometimes 3 = Most of the time 4 = All of the Time NA = Not Applicable

	For the check boxes in the left column, please rate your knowledge/feelings **Before Presentation:**	For the check boxes in the left column, please rate your knowledge/feelings **After Presentation:**
I know where to go to get support if I am emotionally struggling.	☐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 F: 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?

Appendix G: Staff Protocol

Staff Key Informant Interview Protocol

Introduction

Thanks for making the time to join us today. My name is _____ and this is _____. As you know, 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.

Today, we are going to talk about the implementation of the Healthy Ambassadors Program with Youth and what the program achieved, and where the program is growing. This conversation will be focused on activities that were conducted with Cohorts (X X) so that we can include this in our Year X report. We will have follow-up conversations about the next set of Cohorts. While your name will not be attached to the answers you provide in the interview, because of the size of your program, it may be possible to identify you as the source of certain information. We hope you will feel comfortable sharing candidly about your experiences, but please let me know if there are any sensitive comments that you would like us to be especially careful about when writing up the summary of the conversation.

Do you have any questions before we begin?

Background

1. First off, can you share your title and role at your organization? What are your responsibilities with the HAP-Y program?

2. What is the purpose of the HAP-Y program? What are you seeking to accomplish? (prompt: project goal, impact on community, etc.)

Program Activities and Implementation

3. Please take us through the youth's experience of the HAP-Y program, from orientation to presentations.

4. How did you select the curriculum and activities used with the youth? What types of activities did youth engage in? (prompt: curriculum, skill building, communication, teamwork).

5. What kind of skills did youth gain from these activities? How were these activities received?

6. How, if at all, did the program build youth capacity to reduce community mental health stigma? What did the youth accomplish? What change did you see?

7. How did the Youth Ambassadors in Cohort X increase youth access to mental health services? (E.g. Did StarVista get more requests for follow-up phone calls? Did you get more phone calls to your access/crisis line?)

8. What worked well about Cohort X of the HAP-Y program? What has been successful about the program? How are you measuring success?

9. What, if any, were the barriers to program success? (prompt: What did you need more of? What did you need less of? Timing? Resources? Etc.,)

10. What would you change for Cohort X and beyond? (curriculum, training)?

Conclusion

11. What advice would you give someone who was trying to implement a Health Ambassador Program in their community?

12. Do you have anything else to add?

help @ hand™

CONNECTING PEOPLE
WITH CARE

Stakeholder Report

Updated March 31, 2020

CalMHSA
California Mental Health Services Authority

MENTAL HEALTH SERVICES ACT 63 CALIFORNIA
WELLNESS • RECOVERY • RESILIENCE

Help@Hand Stakeholder Report

Background

Updated 3/31/2020

Project Overview

Innovative digital applications for smartphones and other mobile devices have great potential. Apps empower consumers by engaging them as full partners in their behavioral health care, supporting self-care, and offering access to people who face barriers in working with a face-to-face provider.

The Help@Hand project is trying to discover if technology fits within the Behavioral Health System of Care. And if so, how? Technology has many benefits, but there are also many challenges and questions. The project may discover technology does not work well within the Behavioral Health System of Care. If technology fits, it will be an incredible change in a positive direction.

Help@Hand is a collaborative project with 14 city and county Behavioral Health Departments working together. This means Help@Hand is not one project, but many projects across multiple cities and counties. This collaboration is innovative, and working together to implement something that has not been done before is also innovative. In both cases, creative solutions are required.

California Mental Health Services Authority (CalMHSA) previously identified the desire to pilot up to five technologies by December 2019. This goal is expected to be achieved by June 2020, due in part to changes in the Help@Hand budget model, project leadership, and the focus on developing critical foundational education for Digital Mental Health Literacy* during this timeframe.

Innovation

Funding for Help@Hand comes from Proposition 63 and the Mental Health Services Act. The Mental Health Services Oversight and Accountability Commission says Innovation, “provides the opportunity to develop & test new, unproven mental health models that have the potential to become tomorrow’s best practices.” This is important because it helps us remember that innovation is not intended to be a proven solution. There will be learning, there will be challenges, and there will be problem solving.

Read more about Innovation projects in the MHSOAC’s Regulations.

Stakeholders

Innovation is not limited to technology. Help@Hand is also innovative in it’s commitment to have Peers* and Stakeholder involvement throughout the project. This means the communities served by the project also have a voice in how this project develops and is implemented.

The audience for this project varies. Each of the 14 cities and counties is trying to reach unserved and underserved populations within their community, including Transitional Age Youth (TAY), monolingual communities, LGBTQ+, older adults and isolated adults.

Help@Hand Stakeholder Report

Progress Made

Updated 3/31/2020

Listed below are some of the many accomplishments Help@Hand has achieved since the September 2019 Stakeholder Report.

Sep 2019
- Launched 2nd RFSQ* to add qualified vendors to the project

Oct 2019
- Facilitated City/County In-Person Collaboration Meeting in Sacramento
- Held Northern California Help@Hand Peer Summit

Nov 2019
- Facilitated 20 vendor product demonstrations
- Transition of Project Director role to Jeremy Wilson

Dec 2019

Jan 2020
- Launched Help@Hand webpage HelpatHandCA.org
- Cities and Counties approved new budget model

Feb 2020
- Hosted first Help@Hand Stakeholder Update Webinar
- Held Digital Mental Health Literacy Peer-Train-the-Trainer in Kern County
- Presented semi-annual update to OAC

Mar 2020
- Facilitated City/County virtual collaboration event
- Transitioned all Help@Hand staff to remote work environments in response to COVID-19

Additional Project Accomplishments

- Approved 93 technologies for use in the Help@Hand project
- Launched Help@Hand Branded business tools
- Held Northern California Help@Hand Peer* Summit (hosted by Marin and San Mateo Counties with Kern, Marin, Modoc, Riverside, San Mateo, San Francisco, Tehama, Tri-City, Los Angeles, and Santa Barbara Counties)
- Secured Contractor to provide clinical guidance to counties/cities and CalMHSA*
- Published Semi-Annual Report to the Mental Health Oversite and Accountability Commission in January 2020
- Developed and published Digital Mental Health Literacy* Video Series *Tips for Staying Safe Online* (7 videos to date) helpathandca.org/dmhl
- Developed Peer Curriculum to be adapted to Target Population and Communities
- Trained over 30 Peers on *Preventing and Managing Cyberbullying* & *Managing your Digital Presence*
- Developed business continuity plans and facilitated discussions with counties in response to COVID-19
- Performed preliminary research on feasibility of implementing an application at the State (CalMHSA) level in rapid response to COVID-19

Help@Hand Stakeholder Report

Frequently Asked Questions

Updated 3/31/2020

Help@Hand is delighted to have so many supporters eager to engage with, and learn from, the project. Stakeholders have asked the project many excellent questions on a wide range of topics. The topics have been captured here are intended to help keep Stakeholders informed about the progress. Terms with an asterisk (*) can be found in the glossary at the end of the report.

The Collaborative

- Twelve (12) counties and two (2) cities across California have joined together to learn and implement innovative technologies as a team.

  - ⇒ Modoc County
  - ⇒ Tehama County
  - ⇒ San Francisco County
  - ⇒ San Mateo County
  - ⇒ Kern County
  - ⇒ City of Berkeley
  - ⇒ Tri-City
  - ⇒ Los Angeles County
  - ⇒ Orange County
  - ⇒ Riverside County
  - ⇒ Mono County
  - ⇒ Santa Barbara County
  - ⇒ Monterey County
  - ⇒ Marin County

- Cities/counties can join the project by submitting a proposal to the OAC*. Once approved, they enter the collaborative by contracting with CalMHSA*.
- Participation may change over time based on the counties/cities that engage with the collaborative.
- Some decisions are made individually by the cities and counties. Some decisions are made overall by the collaborative.
- CalMHSA has a new director, Jeremy Wilson. Jeremy replaced the (then) retiring project director, Ann Collentine. This change was made effective on November 1, 2019.
- The Help@Hand Leadership formed a Roadmap Workgroup that identified key strategic priorities to guide the work of the Collaborative in order to achieve the project's vision. These priorities correspond to project and change management.
- The December 2019 Report to the Mental Health Service and Oversite Accountability Commission includes a background of the Help@Hand program, Stakeholder Engagement Updates, Success Stories, Learnings, and Looking forward.

Help@Hand Stakeholder Report

Frequently Asked Questions

Updated 3/31/2020

Funding

- Help@Hand is funded by MHSA* dollars through California's Proposition 63.
- As noted in their publicly available MHSA plans, cities and counties allocate funds toward the Help@Hand project. The funds are administered by CalMHSA on behalf of the collaborative.
- This project is funded by county contributions based on their approved OAC Innovation plan. This includes funds for overall project activities such as project management, marketing, implementation* readiness, organizational change preparation and testing. There are also local funds for marketing, implementation, technology configuration, licensing and training.
- As of March 2020, approximately 21.9% of the total project funding has been utilized, leaving 78.1% of the project budget available for the work ahead.*
- In November 2019 a new budget model for Help@Hand was approved by leadership. This new model shifts spending to emphasize locally-directed decisions for Cities and Counties to support their implementation of technology.

Help@Hand Stakeholder Report

Frequently Asked Questions

Updated 3/31/2020

Technology Products

- These technology tools are not intended to meet the needs of every consumer every time. We are always focused on protecting the people who are using these tools. Help@Hand is about person-centered care. Each individual should decide if they want to use the apps or not. We support their right to make that decision.
- This project looks at three areas of technology: 24/7 Peer Chat*, Digital Therapy Avatar* (Interact with a chatbot or avatar for support), and Digital Phenotyping* (monitor wellbeing from passive data* collected from digital devices, like a smartphone, to provide a user and clinician with
feedback).
- The initial technology selected followed a procurement process:

    1) Request for Statement of Qualifications. RFSQ is a process for technology companies to submit a proposal to Help@Hand. The original RFSQ was released in December 2018.

    2) In January 2019 candidates were interviewed.

    3) All those who passed were added to "the bench" for county selection.

    4) Counties selected desired apps.
- To introduce more technology options to the project, an updated RFSQ was launched on September 11, 2019. The RFSQ closed in October and resulted in 93 approved technologies.
- Kern and Los Angeles Counties developed a Digital Mental Health Literacy Brochure, that offers information on a variety of app solutions evaluated by Peers* in their communities.
- Counties and Cities have a Product Matrix tool developed by the Help@Hand team .This Product Matrix includes more than a dozen additional features for Counties/Cities to filter from when searching for an application.
- The Cities/Counties currently have 93 approved RFSQ candidates to evaluate for pilot and implementation* opportunities. In addition Help@Hand has conducted 20 product vendor demonstrations for the Cities and Counties to gain more insight of the products that are available.
- The program now has a Pilot Proposal and Approval Process for each County and City to work through as part of the collaborative.
- The first Product Exploration Training was delivered on January 21, 2020 in San Mateo for two apps: Happify and Remente. This training is available for all counties/cities in the collaborative.
- The Cities/Counties now have a Vendor contract template, which was developed with guidance from digital technology legal experts.
- Cities/counties are currently working with the Help@Hand implementation team to develop an Implementation Playbook for their county/city.

Privacy & Security

- The user's data is protected. Tech companies will have the data and may use it to improve the app, but they cannot sell it or trade it.
- Technology that collects and/or stores PII or PHI* will be HIPAA* compliant.
- Technology that does not collect your data are not HIPAA compliant because they do not collect your data.
- Data is housed by the technology vendors. It will not be sold.
- Many people already share personal data with their city/county. For example, data that is requested by some of the Help@Hand technology apps is very similar to the data that is collected for other county programs, such as CalFresh.
- Program evaluators, University of California Irvine, may use data for learning purposes, but the data will not identify individuals by name.
- Prior to using any technology or app, you will get information about the type of app it is and whether it is anonymous*, confidential or neither.
- Beginning January 1, 2020 a new California Law called the California Consumer Privacy Act. gives Californians new rights and businesses responsibilities in regards to their data and privacy. This new law grants a consumer a right to request a business to disclose the categories and specific pieces of personal information that it collects about the consumer, the categories of sources from which that information is collected, the business purposes for collecting or selling the information, and the categories of 3rd parties with which the information is shared. The bill would require a business to make disclosures about the information and the purposes for which it is used. Read more here.

Help@Hand Stakeholder Report

Frequently Asked Questions

Updated 3/31/2020

Safety

- The need to inform individuals prior to the use of a digital mental health solutions will be addressed by each city/county as it relates to their implementation of each technology, with guidance from their local subject matter experts.
- Help@Hand has developed a Vendor Security Questionnaire for prospective technology vendors to complete. This tool is designed to assist the project in adequately assessing the security of technology being considered for the project.
- The need for an Institutional Review Board (IRB) is considered on a case-by-case basis. Each county and vendor must make this determination considering their use of any data generated by the technology. CalMHSA cannot make any decisions about the need for an IRB*. UCI has obtained an IRB for data collection on the project.
- The Mental Health Services Oversight and Accountability Commission speaks about Innovation saying, “it provides the opportunity to develop & test new, unproven mental health models that have the potential to become tomorrow’s best practices.” This is important because it helps us remember innovation is not intended to be a proven solution or approach. There will be learning, there will be challenges, and there will be problem solving.
- Anonymous vs Confidential—these words are often used interchangeably but mean very different things. Anonymity refers to data that is collected in a way that the person's identity can never be discovered. Confidentiality refers to data that is collected in a way that the person is not immediately identifiable, but they may be identified if the person is believed to be involved a crisis.
- Digital mental health crisis response occurs at the local level, just as with any other mental health crisis response.
- Help@Hand has developed a crisis response protocol that augments current crisis response protocols. The step by step process adds considerations for multi city/county implementation of a digital mental health solutions. Vendors are required to adhere to the crisis protocol and work collaboratively with a city/county to respond to a crisis.
- A Digital Behavioral Health Questionnaire (DBHQ) was developed to asses the products from the RFSQ. David Young, Ph.D., MPH was engaged as the Help@Hand Clinical Consultant/ Psychologist to assist Cities/Counties and CalMHSA in reviewing the DBHQ.

Help@Hand Stakeholder Report

Frequently Asked Questions

Updated 3/31/2020

Implementation & Readiness

- Cities/counties are currently working with the implementation team to develop an Implementation plan for their City/County.
- A variety of templates and guides have been created to assist the Cities/Counties in conducting various activities according to industry best practices (focus groups in early testing, exploration training).
- A Training Schedule has been created for the Collaborative to support education across various efforts within the Help@Hand program. These efforts include: Project Onboarding, Digital Mental Health Literacy, Product Pilot, and Product Portfolio Implementation. The schedule is updated each quarter to reflect the next quarter's schedule.
- Organizational Change Management templates were created to guide Cities/Counties in developing plans to manage aspects of change such as communication, training and process changes.
- The Digital Mental Health Literacy curriculum is not only for Peers involved in the Help@Hand program, the intention of Train-the-Trainer sessions are to empower Peers to share knowledge and resources to their communities. In addition, the Digital Mental Health Literacy video tutorial series on helpathandca.org/dmhl is available for the general public to access.

Evaluation

- These technology tools are not intended to meet the needs of every consumer every time. We are always focused on protecting the people who are using these tools. Help@Hand is about person-centered care. Each individual should decide if they want to use the apps or not. We support their right to make that decision.
- This project looks at three areas of technology: 24/7 Peer Chat*, Digital Therapy Avatar* (Interact with a chatbot or avatar for support), and Digital Phenotyping* (monitor wellbeing from passive data* collected from digital devices, like a smartphone, to provide a user and clinician with feedback).
- The University of California, Irvine (UCI) Provides a quarterly and annual evaluation* report to the collaborative. UCI in partnership with the University of California, San Diego (UCSD) is conducting a comprehensive formative evaluation of Help@Hand. The evaluation involves observing and evaluating the project as it happens in order to provide real-time feedback and capture project learnings.

Help@Hand Stakeholder Report

Frequently Asked Questions

Peers & Stakeholders

- For the Help@Hand Project, our working definition of a Peer is: Someone who publicly self-identifies with having personal lived experience of a mental health/co-occurring issue accompanied by the experience of recovery and is trained to use that experience to support the people we serve.
- After Coordinating the transition plan of the previous Peer and Community Engagement Manager, Kelechi Ubozoh, CalMHSA is actively recruiting a Peer to fill the role to ensure the Peer perspective continues to be integrated throughout the project.
- Many cities and counties involved with Help@Hand continue to have dedicated Peer representation to inform the program and provide input.
- Peers are involved in activities like product exploration, evaluation*, marketing, outreach and engagement.
- Recognizing that many stakeholders have needs and concerns before engaging with technology, the Peer and Community Engagement manager facilitated a series of meetings with stakeholders and as a result developed a Digital Mental Health Literacy Catalogue to respond to emerging needs.
- Pilots are intended to engage a diverse population. During previous pilots, the apps were not only translated but also trans-adapted. This means a person who fluently speaks the language has reviewed the translation to validate the translation. This means an individual from the community provides a first translation and another individual validates. Both individuals ensure cultural context is not lost in the language translation.
- Stakeholders have multiple ways to provide input on the project. Over the course of 11 Digital Mental Health Literacy data-gathering1 sessions with counties, Help@Hand reached over 300 stakeholders to hear about their needs.
- To get more information about stakeholder input for a specific city or county, please contact that location's department of behavioral health.
- The Digital Mental Health Literacy catalogue includes over 7 video tutorials that are available to the public on helpathandca.org/dmhl.
- The Digital Mental Health Literacy Peer-Train-the-Trainer took place in Kern County on February 26-27, 2020 this included the development of Peer Curriculum to be adapted to Target Population sand their communities. Over 30 Peers participated and were trained on the *Preventing and Managing Cyberbullying & Managing Your Digital Presence* curriculums.
- Help@Hand branding including logos, colors and illustrations were finalized in October 2019 based on input from project stakeholders.
- In November 2019 Kelechi Ubozoh provided an overview presentation on the role of Peers in the Help@Hand Innovation Project as the Peer and Community Engagement Manager, the recording is available on helpathandca.org.

Help@Hand Stakeholder Report

Frequently Asked Questions

Updated 3/31/2020

The Help@Hand teams are working diligently with experts and stakeholders to find the best ways to implement the technology, but we know not all questions can be answered today. Some questions will remain unanswered as we work through the project. These questions have not been lost. Help@Hand will track those questions here. As answers are learned they will be added to the FAQ sections of this document and the questions will be removed from this section.

Questions We Are Working On

- After the project is over, can counties and their stakeholders still have ongoing access to the digital solutions that were provided?
- Will all apps have a disclaimer about what will happen in a crisis?

How to Ask a Question

To submit a question to Help@Hand, please contact CalMHSA at HelpatHand@CalMHSA.org.

Help@Hand Stakeholder Report

Looking Forward

Updated 3/31/2020

What We Have Learned

- Implementing technology is complicated and takes time. The American Medical Association Digital Literacy Playbook notes that on average it takes a hospital 23 months to go from identifying a digital innovation need to scaling a digital solution to meet that need. In this case, we don't have one hospital, the Help@Hand project includes 14 cities and counties across the state, with different systems, processes and resources.
- We've heard from diverse communities that more product options are needed. The project opened a RFSQ process in September 2019 for technology companies to apply to be part of the suite of apps Help@Hand considers. There are 93 approved apps from this RFSQ. Only 10 apps from the RFSQ fit under “Peer” Component but are not necessarily chat, do not fit the project definition of Peers, or do not offer 24/7 support.
- Innovation is happening throughout the project on a daily basis. We are looking at different ideas and concepts, including creative ways to use the technology solutions, ways to identify and procure new technology solutions, and creative approaches to marketing and branding that are different than what we might expect to see with a county or city program.
- Every City and County has it’s own unique infrastructure and population. The diversity of the Collaborative requires decisions that are County/City specific with local dollars. The new budget model allows Cities/Counties to make decisions with local dollars to be responsive to their different stakeholder groups by directing more of the budget to local dollars.
- Understanding each product is very important to the Collaborative. A Digital Behavioral Health Questionnaire (DBHQ) was developed to asses the products from the RFSQ to help the cities and counties define the needs of their consumers and what considerations need to be at the center of their assessment.

What’s Ahead

- Los Angeles County has received approval for three pilots (pilot start is subject to the county’s focus on COVID-19)
- Two additional implementations are anticipated in Riverside and Orange counties.
- The next quarterly update of this document will be in June 2020. The next stakeholder webinar is tentatively planned for AUG 2020 (subject to change due to COVID-19).
- CalMHSA is actively recruiting a Peer to fill the role of the Peer and Community Engagement Manager.
- Virtual and written reports to stakeholders will continue.
- Cities/Counties are evaluating a rapid response deployment of a single product to assist their communities in dealing with stress and anxiety related to COVID-19.

Help@Hand Stakeholder Report

Addendum A—Project Terms

Updated 3/31/2020

Glossary of Project Terms and Acronyms

Term	Description
Anonymous	No data is collected from the user
Avatar	A computer program designed to simulate conversation with human users (e.g. chat bot, human-computer interaction).
Virtual Evidence-based Therapy Using an Avatar	Virtual manualized evidence-based interventions delivered via an avatar (e.g. mindfulness exercises, cognitive behavioral or dialectical behavior interventions delivered in a simple, intuitive fashion).
CalMHSA	California Mental Health Services Authority
Confidential	Data is collected from the user, but not shared within the technology. The user is not known to other users, but the vendor, project team, or evaluators may have access to the user's information.
Digital Mental Health Literacy	Knowledge, skills, and behaviors to effectively use digital devices like smartphones and laptops for health information, communication, expression, and collaboration towards mental health and personal recovery.
Evaluation	The project is participating in a formative evaluation. Unlike summative evaluations, which focus primarily on understanding the impact or outcomes of a specific program or intervention, formative evaluations are designed to identify potential and actual influences on the progress and effectiveness of implementation efforts.
HIPAA	Health Insurance Portability and Accountability Act. This Privacy Rule protects all individually identifiable health information that is held or transmitted by a covered entity or a business associate.
Implementation	In the context of this project there are three phases in the process of putting a plan into effect: • Initiation –The project objective or need is identified • Implementation –Project plan is put into motion and the work of the project is performed. • Stabilization –Releasing the final deliverables to the consumer, releasing project resources.

Help@Hand Stakeholder Report

Addendum A—Project Terms

Updated 3/31/2020

Glossary of Project Terms and Acronyms

Term	Description
IRB	Institutional Review Board
MHSA	California Mental Health Services Act
MHSOAC	Mental Health Services Oversight and Accountability Commission
PHI / PII	Protected Health Information / Personally Identifiable Information
Passive Data Collection	Measurement through passive capture of human computer interaction data. Utilize passive sensory data to engage, education and suggest behavioral activation strategies to users.
Peer	Someone who publicly self-identifies with having personal lived experience of a mental health/co-occurring issue accompanied by the experience of recovery and is trained to use that experience to support the people we serve.
1:1 (Peer) Chat & Digital Therapeutics	Utilize technology-based mental health solutions designed to engage, educate, assess and intervene with individuals experiencing symptoms of mental illness.
RFSQ	Request for Statement of Qualifications. Application process where technology vendors can apply to participate in the Help@Hand project.
TAY	Transitional Aged Youth — youth and young adults ages 16-25 that either have, or are at risk of developing, a serious mental health condition; population may include children in the foster care/child welfare system and/or justice involved youth.

APPENDIX 12 FULL SERVICE PARTNERSHIP EVALUATION REPORT, FY 2018-19

AMERICAN INSTITUTES FOR RESEARCH®

Full Service Partnership (FSP) Outcomes

Findings from 2018-2019 Fiscal Year

Aaron M Ogletree, PhD

Yi Lu, PhD

Dierdre Gilmore, MA

JUNE 2019

Full Service Partnership (FSP) Outcomes

Findings from 2018-2019 Fiscal Year

June 2019

Aaron M Ogletree, PhD
Yi Lu, PhD
Dierdre Gilmore, MA

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Executive Summary

Full Service Partnerships (FSPs) are a set of enhanced, integrated services administered through San Mateo County contracted providers to assist individuals with mental and behavioral health challenges. The American Institutes for Research (AIR) is working with San Mateo County ("the County") to understand how enrollment in an FSP promotes resilience and improves health outcomes of individuals served.

This report presents outcomes for child, transitional age youth (TAY), adult, and older adult clients (hereafter referred to as "partners") of the Full Service Partnership (FSP) program in the County using FSP program survey data and Avatar data, the County's electronic health records (EHR) system. In some cases, the EHR data will have a larger sample size than the survey data, as partners did not always complete the survey tools.

The findings from self-reported outcomes (survey data) suggest that the majority of outcomes improved (27 of 32 outcomes) for all reported age groups. Exhibit 1, below, presents the percent change between the year just prior to enrollment in an FSP and the first year enrolled in an FSP, by age group. Red font in the Exhibit indicates percent change that was not favorable (i.e., greater number of hospitalizations or worse grades for TAY partners; 5 out of 32 outcomes). Percent improvement is the percent change in the percent of partners with any outcomes of interest (e.g., homelessness, incarceration, employment). For example, the percent of adult partners experiencing homelessness changed from 91% before FSP enrollment to 58% in the first year following FSP enrollment, a 36.3% improvement.

Exhibit 1 shows improvements for all age groups for the following self-reported outcomes: arrests, mental health emergencies, and physical health emergencies. For children and TAY partners, school suspensions decreased, and the percent of TAY and adult partners with an episode of detention or incarceration decreased as well. Fewer adult and older adult partners reported an active substance abuse problem in the year following FSP enrollment (with fewer corresponding reports of receiving substance abuse treatment). Employment outcomes also increased for adult partners.

Five outcomes showed no improvement for specific age groups. TAY partners reported decreased grade ratings and increased homelessness. Child partners reported decreased grade ratings and attendance, and increased detention or incarceration. However, the increase in incarceration is relatively small (26 in the first year with FSP compared to 22 in the year just prior) when compared to the decrease in arrests (9 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, compared to the year before joining an FSP, there are reductions in the percent of partners with any hospitalization, mean hospital days per partner, percent of partners using any psychiatric emergency services (PES), and mean PES event per partner. The only exception is that the mean hospital days for older adults increase by about one day which is likely be attributed to other medical conditions as both the hospitalization and PES incidence decrease significantly. Also, for all cohorts, the reductions are consistently observed over the years since the inception of the FSP program.

Exhibit 1: Percent Change in Outcomes by Age Group, Year before FSP Compared with First Year with FSP

FSP Outcomes *Self-reported Outcomes*	**Adult (25 to 59 years) N = 366**			**Older adult (60 years & older) N = 62**		
	Yr before	*Yr after*	*change*	*Yr before*	*Yr after*	*change*
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 Emerg.	151	57	-62.3%	13	7	-46.2%
Physical Health Emerg.	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%
Healthcare Utilization (EHR data)	**Adult (25 to 59 years) N = 313**			**Older adult (60 years & older) N = 47**		
	Yr before	*Yr after*	*change*	*Yr before*	*Yr after*	*change*
Hospitalization	120	55	-54%	12	8	-33%
Hospital Days per partner	11.6	3.7	-68%	4.2	5.7	37%
PES	168	120	-29%	15	9	-40%
PES Event per partner	1.8	1.0	-44%	0.7	0.4	-39%

FSP Outcomes *Self-reported Outcomes*	**Child (16 years and younger) N = 166**			**TAY (17 to 25 years) N = 255**		
	Yr before	*Yr after*	*change*	*Yr before*	*Yr after*	*change*
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 Emerg.	57	7	-88%	84	23	-73%
Physical Health Emerg.	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%
Healthcare Utilization (EHR data)	**Child (16 years and younger) N = 210**			**TAY (17 to 25 years) N = 176**		
	Yr before	*Yr after*	*change*	*Yr before*	*Yr after*	*change*
Hospitalization (N)	10	3	-70%	24	19	-21%
Hospital Days per partner	1.3	0.1	-91%	5.0	2.7	-46%
PES (N)	52	24	-54%	77	51	-34%
PES Event per partner	0.5	0.2	-55%	1.0	0.7	-27%

Hospitalization Outcomes**	Overall Improvement	Range (Partnerships Beginning 2006 – 2018)
Healthcare Use (EHR data, N= 746)		
Partners with Hospitalizations	49%	26% – 71%
Mean Hospital Days	61%	(7%) – 86%
Partners with PES	35%	13% – 58%
Mean PES Events	42%	12% – 67%

Note. The table above indicates the percent change in the percent of partners with any events, comparing the year just prior to FSP with the first year on FSP. Percent change in ratings indicates the change in the average rating for the first year on the program as compared to the year just prior to FSP. Value of N/A means a change is not reported due to insufficient sample size (fewer than 10 observations). Red font indicates outcomes that worsened, such as lower school attendance for TAY partners or more days spent in the hospital for older adult partners.
** These outcomes are presented overall for all clients as well as by year of partnership; the range presented is from the lowest to highest percent changes among the calendar years.

Background and Introduction

The Mental Health Services Act (MHSA) was enacted in 2005 and provides a dedicated source of funding to improve the quality of life for individuals living with mental illness. In San Mateo County (the County), a large component of this work is accomplished through Full Service Partnerships (FSP). FSP programs provide individualized integrated services, flexible funding, intensive case management, and 24-hour access to care ("whatever it takes" model) to help support recovery and wellness for persons with serious mental illness (SMI) and their families. In the County there are currently four comprehensive FSP providers: Edgewood Center and Fred Finch Youth Center serving children, youth, and transition age youth; and Caminar and Telecare serving adults and older adults.

The County has partnered with the American Institutes for Research (AIR) to understand how enrollment in the FSP is promoting resiliency and improving health outcomes of the County's clients living with mental illness. The data used for this report are collected by providers from clients' (hereafter, "partners'") self-reports (i.e., survey data), and electronic health records obtained through the County's Avatar system (i.e., EHR data).

This year's report includes data from all FSP providers but does not include Telecare data for the 2018-2019 fiscal year. Telecare changed its electronic healthcare record (EHR) system and is currently in the process of converting its data to the original analytic format.

Initial survey data are collected via an intake assessment, called the Partnership Assessment Form (PAF), which includes information on well-being across a variety of measures (e.g., residential setting) at the start of FSP and over the twelve month "lookback" window of the year prior to FSP enrollment. While participating in the FSP, survey data on partners is gathered in two ways. Life changing events are tracked by Key Event Tracking (KET) forms, which are triggered by any key event (e.g., a change in residential setting). Partners are also assessed regularly with Three Month (3M) forms. Changes in partner outcomes are gathered by comparing data on PAF forms to data compiled from KET and 3M forms.

EHR data collected through the County Avatar system contain longitudinal partner-level information on demographics, FSP program participation, hospital stays, and psychiatric emergency services (PES) utilization before and after the enrollment date within the County health system. The Avatar system is limited to individuals who obtain care in the County health system. Hospitalizations outside of the County, or in private hospitals, are not captured.

This report presents changes in partners' self-reported and hospitalization outcomes in two consecutive years: (1) the baseline year, i.e., the 12 months prior to enrollment in the FSP program, and (2) the first full 12 months of the partner's FSP participation. Children (aged 16 and younger), transition aged youth (TAY; aged 17 to 25), adults (aged 25 to 59), and older adults (aged 60 and older) were included in the analysis if they had completed at least one full year with the FSP program by June 2019 (the data acquisition date). Trends in EHR data are subsequently presented as an average across all years of the program as well as annually, by year of FSP program enrollment.

We have included several appendices to clarify the methods used and provide more detailed findings. Appendix A presents additional detail on residential outcomes. Outcomes for individual FSP providers can be found in Appendix B. Details on our methodology for both the self-reported outcomes and the EHR-based hospitalization outcomes can be found in Appendix C.

Self-reported outcomes

Overview

The following section presents outcomes for: 166 child (aged 16 and younger) FSP partners; 213 TAY (aged 17 - 25) FSP partners; 366 adult (aged 26-59) FSP partners; and, 62 older adult (aged 60 and older) FSP partners. The results compare the first year enrolled in an FSP with the year just prior to FSP enrollment for partners completing at least one year in an FSP program.

Outcomes Assessed. Several outcomes are broken down by age category, as described below. Note that employment, homelessness, incarceration, and arrest outcomes are not presented for adults aged 60 or older, as there are insufficient observations in this age group for meaningful interpretation (i.e., there are less than 5 older adult partners total with any of these events).

1. **Partners with any reported homelessness incident:** measured by residential setting indicating homelessness or emergency shelter (PAF and KET).
2. **Partners with any reported detention or incarceration incident:** measured by residential setting indicating Jail or Prison (PAF and KET).
3. **Partners with any reported employment**: measured by employment in past 12 months and date employment change (PAF and KET).[1]
4. **Partners with any reported arrests:** measured by arrests in past 12 months and date arrested (PAF and KET).
5. **Partners with any self-reported mental health emergencies:** measured by emergencies in past 12 months and date of mental health emergency (PAF and KET).
6. **Partners with any self-reported physical health emergencies:** measured by emergencies in past 12 months and date of acute medical emergency (PAF and KET).
7. **Partners with any self-reported active substance abuse problem**: measured by self-report in past 12 months and captured again in regular updates (PAF and 3M).
8. **Partners in substance abuse treatment**: measured by self-report in past 12 months and captured again in regular updates (PAF and 3M).

In addition, we also examine three outcomes specific to child and TAY partners:

1. **Partners with any reported suspensions**: measured by suspensions in past 12 months (PAF) and date suspended (KET).
2. **Average school attendance ranking**: an ordinal ranking (1-5) indicating overall attendance; measured for past 12 months (PAF), at start of FSP (PAF), and over time on FSP (3M).

[1] Employment outcome is not applicable to child and TAY partners.

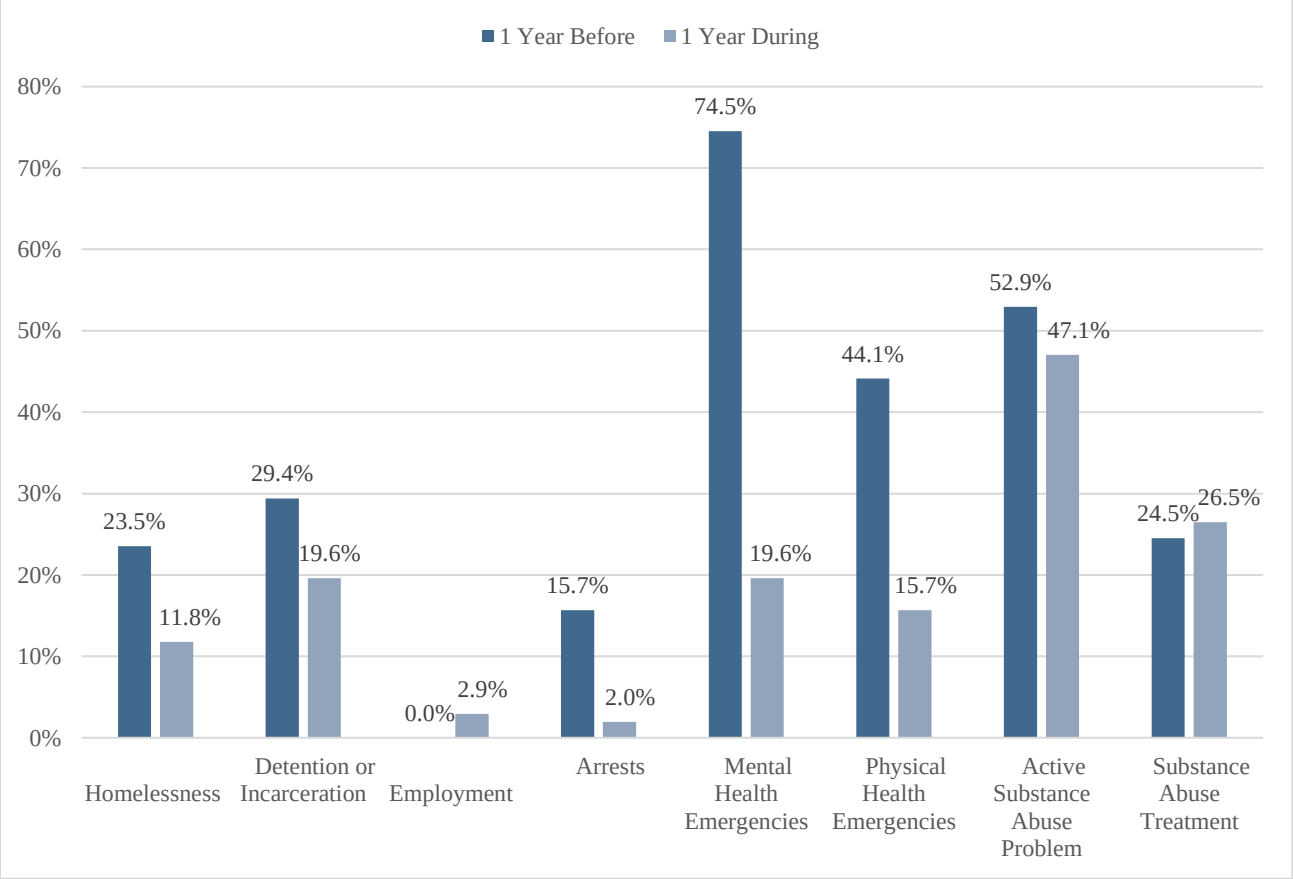
3. **Average school grade ranking**: an ordinal ranking (1-5) indicating overall grades; measured for past 12 months (PAF), at start of FSP (PAF), and over time on FSP (3M).

Mental and physical health emergencies by living situation. Mental and physical health emergencies are considered in conjunction with residential status for all age groups combined. Specifically, we explore the likelihood of an emergency in relation to whether the partner's living situation in their first year of FSP participation is "advantageous" (i.e., living with family or foster family, living along and paying rent, or living in group care or assisted living) or "higher risk" (i.e., homeless, incarcerated, or in a hospitalized setting.

Self-Reported Outcomes by Age Group

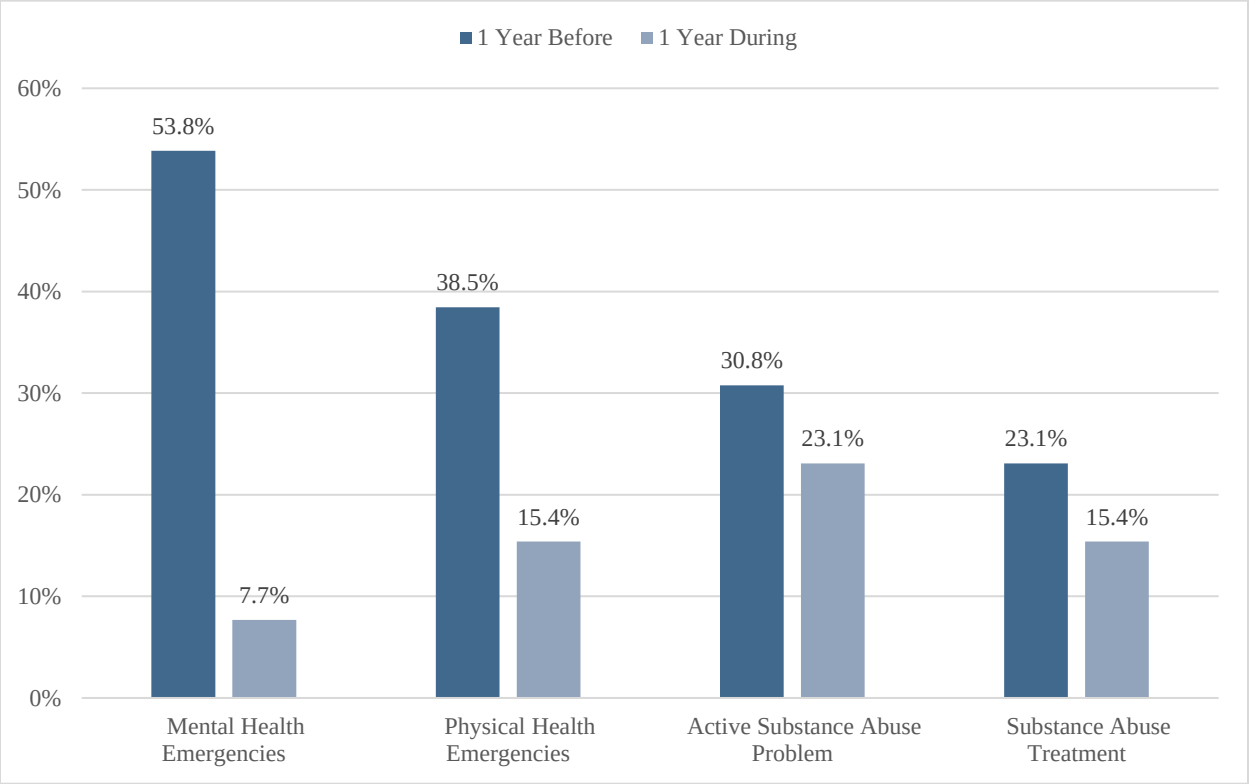
Adults. The comparison of outcomes for adult partners in the year prior to FSP enrollment with the first year in an FSP is shown in Exhibit 2. Homelessness, incarceration, arrests, self-reported mental and physical health emergencies, and substance use problems and treatment all decreased. In addition, employment increased. Each of these demonstrates improvements for adult partners in the first year of FSP enrollment.

Exhibit 2: Outcomes for Adult Partners Completing One Year with FSP (n = 366)



Older Adults. Exhibit 3 compares outcomes in the year prior to FSP enrollment with outcomes reported in the first year of FSP enrollment for older adult partners. Similar to adult partners, self-reported mental and physical health emergencies, and substance use problems and treatment all decrease. Each of these demonstrates improvement for older adult partners in the first year of FSP enrollment.

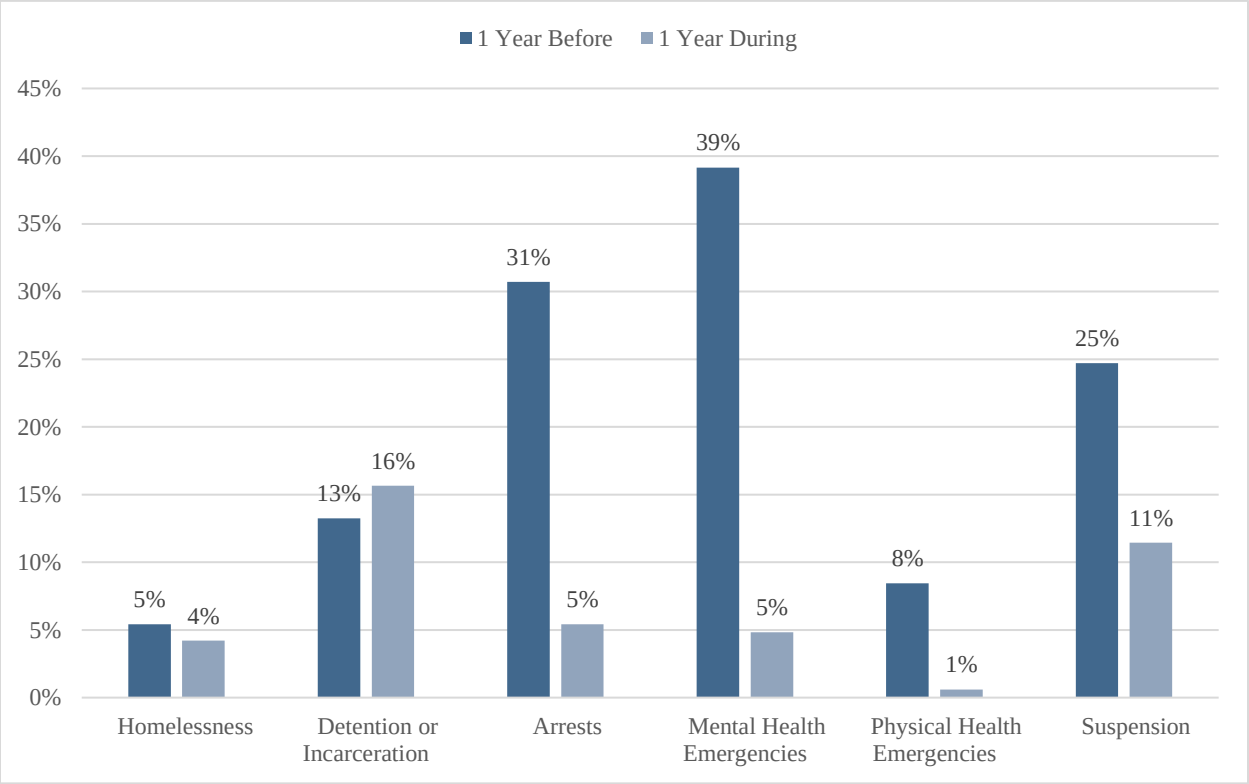
Exhibit 3: Outcomes for Older Adult Partners Completing One Year with FSP (n = 62)



Note: Employment, homelessness, incarceration, and arrest outcomes are not presented for older adults, as there are insufficient observations in this age group for meaningful interpretation.

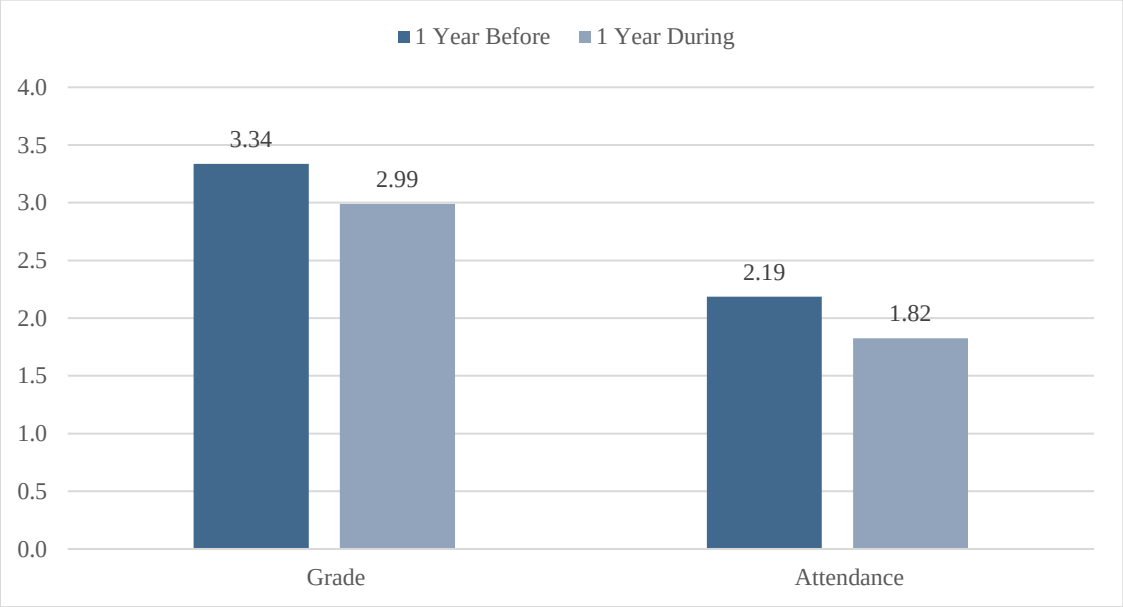
Children. Exhibit 4 below shows the comparison of outcomes in the year prior to FSP enrollment with the first year enrolled in an FSP program for child partners. The findings are essentially the same as those in the last year's report. All but one self-reported outcome decreased while participating in FSP, showing improvements in homelessness, arrests, suspensions, and mental or physical health emergencies. Detention or incarceration increased slightly for children, however (26 incidents in the first year with FSP compared to 22 incidents in the year prior to FSP enrollment). The magnitude of decline in arrest incidence is much larger (9 in the first year with FSP compared to 24 in the year just prior).

Exhibit 4: Outcomes for Child Partners Completing One Year with FSP (n = 166)



Outcomes on school attendance and grades are presented below in Exhibit 5. As can be seen, attendance and grades for child partners declined modestly. These ratings are on a 1-5 scale, coded such that a higher score is better.

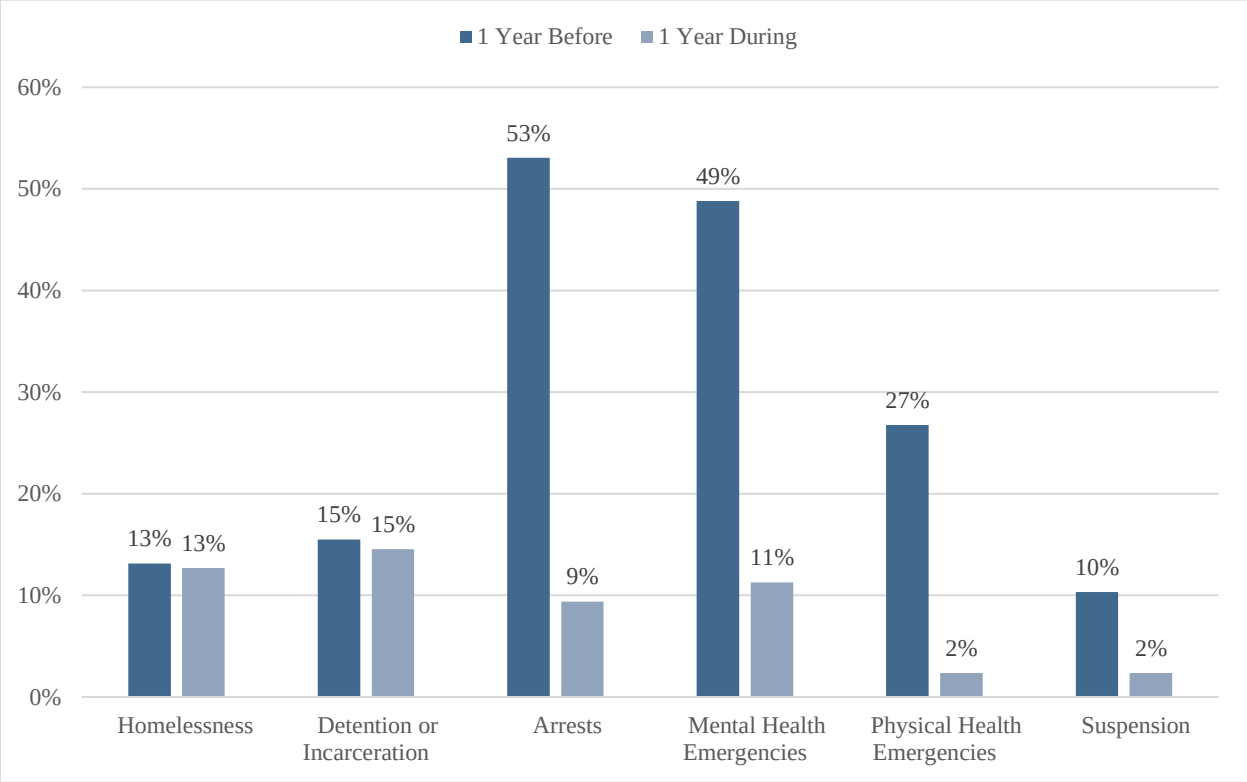
Exhibit 5: School Outcomes for Child Partners Completing One Year with FSP (n = 166)



TAY. Exhibit 6 shows the comparison of outcomes in the year prior to FSP to the first year in the program for TAY partners.[2] All self-reported outcomes decreased (an improved status), though the differences for homelessness and incarceration is small. except for homelessness. Homelessness decreased from 28 (13.1%) in the year prior to enrollment to 27 (12.7%) in the year following enrollment. Incarceration decreased from 33 (15.4%) in the year prior to enrollment to 31 (14.6%) in the year following enrollment. Compared to the last year's report, the magnitudes of decrease are similar and slightly larger.

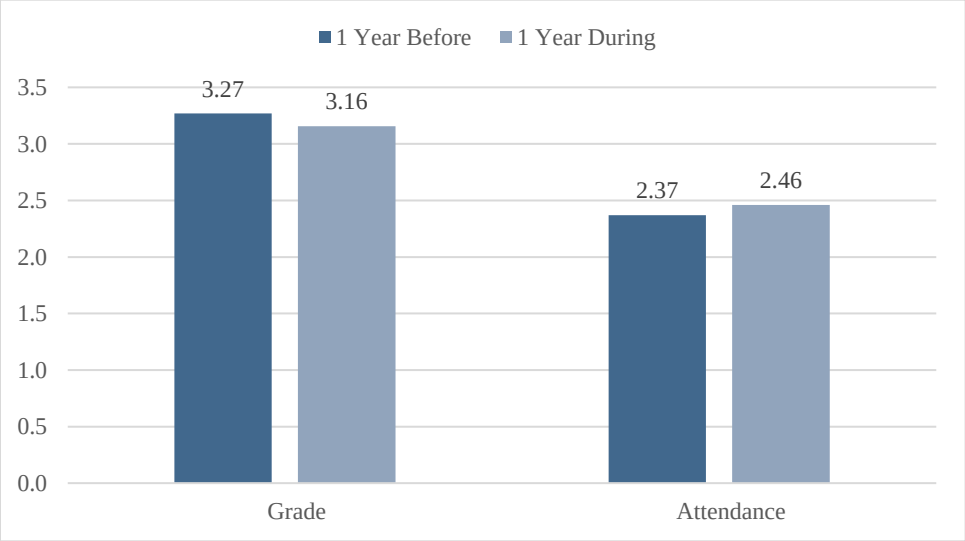
[2] The 40 older TAY partners in Telecare and Caminar are excluded from these outcomes because these providers do not reliably gather TAY specific outcomes. Note that employment as an outcome is not presented for TAY because many of these individuals are in school.

Exhibit 6: Outcomes for TAY Partners Completing One Year with FSP (n = 213)



Outcomes on school attendance and grades are presented in Exhibit 7. Attendance and grades for TAY partners change very little. These ratings are on a 1-5 scale; a higher score is better.

Exhibit 7: School Outcomes for TAY Partners Completing One Year with FSP (n = 213)

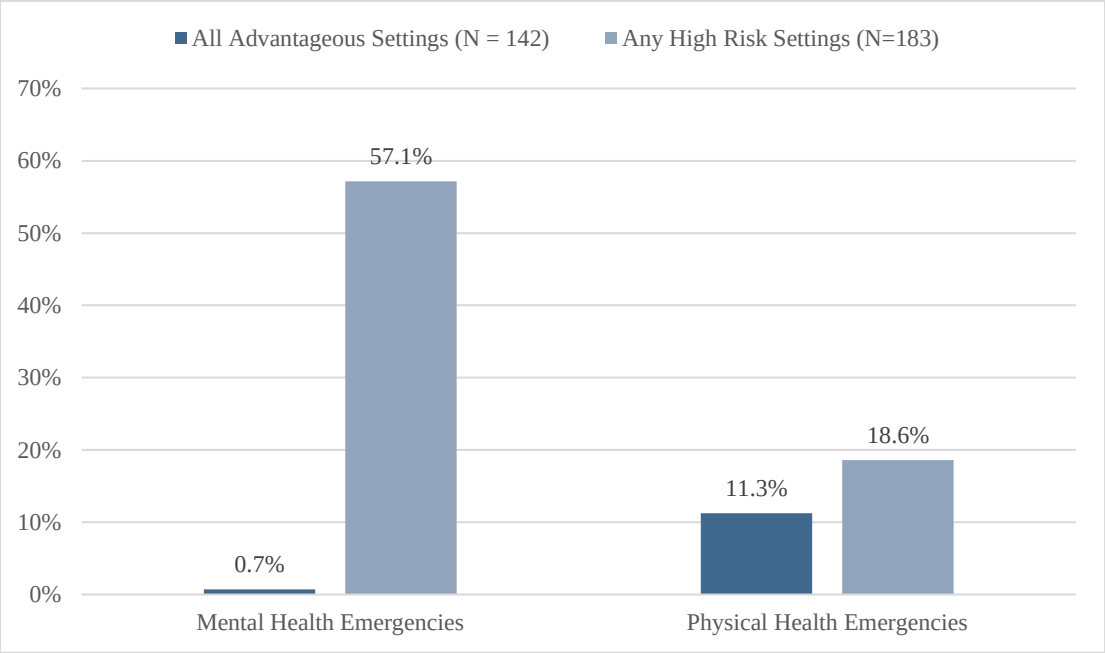


Mental and physical health emergencies by living situation

Exhibit 8 shows the percentage of adult and older adult partners living in advantageous vs higher risk living situations who had a mental or physical health emergency in their first year on FSP. Advantageous settings are defined as living with family or foster family, living alone and paying

rent, or living in group care or assisted living. High risk settings are defined as homelessness, incarceration, or in a hospitalized setting. As shown in the exhibit, both mental and physical health emergencies were more common among individuals who experienced a high-risk residential setting in their first year of FSP participation.

Exhibit 8: Emergency Outcomes as a Function of Residential Setting



Health Care Utilization Overall and Over Time

Overview

This section describes (1) overall healthcare utilization across all partners, (2) healthcare utilization by age group, and (3) healthcare utilization for partners over time (2006-2019).

Four hospitalization outcomes are presented for the 210 child, 176 TAY, 313 adult, and 47 older adult FSP partners using the Avatar system (EHR):

1. **Partners with any hospitalizations:** measured by any hospital admission in the past 12 months;
2. **Partners with any PES:** measured by any PES event in the past 12 months;
3. **Average length of hospitalization (in days):** the number of days associated with a hospital stay in the past 12 months; and,
4. **Average number of PES event:** the number of PES events in the past 12 months.

Note that the difference in the number of partners across the data sources is due to the difference in age group definition (see Appendix C) and not every partner has a health care record in the County's EHR system.

Overall Healthcare Utilization Outcomes Across all Partners

We detected statistically significant changes in outcomes from the year before FSP compared to the first year in FSP for all hospitalization outcomes (Exhibit 9). Percent of partners with any hospitalization decreased from 22% before FSP to 11% during FSP. Days in the hospital decreased from 6.66 days before FSP to 2.60 days during FSP. Percent of partners with any psychiatric emergency services (PES) decreased from 42% before FSP to 27% during FSP. The average number of PES events decreased from 1.18 events before FSP to 0.68 events during FSP.

Exhibit 9: FSP Partners Have Significantly Improved Hospitalization Outcomes (n=746)

	Mean	95% Confidence Interval
Percent of Partners with Any Hospitalization*		
1 Year Before	22%	(19% - 25%)
Year 1 During	11%	(9% - 14%)
Mean Number of Hospital Days, per Partner*		
1 Year Before	6.66	(5.30 - 8.02)
Year 1 During	2.60	(1.75 - 3.45)
Percent of Partners with any PES Event*		
1 Year Before	42%	(38% - 45%)
Year 1 During	27%	(24% - 31%)
Mean PES Events, per Partner*		
1 Year Before	1.18	(1.00 - 1.35)
Year 1 During	0.68	(0.56 - 0.81)

*Significance testing was conducted using Chi-square analysis for percentages and t-tests for means; results are statistically significant at the 95% level.

Health Care Utilization for FSP Partners by Age Group

Hospitalization outcomes are presented in Exhibits 10-13, respectively by age group. For all four age groups, the percent of FSP partners with any hospitalization or PES event decreased after joining FSP. The mean number of hospital days experienced by FSP partners also decreased after FSP enrollment for all but the older adult group. The average number of PES events decreased after FSP enrollment for all the age groups.

Exhibit 10: Hospitalization and PES Outcomes for Adult Partners Completing One Year with FSP (n = 313)

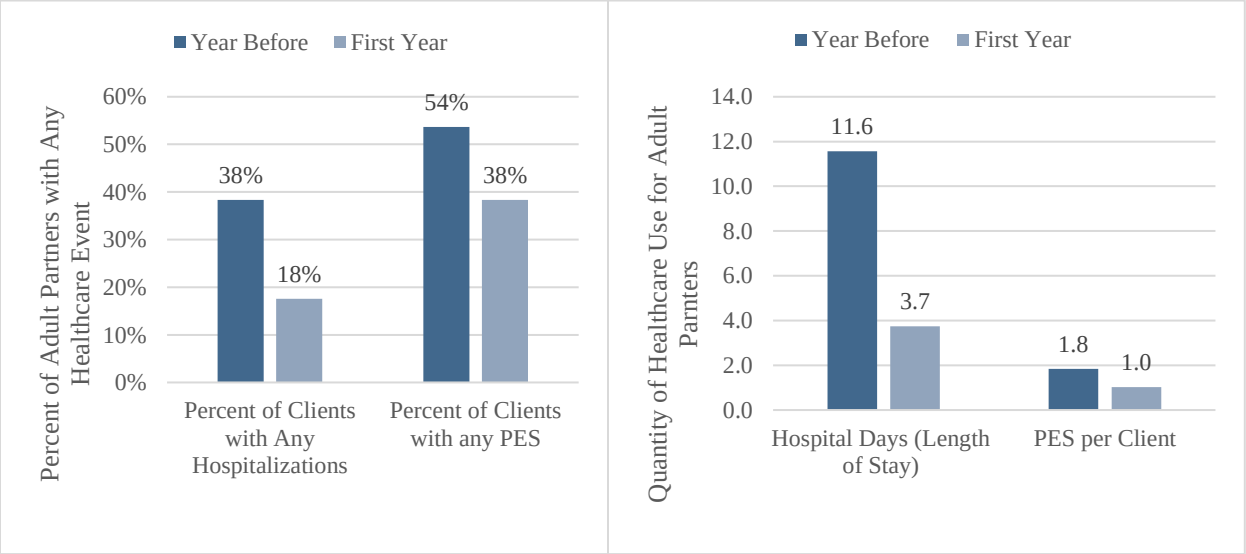


Exhibit 11: Hospitalization and PES Outcomes for Older Adult Partners Completing One Year with FSP (n = 47)

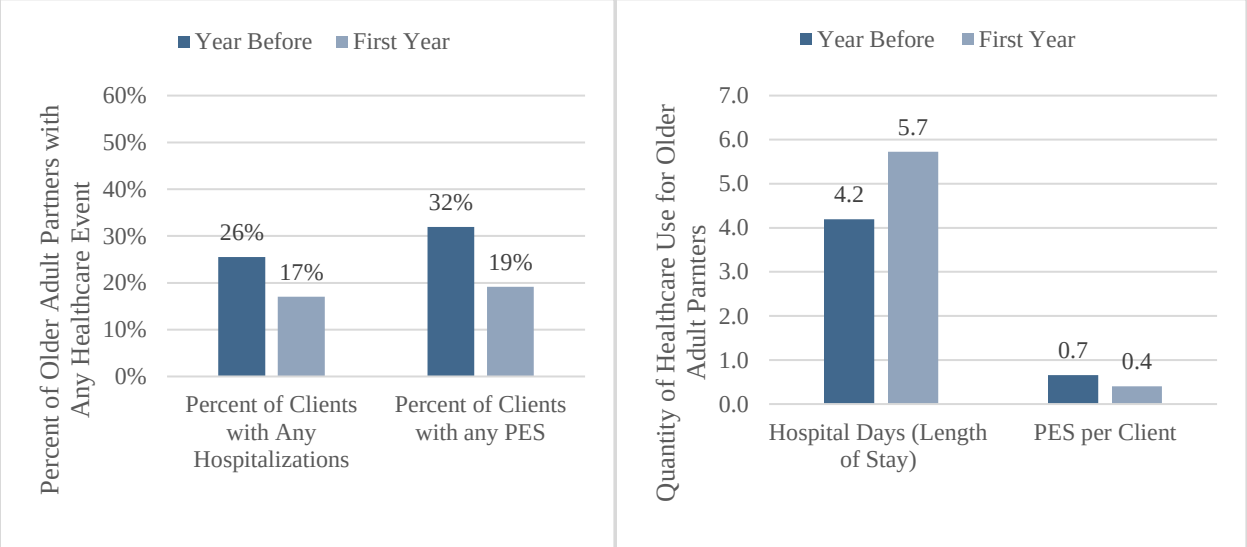


Exhibit 12: Hospitalization and PES Outcomes for Child Partners Completing One Year with FSP (n = 210)

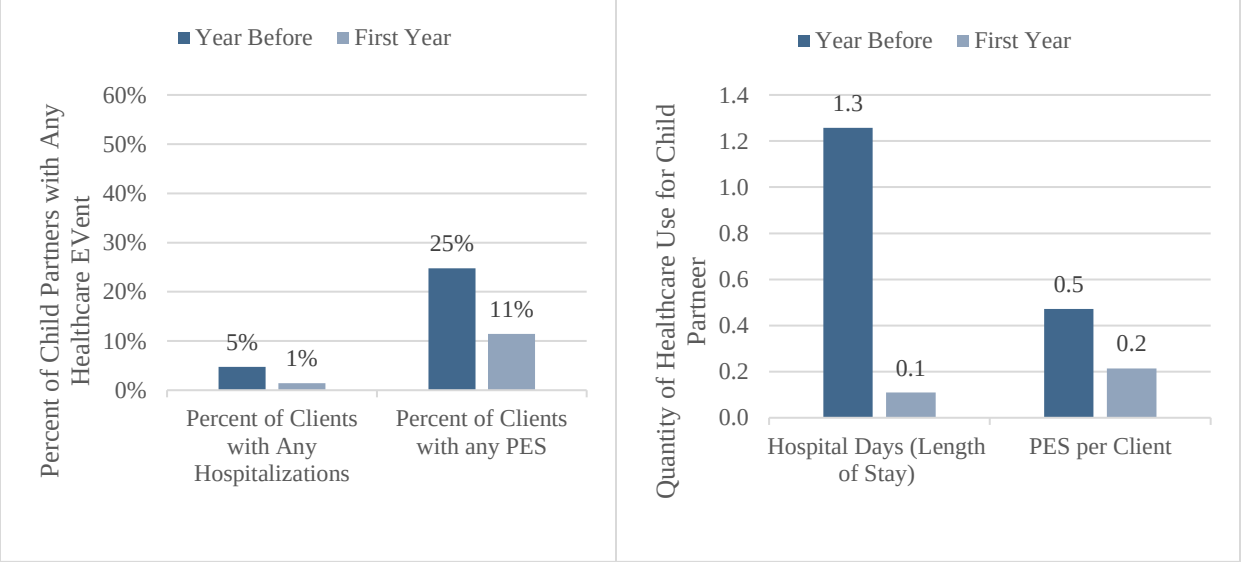
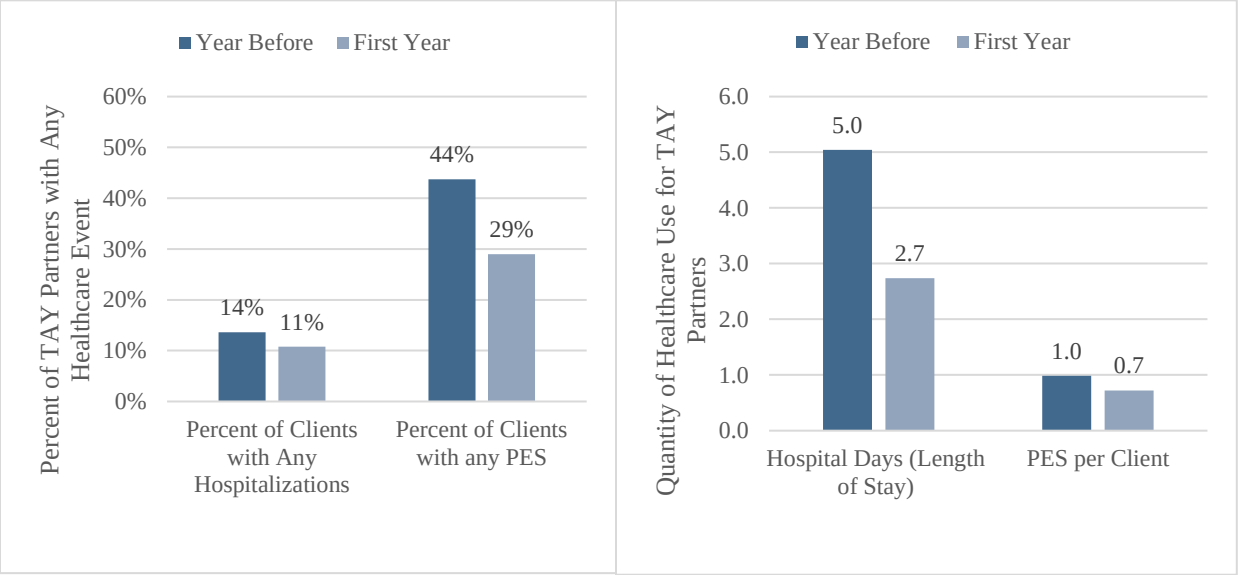


Exhibit 13: Hospitalization and PES Outcomes for TAY Partners Completing One Year with FSP (n = 176)



Health Care Utilization for FSP Partners over Time

Exhibits 14-18 show the four hospitalization outcomes, stratified by enrollment year. As can be seen in Exhibit 14, the percent of partners with any hospitalization decreased after joining an FSP program for all enrollment year cohorts.

Exhibit 14: Percent of Partners with Any Hospitalization by FSP enrollment year.

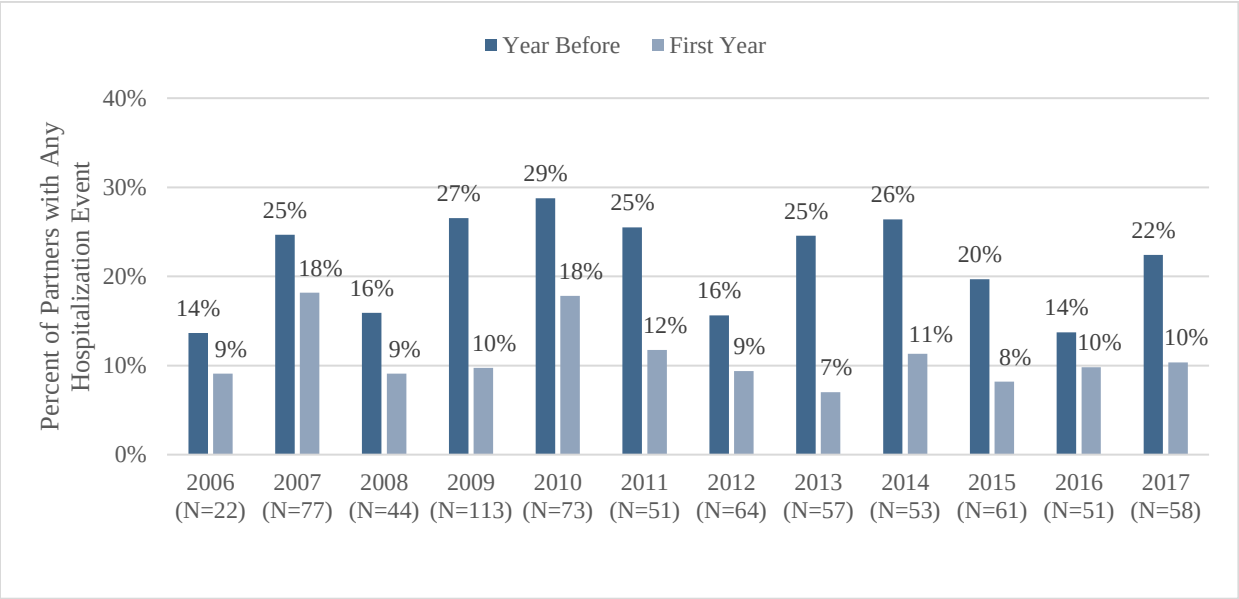


Exhibit 15 displays the mean hospital days per partner by enrollment year. With the exception of 2006 and 2007 cohorts, most partners experienced decreases in the mean number of hospital days regardless of when they enrolled in the program.

Exhibit 15: Mean Number of Hospital Days by FSP Enrollment Year

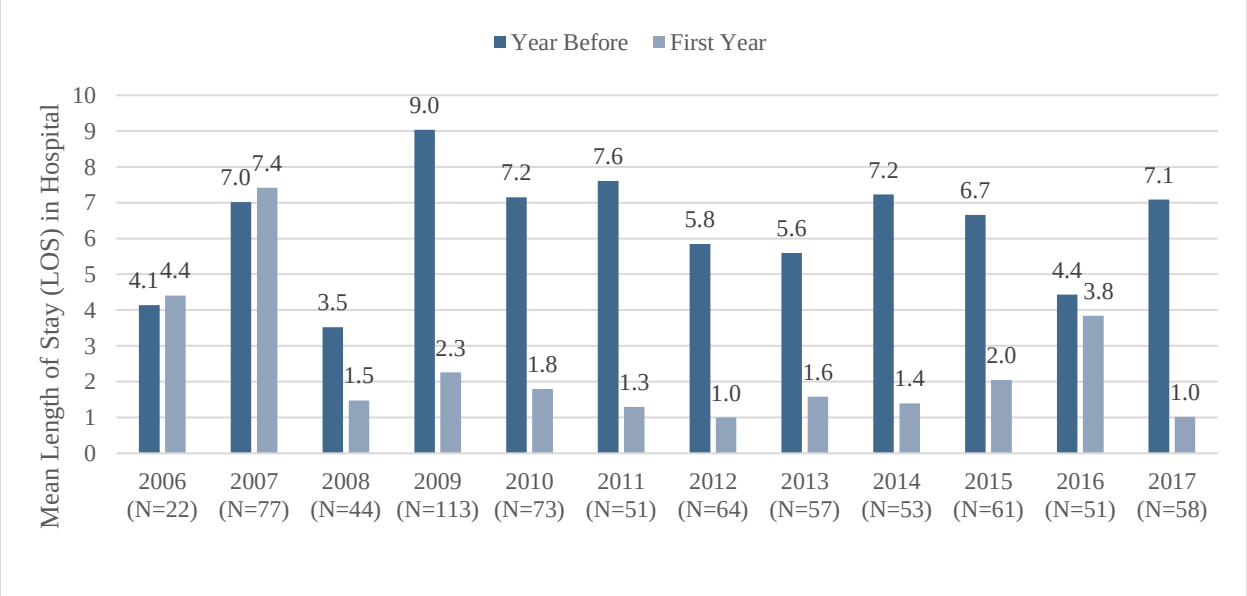
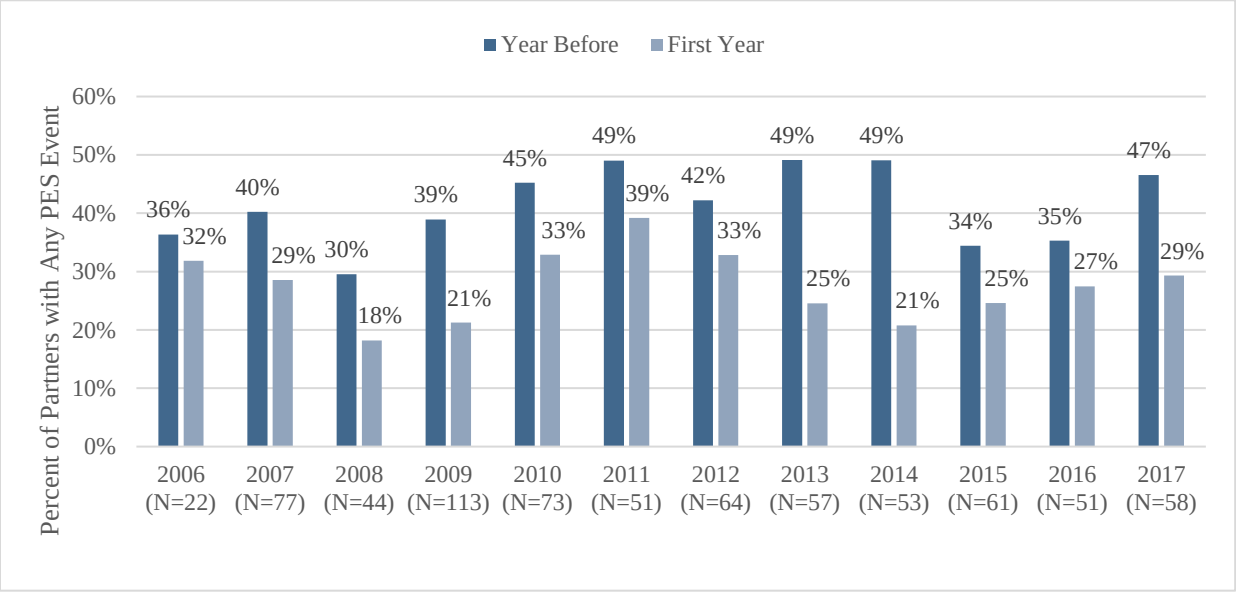


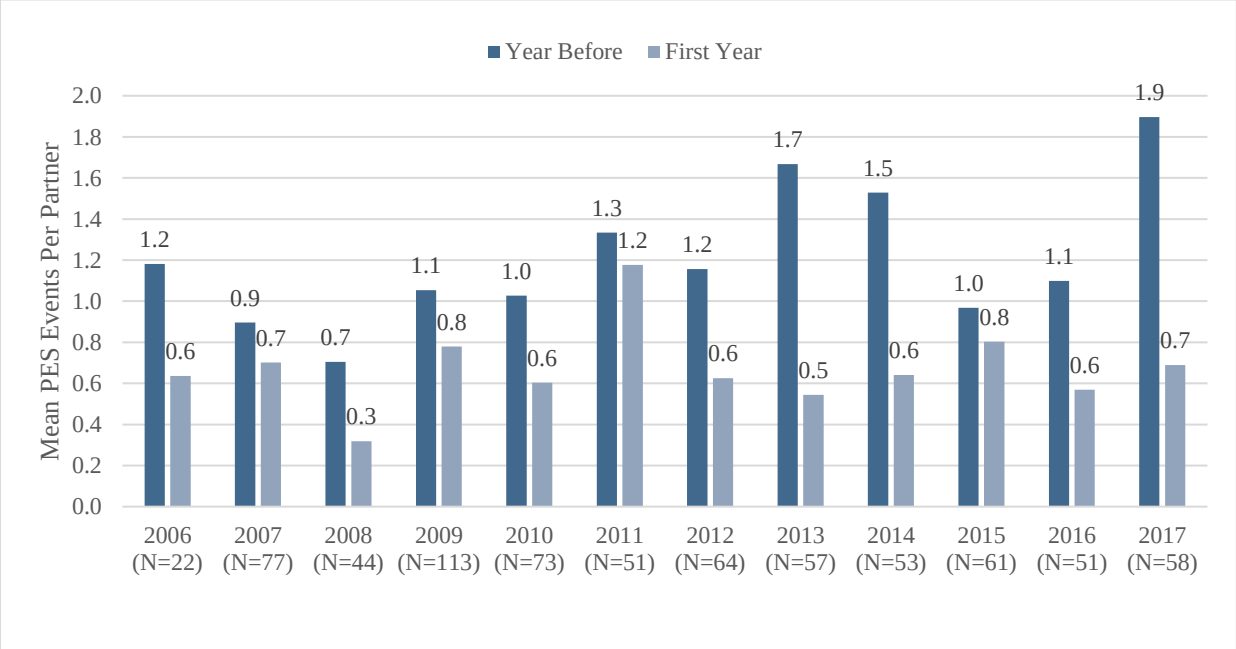
Exhibit 16 displays the percent of partners with any PES event by the year they began FSP. All cohorts experienced a decline in the likelihood of a PES event.

Exhibit 16: Percent of Partners with any PES Event by FSP Enrollment Year



Finally, exhibit 17 displays the mean PES events per partner by FSP enrollment year. Again, all cohorts experienced a reduction in PES events.

Exhibit 17: Mean PES Events by FSP Enrollment Year

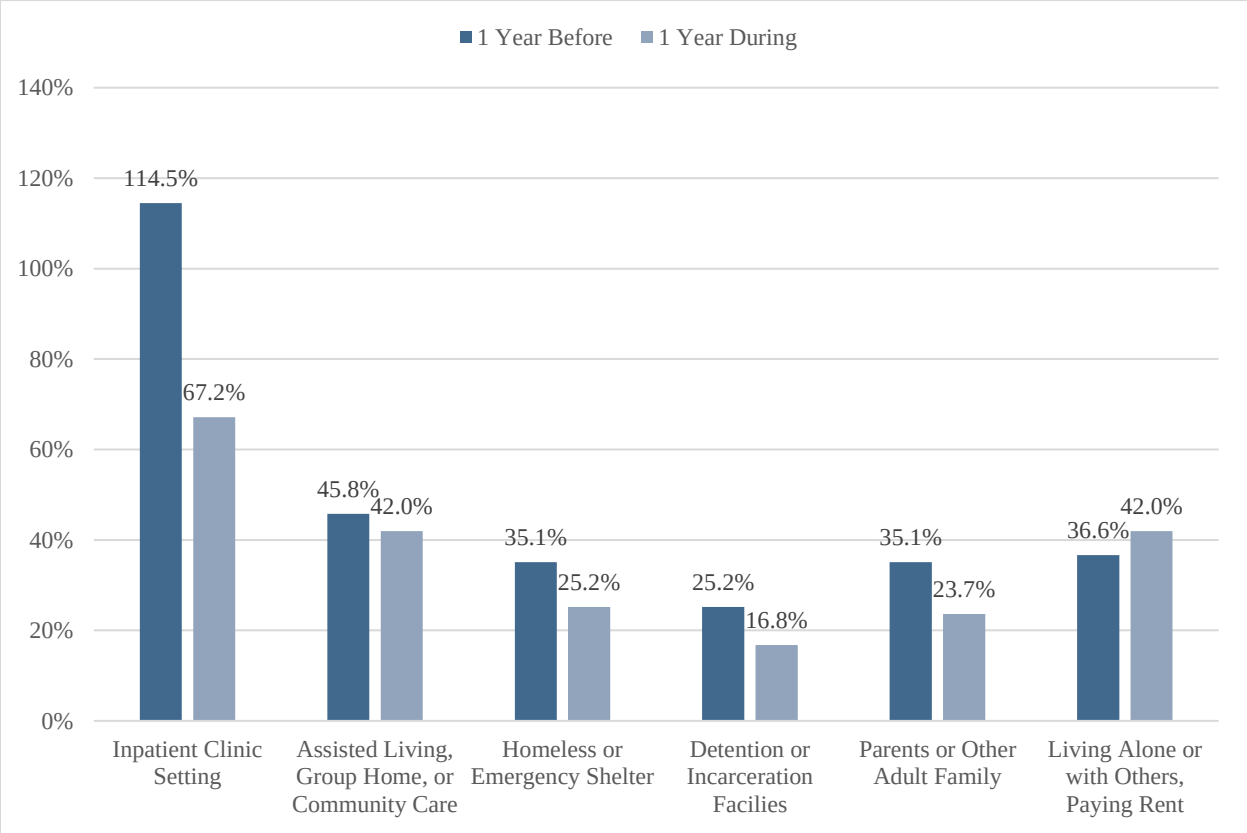


Appendix A: Additional Detail on Residential Outcomes

For residential setting outcomes, we present all the categories of living situations and compare the percentages of any partners spending any time in various residential settings the year prior to FSP and in the first year of FSP participation. A list of all residential settings and how they are categorized, is presented in Appendix C with the methodological approach.

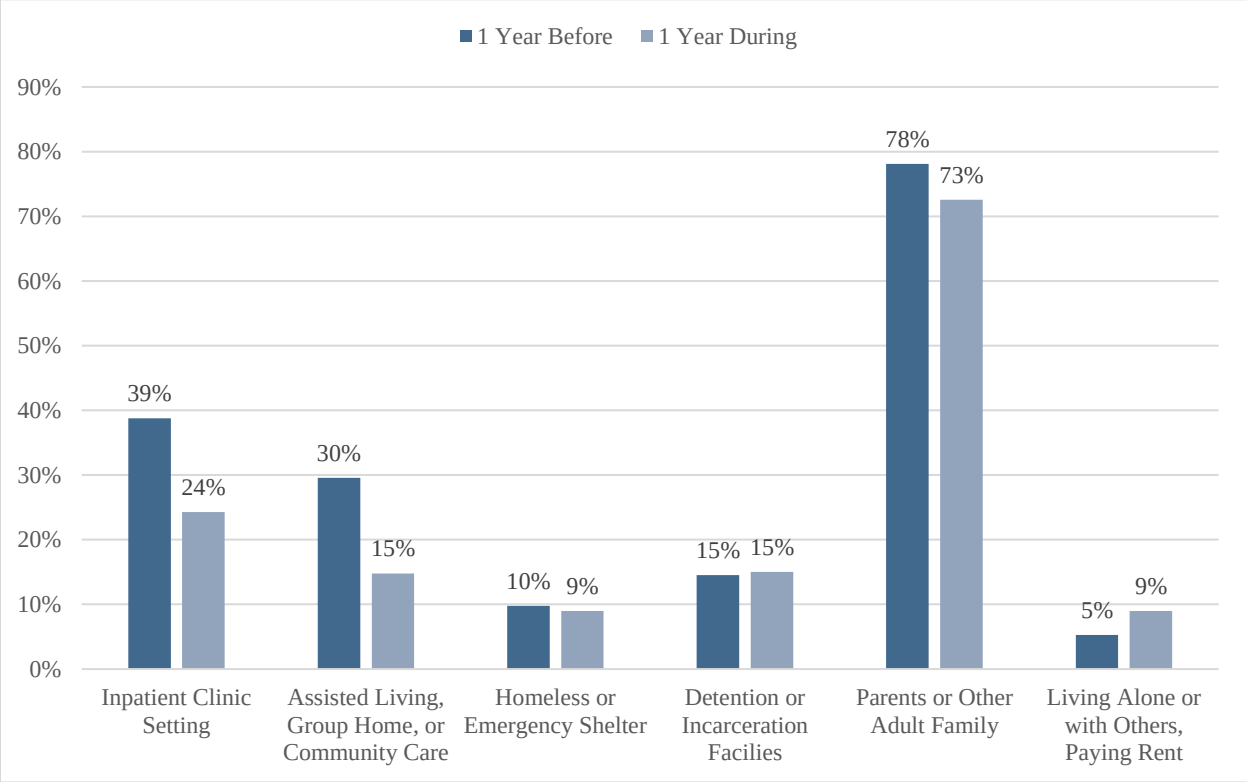
As can be seen in Exhibit A1, the percent of clients reporting any time in an inpatient clinic, assisted living, group home, or community care environment, homeless, incarcerated, or living with parents decreases. In contrast, the percent of clients living alone or with others, paying rent increases.

Exhibit A1: Any Time in Residential Settings – Adult and Older Clients Completing 1 Year in the FSP Program (n = 131)



Note. Residential settings are not mutually exclusive, so percents may exceed 100.

Exhibit A2: Any Time in Residential Settings – Child and TAY Clients Completing 1 Year in the FSP Program (n = 379)



Appendix B: Additional Detail on Outcomes by FSP Providers

This section provides more detail on the results presented in the main report. No outcomes are presented for any group of partners with 10 or fewer individuals.

Exhibit B1-B3, presents the percent of partners with any events the year just prior to FSP enrollment and the first year in an FSP, as well as the percent improvement for each FSP provider. Percent improvement is the percent change in the percent of partners with any events.

As can be seen in Exhibit B1, 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 B1. Percent of Caminar Partners with Outcome Events by Year and Percent Change in Prevalence of Outcome Events (Year before FSP vs. the first year of FSP participation)

Survey Outcomes, Caminar	1 Year Before	Year 1 During	Change (%)
Homelessness	35.1%	25.2%	-28.3%
Detention or Incarceration	25.2%	16.8%	-33.3%
Arrests	0.0%	2.3%	N/A
Mental Health Emergencies	14.5%	1.5%	-89.5%
Physical Health Emergencies	73.3%	16.8%	-77.1%
Employment	41.2%	13.7%	-66.7%
Active Substance Abuse Problem	49.6%	43.5%	-12.3%
Substance Abuse Treatment	23.7%	22.9%	-3.2%

As can be seen in Exhibit B2, 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 B2. Percent of Telecare Partners with Outcome Events by Year and Percent Change in Prevalence of Outcome Events (Year before FSP vs. the first year of FSP participation)

Survey Outcomes, Telecare*	1 Year Before	Year 1 During	Change (%)
Homelessness	24.8%	18.6%	-25.0%
Detention or Incarceration	15.9%	11.2%	-29.6%
Arrests	13.3%	1.8%	-86.7%
Mental Health Emergencies	31.9%	16.5%	-48.1%
Physical Health Emergencies	17.4%	8.3%	-52.5%
Employment	12.1%	13.3%	9.8%
Active Substance Abuse Problem	84.4%	48.1%	-43.0%
Substance Abuse Treatment	61.4%	13.9%	-77.4%

*These data originate from the previous year's report.

Exhibit B3 shows improvement in many outcomes except for detention or incarceration, grade and attendance.

Exhibit B3. Percent of Edgewood Partners with Outcome Events by Year and Percent Change in Prevalence of Outcome Events (Year before FSP vs. the first year of FSP participation)

Survey Outcomes, Edgewood	1 Year Before	Year 1 During	Change (%)
Homelessness	9.8%	9.0%	-8.1%
Detention or Incarceration	14.5%	15.0%	3.6%
Arrests	16.6%	6.3%	-61.9%
Mental Health Emergencies	3.34	3.05	-8.6%
Physical Health Emergencies	2.25	2.05	-8.5%
Suspension	42.7%	7.7%	-82.1%
Grade	41.2%	8.2%	-80.1%
Attendance	17.7%	1.6%	-91.0%

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), 849 partners completed a full year with FSP since program inception.

In general, three datasets are obtained for this report: one from Caminar, one from Telecare and one from Edgewood. Caminar and Edgewood provide their datasets in a Microsoft Excel format while Telecare provides a raw Microsoft Access database, which also included data on individuals who were not affiliated with FSP. In 2019, Telecare changed their reporting format from the Microsoft Access database to a live XML format. Because this format is inconsistent with previous years' reporting format, Telecare data for the 2018-2019 fiscal year was excluded from this report.

For Telecare only, we limit 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. For Telecare, this data originates from the 2017-2018 fiscal year.

Exhibit C1: Summary of Partners One Full Year of FSP

Age Group	Edgewood/ Fred Finch	Caminar	Telecare	Total
Child (aged 16 and younger)	166	--	--	166
TAY (aged 17 – 25)	213	16	26	255
Adult (aged 26 -59)	--	102	264	366
Older Adult (aged 60+)	--	13	49	62
Total	379	131	339	849

A master assessment file with FSP start and end dates and length of FSP tenure was created at the client level. Note that for clients who stopped and then reestablished their FSPs, we only kept the record corresponding with their most recent participation in an FSP (using Global ID), as indicated in the State's documentation.

Partner type (child, TAY, adult, and older adult) is determined by the PAF data.

- For Caminar and Edgewood/Fred Finch, this was done by selecting records with specific Age Group codes, i.e.:
    - Caminar: selected records with Age Group codes of "7" (TAY partner, aged 17 to 25), "4" (adult partner, aged 25 to 59), and "10" (older adult partner, aged 60 and older).

    - Edgewood/Fred Finch: selected records with Age Group codes of "1" (child partner, aged 16 and younger) and "4" (TAY partner, aged 17 to 25).
    - In both cases, this was confirmed using the data file's continuous *Age* variable.
- For Telecare data, partners were given an age appropriate PAF. Records with specific *Form Type* codes were retained in the analysis (i.e., Form Types "TAY_PAF". "Adult_PAF" and "OA_PAF").

Partnership date and *end date* were determined as follows: Partnership date was determined using enrollment start date. End date was determined by the reported date of the partnership status change in the KET to "discontinued." For clients still enrolled at the time of data acquisition, we assigned an end date of June 30, 2019.

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. The partner's first residential status once they joined 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 date (as indicated by the variable, *DateResidentialChange),* this residence was considered to be the first residential setting. If the residences were marked with the same date, both were considered as part of the partner's first year in an FSP.
4. Additional residential settings for the first year were found using the KET data, inclusive of all residence types listed with a corresponding date of residential change (*DateResidentialChange)* occurring within one year of the FSP partnership start date. If no residential data were captured subsequent to the PAF by a KET, it was assumed that the individual remained in their original residential setting.

Exhibit C2: Residential Setting Categories and Corresponding Classification Values used to Derive Them

Category	Telecare Setting Value[3]	Caminar, Edgewood, and Fred Finch Setting Value[4]
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

[3] Setting names determined by *Setting* variable in Telecare data.
[4] Setting names determined by the following guide:
https://mhdatapublic.blob.core.windows.net/fsp/DCR%20Data%20Dictionary_2011-09-15.pdf

Employment

Employment outcomes were generated for adults only. Therefore, Edgewood and Fred Finch data were excluded.

1. The baseline data were populated using the PAF data. An individual was considered as having had any employment if there was a non-zero, non-blank value for one of the following variables (note that variable names differ slightly by dataset):

    a. Any competitive employment in past twelve months (any competitive employment; any competitive employment for any average number of hours per week; any average wage for competitive employment)

    b. Any other employment in past twelve months (any other employment; any other employment for any average number of hours per week; any average wage for any other employment)

2. Ongoing employment was populated using any dates of employment change (variable names vary slightly by file) noted in the KET file within the first year of membership in FSP (as determined by the partnership start date). An employment change was coded if the new employment status code corresponding to the employment change date indicated competitive employment or other employment. If the KET contained no information on employment, the original employment was presumed to sustain throughout FSP membership.

Arrests

1. The baseline arrest data were populated using the variable *ArrestsPast12* collected by the PAF. If *ArrestsPast12* was blank, the partner was assumed to have zero arrests in the year prior to FSP.

2. Ongoing arrests were populated using any dates of arrest (variable names vary slightly by file) noted in the KET file within the first year of membership in FSP (as determined by the partnership date). If the KET contained no information on arrests, the partner was assumed to have had no arrests in the first year in an FSP.

Mental and Physical Health Emergencies

1. The baseline utilization of emergency services was populated using the PAF's variables for mental health emergencies (*MenRelated)* and physical health emergencies (*PhysRelated),* respectively. If either of these fields were blank, the partner was assumed to have have had zero emergencies of that type in the year prior to FSP.

2. Ongoing emergencies were populated using the variable indicating the date of emergency (variable names vary slightly by file) in the KET file, as long as the date is within the first year with FSP as determined by the partnership date. The type of emergency was indicated by *EmergencyType* ("1"=physical; "2"=mental). We assumed that no

information on emergencies in the KET indicated that no emergencies had occurred in the first year on FSP.

Substance Abuse

1. Baseline data on substance abuse were populated using variables in the PAF for active substance abuse problems (*ActiveProblem)* and participation in substance abuse treatment and recovery services (*AbuseServices)*. If these fields were blank, the partner was assumed to have had no substance abuse problems nor received substance abuse treatment and recovery services in the year prior to FSP.

2. Ongoing substance abuse data were populated using the 3M data variables of the same name. Any record of an active substance abuse problem or participation an abuse services during the first year of FSP was recorded. If there were no observations in the variables of interest, clients were assumed to have no ongoing abuse problem or participation in abuse services.

Methodology for Avatar Data Analysis

Hospitalization outcomes were derived from electronic health records (EHR) data obtained through the Avatar system. Using EHR data avoids some of the reliability shortcomings of self-reported information, but presents several challenges as well. The Avatar system is limited to individuals who obtain care in the County hospital system. Hospitalizations outside of the County, or in private hospitals, are not captured. The hospitalization outcomes include 746 partners who were both (1) included in the Avatar system and (2) completed one full year or more in a FSP program by the June 2019 data acquisition date. Thus, individuals included in the EHR analysis had to have started with the FSP between July 2006 (the program's inception) and June 2018.

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 corresponding program codes. 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 August 19, 2019.

Partner type (child, TAY, adult, and older adult) was determined by the partner's age on the start date of the FSP program, as derived from the *c_date_of_birth* variable from the *view_episode_summary_admit* table and the *FSP_admit_dt* variable from the *episode_history* table.

As we have discussed in the previous year's report, the distribution of partners by age group is different between the Avatar data and the FSP Survey data. This is likely due to the different ways age group was determined. For the survey data, AIR determined age group by whether the partner was evaluated using the child, TAY, adult, or older adult FSP survey forms. For the Avatar data, AIR assigned individuals to an age group based upon the date they joined FSP and their reported date of birth.

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APPENDIX 13 OUTREACH COLLABORATIVE EVALUATION REPORT, FY 2018-19

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San Mateo County Behavioral Health and Recovery Services (SMC BHRS) Provider Outreach Annual Report

FY 2018-2019

Quy Nhi Cap, MPH;

Yi Lu, PhD

FEB 2020

San Mateo County Behavioral Health and Recovery Services (SMC BHRS) Provider Outreach Annual Report

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FEBRUARY 2020

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Contents

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Executive Summary

In 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA), to provide funding to Counties for mental health services by imposing a 1% tax on personal income in excess of $1 million. The Community Services and Supports (CSS) component of MHSA was created to provide direct services to individuals with severe mental illness and included Outreach and Engagement activities.

San Mateo County Behavioral Health and Recovery Services (SMC BHRS) funds the North County Outreach Collaborative (NCOC) and the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) to provide outreach and engagement activities throughout San Mateo County.

This report summarizes self-reported outreach data from the attendee at the collaborative and provider-specific level across individual and group outreach events that occurred in fiscal year (FY) 2018-2019 (July 1, 2018 through June 30, 2019). We also present historical data since FY 2014-2015 to show how outreach has changed over time.

Total Attendance

For FY 2018-2019, SMC BHRS providers reported a total of 5,417 attendees at all outreach events. Of these, 865 attendees were reached through individual outreach events and 4,552 attendees were reached across 77 group outreach events. There were 4,781 NCOC attendees and 636 EPAPMHO attendees.

Demographics of outreach attendees

NCOC

NCOC's most common age group among outreach attendees was adults (36%). Over half of the attendees were female (53%). The greatest proportion of attendees were White (28%), followed by Asian (10%). Of those reporting special population status (i.e., homeless, at risk for homelessness, vision impaired, hearing impaired, veterans), 66% were homeless or were at-risk for homelessness.

EPAPMHO

EPAPMHO outreach attendees were largely adults (56%). Over half of the attendees were female (51%). The largest proportion of attendees were Mexican (24%) followed by Black (23%). Of those reporting special population status, 71% were homeless or were at-risk for homelessness.

Outreach event characteristics

NCOC

NCOC individual outreach events lasted from 3 to 90 minutes and lasted on average 20 minutes in FY 2018-2019. Outreach events took place at age-specific community centers, faith-based churches/temples, health care clinics, homes, shelter, jail, job sites, non-traditional locations, offices, residential care facilities, schools, unspecified field locations, other community locations, and over the phone. Of the 249 outreach events, 39% occurred in other community locations, including, “Skyline College Health Fair,” “Serramonte Health Fair,” and “Asian American Pacific Islander Health Fair.” Most individual outreach events were in English (95%).

NCOC group outreach events lasted from 2 to 386 minutes and were on average 116 minutes in length. Of the 76 group outreach events, most were conducted in English (92%) and one-third were conducted in schools. Twenty-eight percent were conducted at unspecified field locations and 22% were conducted in other community locations, such as a “mall.”

At all the NCOCO outreach events (group and individual), 22% received mental health referrals and 10% received substance abuse referrals. Providers also made 330 referrals to social services, including emergency/protective services, financial/employment, food, form assistance, housing/shelter, legal services, medical care and transportation. Even though 66% of the special population attendees were homeless or were at risk for homelessness, only 12% of the attendees received housing referrals.

EPAPMHO

The 616 EPAPMHO individual outreach events lasted from 10 to 120 minutes and were an average of 37 minutes in FY 2018-2019. Outreach events took place at age-specific community centers, faith-based churches/temples, health care clinics, homes, shelter, jail, job sites, non-traditional locations, offices, residential care facilities, schools, unspecified field locations, other community locations, and over the phone. Of the 616 outreach events, 40% occurred in offices. Most of these events were held in English (60%).

Only one EPAPMHO group outreach event was conducted. The event lasted 15 minutes and was conducted in Spanish. It occurred at a library and resulted in 24% of the attendees being referred to mental health and systems of care services and 32% of the attendees being referred to substance abuse and systems of care services. A total of 1,045 referrals were made to social services, including emergency/protective services, financial/employment, food, form assistance, housing/shelter, legal services, medical care, transportation and health insurance. Even though 71% of the special population attendees were homeless or were at risk for homelessness, only 29% of the attendees received housing referrals.

Recommendations

Recommendations based on FY 2018-2019 data 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:

- Conduct more outreach in languages other than English. This will help ensure individuals who do not speak English are able to access services.
- Focus on increasing housing-related resources and referrals. Housing insecurity continues to be a major challenge for individuals served by SMC BHRS in this FY 2018-2019.

To improve data collection, we recommend SMC BHRS work with providers to:

- Make other/unspecified data categories clearer. There are still relatively high proportions of individuals in other/unspecified categories for some topics, such as "other social services."
- Ensure insurance data is capture. Due to the high percentage of missing data from this category, it was not reported 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) 2018-2019 (July 1, 2018 through June 30, 2019) outreach data using an electronic form first implemented in quarter four (Q4) of FY 2014-2015. The information collected is self-reported by the attendee. AIR created this form based on interviews with San Mateo County staff and focus groups with providers. This collective effort sought to improve the data collection process so that SMC BHRS and its providers could better understand the reach of their outreach efforts. After data are entered, AIR cleans the data and calculates aggregated counts and percentages to describe outreach activities. Please see Appendix I for information about calculations.

This report focuses on EPAPMHO and NCOC's outreach events that occurred during FY 2018-2019 and outreach event attendees. We also present historical data from FY 2014-2015, FY 2015-2016, FY 2016-2017, and FY 2017-2018 to show how outreach has changed over time. Counts of attendees do not necessarily represent unique individuals because a person may

have been part of more than one outreach event, taken part in both individual and group outreach events, and/or interacted with different providers. Provider summaries are also available to help SMC BHRS and its providers better understand each individual provider's outreach efforts. Please refer to Appendix A to I.

Overall Outreach

During FY 2018-2019, SMC BHRS outreach providers reported a total of 5,417 attendees at outreach events—865 attendees reached through individual outreach events and 4,552 attendees reached across 77 group outreach events. Each individual outreach event occurs with a single attendee. Group outreach events include multiple attendees. The count of attendees is not necessarily unique because a person may have been a part of multiple individual or group outreach events.

Table 1 shows outreach attendees, by collaborative, provider, and event type (i.e., individual or group) for FY 2018-2019.

Table 1. Outreach Attendees, by Collaborative, Provider, and Event Type, FY 2018-2019

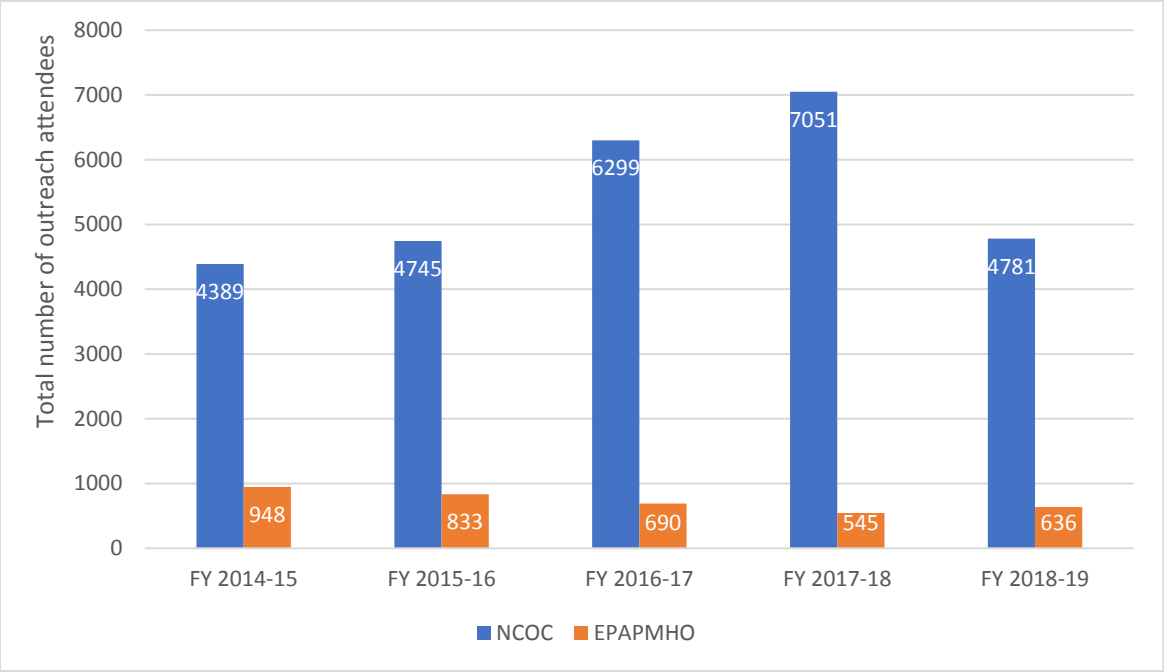
Provider Organization	Number of Individual Outreach Attendees	Number of Attendees at Group Outreach Events	Total Attendees Reported Across All Events**
North County Outreach Collaborative (NCOC)			
Asian American Recovery Services	76	573	649
Daly City Peninsula Partnership Collaborative	1	1656	1657
Daly City Youth Health Center	125	281	406
Pacifica Collaborative	34	1920	1954
StarVista	13	102	115
Total (NCOC)	249	4,532	4,781
East Palo Alto Partnership for Mental Health Outreach (EPAPMHO)			
El Concilio	89	20	109
Free at Last	287	0	287
Multicultural Counseling and Education Services of the Bay Area	240	0	240
Total (EPAPMHO)	616	20	636
Total (NCOC and EPAPMHO)	865	4,552	5,417

It is expected that the NCOC would serve a much larger proportion of the Outreach Collaborative effort as it serves the entire north region of San Mateo County (estimated population 140,149) including the cities of Colma, Daly City, and Pacifica, which is five times the population of the city of East Palo Alto, served by the EPAPMHO. The north region also spans a much wider geographical area, making group events (vs. individual outreach) such as

community wide fairs much more feasible and relevant. In contrast, East Palo Alto spans 2.5 square miles making an individual approach to outreach more achievable

The total number of NCOC outreach attendees increased in FY2014-2018 and decreased in FY 2018-2019. The total number of EPAPMHO outreach attendees decreased in FY 2014-2018 but then increased again from FY 2018-2019 (**Figure 1**).

Figure 1. Total Outreach Attendees by Collaborative, FY 2014-2019



Note: The attendee numbers from previous FYs are slightly higher than those reported in the previous reports because some outreach data was reported after that FY.

Figures 2a and 2b presents the top five race/ethnicity groups served by individual or group outreach in each year for FY 2014-2015, FY 2015-2016, FY 2016-2017, FY 2017-2018, and FY 2018-2019 within each collaborative. A table with the entire breakdown of race/ethnicity groups from FY 2014 to FY 2019 is presented later in the Appendix J.

Figure 2a. Percentage of Race/Ethnicity Groups Served by NCOC, FY 2014-2015 to FY 2018-2019

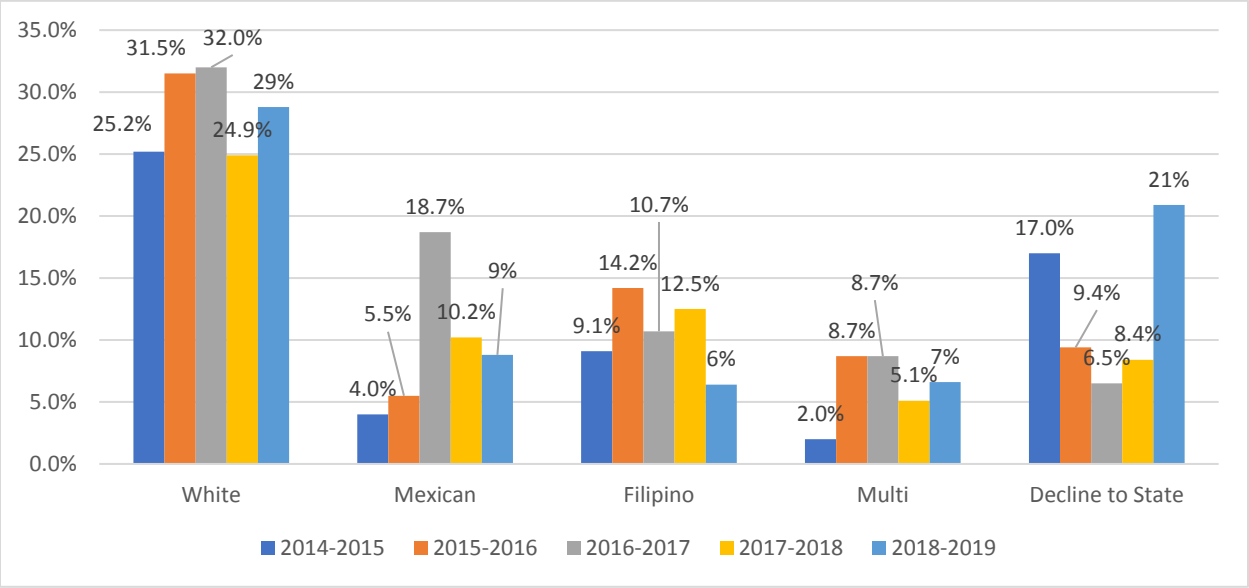
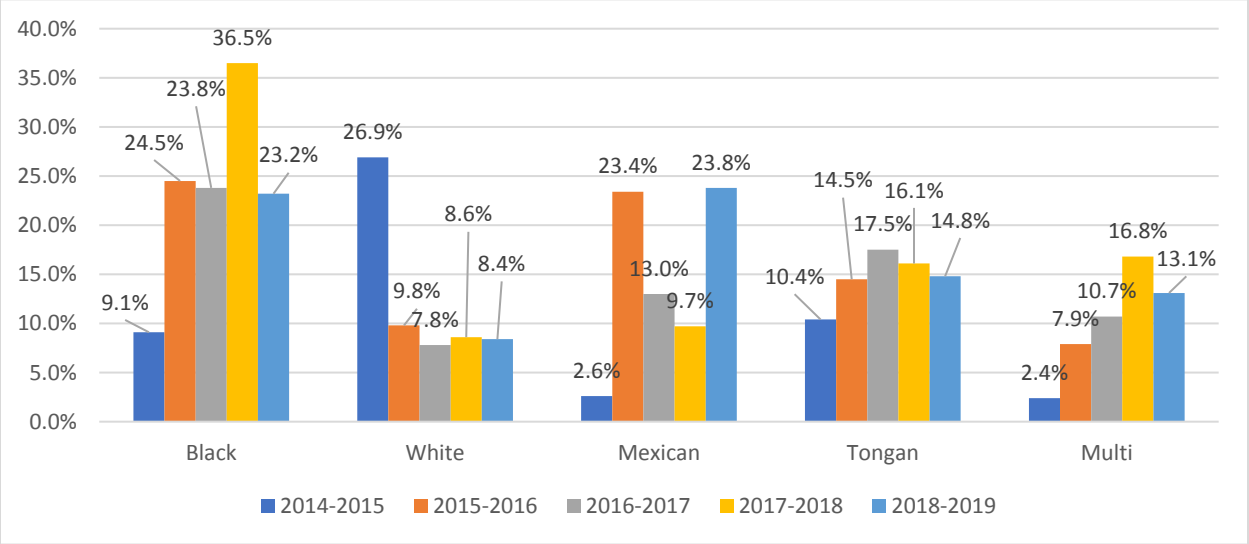


Figure 2b. Percentage of Race/Ethnicity Groups served by EPAPMHO, FY 2014-2015 to FY 2018-2019



The NCOC has seen a fluctuation in outreach numbers overall and there are a few key differences in the racial/ethnic demographics of the outreach attendees. In particular, from FY 2017-2018 to FY 2018-2019 there was an increase in White participants of 4%, multi-racial

participants increased by 2%, and participants who declined to state their race increased by 13%. There was a decrease in Mexican participants by 1% and Filipino participants by 6%.

The EPAPMHO has also seen a decrease in outreach numbers overall and there are a few key differences in the racial/ethnic demographics of the outreach attendees. In particular, from FY 2017-2018 to FY 2018-2019, there was a decrease in Black participants by 13%, White participants decreased by 0.2%, Tongan participants decreased by 1%, and multi-racial participants by 4%. There were increases in Mexican participants by 14% from FY 2017-2018 to FY 2018-2019.

Figures 3a and 3b present the percentages of the mental health and substance abuse referrals made as a result of attending the outreach events by collaborative for FY 2014-2015, FY 2015-2016, FY 2016-2017, FY 2017-2018, and FY 2018-2019.

Figure 3a. Percentage of Mental Health/Substance Abuse referrals by NCOC, FY 2014-2015 to FY 2018-2019

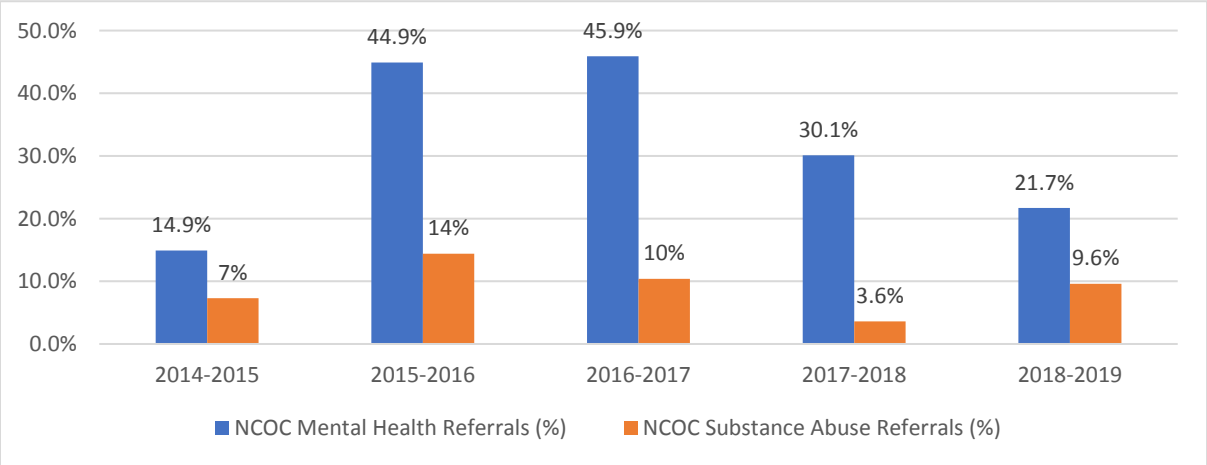
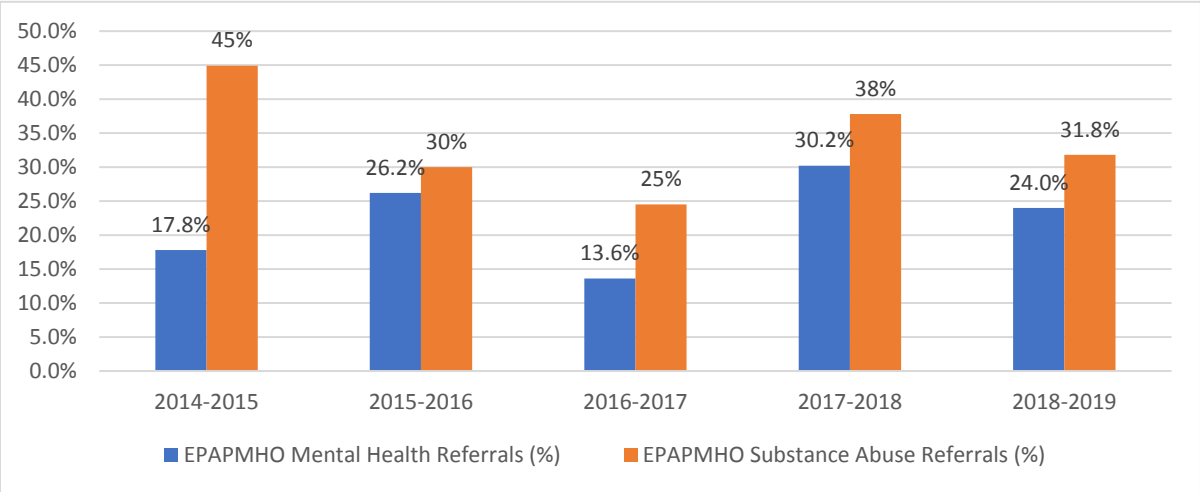


Figure 3b. Percentage of Mental Health/Substance Abuse referrals by EPAPMHO, FY 2014-2015 to FY 2018-2019



Figures 4a and Figure 4b present referrals to social services in FY 2014-2015, FY 2015-2016, FY 2016-2017, FY 2017-2018, and FY 2018-2019 by each collaborative. The percentages represent percent of total attendee referrals to social services.

- In FY 2018-2019, NCOC had 456 referrals to social services, as compared to 783 referrals in FY 2017-2018 and 567 referrals in FY 2016-2017 and 631 referrals in FY 2015-2016 and 431 referrals in FY 2014-2015. In FY 2018-2019, EPAPMHO had 1,045 referrals to social services, as compared to 819 in FY 2017-2018 referrals and 746 referrals in FY 2016-2017 and 1548 referrals in FY 2015-2016 and 448 referrals in FY 2014-2015.
- In FY 2018-2019, NCOC had decreases in the percent of food and housing compared to prior two FYs. Percent of referrals to financial, legal and other services increased.
- In FY 2018-2019, EPAPMHO had decreases in the percent of financial, food, form assistance, and housing referrals. Percent of attendee referrals to legal and other services increased. Referrals to medical care stayed the same.

Figure 4a. Referrals to Social Services made by NCOC, FY 2014-2015 to FY 2018-2019*

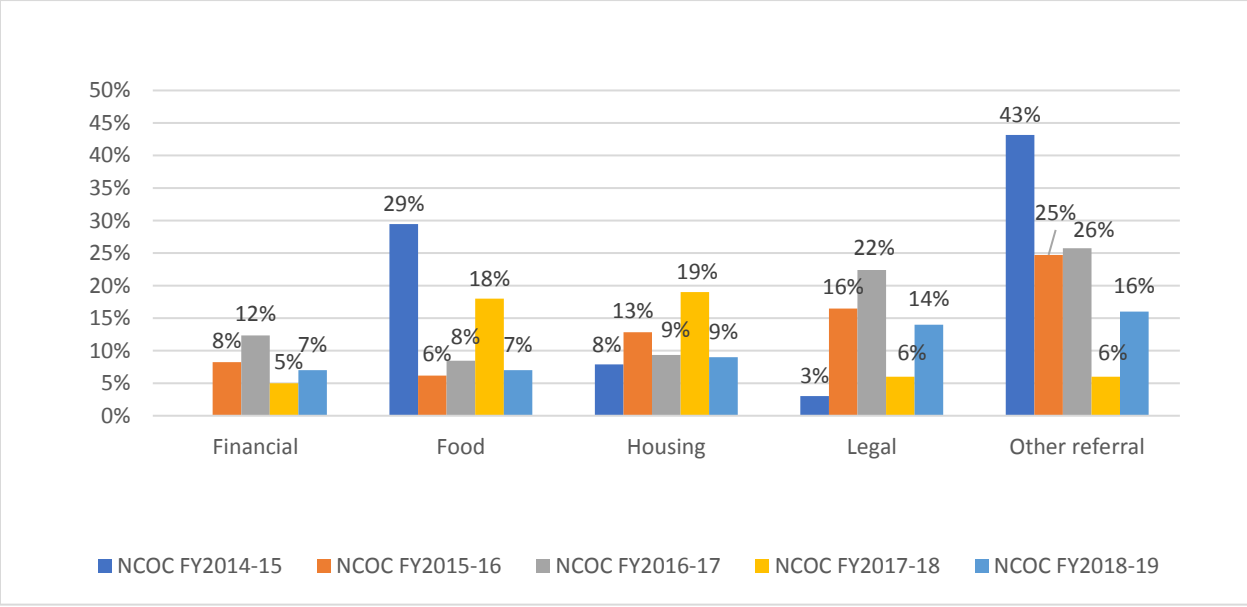
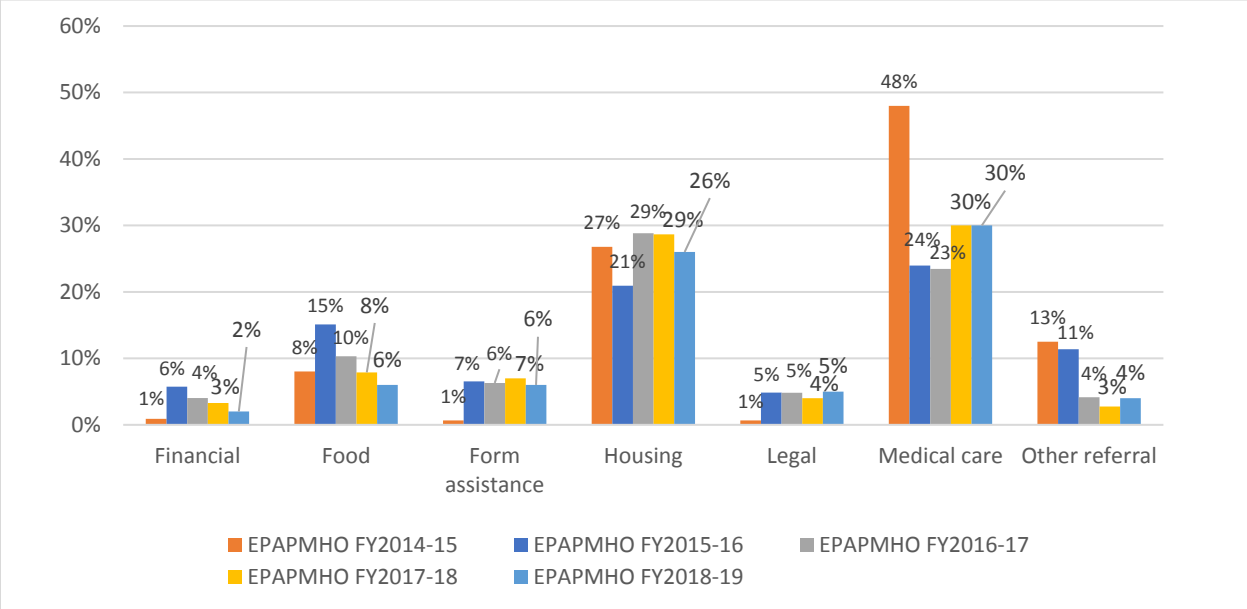


Figure 4b. Referrals to Social Services made by EPAPMHO, FY 2014-2015 to FY 2018-2019*



The next two sections discuss the recipient and event characteristics in FY 2018-2019 for the NCOC and EPAPMHO collaboratives, respectively.

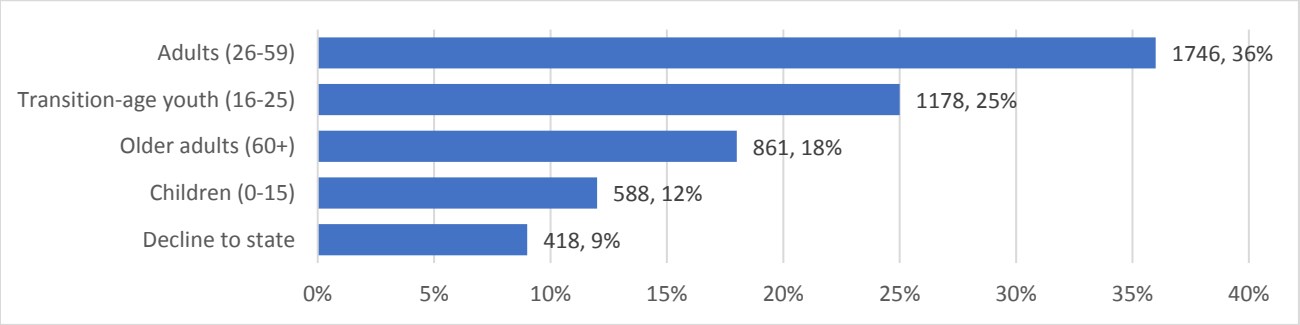
NCOC

In FY 2018-2019, there were 4,781 attendees at individual and group outreach events across the five provider organizations in the NCOC.

Demographics

Age: Attendees across NCOC outreach events were adults (26-59 years, 36%), transition-age youth (16-25 years, 25%), older adults (60 years or older, 18%), and children (0-15 years, 12%) in FY 2018-2019. Nine percent of attendees declined to state their age. See **Figure 5** for the number and percentage of total outreach attendees representing each reported age group.

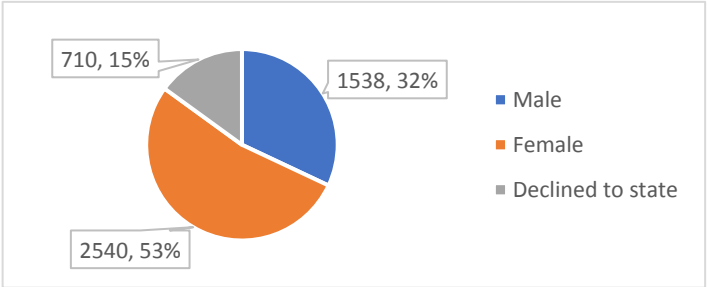
Figure 5. Age of Total Outreach Attendees Served by NCOC, FY 2018-2019



Note: Percentages may not sum to 100% because of rounding. The denominator for age percent is the sum of all age data reported.

Sex at birth: In FY 2018-2019, attendees across NCOC events were females (53%), males (32%). Fifteen percent of attendees declined to state their sex at outreach events. See **Figure 6** for the number and percentage of outreach attendees reporting each sex type.

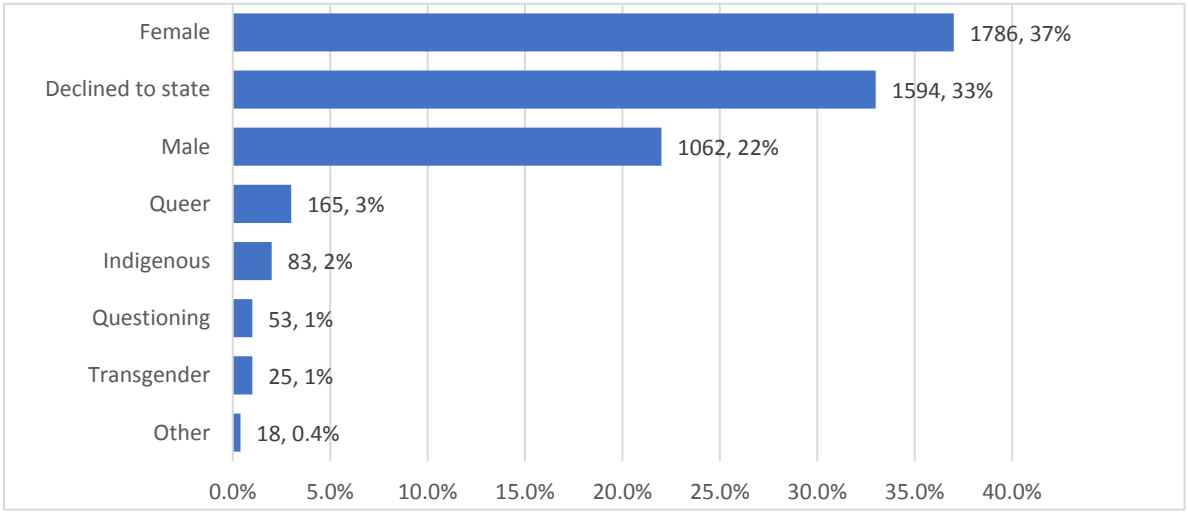
Figure 6. Sex at Birth of Outreach Attendees Served By NCOC, FY 2018-2019



Note: Percentages may not sum to 100% because of rounding. ** Total count for sex reported may exceed the total number of attendees, because some providers may have reported individuals in two or more sex groups, leading to extra counts in some cases for the group outreach attendees. The denominator for sex percent is the sum of all sex data reported.

Gender: Attendees in FY 2018-2019 identified themselves as female (37%), male (22%), queer (3%), indigenous (2%), questioning (1%), transgender (1%), and other gender (<1%). Approximately one-third of the individuals (33%) declined to state their gender. See **Figure 7** for the number and percentage of attendees reporting each gender type.

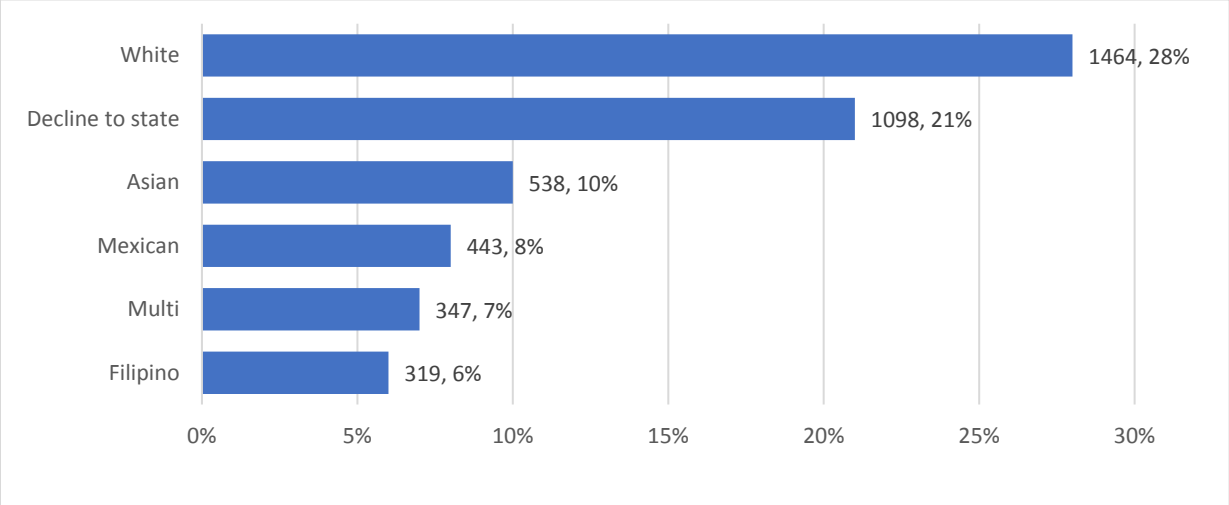
Figure 7. Gender of Outreach Attendees Served By NCOC, FY 2018-2019



Note: Total count for gender because some providers may exceed the total number of attendees, because some providers may have reported individuals in two or more gender groups, leading to extra counts in some cases. The denominator for gender percent is the sum of all gender data reported.

Race and ethnicity: In FY 2018-2019, the five largest racial/ethnic groups represented by all NCOC attendees were White (28%), Asian (10%), Mexican (8%), multi-race (7%), and Filipino (6%). A little under a quarter (21%) of attendees declined to state their race. See **Figure 8** for the number and percentage of attendees representing each reported racial/ethnic group.

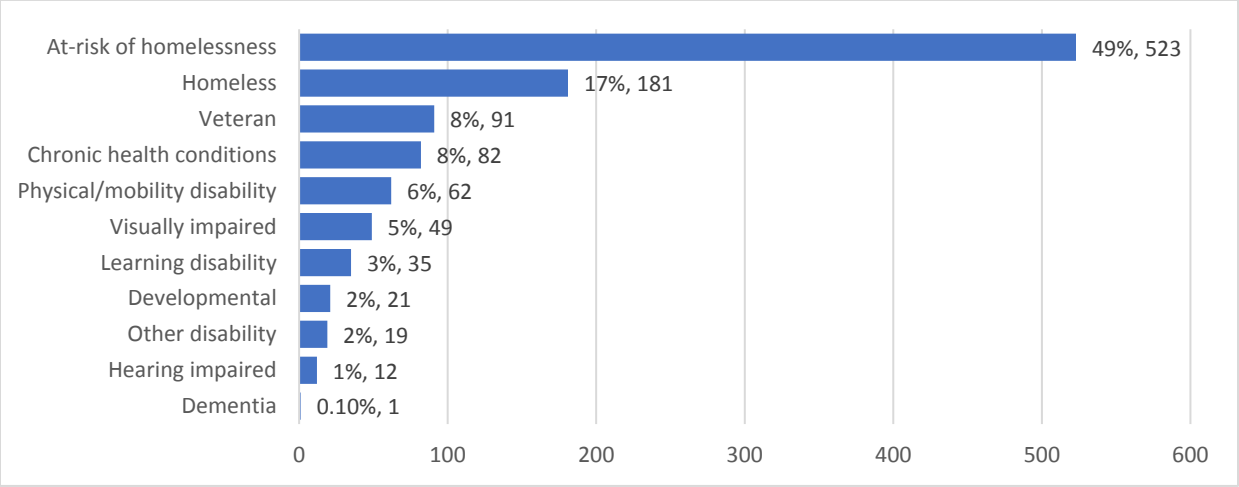
Figure 8. Race and Ethnicity of Outreach Attendees Served By NCOC, FY 2018-2019



Note: The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Special populations: Of the attendees indicating they were part of special populations, 49% were at risk for homelessness, 17% were homeless, 8% were veterans, 8% had chronic health conditions, 6% had a physical/mobility disability, 5% were visually impaired, 3% had a learning disability, 2% had a developmental disability, 2% had other disabilities, 1% were hearing impaired, and less than 1% had dementia. Refer to **Figure 9** for the number and percentage of attendees representing each special population in FY 2018-2019.

Figure 9. Special Populations Served By NCOC, FY 2017-2018



Note: Attendees could be included in more than one special population. Percentages may not sum to 100% because of rounding. The denominator for special population group is the sum of all special population data reported.

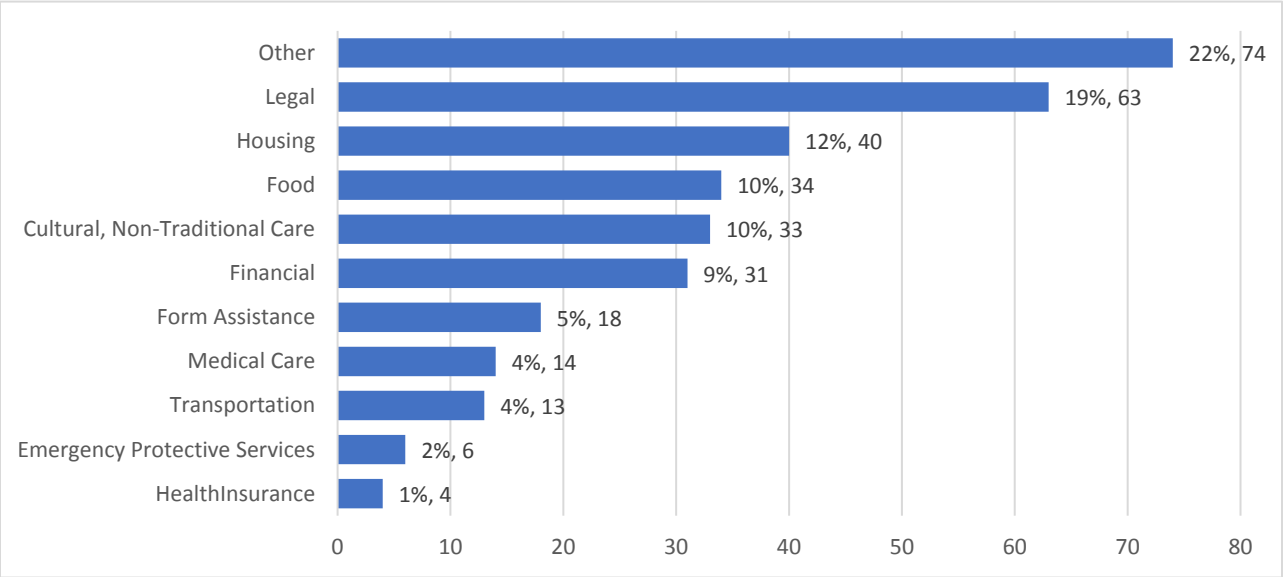
Additional outreach characteristics (individual outreach events only)

Previous Contact: Twelve percent of individual outreach events were conducted with attendees who had a previous outreach contact with NCOC.

Mental Health/Substance Abuse Referrals: NCOC individual outreach events resulted in mental health referrals (22%) and substance abuse referrals (10%) in FY 2018-2019.

Referrals to Social Services: Providers made 330 referrals to 249 NCOC individual outreach attendees. Of the different referral types, the top three types of referrals made for attendees were other (22%), legal (19%) and housing services (12%). Other referrals that were reported included obtaining referrals to other services, access to mental health services, and assistance with job-related matters. In **Figure 10**, we summarize the number and percentage of attendees receiving a given type of referral in FY 2018-2019.

Figure 10. Referrals to Social Services, FY 2018-2019



Note: Percentages may not sum to 100% because of rounding. Attendees can choose more than one category**.** The denominator for referral group is the sum of all referral data reported.

Event characteristics

Location: NCOC individual outreach events primarily occurred in other community locations (39%), unspecified field locations (28%), offices (12%), and other locations (19%) in FY 2018-2019. Other community locations included places such as airports, colleges, public parks, health fairs, and coffee shops. The other locations category includes all the locations that are reported that make up less than 10 percent of the total locations reported. Group outreach events primarily occurred in schools (30%), unspecified field locations (28%), other community locations (22%), and other locations (21%). **Figures 11 and 12** present individual and group outreach event locations in FY 2018-2019.

Figure 11. Locations of NCOC Individual Outreach Events, FY 2018-2019

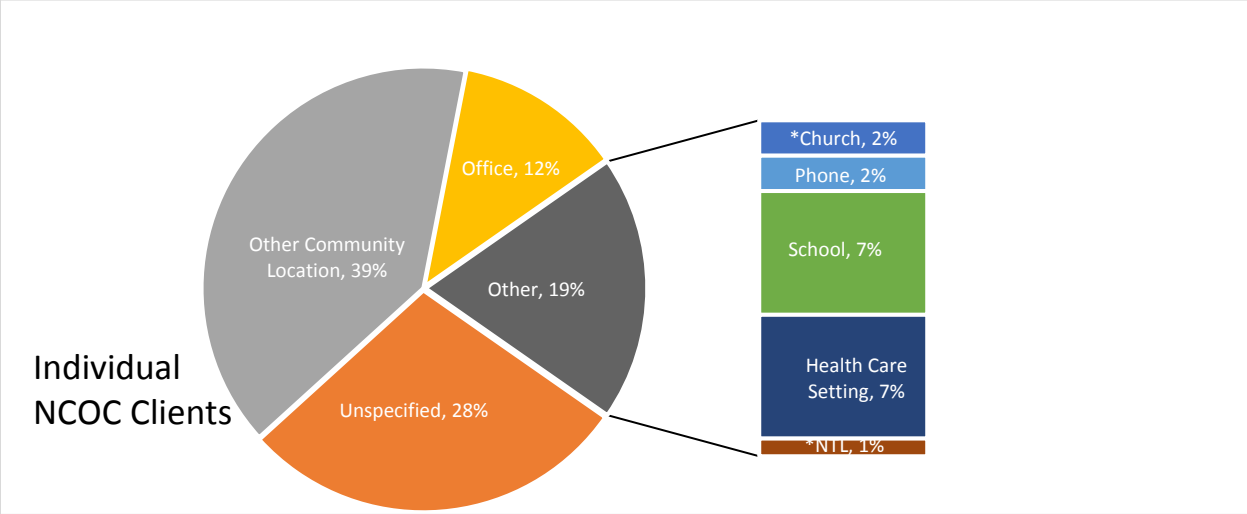
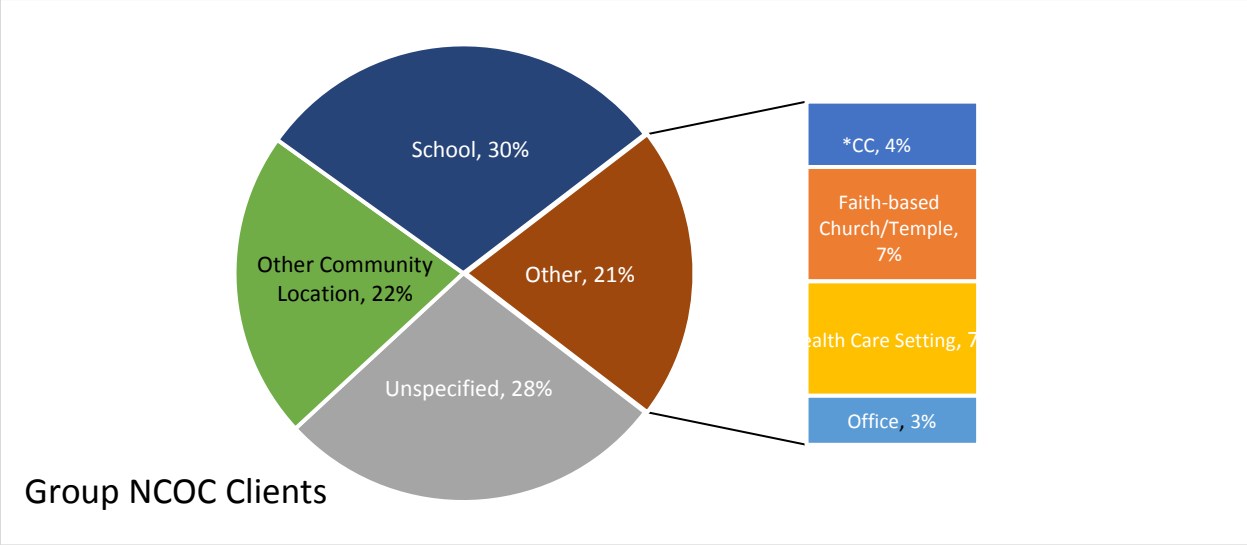


Figure 12. Locations of NCOC Group Outreach Events, FY 2018-2019



Note: Church = Faith-based Church/Temple, CC = Age-Specific Community Center, NTL = Non-Traditional Location, Unspecified = Field (unspecified)
Percentages may not sum to 100% because of rounding. Attendees can choose more than one category. The denominator for location percent is the sum of all location data reported.

Length of contact: For FY 2018-2019, the individual outreach events lasted from 3 to 90 minutes and lasted on average 20 minutes. The average length of NCOC group outreach events ranged from 2 to 386 minutes and lasted 116 minutes on average.

Language used: NCOC individual outreach events were conducted in English (95%), Mandarin (2%), Cantonese (2%), and Spanish (1%) in FY 2018-2019. NCOC group outreach events were conducted in English (92%), Mandarin (3%), Cantonese (3%), and Spanish (3%) in FY 2018-2019.

Preferred language: NCOC individual outreach attendees preferred English (87%), Cantonese (3%), Mandarin (3%), Samoan (2%), Spanish (2%), Tagalog (1%), other languages (2%), and Tongan (<1%). NCOC group outreach attendees preferred English (88%), Spanish (4%), Tagalog (2%), Cantonese (2%), Mandarin (1%), Samoan (<1%), Tongan (<1%) and other language (2%). **Figures 13 and 14** present breakdowns of preferred languages at individual and group outreach events in FY 2018-2019.

Figure 13. Preferred Languages for NCOC Individual Outreach Attendees, FY 2018-2019

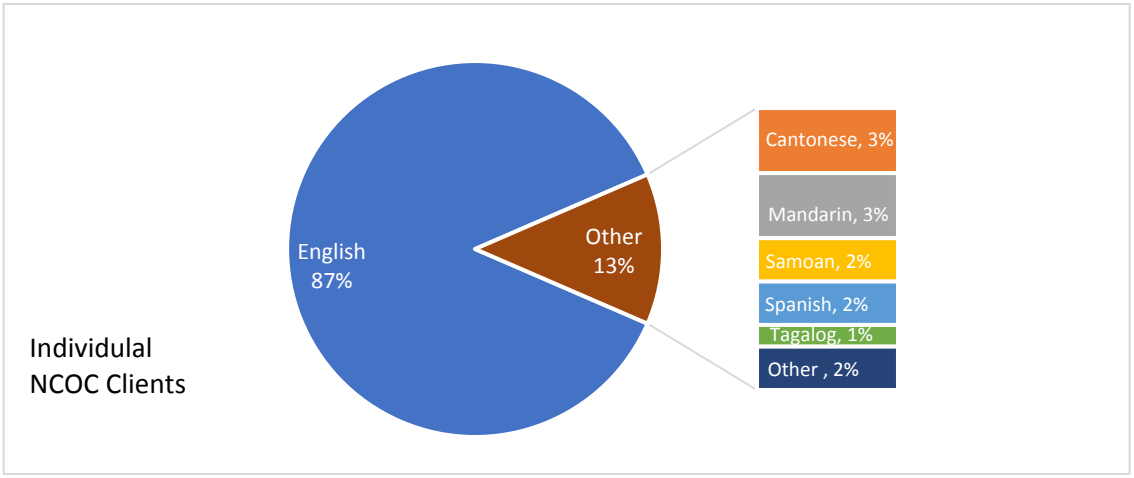
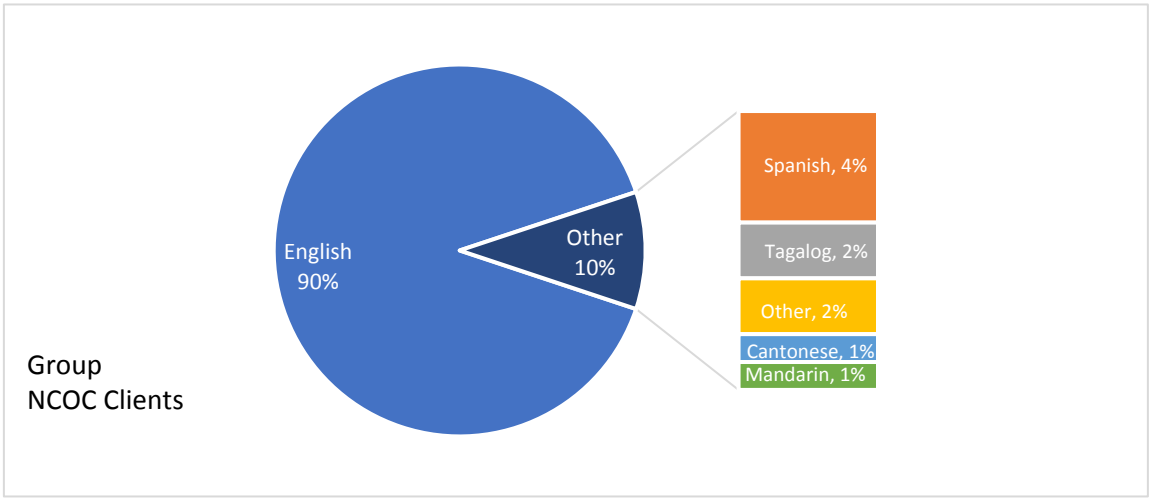


Figure 14. Preferred Languages for NCOC Group Outreach Attendees, FY 2018-2019



Note: Percentages may not sum to 100% because of rounding. The denominator for preferred language percent is the sum of all preferred language data reported.

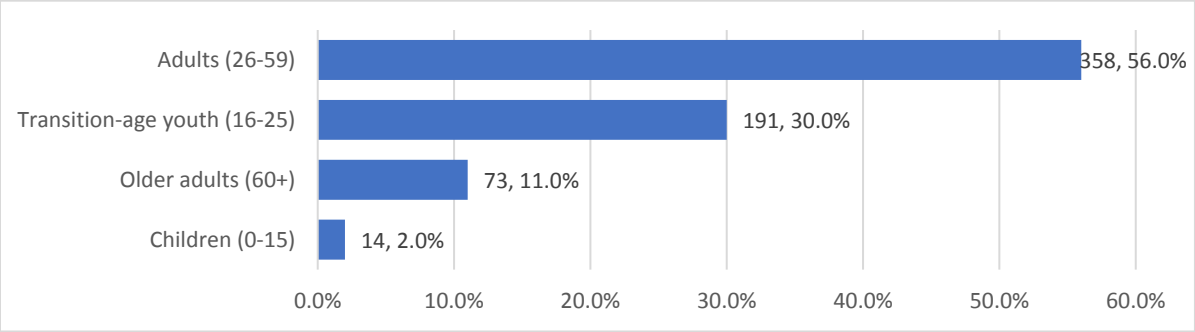
EPAPMHO

In FY 2018-2019, there were 636 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, 56%), transition-age youth (16-25 years, 30%), older adults (60+ years or older, 11%), and children (0-15 years, 2%) in FY 2018-2019. See **Figure 15** for the number and percentage of outreach attendees representing each reported age group.

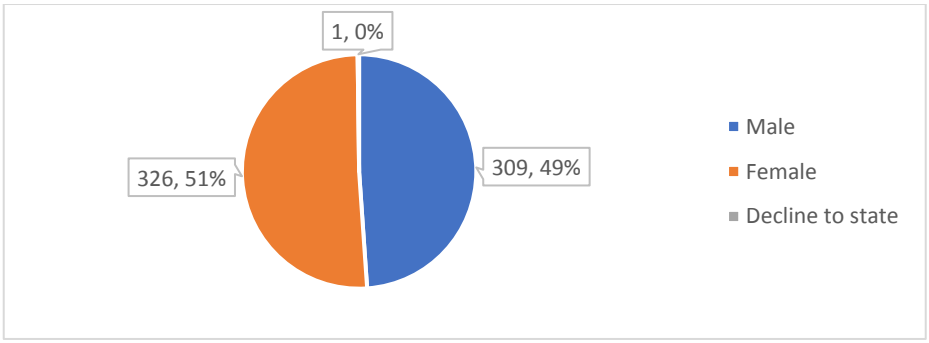
Figure 15. Age of Outreach Attendees Served By EPAPMHO, FY 2018-2019



Note: Percentages may not sum to 100% because of rounding. The denominator for age percent is the sum of all age data reported.

Sex at birth: Attendees across EPAPMHO outreach events were male (49%), female (51%), and declined to state (<1%). in FY 2018-2019. See **Figure 16** for the number and percentage of outreach attendees representing each reported sex.

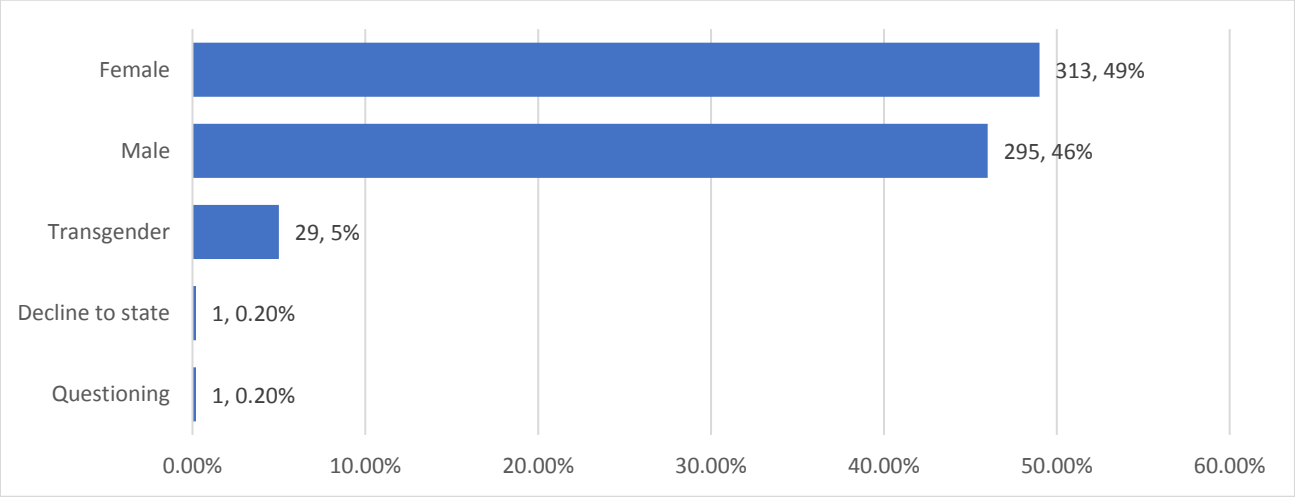
Figure 16. Sex at Birth of Outreach Attendees Served By EPAPMHO, FY 2018-2019



Note: Percentages may not sum to 100% because of rounding. The denominator for sex percent is the sum of all sex data reported.

Gender: Attendees across EPAPMHO individual and group outreach events identified themselves primarily as female (49%), male (46%), and transgender (5%) in FY 2018-2019. See **Figure 17** for the number and percentage of individual and group outreach attendees representing each reported gender.

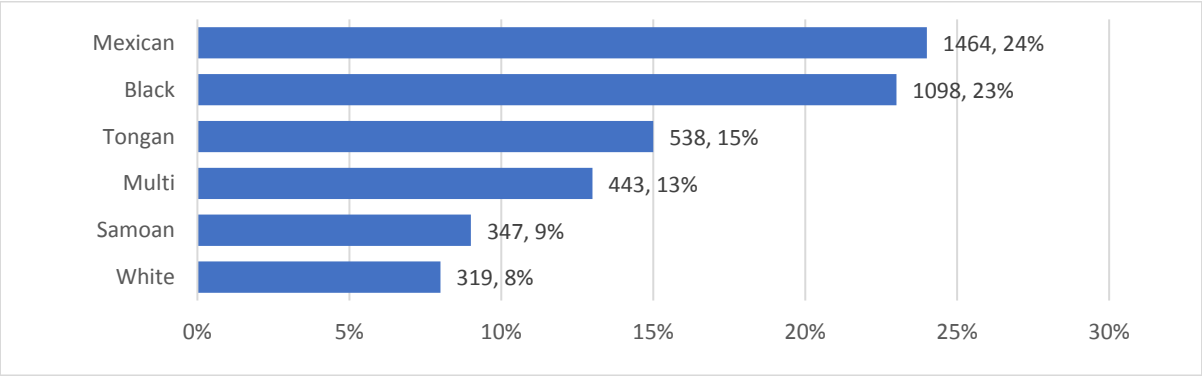
Figure 17. Gender of Outreach Attendees Served By EPAPMHO, FY 2018-2019



Note: Percentages may not sum to 100% because of rounding. The denominator for gender percent is the sum of all gender data reported

Race and ethnicity: In FY 2018-2019, the four largest racial/ethnic groups represented by all EPAPMHO attendees were Mexican (24%), Black (23%), Tongan (15%), and multi-race (13%). See **Figure 18** for the number and percentage of attendees representing each reported racial/ethnic group.

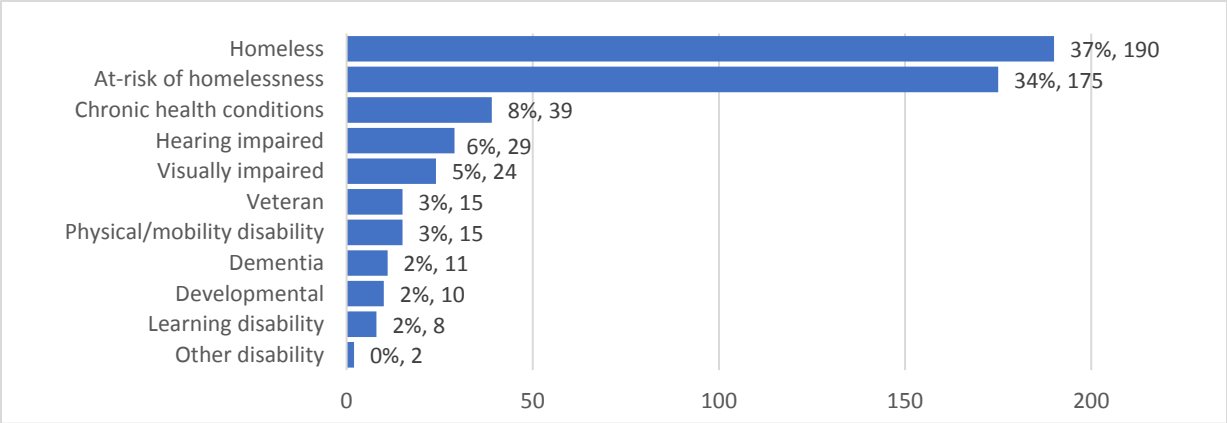
Figure 18. Race and Ethnicity of Outreach Attendees Served By EPAPMHO, FY 2018-2019



Note: Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Special populations: Of the special populations, 37% were homeless, 34% were at-risk of homelessness, 8% had chronic health conditions, 6% were hearing impaired, 5% were visually impaired, 3% were veteran, 3% had a physical/mobility disability, 2% had dementia, 2% had a developmental disability, 2% had a learning disability, and less than 1% had other disabilities. Refer to **Figure 19** for the number and percentage of attendees representing each special population in FY 2018-2019.

Figure 19. Special Populations Served by EPAPMHO, FY 2018-2019



Note: Attendees could be included in more than one special population. The denominator for special population group is the sum of all special population data reported.

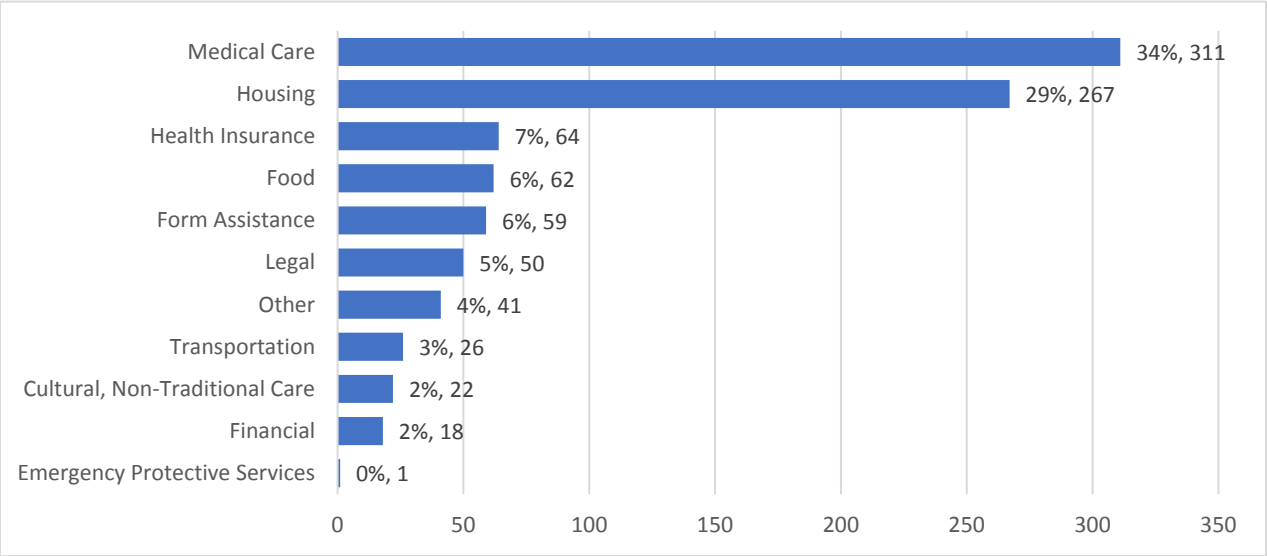
Additional outreach characteristics (individual outreach events only)

Previous Contact: Thirty percent of individual outreach events were conducted with attendees who had a previous outreach contact with EPAPMHO.

Mental Health/Substance Abuse Referrals: EPAPMHO individual outreach events resulted in mental health referrals (24%) and substance abuse referrals (32%) in FY 2018-2019.

Referrals to Social Services: Providers made 1,045 referrals to 616 EPAPMHO individual outreach attendees. Of the different referral types, the top four types of referrals made for attendees were for medical care (34%), housing (29%), health insurance (7%) and food (6%). **Figure 20** summarizes the number and percentage of attendees receiving a given type of referral.

Figure 20. Referrals to Social Services, FY 2018-2019

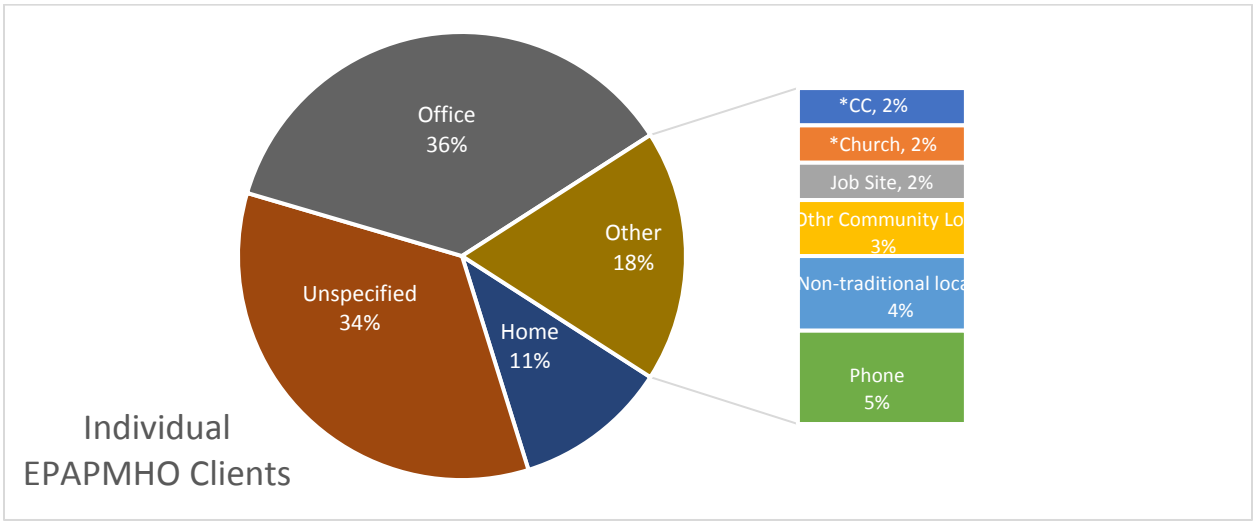


Note: Percentages may not sum to 100% because of rounding. Attendees can choose more than one category. The denominator for referral group is the sum of all referral data reported.

Event characteristics

Location: EPAPMHO individual outreach events primarily occurred in offices (36%) and unspecified field locations (34%) in FY 2018-2019. Other community locations included places such as indigenous day events, senior homes, public parks, and on social media. The other locations category includes all the locations that are reported that make up less than 10 percent of the total locations reported. The one group outreach event occurred at a library. **Figure 21** present individual outreach event locations in FY 2018-2019.

Figure 21. Location of EPAPMHO Individual Outreach Events, FY 2018-2019



Note: *CC = Age-Specific Community Center, Church = Faith-based Church/Temple

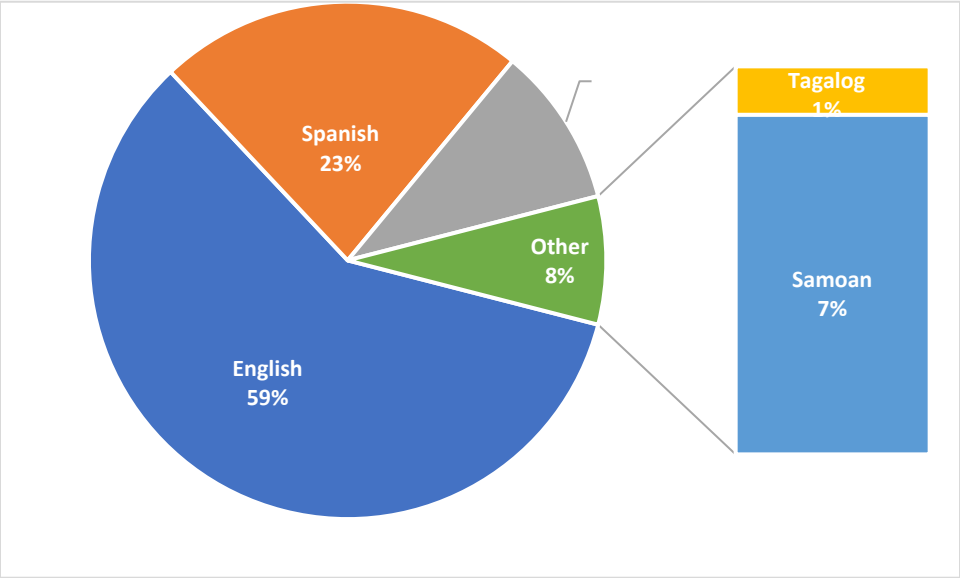
Percentages may not sum to 100% because of rounding. Attendees can choose more than one category. The denominator for location percent is the sum of all location data reported.

Length of contact: In FY 2018-2019, the individual outreach events lasted from 10 to 120 minutes and were on average 37 minutes. The one group outreach event lasted 15 minutes.

Language used: EPAPMHO individual outreach events were conducted in English (60%), Spanish (23%), Tongan (10%), and Samoan (7%) in FY 2018-2019. The one group outreach event was conducted in Spanish (100%) in FY 2018-2019.

Preferred language: EPAPMHO individual outreach attendees preferred English (59%), Spanish (23%), Tongan (10%), Samoan (7%), and Tagalog (1%). Attendees at the one EPAPMHO group outreach preferred Spanish (100%). **Figure 22** presents breakdown of preferred languages at individual outreach events in FY 2018-2019.

Figure 22. Preferred Languages for EPAPMHO Individual Outreach Attendees, FY 2018-2019



Recommendations

We have several recommendations based on FY 2018-2019 data. These recommendations fall under two umbrellas: those aimed at enhancing outreach and those to improve data collection.

Enhance outreach

Conduct more outreach in languages other than English. Of the 942 outreach activities conducted only 21% were in a language other than English (<1% in Tagalog, <1% in Cantonese, <1% in Mandarin, 3% in Samoan, 5%, in Tongan, and 12% in Spanish). This will help ensure individuals who do not speak English are able to access services.

Focus on increasing housing-related resources and referrals. People who reported being homeless or at risk of homelessness make up a high percentage of the special population group. For this year, 66% of the NCOC attendees and 71% of the EPAPMHO attendees reported being homeless or at risk of homelessness. Despite this high number, only 12% and 29% of referrals reported were made to housing in NCOC and EPAPMHO, respectively. In FY 2018-2019, we observed an decrease in the total number of housing-related referrals made compared to previous year.

Improve data collection

Make other/unspecified categories clearer. Last year, AIR recommended minimizing missing data, and outreach staff have made an effort to do a better job in data collection. However, there are still relatively high proportions of individuals in other/unspecified categories for some topics. For example, the percentage of individuals who reported being referred to "other social services" made up 22% of referrals for the NCOC collaborative for FY 2018-2019. This speaks to the need to expand upon the categories for this question.

Ensure insurance data is capture. This year, a large proportion of attendees (55%) reported being uninsured or had unknown insurance status across the two collaboratives. Hence, this data was not presented in this year's report. The high percentage of attendees who reported being uninsured or had unknown insurance status has been a consistent trend in each of the prior years: 57% In FY 2017-2018, 56% in FY 2015-2016, 54% in FY 2015-2016, and 64% in FY 2014-2015 across both collaboratives. 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.

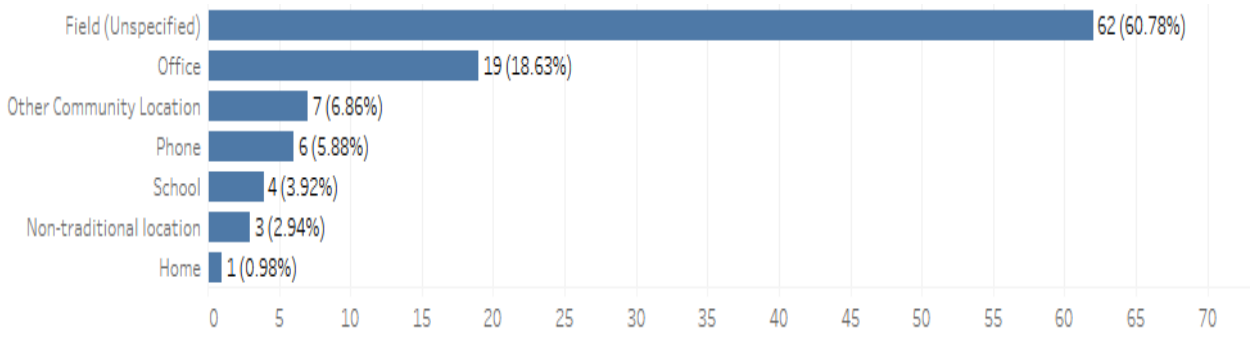
Appendix A. FY 2018-2019 Outreach, Asian American Recovery Services

For FY 2018-2019, Asian American Recovery Services (AARS) reported a total of 102 outreach events, 76 individual events, and 26 group events. There were 649 attendees. Individual outreach events lasted from 15 to 90 minutes and lasted 31 minutes on average. The group outreach events lasted from 15 to 240 minutes and lasted on average 113 minutes.

Outreach events:

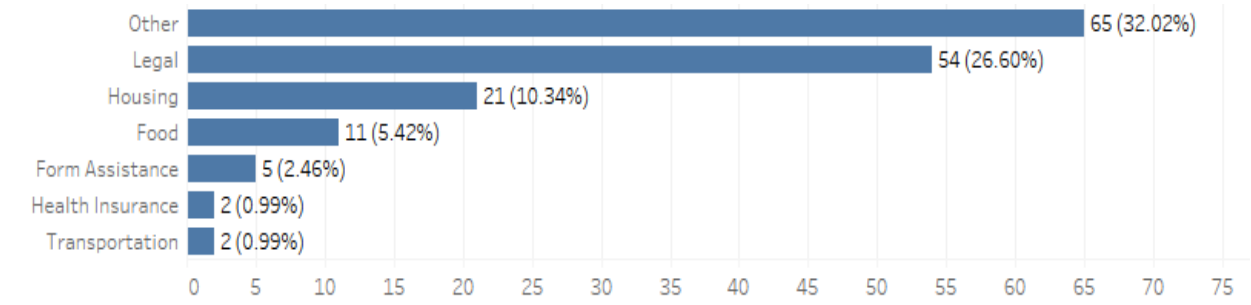
- Most frequently took place in unspecified field locations (**60.8%**; n=72). Other locations of events and their respective percentages are shown in **Figure 1**.

Figure 1. Locations of Outreach events, Fiscal year 2018-2019



- Were conducted in English (**99.0**%; n=101) and Spanish (**1%;** n=1).
- Resulted in 20 mental health referrals and 15 substance abuse referrals at the *individual* outreach events.
- Resulted in 203 social service referrals (**Figure 2**). An *individual* outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Referrals were primarily made to Other (**32.0%;** n=65), Legal (**26.6%;** n=54), and Housing (**10.3**%; n=21) services.

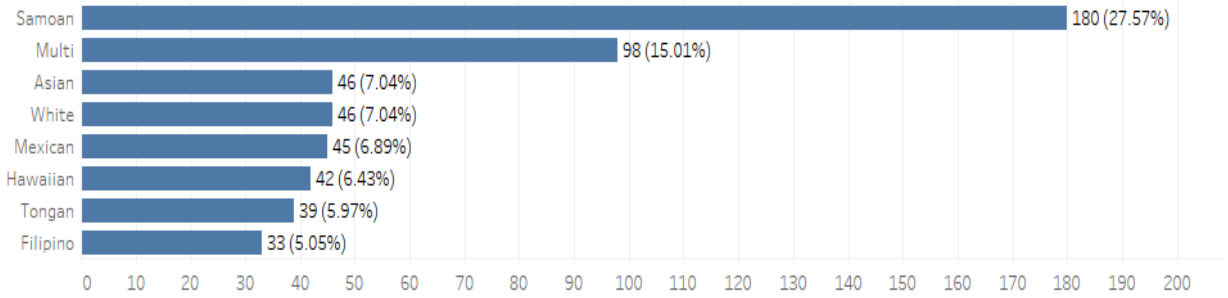
Figure 2. Social Service Referrals, Fiscal year 2018-2019



Outreach event attendees:

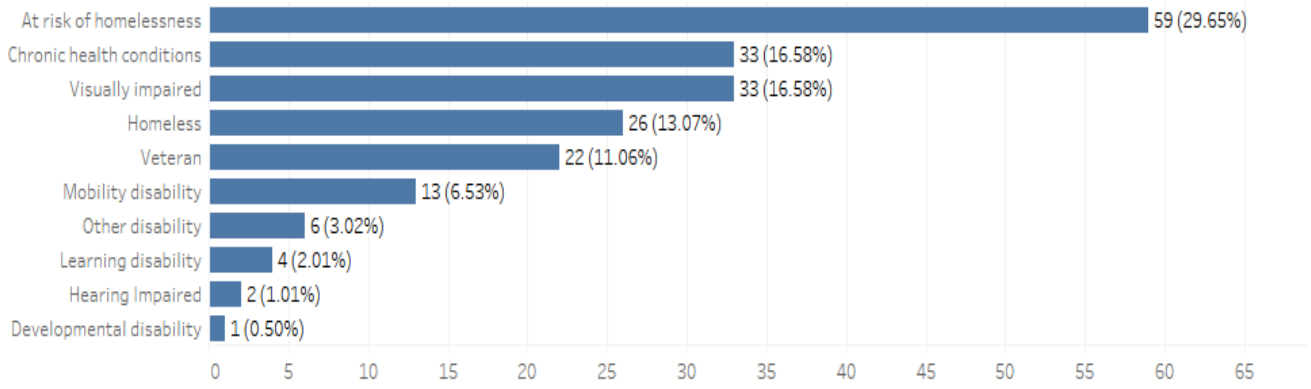
- Most often were female (**61.7%**; n=402). Thirty eight percent were male (**37.9%**; n=247). Less than 1% declined to report their sex at birth
- Identified as Heterosexuals (**81.2%**; n=528), Gay/Lesbian (**6.8%**; n=44), Bisexual (**2.31%;** n=15), Queer (**2.31%;** n=15), "Other" sexual orientation (**0.5%;** n=3), Pansexual (**0.3%;** n=2), or Asexual (**0.2**%; n=1). The remaining attendees declined to state (**6.3%;** n=41) or were questioning (**0.2%;** n=1) their sexual orientation.
- Comprised of adults (26-59 year, **52.2%**; n=341), transition-age youth (16-25 years, **24.3%**; n=159), older adults (60+ years, **11.3%**; n=74), and children (15 years and younger, **11.2%;** n=73).
- Were primarily Samoan (**27.6%**; n=180), of two or more races (**15.0%**; n=98), Asian (**7.0%**; n=46), White (**7.0%**; n=46), or Mexican (**6.9%**; n=45) **(See Figure 3).**

Figure 3. Attendees by Top Race/Ethnicity Category, FY 2018-2019



In FY 2018-2019, **30.7%** (N=199) of AARS attendees were in at least one special population category. Special populations include those who: are veterans, are homeless, are at risk of homelessness, are hearing impaired, are vision impaired, have dementia, have chronic health conditions, have a mobility disability, have a learning disability, or have a developmental disability. Out of 199 recipients in the special population group, **29.8%** were at risk of homelessness, **16.6%** had chronic health conditions, and **16.6%** were visually impaired (**See Figure 4)**.

Figure 4. Service recipients by Special Population, FY 2018-2019



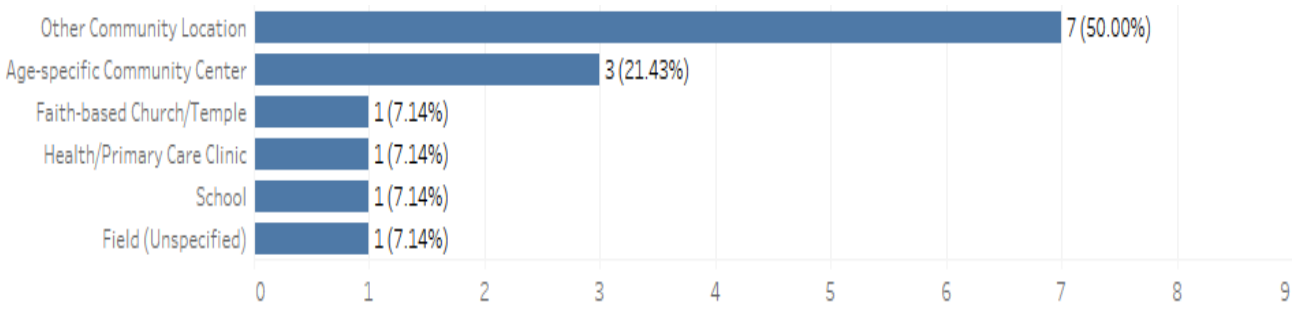
Appendix B. FY 2018-2019 Outreach, Daly City Peninsula Partnership Collaborative

For FY 2018-2019, Daly City Peninsula Partnership Collaborative reported a total of 14 outreach events, 1 individual event and 13 group events. There were 1,657 attendees. The individual outreach event lasted 15 minutes. Group outreach events lasted from 2 to 240 minutes and lasted on average 83 minutes.

Outreach events:

- Most frequently took place in other community locations (**50.0%**; n=7). Other locations of events and their respective percentages are shown in **Figure 1.**

Figure 1. Locations of Outreach events, Fiscal year 2018-2019



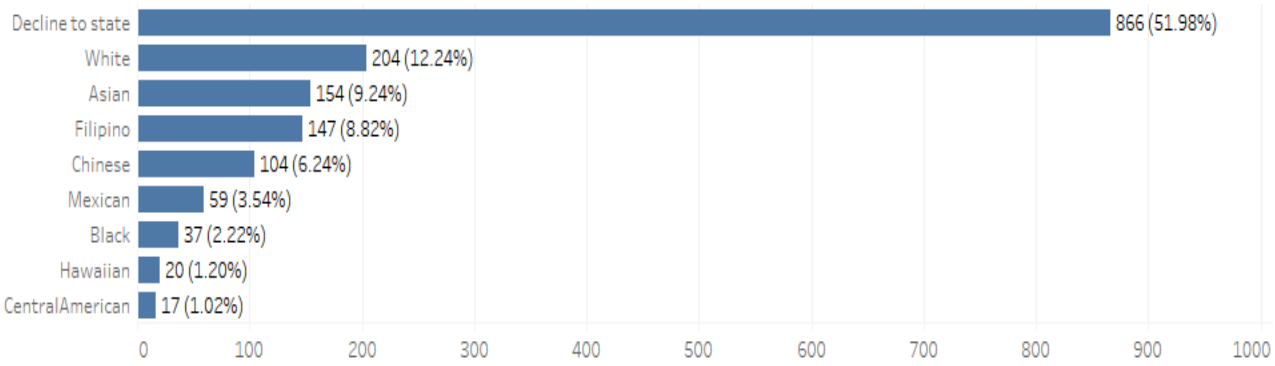
- Were conducted in English (**92.9%;** n=13) and Mandarin (**7.14%;** n=1).
- Resulted in no mental health referrals and substance abuse referrals at the *individual* outreach events.
- Resulted in one social service referral. Daly City Peninsula Partnership Collaborative made one referral to Legal services.

Outreach event attendees:

- Most often were female (**40.9%**; n=679). Twenty six percent were male (**26.3%**; n=437). Approximately one-third of the attendees (**32.8%;** n=545) declined to state their sex at birth.
- Identified as Heterosexuals (**32.4%**; n=536), Gay/Lesbian (**13.9%**; n=231), Bisexual (**0.6%;** n=10), or Queer (**0.6%;** n=10). A little over half of the attendees (**52.5%;** n=870) declined to state their sexual orientation.
- Comprised of transition-age youth (16-25 years, **26.7%**; n=445), adults (26-59 year, **26.5%**; n=441), older adults (60+ years, **21.8%**; n=364), and children (15 years and younger, **6.3%;** n=105). The remaining attendees (**18.7%;** n=312) declined to state their age.

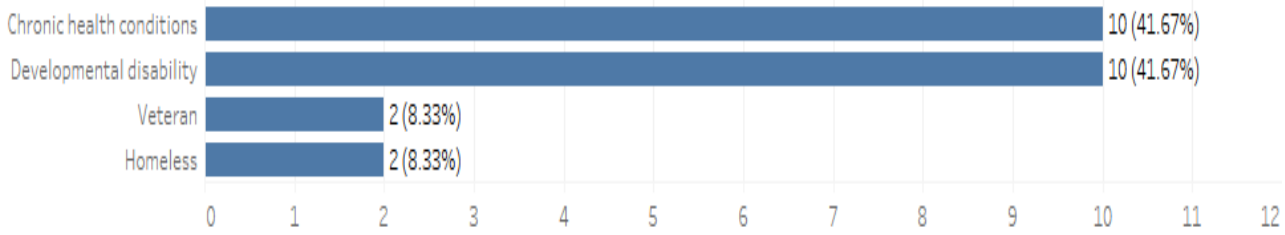
- Were primarily White (**12.2%**; n=204), Asian (**9.2%**; n=154), Filipino (**8.8%**; n=147), or Chinese (**6.2%**; n=104) **(See Figure 2).** Over half of the attendees (**52.0%;** n= 866) declined to state their race/ethnicity.

Figure 2. Attendees by Top Race/Ethnicity Category, FY 2018-2019



In FY 2018-2019, **1.4%** (N=24) of Daly City Peninsula Partnership attendees were in at least one special populations group. Special populations include those who: are veterans, are homeless, are at risk of homelessness, are hearing impaired, are vision impaired, have dementia, have chronic health conditions, have a mobility disability, have a learning disability, or have a developmental disability. Out of 24 recipients in the special population group, **41.7%** had chronic health conditions, **41.7%** had a developmental disability, **8.3%** were veterans, and **8.3%** were homeless (**See Figure 3)**.

Figure 3. Service recipients by Special Populations, FY 2018-2019



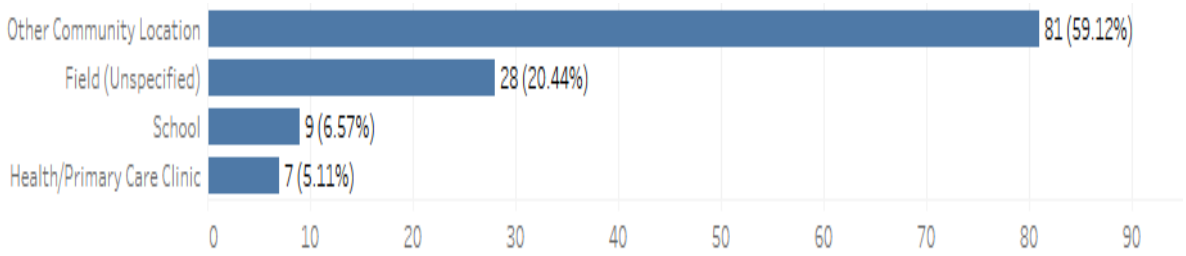
Appendix C. FY 2018-2019 Outreach, Daly City Youth Center

For FY 2018-2019, Daly City Youth Center reported a total of 137 outreach events, 125 individual events, and 12 group events. There were 406 attendees. Individual outreach events lasted from 3 to 50 minutes and lasted on average 7 minutes. Group outreach events lasted from 30 to 386 minutes and lasted on average 138 minutes.

Outreach events:

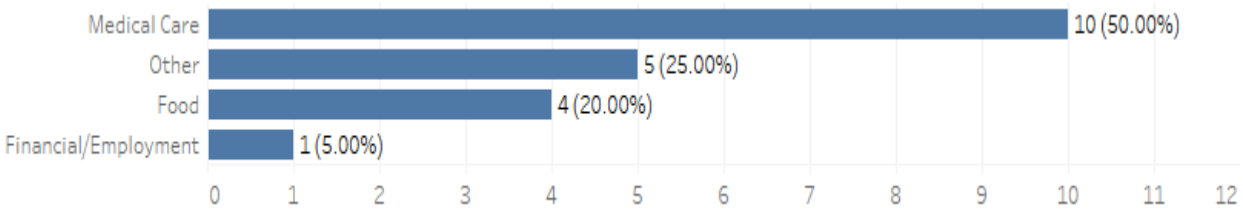
- Most frequently took place in other community locations (**59.1%**; n=81). Other locations of evens and their respective percentages are shown in **Figure 1.**

Figure 1. Locations of Outreach events, Fiscal year 2018-2019



- Were conducted in English (**97.8%;** n=134) or Spanish (**2.2%;** n=3).
- Resulted in seven mental health referrals at the *individual* outreach events.
- Resulted in 20 social service referrals **(See Figure 2)**. An *individual* outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Referrals were made to Medical Care (**50.0%;** n=10), Other (**25.0%;** n=5), Food (**20.0%;** n=4), and Financial/Employment (**5.0%;** n=1) services**.**

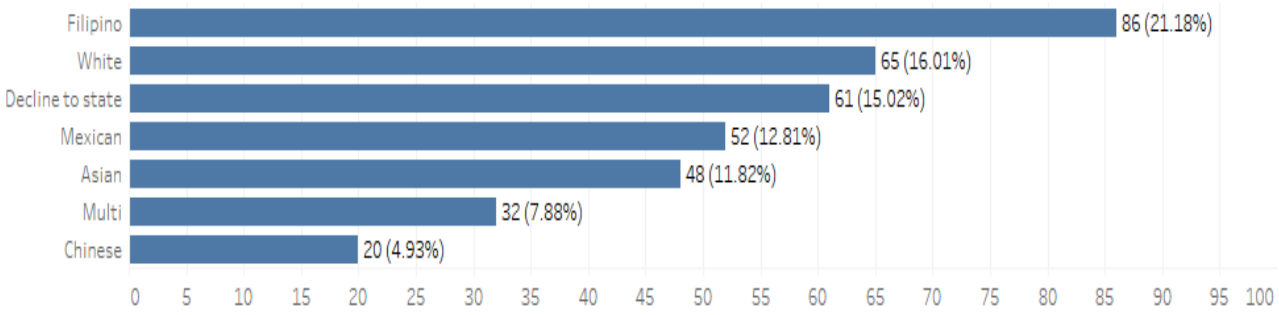
Figure 2. Social Service Referrals, Fiscal year 2018-2019



Outreach event attendees:

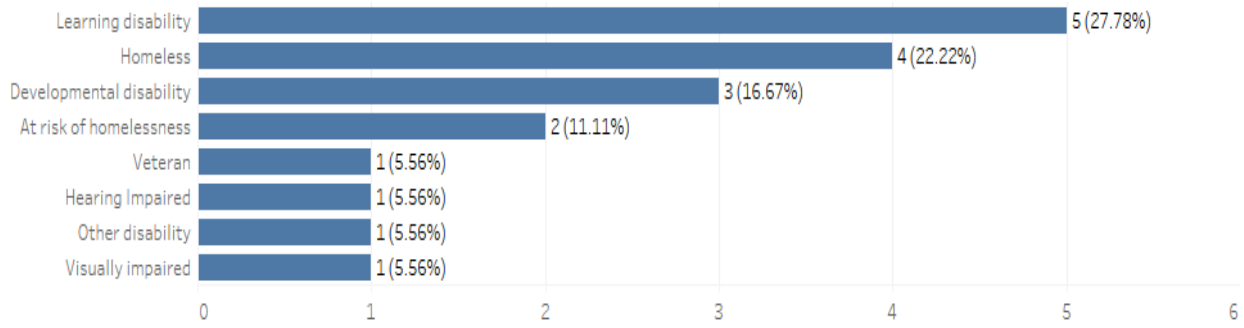
- Most often were female (**60.3%**; n=245). Twenty six percent were male (**25.6%**; n=104). The remaining attendees (**14.0%;** n=57) were of declined to state their sex at birth.
- Identified as Heterosexual (**30.8%**; n=125), Gay/Lesbian (**6.4%**; n=26), Bisexual (**4.4%;** n=18), Pansexual (**0.5%;** n=2), or Queer (**0.5%;** n=2). Less than one percent chose more than one sex orientation (**0.3%;** n=1). A little over half of the attendees (**55.9%;** n=227) declined to state their sexual orientation, and the remaining were questioning (**1.2%;** n=5) their sexual orientation.
- Comprised of transition-age youth (16-25 years, **53.6%**; n=215), adults (26-59 year, **19.0%**; n=76), children (15 years and younger, **16.2%;** n=65), and older adults (60+ years, **5.0%**; n=20). The remaining attendees (**6.2%;** n=25) declined to state their age.
- Were primarily Filipino (**21.2%**; n=86), White (**16.0%**; n=65), Mexican (**12.8%**; n=52), or Asian (**11.8%;** n=48) **(See Figure 3).** Fifteen percent of attendees declined to state their race/ethnicity (**15.0%;** n=61).

Figure 3. Attendees by Top Race/Ethnicity Category, FY 2018-2019



In FY 2018-2019, **4.5%** (N=18) of Daly City Youth Center attendees were from the special populations group. Special populations include those who are veterans, are homeless, are at risk of homelessness, are hearing impaired, are vision impaired, have dementia, have chronic health conditions, have a mobility disability, have a learning disability, or have a developmental disability. Out of the 18 recipients in the special population group, **27.8%** had a learning disability, **22.2 %** were homeless, **16.7 %** had a developmental disability, and **11.1 %** were at risk of homelessness (**See Figure 4)**.

Figure 4. Service recipients by Special Populations, FY 2018-2019



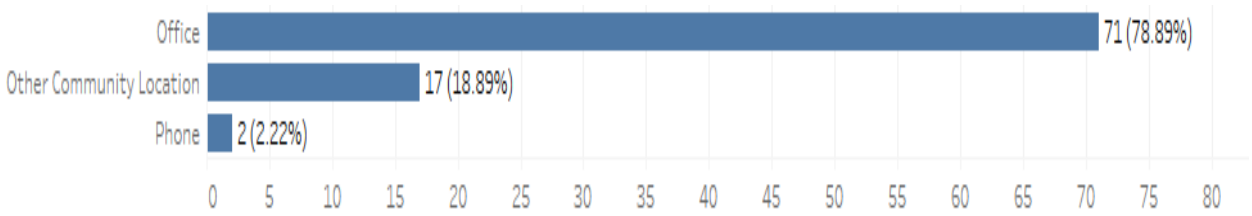
Appendix D. FY 2018-2019 Outreach, El Concilio

For FY 2018-2019, El Concilio reported a total of 90 outreach events, 89 individual events, and 1 group event. There were 109 attendees in total. Individual outreach events lasted from 10 to 30 minutes and lasted on average 19 minutes. The group outreach event lasted 15 minutes.

Outreach events:

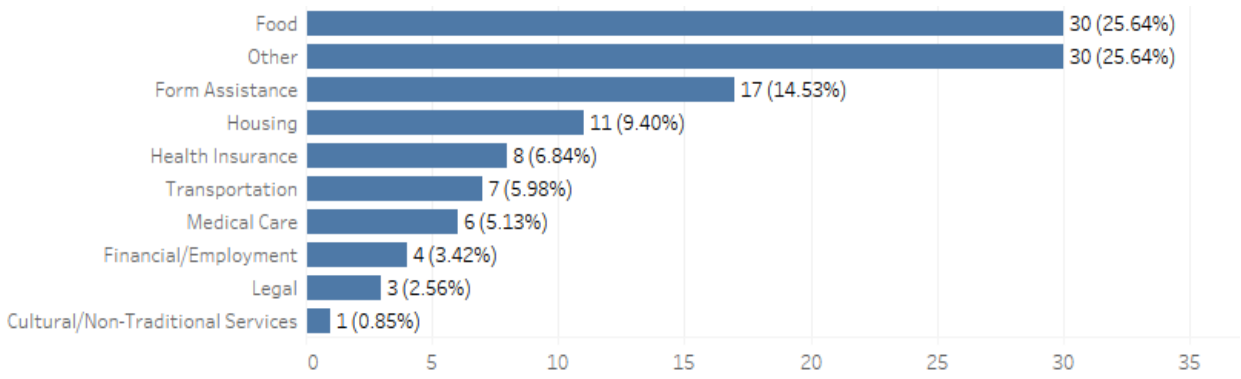
- Most frequently took place in offices (**78.9%**; n=71). Other locations of evens and their respective percentages are shown in **Figure 1. (See Figure 1).**

Figure 1. Locations of Outreach events, Fiscal year 2018-2019



- Were conducted in Spanish (**64.4%;** n=58) and English (**55.6%;** n=32).
- Resulted in 19 mental health referrals at the *individual* outreach events.
- Resulted in 117 social service referrals **(See Figure 2)**. An *individual* outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Referrals were made for food, legal, housing, financial/employment, transportation, cultural, and health-related services. Referrals were made primarily to Food (**25.6%;** n=30), other services outside of the primary list (**25.6%;** n=30), and Form Assistance (**14.5%;** n=17) services.

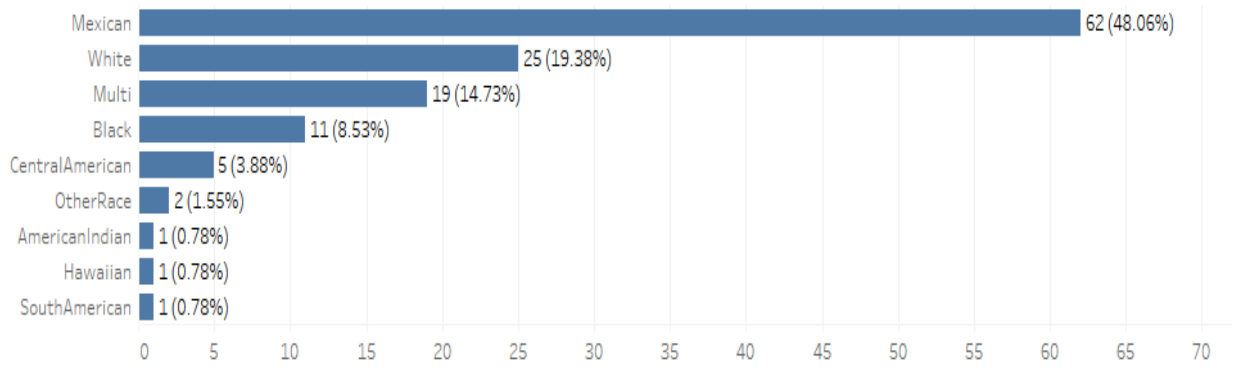
Figure 2. Social Service Referrals, Fiscal year 2018-2019



Outreach event attendees:

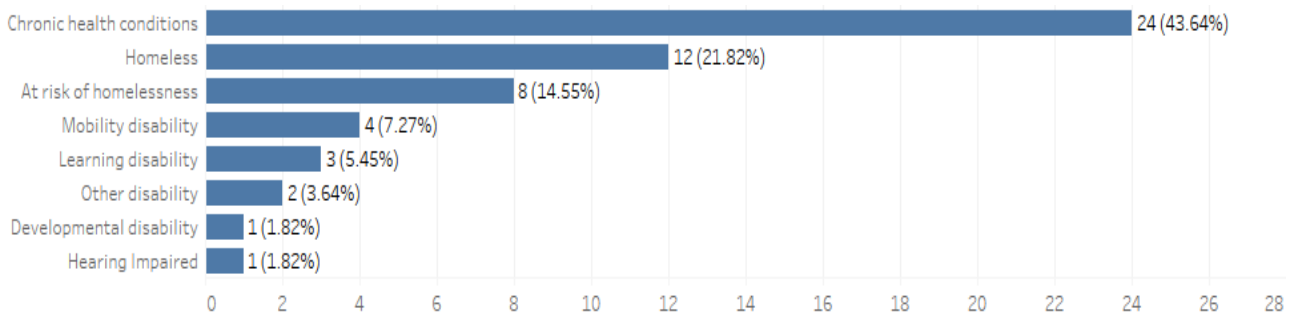
- Most often were female (**78.9%**; n=86). Twenty one percent were male (**21.1%**; n=23).
- Were Heterosexuals (**100.0%**; n=109).
- Comprised of adults (26-59 year, **61.5%**; n=67), older adults (60+ years, **23.9%**; n=26), and transition-age youth (16-25 years, **14.7%**; n=16).
- Were primarily Mexican (**48.1%**; n=62); White (**19.4%**; n=25), two or more races (**14.7%;** n=19), or Black (**8.5%**; n=11) **(See Figure 3).**

Figure 3. Attendees by Top Race/Ethnicity Category, FY 2018-2019



In FY 2018-2019, **53.6%** (N=55) of El Concilio attendees were in at least one special populations group. Special populations include those who are veterans, are homeless, are at risk of homelessness, are hearing impaired, are vision impaired, have dementia, have chronic health conditions, have a mobility disability, have a learning disability, or have a developmental disability. Out of the 55 service recipients in the special population group, **43.6%** had chronic health conditions, **21.8%** were homeless, and **14.6%** were at risk of homelessness (**See Figure 4)**.

Figure 4. Service recipients by Special Populations, FY 2018-2019



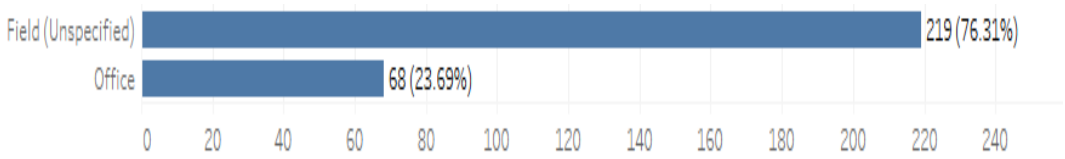
Appendix E. FY 2018-2019 Outreach, Free at Last

For FY 2018-2019, Free at Last reported a total of 287 individual outreach events. The events lasted from 10 to 45 minutes and were on average 32 minutes.

Outreach events:

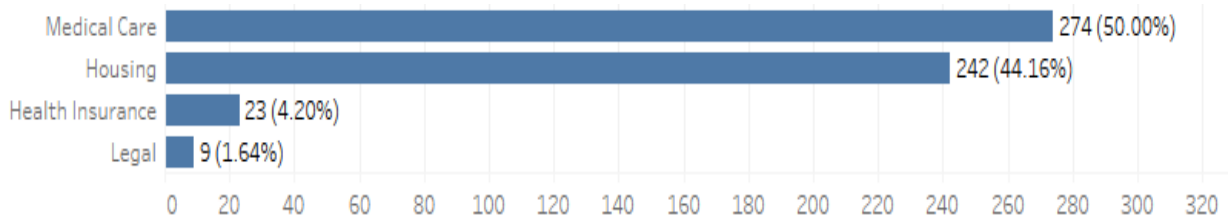
- Most frequently took place in unspecified field locations (**76.3%**; n=219). Other locations of events and their respective percentages are shown in **Figure 1.**

Figure 1. Locations of Outreach events, Fiscal year 2018-2019



- Were conducted in English (**69.3%;** n=199) and Spanish (**30.0%;** n=86).
- Resulted in 49 mental health referrals and 1 substance abuse referrals at the *individual* outreach events.
- Resulted in 548 social service referrals **(See Figure 2).** An *individual* outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Referrals were made to Medical Care (**50.0%;** n=274), Housing (**44.2%;** n=242), Health Insurance (**4.2%;** n=23), and Legal (**1.6%;** n=9) services.

Figure 2. Social Service Referrals, Fiscal year 2018-2019

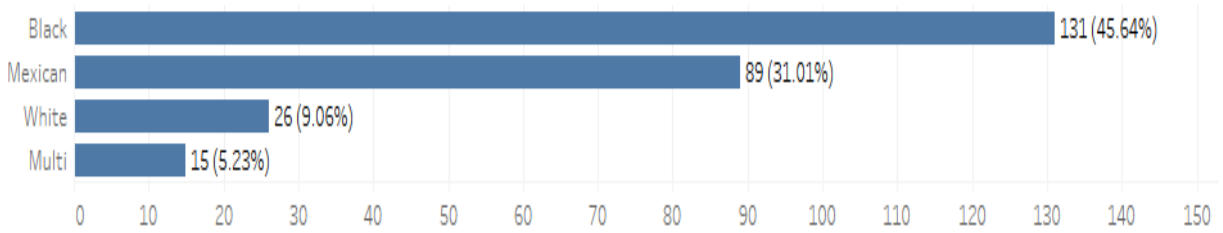


Outreach event attendees:

- Most often were female (**41.1%**; n=118). Fifty nine percent were male (**58.9%**; n=169).
- Identified as Heterosexuals (**62.0%**; n=178), Bisexual (**11.9%;** n=34), Gay/Lesbian (**11.5%;** n=33), or Pansexual (**0.7%;** n=2). Thirteen percent chose more than one sexual orientation (**13.9%**; n=40).
- Comprised of adults (26-59 year, **77.0%**; n=221), transition-age youth (16-25 years, **17.1%**; n=49), and older adults (60+ years, **5.9%**; n=17).

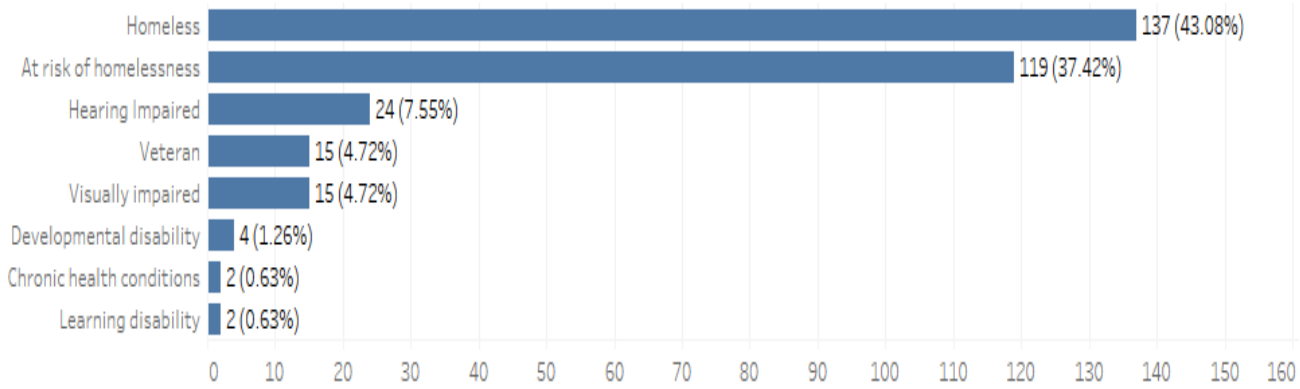
- Were primarily Black (**45.6%**; n=131); Mexican (**31.0%**; n=89), or White (**9.1%**; n=26) **(See Figure 3).**

Figure 3. Attendees by Top Race/Ethnicity Category, FY 2018-2019



In FY 2018-2019, 318 El Concilio attendees were in at least one special populations group. Special populations include those who are veterans, are homeless, are at risk of homelessness, are hearing impaired, are vision impaired, have dementia, have chronic health conditions, have a mobility disability, have a learning disability, or have a developmental disability. Out of the 318 service recipients in the special population group, **43.1%** were homeless, **37.4%** were at risk of homelessness, and **7.6%** were hearing impaired (**See Figure 4)**.

Figure 4. Service recipients by Special Populations, FY 2018-2019



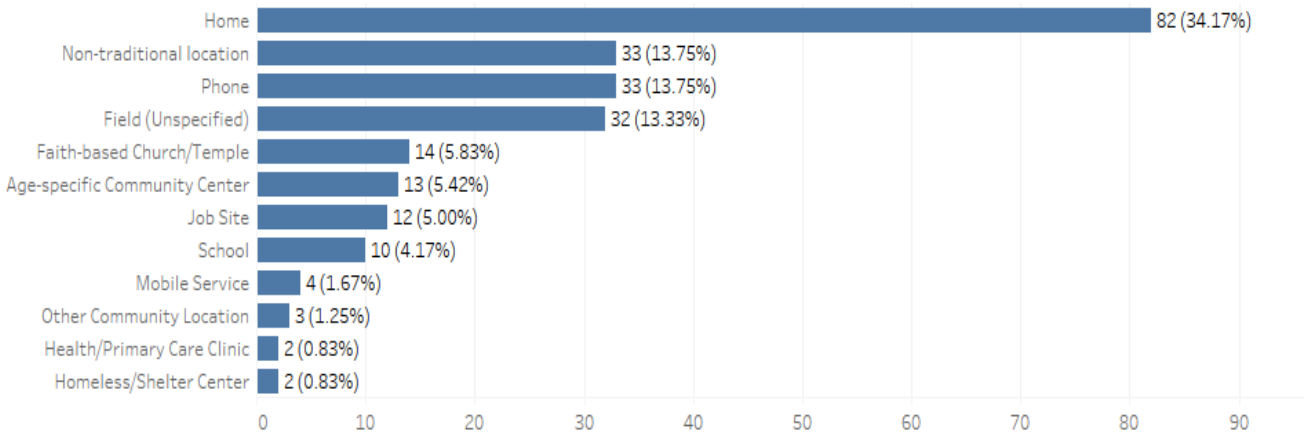
Appendix F. FY 2018-2019 Outreach, Multicultural Counseling and Education Services of the Bay Area

For FY 2018-2019, Multicultural Counseling and Education Service of the Bay Area (MCESBA) reported a total of 240 individual outreach events. The outreach events lasted from 30 to 120 minutes and lasted on average 49 minutes.

Outreach events:

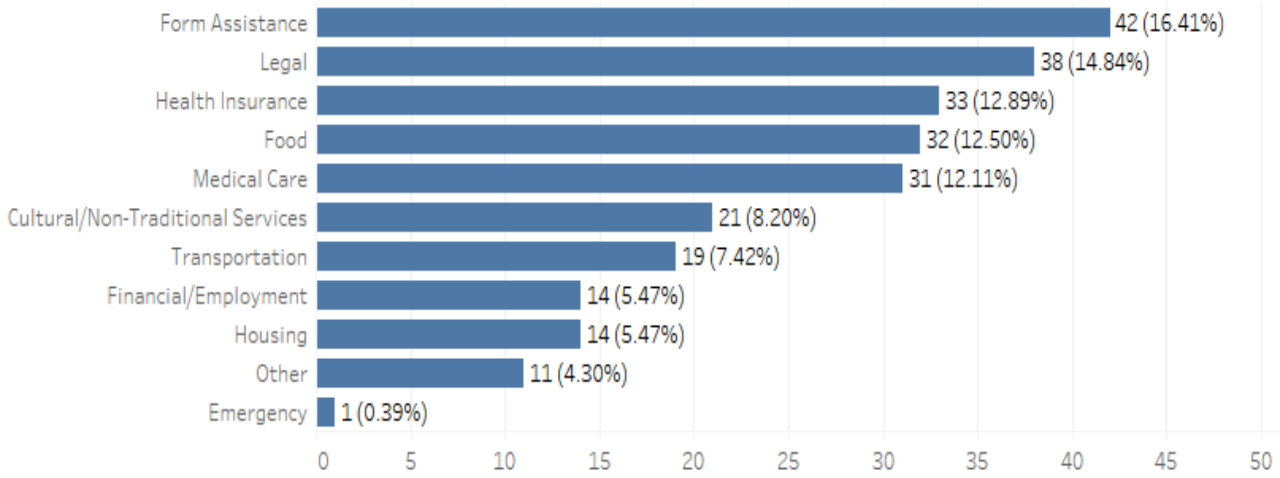
- Most frequently took place in homes (**34.2%**; n=82). Other locations of events and their respective percentages are shown in **Figure 1.**

Figure 1. Locations of Outreach events, Fiscal year 2018-2019



- Were conducted in English (**57.1%;** n=137), Tongan (**24.2%;** n=58), and Samoan (**17.9%;** n=43).
- Resulted in 80 mental health referrals.
- Resulted in 256 social service referrals **(See Figure 2).** An *individual* outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Referrals were made primarily to Form Assistance (**16.4%;** n=42), Legal (**14.8%;** n=38), Health Insurance (**12.9%;** n=33), Food (**12.5%;** n=32), and Medical Care (**12.1%;** n=31) services.

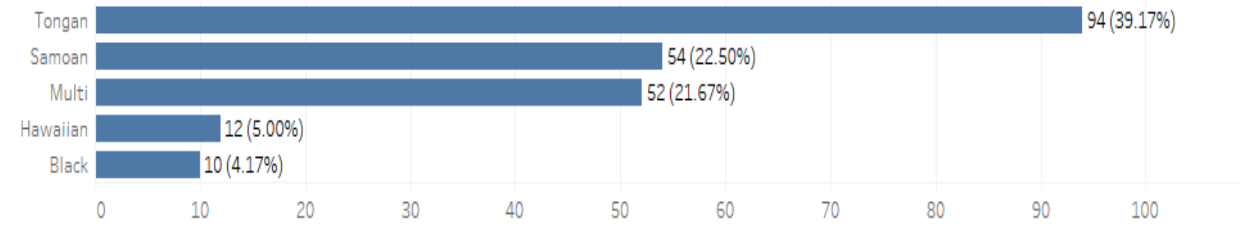
Figure 2. Social Service Referrals, Fiscal year 2018-2019



Outreach event attendees:

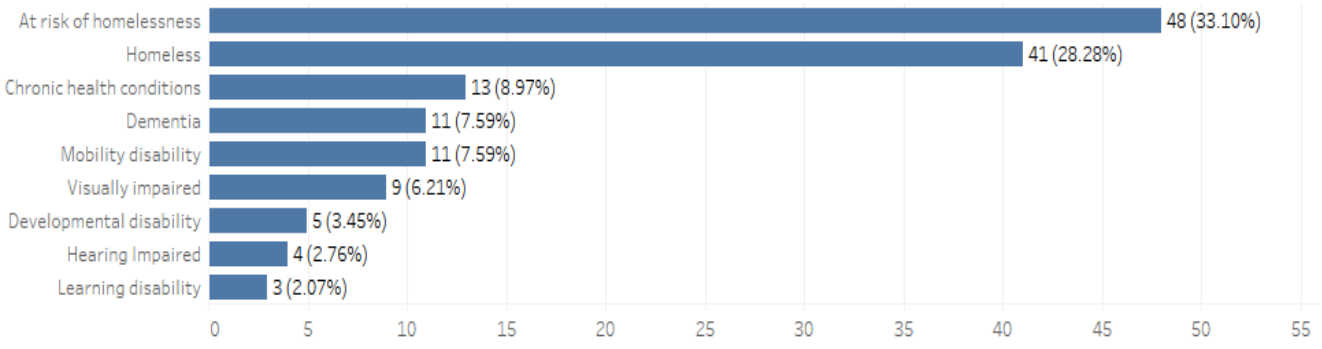
- Most often were female (**50.8%**; n=122). Forty nine percent were male (**48.8%**; n=117). One individual decline to state their sex at birth.
- Identified as Heterosexuals (**86.7%**; n=208), Bisexual (**6.7%**; n=16), Gay/Lesbian (**3.8%;** n=9), or Questioning (**1.7%;** n=4). One percent of the attendees declined to state their sexual orientation (**1.3%;** n=3).
- Comprised of transition-age youth (16-25 years, **52.5%**; n=126), adults (26-59 year, **29.2%**; n=70), older adults (60+ years, **12.5%**; n=30), and children (15 years and younger, **5.8%;** n=14).
- Were primarily Tongan (**39.2%**; n=94), Samoan (**22.5%**; n=54), or of more than one race (**21.7%**; n=52) **(See Figure 3).**

Figure 3. Attendees by Top Race/Ethnicity Category, FY 2018-2019



In FY 2018-2019, **60.4%** (N=145) MCESBA attendees were in at least one special populations group. Special populations include those who are veterans, are homeless, are at risk of homelessness, are hearing impaired, are vision impaired, have dementia, have chronic health conditions, have a mobility disability, have a learning disability, or have a developmental disability. Out of the 145 service recipients in the special population group, **33.1%** were at risk of homelessness, **28.3%** were homeless, and **9.0 %** had chronic health conditions (**See Figure 4)**.

Figure 4. Service recipients by Special Populations, FY 2018-2019



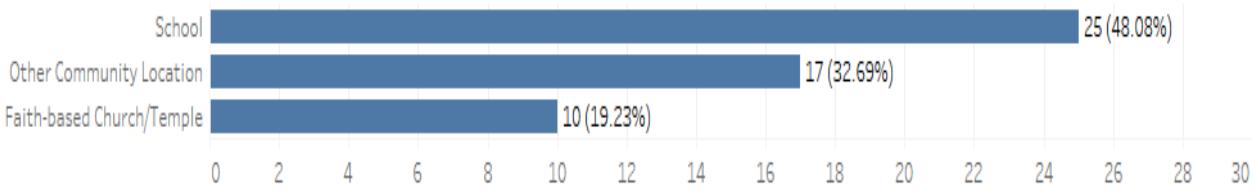
Appendix G. FY 2018-2019 Outreach, Pacifica Collaborative

For FY 2018-2019, Pacifica Collaborative reported a total of 52 outreach events, 34 individual outreach events, and 18 group outreach events. There were 1,954 attendees. Individual outreach events lasted from 15 to 45 minutes and lasted an average of 26 minutes. Group outreach events lasted from 90 to 240 minutes and lasted an average of 132 minutes.

Outreach events:

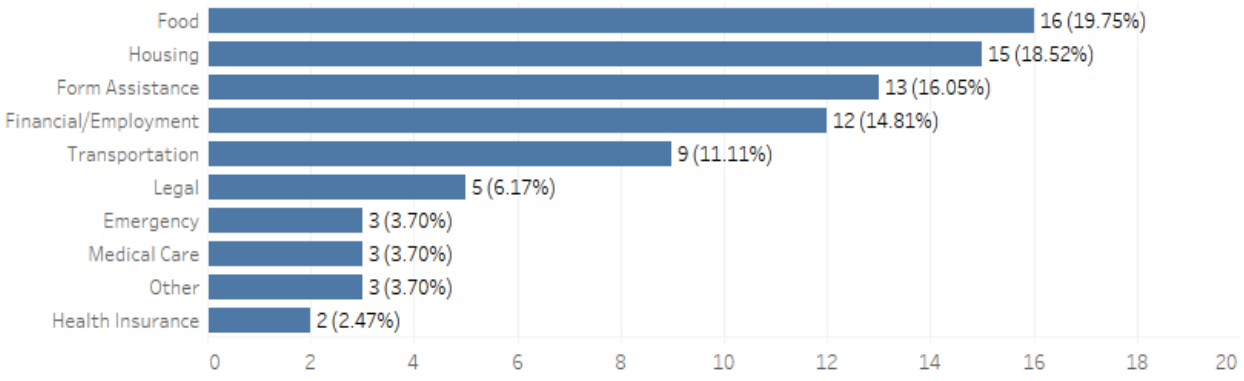
- Most frequently took place in schools (**48.1%**; n=25). Other locations of events and their respective percentages are shown in **Figure 1.**

Figure 1. Locations of Outreach events, Fiscal year 2018-2019



- Were conducted in English (**100.0%;** n=52).
- Resulted in 16 mental health referrals and 6 substance abuse referrals.
- Resulted in 81 social service referrals **(See Figure 2).** An *individual* outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Referrals were made primarily to Food (**19.8%;** n=16), Housing (**18.5%;** n=15), Form Assistance (**16.1%;** n=13), Financial/Employment (**14.8%;** n=12), and Transportation (**11.1%;** n=9) services.

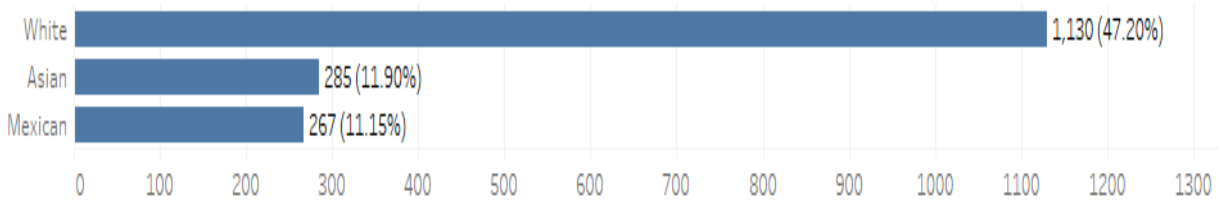
Figure 2. Social Service Referrals, Fiscal year 2018-2019



Outreach event attendees:

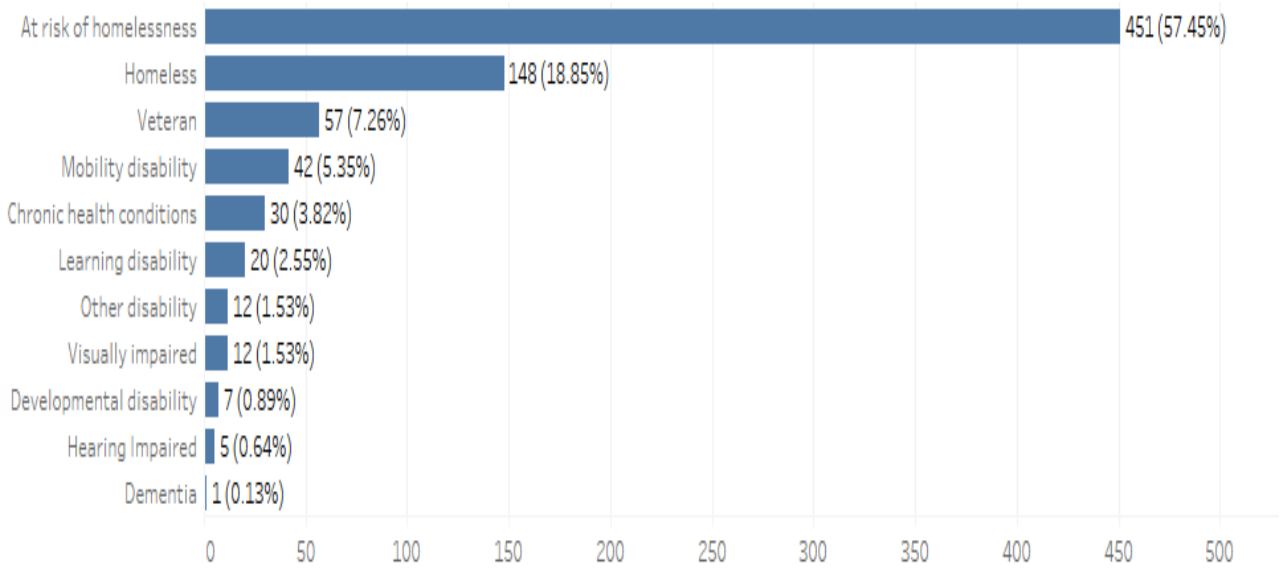
- Most often were female (**58.4%**; n=1,142). Thirty six percent were male (**36.2%**; n=707). There were 105 (5.4%) individuals who declined to state their sex at birth.
- Identified as Heterosexual (**49.4%**; n=966), Gay/Lesbian (**3.8%;** n=74), Bisexual (**0.8%;** n=15), or Questioning (**0.3%;** n=5). Forty six percent (n=895) declined to state their sexual orientation.
- Comprised of adults (26-59 year, **42.3%**; n=827), older adults (60+ years, **20.1%**; n=393), children (15 years and younger, **17.1%;** n=335), transition-age youth (16-25 years, **16.7%**; n=326), and those who declined to state their age (**3.8%;** n=75).
- Were primarily White (**47.2%**; n=1,130), Asian (**11.9%**; n=285), or Mexican (**11.2%;** n=267) **(See Figure 3).**

Figure 3. Attendees by Top Race/Ethnicity Category, FY 2018-2019



In FY 2018-2019, **40.2%** (N=785) Pacifica Collaborative attendees were in at least one special populations group. Special populations include those who are veterans, are homeless, are at risk of homelessness, are hearing impaired, are vision impaired, have dementia, have chronic health conditions, have a mobility disability, have a learning disability, or have a developmental disability. Out of the 785 service recipients in the special population group, **57.5%** were at risk of homelessness, **18.9%** were homeless, and **7.3%** were veterans (**See Figure 4)**.

Figure 4. Service recipients by Special Populations, FY 2018-2019



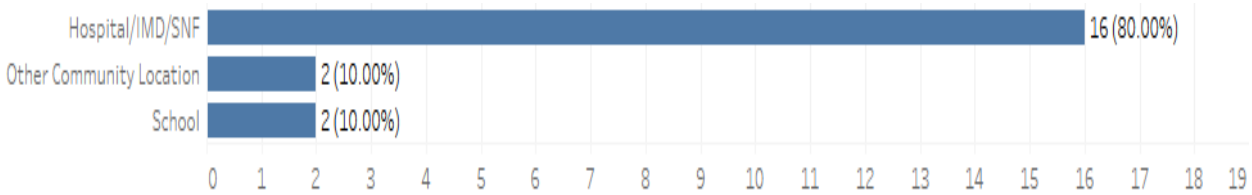
Appendix H. FY 2018-2019 Outreach, StarVista

For FY 2018-2019, Pacifica Collaborative reported a total of 20 outreach events, 13 individual outreach events, and 7 group outreach events. There were 115 attendees. Individual outreach events lasted from 60 to 90 minutes and lasted on average 70 minutes. Group outreach events lasted from 90 to 120 minutes and lasted on average of 111 minutes.

Outreach events:

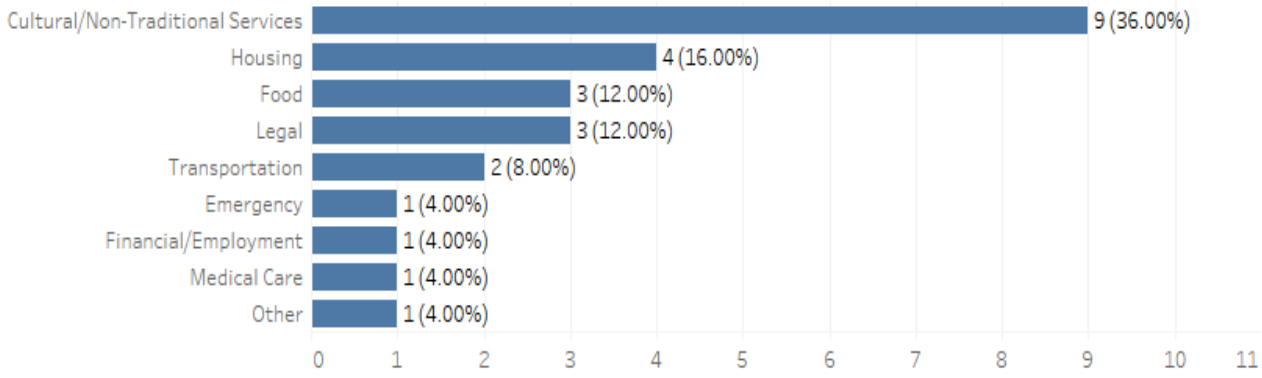
- Most frequently took place in a hospital/MD/SNF (**80.0%**; n=16). Other locations of events and their respective percentages are shown in **Figure 1.**

Figure 1. Locations of Outreach events, Fiscal year 2018-2019



- Were conducted in English (**35.0%;** n=7), Cantonese (**35.0%;** n=7), and Mandarin (**30.0%,** n=6).
- Resulted in 11 mental health referrals and 3 substance abuse referrals.
- Resulted in 25 social service referrals **(See Figure 2).** An *individual* outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Referrals were made primarily to Cultural/Non-Traditional (**36.0%;** n=9), Housing (**16.0%;** n=4), Food (**12.0%;** n=3), and Legal (**12.0%;** n=3) services.

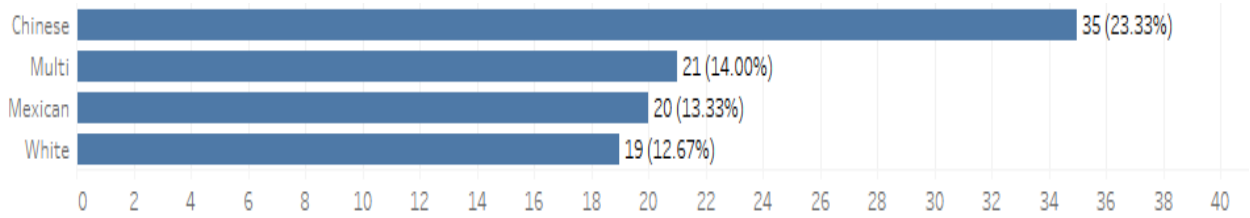
Figure 2. Social Service Referrals, Fiscal year 2018-2019



Outreach event attendees:

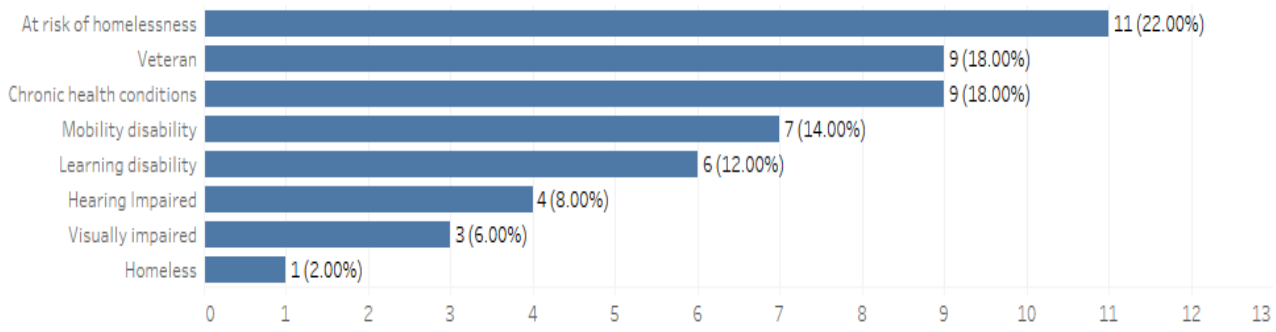
- Most often were female (**62.6%**; n=72). Thirty seven percent were male (**37.4%**; n=43).
- Identified as Gay/Lesbian (**22.1%**; n=38), Heterosexual (**21.5%**; n=37), Questioning (**21.5%;** n=37), Queer (**20.4%;** n=35), Pansexual (**9.3%;** n=16), Bisexual (**2.9%;** n=5), "Other" sexual orientation (**1.7%;** n=3), or declined to state their sexual orientation (**0.6%;** n=1).
- Were adults (26-59 year, **35.5%**; n=61), transition-age youth (16-25 years, **29.0%**; n=33), children (15 years and younger, **8.8%;** n=10), and older adults (60+ years, **8.8%**; n=10).
- Were primarily Chinese (**23.3%**; n=35), of more than one race (**14.0%**; n=21), Mexican (**13.3%;** n=20), or White (**12.7%**; n=19) **(See Figure 3).**

Figure 3. Attendees by Top Race/Ethnicity Category, FY 2018-2019



In FY 2018-2019, **43.5%** (N=50) StarVista attendees were in at least one special populations group. Special populations include those who are veterans, are homeless, are at risk of homelessness, are hearing impaired, are vision impaired, have dementia, have chronic health conditions, have a mobility disability, have a learning disability, or have a developmental disability. Out of the 50 service recipients in the special population group, **22.0%** were at risk of homelessness, **18.0%** were veterans, **18.0 %** had chronic health conditions, and **14.0%** had a mobility disability (**See Figure 4)**.

Figure 4. Service recipients by Special Populations, FY 2018-2019



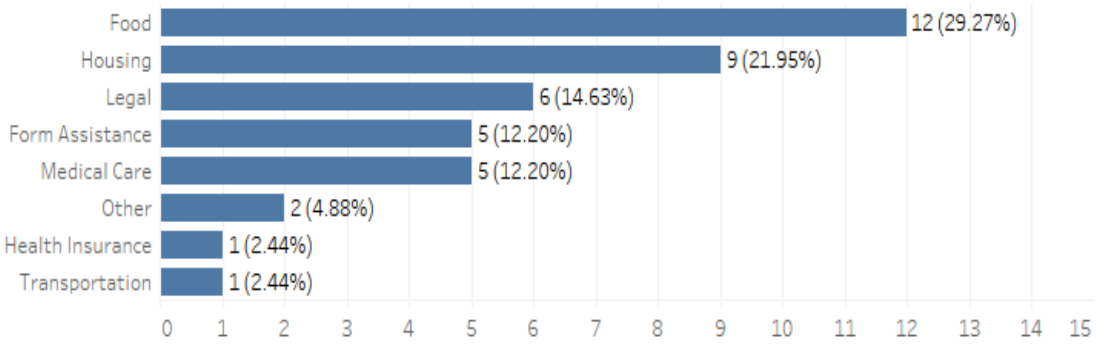
Appendix I. FY 2018-2019 Outreach, The Mouton Center

For FY 2018-2019, Mouton Center reported a total of 129 individual outreach events. They all lasted 30 minutes.

Outreach events:

- Took place in offices (**100.0%**; n=129).
- Were conducted in English (**99.2%;** n=128) and Tongan (**0.8%;** n=1).
- Resulted in 125 mental health referrals.
- Resulted in 41 social service referrals **(See Figure 1).** An *individual* outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Referrals were made primarily to Food (**29.3%;** n=12), Housing (**22.0%;** n=9), Legal (**14.6%;** n=6), Form Assistance (**12.2%;** n=5), and Medical Care (**12.2%;** n=5) services.

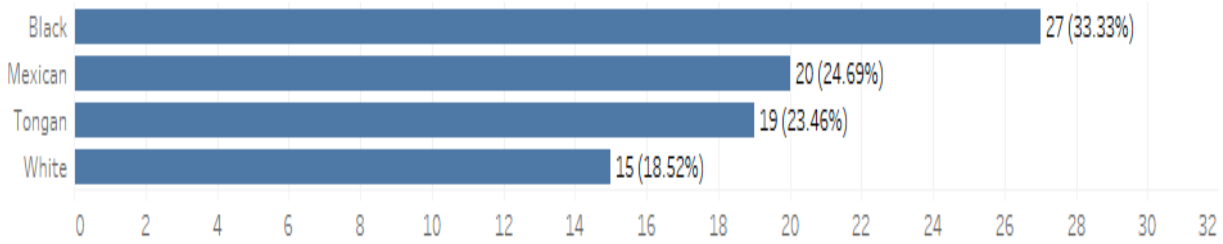
Figure 1. Social Service Referrals, Fiscal year 2018-2019



Outreach event attendees:

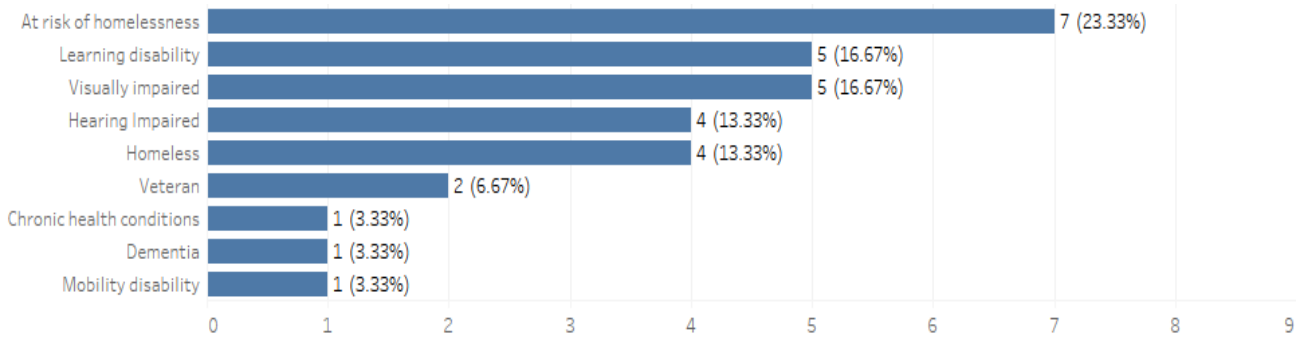
- Most often were female (**61.2%**; n=79). Thirty eight percent were male (**38.0%**; n=49) less than one percent declined to state sex at birth (**0.8%;** n=1).
- Identified as Heterosexual (**86.8%**; n=112) or Bisexual (**1.6%;** n=2). Twelve percent (11.6%; n = 15) declined to state their sexual orientation.
- Were adults (26-59 year, **58.5%**; n=72), older adults (60+ years, **21.1%**; n=26), and transition-age youth (16-25 years, **20.3%**; n=25).
- Were primarily Black (**33.3%**; n=27), Mexican (**24.7%**; n=20), Tongan (**19.0%;** n=19), or White (**18.5%**; n=15) **(See Figure 2).**

Figure 2. Attendees by Top Race/Ethnicity Category, FY 2018-2019



In FY 2018-2019, **23.3%** (N=50) StarVista attendees were in at least one special populations group. Special populations include those who are veterans, are homeless, are at risk of homelessness, are hearing impaired, are vision impaired, have dementia, have chronic health conditions, have a mobility disability, have a learning disability, or have a developmental disability. Out of the 30 service recipients in the special population group, **23.3%** were at risk of homelessness, **16.7%** had a learning disability, and **16.7 %** were visually impaired (**See Figure 3)**.

Figure 3. Service recipients by Special Populations, FY 2018-2019



Appendix J. Attendees by Race/Ethnicity by Collaborative, FY 2014-2019

	NCOC					EPAPMHO				
Race/Ethnicity	**2014-2015**	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**	**2014-2015**	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**
Black	152 (4.1%)	153 (3.2%)	200 (2.7%)	249 (3.1%)	155 (2.9%)	150 (9.1%)	205 (24.5%)	164 (23.8%)	200 (36.5%)	152 (23.2%)
White	930 (25.2%)	1502 (31.5%)	2394 (32.0%)	1981 (24.8%)	1464 (27.8%)	444 (26.9%)	82 (9.8%)	54 (7.8%)	47 (8.6%)	55 (8.4%)
American Indian	7 (0.2%)	48 (1.0%)	94 (1.3%)	67 (0.8%)	56 (1.1%)	0 (0.0%)	8 (1.0%)	5 (0.7%)	1 (0.2%)	2 (0.3%)
Middle Eastern	7 (0.2%)	60 (1.3%)	66 (0.9%)	114 (1.4%)	28 (0.5%)	0 (0.0%)	0 (0.0%)	1 (0.1%)	0 (0.0%)	0 (0.0%)
Eastern European	0 (0.0%)	0 (0.0%)	10 (0.1%)	12 (0.2%)	2 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
European	0 (0.0%)	0 (0.0%)	6 (0.1%)	8 (0.1%)	21 (0.4%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Mexican	147 (4.0%)	260 (5.5%)	1403 (18.7%)	816 (10.2%)	443 (8.4%)	43 (2.6%)	196 (23.4%)	90 (13.0%)	53 (9.7%)	156 (23.8%)
Puerto Rican	1 (0.0%)	6 (0.1%)	28 (0.4%)	4 (0.1%)	10 (0.2%)	1 (0.1%)	4 (0.5%)	0 (0.0%)	1 (0.2%)	2 (0.3%)
Cuban	0 (0.0%)	0 (0.0%)	9 (0.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.1%)	0 (0.0%)	0 (0.0%)	1 (0.1%)
Central American	0 (0.0%)	0 (0.0%)	79 (1.1%)	471 (5.9%)	32 (0.6%)	0 (0.0%)	0 (0.0%)	9 (1.3%)	7 (1.3%)	12 (1.8%)
South American	0 (0.0%)	0 (0.0%)	24 (0.3%)	51 (0.6%)	15 (0.3%)	0 (0.0%)	0 (0.0%)	1 (0.1%)	1 (0.2%)	1 (0.1%)
Caribbean	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Other Latino	192 (5.2%)	87 (1.8%)	N/A	N/A	N/A	228 (13.8%)	0 (0.0%)	N/A	N/A	N/A
Asian	N/A	N/A	20 (0.3%)	1025 (12.8%)	538 (10.2%)	N/A	N/A	0 (0.0%)	0 (0.0%)	0 (0.0%)
Filipino	336 (9.1%)	678 (14.2%)	804 (10.7%)	1000 (12.5%)	319 (6.1%)	248 (15.0%)	18 (2.2%)	17 (2.5%)	8 (0.1%)	9 (1.3%)
Chinese	96 (2.6%)	246 (5.2%)	308 (4.1%)	297 (3.7%)	200 (3.8%)	96 (5.8%)	2 (0.2%)	2 (0.3%)	0 (0.0%)	0 (0.0%)
Japanese	11 (0.3%)	30 (0.6%)	59 (0.8%)	55 (0.7%)	26 (0.5%)	3 (0.2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Korean	17 (0.5%)	29 (0.6%)	45 (0.6%)	34 (0.4%)	12 (0.2%)	4 (0.2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
South Asian	15 (0.4%)	16 (0.3%)	44 (0.6%)	70 (0.9%)	13 (0.2%)	11 (0.7%)	2 (0.2%)	2 (0.3%)	1 (0.2%)	2 (0.3%)
Vietnamese	1 (0.0%)	23 (0.5%)	13 (0.2%)	13 (0.2%)	7 (0.1%)	35 (2.1%)	2 (0.2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Cambodian	18 (0.5%)	1 (<0.1%)	0 (0.0%)	8 (0.1%)	2 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Laotian	0 (0.0%)	2 (<0.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.1%)	4 (0.5%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Mien	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Other Asian	37 (1.0%)	0 (0.0%)	N/A	N/A	N/A	4 (0.2%)	0 (0.0%)	N/A	N/A	N/A
Tongan	287 (7.8%)	237 (5.0%)	176 (2.4%)	61 (0.8%)	47 (0.9%)	172 (10.4%)	121 (14.5%)	121 (17.5%)	88 (16.1%)	97 (14.8%)
Samoan	280 (7.6%)	343 (7.2%)	347 (4.6%)	163 (2.0%)	189 (3.6%)	123 (7.5%)	90 (10.8%)	49 (7.1%)	35 (6.4%)	57 (8.7%)
Fijian	9 (0.2%)	24 (0.5%)	0 (0.0%)	8 (0.1%)	3 (0.1%)	1 (0.1%)	14 (1.7%)	3 (0.4%)	3 (0.5%)	5 (0.8%)
Hawaiian	31 (0.8%)	29 (0.6%)	40 (0.5%)	150 (1.9%)	108 (2.0%)	16 (1.0%)	7 (0.8%)	2 (0.3%)	5 (0.9%)	15 (2.3%)
Guamanian	10 (0.3%)	26 (0.5%)	24 (0.3%)	5 (0.1%)	0 (0.0%)	1 (0.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Multi	72 (2.0%)	414 (8.7%)	651 (8.7%)	407 (5.1%)	347 (6.6%)	39 (2.4%)	66 (7.9%)	74 (10.7%)	92 (16.8%)	86 (13.1%)
Other Race	402 (10.9%)	101 (2.1%)	151 (2.0%)	254 (3.2%)	136 (2.6%)	14 (0.8%)	2 (0.2%)	3 (0.4%)	4 (0.7%)	3 (0.5%)
Unknown Race	626 (17.0%)	446 (9.4%)	488 (6.5%)	671 (8.4%)	1098 (20.8%)	16 (1.0%)	12 (1.4%)	93 (13.5%)	2 (0.4%)	1 (0.2%)
Total**	**3684**	**4761**	**7483**	**7996**	**5271**	**1650**	**836**	**690**	**548**	**656**

Note: Percentages may not sum to 100% because of rounding. **Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported. N/A indicates the category was not available or discontinued during the specific fiscal year.

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APPENDIX 14 THREE-YEAR PEI EVALUATION REPORT, FY 2016-18

SAN MATEO COUNTY HEALTH

BEHAVIORAL HEALTH & RECOVERY SERVICES

PREVENTION & EARLY INTERVENTION EVALUATION

FY 2016/2017 & 2017/2018

EXECUTIVE SUMMARY

San Mateo County funded 20 program utilizing Prevention and Early Intervention fund during fiscal years (FY) 2016-2017 and 2017-2018. Most of SMC PEI programs are delivered by community-based providers and they serve children, adults, older adults as well as marginalized and diverse populations. Approximately 32,630 community members received services; and they ranged from trainings, psycho-education workshops, teacher consultations, summer employment, direct treatment to fun family events.

INTRODUCTION

OVERVIEW

Prevention and Early Intervention (PEI) is one of the five components of MHSA. This component has its own reporting requirements, the most updated reporting requirements were implemented June 2018 by the California Mental Health Services Oversight and Accountability Commission (MHSOAC). PEI targets individuals of all ages prior to the onset of mental illness, except for early onset of psychotic disorders. PEI emphasizes reducing the seven negative outcomes of untreated mental illness; suicide; incarceration; school failure or pushout; unemployment; prolonged suffering; homelessness; and removal of children from their homes.

PEI REGULATIONS

In June 2018, the PEI regulations were amended, and specific requirements were added that include indicators, data trackers, the explanation of a 3-year evaluation plan, annual evaluation report and the PEI component of a 3-year plan.

PROGRAM CATEGORIES

Prevention- Set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. Prevention program services may include relapse prevention for individuals in recovery from a serious mental illness.

Early Intervention- 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, including negative outcomes that may result from untreated mental illness. Early Intervention program services may include services to parents, caregivers, and other family members of the person with early onset of a mental illness as applicable. Services shall not exceed 18 months, unless the individual receiving 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.

Outreach for increasing recognition of early signs of mental illness- The process of engaging, encouraging, educating, and/or training and learning from potential responders (family, school personnel, peer providers, etc.) about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness. Outreach for increasing recognition of early signs of mental illness may include reaching out to individuals with signs and symptoms of a mental illness, so they can recognize and respond to their own symptoms.

Stigma and Discrimination reduction program- The County's direct activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and /or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services and to increase acceptance, dignity, inclusion and equity for individuals with mental illness, and members of their families.

Access to linkage and treatment program- A set of related activities to connect children, adults and seniors 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 (e.g. screening, assessment, referral, telephone help lines, and mobile response).

Suicide prevention program- Organized activities that the County undertakes to prevent suicide because of mental illness.

PEI STRATEGIES

All programs need to be designed and implemented to further at least one of these strategies:

Create access and linkage to treatment- See above definition

Timely access to mental health services for individuals and families from underserved population- To increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness received appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available, and cost of services. Services shall be provided in a convenient, accessible, acceptable, culturally appropriate setting.

Non stigmatizing and Non-Discriminatory Practices- Promoting, designing, and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services accessible, welcoming, and positive.

DATA SOURCES AND ANALYSIS

A mixed-methods research framework was used to conduct this evaluation plan and included both qualitative and quantitative data that was provided by our contractors and staff. While a standardization of data is our goal, currently there are some variations across programs that reflect staffing capacity, technology access and the differences between target populations. However, all our PEI programs have been implemented and designed to work towards reaching PEI goals consistent with MHSA legislation.

The data sources that were used for the completion of this report were the following:

1) ### MHSA ANNUAL REPORT TEMPLATES
   In 2017 a new MHSA annual report template was created to standardize information collected. Each contractor is responsible for completing this template on an annual basis. Currently the template collects metrics such as unduplicated number of clients served, demographics, outcomes as well as narrative regarding program activities, interventions, program successes and challenges. This template continues to be refined as we adhere to new PEI guidelines as well as customize to program needs.

2) ### KEY STAKEHOLDER INTERVIEWS
   Some of the data analysis and collection of PEI programs is done externally through a contract with the American Institutes for Research (AIR). To supplement this quantitative data analysis and give context to data collection key stakeholder interviews were conducted with these programs.

3) ### PROGRAM TRACKING LOGS AND SIGN-IN SHEETS
   Internal PEI programs use tracking logs and sign in sheets to document the number of clients, outreach, and referrals made. Some tracking sheets are also online through survey monkey and are analyzed by AIR.

4) ### PROGRAM TOOLS/SURVEYS
   Many of the PEI programs use pre-post test program surveys to collect outcome data as well as client satisfaction with the program. These surveys include Likert scales, open ended questions, and capture a variety of outcomes such as changes in attitude, knowledge, behaviors. Measures also capture the increase in protective factors to mental illness as well as social-emotional wellbeing and use of new skills. The use of pre

and post tests are being reviewed to make sure they align with the outcome metrics we hope to collect across programs.

5) PREVIOUS EVALUATION REPORTS

For fiscal years 2013-2014 as well as 2014-2015 an independent evaluation consultant was hired to evaluate MHSA funded programs. This consultant was able to evaluate whether programs were implemented efficiently, how effective the strategies were, the state of client satisfaction, responsiveness to target population, how programs advanced the MHSA vision as well as recommendations for improvement. This initial evaluation report served as a starting point for this evaluation plan.

OPPORTUNITIES FOR IMPROVEMENT

San Mateo County has had extremely limited organizational capacity due to the staffing of the MHSA team. Currently, the MHSA team includes the MHSA coordinator, and one Community Health Planner that assist with various MHSA administrative and programmatic duties. A dedicated PEI Coordinator would make it easier to monitor PEI data collection, oversight, as well as the structure and maintenance of new MHSA requirements and regulations. Contract monitoring for our some of our programs is done through clinical supervisors who are expected to meet with contractors regularly, however due to increased workloads, this is not always possible and places a strain on our workforce's ability to engage in meaningful oversight.

Additionally, another challenge we face is that there is no PEI database or centralized portal for data collection. This poses a challenge for data collection because different contractors and internal programs have varying levels of understanding when it comes to data reporting, measurements and the requirements for PEI funded programs. We can capture data with Electronic Health Records for other MHSA programs; however, these systems are not integrated into PEI programs. Furthermore, since there is no centralized system it is difficult to make comparisons from year to year effectively. This affects coordination and our ability to implement data driven quality improvement strategies that are needed across our system of care. Recently, through a local stakeholder planning process, $200,000 one-time available funds was allocated for this purpose and we look forward to implementing this priority next fiscal year (FY) 2020-21.

STRENGTHS

San Mateo County has implemented 19 different PEI programs, that provide services to a variety of target populations, are located across our county and work to prevent the negative outcomes associated with mental illness as well as severe mental illness. Our most current PEI budget for FY 2020-21 is $7 million with 51% allocation to Children and Transitional Age Youth (TAY) ages 0-25.

Additionally, as mentioned previously, SMC engaged in an evaluation process for FY 2013-2014 and FY 2014-2015. Programs have been added since then however, the recommendations from the evaluator enabled SMC to implement several changes that are the building blocks for systems change and is congruent with thoughtful PEI evaluation. Some of these changes include adding detailed evaluation requirements to the Request for Proposal (RFP) process. This section includes requirements for evaluation tools, data collection frequency and analysis. The contracting process has also changed, when our last evaluation occurred, many of the PEI contracts did not have deliverable requirements, now contracts include expectations of deliverables which include minimum numbers for outreach, groups, events, workshops, and presentations etc. The most recent contracts for new programs to be implemented in the future have included the requirement for client/family satisfaction with the program, specific validated scales to be used pre and post to collect data on outcomes and updated demographic forms for participants.

Another strength that was found when reviewing PEI programs is our compliance with the new regulations that state, that each PEI programs need to fall within each of the six strategies mentioned above. The PEI programs that have been implemented thus far also further the strategies required by the new regulations which are:

- Create access to linkage and treatment
- Timely access to mental health services for individuals and families from underserved populations
- Non-stigmatizing and non-discriminatory

Furthermore, within SMC the MHSA team is housed under the Office of Diversity and Equity (ODE), which results in all MHSA PEI programs being designed, implemented, and evaluated with an equity lens. The Office of Diversity and Equity serves Behavioral Health and Recovery services, but also influences and touches many parts of San Mateo County Health. Having MHSA housed under ODE enables the administrative team to stay close to community partners, stakeholders, as well as clients and family members. These sustained relationships have developed into meaningful partnerships that optimize our ability to stay connected to community so that the voice of marginalized communities is always at the center of all the work that is carried out; from the three-year planning process, the design and implementation of programs, needs assessments, as well as advance systems change policies.

MOVING FORWARD

Based on the findings of this report, some system improvement needs, oversight limitations and data collection needs have been identified. First, we acknowledge that currently we do not have the staffing or structure to carry out an evaluation internally. To be able to comply with the new PEI requirements below are some action steps that need to be implemented to make the evaluation of PEI programs sustainable, meaningful and community centered. There are

several programs in this report that use the number of clients served as their only outcome. The data reporting for these programs is out of compliance with new regulations that ask for specific metrics such as # of referrals, time from initial contact to engaging in services etc. Below are the action steps that SMC will take to ensure that data collection of the PEI programs is in compliance and used meaningfully to evaluate success, as well as improvement.

- CONTRACT AN EXTERNAL EVALUATOR: Due to limited staffing capacity, an evaluator from an outside agency will be contracted to guide the PEI evaluation process, outcomes, and implementation of tools. They will work with PEI administration staff to meet with contract monitors, contract agencies, establish and implement outcome metrics for each of the programs. The standardized outcome template will be changed to reflect specific data requirements. The outcome metrics will be developed with contractors, clients/family members as well as staff to ensure outcomes that they are representative of the work being done, that they fulfill the PEI requirements and are meaningful to the community. This will enable us to develop an evaluation plan that is culturally competent and includes the perspective of diverse people with lived experience.

- HOLD REGULAR MEETINGS WITH CONTRACT MONITORS: These meetings will be held with each of the contract monitors to update and provide them with the new PEI regulations. It will enable us to gain understand as to their involvement with the contractor, familiarity with the data requirements and establish oversight procedures for data collection.

- HOLD REGULAR MEETINGS WITH PEI PROGRAMS AND CONTRACT AGENCIES: These meetings will be held with each of the contractors regarding implementation, data collection and analysis. One of the recommendations from our previous evaluator was that contract agencies needed training on data collection. These preliminary meetings will serve to gauge the capacity of the agency, obtain feedback on outcome measures and tools proposed, creation of a PEI data base, and review of the new PEI guidelines as well as updated expectations and potential contract amendments.

- DEVELOP A PEI DATABASE: Currently, data collection is not standardized. Many programs submit annual reports with quantitative data that changes from year to year based on their capacity/turn over and many outcomes are based on what the agencies deem to be meaningful at the time. With the standardization of outcome metrics and reporting, as well as a centralized data base, it will enable us to make data driven systems improvements, compare year to year outcomes and comply with PEI regulations.

- CREATE PROTOCOLS: Formal written protocols are needed for PEI programs, these protocols would include communication of PEI requirements, clear expectations of what needs to be completed by each program, who is responsible for each task assigned, as well as timelines for all activities. These protocols would specify the expectations

around data collection, the role of the contract monitors and reporting expectations, such as quarterly reports, and annual reports for programming.

PREVENTION AND EARLY INTERVENTION AGES 0-25

The following programs serve children and transitional age youth 0-25 exclusively. Some programs serve both populations. The MHSA guidelines require 19% of spending to fund PEI and of that 51% of the PEI budget is required to fund programs for children and youth. In San Mateo County there are five programs that serve this age group. Other programs in our PEI category also serve this age group, however it is not exclusively. These programs serve several special populations and are found in geographically underserved areas of the county. These programs include consultations with teachers, parents, workshops, outreach as well as employment.

PEI Ages 0-25

- Early Childhood Community Team (ECCT)
- Project SUCCESS
- Seeking Safety
- Teaching Pro Social
- Crisis Hotline, Youth Outreach and Intervention Team

910 total clients served

EARLY CHILDHOOD COMMUNITY TEAM

ECCT employs both prevention (60%) and early intervention (40%) strategies. ECCT incorporates several major components that build on current models in the community, to support healthy social emotional development of young children.

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, geographically isolated community. 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.

METHODS

ECCT is a program with three service modalities some of which are evidence based and others are promising practices.

PROGRAM STRATEGIES

Timely Access to Mental Health Services for Individuals and Families from Underserved Populations

Non-Stigmatizing and Non-Discriminatory Practices

PROGRAM HIGHLIGHTS

213 clients served

39 teachers served

51 families received mental health services

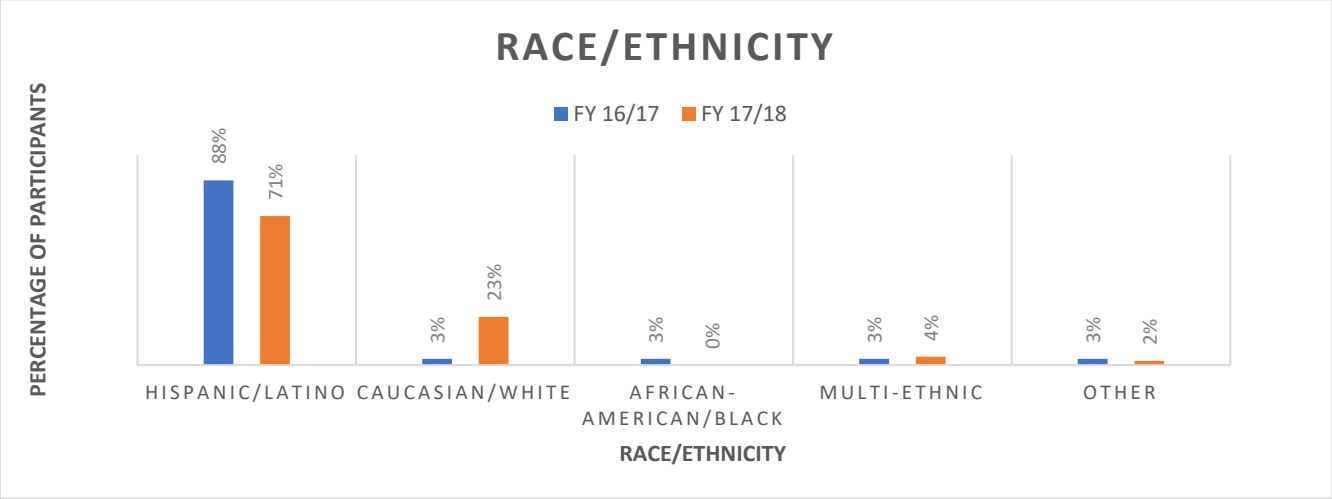
50 children and their families received weekly child-parent psychotherapy services

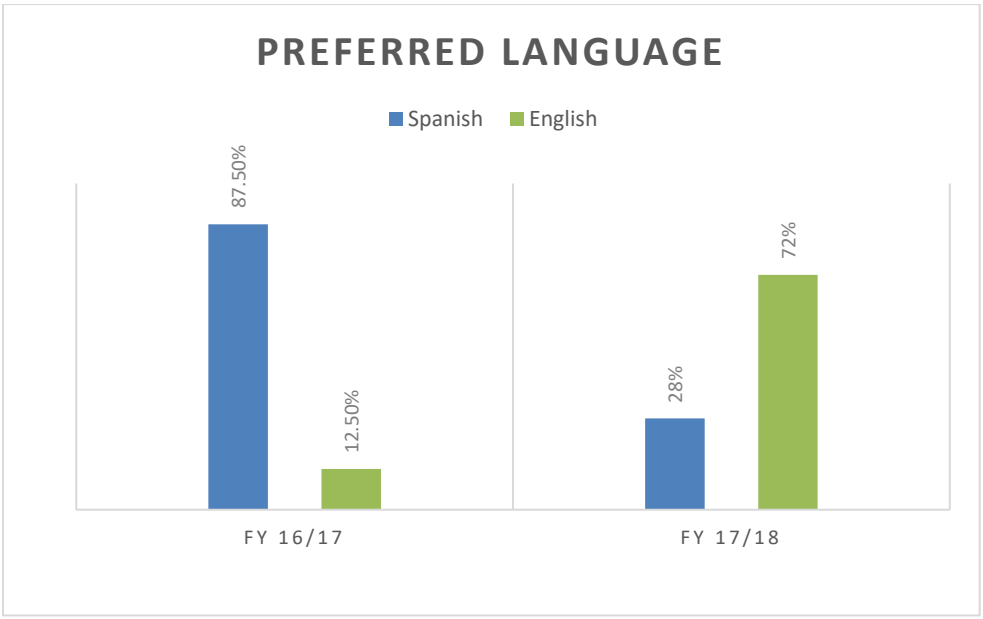
18 families received intensive case consultation

DEMOGRAPHIC DATA

EECT served 213 clients in fiscal years 16/17 and 17/18. The demographic data in this section represents unduplicated data provided by those who were active in the program. The data shows that those who were most served were Latinos, as well as Spanish speakers. This is

congruent with the programs target population, as well as county wide demographic data that shows that Latinos from this region experience mental health challenges at a higher rate than other ethnic groups.





OUTCOMES

ECCT tracks outcomes via the Child Behavioral Checklist that is filled out by the client's teachers, teacher satisfaction surveys, parent satisfaction surveys as well as informal conversation and observation. It has been a challenge obtaining high survey participation from parents.

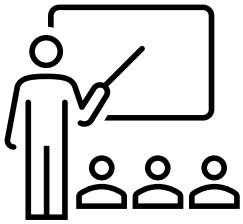
TEACHER SATISFACTION SURVEY RESULTS

FY 16/17

% of Respondents that Reported:	
Consultation was very effective in helping them think about children's development and behavior	93%
Consultation was very effective or effective in contributing 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 understand a family's situation and its effects on the child's current behavior	86%
Consultation was very effective or effective in helping them apply what they learned about a specific child to other children	100%

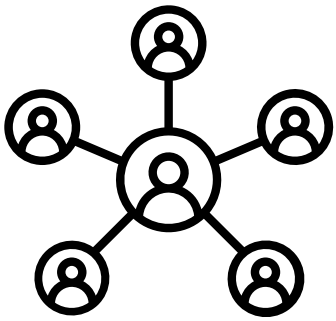
FY 17/18

% of Respondents that Reported:	
Consultation was very effective or effective in contributing to their willingness to continue caring for a specific child with challenging behaviors	92%
Consultation was very effective or effective in helping them in their relationship with this child's family	91%
Consultation was very effective or effective in helping to relieve some of the pressure in responding to the family's needs.	92%
Consultation was very useful or very useful in thinking with them about supporting all children in their classroom.	92%
Consultation was very useful or useful in helping them think about children's engagement in classroom activities.	92%



All teachers reported a greater ability to understand and respond to the social-emotional needs of children in their centers

FAMILY CENTERED OUTCOMES



18 families have increased their capacity to understand their child's behaviors and respond effectively to their social-emotional needs

22 families reported an improvement in multiple areas related to the child's development and/or behavior

100% of families that engaged in parenting education reported an improvement in their child's behavior

QUALITATIVE DATA

"A mother became much more engaged [after services] speaking to teachers more often, spending more time at school, expressing a wider range of affect and greater involvement with her child"

PROJECT SUCCESS

Project SUCCESS, or Schools Using Coordinated Community Efforts to Strengthen Students, is a research-based program that uses interventions that are effective in reducing risk factors and enhancing protective measures.

Project SUCCESS is designed for use with youth ages 9-18 and includes parents as collaborative partners in prevention through parent education programs. Clinical staff trained in culturally competent practices ran all the groups. The school district's small size provides an opportunity for every student in the district, ages 9-18, to participate in one or more Project SUCCESS activities. All groups were offered in English and in Spanish.

METHODS

Project SUCCESS is a SAMHSA model program that prevents and reduces substance use and abuse and associated behavioral problems among high risk; multi-problem youth ages 9-18. It is an evidence-based program.

PROGRAM STRATEGIES

Create Access to Linkage and Treatment

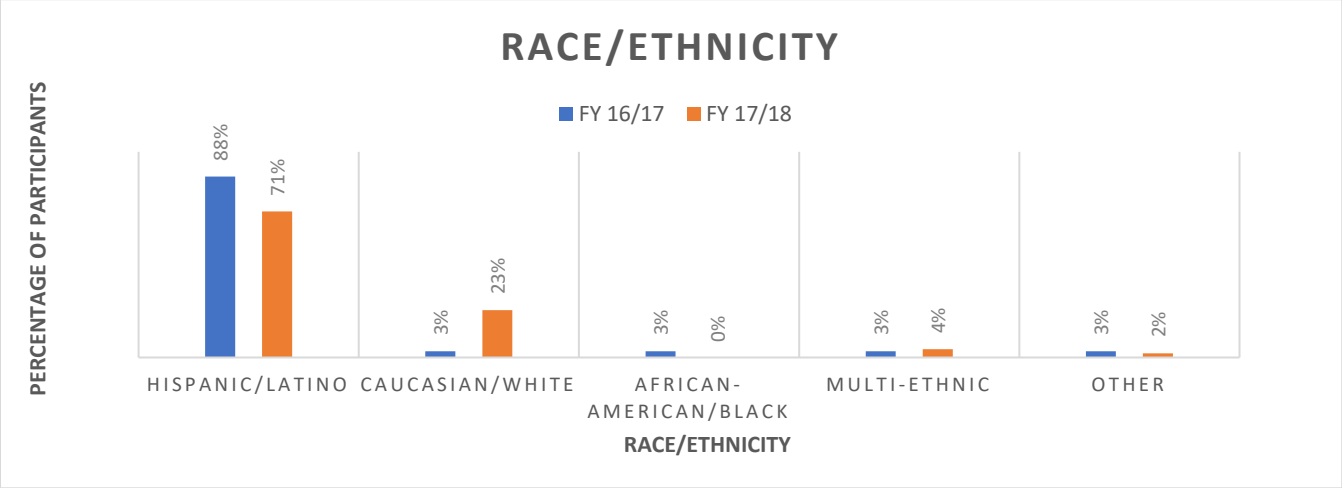
PROGRAM HIGHLIGHTS

222 clients served

84 families served

DEMOGRAPHIC DATA

Project SUCCESS served 222 clients in fiscal years 16/17 and 17/18. The demographic data in this section represents unduplicated data provided by those who were active in the program. The data shows that those who were most served were Latinos. This is congruent with the programs target population, as well as county wide demographic data that shows that Latinos from this region experience mental health challenges at a higher rate than other ethnic groups.



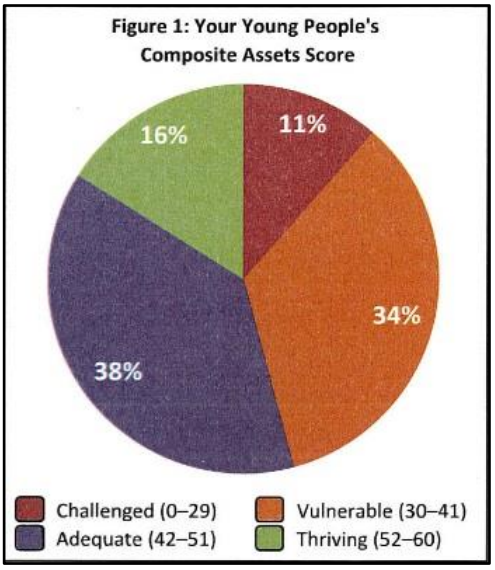
OUTCOMES

Project SUCCESS tracks outcomes via the Developmental Asset Profile that is filled out by the students and analyzed by the Search Institute. The Developmental Asset profile incorporated 40 developmental assets framework that addresses the needs of young people in the community. This survey focuses on understanding the strengths and supports (or Developmental Assets) that young people experience in their lives. These assets are tied to young people making positive life choices. Research has shown that youth with higher level of assets are more likely to; do better in school, be prepared for post-high school graduation and careers, contribute more to their communities and society and avoid high risk behaviors, such as violence, substance abuse and sexual activity.

COMPOSITE ASSETS SCORE

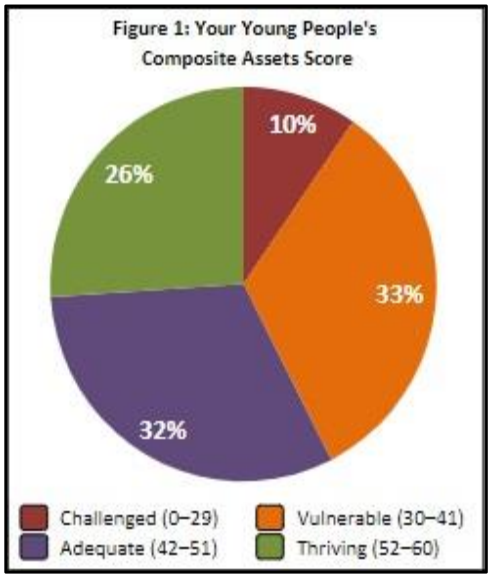
This score shows the percentage of youth who fall into four levels based on their survey results, each score is out of 60: challenged (0-29); vulnerable (30-41); adequate (42-51); and thriving (52-60).

FY 16/17



54% of the youth scored in the adequate and thriving level, and about 11% of the youth scored as challenged. This composite score sheds light on the foundation of assets that youth have. A further look at the data suggests that the groups that have the lowest composite scores are Latinos (40.3) as well as 8th graders and 11th graders which mark years of transition.

FY 17/18



58% of the youth scored in the adequate and thriving level, and about 1-% of the youth scored as challenged. A further look at the data suggests that the groups with the lowest composite scores are Latinos (36.7) as well as 8th graders and 10th graders.

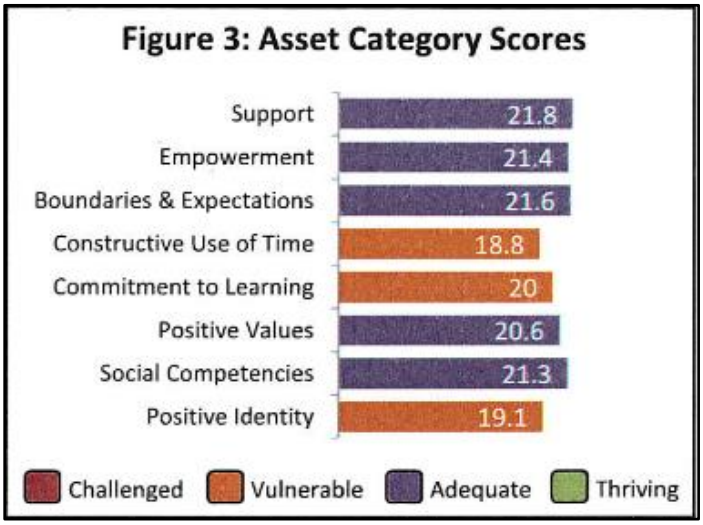
ASSET CATEGORY SCORES

The framework of the Developmental Assets is organized into eight categories which are shown below. These categories represent key supports (external assets) and strengths (internal assets) that young people need to have and develop in order to thrive. The external assets are relationships and opportunities provided by family, school, and community. The internal assets are internal values, commitments, skills, and self-perception that young people develop within

themselves that lead to self-regulation, internal motivation, and personal character. A youth who can make positive life choices, need to have both external and internal assets.

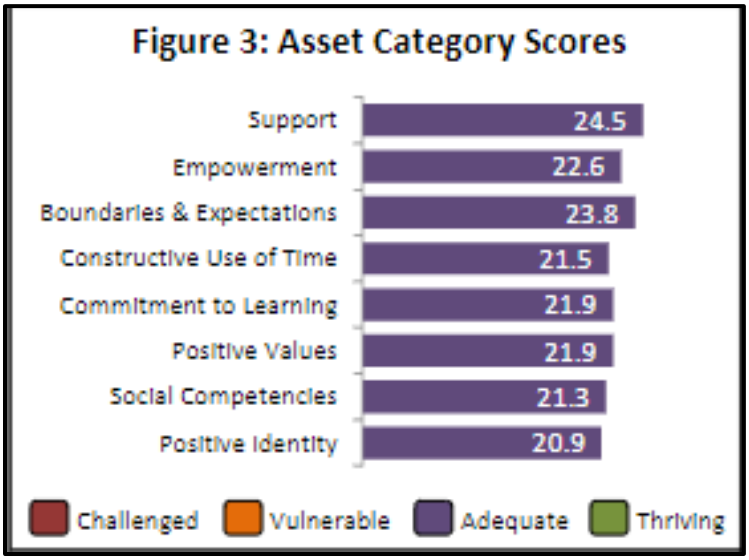
THE EIGHT CATEGORIES OF DEVELOPMENTAL ASSETS	
External Assets	**Internal Assets**
SUPPORT Young people need to be surrounded by people who love, care for, appreciate, and accept them.	**COMMITMENT TO LEARNING** Young people need a sense of the lasting importance of learning and a belief in their own abilities.
EMPOWERMENT Young people need to feel valued and valuable. This happens when youth feel safe and respected.	**POSITIVE VALUES** Young people need to develop strong guiding values or principles to help them make healthy life choices.
BOUDARIES AND EXPECTATIONS Young people need clear rules, consistent consequences for breaking rules, and encouragement to do their best.	**SOCIAL COMPETENCIES** Young people need the skills to interact effectively with others, to make difficult decisions, and to cope with new situations.
CONSTRUCTIVE USE OF TIME Young people need opportunities—outside of school—to learn and develop new skills and interests with other youth and adults.	**POSITIVE IDENTITY** Young people need to believe in their own self-worth and to feel that they have control over the things that happen to them.

FY 16/17



The survey results show that the relative areas of strength are Support, Boundaries and Expectations. The areas that are not as strong are Positive Identity, Commitment to Learning, and Constructive Use of time. When analyzing the data more closely, Latino youth struggle with Positive Identity the most.

FY 17/18



The survey showed that the relative areas of strength are Support and Boundaries and Expectations. The categories that are not as strong are Social Competencies and Positive Identity. When analyzing the data more closely, Latinos continue to struggle with Positive Identity more so than any other asset category.

Project SUCCESS has increased the composite asset scores as well as the asset category scores for the past two years. These results show that the foundations for youth assets is continuing to strengthen as youth go through the program. Puente was also able to extend their programs to all 5th to 12th graders in the school districts of Pescadero and La Honda, which gives the agency the potential to touch all the students in these school districts.

QUALITATIVE DATA

Our families struggle with domestic violence, sexual abuse, family drug and alcohol abuse, and for many of our migrant families who are monolingual Spanish, their children learn English and are then expected to take on enormous amounts of responsibility. Our programs give families access to tools like mental health, referrals, and parent education in their own communities.

SEEKING SAFETY

Seeking Safety is a curriculum that focuses on environmental and treatment solutions for substance use and Post-Traumatic Stress Disorder and relies on strong case management direction and referrals to community resources. Seeking Safety groups address the needs of this age group by utilizing a developmental framework that provides general supports for young adults, such as safety, relationship building, youth participation, community resources, and skill building. By incorporating these practices into the group framework, youth learned to build upon internal and external assets which are essential for a healthy transition to young adulthood. The age group for this program is Transitional Age Youth 18 to 25.

METHODS

Seeking Safety is an evidence-based program that is a present-focused model to help people attain safety from trauma and/or substance abuse. It is a safe model as it addresses both trauma and substance use, but without requiring clients to delve into trauma narrative.

PROGRAM STRATEGIES

Timely Access to Mental Health Services for Individuals and Families from Underserved Populations

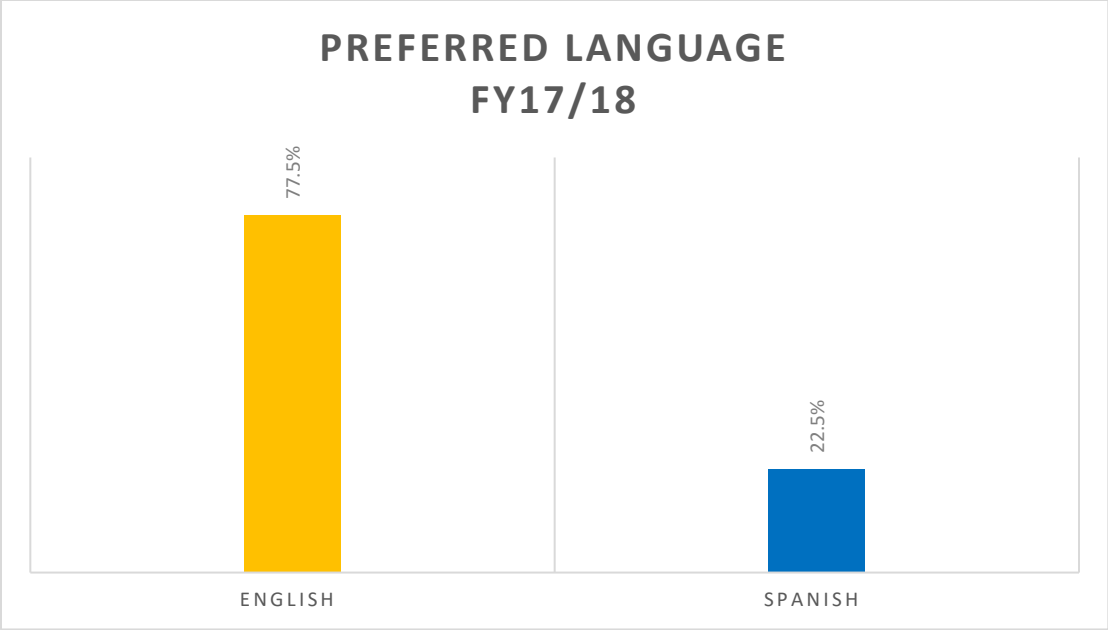
PROGRAM HIGHLIGHTS

113 clients served

265 groups were held serving TAY

DEMOGRAPHIC DATA

Seeking Safety served 113 youth in fiscal years 16/17 and 17/18. They did not collect any race/ethnicity demographic data for the dates that this report covers. Additionally, the Seeking Safety program was ended in June 2018. From preliminary data shared with us, most of the participants identified as cis gendered male.

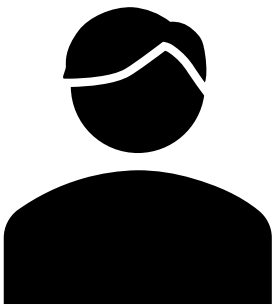


The language preference data shows that most of the participants were English speaking, however over 20% were Spanish speakers. When looking closely at the data, most of the Spanish speakers accessed this program in Redwood City versus Halfmoon Bay. In FY 16/17 the data read that in Redwood City 70% of participants were bilingual and in Halfmoon Bay 100% were bilingual.

OUTCOMES

This program was able to provide us with only qualitative data for their evaluation in the form of a client story.

QUALITATIVE DATA



Mark is a 24-year-old, single, Latino male. He had multiple arrests including, felonies. He went to El Centro to receive treatment for his substance abuse to methamphetamines, heroin, cannabis, and alcohol.

He attained abstinence form all drugs through treatment and guidance of the program. He signed up for college courses, re-established relationships with his family and found housing as well as employment.

After 10 months he completed his outpatient program, and both his Fall and Spring college courses with passing grades. Has strengthened his relationship with his family and has built a foundation for recovery.

"The encouragement, support and guidance that he received at El Centro have empowered him and enabled him to build a stronger foundation for himself"

TEACHING PRO SOCIAL

The purpose of TPS is to help elementary school children learn pro-social skills to improve their social and behavioral functioning in school. TPS serves children in San Mateo County where Family Resource Centers (FRC) are located, and these centers include mental health programming. FRC's are available at schools that have high needs among the student population and a lack of other resources available to the broader community. Underserved students face greater academic and social struggles and benefit from a pro social skills group that is culturally sensitive.

METHODS

TPS is a ten-week program that uses "skill streaming" an evidence-based, social skills training program designed to improve students' behaviors, replacing less productive ones.

PROGRAM STRATEGIES

Timely Access to Mental Health Services for Individuals and Families from Underserved Populations

Non-Stigmatizing and Non-Discriminatory Practices

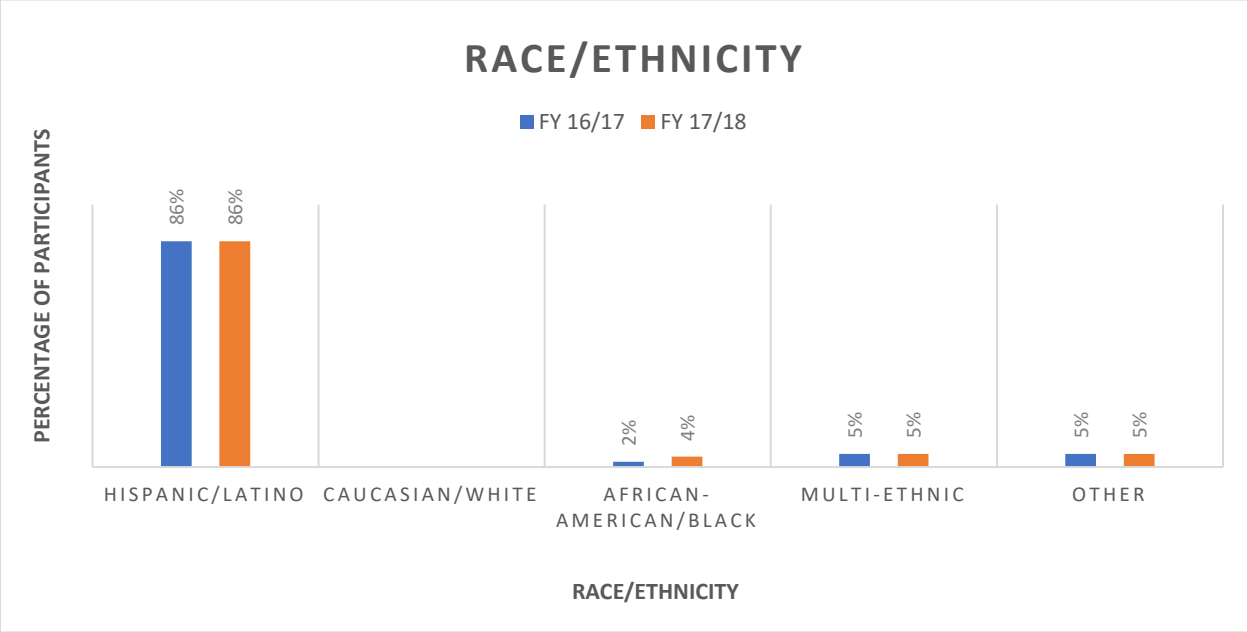
PROGRAM HIGHLIGHTS

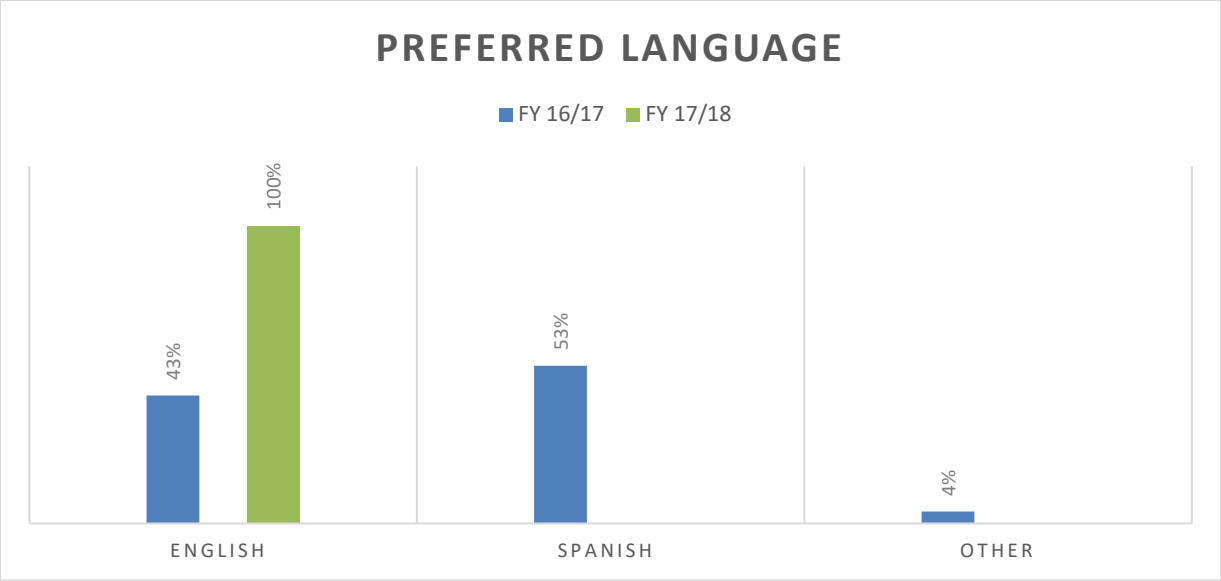
132 clients served

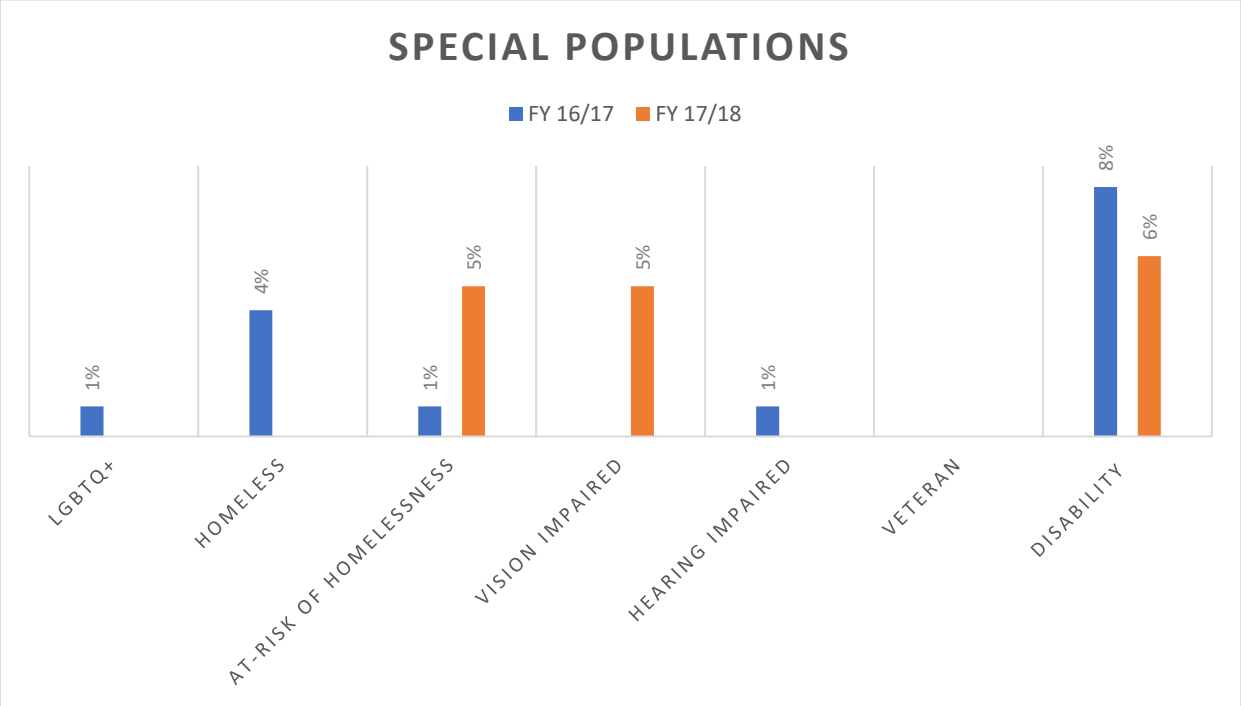
28 groups implemented at family resource centers

DEMOGRAPHIC DATA

TPS served 152 clients in fiscal years 16/17 and 17/18. The demographic data in this section represents unduplicated data provided by those who were active in the program. The data shows that those who were most served were Latinos. Additionally, in fiscal year 16/17 there was more of a demand for Spanish sessions. TPS is implemented by bilingual staff. The most prevalent special populations were homeless, risk of homelessness, and those with a disability.





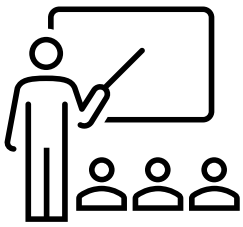


OUTCOMES

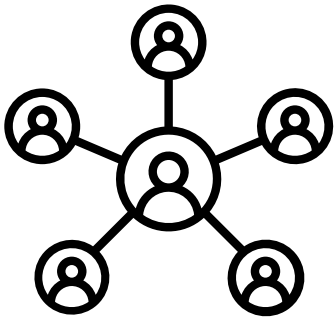
Students are referred to TPS by their teachers, who fil out the streamlining teacher behavior checklist. This tool is a 60-item survey that asks teachers to rank 60 positive behaviors, then based off this survey the curriculum for the groups are implemented in a series of six to ten sessions each semester. The teachers choose their top 10 social skills from the survey and they pretest their students in each skill included in the curriculum and then fill out a post-test after. Satisfaction surveys are also used, for the parents and teachers.

GROUPS

Family Resource Center Site	Number of groups		Number of Participants	
	FY 2016/2017	FY 2017/2018	FY 2016/2017	FY 2017/2018
Taft	1	1	4	4
Hoover	3	1	14	3
Fair Oaks	1	1	4	6
Belle Haven	3	4	0	23
Brentwood	2		9	
Bayshore	2	2	13	12
Sunset Ridge	2		13	
LEAD	3		19	
Puente		2		8
Total	17	11	76	56



Lead facilitators observed significant behavior changes among students in areas of: understanding and coping with their feelings, dealing with anger, apologizing, empathy and self-control. Improvements in scores between pre and post test indicate progress for the majority of participants

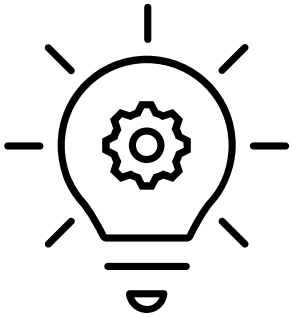


Consistent communication among facilitators, teachers, school staff, and parents

Positive behavior changes such as friendship making skills, and aggression

TPS homework was completed with more frequency due to higher parent involvement

FEEDBACK



- Teachers requested that groups be provided more frequently such as twice per week and held at varied times so a student would not miss too much for one class
- Weekly emails informing teachers what skill was taught that week so they could support the skill in class

POSSIBLE OUTCOME METRICS

- Improve performance in school
- Increase awareness of mental health wellness and recovery
- Reduce stigma

YOUTH CRISIS RESPONSE & PREVENTION

The Crisis Intervention & Suicide Prevention Center (CISPC) has four components with the sole purpose of providing crisis and suicide support to all ages of the SMC community. The four components include: a 24/7 Crisis Hotline, a youth website and teen chat service, outreach and training and mental health services. This team employs both early intervention (70%) and prevention (30%).

METHODS

Youth Crisis Response and Prevention is an evidence-based practice withs components embedded that are promising practices.

PROGRAM STRATEGIES

Create Access to Linkage and Treatment

PROGRAM HIGHLIGHTS

277 new cases for case management consultation

388 sessions provided for case management/follow up consultation

21,721 calls received and answered

139 interventions with new youth

DEMOGRAPHIC DATA

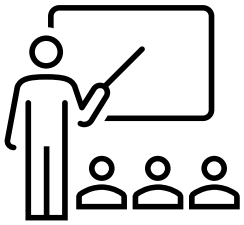
Youth Crisis Response and Prevention did not report any demographic data for FY 16/17 or 17/18.

OUTCOMES

The CISPC program impacts the health outcomes of clients served in several ways including; the reduction of stigma, talking non-judgmentally about mental illnesses, mitigating undiagnosed mental illnesses, prevention and early recognition for youth, and suicide prevention. Below is the quantitative data recorded for delivery of each service.

CASE MANAGEMENT/FOLLOW-UP PHONE CONSULTATION (youth and adults)	FY 16/17	FY 17/18
# of new cases	132	145
Total # of sessions provided	202	186
YOUTH OUTREACH INTERVENTIONS (evaluations at school sites)		
# of initial interventions (new youth served)	91	48
# of follow up sessions with youth	165	131
# of follow up contacts w/ collateral contacts	154	226
CLINICAL TRAINING/SUPERVISION (youth and adults)		
hours provided (including prep. time)		77
number of trainings attended		11
CRISIS HOTLINE & CHAT ROOM		
Number of calls	10574	11147
Total Number of Chatters (group &/or private)		2
Teen Chat Room # of Private Chats this month		115

OUTREACH PRESENTATIONS		
# of presentations	72	90
# of people served	5609	8533
School-Community Training in Suicide Prevention (# of presentations, the number served is captured on separate worksheet)	70	81



Reduction of stigma associated with mental illness through psychoeducational presentations, working with clients in crisis, and conversations with hotline callers

QUALITATIVE DATA

A mother called the mental health clinician concerned about her adolescent son who was suicidal. The clinician assessed the child and began short term therapy when it was clear there was no immediate risk. His main source of stress was school, he needed an IEP. The clinician helped him and his mother through that process. His suicidal thoughts decreased to zero.

College student called the hotline in distress and shared how she was struggling and the self-harm she was inflicting on herself because of stress. Volunteer was able to offer support, and tools. The caller was able to feel better and expressed her gratitude with the service.

POSSIBLE OUTCOME METRICS

- Increase access to timely care
- Increase access to early mental health services
- Reduce stigma

EARLY INTERVENTION

The following programs are Early Intervention programs. These programs provide treatment and other services and interventions including relapse preventions, to address and promote recovery and related functional outcomes for a mental illness early in its emergence. Programs in this category include emergency response teams, referrals, as well as programs.

Early Intervention

- Early Psychosis Program- Re(MIND)/BEAM
- Primary Care Interface
- SMC Mental Health Assessment and Referral Team

9347 Clients served

EARLY PSYCHOSIS PROGRAM-RE(MIND)

Re (MIND) identifies and intervenes with individuals experiencing a recent onset episode of psychosis. By intervening early with evidence based, culturally responsive, and comprehensive assessment and treatment, the impact of psychosis can be transformed and treated to remission. The program provides treatment and support for the client and family through an intensive outpatient model of care.

METHODS

Early Psychosis- Re (MIND)/BEAM integrated five evidence-based practices into a single treatment approach.

PROGRAM STRATEGIES

Timely Access to Mental Health Services for Individuals and Families from Underserved Populations

Non-Stigmatizing and Non-Discriminatory Practices

PROGRAM HIGHLIGHTS

214 clients served

3,271 sessions of Cognitive Behavioral Therapy for Early Psychosis (CBTp)

538 sessions of Family Support Services

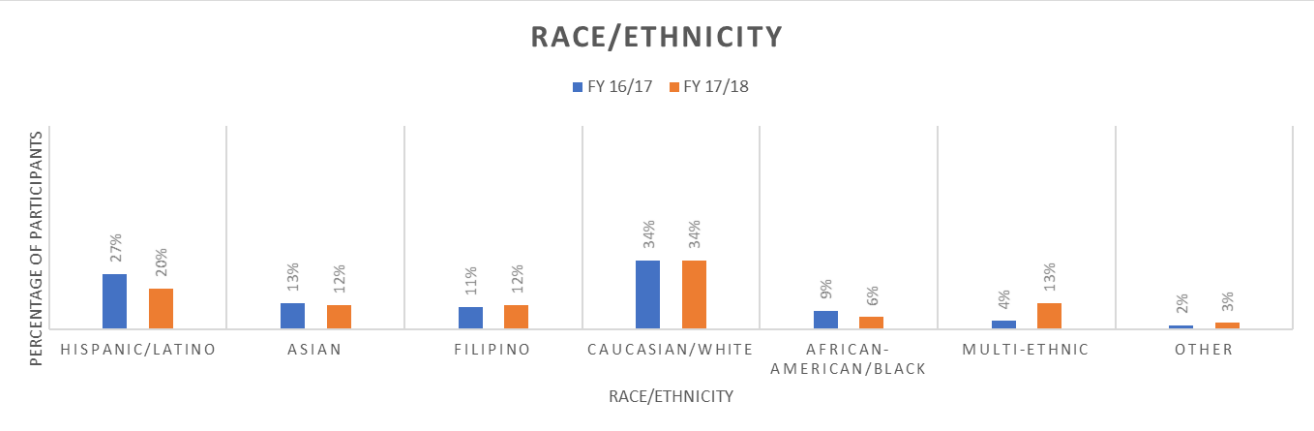
645 sessions of Peer Support Services

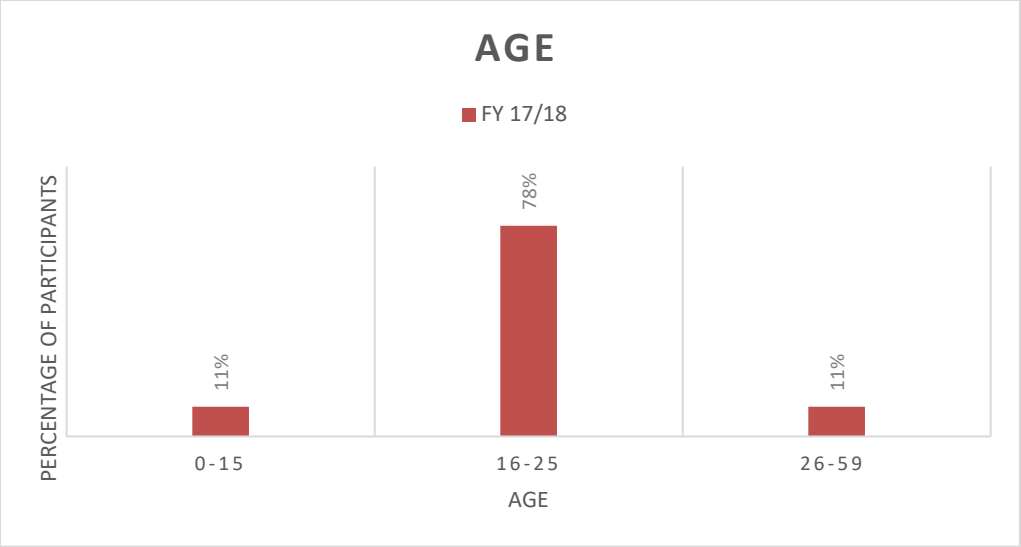
1,568 sessions of Education/Employment & Case Management

830 medication management consultations

DEMOGRAPHIC DATA

Re (Mind)/BEAM served 214 clients in FY 16/17 and 17/18. The racial group that is most represented in services are the Caucasian/white population. Most clients were 16-25 years old.



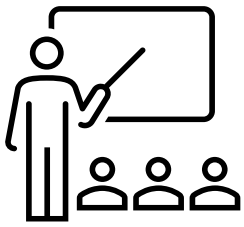


OUTCOMES

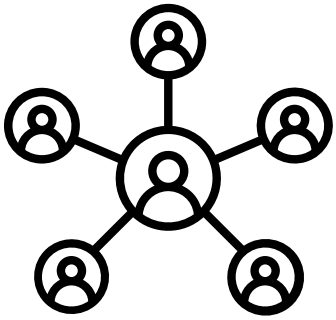
The BEAM program is evaluated via a series of surveys that include, California Department of health Care Services Consumer Perception Survey to evaluate participants satisfaction and quality of life. Hospitalization data are collected through the county database (AVATAR) and entered into Felton's EHR database. Medication adherence and symptom reduction data is collected using the Adult Needs and Strengths Assessment (ANSA). Supportive Employment and Education Services (SEES) are tracked via an internal tracker to provide education and employment data for participants. SEES staff and Director work to update the spreadsheets and database monthly. As seen below the PREP program was changed to BEAM halfway through 17/18. However, both programs saw positive outcomes in hospitalization reduction, medication adherence increase, vocational and educational engagement, and service satisfaction.

Overall, the outcomes show that clients who participate in this program experience reduced acute hospitalizations, increase their medication adherence, and can engage in part time or full-time school or work. Additionally, the great majority are satisfied with services and report an increase in quality of life due to this program.

Evaluation Metrics	16/17	Prep 17/18	BEAM 17/18
Hospitalizations			
Participants with prior hospitalizations (12 months from enrollement) that experienced a reduction in acute hospitalizations within the first 12 months of	59%	53%	93%
Participants experienced a reducation in days hospitalized	59%	56%	60%
Participants with no history of hospitalizations (12 months from enrollment) that continued to not have hospitalizations within the first 12 months of engagement		19%	40%
Employment and Educational Engagement			
Participants engaged in part-time or full-time work during their first year of treatment	44%	86%	87%
Medication Adherence			
Participants that either imporved or maintained high medication adherence with an ANSA score of 1 or 0	71%	69%	
Symptom Reduction			
Participants that demonstrated an improvement or maintained low symptom serverity in psychosis			47%
Participants that demonstrated an improvement or maintained low symptom serverity in depression			80%
Service Satisfaction			
Agreed or strongly agreed that they found services to be satisfactory		96%	100%
Agreed or strongly agreed that as a direct result of services they received they feel more effective at handling daily life		78%	100%



Implementation of a Quarterly Community Advisory Board that has met three times and included participation of family members and staff. Board gives stakeholders the opportunity to inform the service delivery system and better meet the needs of the community especially cultural needs



Development of new peer and family activity groups to foster connection and recovery. Additional weekly social networking/ activity group and biweekly teen and adult peer support group.

PRIMARY CARE INTERFACE

Primary Care Interface focuses on identifying persons in need of behavioral health services in the primary care setting. BHRS clinicians are embedded in primary care clinics to facilitate referrals, perform assessments, and refer to appropriate behavioral health services if deemed necessary. The model utilizes essential elements of the IMPACT model to identify and treat individuals in primary care who do not have Serious Mental Illness (SMI) and are unlikely to seek services from the formal mental health system. This program also provides services to those with ACE coverage who otherwise would not be able to access these services. Services include harm reduction, psychoeducation, and motivational interviewing by case manager.

METHODS

Primary care interface is an evidence-based practice that uses elements of the IMPACT model.

PROGRAM STRATEGIES

Create Access to Linkage and Treatment

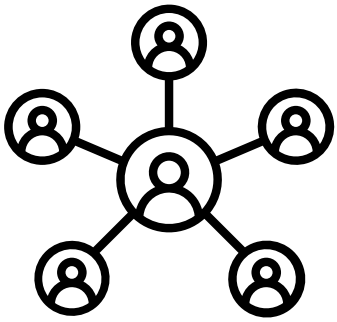
PROGRAM HIGHLIGHTS

3,642 clients served

DEMOGRAPHIC DATA

The Primary Interface program did not report demographic data for FY 16/17 and 17/18.

OUTCOMES



In 16/17 620 clients were referred for co-occurring case management. They were referred directly from their PCP and assessed by an interface IMAT case manager

As a result of this service clients were able to reduce or abstain from the use of substances, reconnect with family, secure housing, or employment, and reduce symptoms of anxiety

In 16/17, 21 SMI clients were transferred to BHRS regional clinics

POSSIBLE OUTCOME METRICS

- Improve access to linkages for services
- Reduce the number of hospitalizations
- Increase individual engagement in services/improve continuity of care

SMC MENTAL HEALTH ASSESSMENT AND REFERRAL TEAM (SMART)

The SMART team are specially trained paramedics that are a part of the American Medical Response west. They are trained to respond to law enforcement Code 2EMS which are requests for individuals having a behavioral health emergency. The SMART paramedic performs the mental health assessment, places a 5150 hold if needed and transports the client to Psychiatric Emergency Services, or if they do not meet criteria another community resource such as a crisis residential facility, doctor's office, detox, shelter, home etc. This ensures increased connectivity and treatment for community members. Additionally, many individuals are more likely to be forthcoming with a psychologically trained medic about what they are experiencing as compared to law enforcement. This resource can only be accessed through the County's 911 system.

METHODS

SMART is a promising practice that provides the SMC community with an alternative to law enforcement and having to go to the hospital for an assessment.

PROGRAM STRATEGIES

Create Access to Linkage and Treatment

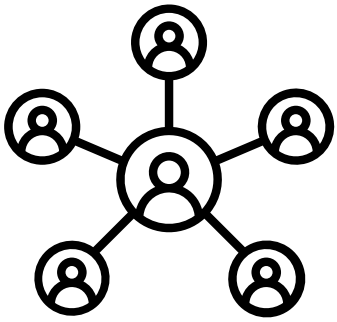
PROGRAM HIGHLIGHTS

5,491 community members served

DEMOGRAPHIC DATA

The SMART program did not report demographic data for FY 16/17 and 17/18. The demographic data that is collected is inputted into a database that is not readily accessible.

OUTCOMES



AMR has successfully diverted 37.5% of calls, were a 5150 was not placed, the goal was to divert at least 10% of calls.

SMART has successfully responded to many people under 18, who are in crisis and the team is able to address the youth's concerns, provide supportive services and directly involve the parents

SMART is continuing to work and train law enforcement to wait before they place a 5150 hold.

POSSIBLE OUTCOME METRICS

- Reduce the number of hospitalizations
- Improve access to linkages to services
- Increase individual engagement in services/improve continuity of care

SYSTEM TRANSFORMATION

The SMART team continues to work alongside law enforcement and engages in training them when it comes to mental health emergencies. This move away from law enforcement always being involved in 5150 allows individuals who may have had traumatic experiences with law enforcement to feel more comfortable asking for help, staying safe and being placed appropriately. Additionally, instead of going to PES they are referred to a resource that fits their needs.

ACCESS AND LINKAGE TO TREATMENT

The following programs provide access and linkage to treatment, they connect individuals with severe mental illness to medically necessary care and treatment, including, but not limited to, care provided by county mental health programs.

Access and Linkage to Treatment

- Ravenswood Family Health Center (40% CSS; 60% PEI)
- Senior Peer Counseling (50% CSS; 50% PEI)
- HEI Outreach Worker Program
- North County Outreach Collaborative
- East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) and East Palo Alto Behavioral Health Advisory Group (EPABHAG)

16,123 clients served

RAVENSWOOD FAMILY HEALTH CENTER

Ravenswood Family Health Center 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 behavioral health needs. Many of the diverse populations that underserved, or underserved will more likely visit the doctor for a physical health concern. If Ravenswood identifies someone that could benefit from services, they provide a referral for SMI and SED clients to be seen in the county clinic.

METHODS

This practice is evidenced based and a promising practice, it is not uncommon to see that physical and mental health services are integrated or offered in coordination with each other.

PROGRAM STRATEGIES

Timely Access to Mental Health Services for Individuals and Families from Underserved Populations

Non-Stigmatizing and Non-Discriminatory Practices

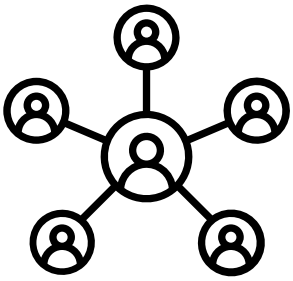
PROGRAM HIGHLIGHTS

944 clients served

DEMOGRAPHIC DATA

Ravenswood Family Health Center did not report demographic data for FY 16/17 and 17/18.

OUTCOMES



944 clients served in FY 16/17 and 17/18

POSSIBLE OUTCOME METRICS

- Increase access to care
- Increase awareness of mental health, wellness and recovery
- Improve participant engagement in services

SENIOR PEER COUNSELING

The Senior Peer Counseling Program, 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.

METHODS

This practice is evidenced based and a promising practice, it is not uncommon to see that physical and mental health services are integrated or offered in coordination with each other.

PROGRAM STRATEGIES

Timely Access to Mental Health Services for Individuals and Families from Underserved Populations

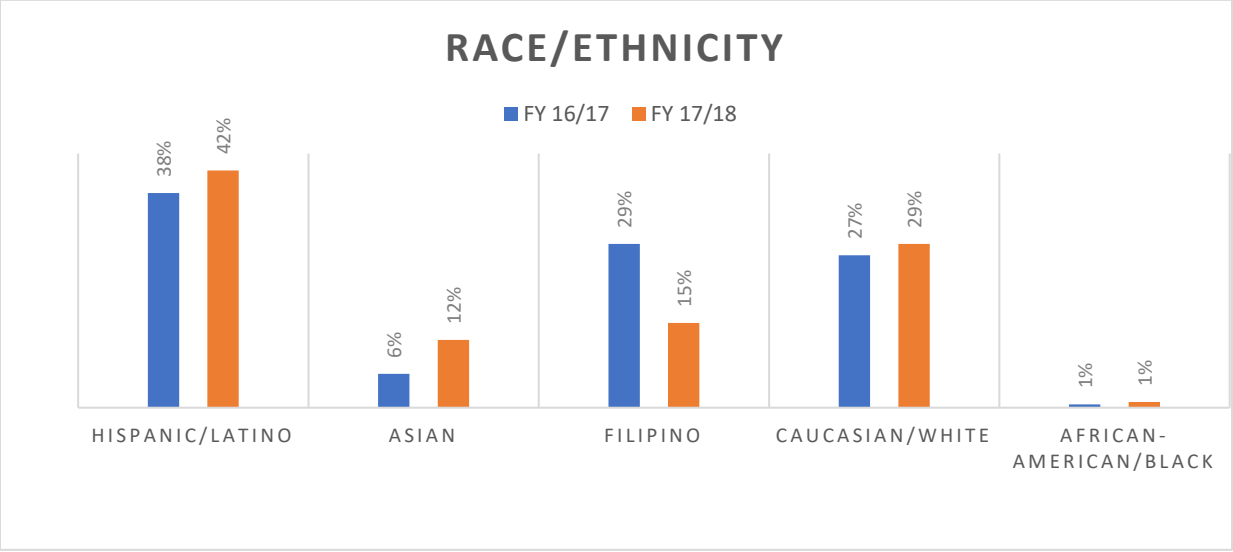
Non-Stigmatizing and Non-Discriminatory Practices

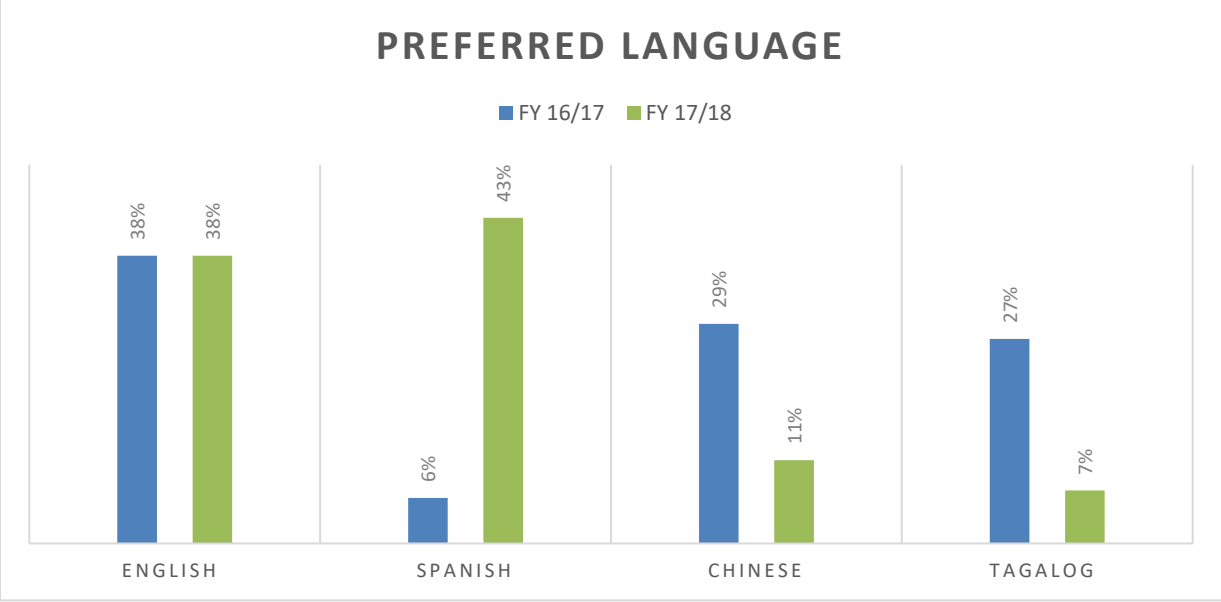
PROGRAM HIGHLIGHTS

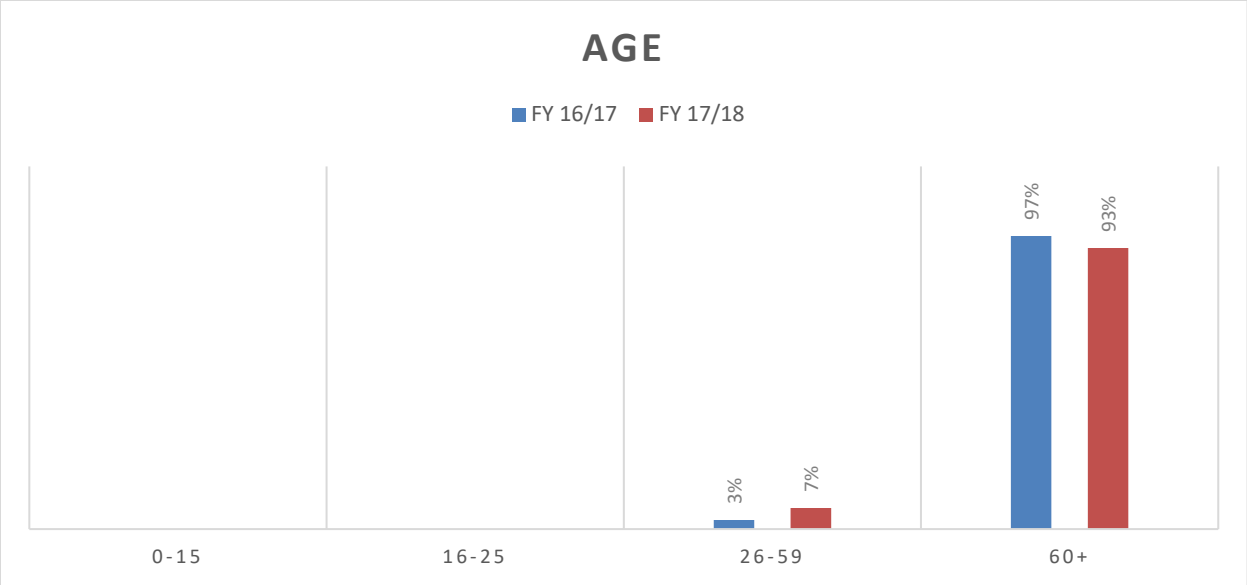
1032 clients served

DEMOGRAPHIC DATA

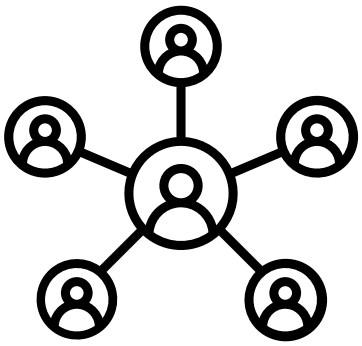
The Senior Peer Counseling program served a diverse population for FY 16/17 and 17/18 with the largest groups served being Latinos, Filipinos and Caucasians. The preferred languages included English, Spanish, Chinese, and Tagalog. The largest age group served were those who were 60 years and older.







OUTCOMES



12 weekly support groups located in senior centers, senior housing, the PRIDE center etc.

Recruited 125 new peer counselors

Trained 72 new peer counselors, 104 counselors currently active

POSSIBLE OUTCOME METRICS

- Improve access to linkages for services
- Reduce stigma
- Improve understanding of mental illness

OUTREACH COLLABORATIVES

Community outreach collaboratives include the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) and the North County Outreach Collaborative (NCOC) This collaborative provides advocacy, systems change, resident engagement, expansion of local resources, education and outreach to decrease stigma related mental illness and substance abuse and increase awareness of and access and linkages to culturally and linguistically appropriate behavioral health, entitlement programs, and promote and facilitate resident input into the development of MHSA funded services

PROGRAM STRATEGIES

Timely Access to Mental Health Services for Individuals and Families from Underserved Populations

Non-Stigmatizing and Non-Discriminatory Practices

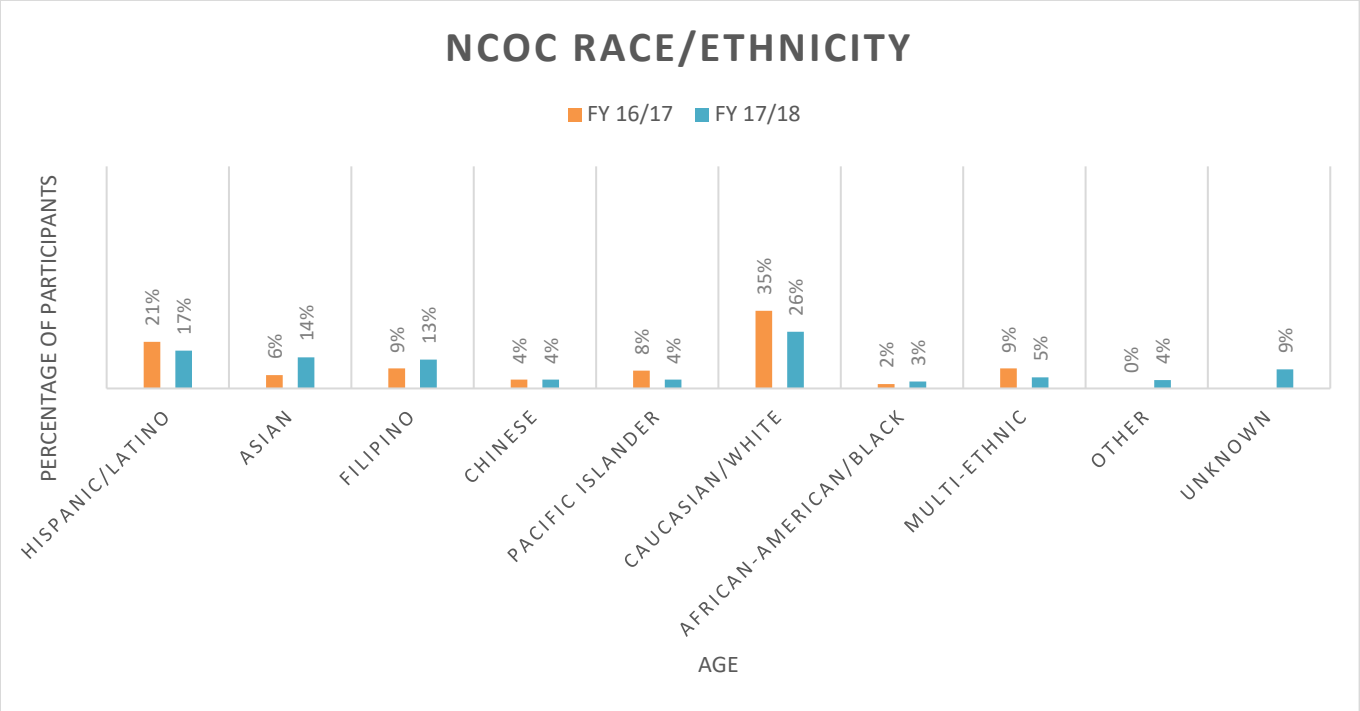
PROGRAM HIGHLIGHTS

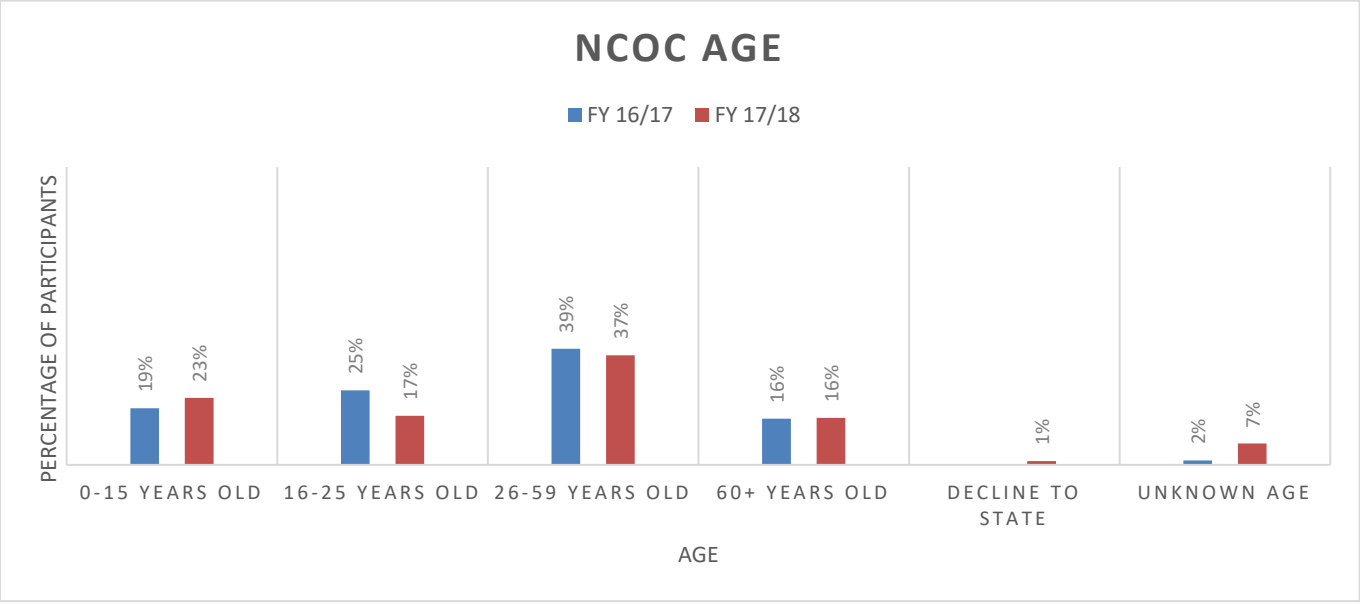
16,123 clients served

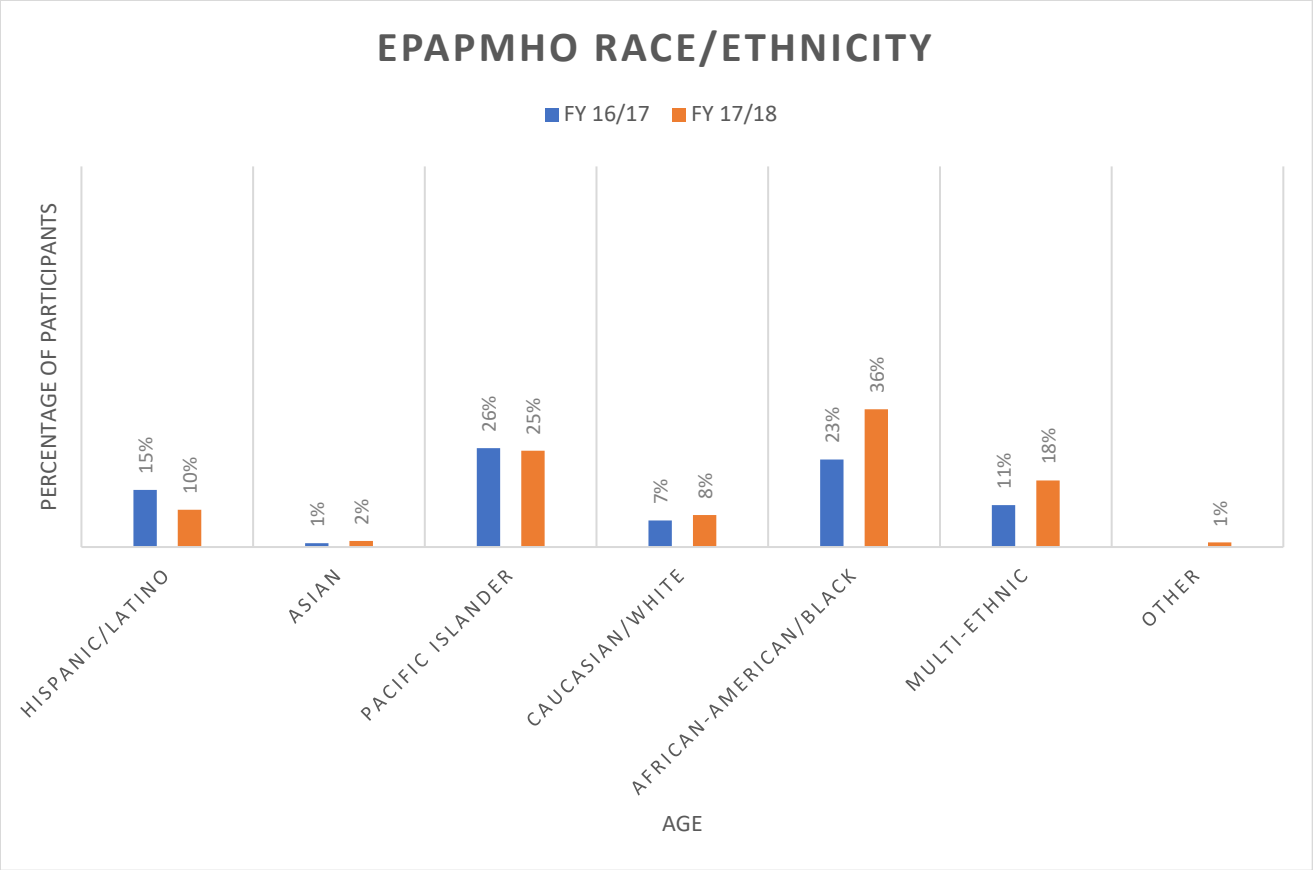
190 referrals to mental health services

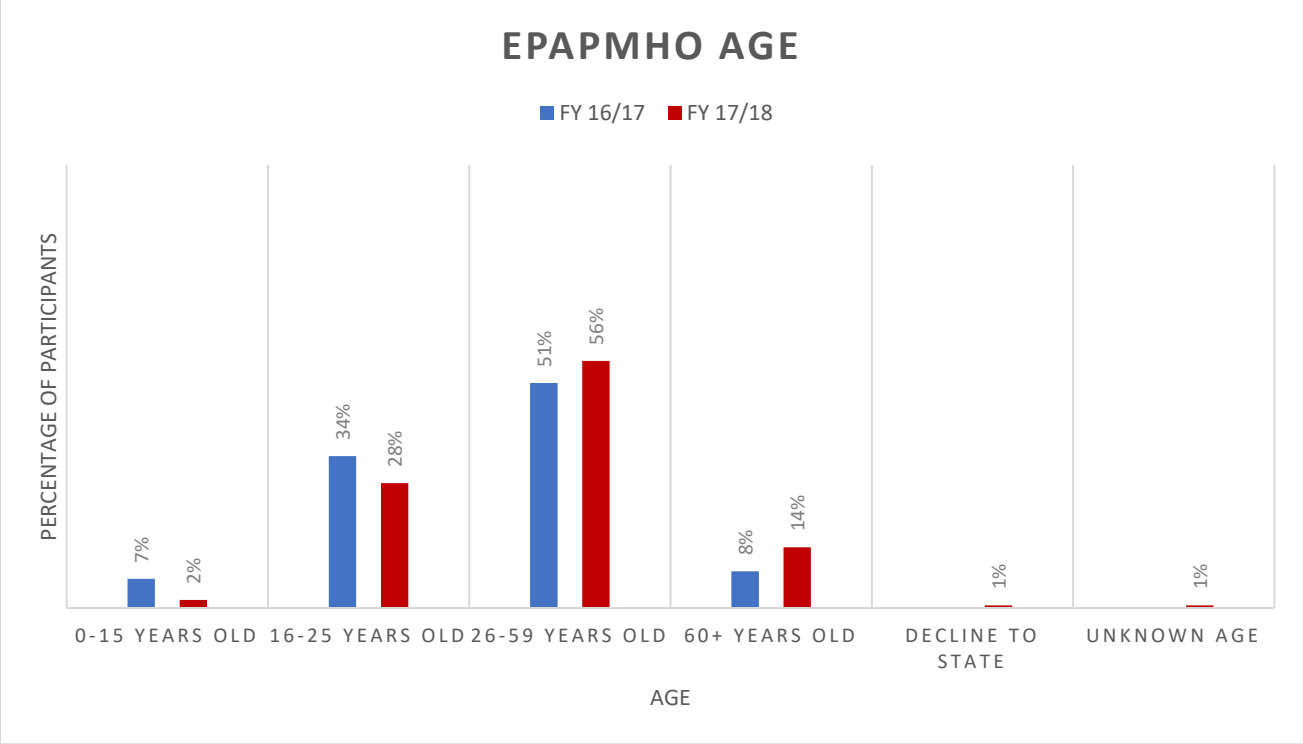
381 substance abuse referrals

DEMOGRAPHIC DATA

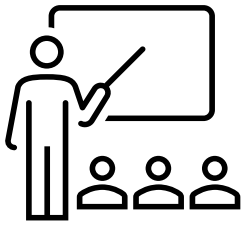




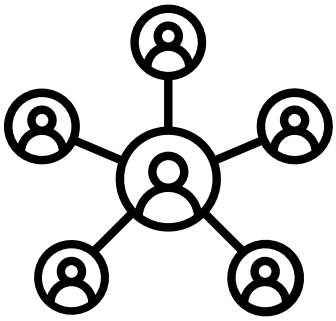

EPAPMHO RACE/ETHNICITY
FY 16/17
FY 17/18
PERCENTAGE OF PARTICIPANTS
15%
10%
1%
2%
26%
25%
7%
8%
23%
36%
11%
18%
1%
HISPANIC/LATINO
ASIAN
PACIFIC ISLANDER
CAUCASIAN/WHITE
AFRICAN-AMERICAN/BLACK
MULTI-ETHNIC
OTHER
AGE


EPAPMHO AGE
FY 16/17
FY 17/18
PERCENTAGE OF PARTICIPANTS
7%
2%
34%
28%
51%
56%
8%
14%
1%
1%
0-15 YEARS OLD
16-25 YEARS OLD
26-59 YEARS OLD
60+ YEARS OLD
DECLINE TO STATE
UNKNOWN AGE
AGE

OUTCOMES



The outcomes of the outreach collaboratives are being impacted by less outreach being conducted due to gentrification, fear provoked by immigration policies and fear of deportation, and impact of drug MediCal on outreach cases.



Largest number of referrals given for social services by the NCOC were for housing, legal assistance, and food. For EPAPMHO they were medical care and housing.

Special population served by NCOC were at-risk of homelessness, veterans and homeless. Special populations served by EPAPMHO were homeless, and those at-risk of homelessness.

QUALITATIVE DATA

A 17-year-old cis gendered male student from Brazil was referred to DCYHC for major depression, anxiety, and substance use. He started seeing a counselor. He disclosed his immigration status and a clinician worked closely with the school to create a safe place to speak about both immigration and his mental health.

SYSTEM TRANSFORMATION

The outreach collaboratives are the front line to the community, they many times are from the community in which they work, they have rapport with community and they culturally identify with the population that they serve. Through the outreach collaboratives, and their data collection it becomes apparent the most pressing needs of the community. The most pressing social service referrals are around housing and that speaks to the cost of living in SMC, and concurrently the gentrification that continues in low income and unserved communities. This

information is vital to MHSA because it allows us to think of prevention in an upstream approach and see the social determinants of health such as housing, food access/insecurity and political climate as factors that affect the mental health of the community. It guides our efforts as we expand our programs, and ideas for new programming.

PREVENTION

OFFICE OF DIVERSITY AND EQUITY (ODE)

ODE is committed to advancing health equity in behavioral health outcomes of marginalized communities. The office was established in 2009 via dedicated MHSA funding allocated to address cultural competence and access to mental health services to underserved communities. This office demonstrates 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 with the County's behavioral health service system and in partnership with communities. The following programs are housed under ODE:

Prevention

- **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**
- **San Mateo County Suicide Prevention Committee (SPC)**

6250 community members served

METHODS

The **evidence-based programs** found under ODE are the following:

- The Parent Project
- Adult Mental Health First Aid
- Digital Storytelling and Photovoice

These three programs are curriculum-based programs with extensive research validating the effectiveness, and minimum modifications.

Programs that are a **promising practice** are the following:

- Health Ambassador Program- This program follows the ideology and evidence-based practice of a Promotora program with added trainings, workshops, and leadership development
- Health Equity Initiatives- There are nine initiative under ODE, they each represent groups that are typically underserved in mental health services. These nine meeting groups allow for community, providers, and contractors to come together and decrease stigma, educate and empower community members, support wellness and recovery and build culturally responsive services
- Stigma Free San Mateo County- Online social media campaign to raise awareness of mental health and substance use
- Suicide Prevention Committee- A workgroup that coordinates efforts to prevent suicide in SMC.

ODE STRATEGIES

Timely Access to Mental Health Services for Individuals and Families from Underserved Populations

Non-Stigmatizing and Non-Discriminatory Practices

PROGRAM HIGHLIGHTS

5,000 community members served by the Health Equity Initiatives

The Pacific Islander Initiative created a communication campaign on social media about suicide and the images were shared 300 times and 6,000 people saw them

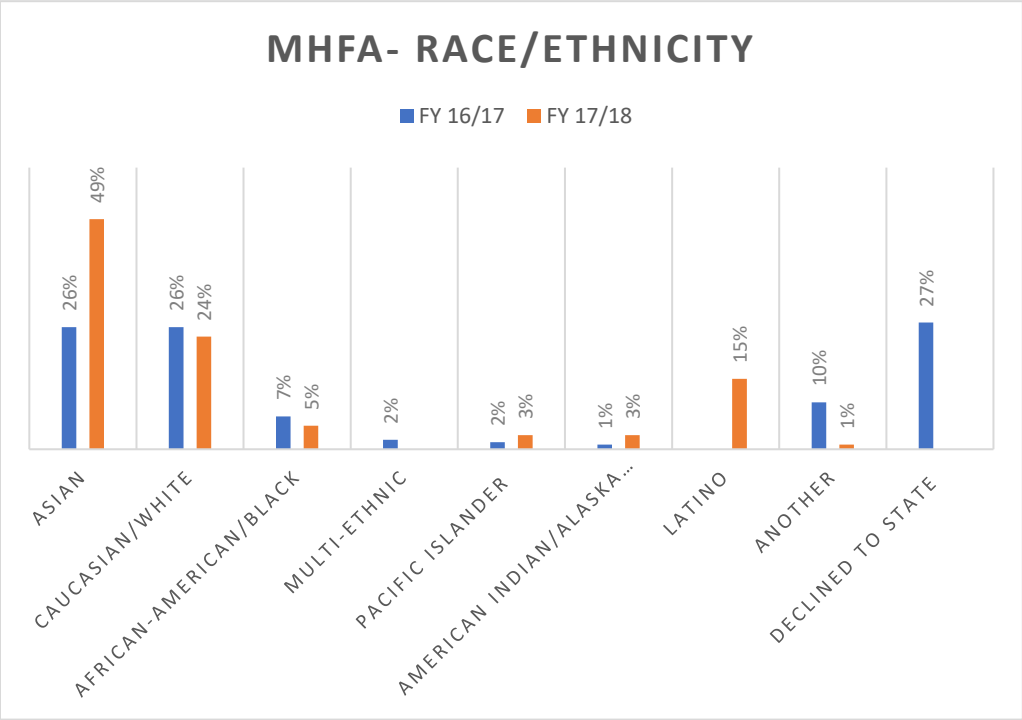
Parent Project reached 1,000 graduates

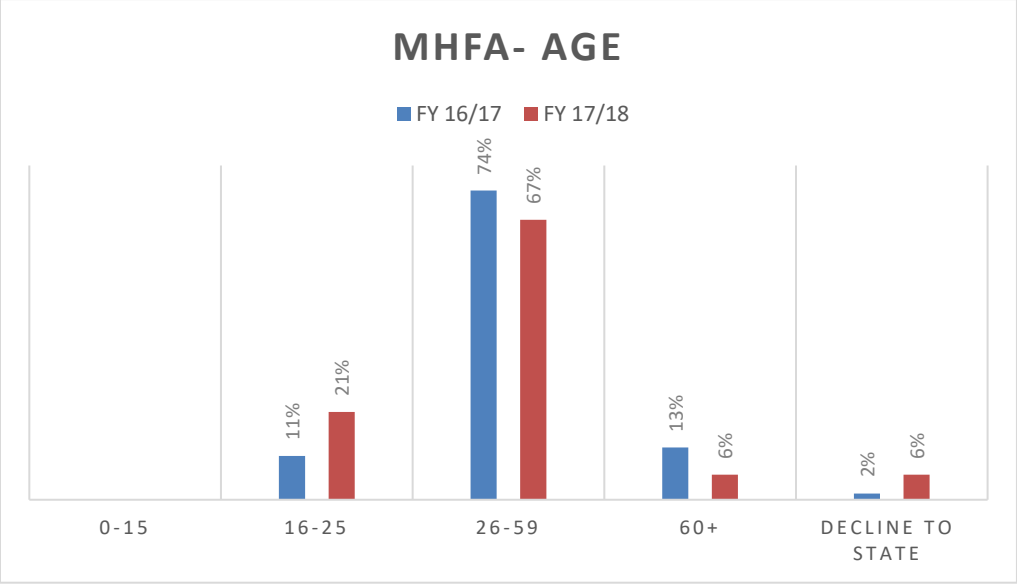
97% of Adult Mental Health participants feel confident to recognize and correct misconceptions about mental health, substance use and mental illness as they encounter them

DEMOGRAPHIC DATA

Demographic data was not available for the Health Equity Initiatives, Health Ambassador Program, Digital Storytelling and Photovoice, Stigma Free San Mateo, and SMC Suicide Prevention Committee for FY 2016-17 and FY 2017-2018.

MENTAL HEALTH FIRST AID





Additional demographic data was collected for the Mental Health First Aid program including, language, and disability status. However, these data points changed when the demographic form was updated, making them difficult to compare year to year.

DIGITAL STORYTELLING & PHOTOVOICE

Demographic data was not collected for Digital Storytelling & Photovoice 16/17 was the startup year. Demographic started to be collected FY 18/19.

EVALUATION FRAMEWORK

The Office of Diversity and Equity measures progress along 5 indicators. These definitions are influenced by (1) public health frameworks and (2) ODE's mission, values, and strategy.

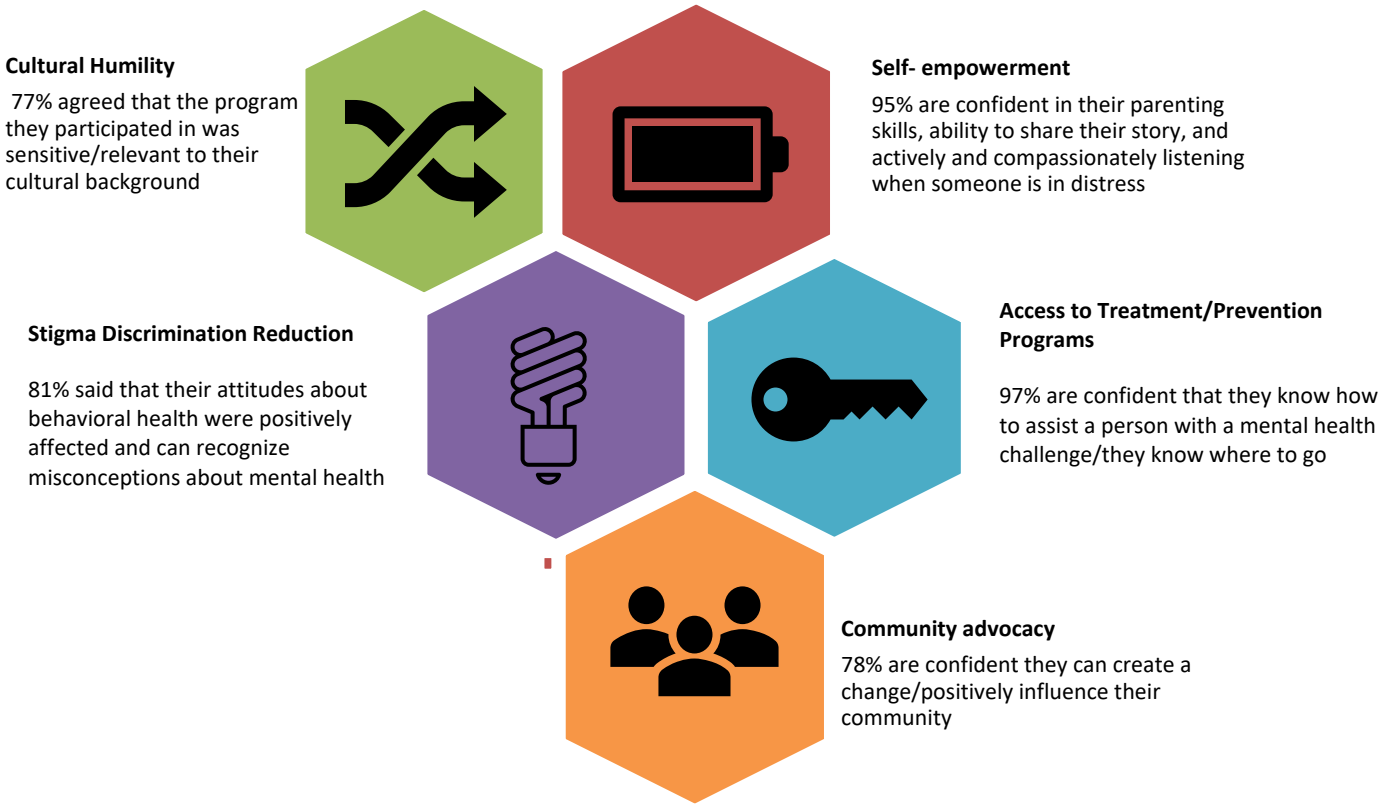
1. Self-Empowerment - enhanced sense of control and ownership of the decisions that affect your life
2. Community Advocacy- increased ability of a community (including peers and family members*) to influence decisions and practices of a behavioral health system that affect their community
3. Cultural Humility
    - heightened self-awareness of community members' culture impacting their behavioral health outcomes

- heightened responsiveness of behavioral health programs and services for diverse cultural communities serve

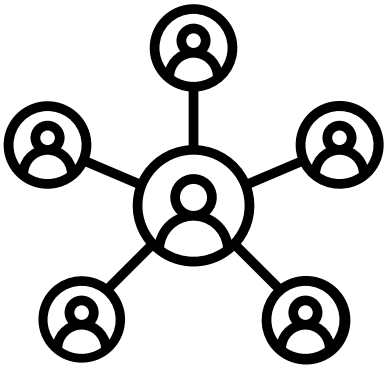
4. Access to Treatment/Prevention Programs (Reducing Barriers) - enhanced knowledge, skills, and ability to navigate and access behavioral health treatment and prevention programs despite potential financial, administrative, social, and cultural barriers.
5. Stigma Discrimination Reduction - reduced prejudice and discrimination against those with mental health and substance use conditions

OUTCOMES

Implementation of the five evaluation indicators is currently being implemented with Adult Mental Health First Aid, The Parent Project, and Digital Storytelling and photovoice. Below are the results for the aggregated survey results across three of our evidence-based programs. All the programs will ultimately feed into these five indicators to measure impact of the Office of Diversity and Equity as a whole.



PROGRAM SPECIFIC OUTCOMES



The HEI's hosted 156 events. These events included psycho-education workshops, trainings, community events, and ranged from attendance of 40 people to 1200.

More than 1,119 individuals have been trained in Adult Mental Health First Aid. Those trained have been teachers, leadership from Family Health services, Second Harvest Food Bank, Peninsula Library System, and students from San Mateo Adult School.

The Suicide Prevention Committee held 12 events in 2017 up from 1 event in 2016. Additionally, they held 7 gatekeeper trainings including ASIST, MHFA, QPR, Reconozca las señales (Spanish)

QUALITATIVE DATA

Parent Project

"I was passing through one of those hardships in life when I learned about the Parent Project class. After enrolling and completing 12-week training, I knew that I needed to learn not only about parenting but also about behavioral health" – Client is now a HAP

Storytelling Program

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

Health Equity Initiatives

"In collaboration with the Latino Collaborative and Spirituality Initiative, NIPI hosted a Drumming Circle. Participant stated feeling a calming effect and being open to drumming as tool for recovery.

HAP Program

"HAP has given me the tools to encourage other people to recognize the signs and symptoms of mental health and substance use"

SYSTEM TRANSFORMATION

ODE is an integral part of BHRS in San Mateo County, it is the driver for many system transformation initiatives including the Government Alliance on Race and Equity which is an initiative that currently carried out within the Health System but is being expanded to all other county departments. Additionally, ODE is also tasked with leading the Multi-Cultural Organizational Development process which is internal to BHRS. MHSA being housed under ODE has allowed administrators to consider all funding through an equity lens, and this affects the way we conduct our needs assessments, hours of operation and events, co-location of services, as well as thoughtful inclusion of clients and families in decision making processes.