



# San Mateo County Health System

Behavioral Health and Recovery Services



## Mental Health Services Act (MHSA)

**Three-Year Program and Expenditure Plan Fiscal Year(FY) 2014-25 through 2016-17  
& Annual Update FY 2014-2015**



WELLNESS • RECOVERY • RESILIENCE

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# MHSA COUNTY COMPLIANCE CERTIFICATION

## MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: San Mateo

X Three-Year Program and Expenditure Plan  
X Annual Update

Local Mental Health Director	Program Lead
Name: Stephen Kaplan, LCSW	Name: Doris Estremera, MPH
Telephone Number: 650-573-2541	Telephone Number: 650-573-2889
E-mail: skaplan@smcgov.org	E-mail: destremera@smcgov.org
Local Mental Health Mailing Address:	
Behavioral Health and Recovery Services 225 37th Avenue, 3rd Floor-BHRS San Mateo, CA 94403	

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

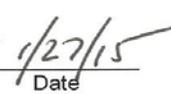
This Three-Year Program and Expenditure Plan or Annual Update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Three-Year Program and Expenditure Plan or Annual Update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on **January 27, 2015**.

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

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

Stephen Kaplan, LCSW  
Local Mental Health Director

  
 Signature

  
 Date

# MHSA COUNTY FISCAL ACCOUNTABILITY COMPLIANCE

## MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION<sup>1</sup>

County/City: SAN MATEO COUNTY

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

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: <u>STEPHEN KAPLAN</u>	Name: <u>Juan Raigoza</u>
Telephone Number: <u>(650) 573-3609</u>	Telephone Number: <u>650-363-4777</u>
E-mail: <u>SKAPLAN@SMLGOV.ORG</u>	E-mail: <u>controller@smcgov.org</u>
Local Mental Health Mailing Address: <u>BEHAVIORAL HEALTH AND RECOVERY SERVICES</u> <u>225 37TH AVENUE</u> <u>SAN MATEO, CA 94403</u>	

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

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

STEPHEN KAPLAN  
 Local Mental Health Director (PRINT)

[Signature] 11/18/14  
 Signature Date

I hereby certify that for the fiscal year ended June 30, 2014, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated 10-31-14 for the fiscal year ended June 30, 2014. I further certify that for the fiscal year ended June 30, 2014, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

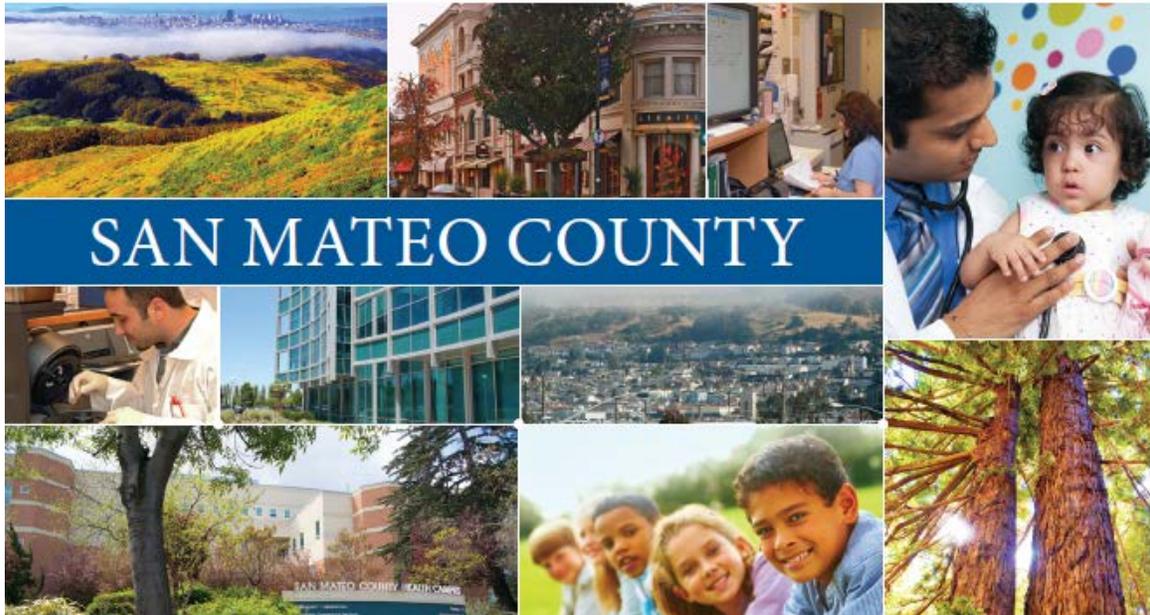
Juan Raigoza  
 County Auditor Controller / City Financial Officer (PRINT)

[Signature] 12-23-14  
 Signature Date

<sup>1</sup> Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)  
 Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (02/14/2013)

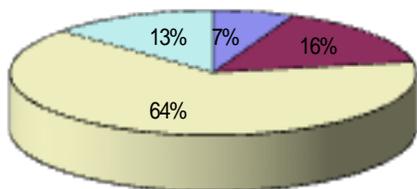
# INTRODUCTION

## About San Mateo County



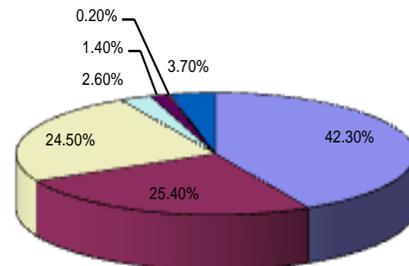
Home to 739,311 people (2012 estimate, US Census); San Mateo is a diverse county, both in terms of population and geography.

Age Breakdown for San Mateo County



Under 5 years:
  5 to 17 years:
  18 to 64 years:
  65 years and over:

San Mateo County Demographics



White
  Hispanic or Latino
  Asian
  African American

Native American
  American Indian
  Other

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

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

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

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



**CRYSTAL SPRINGS RESERVOIR**

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



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

**SAN FRANCISCO INTERNATIONAL AIRPORT  
(ABOVE)**

**PORT OF REDWOOD CITY (RIGHT)**



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# STAKEHOLDER INPUT

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## Background

Since the inception of the Mental Health Services Act (MHSA), San Mateo County Behavioral Health and Recovery Services (BHRS) made a conscious decision to promote a vision of collaboration and integration by embedding MHSA programs and services within existing programmatic and administrative structures. San Mateo County does not separate MHSA planning from its other continuous planning processes. Given this, stakeholder input from system-wide planning activities is taken into account in MHSA planning.

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

Since our last annual update, we've continued weeklong stakeholder convenings focused on tailoring the CSA model to the needs of specific geographical areas and developing action plans to guide the work moving forward. The following CSA planning activities have been completed to date:

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

We expect to hold similar workshops in the one remaining area, Northeast CSA (Brisbane, South San Francisco, San Bruno, Milbrae); hence, officially shifting the entire County and MHSA activities to this new service delivery approach.

Each CSA will have a Community Planning Committee comprised of 51% clients and family members, this committee is the heart and soul of the stakeholder process. These permanent committees will have an important role in the local system transformation, its values, activities and directions. And they will also have an important role in MHSA planning. These are permanent ongoing committees that build consumer feedback into the planning process in a foundational way. For more on the CSA model please visit [www.smchealth.org/BHRSGoodModern](http://www.smchealth.org/BHRSGoodModern)

## Community Program Planning (CPP) Process

### INPUT STRUCTURE

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

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

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

MHSA implementation is very much a part of BHRS' day-to-day business. Information is shared and input collected with a diverse group of stakeholders on an ongoing basis. All the MHSA information is made available to stakeholders on the San Mateo County Behavioral Health and Recovery Services MHSA webpage, [www.smchealth.org/bhrs/mhsa](http://www.smchealth.org/bhrs/mhsa). The site includes a subscription feature to receive an email notification when the website is updated with MHSA developments, meetings and opportunities for input. This is currently at over 500 subscribers. Hard copies of materials are made available upon request.

The BHRS's e-journal, Wellness Matters is published the first Wednesday of every other month and distributed electronically to over 700 stakeholders and serves as an information dissemination and educational tool, with a standing column written by the County's MHSA Manager. In addition, presentations and ongoing progress reports are provided by BHRS, and input is sought on an ongoing basis at the monthly MHSARC meeting at the MHSA Steering Committee meeting; at meetings with community partners and advocates; and internally with staff.

### ***Mental Health Services Act Steering Committee Members***

<b>Stakeholder Group</b>	<b>Name(s)</b>	<b>Title (if applicable)</b>	<b>Organization (if applicable)</b>
<b>Family</b>	Cameron Johnson*	Chair, MHSARC	
<b>SMC District 1</b>	David Pine*	Supervisor, District 1	Board of Supervisors *Co-chairs, MHSARC
<b>Advocate</b>	Randall Fox		
<b>African American Community</b>	Sheri Broussard		HIP Housing
<b>Aging Community Provider</b>	Michelle Makino	Community Program Supervisor	SMC Health System, Aging & Adult Services
<b>AOD Service Provider</b>	Clarise Blanchard	Director of Substance Abuse and Co-occurring Disorders	Star Vista and BHRS Contractors Association
<b>AOD Service Provider</b>	Ray Mills	Executive Director	Voices of Recovery
<b>Chinese Community</b>	Michael Lim		Chinese Health Initiative
<b>Consumer/Client</b>	Patrick Field		
<b>Consumer/Client - Adult</b>	Christopher Jump	Executive Assistant	Heart & Soul, Inc
<b>Consumer/Client - Older Adult</b>	Carmen Lee	Program Director	Stamp Out Stigma
<b>Consumer/Client Liaison</b>	Jairo Wilches	Liaison and BHRS Wellness Champion	BHRS, Office of Family and Consumer Affairs
<b>Courts</b>	Rodina Catalano	Deputy Court Executive Officer	Superior Court
<b>Disabilities Community</b>	Maisoon Sahouria		Center for Independence of Individuals with Disabilities
<b>Disabilities Community</b>	Vincent Merola		Center for Independence of Individuals with Disabilities
<b>East Palo Alto (EPA) Community</b>	Shanna 'Uhila		East Palo Alto Behavioral Health Advisory Group (EPA BHAG)
<b>EPA Community</b>	Tiffany Hautau		EPA BHAG
<b>EPA Community</b>	Jeff Austin		EPABHAG; Mid-Peninsula Athletic Association
<b>Education</b>	Joan Rosas	Associate Superintendent	SMC Office of Education
<b>Family Member</b>	Patricia Urbina		
<b>Filipino Community</b>	Athila Lambino	Community Partner	Filipino Mental Health Initiative
<b>Health Care</b>	Maya Altman	Executive Director	Health Plan of San Mateo
<b>Health Care</b>	Dan Becker	Medical Director	Mills Peninsula Health Svcs
<b>Health Care</b>	Louise Rogers	Deputy Chief	San Mateo County Health System
<b>Health Care</b>	Gina Wilson	Financial Services	San Mateo County Health System
<b>Latino Collaborative</b>	Héctor J. Robles	Supervising Mental	BHRS

	Moncada	Health Clinician	
<b>LGBTQQI Community; Food Insecure</b>	Susan Takalo		PRIDE Initiative; Second Harvest Food Bank
<b>LGBTQQI Community</b>	Lauren Szyper		PRIDE Initiative
<b>Native American Community</b>	Gloria Gutierrez	MH Counselor	BHRS
<b>North County Community</b>	Mary Bier		North County Outreach Collaborative
<b>Pacific Islander Community</b>	Agnes Tuipulotu		Pacific Islander Initiative
<b>Pacific Islander Community</b>	Juliet Vimahi		Pacific Islander Initiative
<b>Service Provider - Adult</b>	Patricia Way		NAMI
<b>Service Provider - Adult</b>	Juliana Fuerbringer		NAMI; Clubhouse
<b>Social Service Provider</b>	Melissa Platte	Executive Director	Mental Health Association
<b>South Coastside</b>	Joann Watkins	Clinical Director	Puente de la Costa Sur
<b>Spirituality Community</b>	Chase Montara		Spirituality Initiative

***Mental Health and Substance Abuse Recovery Commission (MHSARC)***

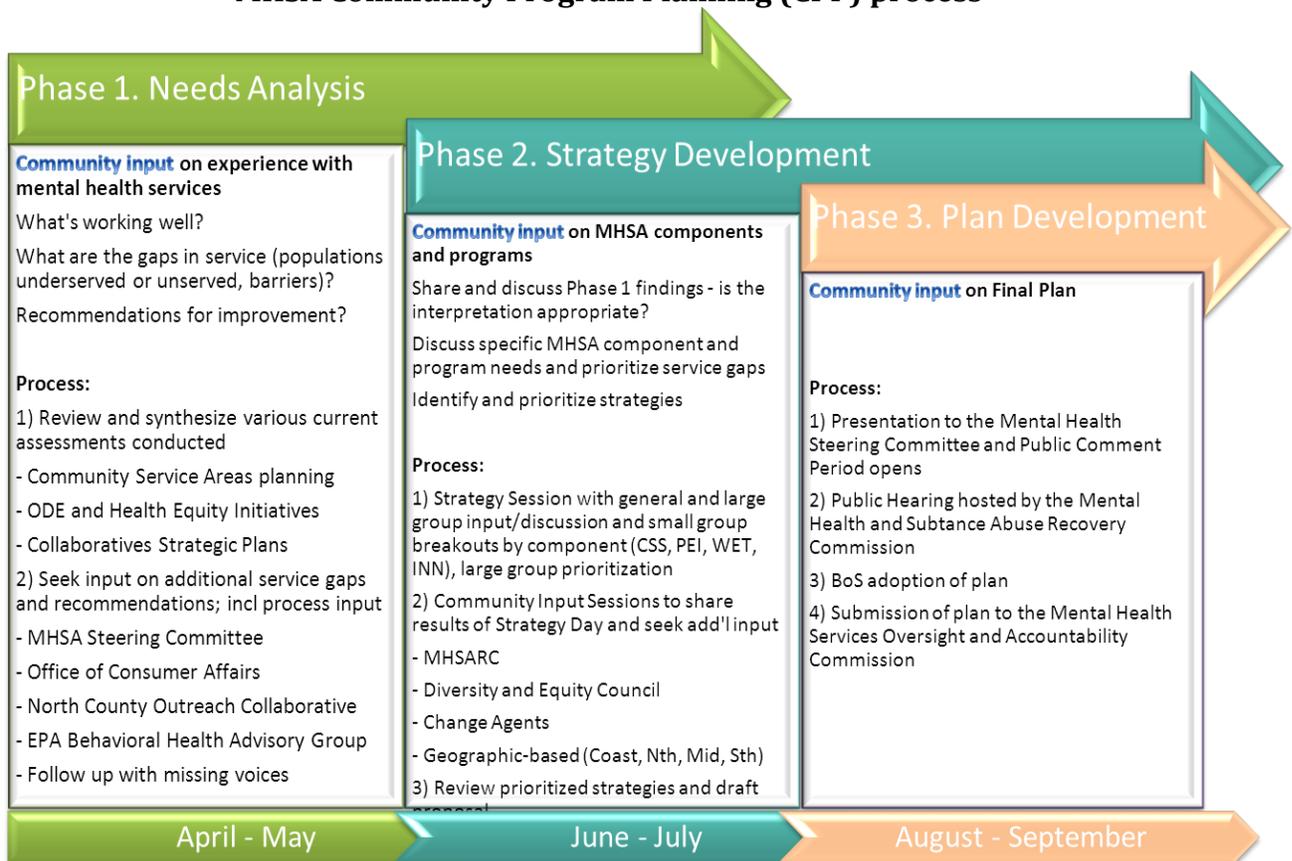
All members of the MHSARC are members of the MHSA Steering Committee.

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

## CPP PROCESS FOR THE DEVELOPMENT OF THE THREE-YEAR PLAN

In March 2014, a comprehensive CPP process to develop the MHSAs Three-Year Plan was kicked off by the MHSARC. Planning was led by the MHSAs Manager, the Office of Diversity and Equity Manager and the Director of BHRS along with stakeholder engagement through the MHSARC and the MHSAs Steering Committee.

### MHSAs Community Program Planning (CPP) process



A draft CPP process was presented to and vetted by the MHSARC, the North County Outreach Collaborative, the East Palo Alto Behavioral Health Advisory Group and the Office of Consumer and Family Affairs. These groups were asked for their input and comments on the process and what other groups should we be reaching out to in each of the CPP Phases.

#### **Phase 1. Needs Analysis**

As mentioned earlier, San Mateo County does not separate MHSAs planning from its other continuous planning processes. In this spirit, stakeholder input from the following BHRS planning activities was included in the Needs Analysis phase of the CPP process:

- Community Service Areas planning (Central, Coast, South and East Palo Alto)
- ODE and Health Equity Initiatives assessments
- MHSAs Collaborative strategic plans

Additionally, stakeholders including consumers/clients, family members, community partners and organizations were engaged in facilitated dialogues to seek input on the following two questions:

1. What are the continuing and existing barriers to accessing mental health services? What are the gaps in services?
2. With regards to current mental health services, what's working well?

All comments were grouped into themes and presented to the MHSA Steering Committee on June 10, 2014 and to the various Community Input Sessions during the Strategy Development Phase. See Appendix 1, for the Needs Analysis Overview and Summary of Input.

### ***Phase 2. Strategy Development***

The MHSA Steering Committee kicked off the Strategy Development Phase by reviewing and providing input specifically on the CPP process. Extensive outreach at community events, trainings, programs, community meetings, and through word of mouth from our community partners, outreach workers and front-line staff was conducted to promote the Community Input Session that took place on July 16, 2014. Flyers were made available in English, Spanish, Chinese, Tagalog, Tongan and Samoan. Stipends to consumers/clients and their family members, language interpretation and child care for families were offered.

Over 95 diverse and engaged community members were in attendance and provided input on MHSA strategies for the next three years of services. Of the participants in attendance, 72 were non-BHRS staff, 43 identified as a consumer/client and/or a family member, 21 stipends were provided as well as childcare services for 4 families. See Appendix 2, Participant Demographics, for an overview of stakeholders in attendance. Additional community input sessions were conducted to ensure we heard from diverse communities, see Appendix 3 Strategy Development Summary of Input.

### ***Phase 3. Plan Development***

The final Phase of the CPP Process was kicked off at an MHSA Steering Committee meeting on August 27, 2014. Steering Committee members reviewed the recommendations and results from the Community Input Sessions and voted for priority strategies, programs or expansions to current programs to be included in the MHSA Three-Year Plan. See Appendix 4 Priority Strategies – Summary of Voting Results.

The MHSA Three-Year Plan was developed taking specific priorities identified through stakeholder input from previous years, new priorities identified through this year's CPP process, and the fiscal landscape for the next three years, including a projected \$2.45m PEI funding shortfall for San Mateo County and uncertainty about total revenue.

## STAKEHOLDERS INVOLVED IN THE CPP PROCESS

During the Needs Analysis and Strategy Development Phase, over 200 individuals were engaged in the CPP process, as detailed below. All groups were provided MHSAs background information, the CPP process overview and an opportunity for input either at the time of the meeting through a facilitated structured dialogue and/or at a future planning meeting.

<b>Date</b>	<b>Stakeholder Group</b>	<b>Level of engagement</b>
4/2/14	MHSARC	Input on CPP process
4/18/14	North County Outreach Collaborative	Input on needs and CPP process
4/29/14	East Palo Alto Behavioral Health Advisory Group	Input on needs and CPP process
5/6/14	Office of Consumer and Family Affairs	Input on needs and CPP process
5/14/14	School Wellness Alliance	Presentation and invitation
5/15/14	Countywide School Nurses meeting	Presentation and invitation
5/19/14	Peer Support Workers	Input on needs
5/21/14	Sequoia Union HSD, MH Advisory Committee	Input on needs
5/21/14	Chinese Health Initiative	Presentation and invitation
5/27/14	Spirituality Initiative	Limited input on needs
5/27/14	Latino Collaborative	Presentation and invitation
5/27/14	Voices of Recovery	Input on needs
6/6/14- 7/2/14	School Wellness Coordinators, San Mateo County Office of Education –key interviews	Input on needs
6/9/14	Heart & Soul, Inc.	Input on needs
6/10/14	African American Community Initiative	Presentation and invitation
6/10/14	MHSA Steering Committee	Input on needs and process
6/16/14	Family Partners, OCFA	Input on needs
6/26/14	Filipino Mental Health Initiative	Presentation and invitation
7/9/14	PRIDE Initiative	Presentation and invitation
7/16/14	Strategy Development Community Input Session – over 90 diverse stakeholders	Input on strategy development
7/23/14	NAMI San Mateo	Input on strategy development
7/24/14	Native American Initiative	Input on strategy development
8/1/14	Diversity and Equity Council	Input on strategy development
8/1/14	Chinese Health Initiative	Input on strategy development
8/7/14	Change Agents Meeting (co-occurring disorders)	Input on strategy development
8/21/14	Coastside CSA Advisory Committee	Input on strategy development
8/27/14	MHSA Steering Committee	Input on plan development

## Public Comment and Public Hearing

The Three -Year Program and Expenditure Plan was presented to a combined MHSARC and MHSA Steering Committee meeting on October 1, 2014. At this meeting the MHSARC released the full document, Three-Year Program and Expenditure Plan Fiscal Year (FY) 2014-2015 through FY 2016-2017 & Annual Update FY 2014-2015 (covering highlights and data from FY 2012-2013 programs), for a 30-day public comment. The MHSARC held a public hearing on November 5, 2014. Please see Appendix 5 for all public comments received during the planning phase and the 30 day public comment period. The final steps include a presentation to the Board of Supervisor for adoption of the plan and to the Controller to certify expenditures.

### OUTREACH STRATEGIES

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

- Flyers created and sent to/placed at County facilities, as well as other venues like family resource centers and community-based organizations;
- Numerous internal and external community meetings;
- Information through program activities (Parent Project, Mental Health First Aid trainings, etc.);
- E-mails disseminating information to over 1,300 electronic addresses;
- Notices published in local news outlets;
- Word of mouth on the part of our committed staff and active stakeholders,
- Posting on our MHSA webpage [smchealth.org/bhrs/mhsa](http://smchealth.org/bhrs/mhsa).

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# THREE-YEAR PROGRAM PLAN

## FY 2014-15 THROUGH 2016-17

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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.

MHSa-funded activities described in this Three-Year Plan also support and further BHRS' nine strategic initiatives, which represent the main areas of focus of work. These include:

- advance prevention and early intervention;
- build organizational capacity;
- empower consumers and family members;
- be prepared for the unexpected;
- enhance systems and supports;
- foster "total wellness" understood as an approach to health that includes both the behavioral and the physical;
- promote diversity and equity;
- cultivate learning and improvement; and
- be welcoming and engaging to those who seek our services and work with us.

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 multiyear approach facilitates stability, ensures a balanced approach when considering programmatic changes, and utilizes higher revenue years to cushion lower revenue years.

### **Community Services 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.

Current programs under CSS FSP component category will continue. In FY 2014-15 through FY 2016-17, the following FSP services will be provided:

***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 the family of origin in San Mateo County.

*Projected number of children and youth to be served through FSPs: 100*

***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 negotiation skills are a part of the treatment and education of the youth accessing housing support.

*Projected number of TAY to be served through FSPs: 40 Comprehensive FSPs, 40 Enhanced Education, 20 Supported Housing*

**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. Similar to the FSP for adults, the goal of the older adult/medically fragile FSP programs 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: 274*

## **OUTREACH AND ENGAGEMENT**

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. We’ve seen a consistent increase in representation of underserved communities in our system since these MHSA-funded strategies were deployed. Strategies include:

**Community outreach collaboratives** that provide advocacy, systems change, resident engagement, expansion of local resources, education and outreach to increase awareness of and access to culturally and linguistically competent behavioral health, Medi-Cal and other public health services, and other social services; a referral process to ensure those in need receive appropriate services; and promote and facilitate resident input into the development of MHSA funder services and other BHRS program initiatives.

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

**Primary care-based and BHRS outreach and engagement** to identify and engage diverse populations with behavioral health care needs.

*Projected number of people reached under CSS Outreach and Engagement: 5,210*

## SYSTEM DEVELOPMENT (SD)

System development initiatives strengthen and expand our internal capacity to respond to service demands by funding culturally competent clinical positions trained in cutting edge evidence-based practices; peer support services; and supported education/employment, to name a few. Current programs under this component category will continue and include:

**Older adult system of care development** – to create integrated services for older adults to assure that there are sufficient supports to maintain the older adult population in need in their homes and community, and in optimal health. The intent is to assist seniors to lead dignified and fulfilling lives, and in sustaining and maintaining independence and family/community connections to the greatest extent possible.

**Pathways, Criminal Justice Initiative** – to provide treatment and support services to seriously mentally ill non-violent offenders with co-occurring disorders and address their underlying behavioral health issues and divert from incarceration into community-based services.

*Projected number of consumers/clients to be served under CSS System Development: 340*

## SD – SYSTEM TRANSFORMATION AND EFFECTIVENESS STRATEGIES

**Peer and family partners** – 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.

**Co-occurring disorders services** –to support services for clients with co-occurring disorder 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 residential or non-residential treatment.

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

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

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

*Projected number of consumers/clients to be served for System Transformation and Effectiveness Strategies: 2,260*

## Prevention and Early Intervention (PEI)

PEI interventions target individuals of all ages prior to the onset of mental illness, with the sole exception of programs focusing on early onset of psychotic disorders such as schizophrenia. PEI programs are designed and implemented to help create access and linkage to treatment, improve timely access to mental Health services for individuals and/or families from underserved populations and are non-stigmatizing and non-discriminatory. San Mateo has focused its PEI dollars primarily on evidence-based interventions that have a proven track of success. PEI is approximately 15-20% of the MHSA budget. The latest regulations no longer require 51% of PEI funds be spent on children and youth ages 0 to 25. Counties are required to include:

- At least one Prevention program to reduce risk factors for developing a potentially serious mental illness and to build protective factors.
- At least one Early Intervention program to 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.
- At least one Outreach program for increasing recognition of early signs of mental illness through engaging, encouraging, educating, and/or training potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness.

In addition Counties may include one or more stigma and discrimination reduction programs and suicide prevention programs. Current programs under the PEI will continue.

In FY 2014-15 through FY 2016-17, the following FSP services will be provided:

### COMMUNITY INTERVENTIONS FOR YOUNG CHILDREN, SCHOOL AGE, AND TAY

**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: 80*

**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. There are four interventions under this category: Teaching Pro-social Skills, Project SUCCESS, Seeking Safety, and the Middle School Initiative, Project Grow.

*Projected number of school-age youth to be served 380*

## PRIMARY CARE INTERVENTIONS

**Total Wellness trainings** – provides professionals with training on the interconnectedness and the interdependence between mental and physical health.

**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 consumer/clients to be served: 750*

## COMMUNITY OUTREACH, ENGAGEMENT AND CAPACITY BUILDING

**Office of Diversity and Equity (ODE) programs** – ODE programs promotes cultural competence and address health inequities through information and data, training, dialogue and collaboration regarding diversity and social justice. The current programs under ODE that will continue in FY 13-14 through 16-17 include culturally-relevant provider trainings, Digital Storytelling, Mental Health First Aid for adults and youth, Parent Project, Photovoice, and the Health Equity Initiatives. In addition, two programs were started this FY 13-14, the Chinese Outreach Worker pilot project and the Health Ambassador Program.

*Projected number of people reached through ODE programs: 1,600*

Additional programs that will continue to be funded in FY 13-14 through 16-17 for PEI community outreach, engagement and capacity building include:

**Crisis Hotline** – 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.

**Training, wellness services and health and wellness groups and activities** – for Total Wellness programs at BHRS sites.

**Psychiatric Emergency Services (PES)** – provides for the behavioral health treatment needs of clients who seek services or are brought in for services to the SMMC PES and Acute Psychiatric Inpatient Units.

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

*Projected number of consumer/clients to be served for additional community outreach, engagement and capacity building: 1,800*

***Suicide Prevention*** - 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 participants for FY 2014-2015: 200*

***Student Mental Health Initiative*** - The Student Mental Health Initiative seeks to raise mental health awareness and reduce stigma among young people enrolled in K-12 schools and community colleges. Work is done in partnership with the San Mateo County Office of Education and includes student programming, education and awareness for teachers and administrators, and school board policies to increase mental health education in schools.

*Projected number of participants for FY 2014-2015: 200*

## **STIGMA AND DISCRIMINATION REDUCTION**

***Stigma Free San Mateo County*** 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. It is an extension of stigma reduction work started years ago as part of the Anti-Stigma Initiative. This program will continue in FY 13-14 through 16-17.

*Projected number of individuals served: 400*

## **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 consumers/clients served: 30*

## **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. BHRS will contribute 2% of PEI funding for sustainability of these projects.

## Innovation (INN)

**Total Wellness (TW)** – launched in 2011, this three-year program received a 1 year extension with an end date of June 30, 2015. Beginning July 1, 2015, TW will be partially funded through Community Services and Support (CSS) component. San Mateo County BHRS will begin the process of developing a new Innovation Project in January 2015. A new Innovation Project plan will be submitted for both local and State approval in 2015 and begin implementation within the time frame of this Three-Year Plan.

TW aims to improve the physical health status of individuals with serious and persistent mental illnesses (SPMI) by integrating primary care services into the community-based behavioral health clinics, specifically at our South and Central County locations. The overarching goal is to improve health outcomes, promote wellness, and foster recovery for SPMI individuals who also have chronic physical health conditions.

The pillars TW's service model are (1) integration of primary behavioral health care, (2) care coordination provided by behavioral health nurses, and (3) an array of peer-based recovery interventions. Targeted health outcomes of the program include improvement in the individuals' management of diabetes, lower blood pressures, lower cholesterol levels, better weight management, tobacco cessation, and improve social connectedness.

With inception of TW, the primary care access at Central and South County Adult Mental Health clinics has been expanded from 1.5 days a week to 5 days a week seeing exclusively BHRS clients. This is crucial as many SPMI clients fail to get linked and stay connected with a primary care provider (PCP) due to their psychiatric issues, resulting in dying 25 years earlier than the general population. Embedding primary care within a behavioral health setting provides easy access, fosters integrated care, and paves the way for a behavioral health home for these individuals with high levels of behavioral and physical health needs. As part of the integrated model, TW's holistic care approach includes weekly clinical huddles of the PCP and TW BHRS team who together review, discuss and deploy an integrated treatment plan for our clients. Nurse care managers coordinate the implementation of the discussed plan with all the treatment providers, and identify and address any treatment gaps in order to enhance treatment adherence and maximize health outcomes.

Finally, health and wellness services offered by peer coaches and health educators include both individual coaching support and psycho-educational groups. The groups include evidence-based, stage based tobacco cessation groups such as Ash Thinkers and Ash Kickers, Wellness Recovery Action Plan (WRAP), and wellness classes such as Well Body (weight management), Diabetes Management, Total Nutrition & Cooking, monthly classes on chronic diseases & their management, walking and physical activities group, etc.

*Projected number of consumers/clients served: 400*

## Workforce Education & Training (WET)

San Mateo County BHRS recently updated the WET Plan enacted in 2009, which will be submitted for both local and State approval along with this Three-Year Plan and begin implementation within the same time frame. See Appendix 6 for the MHSW WET Three-Year Plan Update (FY 2014-15 to 2016/17).

WET categories for funding remain as follows:

***Training, technical assistance, and capacity building*** – Training opportunities have greatly increased the capacity of community members and providers to respond to behavioral health issues; use evidence-based practices to help address an array of mental illness identification strategies including suicidality; and address public perception on behavioral health issues (stigma, suicide, etc.).

***Workforce staffing support*** – The plan and all BHRS training activities are overseen by a Workforce Development Director and a 0.5 FTE Community Resource Specialist. This team has system wide responsibility for managing implementation, reporting and evaluation of the MHSW Education and Training Plan.

***Training and technical assistance for and by consumers and family members*** – This program aims at providing a range of trainings activities, as follows:

- Trainings delivered by and for consumers and family members;
- Trainings provided by consumers and family members to providers and the general public to increase understanding of mental health issues and to reduce stigma;
- Trainings provided by consumers and family members to increase understanding of mental health issues and substance use/abuse issues, recovery and resilience, and available treatments and supports;

In addition, this program also provides for selected consumers and family members to attend leadership trainings to support increased involvement of consumers and family members in various committee, commission, and planning roles.

***Trainings to support wellness and recovery*** – San Mateo County BHRS engages in training to extend and support consumer wellness and recovery. An example of an activity to this end is the implementation of Wellness Recovery Action Plan Trainings (WRAP). WRAP is a self-help approach to achieve and maintain wellness that has been used successfully with mental health consumers and consumers with co-occurring disorders. With a train-the-trainer approach, consumers, family members, and selected staff (County and contracted providers) are trained as Master Trainers. The “Master Trainers” then provide training and support in developing WRAP plans for consumers and staff throughout our system.

***Cultural competence training*** – Training in the area of cultural competence is designed to reduce health disparities in our community, to provide instruction in culturally and linguistically competent services, and to increase access, capacity, and understanding by partnering with community groups and resources. Educational and training activities are made available to consumers, family members, providers, and those working and living in the community. Trainings are also used to help support key Health Equity Initiatives (HEI).

***Evidence-based practices training for system transformation*** – System transformation is supported through an ongoing series of trainings that increase utilization of evidence-based treatment practices that better engage consumers and family members as partners in treatment and that contribute to improved consumer quality of life. Recommendations for training on evidence-based practices (EBPs) to incorporate into the different series may come from consumers, family members, or public and private agency staff by submitting a form to the Workforce Development Director, who then submits the request to the Training Committee for consideration. Suggested trainings shall be consistent with the values of the MHSa and shall contribute to the creation of a more culturally competent system.

***Mental health career pathway programs*** – Multiple workgroup discussions concluded that strategies are necessary to address ongoing vacancies in positions which are difficult to fill. Strategies include:

- Attract prospective candidates to hard to fill positions via addressing barriers in the application process
- Attract prospective candidates to hard to fill positions through incentives
- Promote mental health field in academic institutions where potential employees are training in order to attract individuals to the public mental health system in general, and to hard to fill positions in particular
- Promote interest among and provide opportunities for youth/Transition Age Youth (TAY) in pursuing careers in behavioral health.
- Increase diversity of staff to better reflect diversity of client population
- Retain diverse staff
- Expand existing efforts and create new career pathways for consumers and family members in the workforce to allow for advancement within BHRS and in other parts of the County system
- Ongoing engagement and development of client and family workers

***Financial incentive programs/Stipended Internships*** – to create a more culturally competent system, this program provides stipends to trainees from local universities who contribute to expand the diversity as well as the linguistic and cultural competence of our workforce. Our stipend program for interns offers a fixed amount to students in our system to assist in covering their expenses in hopes they will pursue careers in public mental health.

## Housing

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

San Mateo County MHSA funds have supported three housing developments to-date, see Annual Update, Housing section for details. Within this Three-Year Plan time frame, BHRS will seek to support the development of at least one more housing structure. The Mental Health Association (MHA) of San Mateo County submitted a proposal to develop Waverly Place Apartments in North Fair Oaks community, which was reviewed and accepted by committee in February, 2014.

## Capital Facilities and Information Technology (CF/IT)

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

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

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

## Priority Expansions and Programs

MHSA-specific priorities identified by stakeholders in previous planning years remain top priorities moving forward:

Component	Previous Projected Expansions for FY 2011-12 to FY 2013-14	Implemented
<b>Community Services &amp; Supports (CSS), Full Service Partnerships (FSP)</b>	FSP slots for Psychiatric Emergency Services and the Medical Center’s Psychiatric Inpatient Unit (Transition Age Youth and Adults)	YES
	FSP slots for Transition Age Youth, with housing	NO
	Integrated FSPs to the Central Region (Adults)	YES
	Wraparound services for children and youth	NO
	Housing for existing FSP Adults	YES
<b>CSS, Non-FSP</b>	Pre-crisis response services	YES
	Supports for youth transitioning to adulthood	NO
	Assessment, supported employment, and financial empowerment	YES
<b>Prevention &amp; Early Intervention (PEI)</b>	Teaching Pro-social Skills	YES
	Parent Project	YES

Through the Three-Year Plan development Community Program Planning process, Steering Committee members reviewed recommendations from various Community Input Sessions conducted throughout San Mateo County with diverse input. The Steering Committee voted for priority strategies, programs or expansions to current programs to be included in the Three-Year Plan. See Appendix 4 Priority Strategies – Summary of Voting Results.

After careful analysis of the Steering Committee priority recommendations, including fiscal projections, community opportunities and strengths, and readiness, the following projects/programs were prioritized for funding in FY 2014-15 through FY 2016-17. Implementation of prioritized items will be started as revenue becomes available, and ongoing reports will be provided through our regular reporting and communication structure.

Component	Updated Priority Expansions for FY 2014-15 to FY 2016-17	Per Unit (#)	Cost		
			FY 14/15*	FY 15/16	FY 16/17
<b>Community Services &amp; Supports (CSS), Full Service Partnerships (FSP)</b>	Support and assistance program for individuals living in the community to connect them with vocational and social services, etc.		**	\$300,000	\$300,000
	Drop-in Center (South)***		\$75,000	\$300,000	\$300,000
	FSP slots for transition age youth with housing	\$46,000 (5)	\$57,500	\$230,000	\$230,000
	FSP slots for older adults	\$23,000 (5)	\$28,750	\$115,000	\$115,000
<b>CSS, Non-FSP</b>	Expansion of supports for transition age youth	\$3,500 (40)	\$35,000	\$140,000	\$140,000
	Expansion of supports for older adults	\$3,700 (35)	\$32,500	\$130,000	\$130,000
<b>TOTAL CSS</b>			<b>\$228,750</b>	<b>\$1,215,000</b>	<b>\$1,215,000</b>

\* One Quarter

\*\* Will be funded through Measure A per Board of Supervisors 11/18/2014

\*\*\* Reprioritized from Previous Expansion Plan

Component	Updated Priority Expansions for FY 2014-15 to FY 2016-17	Cost			
		FY 14/15*	FY 15/16	FY 16/17	
<b>Prevention &amp; Early Intervention (PEI)</b>	Expansion of culturally aligned and community -defined outreach and engagement with a focus on emerging communities and outcome-based replicable practices		\$37,500	\$150,000	\$150,000
	Expansion of Stigma Free San Mateo, Suicide Prevention and Student Mental Health efforts		\$12,500	\$50,000	\$50,000
<b>TOTAL PEI</b>		<b>\$50,000</b>	<b>\$200,000</b>	<b>\$200,000</b>	

\* One Quarter

# THREE-YEAR EXPENDITURE PLAN

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan						
Funding Summary						
County: San Mateo						Date: 9/30/14
	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
<b>A. Estimated FY 2014/15 Funding</b>						
1. Estimated Unspent Funds from Prior Fiscal Years	1,882,824	3,400,152	3,898,043	1,367,948	39,593	
2. Estimated New FY2014/15 Funding	19,661,894	5,243,172	1,310,793	0		
3. Transfer in FY2014/15 <sup>a/</sup>	0	0	0	0	0	0
4. Access Local Prudent Reserve in FY2014/15	0	0	0	0		0
5. Estimated Available Funding for FY2014/15	21,544,718	8,643,324	5,208,836	1,367,948	39,593	
<b>B. Estimated FY2014/15 MHSA Expenditures</b>	11,844,436	5,913,402	1,420,069	392,228	39,593	
<b>C. Estimated FY2015/16 Funding</b>						
1. Estimated Unspent Funds from Prior Fiscal Years	9,700,282	2,729,922	3,788,767	975,720	0	
2. Estimated New FY2015/16 Funding	16,970,275	4,525,407	1,131,352			
3. Transfer in FY2015/16 <sup>a/</sup>	0	0	0	0		0
4. Access Local Prudent Reserve in FY2015/16	0	0	0			0
5. Estimated Available Funding for FY2015/16	26,670,557	7,255,329	4,920,119	975,720	0	
<b>D. Estimated FY2015/16 Expenditures</b>	14,761,528	6,053,219	1,800,000	412,301	39,593	
<b>E. Estimated FY2016/17 Funding</b>						
1. Estimated Unspent Funds from Prior Fiscal Years	11,909,029	1,202,110	3,120,119	563,419	(39,593)	
2. Estimated New FY2016/17 Funding	17,993,348	4,798,226	1,199,557			
3. Transfer in FY2016/17 <sup>a/</sup>	0	0	0			0
4. Access Local Prudent Reserve in FY2016/17	0	0	0			0
5. Estimated Available Funding for FY2016/17	29,902,377	6,000,336	4,319,676	563,419	(39,593)	
<b>F. Estimated FY2016/17 Expenditures</b>	15,603,635	6,200,307	1,893,000	433,740	39,593	
<b>G. Estimated FY2016/17 Unspent Fund Balance</b>	14,298,742	(199,971)	2,426,676	129,679	(79,186)	
<b>H. Estimated Local Prudent Reserve Balance</b>						
1. Estimated Local Prudent Reserve Balance on June 30, 2014		600,000				
2. Contributions to the Local Prudent Reserve in FY 2014/15		0				
3. Distributions from the Local Prudent Reserve in FY 2014/15		0				
4. Estimated Local Prudent Reserve Balance on June 30, 2015		600,000				
5. Contributions to the Local Prudent Reserve in FY 2015/16		0				
6. Distributions from the Local Prudent Reserve in FY 2015/16		0				
7. Estimated Local Prudent Reserve Balance on June 30, 2016		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 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan  
Community Services and Supports (CSS) Component Worksheet**

County: San Mateo Date: 9/30/14

	Fiscal Year 2014/15					
	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
<b>FSP Programs</b>						
1. Youth /TAY	4,949,275	1,607,158	836,658	54,688	669,326	1,781,445
2. Adults and Older Adults	5,890,340	4,092,930	1,653,633	0	0	143,777
3. PES and 3AB FSP Expansion	110,965	110,965	0	0	0	0
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
<b>Non-FSP Programs</b>						
1. Community Outreach and Engagement	257,500	250,000	0	0	0	7,500
2. Criminal Justice Initiative	207,600	207,600	0	0	0	0
3. Older Adult System of Care	150,064	141,570		0	0	8,494
4. System Transformation	6,251,252	5,012,007	851,754	55,601	222,404	109,486
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
<b>CSS Administration</b>	298,943	222,206	40,105	1,323	10,701	24,608
<b>CSS MHSA Housing Program Assigned Funds</b>	200,000	200,000				
<b>Total CSS Program Estimated Expenditures</b>	18,315,939	11,844,436	3,382,150	111,612	902,431	2,075,310
<b>FSP Programs as Percent of Total</b>	92.5%					

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
<b>FSP Programs</b>						
1. Youth /TAY	5,164,774	1,822,657	836,658	54,688	669,326	1,781,445
2. Adults and Older Adults	6,196,638	4,399,228	1,653,633	0	0	143,777
3. PES and 3AB FSP Expansion	116,735	116,735	0	0	0	0
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
<b>Non-FSP Programs</b>						
1. Community Outreach and Engagement	634,323	550,406	68,551	0	0	15,366
2. Criminal Justice Initiative	218,395	218,395	0	0	0	0
3. Older Adult System of Care	157,867	149,373	0	0	0	8,494
4. System Transformation	6,576,317	5,337,072	851,754	55,601	222,404	109,486
5. Total Wellness	2,103,184	1,908,495	159,419	0	0	35,270
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
<b>CSS Administration</b>	339,158	259,167	42,840	1,323	10,701	25,126
<b>CSS MHSA Housing Program Assigned Funds</b>	0					
<b>Total CSS Program Estimated Expenditures</b>	21,507,391	14,761,528	3,612,855	111,612	902,431	2,118,964
<b>FSP Programs as Percent of Total</b>	77.8%					

	Fiscal Year 2016/17					
	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
<b>FSP Programs</b>						
1. Youth /TAY	5,317,670	1,975,553	836,658	54,688	669,326	1,781,445
2. Adults and Older Adults	6,442,155	4,644,745	1,653,633	0	0	143,777
3. PES and 3AB FSP Expansion	123,121	123,121	0	0	0	0
4.						
5.						
6.						
7.						
8.						
9.						
10.						
<b>Non-FSP Programs</b>						
1. Community Outreach and Engagement	664,658	580,741	68,551	0	0	15,366
2. Criminal Justice Initiative	230,342	230,342	0	0	0	0
3. Older Adult System of Care	166,062	157,568	0	0	0	8,494
4. System Transformation	6,868,225	5,628,980	851,754	55,601	222,404	109,486
5. Total Wellness	2,188,121	1,993,432	159,419	0	0	35,270
6.						
7.						
8.						
9.						
10.						
<b>CSS Administration</b>	349,143	269,153	42,840	1,323	10,701	25,126
<b>CSS MHSA Housing Program Assigned Funds</b>	0					
<b>Total CSS Program Estimated Expenditures</b>	22,349,497	15,603,635	3,612,855	111,612	902,431	2,118,964
<b>FSP Programs as Percent of Total</b>	76.2%					

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan  
Prevention and Early Intervention (PEI) Component Worksheet**

County: San Mateo Date: 9/30/14

	<b>Fiscal Year 2014/15</b>					
	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>	<b>F</b>
	<b>Estimated Total Mental Health Expenditures</b>	<b>Estimated PEI Funding</b>	<b>Estimated Medi-Cal FFP</b>	<b>Estimated 1991 Realignment</b>	<b>Estimated Behavioral Health Subaccount</b>	<b>Estimated Other Funding</b>
<b>PEI Programs - Prevention</b>						
1. Early Childhood Community Team Community Outreach and Engagement and Capacity	378,043	367,032	0	0	0	11,011
2. Building	3,580,654	3,205,302	298,551	0	0	76,801
3. Total Wellness for Adults and Older Adults	366,367	363,367	0	0	0	3,000
4. Community Interventions for School Age and TAY	511,518	506,814	0	0	0	4,704
<b>PEI Programs - Early Intervention</b>						
5. Youth/TAY Identification and Early Referral	824,000	800,000	0	0	0	24,000
6. Primary Care/Behavioral Health Integration for Adults	388,662	386,080	0	0	0	2,582
<b>PEI Administration</b>	286,152	284,807	0	0	0	1,345
<b>PEI Assigned Funds</b>	0					
<b>Total PEI Program Estimated Expenditures</b>	6,335,396	5,913,402	298,551	0	0	123,443

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
<b>PEI Programs - Prevention</b>						
1. Early Childhood Community Team Community Outreach and Engagement and Capacity	397,701	375,349	0	0	0	22,352
2. Building	3,766,848	3,284,076	298,551	0	0	184,221
3. Total Wellness for Adults and Older Adults	385,418	371,427	0	0	0	13,991
4. Community Interventions for School Age and TAY	538,117	518,067	0	0	0	20,050
<b>PEI Programs - Early Intervention</b>						
5. Youth/TAY Identification and Early Referral	866,848	818,128	0	0	0	48,720
6. Primary Care/Behavioral Health Integration for Adults	408,873	394,631	0	0	0	14,242
<b>PEI Administration</b>	294,727	291,541	0	0	0	3,186
<b>PEI Assigned Funds</b>	0					
<b>Total PEI Program Estimated Expenditures</b>	6,658,532	6,053,219	298,551	0	0	306,762

	Fiscal Year 2016/17					
	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
<b>PEI Programs - Prevention</b>						
1. Early Childhood Community Team Community Outreach and Engagement and Capacity	418,381	384,098	0	0	0	34,283
2. Building	3,962,724	3,366,947	298,551	0	0	297,226
3. Total Wellness for Adults and Older Adults	405,460	379,906	0	0	0	25,554
4. Community Interventions for School Age and TAY	566,100	529,906	0	0	0	36,194
<b>PEI Programs - Early Intervention</b>						
5. Youth/TAY Identification and Early Referral	911,924	837,199	0	0	0	74,725
6. Primary Care/Behavioral Health Integration for Adults	430,134	403,626	0	0	0	26,508
<b>PEI Administration</b>	303,747	298,625	0	0	0	5,122
<b>PEI Assigned Funds</b>	0					
<b>Total PEI Program Estimated Expenditures</b>	6,998,470	6,200,307	298,551	0	0	499,612

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan  
Innovations (INN) Component Worksheet**

County: San Mateo

Date: 9/30/14

	Fiscal Year 2014/15					
	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
<b>INN Programs</b>						
1. Total Wellness	1,999,224	1,420,069	159,419	0	0	419,736
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
<b>INN Administration</b>	0	0	0	0	0	0
<b>Total INN Program Estimated Expenditures</b>	1,999,224	1,420,069	159,419	0	0	419,736

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
<b>INN Programs</b>						
1. (New Innovation Program)	1,800,000	1,800,000	0	0	0	0
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
<b>INN Administration</b>	0	0	0	0	0	0
<b>Total INN Program Estimated Expenditures</b>	<b>1,800,000</b>	<b>1,800,000</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

	Fiscal Year 2016/17					
	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
<b>INN Programs</b>						
1. (New Innovation Program)	1,893,600	1,893,600	0	0	0	0
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
<b>INN Administration</b>	0	0	0	0	0	0
<b>Total INN Program Estimated Expenditures</b>	1,893,600	1,893,600	0	0	0	0

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan  
Workforce, Education and Training (WET) Component Worksheet**

County: San Mateo Date: 9/30/14

	<b>Fiscal Year 2014/15</b>					
	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>	<b>F</b>
	<b>Estimated Total Mental Health Expenditures</b>	<b>Estimated WET Funding</b>	<b>Estimated Medi-Cal FFP</b>	<b>Estimated 1991 Realignment</b>	<b>Estimated Behavioral Health Subaccount</b>	<b>Estimated Other Funding</b>
<b>WET Programs</b>						
1. Workforce Staffing Support	265,542	257,808	0	0	0	7,734
2. Training and Technical Assistance	34,916	34,420	0	0	0	496
3. Behavioral Health Career Pathways Cultural Competence Stipend and	51,500	50,000	0	0	0	1,500
4. Internship Program	100,000	50,000	0	0	0	50,000
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
<b>WET Administration</b>	0	0	0	0	0	0
<b>Total WET Program Estimated Expenditures</b>	451,958	392,228	0	0	0	59,730

	<b>Fiscal Year 2015/16</b>					
	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>	<b>F</b>
	<b>Estimated Total Mental Health Expenditures</b>	<b>Estimated WET Funding</b>	<b>Estimated Medi-Cal FFP</b>	<b>Estimated 1991 Realignment</b>	<b>Estimated Behavioral Health Subaccount</b>	<b>Estimated Other Funding</b>
<b>WET Programs</b>						
1. Workforce Staffing Support	279,350	271,384				7,966
2. Training and Technical Assistance	36,731	35,684				1,047
3. Behavioral Health Career Pathways Cultural Competence Stipend and	54,178	52,633				1,545
4. Internship Program	105,200	52,600				52,600
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
<b>WET Administration</b>	0	0	0	0	0	0
<b>Total WET Program Estimated Expenditures</b>	475,459	412,301	0	0	0	63,158

	Fiscal Year 2016/17					
	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
<b>WET Programs</b>						
1. Workforce Staffing Support	293,877	285,496	0	0	0	8,381
2. Training and Technical Assistance	38,641	37,539	0	0	0	1,102
3. Behavioral Health Career Pathways	56,995	55,370	0	0	0	1,625
4. Cultural Competence Stipend and Internship Program	110,670	55,335	0	0	0	55,335
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
<b>WET Administration</b>	0	0	0	0	0	0
<b>Total WET Program Estimated Expenditures</b>	500,183	433,740	0	0	0	66,443

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan  
Capital Facilities/Technological Needs (CFTN) Component Worksheet**

County: San Mateo Date: 9/30/14

	<b>Fiscal Year 2014/15</b>					
	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>	<b>F</b>
	<b>Estimated Total Mental Health Expenditures</b>	<b>Estimated CFTN Funding</b>	<b>Estimated Medi-Cal FFP</b>	<b>Estimated 1991 Realignment</b>	<b>Estimated Behavioral Health Subaccount</b>	<b>Estimated Other Funding</b>
<b>CFTN Programs - Capital Facilities Projects</b>						
1. eClinical Care	0	39,593				
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
<b>CFTN Programs - Technological Needs Projects</b>						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
<b>CFTN Administration</b>						
<b>Total CFTN Program Estimated Expenditures</b>	0	39,593	0	0	0	0

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
<b>CFTN Programs - Capital Facilities Projects</b>						
1. eClinical Care	0	39,593				
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
<b>CFTN Programs - Technological Needs Projects</b>						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
<b>CFTN Administration</b>						
<b>Total CFTN Program Estimated Expenditures</b>	0	39,593	0	0	0	0

	Fiscal Year 2016/17					
	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
<b>CFTN Programs - Capital Facilities Projects</b>						
1. eClinical Care	0	39,593				
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
<b>CFTN Programs - Technological Needs Projects</b>						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
<b>CFTN Administration</b>						
<b>Total CFTN Program Estimated Expenditures</b>	0	39,593				

## FUNDING CONSIDERATIONS

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

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

Changes in the tax law that took effect on January 1, 2013, led to several taxpayers filing in December 2012 in order to avoid paying higher taxes. This resulted in an additional "one time" increase in funding.

For FY 2015-16, PEI revenue will decrease in from \$6.3 to \$4 million. Overall spending in the Three-Year Plan will need to decrease as well to make up for this deficit.

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

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# ANNUAL UPDATE FY 2014-2015

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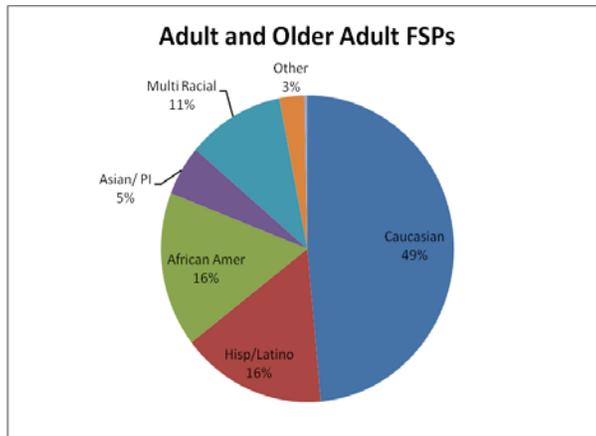
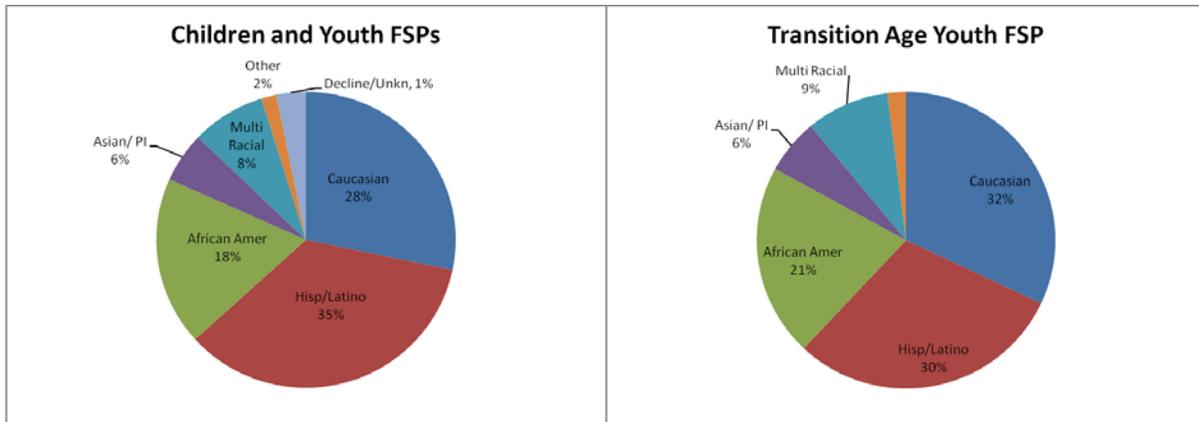
(covering highlights and data from FY 2012-2013 services)

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

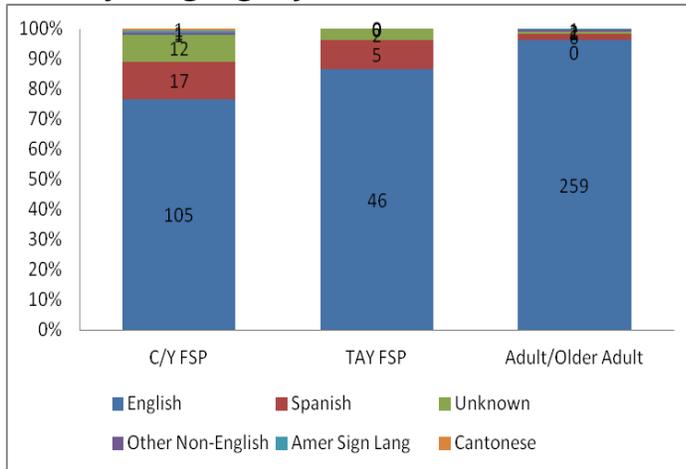
In FY 2012-13, 491 clients of all age groups were served by FSPs in San Mateo County. Edgewood, Fred Finch, and Telecare FSPs have been fully operational since 2006. A fourth site, Caminar’s Adult FSP, was added in 2009. Edgewood and Fred Finch use the Wraparound model to serve children, youth, TAY, and their families, while Caminar and Telecare offer Assertive Community Treatment (ACT) services to adults, older adults, and their families.

### FSP DEMOGRAPHICS FOR FY 12/13

#### *Race, ethnicity by age group*



**Primary Language of FSP Enrollees:**



**FSP COST PER CLIENT**

Program	Clients served	Cost per client
<b>Children/Youth</b>		
Children and Youth Placed in Out-of-County Foster Care Settings FSP	26	\$19,987
Integrated Services, Individualized Supports (ISIS) FSP	54	\$24,009
“Turning Point” Comprehensive FSP	57	\$25,495
<b>Transitional Age Youth (TAY)</b>		
“Turning Point” Comprehensive FSP	53	\$25,495
Enhanced Supported Education Services	45	\$3,656
Supported Housing Services	20	\$10,000
<b>Adult/Older Adult</b>		
Adult and Older Adult/Medically Fragile FSP	231	\$13,775
FSP Housing Support	90	\$9,079
Comprehensive FSP and Housing Support	38	\$22,153
Integrated FSP	31	\$3,352

Based on currently contracted amounts, the average FSP cost per client was \$21,196 with age breakdowns as shown in the above table. Cost-per-person figures do not fully reflect the span or quality of services available to clients either through BHRS or through contracted providers and may overlook important local issues such as the cost of housing.

## FSP PERFORMANCE OUTCOMES

We track year-to-year outcomes for individual clients. Information collected for FSPs include data in 10 domains; residential (e.g. homeless, emergency shelter, apartment alone) education (e.g. school enrollment and graduation, completion dates, grades, attendance, special education assistance), employment, financial support, legal issues, emergency interventions, health status, substance abuse, and for older adults, activities of daily living and instrumental activities of daily living.

Our data through December 31, 2013, demonstrate notable improvements across two key dimensions for FSPs, average number of days spent in hospitals and average number of psychiatric and emergency service (PES) visits:

- **Number of days hospitalized decreased by eight days, or 39.52%**
- **Number of PES visits decreased by 14.23%**

In addition, the following FSP data outcomes represents 698 new enrollments from the inception of the MHSA FSP programs through December 31, 2013. About 10% of these individuals enrolled discontinued their services then reestablished their services, greater than 1 year after discontinuing. If an individual returns within one year of their initial discontinuation from the program, then they are not considered a new enrollment.

Age Group Served	Adult (260)	Child / Youth (152)	Older Adult (66)	TAY (220)	Weighted Average for All FSP Programs
Decreased Homelessness	73%	67%	100%	42%	62%
Decreased Hospitalization	63%	52%	29%	68%	61%
Decreased Incarceration	39%	43%	100%	49%	45%
Decreased Arrests	80%	40%	n/a	71%	67%
Decreased School Suspensions		83%		80%	82%
Increased School Attendance		39%		32%	36%
Decreased Out-Of-Home Placement (Grp Home)		60%		77%	72%
Increased School Grades		47%		35%	43%

These are promising data that signal the need for additional study across other domains to fully capture the impact of the FSP model in San Mateo County.

## FSP QUALITATIVE EVALUATION

In May 2013, Davis Y. Ja and Associates, Inc., an independent consulting firm, was contracted to conduct a qualitative evaluation of San Mateo County Full Service Partnership (FSP) programs to understand how well FSPs are working from the perspective of administrators, providers and consumers/clients. See Appendix 7 for the FSP Evaluation Executive Summary, the full report is available at [www.smhealth.org/bhrs/mhsa](http://www.smhealth.org/bhrs/mhsa).

### ***Overall Findings and Recommendations***

There were common themes that emerged from the interviews and focus groups with FSP administrators, service providers, and consumers and caregivers and included:

- ✓ High level of satisfaction with the Wraparound model for child/youth FSPs and with the Assertive Community Treatment (ACT) approach for adult/older adults. However, there were some challenges with the Wraparound model for TAY, a peer-driven and recovery oriented model may be more appropriate for this population.
- ✓ Challenges with maintaining consistent staffing and providing an ideal spectrum of services with current funding levels.
- ✓ Greater demand than available slots.
- ✓ Insufficient linkages between FSP systems for transitioning C/Y/TAY and community supports for consumers leaving FSP services.
- ✓ Family/caregiver involvement and collaboration as a vital component
- ✓ Insufficient availability of safe, accessible, affordable housing.

Overall, the sense is that while challenges exist in serving the complex populations targeted by the FSPs, the programs are having a positive impact on the lives of those served. While many individuals served through an FSP have shown significant improvements in their lives, we know there is more to do. The findings and recommendations made in this report will help guide our future FSP development, funding allocations and evaluation.

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### **Key Recommendations**

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- ✓ Review current referral criteria for child/youth/TAY (BHRS/providers)
  - ✓ Address the service gaps between TAY, adult FSP systems and community supports
  - ✓ Explore options for a more integrated model of dependency treatment and medical care, especially for TAY, medically fragile, and older adults
  - ✓ Conduct a needs assessment for specific youth populations, especially those with justice involvement, co-occurring, and psychotic disorders
  - ✓ Provide a provider or BHRS-initiated orientation for new families entering FSP
  - ✓ Identify safe, accessible, appropriate, and affordable housing for TAY and adults
  - ✓ Clarify whether supportive services are available at housing sites; if not, develop plan for monitoring consumer progress/decompensation
- 

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

## FSP PROGRAMMATIC HIGHLIGHTS FOR FY 12/13

***Children and Youth Placed in Out-of-County Foster Care Settings*** - Youth ages 6-17 who are admitted to this FSP provided by Fred Finch Youth Center have challenges in maintaining their placement. Youth may reside in foster family agencies or relative homes. Some youth are attempting to reunify with biological family. Out-of-County placed youth face additional struggles accessing services and getting mental health needs met. The youth and their caregivers in the FFYC FSP are given wraparound services to help stabilize the placement and help form healthy connections. Services are community based and are typically conducted at the youth's home or school. This FSP also supports older adolescents transitioning out of foster care (18 years old and above) in their journey toward adulthood.

All youth and their families participate in Child and Family Team (CFT) Meetings. Clinicians, FFYC team members, County staff and other supports are invited. Client and family members are encouraged to express their requests and all team members contribute to helping meet their needs. The needs are varied including financial assistance for housing, moving expenses, laptop purchase, funding tutors, and linking individuals with community resources. These meetings are occurring approximately once per month per family.

The FFYC treatment team is 2.5 Care Coordinators, one Youth Partner and one Parent Partner; both have lived experience as a consumer or family member. Twenty slots are available for this program. FFYC served 26 youth, of the enrollees, 55% were female and 45% were male; the average age was 12.7 years (range is 4 years old to 19 years old); 65% (13) were Non-Hispanic and 35% (7) Mexican/Mexican American. All clients reported English as their primary language and resided in cities across the Bay Area.

A challenge that the program experienced was a period of understaffing at the end of 2012. With a small program (four staff at the time), there was little latitude in staffing. A staff member was hired but left the position after six weeks of employment. This created some challenges for clients and program planning. To address this issue, the program took significant efforts to screen good candidates, communicate the importance of retention, provide a welcoming environment and provide staff with leadership opportunities within the agency. The department also added a half-time Care Coordinator position. This will help maintain proper staffing levels for the program and will assist in times when employees vacate their position. The program was fully staffed again by January 2013.

Another challenge was difficulty in getting all parties to attend the CFT Meetings. FFYC often held the meetings without Child Welfare Workers or other key figures. Attendance issues were due to: scheduling priorities and location. The program continues to make an effort to encourage all important stakeholders to attend CFT's and to provide meeting highlights to members who are present or absent.

*In FY 12-13, Fred Finch Youth Center served 26 youth.  
Cost per person: \$19,987*

***Integrated Services, Individualized Supports (ISIS) FSP for Children/Youth/TAY*** – Edgewood Center for Children and Families was awarded the contract to provide integrated clinic-based FSP services for the Central/South Youth Clinic (outpatient), as well as the integrated FSP for intensive school-based services which are provided in the Therapeutic Day School (TDS) setting, school-based milieu services, and the Non-Public School setting. Youth served are 6 to 21 years old. These two integrated FSPs provide a full array of wraparound services to support our existing mental health teams. Services are open to all at-risk clients. However, they are specifically targeted to clients among underserved Asian/Pacific Islander, Latino, and African American populations.

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

The integrated FSP program continues to have many successes with maintaining youth in their homes and school placements. Both integrated FSPs have 20 slots each. At the end of the FY, ISIS clients were 36% Caucasian, 9% African American, 30% Latino, 9% Asian (Chinese and Japanese) and 9% identified as multi-racial/ethnicities and 3% of identified as Persian or Asian Indian and 3% declined to identify a specific cultural identity.

*In FY 12-13, ISIS FSP served 54 youth, 30 clinic-based and 24 school-based.  
Cost per person: \$24,009*

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

***Child and Youth (C/Y)*** – The Turning Point FSP for C/Y has a capacity to serve 40 youth and families at a time. Participants have very high intensity needs. Enrollees had a moderately high level of acuity, with a high incidence rate of youth coming out of multiple prior hospitalizations and extended juvenile justice stays. There was also a moderately-high incidence of co-occurring substance abuse problems and developmental delays. These numbers are notable as the average age for C/Y participants was approximately 14 years.

The cultural diversity of the C/Y staff team included African American (22%), Asian (11%), Caucasian (28%), and Latino staff (39%, all Spanish bilingual). There were two Therapeutic After School Support Specialists (formerly peer partners) and one Transportation and Safety Worker serving the new After School Intensive Services Program at the San Carlos Youth Center, and two Family Partners on staff (caregivers who have raised special needs children). The age range of our staff was 21 to 60, with most being in their 30s and 40s.

The After School Intensive Services Program (ASIS), served 20 youth between the ages 6-15 years old. Attendance has maintained stable, with the highest attended days serving as many as 12 youth from ISIS, Turning Point C/Y, Collaborative and Kinship programs combined. The average age of attendees was 9.5 years old, and of the 20 enrollees, 13 were male, 7 were female and the ethnic makeup of attendees was 30% Caucasian, 20% Latino, 5% Asian/Pacific Islander, 5% American Indian/Alaska Native, 25% African-American and 15% declined to answer.

The children/youth FSP had many successes in FY 12-13 maintaining youth in their homes and communities and supporting return transitions from out of home placements. In the first half of the year, two C/Y enrollees graduated, having achieved all of their goals.

Challenges for the C/Y FSP included the rising cost of living in the Bay area, specifically the Peninsula and San Mateo County. Families are unable to locate suitable housing which is affordable. A number of C/Y FSP enrollees' parents are monolingual Spanish speaking. While a substantial number of our staff are bilingual and bicultural, the numbers of youth needing this type of support has been increasing. Finally, a number of the youth being referred to C/Y FSP have parents with undiagnosed and/or untreated mental and physical health issues of their own, including their own traumatic life experiences, which seemed to lead to difficulty in their ability to fully engage in their children's treatment.

*In FY 12-13, Turning Point Comprehensive FSP for Child, Youth served 57 children/youth.  
Cost per person: \$25,495*

**Transitional Age Youth (TAY)** - Turning Point's TAY program has a capacity to serve 40 transitional age youth at one time. The primary referrals for the TAY Program are San Mateo County Behavioral Health & Recovery Services, Human Service Agency (foster care), and the juvenile justice system; since its inception in 2006 all TAY slots have been utilized with an average waitlist of 6-8 youth and an average wait time of 4-6 months. During FY 2012-13, there were 21 graduations from the program, which allowed the program to enroll youth within 2-3 weeks of their presentation to the referral review committee.

In addition to providing individualized support, the TAY Program also offers group/peer based support through the Support for Emerging Adult (SEA) programming at our Drop In Center site in San Bruno. This programming offers a safe environment, meals, groups and activities, resources, and staff support. In addition to serving the 40 TAY, the Center is also open to any San Mateo County youth who is between the ages of 18-25. On average, 62% of

the youth who attend are from the community and unattached to Edgewood programs. Often these individuals have “fallen through the cracks” or refused services; at the Center they are able to access support and appropriate resources/referrals.

Groups and activities are designed specifically for and with the input of the participants and include: LGBTQIQ group and activities, recreation activities, Supported Education nights, career/vocational workshops, Cooking& Nutrition group, Independent Living series, Seeking Safety group, Young Philosophers Nights, and off-site outings. During the year, the SEA hosted its first TAY participant-led group which focused coordinating community service activities for and with participants. The first panel in the Let’s Talk series was facilitated by two staff members and featured young women from the community who shared their stories and responded to questions on their experiences as ‘Young Mothers.’ Additional new groups/activities included a DIY (Do it Yourself) series, a 2x/week group who trained to run a 12k race, and extended SEA program hours to 3-8 p.m. Mondays-Fridays.

A recent graduate of the program co-led a weekly hiking group. The SEA hosted Tech Tuesdays, a two hour time slot each week for participants to have one-on-one or small group workshops on all things tech related. Community Meeting was a weekly participant-led discussion on issues, concerns and ideas regarding SEA programming and the greater community. In addition to these weekly activities, the SEA offered a two-night Vegan Cooking event which was followed by a vegan meal, each led by a professional caterer. The professional caterer and chef created significant enthusiasm and increased participation in nutrition related-discussions and upcoming meal planning.

This year, a proposal from the Family Partner cohort was selected for a workshop at the California Mental Health Advocates for Children and Youth (CMHACY) conference at Asilomar. The workshop, entitled “Non-Traditional Family Engagement Approaches to Caregiver Wellness: Nature, Mindfulness and Chaos Reduction,” included new approaches to effective self-care and family engagement. This workshop was presented by both Family Partners and caregivers of youth in the TAY program. The workshop was highly attended and highly praised.

Fifty five percent of enrollees had a history of psychiatric hospitalization; 17% had a history of involvement in the juvenile or adult justice systems; 38% had a co-occurring disorder; 34% had developmental delays, 43% were involved in vocational training, unpaid or paid employment; 28% were involved in educational attainment; and 16% were involved in both vocational and educational attainment. The FSP is staffed by a diverse multi-disciplinary team who partner with the youth (and their “family”) to identify their needs and create strategies utilizing their strengths to address these needs.

The TAY FSP had 21 individuals graduate from the program, including two that began their first semesters at four year universities having successfully completed the required classes at local community colleges.

This year saw significant change within the TAY FSP graduations, new referrals, and infrastructure change designed to enhance the program components and delivery of services. The FSP model is still based on the principles and practices of Wraparound, and now more effectively utilizes a variety of modalities proven effective in meeting the needs of this underserved and often marginalized population, including Dialectical Behavior Therapy (DBT), Harm Reduction, Motivational Interviewing, and Youth Development.

*In FY 12-13, Turning Point Comprehensive FSP for TAY served 53 youth.  
Cost per person: \$25,495*

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

Supported Education includes the following components:

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

There were continued challenges engaging TAY in educational activities and completion of educational goals. Caminar and the College of San Mateo's DSPS program (Disabled Student Programs and Services) developed an enhanced structured and supportive cohort program called "Connections" that consisted of academic skills development classes, planned outreach, individualized support, and coordination with community supports and services. The elements of this program include: expected meetings during the semester with a DSPS counselor and the Transition to College staff, concurrent classes developed for academic and personal skills development, educational planning, and peer counseling skills. The expectation is with structured and supportive entry or re-entry, outcomes will be an improved retention rate and measurable student academic success. Success was an increase in contacts and engagement activities with TAY, achieving an 80% retention rate in Transition to College classes, and in providing services to 45 Transition-Aged Youth. There are a total of 40 slots available for this program.

*In FY 12-13, 45 transition age youth were served by this program.  
Cost per person: \$3,656.*

***TAY Supported Housing*** - Mental Health Association (MHA) secures and manages 20 units of high quality housing for TAY FSP enrollees and collaborates with the Edgewood TAY FSP. The challenges in addressing the housing needs enrollees include developmental appropriateness, the lack of appropriate housing options for those not meeting criteria for a social rehab and yet not ready for supported housing and a housing system/network which hold transition age youth to adult standards. Continuity and permanence is also a challenge given the lack of long-term, affordable and appropriate housing options for TAY in the Bay Area.

Building and maintaining relationships with the managers at the Silver Hotel and Ohevet's Board & Care Homes, has given enrolled and former clients options for current and long-term housing. For these two entities, unrestricted length of stay is notable as well as managers who are invested in supporting and mentoring transition age youth. Strategies implemented through the years which the program continues to find helpful include the requirement that all transition age youth with "housing" as an identified need complete an Independent Living Skills (ILS) Assessments with an Occupational Therapist through the MHA. This assessment yields detailed information regarding skill level, learning styles and appropriateness for community housing. In addition, the TAY Program has implemented the use of the Casey Life Skills Assessment (CLSA) for this same sub-population of youth, in order to inform the work of our Independent Living Skills Specialist, as well as the entire team working with each individual youth. This Assessment is completed annually to track growth and provide data to the youth, treatment team and family.

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

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

This past year, the program came to a shared understanding with San Mateo County Adult Resource Management that those stepping down from a high level mental health facility (e.g. Cordilleras, Canyon Oaks, out-of-county youth residential placement, state hospital) will generally need and meet criteria for a social rehab program. The program identified the many needs of TAY returning to a community setting: to support individual and community safety, to increase the likelihood of medication compliance, decrease the instances of psychiatric emergency services (PES) visits, allow youth and families the opportunity to connect/re-connect without the pressure associated with living together, and provide a supportive living environment. This has eased transition, decreased PES visits, and increased motivation to stabilize and learn the necessary skills to move to a lower level of housing. In addition, it has allowed our treatment teams to partner with social rehab staff in assessing and addressing the immediate and on-going needs.

After successfully piloting the use of the Casey Life Skill Assessment (CLSA) this year with a sub-population of our enrolled clients, the program will begin full implementation in July 2014 ensuring that all youth complete the CLSA within 60 days of enrollment and on a yearly basis while in the TAY Program. This is significant and a much anticipated endeavor as it will be the first TAY-specific tool utilized for data collection within the TAY Program.

Housing utilized by enrolled clients:

Caminar: Redwood House\*  
Caminar: Eucalyptus House\*  
Caminar: Hawthorne House\*  
Mateo Lodge: Wally's Place  
Shelter Network: Maple Street Shelter\*\*  
Spring Street Shelter  
Ohevet's Board & Care\*\*  
Lily's Board & Care\*  
Silver Hotel\*  
Edgewood San Benito apartments\*  
Caminar: YAIL\*  
GGRC: Host Homes  
THP Plus  
MHA: SAYAT housing voucher for community living  
Edgewood: scattered site housing\*  
Family/friends

\*Indicates MHSA dollars have been utilized to subsidize individual transition age youth.

\*\*Indicates MHSA dollars have been utilized for a dedicated bed(s).

*In FY 12-13, 20 transition age youth were served by MHA Supported Housing.  
Cost per person: \$10,000*

***FSP and Housing Support Program for Adult, Older Adult, and Medically Fragile*** - This FSP program, ran by Telecare, Inc., provides services to our highest risk adults, highest risk older adults/medically fragile adults and Outreach and Support Services for potential FSP enrollees receiving outreach and support services. The purpose of these three programs is to assist consumers/members to enroll and once enrolled, to achieve independence, stability and wellness within the context of their cultures and communities.

Program staff are available 24/7 and provide services including: medication support, continuity of care during inpatient episodes and criminal justice contacts, medical treatment support, crisis response, housing and housing supports, vocational and educational services, and individualized service plans, transportation, peer services, and money management. Services specific to Older Adult/Medically Fragile include maximizing social and daily living skills and facilitating use of in-home supportive agencies.

The overall goal of the program is to divert from the criminal justice system and/or acute and long term institutional levels of care (locked facilities) seriously mentally ill and dually diagnosed individuals who can succeed in the community with sufficient structure and support. The program is grounded in research and evaluation findings that demonstrate that diversion and post incarceration services reduce incarceration, jail time and re-offense rates for offenders whose untreated mental illness has been a factor in their criminal behaviors. The program also follows the model and philosophies of California's AB 2034 Homeless Mentally Ill Adult programs and the assertive community treatment approach, aiming to use community-based services and a wide range of supports to enable seriously mentally ill and dually diagnosed adults to remain in the community and to reduce incarceration, homelessness, and institutionalization.

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

The program targets seriously mentally ill older adults and medically fragile individuals who either would be at risk of placement in a more restrictive setting without intensive supports or who could be moved to a less restrictive setting with these additional supports. The program works with board and care facilities and with consumers living in the community to prevent them from being placed in locked or skilled nursing facilities, and with residents of skilled nursing and locked facilities to facilitate their returning to a less restrictive setting. Referrals to the program are received from locked facilities, skilled nursing facilities, acute care facilities, board and care facilities, primary care clinics, Aging and Adult Services, community agencies, and from individuals/family members.

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

Telecare, Inc. was contracted in October 2009 for a total of 200 members: 75 Adult, 75 Older Adult/Medically Fragile, 40 Community Case Management and ten in a new Wellness category. In February 2011, there was an amendment to the Telecare FSP to more effectively align needs with BHRS resources: ten case management slots were reduced in order to add seven intensive slots, and the rest of the savings was shifted to support the Housing Support Program for a total of 187 slots. During FY 2012-2013, Telecare FSP was contracted to provide services to a total of 229 unduplicated individuals. These services encompassed three different levels of intensity. Staff to client ratios were, Full Service Partnership 1:10, Community Case Management 1:27 and Wellness 1:40.

Over the past year, the program was largely been impacted with the entirety of referrals coming to the FSP level, while the CCM and Wellness levels remained full. In addition to psychiatric services, personal service coordination, fiscal and budgetary services, housing and crisis management, etc, the Telecare FSP is also led the following groups totaling between 22-30 week: WRAP groups, Seeking Safety, CBT groups, a DBT skills group, Co-Occurring/Dual Diagnosis Recovery group, Consumer Advisory Family and Friends.

The Recovery Center at the Industrial Hotel was a great success with numerous social and clinical groups on site as well as health related services there weekly.

Staffing has been unsettled as two Team Leaders and one psychiatrist was lost. For one Team Leader, recruitment was covered in house but it took over three months to fill both the other Team Leader and the psychiatrist positions.

The program Outcomes for the year are as follows:

Hospital episodes = a decrease of 94%

Hospital days = a decrease of 78%

Incarceration episodes = a decrease of 90%

Incarceration days = a decrease of 81%

Homeless episodes = a reduction of 88%

Homeless days = a reduction of 83%

Of the individuals served 17% were 60+ years of age and 83% were 19-59 years of age. As for cultural makeup, 79% identified as non-Hispanic, 14% as Hispanic and 8% other or non-identified. Furthermore, race makeup included 54% identified as Caucasian, 21% African American, 10% Latino/Hispanic, 4% Asian, 4% Pacific Islander, 4% Native American, and 4% Other.

The program had bilingual language capacity in English, Spanish, Greek, French, Nepali, Amharic and Tigrigna.

The primary challenges for the year largely revolved around program funding. Recruitment has been increasingly challenging for clinical management positions as the funding has remained flat since 2006 (rate per client). Furthermore, the program continues to receive referrals for clients who have exhausted all housing options, necessitating the use of both program subsidy for rents as well as total capital for housing development. It is our hope that with the coming RFP, that we can partner to fund the services at an appropriate level to adequately support existing services as well as continue to grow options for the clients and for the County. A case example of this point is made below under Housing.

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

The housing program has been very successful with more members in stable housing through the development of additional housing options that are either directly managed or supported by Telecare with onsite staff. This has enabled members who might otherwise be at risk of losing their housing to receive the additional oversight and support they need to stay consistently housed. Additionally Telecare is supplementing some residential care facilities in order to enable clients to live in the community who require this level of supervision and services.

Telecare's Supported Housing Program continues to be a huge clinical success. Not only does the program house nearly 140 individuals in any given month, we often house those clients who have been refused by every other housing provider on the county. Furthermore, by developing a dynamic housing continuum, we are able to respond to the varying levels of need and willingness of each particular client so that they have the greatest opportunities for housing success and contentment.

However, although funding has remained flat (cost per client) neither rents, nor related expenses (such as damages) have remained flat. Furthermore, the total number of new clients needing housing at admission continues to increase and is nearing 100% of new admissions.

A prime example of such an issue is Telecare's attempts to address a bed bug infestation in the Industrial Hotel. Over the course of the past FY as well as the preceding fiscal year, Telecare has invested several tens of thousands of dollars in combating an infestation in a building that we did not fully control and which was caused by a non-Telecare individual. Beds were purchased several times, linens were purchased several times, numerous pest control agencies and fumigations efforts were made all funded by Telecare but, for which, Telecare was not funded.

*In FY 12-13, Telecare FSP and Housing Support Services served 231 clients (145 adults and 86 older adults/medically fragile).*

*Cost per person: \$13,775*

*Housing Cost per person: \$9,079*

***Comprehensive FSP and Housing Support for Adults and Older Adults/Medically Fragile*** – Caminar was contracted to provide beginning October 2009 for a maximum of 30 enrollees. The FSP provides intensive case management services including full-service psychiatric services, injections (in-home when necessary), daily in-home medication monitoring and weekly medi-sets. Nurses provided in-home assistance with teaching skills to manage diabetes, assessment, coordination and communication with medical providers. On occasion psychiatrists saw clients in their homes/in the field. The FSP transported clients to appointments, offered an after-hours warm-line, and 24/7 emergency response. Fiscal and budgetary services were provided through a sub-payee function in conjunction with the program's personal services coordination.

During the year, nine new clients were enrolled and nine were discharged. Most of the clients were beginning to experience medical issues and were in need of long term medical assistance. All FSP clients were seen weekly for at least two hours by their case managers, nurses, psychiatrists, assistant case managers and/or community support workers who provide medication support in the community.

There was an extreme lack of housing options for clients. Landlords were renting to higher paying consumers and the FSP clients cannot afford the higher rents given their fixed incomes. Another concern is the lack of long-term facilities to accommodate the aging and medically fragile population, so it is difficult to provide adequate case management care for clients who are struggling with medical concerns in the community for much longer than is appropriate for them.

Since moving to a strengths-based case management model, there were improvements toward a better quality of living and some success with clients moving to a lower level of care. In the last quarter of the fiscal year, 73% of FSP clients had WRAP plans and 90% of them participated in self-help and other community activities.

The following were average outcomes for last quarter of the fiscal year:

Homelessness: 6% (2 out of 30 this quarter)

Hospitalizations: 16% (5 out of 30)

Incarcerations: 3% (1 out of 30 this quarter)

Stable Housing: 75% remained in stable housing for at least one year

In addition, 14% of clients provided their own transportation; 97% of clients lived in satisfactory living environments (apartments, SRO hotels, independent supportive housing or with family); 37% of clients received housing subsidies, and 13% received Caminar's Sponsor-based Shelter+Care Supportive Housing.

*For FY 2012-13, Caminar FSP and Housing Support Program served 38 clients.*

*Cost per person: \$22,153*

***Integrated FSP Program*** – Mateo Lodge was contracted to run the South County Mental Health Clinic (SCC). A 1.0 FTE Mental Health Counselor and a 0.25 FTE Community Worker are assigned to SCC to provide case management services to a small caseload (up to 15 clients) of high risk, marginally engaged clients for six months to a year, with the goal of stabilizing and engaging clients in services at the SCC. Clients referred for supplemental case management are those who require services beyond the level an outpatient team or clinic can provide, but less than is needed for full service partnership.

Challenges during FY 12/13 included filling the .25 case manager assistant position; lack of bi-lingual capability, and declining quality of service provided by the assigned case manager. Consequently, the clinic Unit Chief conducted a review of the program by surveying staff who were utilizing the supplemental services for their clients. Clinic staff reported on the strengths, challenges and barriers of the program. Based on feedback from staff, quality improvement meetings were held with the Mateo Lodge director and BHRS Clinical Services Manager, resulting in improvements to the program. Improvements included establishing a more robust clinical case review protocol; replacing the English-speaking case manager with a bilingual- bicultural case manager, hiring a 0.25 FTE assistant to the case manager; increased expectation regarding attendance at clinic staff and team meetings; required completion of evidence-based practice interventions; development of a Needs-Assessment tool to be used with each new client, and improved transparency of case managers' schedule and availability. These changes were met with positive feedback from staff, and improved collaboration between team and contract services.

*For FY 2012-13, the SCC Integrated FSP served 31 clients.*

*Cost per person: \$3,352*

## **Telecare's Story**

### **Full Service Partnership (FSP) - Adult and Older Adult/Medically Fragile FSP**

*“Telecare helps give people hope that there's options for them  
in the world and in their lives”*

Kevin D. Jones, Administrator of Telecare, describes the mission of Telecare as being one that involves taking “[...] clients with serious, persistent mental health issues, co-occurring substance abuse issues, history with law enforcement and medical concerns; clients who have a variety of concurrent complexities with their lives, whether they be medical, psychiatric, drug abuse, financial, behavioral – no matter what – we take these clients and do everything we can within our funding stream to provide them a quality of life and an opportunity to improve their circumstances in a way that is sustainable for themselves”.

A Telecare client was living on the street with his pregnant girlfriend. After years of homelessness, incarceration, and alcohol-use, the client was not only able to be treated for his psychiatric symptoms through Telecare, but they were both housed through Telecare's subsidized housing. This client has been with Telecare for over two years and he and his family are all living in an apartment Telecare helps to subsidize.

Telecare services have drastically decreased homelessness, incarceration, hospitalization, and a myriad of other challenges among their client population.

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

In FY 09/10, we commenced a redirection of most of the services within this program that are fundable under the Prevention and Early Intervention component.

The following are highlights for FY 12/13, per program:

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

*In FY 12-13, CSS funded 40% of MHSA services provided by the Ravenswood Family Health Center (the remaining 60% is funded through Prevention and Early Intervention).*

*Ravenswood Family Health Center served 348 total clients.*

*Cost per person: \$506*

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

*In FY 2012-13, FAST team served 80 clients.*

*Cost per person: \$561*

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

*In FY 2012-13, CSS Outreach and Engagement partially funded staff served 133 clients.*

*Cost per person: \$5,069*

## **Jennifer's Story - Family Assertive Support Team (FAST)**

*"It saved my life and it saved my marriage"*

Jennifer, a client of Family Assertive Support Team (FAST), hadn't left her home to have a meal with her husband in over five years. FAST helped to change all of that by offering Jennifer and her husband services in the privacy of their own home. Jennifer worked with a team of providers from FAST, one of whom was a peer counselor who had struggled with similar challenges. In three short months, after being enrolled in the program, Jennifer was able to sit in a car, go around her neighborhood block, and visit the shopping center three blocks from her home, she reflected on this experience, "someone actually coming to my home and talking to me, counseling me to go outside – not forcing me to leave my home [...], helped me get comfortable with going outside and that's a huge deal".

Jennifer found the services offered by FAST very helpful, in her words she stated "this is the first program that worked and really helped me". Not only did Jennifer benefit from the services FAST had to offer but her husband, Will, reflected on how FAST helped him too, "what I enjoyed about the program is it gave me some tools to help me deal with my frustration over my wife's condition". Although Jennifer is no longer with FAST, she believes the new attitude she has towards her life and her hope for getting better is a result of her time with FAST, "I no longer get up dreading life any more, I want to get up, I want to get better".

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

The following are highlights for FY 12/13, per program:

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

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

The field-based mental health clinical team provides in-home mental health services to homebound seniors with Serious Mental Illness (SMI). The team consists of psychiatrists, case managers, and a community mental health nurse, and provides assessment, medication monitoring, psycho-education, counseling and case management. The team partners with other programs serving older adults such as Aging and Adult Services and the Ron Robinson Senior Care Center with the goal of providing comprehensive care and to help consumers achieve the highest possible quality of life and remain living in a community-based setting for as long as possible.

OASIS saw an increase in the number and complexity of clients being referred. Many of the older adults being referred come in crisis, losing their housing, facing acute medical issues, grappling with legal issues, etc. that affect their mental health and exacerbate their depression/anxiety. The number of clients dealing with multiple co-occurring conditions including mental health diagnoses, medical conditions, substance abuse issues, cognitive impairment, and physical disabilities grew making treatment interventions more intensive and time consuming which impacted the limited staffing resources of the field based team.

OASIS saw a significant increase in the number of monolingual Chinese speaking clients enrolled in the program. There are currently about 30 Mandarin and Cantonese speaking clients being treated by the Chinese speaking clinician and psychiatrist on the team. There are additional challenges in working with non-English speaking clients as the treatment team is the clients' communication link to the outside world increasing the amount of staff time involved with these cases.

The number of new referrals and services needs of the monolingual Chinese-speaking older adult clients particularly impacted the team's only Chinese-speaking clinician as her caseload continued to expand with new clients in need of an intensive level of services while she was also focused on her role as the primary support for her caseload of Chinese-speaking clients. In recognition of the need for this clinician to prioritize her services for the established and new Chinese speaking clients, steps were taken to review her English-speaking caseload and wherever clinically appropriate to transfer these clients to another clinician on the team. While this created caseload capacity for the Chinese-speaking clinician to meet the cultural/linguistic needs of the monolingual population, challenges remained in continuing to absorb the new referrals to the program. Although some cases were closed, this did not really reflect the demand for services. In general, clients being closed to services were more stable and required a lesser level of intervention than the new clients who often came into services at a time of crisis.

At the same time, the job responsibilities of the Clinical Services Manager overseeing OASIS continued to increase resulting in the manager being less available to handle the incoming referrals to the program as OASIS is a direct entry point to services. This resulted in a delay in response to callers seeking OASIS services. To address this situation, a system was set up for the team's clinicians to handle the intake calls as part of their Officer of the Day (OD) duties. This approach had numerous challenges in that the intake functions did not work smoothly with the clinician's other responsibilities providing field based services, as intake work tended to transcend what could be accomplished during the OD shift. A request was made and approval was received to hire a Program Specialist to coordinate client intakes and oversee some of the day-to-day operations of the team. A recruitment process for the Program Specialist position was initiated.

The team's Chinese-speaking clinician was promoted to the Program Specialist position. The next step was to respond to the increasing service needs of the monolingual Chinese-speaking client population. The decision was made to fill behind the clinician who was promoted by hiring a second Chinese-speaking clinician. This would expand the team's Chinese bilingual/bicultural service capacity as the Program Specialist would continue to carry a half-time client caseload. The second Chinese-speaking clinician was hired in May and came to OASIS with extensive experience with San Mateo County and was therefore able to take on a caseload responsibility very quickly and effectively.

As the new Program Specialist had been with OASIS for eight years, she was able to make a very smooth transition into her new role and was able to soon develop an efficient and effective system for managing the intake process and responding to inquiries, referrals and transfers. The establishment of the Program Specialist position became even more critical with other changes in the leadership of the OASIS team. In May, the long-standing OASIS Clinical Services Manager was promoted to a Work out of Class position requiring her to no longer have oversight of the OASIS program. In turn, a supervisor from one of the county's outpatient adult clinics was promoted to the Work out of Class OASIS Clinical Services Manager position. These changes were understandably challenging for the OASIS team

especially since these new assignments were being filled on a temporary basis. The uncertainty of the situation was very hard for all concerned and much effort went into working to provide as much stability for the team as possible to ensure that the staff continued to have the support they needed to effectively work with their clients. Having a well-established and highly respected Program Specialist in place was instrumental in enabling the team to continue to function very effectively during this challenging time.

One of the Board and Care facilities serving about 24 older adult clients closed in September. This home had a contract with the County and was an excellent placement for OASIS clients due to the skilled and compassionate care provided by the caregiver there. Clients had been living there for many years and the closure of the home was very hard on the clients. OASIS and Public Guardian staff did a very good job of finding new placements for all the individuals living there and helping the clients to make a smooth transition to their new living environment. The majority of these clients were moved to other board and care homes contracted by the County and are still living in these placements and doing well.

**OASIS Demographics:**

Clients Served:	237
New Referrals:	31
Cases Closed:	31
Chinese-speaking clients:	32
Spanish-speaking clients:	33

*In FY 12-13, this program served 180 clients (based on clinicians funded by MHSA).  
Cost per person: \$1,895*

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

This year the recruitment goal was 60 new peer counselors. The annual goal is to train 36 new peer counselors, and 29 new senior peer counselors graduated from training this year, 81% of the goal. This program year the Senior Peer Counseling Program had 112 senior peer counselors participating in the program, 124% of goal. Fifteen counselors retired during the year, so the number of active peer counselors was 97.

During the year, 129 new clients entered the program (264% of goal) and 140 clients' cases were closed. As of June 30, 2013, 248 senior peer counseling clients were active in the program and 388 clients have been served during the year, 120% of goal.

The demographics of clients served by culture were 62% Latino, 7% Chinese, 4% LGBT and 3% Filipino. 25% of clients were English-speaking.

The program hired Catherine Koger, MFT, as the new LGBT Coordinator. Peninsula Family Service was one of the sponsors of the first San Mateo County Pride Event on Saturday, June 15, 2013. The program “manned” a booth at the event and Cathy also participated on a panel presentation at this event which was attended by approximately 300 people.

The La Esperanza Vive Coordinator left the program and recruitment was underway for the coordinator position. Staff “manned” booths at four health or older adult fairs to distribute program flyers and recruit new potential volunteers. The Program Manager and a Senior Peer Counselor also presented at the Making the Connection, Combat Loneliness and Isolation in Older Adults BHRS Older Adults Forum on June 11. Articles about the senior peer counseling program were published in a local Filipino and a local Chinese newspaper, thanks to our Coordinators’ relationship with the staff at these newspapers.

In order to better serve the underserved older adult Filipino and LGBT populations, Peninsula Family Service worked with Applied Survey Research to conduct focus groups and interview key informants from these communities to develop new strategies in reaching these populations. All senior peer counseling clients were asked to complete a survey regarding our services. This survey was administered in June.

The biggest current challenge is recruiting volunteers who will commit to the nine-week training. Another challenge is finding volunteers who live in the North County area. We currently have a waiting list of clients in that area and also with the Spanish-speaking group.

*In FY12-13, CSS funded 50% of Senior Peer Counseling (the remaining 50% is funded through Prevention and Early Intervention). The program served 388 total clients.  
Cost per person: \$735*

***Pathways, Court Mental Health Program (Adults)*** – The Pathways Program serves seriously mentally ill (SMI) nonviolent offenders with co-occurring disorders. The program is a partnership of San Mateo County Courts, the Probation Department, the District Attorney, the Private (Public) Defender, the Sheriff’s Department, Correctional Health, and the Behavioral Health and Recovery Services Division. Through criminal justice sanctions/approaches, and treatment and recovery supports addressing individuals’ underlying behavioral health issues, offenders are diverted from incarceration into community-based services.

Typically, a Pathways client is sentenced to three years’ probation and remains as an active member of the Pathways Program for the three years. When they graduate from Pathways there is a formal ceremony in court where their case and their accomplishments are shared with all in the courtroom including prisoners who may become Pathways clients. Graduates receive a Pathways Certificate signed by the Pathways Judge. Pathways

Graduates are no longer on probation but remain in the Pathways Program as Alumni for activities and to help guide and support others in the program.

The Pathways clients have unique challenges and they come to the program with a range of life situations. They are provided with a variety of resources and treatment approaches depending on their needs. Almost all of them have a need to belong. Pathways usually starts off a new client with increased case management and works on getting them connected with their peers. The connection with others in Pathways is done through the weekly Pathways Women's Group which meets on Thursdays and our Pathways Club House which meets on Saturday mornings. Pathways clients look forward to attending the Clubhouse on Saturdays and attendance has increased, averaging 13 to 15 members. Pathways operates six days a week to help to fill in the gap in our clients' lives. In addition Pathways has other activities scattered through the year such as picnics/barbecues and other outings to help build their sense of community.

The program continues to be challenged with the clients only serving half of their jail sentence. Inmates who are not motivated for treatment choose to serve out their sentence instead of choosing treatment. This change has impacted all treatment courts. However, we have been successful in identifying clients who are already sentenced. This allows us to modify them into our program for treatment. In addition, Pathways have helped inmates choose treatment with the help of peer outreach that meets with clients while in custody to share experiences of recovery.

Pathways hosted two student Interns. The Pathways Team was the recipient of the STARS Award Honorable Mention in the Program Performance category.

Since the program's inception through FY 12-13, the Pathways program has had 50 graduates. The program celebrated this milestone with a lunch with Pathways staff, Judge Mark Forcum, District Attorney Steve Wagstaff, NAMI And other community partners.

*In FY 11-12, Pathways served 70 individuals, of which 38% were Caucasian, 33% African American, 18% Latino, 10% Asian, and 3% non-American Indian.  
Cost per person: \$8,806*

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

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

## SYSTEM TRANSFORMATION AND EFFECTIVENESS STRATEGIES

System Transformation and Effectiveness Strategies includes a focus on recovery/resilience and transformation; increased capacity and effectiveness of County and contractor services through training, bilingual/bicultural clinicians, peers/peer-run services and family partners; implementation of evidence-based and culturally competent practices; family support and education training for all providers serving all ages. Other system transformation strategies include expanded family support/education services for children/youth/transition age youth, and peer supports for adults and older adults.

The following initiatives substantially support capacity development within the existing county-operated and contracted public behavioral health system.

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

In the Adult System, there are 10 Peer Consumer Partners who have lived experience as a consumer/client. These positions are mostly full time, civil service positions that are embedded on clinical teams. The Consumer Partners represent diverse cultural and linguistic experience including bicultural and bilingual Spanish, Tagalog and Chinese as well as English speaking African American and Caucasian persons.

Consumer Partners assist adult clients in the following ways: Facilitate groups such as WRAP, WRAP for housing, Dual Diagnosis Group, Welcome Registration/Orientation, Crochet and Knitting Group, Healthy Living group, Case Management Workshop, Ash Thinkers, Ash Kickers, Chinese Family Support Group, Cooking with Ease, Stress group. They also help clients find shelter beds, connect to vocational resources and transportation.

Consumer Partners bring their lived experience to the broader community by participating on the following community groups: African American Initiative, Co-Occurring Committee, Lived Experience Speakers Academy and Speakers Bureau, Housing Committee, Mental Health and Education Workforce Collaborative: Integrated Care, Co-Occurring Change Agents, Housing Operations and Policy Committee, Change Agent Housing Committee, Change Agent Recruitment and Education and Community Service Area planning.

***Family Partners (FPs)*** – provide individual support to parents of the youth, sharing their lived experience with the families. They also provide group support to parents/caregivers by providing educational activities around children, mental health and self-care and organizing such programs such as “Drug Presentation for Family Members” and “Ask the Psychiatrist” events for parents in Spanish. Groups co-facilitated by Family Partners are: Wellness Recovery Action Planning (WRAP), Parent Project, Peer to Peer Tobacco Recovery Program, Peer to Peer Well Body Program, Equip Educate and Support (EES), Parent support groups, Aggression Replacement Therapy, NAMI BASICS and Cultura Cura.

In the Youth System, there are 10 Family Partners with lived experience as a family member of someone with behavioral/mental health challenges. These positions are mostly full time and all are civil service positions that are embedded on the youth clinical service teams. The Family Partners represent diverse cultural and linguistic experience including bicultural and bilingual Spanish and Tongan, as well as African American and Caucasian.

Family Partners also bring their lived experience to the broader community by participating on the following community groups and initiatives: African American Initiative, Latino Collaborative, CASA of SMC presentation about acculturation and reunification, North County Outreach Committee, and Co-Occurring Change Agents,

*In FY 2012-13, 746 clients were served, Peer Partners 448 and Family Partners 298 clients. Cost per person: \$1,252*

**Puente Clinic** - This specialty clinic sponsored by Behavioral Health and Recovery Services, Golden Gate Regional Center and Health Plan of San Mateo serves the special mental health needs of clients with developmental disabilities. Since its inception in June of 2008, the Puente Clinic has received 228 referrals. Age group demographics for clients served included: Ages 18-29: 25 (6%); Ages 30-39: 35 (16%); Ages 40-49: 29 (18%); Ages 50-59: 41 (25%); Ages 60-69: 20 (12%); and Age 70+: 6 (4%).

The psychiatric nurse practitioner triaged and transferred clients from the substantial caseload of a retiring psychiatrist in the community. Some cases she has taken on her own caseload and many who were considered stable had their care transferred to a primary care physician. This is a long and delicate process requiring diplomacy in helping care home staff transition from the care of a physician with whom they had worked with for many years and providing support to PCPs who were unused to or uncomfortable in prescribing psychiatric medications.

One challenge we met was in dealing with aggressive or assaultive clients. One of our clinicians was assaulted by a client during a first meeting even though the client was accompanied by two male care staff. We had to reassess our process in using more caution when meeting with clients with an aggressive or assaultive history. We are in the process of producing and fine tuning a safety protocol to avoid future assaults.

One of our major challenges has been the recent change in legislation regarding limiting the length of stay for clients at locked facilities such as California Psychiatric Transitions (CPT). Some of our clients who were doing well at CPT and forced to leave, due to the new time limitations, are having a very difficult time transitioning to the community despite being placed in specialized group homes.

We have also received quite a few referrals for clients with serious drug and alcohol issues. The request for services typically comes from case managers or family members for whom the substance use has presented a problem and often the client is not invested.

Another challenge has been receiving referrals for clients whose issues are behavioral challenges rather than mental health related. Often the family or group home is resistant to behavioral interventions.

*In FY 12-13, the Puente Clinic caseload was 161, of these, MHSA partially funds two clinical positions, and they served 49 clients.*

*Cost per person: \$3,012*

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

*In FY 12-13:*

*El Centro - 330 hours of COD services delivered, 100% of contracted amount.*

*Free At Last - 457 hours of COD services delivered, 109% of contracted amount.*

*Our Common Ground - 612 days of COD services delivered, 98% of contracted amount.*

*Project 90 - 1026 days delivered, 106% of contracted amount.*

*Pyramid - 912 hours delivered, 110% of contracted amount.*

*Service League - 1260 days delivered, 100% of contracted amount.*

*Sitike - 1260 hours delivered, 100% of contracted amount.*

*StarVista - 3600 hours delivered, 122% of contracted amount.*

*WRA - 576 days delivered, 111% of contracted amount.*

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

*In FY 2012-13, StarVista's AOD Juvenile Program served 19 clients.*

*Cost per client: \$7,068*

**Evidence-based practice (EBP) expansion (All Ages)**- MHSA funding supports staffing specialized in the provision of evidence-based services throughout our system, for youth and adult clients.

In FY 12-13, clinicians served 1,466 youth and adult clients.

Cost per person: \$945

**Child Welfare Partners** – As part of the 2009-10 MHSA expansion plan, BHRS partially funds two clinicians serving high risk children/youth referred through Child Welfare to Partners program.

In FY 2012-13, Child Welfare Partners program served 50 clients.

Cost per person: \$4,431

## **Nadine's Story - Older Adult System of Integrated Services (OASIS)**

*"I still don't believe I'm here. It's great; it made that big of a difference..."*

*[In reference to her new apartment]*

Nadine is an older adult who had been homeless for over ten years. At one point, her mental health had declined so much that she was not able to carry on a conversation and experienced trouble making decisions. She stated, "That's why I started to give up, my head just didn't work with me anymore and my mental health was going down". A social worker from OASIS was paired with Nadine to help address her homelessness. Within a month of meeting her social worker, Nadine was placed in an apartment. "I kept praying that something would happen". The services Nadine received through her social worker from OASIS changed her life, "she's the main reason I'm here, and she really put herself out there and was determined to help me get out of my street condition". Since then, Nadine has been in her apartment for over seven months, her mental health has improved. "If it wouldn't have been for the program, I doubt very much that I would have been able to get in; they helped me with a lot of paperwork. My head just wasn't together yet." As a result of the coordinated efforts of OASIS, Nadine is now living in a safe and clean environment. She still meets with her social worker regularly, she stated "I still don't believe I'm here. It's great; it made that big of a difference in my life".

## Prevention and Early Intervention (PEI)

### PEI PROGRAMS FOR AGES 0-25

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

StarVista provides the ECCT and this past year continued to provide community outreach, case management, parent education, mental health consultation, and child-parent psychotherapy services to families with young children in Half Moon Bay and the surrounding areas, as well as in Daly City and the North County region.

**Continued Collaboration and Community Partnership:** In the Coastsides, the ECCT staff has continued to maintain and expand their connections and collaborations in the community. They have built strong partnerships with existing agencies within the communities we are serving, and have developed new care options from these collaborations. Our partnership with Coastsides Community Mental Health, with the four ECE programs receiving mental health consultation and with the three local elementary schools has deepened our presence in this underserved community. In conjunction with Coastsides Mental Health, the ECCT Case Manager has been able to plan and begin to implement a Teen Mother's group to be facilitated by both Coastsides Mental Health and StarVista staff. The team also collaborated to provide a series of workshops for parents at Moonridge Head Start, and hope to repeat the series this year, as well as presenting the workshops at other sites. Staff worked with the Library to provide workshops and activities for parents and children starting in 2013. Clients have responded well to these enhanced services and have given great feedback and have asked for additional topics. We will also be providing a series of workshops for parents of Kindergarteners at each of the elementary schools in the community over the school year.

In our Daly City ECCT Project, StarVista's Department Director and Program Director worked to support the structure of the team within the Our Second Home family resource center (FRC). The loss of key staff within the FRC the past year continued to be a significant challenge and impacted our capacity to offer the full range of services to this community. While the child-parent psychotherapy and mental health consultation services continue to be well received and are growing, we have not seen the community collaboration we were anticipating when first starting this project. StarVista will continue in the coming year to assess the current partnership with the FRC while growing new community partnerships that may serve the goals of the ECCT more fully.

Community-Based Services: As part of the philosophy of the ECCT Project, StarVista's ECCT is committed to outreaching to underserved and unserved populations. All of the services offered through our ECC Team are provided within the community, embedded within childcare programs, schools, family resource centers, and community centers. By providing prevention and early intervention services within these community settings, we are able to access families who might not otherwise seek out mental health supports. Additionally, offering our mental health services in families' homes, at their child's school, or within familiar community agencies, provides flexibility in service delivery that enables the ECC Team to reach underserved/unserved families. By targeting our services within programs serving low-income, migrant, isolated, culturally diverse families, we aim to address economic, cultural and racial disparities within these communities, and the challenges of accessing mental health services that often accompanies such disparities.

This past year, the request for services through our ECC Teams has increased and expanded. Our clinicians served 22 families this past year and have waitlists in both Daly City and Half Moon Bay communities, providing intensive child-parent psychotherapy services, case management and linkages to resources and additional referrals. Families struggling with depression, stress, trauma, domestic violence and worries regarding their child's behavior and/or development were supported by the ECCT clinicians.

On the coast, mental health consultation continued at four sites this past year, providing much needed support to 18 teachers and approximately 107 children total (11 children under 3 years of age and 96 aged 3-5 years). Weekly visits to each center advanced the relationships between the consultant and the teachers and created increased opportunities for reflection both on their own experiences as well as on their relationships with the children. In addition to the program based work, the consultant opened 21 cases over the program year and worked closely with teachers in thinking about each of these children, all of whom were able to remain in the programs until the close of the school year. Of these cases, the consultant met regularly with parents in about 12 cases. Along with the ECCT Community Outreach/Parent Education Specialist, the consultant participated in developing and presenting workshops for parents of children in the Migrant Program preschool at the Cabrillo Unified School District. The workshops gave parents opportunities to think about their children's development, positive discipline, and parental stress.

Additionally, the work of the Community Outreach and Parent Education Specialist has continued to expand and create new opportunities for partnerships and services. This past year, we partnered with Coastside Community Mental Health to offer a support and parent education group for teen mothers. Our partnership with Cabrillo Unified School District led to a new request to provide ASQ (Ages and Stages Questionnaire) assessments for children participating in the Kickoff to Kindergarten program in Half Moon Bay, providing useful information to support children's learning and development.

*In FY 12-13, ECTT-Star Vista served 91 clients.  
Cost per person: \$4,033*

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

***Project SUCCESS (Puente de la Costa Sur)*** – Project SUCCESS, Schools Using Coordinated Community Efforts to Strengthen Students, is a program that prevents and reduces substance use and abuse and associated behavioral issues among high risk, multi-problem adolescents. It works by placing trained counselors in the schools to provide a full range of prevention and early intervention services.

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

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

Puente assessed all students in the La Honda Pescadero Unified School District ages 10-18. Based on those assessments students were assigned to groups based on their level of use or family exposure; the User Groups, and the COSAP groups.

Students were involved in groups of eight sessions each using the Project SUCCESS guidelines and tools. Two parenting classes were held, one in English and one in Spanish. Project Success materials were utilized to create an interactive setting.

Access to students was our biggest challenge. Teachers and administrators were reluctant to allow students to miss class for group participation. We overcame this problem by alternating groups during lunch time for all grades. Once we were able to solidify a schedule things went well.

Cultural differences made it difficult to run groups with both Hispanic and Caucasian participants at the high school level. The team tried to start the year with a bi-cultural

group but it was apparent early on that it was not comfortable and the students began to drop off because of the atmosphere. The team decided to split the group and run two groups, one in Spanish and one in English, and this approach worked well. Both therapists are bilingual so it was an easy transition. The elementary and middle school groups did not have the same difficulty and so were mixed for all eight sessions.

The team focused on building a trusting and confidential space for the groups. This really was the key to the success of the groups. Most, if not all, of the participants shared stories readily with the groups and activities were designed to address the needs as they arose.

Food was a big motivator. La Honda Pescadero Unified School District (LHPUSD) is a very rural and isolated community so each week the therapist would bring a snack or lunch to the group. This helped to solidify the group in the beginning, and we do not underestimate its power to maintain attendance.

The Puente team created a service project for high school students where group members raised money to give back something to their school. The group chose to raise money for physical education uniforms for all middle school and high school students. This project helped to bridge the cultural gap as all groups participated together and chose the project. At the end of the project the group members received a Project SUCCESS sweatshirt. This event instilled school pride, raised self-esteem, helped students look beyond barriers and created a sense of community within the school.

The Puente team ran a pre-prom event aimed primarily towards high school girls. The district is very small and rural, and the prom is not usually well attended. We utilized this platform to teach self-care, healthy dating, and how drugs and alcohol affect each of those. The team gathered hair products, make-up, nail polish, and hair dryers. The event was open to all high school students and each student who attended got a bag to fill with products of their choosing, a person helped them put on makeup, and there was someone to consult with about appropriate fashion choices. This event was very well received and we hope to do it again next year.

*In FY 12-13, Project Success served 111 people, including 53 individuals and three groups.  
Cost per person: \$2,252*

**Seeking Safety (El Centro)** - Seeking Safety is an evidence based treatment model designed by Dr. Lisa Najavits to address trauma related symptoms and co-occurring substance use issues. It targets Transition Age Youth through their contacts with community-based organizations. Strategies specific to Seeking Safety include, coping skills, reinforcement of negative consequences, present moment awareness, behavior modifications, identifying risky behavior, and establishing triggers, creating tools and preventing relapse of substance abuse or behaviors. It is conducted in group and individual format; with diverse populations; for women, men, and mixed-gender groups; using all topics or fewer topics; in a variety of settings; and for both substance abuse and dependence. It has also been used with people who have a trauma history, but do not meet criteria for PTSD.

### Program Challenges:

Absence of /recognizing problem (i.e. individuals with marijuana addiction feel they do not have a drug problem, have no desire for help and are not ready for treatment)

Mental health issues; no diagnosis, medication non-compliance, no medical coverage, lack of collaboration with service agencies. (i.e. prescribing physicians, case managers and therapist – no return phone calls to discuss individual’s specifics, no return documentation shared treatment plans not collaborated

Legal issues; causes fear of treatment and admittance to a problem

Privacy Concerns

Negative social support, financial, familial and environmental

Some of the strategies used to overcome these barriers include

Motivational Interviewing

Constant Encouragement

Collaboration of agencies and treatment teams

Family involvement, support, education and treatment

Recognition of personal rewards and consequences

CBT

12 step and Community Support

*In FY 2012-13, Seeking Safety program at El Centro served 43 clients.*

*Cost per person: \$930*

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

### Culture:

Transition Age Youth - All 131 YES program participants are transition age youth. For successful service provision this historically underserved population requires attention to unique age-specific needs relating to assessment, engagement, crisis management, and case management.

LBGTQQI - Due to the developmental age of our population, many of our youth identify as LBGTQQI at different times. There is a great deal of gender fluidity in our age group and identification often falls on a spectrum for our youth. Rarely do our youth consistently report a specific adherence to a particular gender/orientation.

Former Foster Youth - The majority of our youth are former foster youth or were in custody when they turned 18 years of age.

Newly Diagnosed Youth - Due to the age range, many of our youth are newly diagnosed with a serious mental health issue. Early engagement offers newly diagnosed youth the

opportunity to develop necessary coping skills to manage the symptoms of their diagnosis before they manifest into more severe issues with long term implications.

In 2012-13, the YES program provided 541 individual groups to 131 youth. Ten unique group-courses were provided at six different service locations. Groups were provided in a wide variety of settings including a locked psychiatric unit, crisis residential program, county clinic, residential program, community based youth drop-in center, and juvenile corrections facility.

The YES program successfully engaged, assessed, and completed groups with 131 youth in San Mateo County. These youth have all experienced trauma and are at risk for, or recovering from substance use issues.

Transition Age Youth are a historically under-served population. Outreach to this unique population requires a culturally sensitive approach to service provision. In addition to utilizing a variety of age specific strategies, the YES program has been successful in engaging youth from a variety of cultural/ethnic backgrounds. The YES program was able to engage these youth in voluntarily participating in services.

Underserved populations based on ethnicity:

42% Hispanic

12% Asian/Pacific Islander

14% African American/Black

Youth in Cordilleras: Youth in adult hospital settings typically rarely have access to age appropriate services. The YES program successfully partners with the primary locked adult mental health unit in the County to provide culturally sensitive/youth specific services to this underserved population. Youth in this setting who were identified as being disengaged from other mental health services readily and regularly engaged in YES services.

Continued service across domains: Transition Age Youth typically experience disruptions in service provision, often struggling with maintaining engagement with services through the various transitions that take place during this period. Youth in the YES program were able to access continuous YES group services as they transitioned from placement/service facility to other living and care situations throughout the county. For example, some YES youth received services while in hospital, continued to engage in services when they transitioned into Redwood House Caminar's Crisis Residential Facility), and then continued to engage in YES groups at Edgewood's Drop In Center after leaving Redwood House.

*In FY 12-13, Seeking Safety at Caminar served 131 clients.*

*Cost per person: \$916*

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

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

Program challenges and barriers are those typical of families with limited resources and coping skills. Many of our families have problems other than the experiences for which their children are referred. Lack of transportation has been addressed though home rather than office visits and scheduling parent appointments when parents need to be a school for another purpose. A major challenge has been lack of response from a significant number of parents in both school locations. This has been handled through multiple approaches – written contact when calls are not returned, follow-up by the family partner, multiple outreach attempts, and requesting that the vice principal contact the parent (since parents might respond better to the school administrator than to the child's therapist). The program also attempts to find mentors for children whose parents are particularly disengaged from what their children are doing.

Success is seen through improvement in both grades and behavior in the children involved in the program and reports from parents that their children are happier and presenting fewer problems at home. Most recently, the vice principal at one of the schools commented that, at three weeks into the school year, he has not seen any of the program's "frequent flyers" – students sent to the office for behavior problems on pretty much a weekly basis. A remaining challenge is finding linguistically appropriate services for families.

Last spring, the program initiated a three-session "job skills" group for some of the 8th graders; this fall, the family partner is conducting a three session "transition group" for 6th graders who are identified as likely to have difficulty with the transition to middle school. Similar groups on respect (anti-bullying) and healthy relationships are in the planning stages. Project Grow has also expanded the number of families being seen for family therapy and hopes to expand both group and family involvement when school is not in session next summer.

*In FY 12-13, Project Grow served 44 clients.  
Cost per person: \$4,355*

## PEI PROGRAMS FOR ADULTS AND OLDER ADULTS

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

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

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

The consolidation of the South County Primary Care Medical Clinics moved forward with the scheduling of six-week long Kaizen events aimed at addressing patient flow. The first was attended by the Interface Team Program Specialist and other Interface staff attended subsequent events. This had a most positive outcome as the Program Specialist was fully engaged in the necessity of BHRS patient scheduling in the primary care eClinical system and led the redesign for referral and follow up in the South County primary care clinics. Her enthusiastic report to Interface Team staff resulted in several volunteers for the remaining Kaizen events.

There were delays in transferring Seriously Mentally Ill Youth to the Central South Region. There are five youth whose transition to regional services has been delayed, some for as long as 60 days. Managers were been notified of this problem. Treatment continued for these youth within the Interface Team. The delay was reduced after managers met to discuss the need for additional Youth therapists for Central and South County. The intervention is to allow those teams to hire extra help staff while waiting for County Manager's approval for new ordinance positions for that team. The BHRS Medical Director became involved in finding a solution and the delay in transferring Seriously Mentally Ill Youth to the Central South Region was reduced.

The team hired a full time Adult/Youth bi-cultural and bi-lingual Spanish AOD Specialist and another bi-lingual Spanish speaking youth clinician. The development of Alcohol and Other Drug services for the Interface Team progressed. The specialist has met with community and County AOD staff and providers and the BHRS Manager for AOD to discuss plans to gain better access to primary care providers by community AOD treatment providers. This would open up the link and allow primary care providers to make referrals to community providers. In March, the Interface team met with AOD community treatment leaders to discuss how we can facilitate their interface with primary care providers. A second meeting to support the collaborative between AOD and Primary Care was attended by the Interface Unit Chief, Program Specialist and AOD Case Management Specialist. Community Based AOD providers and the BHRS Manager for AOD were also in attendance. At that meeting we gave the providers a survey of talking points, Interface staff schedules at each Primary Care Clinic and “back door” (provider only) phone numbers for those clinics. The AOD Case Management Specialist received and documented referrals from primary care providers as well as Interface Therapists. We are waiting for confirmation that the Interface team will add another AOD position.

The new Spanish speaking youth therapist was assigned to the Willow Primary Care Clinic. This is the first time placing youth staff in that clinic. We also have started five evening clinics, four at Willow and one at South San Francisco Primary Care. Two of the evening clinics at Willow are for Alcohol and Other Drug service.

The Interface Team Unit Chief and Program Specialist became members of the South County Health Clinic Standing Committee which monitors the progress of the building of the South County Health Clinic and makes decisions regarding staff and patient flow. The Interface Team was also invited to the new clinic’s “Topping Off” ceremony. The inclusion of Interface in the building and staffing of the South County Health Center is a model for collaboration between Primary Care and Behavioral Health.

One challenge was filling the Program Specialist position knowing we would be unable to backfill her clinical position. This meant her caseload needed to be redistributed to other team members. In the process we realized there were some inefficiencies. The Program Specialist implemented a redesign as to how referrals are processed. The implementation of the redesign is expected to reduce the amount of time spent outreaching to new patients.

Another challenge is the protocol to handle requests for a youth psychiatrist from community therapists by the ACCESS Team. As a result, the primary care physicians were getting these referrals and sending them to the Interface Team youth psychiatrist. This created a problem because the patient is not connected to an Interface Team therapist, the treatment could go on for an extended period of time and treatment by the Interface Team psychiatrist was designed to be consultation and brief intervention.

The adult Interface Psychiatrist is a member of the medication committee. She helped develop and implement a medication protocol for a pilot to address alcohol craving by addicted patients.

During FY 2012-13, the Interface Team provided one or more services to 3,462 adult and youth primary care patients (the adult team treated 1488 the youth team treated 1,454). The various part time psychiatrists provided consultation or assessment and brief medication monitoring to 339 patients. The bi-lingual Spanish speaking Alcohol and Other Drug Specialist served 181 patients.

One of the challenges faced at the end of the year was collaborating with the PREP team. A client was open to Interface in late April and referred to PREP in late May but no assessment had been done by the end of June.

*In FY12-13, MHSA funded Primary Care Interface clinicians served 771 clients.  
Cost per person: \$1,055*

## **PEI PROGRAMS FOR ALL AGE GROUPS**

### ***Stigma Free San Mateo County***-124 participants

The Anti-Stigma Initiative continued supporting trained facilitators to host trainings using the stigma vignette DVD. In FY 2012-2013, a number of facilitated presentations were hosted by the PRIDE Initiative and Filipino Mental Health Initiative. The name of the Anti-Stigma Initiative was formally changed to Stigma Free San Mateo County in Sept. 2013. Stigma Free presentation to Second Harvest Food Bank, San Jose on 7/12/2012 (10 attendees).

Stigma Free presentation to Second Harvest Food Bank, San Carlos on 7/19/2012 (7 attendees).

Stigma Free presentation to Second Harvest Food Bank, San Jose on 8/4/2012 (6 attendees)

Presentation and discussion at FMHI General Meeting on 8/9/2012 (11 attendees)

Stigma training for senior site distribution volunteers on 7/22/2012 (35 attendees)

Anti-Stigma Training with 2nd Harvest Food Bank volunteers on 3/22/2013 (21 attendees)

Anti-Stigma Training with 2nd Harvest Food Bank volunteers on 6/24/2013 (34 attendees)

***Office of Diversity and Equity*** – ODE was established within BHRS in 2009 primarily as an information and resource hub for data, training, dialogue and collaboration regarding diversity and social justice. ODE promotes cultural competence and addresses health inequities through the following current projects and Health Equity Initiatives. Highlights for FY 12/13, per ODE program include:

***Culturally-Relevant Provider Trainings*** - two trainings, 124 participants.

How to Effectively Use an Interpreter in a Behavioral Health Setting

December 4, 2012 (43 participants)

June 28, 2013 (24 participants)

Cultural Humility in the Era of Cultural Competence: Addressing Health and Health Care Disparities -Dr. Melanie Tervalon, MD, MPH

March 2013 (57 participants)

**Digital Storytelling** - A total of 12 individuals completed a 5-day Digital Storytelling training that was held from 6-3-13 to 6-7-13. Six of the participants were trained as facilitators, and the other six attended only as participants.

**Mental Health First Aid** - 12 trainings and 1 instructor training, 270 participants.

August 2012 (Mabuhay Health Clinic, SF) – 36 participants

September 2012 (Spanish – East Palo Alto) – 15 participants

September 2012 (Instructor Training – San Mateo) – 30 participants

January 2013 (BHRS Admin Staff – San Mateo) - 15 participants

January 2013 (Filipino Mental Health Initiative & Skyline College – San Bruno) – 29 participants

March 2013 (Foster City) – 27 participants

March 2013 (Westbay - SF) – 9 participants

April 2013 (Pacific Islander Initiative – Daly City) – 21 participants

May 2013 (PCRC – San Mateo) – 16 participants

May 2013 (MRMMG – SF) – 26 participants

May 2013 (East Palo Alto) – 15 participants

June 2013 (Bayanihan – SF) – 16 participants

June 2013 (Pyramid – San Mateo) – 15 participants

**Parent Project** - Five classes (87 total participants)

December 2012, Half Moon Bay (12 participants)

December 2012, Redwood City (18 participants)

May 2013, South San Francisco (15 participants)

May 2013, Menlo Atherton High School (20 participants)

May 2013, East Palo Alto (22 participants)

**Photovoice** - Four sessions (33 total participants)

October 2012 – Latino North County (5 participants)

November 2012 – Sequoia High School Dream Act (10 participants)

November 2012 – Pacific Islander (9 participants)

March 2013 – Filipino Mental Health Initiative (9 participants)

*In FY 2012-13, ODE programs reached 526 participants.*

**Health Equity Initiatives:**

**African American Community Initiative** – 200 contacts

Black History Month Summit called “Still I Rise: The Resilience of African American Families” held on Feb 28, 2013 (Approx 90 attendees).

Participation in annual Soul Stroll event at Coyote Point Park in San Mateo held on May 18, 2013 (Approx 110 contacts made).

***Chinese Health Initiative*** – 104 participants

Training on “Improving Access to Care for the Chinese Community in SMC” - 7/26/2012

Training on “Engaging Chinese Families in Health and Wellness” held on 9/21/2012

***Pacific Islander Initiative*** – 53 participants

Training on “How to Serve the PI Community” for Sitike Counseling on July 18, 2012 (10 attendees)

Training on “How to Serve the PI Community” for Community Overcoming Relationship Abuse on July 31, 2012 (10 attendees)

Hosted Parent Project series in Redwood City on December 2012 (18 participants)

Hosted Parent Project series in South San Francisco on March 2013 (15 participants)

***Filipino Mental Health Initiative*** – 369 participants

Outreach at Filipino Health Day event in San Bruno on 8/25/2012 (Approx. 15 contacts)

Outreach at BHRS Intern Orientation on 9/7/2012 (Approx. 50 attendees)

Presentation to Pilipino Bayanihan Resource Center Board of Directors on 8/9/2012 (6 attendees)

Youth forum “Sala Talks” at Jefferson High School on 10/17/2012 (5 participants)

Youth forum “Sala Talks” at Jefferson High School on 11/14/2012 (4 participants)

Youth forum “Sala Talks” at Jefferson High School on 1/30/2013 (5 participants)

Hosted Mental Health First Aid series at Skyline College in January 2013 (29 attendees)

Hosted Photovoice workshop on March 2013 (15 participants)

Presentation to Skyline College Filipino Club on 3/12/2013 (10 attendees)

Young Adult focus group at Skyline College on 3/20/2013 (10 participants)

Outreach at Second Harvest Food Bank Resource Fair on 4/12/2013 (Approx. 200 attendees)

Youth forum “Sala Talks” at South San Francisco High School on 4/30/2013 (12 participants)

Strategic planning meeting on 6/27/2013 (8 participants)

***Latino Collaborative*** -296 participants

Supported Parent Project series on December 2012 in Half Moon Bay (12 participants)

Collaboration with Peninsula Conflict Resolution Center to host Theatre of the Oppressed – July-September 2012

Outreach to Sequoia High School Dream club on 11/15/2012 (Approx. 100 attendees)

Supported Parent Project series on May 2013 at Menlo Atherton High School (20 participants)

Hosted Photovoice workshop with Sequoia High School in November 2012 (10 participants)

Attended Chicana/Latina Foundation dinner on 9/12/2012 (20 attendees)

Presentation on Cultural Humility on Heart and Soul on 10/4/2012 (10 attendees)  
Presentation on Managing Depression and Anxiety for the Latino Population at the Black History Month Summit on 2/28/2013.  
Supported East Palo Alto Parent Project on May 2013 (22 participants)  
Presentation to Millbrae High School Latina Leadership group on 4/12/2013 (40 attendees)  
Presentation to La Esperanza Vive – Peer Counselors on 5/28/2013 (14 attendees)  
Presentation on Teen Dating Violence to Latino Youth at Puente on 6/14/13 (48 youth)

***PRIDE Initiative*** – 566 participants

Participated in Recovery Month picnic in September 2012 (Approx 200 attendees)  
LGBT Aging Conference 11/7/2012 (2 attendees)  
Photovoice project 12/7/2012 (6 participants)  
Presentation on LGBTQ Aging at OASIS on 3/28/2013 (12 attendees)  
1st Annual LGBTQI Celebration on 6/15/2013 in San Mateo (Approx 300 attendees)  
Anti-Stigma Training with 2nd Harvest Food Bank volunteers on 6/24/2013 (34 attendees)  
PRIDE event at Spanish Providers Consultation Group meeting (12 attendees)

***Spirituality Initiative*** – 327 participants

Spirituality policy presentation on 9/4/2012.  
Outreach during BHRS Intern Orientation on 9/7/2012 (Approx 50 attendees)  
Presentation to SMC Mental Health and Substance Abuse Recovery Commission on 1/12/2013 (35 attendees)  
Presentation to Board and Care operators group 3/7/2013 (20 attendees)  
Presentations at BHRS Staff Meetings on new Spirituality Policy:  
ODE Leadership – 4/5/2013 (17 attendees)  
Central County – 4/25/2013 (16 attendees)  
Interface Team – 4/29/2013 (12 attendees)  
ARM – 5/1/2013 (10 attendees)  
Pre to 3 – 5/3/2013 (9 attendees)  
Youth Services – 5/8/2013 (16 attendees)  
Child Welfare – 5/9/2013 (6 attendees)  
South County – 5/9/2013 (16 attendees)  
North County – 5/16/2013 (8 attendees)  
Canyon Oaks – 5/17/2013 (14 attendees)  
NAMI – 5/22/2013, adapted presentation of policy for families (28 people present)  
North County Mental Health Clinic – 5/23/2013 (8 present)  
EPA – 5/31/2013 (14 attendees)  
School Based Mental Health – 6/5/2013 (18 attendees)  
Total Wellness – 6/13/2013 (15 attendees)  
Pathways – 6/13/2013 (8 attendees)  
Puente – 6/26/2013 (7 attendees)

*In FY 2012-13, ODE Health Equity Initiatives reached 1,811 participants.*

## ***Community Outreach, Engagement and Capacity Building***

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

*2,157 individuals were served in FY 12-13.*

*Cost per person: \$89*

***East Palo Alto Behavioral Health Advisory Group (EPA BHAG)***– EPA BHAG purpose is to increase community engagement to improve access to and delivery of behavioral health services in East Palo Alto. Outreach and linkage services to gain access to Medi-Cal, other public health services, behavioral health, and other services is conducted by El Concilio of San Mateo County, Live in Peace, Free at Last, and Pacific Ma’a Tonga

EPA BHAG is committed to bridging the mental health divide through advocacy, systems change, resident engagement and expansion of local resources leading to increased resident awareness of and access to culturally and linguistically competent professional services. EPA BHAG provides the following services among others:

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

*3,945 individuals were served in FY 12-13.*

*Cost per person: \$37*

***Crisis Hotline*** – StarVista provides a free, confidential 24-hour, seven days a week crisis intervention hotline. Trained volunteers and staff provide referrals for community resources and services for anyone who feels sad, hopeless, or suicidal; family and friends who are concerned about a loved one; anyone interested in mental health treatment and service referrals; and/or anyone who just needs some support through a personal crisis. The mental health clinician provided services to through 57 new cases (case management/phone consultation); 38 new youth served in youth outreach interventions (evaluations at school sites), 239 follow-up sessions with youth, 281 follow up contacts with collateral contacts; and 710 youth and adults served through community outreach.

*The total number of clients served by the Crisis Hotline for FY 12-13 was 1,325.*

*Cost per person: \$80*

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

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

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

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

*In FY12-13, PEI funded 50% of Senior Peer Counseling (the remaining 50% is funded through Community Services and Supports). The program served 388 total clients  
Cost per person: \$735*

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

*In FY 12-13, PEI funded 60% of Ravenswood Family Health Center (the remaining 40% is funded through Community Services and Supports). The program served 348 total clients, 60% of which equals 209 clients.  
Cost per person: \$506*

**Pedro's Story**  
**Office of Diversity and Equity (ODE) - Health Ambassador Program (HAP)**

*"I have a lot of good people saying 'you can do it!'"*

Ten years ago, Pedro, a resident from East Palo Alto, came to the East Palo Alto Clinic looking for help. In his words, "I was lost, real lost... I came by myself; like I said I was out of my mind". He was transferred to San Mateo Medical Center for treatment. Since then Pedro takes advantage of the services and classes offered by Behavioral Health and Recovery Services in San Mateo County. He was recently recognized as the first Health Ambassador and also became a Parent Project® facilitator. In order to become a Health Ambassador, Pedro completed over the past two years numerous classes, specifically Parent Project®, Mental Health First Aid (youth and adult), several WRAP courses, and the NAMI Family to Family Class. After completing the Parent Project®, Pedro noted, "[It] helped me with the way I talk to my kids, I now listen to them and then I give them advice, they can be comfortable with me. They can say whatever they want to me." According to Pedro, the pivotal changes he has made are a direct result of his dedication to learning and taking advantage of the courses offered "The things that have been helping me a lot is the classes...I have a lot of good people saying, 'you can do it!' "I take advantage of the programs. I use them to talk better to my kids, to take care of myself, and to help someone". I've made a lot of progress...It wasn't easy, it's still not easy but I'm still working on it".

## PEI PROGRAM FOCUSED ON EARLY ONSET OF PSYCHOTIC DISORDERS

**Prevention and Recovery in Early Psychosis (PREP)** – The PREP program braids together five evidence-based practices into one integrated treatment approach, and uses community education and outreach to facilitate early identification of individuals at risk of psychosis.

Family Service Agency’s PREP program identifies and intervenes with transition age youth (14-25 years) experiencing a recent onset episode of psychosis and their families. The PREP Program provides evidence-based treatment and support for youth and families through an intensive outpatient model of care that includes the provision of: algorithm-based medication management, cognitive behavioral therapy for psychosis (CBTp), individual placement and support (IPS), assertive outreach, multi-family groups, cognitive remediation, and strength-based care management services.

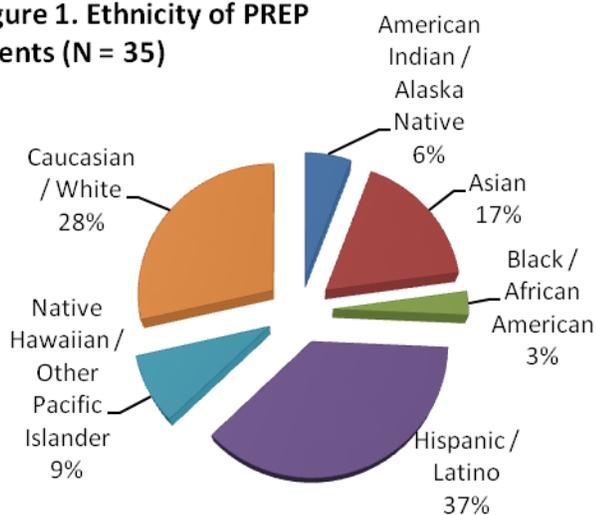
The program began implementation in June 2012, and has completed assessments on 74 young adults in the past year, enrolled and served 35 youth/young adults and 55 family members during the past year. Change analysis was conducted using outcome data from a subset of 17 PREP clients for whom both admission and 6 months post-enrollment data were available. Preliminary findings from this analysis revealed:

- Highly significant reductions in psychiatric hospitalizations and days hospitalized;
- Highly significant reductions in positive and negative symptoms of psychosis;
- 64% of consumers who had participated in PREP for 6 months had been employed, volunteering or in school during their participation in the program; and
- High ratings of satisfaction, perceptions of services and working alliance.

*During FY 12/13, 35 clients and 55 family members were enrolled and received PREP services.*

*Cost per person: \$23,130*

**Figure 1. Ethnicity of PREP Clients (N = 35)**



As displayed in Figure 1, a diverse group of clients is served by the PREP program.

The largest percentage of clients self-identified as “Hispanic/Latino” (37%), while the smallest percentage of clients identified as “Black / African American” (3%).

**Figure 2. Age at Admission to PREP (N = 35)**

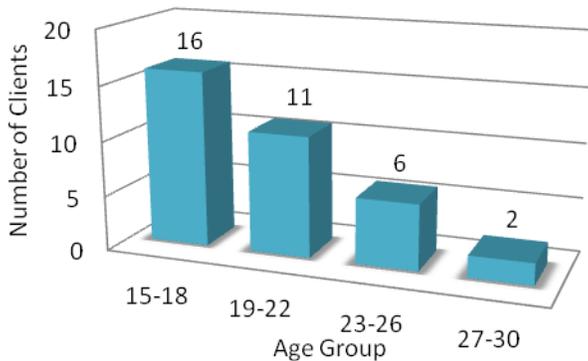


Figure 2 provides the age of active clients during FY 12/13.

The average age of clients was 20 years with an overall range between 15 to 30 years. The largest number of participants fell within the 15 to 18 year old age range.

More than two times as many males (n=24) as females (n=11) were enrolled in the PREP program during the FY12/13 fiscal year. This is somewhat consistent with the epidemiology of schizophrenia, which occurs at a slightly higher rate in males than in females. Challenges and solutions to enrolling females is discussed below.

The primary diagnosis at intake was collected from the Structured Clinical Interview for DSM-IV (SCID) for each of the 35 clients. Client diagnoses are summarized in Table 1.

**Table 1. Primary SCID Diagnoses of Clients During FY 12/13**

Diagnosis	Frequency	Percent
Schizophrenia	19	54.3%
Schizoaffective Disorder	7	20.0%
Schizophreniform Disorder	6	17.1%
Psychotic Disorder NOS Disorder	3	8.6%

**Progress in Achieving Contract Start-Up Requirements**

The PREP program’s contract with San Mateo County was signed in June of 2012. The PREP program has completed assessments on approximately 74 San Mateo county residents, and currently carries a caseload of 28 clients and 56 family members. PREP continues to offer assessments and anticipates continuing to admit new clients and families to the program throughout the next fiscal year at an approximate rate of two new clients per month.

PREP has offered multiple outreach presentations to the community and continues to be actively involved in this process. The program is currently working to develop outreach

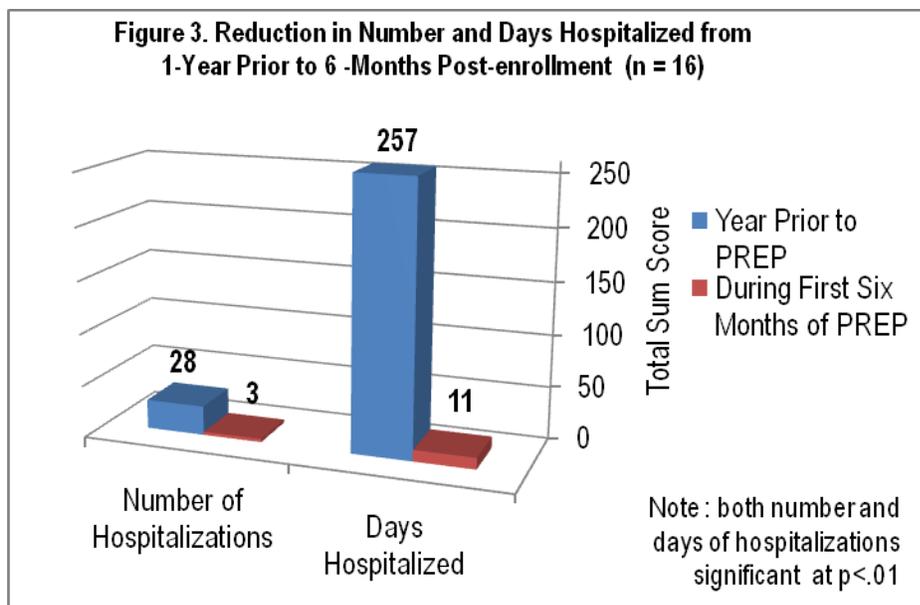
aimed at meeting the needs of specific cultural groups and geographical locations in San Mateo County (i.e., developing an outreach plan for the East Palo Alto community). PREP will also focus on educating referral sources about identification of females with primary psychotic disorders. On an as needed basis, satellite location arrangements have been secured with East Palo Alto and the North County.

In June, PREP SM had a family BBQ at Central Park in SM. PREP staff also attended a housing symposium and recently participated in a tabling event at East Palo Alto. PREP SM will engage in another round of outreach presentation in the next two months. Outreach efforts have been on hold for the last month due to staff turnover; however, with two psychology practicum students joining the team, community outreach and planning will be pursued more aggressively.

Supervision and competence review for CBT for psychosis and clinical assessment are being fully implemented. PREP SM currently has one clinician who has reached full competency in CBTp, while all other clinicians are in process to reach competency. Clinical supervision for both CBTp and SCID assessments occur weekly. PREP clinicians also continue to receive training in Motivational Interviewing (MI), Multi-family Group (MFG) and diagnostic assessment. The educational specialist is also in the process of completing the IPS training module.

### **Progress in Achieving Program Goals and Objectives**

The PREP evaluation is a critical ongoing component of program implementation. The evaluation is designed to assist with ongoing program improvement, clinical and program decision-making, and to evaluate program outcomes and impact. PREP collects a range of symptom and functioning measures from staff and clients to assess the impact of the program on individuals served over time. For the annual report, change analysis was conducted using data from individuals who had completed baseline and six month surveys. It is important to note that since the program just completed its first year of implementation, not all clients have reached their 6th month in the program; hence, at this time change analysis reflects a subset of all clients served. Specifically, 6 month data was available for a maximum of 17 of the 35 enrolled clients. As more clients are enrolled and progress through the program, the number of semi-annual evaluations and capacity for analysis will increase. A sample size of seventeen does not necessarily provide enough statistical power for formal comparison, however, the measures and preliminary results of client-level data are summarized in this section.



**Psychiatric Hospitalizations.** Baseline hospitalization data was available for 34 of the 35 enrolled clients. During the year prior to admission, 30 of these 34 clients (88%) had experienced at least one psychiatric hospitalization. At 6 months, 3 of the 17 clients for whom data was available (18%) had experienced a hospitalization. Change analysis was conducted on a subsample of 16 clients for whom data was available at both baseline and 6 months time. Results revealed a highly significant reduction in hospitalizations ( $t=4.58$ ,  $p < .01$ ) and number of days hospitalized ( $t=4.13$ ,  $p < .01$ ) from baseline to 6 months (see Figure 3 below). The total number of hospitalizations for this subset of PREP consumers totaled 28 (257 total days) during the year prior to admission to PREP and 3 hospitalizations (11 total days) over the six months following enrollment. This represents an 89% reduction in the total number of hospitalizations, and a 96% reduction in total number of days hospitalized. It is important to note that the time frames represented within this statistical analysis are incomparable (e.g. hospitalizations 1 year prior to admission versus 6 months post-enrollment), and should be interpreted more as a reflection of trending in the reductions of hospitalizations.

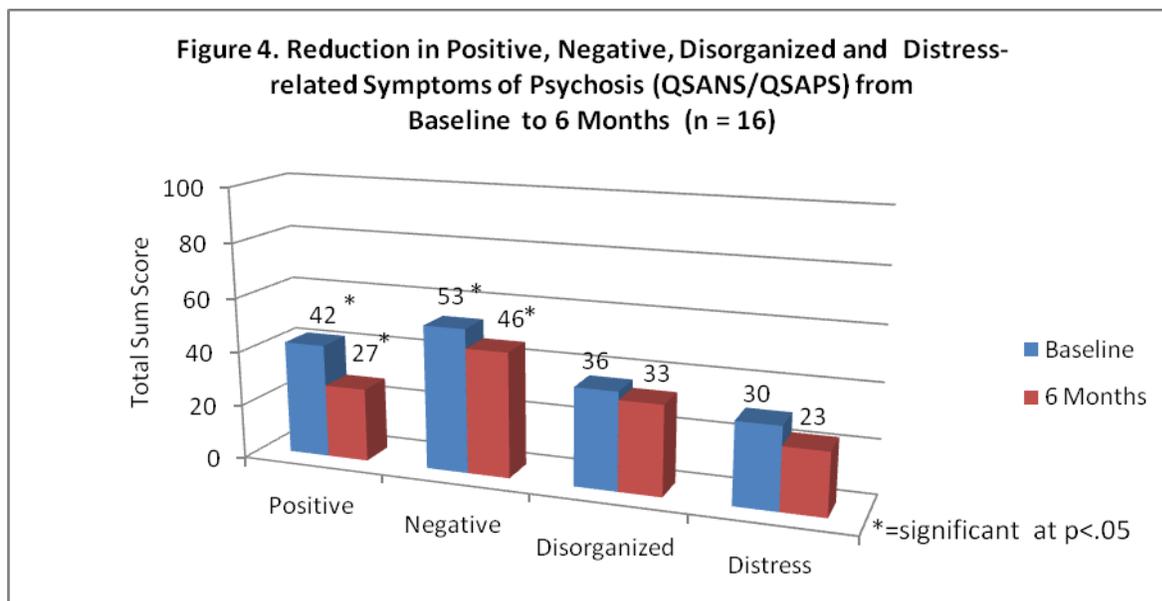
**Improvements in Functioning.** The PREP program collects data on changes in employment and education status. At baseline, 17% of all enrolled consumers ( $n=6$ ) were employed, and 34% ( $n=12$ ) were enrolled in part-time or full-time education. Data was available for a subset of 17 consumers at 6 months. Of these 17 consumers, 29% ( $n=5$ ) were employed or volunteering, and 35% ( $n=6$ ) were in school. In total, 64% of the consumers were involved in employment, volunteer or education-related activities at during the first 6 months of their participation in PREP. The performance benchmark used is consistent with the effectiveness research on the Individual Placement and Supports (IPS) model that at least 75% of PREP clients will have participated in employment, education or volunteer activities by the 12th month of program participation. As more consumers progress and reach their 6th and 12th month in the program, we anticipate that this number will continue to increase and we will reach and exceed this benchmark.

The Global Functioning Scale (GFS) was used to assess social and role functioning. In particular, the quality of peer relationships, peer conflict, age-appropriate intimate relationships and involvement with family. The GFS Role scale assesses performance in school, work and domestic responsibilities. Both scales provide an assessment of functioning that accounts for age and stage of illness, that avoids confounding functioning with symptoms of illness, and that are specifically designed for use with individuals in prodromal and recent onset phases of psychosis. Each of the scales consists of 1-item that rates social or role functioning from 1 (extreme dysfunction) to 10 (superior functioning) for current functioning, past year high, and past year low. Results of provider-rated change in social and role functioning was not significant (N=16).

**Symptoms of Depression.** The Patient Health Questionnaire Depression Scale (PHQ-9) is a 9-item client self-report depression scale from the Patient Health Questionnaire (PHQ). It provides a single score ranging from 0 to 27 that yields both provisional diagnosis of depression and a measure of symptom severity. Paired t-tests were conducted to evaluate change in depression scores from baseline to 6 months. Data at both time points was available for 14 of the 35 enrolled clients. While change in depression scores were not statistically significant from baseline to 6 months, average depression scores decreased from the “moderate” range at baseline (mean = 10.8) to the “mild” range at 6 months (mean = 9.8). It is suspected that the small sample size contributed to the lack of statistically significant change at 6 months.

**Symptoms of Anxiety.** The Patient Health Questionnaire Anxiety Scale (GAD7) is a validated 7-item client self-report measure of generalized anxiety scale which also comes from the Patient Health Questionnaire (PHQ). It provides a single score ranging from 0 to 21 that yields both provisional diagnosis and a measure of symptom severity. Paired comparison of mean anxiety scores from baseline (mean = 8.5) to 6 months (mean = 8.0) revealed no statistically significant change on this scale.

**Symptoms of Psychosis.** Provider ratings of positive and negative symptoms of psychosis were collected using the Quick Scale for the Assessment of Positive Symptoms (QSAPS) and the Quick Scale for the Assessment of Negative Symptoms (QSANS). On both scales, providers are asked to rate the presence of positive and negative symptoms on a scale of 0 to 100, with the following response anchors: 0= “Absent,” 20= “Minimal/Questionable,” 40= “Mild/Minimal,” 60= “Moderate,” 80= “Marked,” and 100= “Severe.” Responses associated with positive symptoms (e.g. hallucinations, delusions), disorganized symptoms (e.g. disorganized speech, disorganized behavior, agitation/aggression), and negative symptoms (e.g. affective flattening or blunting, alogia, avolition, anhedonia, and asociality) were summed and averaged to create 3 scales. Two items were also added to assess distress associated with hallucinations and delusions, respectively. Change analysis (n=15) revealed a significant reduction in positive symptoms from baseline (mean=42) to 6 months (mean=27) and negative symptoms from baseline (mean=53) to 6 months (mean=46). Although a mean reduction was observed for symptoms of disorganization and distress, this change was not significant. Results are displayed in Figure 4 below.



**Medication Adherence.** The MARS is a 10-item self-report scale of medication adherence, which assesses willingness and ability to take oral medications and perceptions of medication side effects. The MARS is completed by clients who are currently being prescribed medication for psychosis at the time of evaluation. Paired comparisons of total MARS scores from baseline (mean = 6.2) to 6 months (mean = 6.7) revealed no significant change in medication adherence. Of the three MARS subscales only scores on the negative side-effects and attitudes subscale yielded significant improvements from baseline (mean = 1.1) to 6 months (mean = 1.6;  $t = -2.65$ ).

**Substance Use.** The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) was developed with support from the World Health Organization (WHO) to detect and manage substance use and related problems in primary care settings. Two items are used from this scale to assess the frequency of lifetime use of specific substances – tobacco products, alcoholic beverages, cannabis, cocaine, amphetamine type stimulants, inhalants, sedatives, hallucinogens, and opioids, as well over the past three months at the time of administration. Paired comparison of mean substance use scores from baseline (mean = 7) to 6 months (mean = 8.3) did not reveal a significant change in total substance use.

**Service Satisfaction.** The PREP evaluation uses Naik and Bowden's (2008) Service Satisfaction Scale. The 18-item scale assesses satisfaction with services in the following areas: 1) pathway to services, 2) appointments, 3) social/educational pathways, 4) psychological and emotional support, 5) medication, 6) service-user involvement and recovery, 7) promoting hope, and 8) understanding problems. Items were scored on a 5 point scale ranging from “Strongly Disagree” to “Strongly Agree.” Overall, PREP clients reported generally high levels of satisfaction and perceptions of services, with an average total mean score of 3.8 out of 5 across all responses on the survey. This is consistent with prior reports at 3 months of service. Satisfaction scores on the subscales ranged from 3.7 to

4, all within the “Agree” range. The lowest was promoting hope subscale (mean = 3.7), the highest was medication (mean = 4).

**Working Alliance.** The PREP evaluation uses the shorter 12-item version of the Working Alliance Inventory (WAI) developed by Horvath & Greenberg (1989). The WAI-S subscales assess “1) client and therapist agreement on goals, 2) client and therapist agreement on how to achieve the goals (task agreement), and 3) the development of a personal bond between the participants” (Tracey & Kokotovic, 1989). Overall, at 6 months clients rated their perception of the working alliance as “high” (mean = 63). On the three subscales, clients rated their perception of the bond (mean = 22.6), agreement on goals (mean = 21.4), and agreement on tasks (mean = 20.9) as “high.”

**Challenges and Successes in Program Implementation Staffing.** PREP currently has one opening for a full-time therapist. This position has not been filled and PREP is actively seeking a bilingual, Spanish-speaking therapist. The position has been posted on several career sites, including the SMC non-profit employment website.

**Family and Community Engagement.** In an effort to improve family engagement and community involvement, PREP hosted a family/community barbeque in June. Four families attended the BBQ. Additionally, the family member support group is also being offered two nights a month; however, attendance has been low. With the new psychology practicum students beginning their training year at PREP, PREP SM hopes to create more interest in the family support group by having one of the trainees who has expressed interest co-lead the group and help with the outreach efforts. Moreover, PREP as an agency continues to develop a protocol for increased familial involvement that will be implemented in the next several months. Lastly, in the next several months, PREP intends to begin another intensive round of outreach to SMC clinics and residents, including outreach to medical providers in the area and local schools.

**Multi-family Groups (MFG).** The first two-session multi-family psychoeducation group occurred in May of 2013. Twenty clients and family members attended each night of the workshop. Although the ongoing group meetings began in June, lack of attendance resulted in the group being temporarily postponed until September 2013. Three sessions were scheduled, the first occurred in June, but was cancelled due to lack of attendance. Two additional meetings were scheduled and only one family showed up to each meeting, despite reminder calls and outreach from staff. PREP staff are currently in the process of recruiting and joining with new families and offering individual family sessions for those families who have already participated in the joining process.

## **Michael's Story\*- Prevention and Recovery in Early Psychosis (PREP)**

*"I'm proud of where I am right now as compared to where I was before"*

"I don't really consider myself a success story, just a lucky person I guess. Who had a ton of support thanks to this program, as well as friends. I'm proud of where I am right now as compared to where I was before. Alone, miserable, all of that, but now, I'm in a good place. With tons of new opportunities, such as being in an internship that helps at risk high-school student's graduate. I couldn't have pictured getting this far without my friends. For example, when they stood up for me when I was going to get transferred to another school last year so I couldn't go to prom, still didn't go anyway, but most importantly not being able to graduate on stage with them. Currently I'm devoting my time to this new internship where I help take care of the students such as when they're absent I have to take make sure they have an excused note and stuff like that I'm currently in love with where my life is going right now in this direction. Later on, in a couple of months, I'm going to be a tutor at Skyline College and later on becoming a supplemental instructor where I have my own class and teach English, basically a partner class to a main class such as an ENG 846. Everything seems to be going really well right now so I am thankful for that. What I always tell myself is nothing bad lasts forever; but nothing good lasts forever either there's always has to be a balance in life where they both come back and meet in a circle."

\* Directly quoted from client's story; name has been changed to protect their privacy

## INNOVATION (INN)

**Total Wellness (TW)** – aims to improve the physical health status of individuals with serious and persistent mental illnesses (SPMI) by integrating primary care services into the community-based behavioral health clinics.

Health and wellness activities included:

- Weekly walking group and physical activities.
- Health WRAP group – A ten week series of Wellness Recovery Action Plan 10 session weekly nutrition workshop.
- Total Nutrition – A ten-week nutrition workshop.
- Peer-to-Peer Well Body Group – A condensed four week weight management series.
- Peer-to-Peer Smoking Cessation group – A six-session series of Ash Kickers adopted from the University of Colorado’s curriculum.
- Breathe California’s Ash Kickers group – A six-session series of smoking cessation groups for clients who are ready to set a quit date, as well as be able to obtain NRT patches support provided by Breathe California.
- Diabetes Group – Four-week class in collaboration with Fair Oaks (County primary care clinic) and Caminar (community residential treatment facility).
- Monthly Health Classes – Topics included “Stress Management,” “Seated Exercises,” “Sleep Hygiene,” “What Goes Into Your Wallet,” Asthma/COPD,” Hope for the Holiday,” “Food and Feelings,” “Coping with Pain,” “Dental Care and Psychotropic Medications,” “Spirituality,” “Happy Feet,” and “Weight Gain Induced by Psychotropic Medications.”

Monthly TW group flyers and calendars were mailed to all enrollees and collaborative partners and providers.

Peers and consumers have ample opportunities to get involved in various levels and aspects of Total Wellness. The monthly Consumer and Family Advisory Committee had nine members, comprised of five consumers and one family member in addition to the three BHRS staff. Total Wellness also employed part-time peer coaches contracted through consumer-run organizations such as Heart and Soul, Voices of Recovery and Vocational Rehabilitation Services.

The following is a list of some of our pertinent project outcomes:

- A total of 417 unduplicated clients were enrolled by the end of June 2013. A client must meet the following criteria to be eligible for TW enrollment: a) Receive behavioral health services at the South and Central County Clinics or one of BHRS’ contract agency partners; and, b) Receive primary care services from the TW Primary Care team or from the County’s Primary Care Providers.

- TW has had a very low attrition rate and majority of our clients have stayed with our services over period that our 6-month reassessment rates to monitor outcomes have remained above 80%.
- Total Wellness Consumer Advisory Committee was reinstated in February 2012 and since, the Committee has been meeting monthly. The mission of the Committee is to encourage consumer inputs and ideas in our continuous efforts to improve quality care to our community.
- TW has adopted evidence-based practices in our services. The EBP adopted include the peer-to-peer smoking cessation model of University of Colorado, “ready to set quit date” smoking cessation model of Breathe California, motivational interviewing on Brief Action Planning (BAP), and Wellness Recovery Action Plan (WRAP – on Wellness).
- TW held our first “Celebrating Wellness” event in January 2013 in which 13 TW clients were acknowledged and awarded for their remarkable achievements in reaching their wellness goals.
- Continuous promotion of TW integration model via program presentations at the national, state, and local levels. Prominent presentations provided in FY 12-13 included:
  - Oct. 12 – Mental Health Association of San Mateo
  - Jan 13 – Alcohol & Other Drug Services, San Mateo County
  - Feb 13 – SAMHSA PBHCI Regional Conference in the Bay Area
  - Feb 13 – BHRS Leadership, San Mateo County
  - Feb 13 – Southcentral Foundation of Alaska/SAMHSA PBHCI
  - Mar 13 – MHSa Steering Committee
  - April 13 – San Francisco County/ SAMHSA PBHCI grantee
  - May 13 – Solano County’s Mental Health Division
  - June 13 – Catholic Charities of Santa Clara/SMAHSA PBHCI grantee
  - June 13 – Bay Area Behavioral Health-Primary Care Conference 2013

Client Health Outcomes:

- TW clients with elevated blood pressure, fasting glucose or HgbA1C, and/or cholesterol when first seen by TW have closer to normal levels as soon as within 6 month into enrollment. Hence, our clients show better self-management of diabetes, hypertension, hyperlipidemia, and adherence to lifestyle changes after enrollment.
- TW clients with their body mass indexes (BMI) in the overweight or obese range are losing weight and showing continuous improvement.
- TW clients expressed being more socially connected and feeling better about their overall health with less psychological distress after enrollment.

*By the end of FY 12-13, Total Wellness served 1,312 clients.*

*Cost per person: \$1,218*

### **Brian's Story\* - Total Wellness program**

A 75 years-old behavioral health client with Schizophrenia and complex multiple medical issues including failure to thrive and Type II Diabetes, was non-compliant with medication regimen and nutritional diets, which in turn resulted in the client developing an infection requiring him to be hospitalized and eventually amputating his left second toe. Due to his complex medical and psychiatric issues as well as non-compliant oppositional behaviors, his board and care home refused to take him back at the time of discharge from hospital. A Total Wellness nurse care manager took the lead role in communicating with his conservator, his placement staff, board and care director and supervisor; developed a care plan which included monitoring of his surgical wounds to prevent further infection and complication; worked with benefits staff to continue supplying the board and care with daily Ensure diet; provided on-going monitoring and one-on-one education & coaching to support client around his eating habits. The client did not only get accepted back to the board and care facility, but he has also been medically stable and gained 7 lbs within 5-6 weeks of his return to the facility!

\* Client's name has been changed to protect their privacy

## Workforce Education and Training

The Workforce Development and Education program continued to implement the prioritized items in the MHSA WET plan. Staff from BHRS and contracting agencies - 250 staff total and 20 consumers completed the 2011 Training Survey which reflected the ongoing and changing educational priorities of the staff. The most prioritized training topics for the staff and consumers as indicated in this survey: trauma, anxiety treatment, self-care, and legal and ethical issues.

Training	Date(s)	Training Plan or Systems Need Addressed
<b>Neurosequential Model of Therapeutics (NMT) Phase I Training and Implementation</b>	8/28 Implementation calls 8/28 NMT DVD day long training on the basics 9/27 Applied NMT 8/29, 10/15, 11/19, 12/10 NMT for PREP team and ten additional webinars viewed by staff 10/23 and 11/28 two implementation calls. 10/11 and 11/15 Additional metric scoring webinars 1/28/13 final site certification training for Phase 1. Post-tests and completion of viewing required media	EBP; Trauma Treatment  37 staff completed Phase 1 NMT training
<b>Neurosequential Model of Therapeutics Phase 2</b>	Monthly Training for Trainers webinar and practice. Viewing of monthly educational webinars; completion of fidelity metric	10 staff enrolled in NMT training for trainers
<b>Law and Ethics for Clinicians</b>	8/8	Law and Ethics training for all BHRS clinical staffs – 6 hours CME
<b>Supervisor Training – The Basics</b>	8/30	Review of basic clinical supervision skills with training on Relational Supervision and Motivational Interviewing approach– 6 hours CEU
<b>Motivational Interviewing for Intern and Trainee Staff</b>	9/24	Motivational Interviewed based on the most recent edition (3rd) of MI book. EBP, core competency development.

<b>Motivational Interviewing</b>	10/9 and 10/10	EBP; Engagement and motivational enhancement strategies; Core competency and foundational knowledge. Day 1: Basic listening and responding micro-skills, Day 2: Listening and responding to “change talk”
<b>Motivational Interviewing with Youth and Young Adults</b>	1/30	EBP; Engagement and motivational enhancement strategies; Core competency and foundational knowledge.
<b>Co-Occurring Training: Revisions for DSM 5</b>	8/22	Core Competencies in AOD and MH assessment and diagnosis.
<b>Prevention and Management of Assaultive Behavior in Outpatient Settings</b>	10/18 (Part 1 – the basics) and 10/25 (Part 2 – Practice sessions)	EBP; Risk management; Engagement strategies for clientele with behavioral health conditions; Foundational knowledge
<b>Coding and Administration of the Addiction Severity Index</b>	10/4	Alcohol and other Drug (AOD) tool; Core competency for staff working primarily with AOD clients.
<b>Trauma-Informed Care: Technical assistance and training provided by experts contracted with the National Center for Trauma-Informed Care (NCT-IC)</b>	11/15 (TIC for Leadership) and 11/16 (Creating Resilient Systems for all Staff and Trauma-Informed Peer Helping)	Continue to partner with NCT-IC to provide evidence based practice training to line staff and supervisors on implementing and sustaining trauma-informed care in practice. TIC – systems priority per CCISC Charter Document and staff/ consumer training request.
<b>Introduction to Harm Reduction Principles</b>	2/7	Engagement and motivational enhancement strategies; Core competency and foundational knowledge. MHS - WET
<b>Hope at Work Star-Vista/BHRS collaboration</b>	2/13	Strength-based supervision and management strategies. Supports trauma-informed care for providers and clients. MHS - WET

## ONGOING WET TRAININGS:

- The Avatar Training for New Clinicians - electronic documentation training. The live training was been expanded to include The Basics, Solving Problems, Treatment Plans and Progress Notes, and Q and A. These topics are held once a month from 9 AM to 3 PM the first Friday of the month. Also added Avatar Assessments, Discharges and Transfers for Mental Health (online).
- Online: Critical Incident Management & Mandated Report, 5150 Certification, and Basic Documentation Training for BHRS staff.
- Family Partner Training – Weekly, 1.5 hours on Tuesdays.
- Applied Suicide Intervention Skills Training (ASIST) – October 18th and October 19th. BHRS and contracted staff, regional partners from Santa Clara, Alameda and Marin County attended ASIST (27 participants). November 29th and 30th ASIST training was provided for staff at Skyline College in San Bruno (15 participants).
- Spanish Speaking Providers’ Consultation – monthly meeting
- Psychiatric Grand Rounds – “Emotional and Cognitive Processing in Children with History of Interpersonal Violence (September 11th) and “Understanding Family Member Perspective” (September 25th), Adjunctive Psychosocial Interventions for Psychosis (October 9th); Pathways Program (October 23rd); Mental Health: Connecting Spirituality and Recovery (November 13th); Effectively Treating PTSD: Best Practices and Promising Innovations (November 27th), and Substance Abuse in the VA Population (December 11th), Social Media and the Medical Profession (January 8th); Durability of Improvement in PTSD Symptoms after MDMA Assisted Psychotherapy (January 22nd); Affordable Care Act (ACA) Health Reform (February 12th); Suicide in Veterans (February 26th), and Substance Abuse in the VA; Psychiatric Ethics (Population (March 12th); Jungian Dream Analysis (March 26th)
- Suicide Prevention Initiative – Monthly meeting often includes a training component. July meeting addressed consumer-driven conceptualization of suicide prevention and intervention. Lived Experience Speakers Bureau – Held Suicide Survivors Forum, 9/10 to educate on the issues of recovery and treatment.
- Seeking Safety- Ongoing consultation for providers who were incorporating Seeking Safety model to address trauma and addiction. Staff at Cordilleras Medical Center engaged in two brief training sessions to introduce the model and assist where some Seeking Safely group work has been initiated. Around 24 staff participated in these trainings. The Seeking Safety consultation is provided to build on a formalized Seeking Safety training in April 2011 with Dr. Lisa Najavits, and is an effort to fully implement the model through coaching and problem-solving at each location. Consults were held once a quarter. Staff from Invision Shelter Network and Telecare participated in the February consultation.
- Mindfulness Practice – Monthly group on fourth Friday to build mindfulness practice skills. This group functions to build skills in providing evidence-based cognitive behavioral therapies and also helps build self-care skills for employees.
- Lived Experience Forums – Ongoing programming in which people with lived experience design the topic and the presentation. “Surviving Suicide” was presented

as part of a National Suicide Prevention Week, September 9th -16th. As a follow up to the presentation provided by the National Center for Trauma Informed Care, community workers, family partner and speakers with lived experience participated in a follow up group designed to educate and support LE staff with life skills to manage stress from trauma and find ways to create boundaries when discussing trauma. Thirty two individuals with lived experience attended this event.

- Youth Service Center training included Crisis Intervention and Suicide Assessment (9/12), Differences in Youth (October 17th), Neurosequential Model of Therapeutics I (November 14th), and Organizational Trauma and Self Care (December 12th), Complicated Conditions in Family Systems (January 16), Self-Harming Behaviors (February 13th) and Commercially and Sexually Exploited Youth ( March 13th).
- Motivational Interviewing Implementation (MI) – In addition to the basic skills sessions held in October, MI follow up, specialized and in-depth training was held for primary care doctors at San Mateo Medical Center (40 participants, 12/5) and for Human Service Agency Welfare to Work staff (30 participants, 12/12).
- In addition to the MI skills session with youth and young adults in January, targeted MI training was provided to Youth and Family Enrichment Services staff (2/26 and 3/5 – 40 attendees), Change Agents – MI and Co-Occurring Conditions (40 attendees) and to Job Train staff (total of 12 hours Jan-March – 9 staff members).
- Trauma 101 continued to be offered throughout the community. Staffs from San Mateo Special Education programs received Trauma 101 training specifically designed to meet the needs of teachers and education para-professionals. Attendees in the sessions were actively participating in the adaptations of the curriculum to help them address trauma-based presentations of acting out or withdrawal which could manifest in the classroom. The training was offered the third Wednesday of the month for 1.5 hours, starting in October
- Trauma Learning Collaborative - continued to offer training to Special Education Teacher on the basics of trauma, and appropriate ways to respond to trauma in the classroom (2/13 - ~30 teachers). Members of the Learning Collaborative also provide training to attendees at the Healing Trauma Summit in Oakland, California. Workshops presented by the TLC at the summit included: Tools Trauma Informed Approach to Assessment and Trauma Specific Assessment and Strategies for Building Trauma Informed Care and Service.

## **WET WORKFORCE DEVELOPMENT**

***Lived Experience Education Workgroup*** – is continuing to build on success and completed two Lived Experience Training Academies in July/August. Twenty diverse speakers with lived experience were graduated from the academies, and immediately were involved in forums, grand rounds, EBP training, Crisis Intervention Training, Motivational Interviewing, Harm Reduction and Change Agent meetings, among others. A special effort was made to involve family members to further diversify the Speakers Bureau.

One East Palo Alto organized a week of behavioral health career education for about 35 students enrolled in a Health Careers course at East Palo Alto Academy. Students learned

about the discipline of behavioral health, met people with Lived Experience and another panel of health care providers. Students stated in feedback that they appreciated learning about the field and meeting consumers and family members. The variety of professionals on the panel – nurses, managers, counselors, social workers – helped them realize the diversity of work options in the field.

**One East Palo Alto and Daly City Youth Health Center** – continued to work in the classrooms as creators and leaders of the Behavioral Healthcare Career Pathways Program at Westmoor High in Daly City and East Palo Alto Academy in Menlo Park. On August 10th, the high school pathways organizers met to prepare for the upcoming academic year. Both Daly City Youth Health Center and One East Palo Alto participated in pathways programs in the 12/13 school year, and adjustments were made to ensure the programs were increasingly sustainable, engaged students, and helped them learn about behavioral health care careers while challenging stigma. In addition to looking at career development inventories and engaging with classroom speakers, students were able to travel the South County Behavioral Health Clinic and visit with staff and consumers. Both the staffs and the students found the visits engaging and inspiring, and other interactive visits will be planned in the spring to different locations.

***The Behavioral Health College*** – Thirty two BHRS staff members from diverse work and cultural backgrounds attended ten classes on various topics related to the operations of BHRS. The intention is to build the knowledge base of the staff interested in taking on leadership positions in the organizations. Topics taught include the following: Behavioral Health: History and Policy; Health System and Health Policy; and County Governance and Administration.

***Students with lived experience*** – continued to apply for the Lived Experience Scholarship for their ongoing education to prepare them for jobs in the behavioral health care field. Each scholarship is \$500 and must be spent on educational related supplies or services. BHRS Interns and Trainees started in their placements for the academic year. About 50 of the new trainees and interns attended a two day orientation 9/6 and 9/7 in which they were introduced to San Mateo County system of care. They were also educated by consumers and family members on Wellness and Recovery, as well as the Office of Diversity and Equity on concepts of cultural competence and reducing health disparities. Attendees also had opportunity to learn about best practice regarding trauma-informed care, crisis intervention and co-occurring disorders. In October, their Intern Trainee Seminars begin at North, Central and Coastside BHRS clinics. The seminars provided rich learning experiences for the trainees and involve such activities as expert trainers providing curriculum on evidence based practice, case review and field trips to hospitals and treatment centers. Clinical Supervisors are dedicated to building the internship program which provides placements at about 23 distinct clinical programs throughout San Mateo County BHRS. In addition to MFT and SW interns/trainees, Ph.D., nursing, nurse practitioner, occupational therapist and AOD certificate students are placed at sites throughout the year.

Much effort is made to attract diverse students, and the Cultural Competency Stipend helps to provide incentive for those applicants with diverse cultural, lifestyle and/or life experience backgrounds to apply. The Workforce Education and Training Team worked with the Office of Diversity and Equity and were able to select twenty students, mostly graduate students in counseling, nursing, social work or psychology, to receive the stipend. In addition to participating on their clinical teams, the recipients of the stipends agree to participate in one of BHRS Health Equity Initiatives or systems change initiatives

Mentoring Project –Workforce Development and Latino Collaborative presented Cross Cultural Communication with Andres Connell (October 30th). The presentation helped to inspire attendees to identify ways to engage diverse and “under-mentored” employees in considering mentoring relationships. The Mentoring Project hosted a January Mentoring Month partnering kick off and interested mentors and mentees were partnered in February based on their feedback submitted via survey in January. A diverse group of staff participated in the partnerships. Partnerships involved staff in administrative, clinical and supervisory/management roles. Twelve new mentoring partnerships were created, and the survey was sent again in June. The intention is to send survey and create partnerships about twice a year.

## Housing

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

All MHSA housing buildings are close to transportation and basic amenities. Each building design focuses on creating community among the tenants by including common areas, meeting spaces and walkways for tenants to meet each other.

### APPROVED PROJECTS TO DATE

\$ 6,762,000 MHSA funding was allocated for both construction and operation of supportive housing with \$121,665 cost per unit not to exceed one third of total cost of unit; and up to \$121,665 per unit for unit operating costs. BHRS is responsible for services through Full Service Partnerships.

Development	Units	Year Approved	MHSA Funding Amt
<b><i>Cedar Street Apartments</i> – developed by Mental Health Association of San Mateo. The City of Redwood City, County of San Mateo and the federal Housing and Urban Development (HUD) provided funding for construction and ongoing rental subsidy.</b>	5 MHSA units 14 total units	2009	\$524,150
<b><i>El Camino Apartments</i> – developed by MidPen Housing in South San Francisco. Funding for construction was provided by the City of South San Francisco, County of San Mateo Dept of Housing, state of California and others.</b>	20 MHSA units 106 total units	2010	\$2,163,200
<b><i>Delaware Pacific Apartments</i> – developed by MidPen Housing in San Mateo. Partners in the funding include the City of San Mateo, County of San Mateo Dept. of Housing, state of Calif and others.</b>	10 MHSA units 60 total units	2011	\$1,124,860
<b>TOTAL COMMITTED</b>			<b>\$3,812,210</b>

Cedar Street Apartments - Approved in 2009 (5 units)



El Camino Apartments - Approved in 2010 (20 units)



Delaware Street Apartments - Approved in 2011 (10 units)



## MHSA PROGRAMMATIC ACTIVITIES FOR FY 14/15

Due to staff transitions, we began our 3-year planning process for in April 2014 through August 2014. We sought input from the broad San Mateo stakeholder community through the Community Program Planning and Stakeholder Input Structure process we set in place involving the Mental Health and Substance Abuse Commission, the MHSA Steering Committee and many other outreach and input venues.

The list of priorities for funding that was developed in the previous Three-Year Plan and updated on an ongoing basis with stakeholder input have remained priority for implementation. Prioritized items were kick-started as revenue became available and ongoing reports were provided through our regular reporting and communication avenues.

FY 12/13 expansion priorities for funding that were completed included:

- FSP slots for Psychiatric Emergency Services and our Medical Center's Psychiatric Inpatient Unit (3AB) for transition age youth and adults
- Integrated FSP to the Central Region for adults
- Wraparound services for children and youth
- Housing for existing FSP for adults
- Pre-crisis response services and targeted outreach to clients at risk of destabilizing
- Teaching Pro-social Skills
- Parent Project\*

FY 12/13 priorities that were not completed and continue as priority for funding include:

- Expansion of FSP slots for Transition Age Youth, with housing
- Expansion of supports for youth transitioning to adulthood
- Assessment, supported employment, and financial empowerment for clients.

\*A voter approved tax increase in November 2012, Measure A, increased the sales tax paid on the purchase of goods and services in San Mateo County by one-half cent for 10 years. The San Mateo County Board of Supervisors approved funding from Measure A for the expansion of the Parent Project.

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## APPENDICES

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# APPENDIX 1. Needs Analysis Overview and Summary of Input

San Mateo County Behavioral Health & Recovery Services (BHRS)  
 MHSA Three-Year Program and Expenditure Plan for FY 14/15 through FY 16/17



## Stakeholder Input – Quick Overview

What are the consistent and existing barriers to accessing mental health services? What are the gaps in services?

THEMES/NEEDS - (in order by # of times mentioned)	Source of Input	
<ol style="list-style-type: none"> <li>1. Timely Access               <ul style="list-style-type: none"> <li>• Cross-Sector Collaboration and Capacity Building for Service Providers</li> </ul> </li> <li>2. Cultural Competence/ Humility               <ul style="list-style-type: none"> <li>• Building Community Relationships/Trust</li> <li>• Language Access</li> </ul> </li> <li>3. Education, Outreach and Engagement               <ul style="list-style-type: none"> <li>• Parent and Family Education and Engagement</li> <li>• Media/Social Media</li> </ul> </li> <li>4. Coordination and Integration*</li> <li>5. Collaboration</li> <li>6. Housing</li> <li>7. Consumer Voice</li> <li>8. Transportation</li> <li>9. Stigma</li> <li>10. Meaningful Employment</li> <li>11. Undocumented</li> <li>12. Additional Service Needs               <ul style="list-style-type: none"> <li>• Parents and Children with Developmental Disabilities</li> <li>• Drop-in Centers/ Self-Help</li> </ul> </li> <li>13. Warm handoff and follow up</li> <li>14. Childcare</li> <li>15. Recovery</li> <li>16. Homeless Population</li> <li>17. Poverty</li> <li>18. Staff Wellness</li> <li>19. Suicide Prevention</li> </ol>	<p><b>BHRS planning activities</b></p> <ul style="list-style-type: none"> <li>• Central Community Service Area (CSA)</li> <li>• Coastside CSA</li> <li>• East Palo Alto CSA</li> <li>• South CSA</li> <li>• Health Equity Initiatives</li> </ul> <p><b>Stakeholder Groups</b></p> <ul style="list-style-type: none"> <li>• East Palo Alto Behavioral Health Adv Group</li> <li>• Family Partners</li> <li>• Heart &amp; Soul, Inc</li> <li>• North County Outreach Collaborative</li> <li>• Office of Consumer and Family Affairs</li> <li>• Peer Support Workers</li> <li>• Spirituality Initiative</li> <li>• Voices of Recovery</li> </ul> <p><b>Key Interviews</b></p> <ul style="list-style-type: none"> <li>• San Mateo County Office of Education</li> <li>• School Wellness Coordinators</li> </ul>	<p><b>KEY:</b></p> <ul style="list-style-type: none"> <li>• C- CSA</li> <li>• CS-CSA</li> <li>• EPA- CSA</li> <li>• S- CSA</li> <li>• HEI</li>   <li>• EPABHAG</li> <li>• FP</li> <li>• H&amp;S</li> <li>• NCOC</li> <li>• OCFA</li> <li>• PSW</li> <li>• SI</li> <li>• VR</li>   <li>• SMCOE</li> <li>• SWC</li> </ul>

\*Coordination is based on the “good will” of people whereas integration begins with this “good will” and adds system changes to how we do our work and includes resourcing that work. <sup>1</sup>



## Stakeholder Input – Themes, Resources and Comments

THEMES (in order of times mentioned)	What resources are available to address these needs/gaps?	Comments (Stakeholder Group)
<b>1. Timely Access</b>	<ul style="list-style-type: none"> <li>Community Service Areas</li> <li>Adult Resource Management</li> </ul>	<ul style="list-style-type: none"> <li>Services are difficult to access in a timely manner (CSAs, HEI, NCOC, EPABHAG)</li> <li>Medication/services, can't get it in a timely manner (EPABHAG)</li> <li>Improved availability, 24 hours (CS-CSA)</li> <li>We need more "open-door" and easier drop-in policies, same day access (PSW)</li> <li>It was a 4 month process from the time they were assessed to the next interview to the connection with a case manager (VR)</li> <li>Waited 5 months before a referral called her back (VR)</li> <li>Getting that initial/first service is difficult (VR)</li> <li>Waiting list for counseling/mental health services on school sites (SWC)</li> <li>Need more flexible hours of services – clinics are 8-5, security is a big issue... some clinics have a one day late hours or one weekend with childcare but security is not available (FP)</li> </ul>
<ul style="list-style-type: none"> <li>Cross-Sector Collaboration and Capacity Building for Service Providers</li> </ul>	<ul style="list-style-type: none"> <li>Mental Health First Aid</li> <li>San Mateo County Mental Health Assessment and Referral Team (SMART)</li> <li>Crisis Intervention Training (CIT) for law enforcement</li> <li>Adult Resource Management (ARM)</li> <li>Family Assertive Support Team (FAST)</li> </ul>	<ul style="list-style-type: none"> <li><b>Doctors</b> are too overwhelmed, busy and rushed to deal with behavioral health issues, it feels impersonal (VR)</li> <li>Asked for help through their <b>primary care provider</b> and access was difficult, it took a very long time and a lot of asking for help before the doctor finally referred them to an appropriate service/program. It's difficult to know where to turn when need behavioral health services, feel hopeless. (VR)</li> <li>All <b>service providers</b> need to know what resources are available – mental health first aid for <b>primary care</b> providers and <b>emergency response</b> (VR)</li> <li>When on a 5150 hold (<b>emergency response</b>), clients are released and put into institutions (e.g. cordilleras), need options at this access point (VR)</li> <li><b>Police</b> have a resource list but it's confusing, don't know who to call and when do call, they get transferred. Police need to know how to guide (VR)</li> <li>Education of <b>providers</b> and partner agencies - <b>law enforcement</b>, etc. (CS-CSA)</li> </ul>



**San Mateo County Behavioral Health and Recovery Services (BHRS)  
MHSa Three-Year Program and Expenditure Plan FY 14/15 through FY 15/16**



THEMES (in order of times mentioned)	What resources are available to address these needs/gaps?	Comments (Stakeholder Group)
		<ul style="list-style-type: none"> <li>• Need a referral system and resources at <b>shelters</b> (VR)</li> <li>• Where to start if need services, if an individual goes to their <b>congregation</b> for help, will there be a connection to services? (SI)</li> <li>• Need to think of non-traditional venues to connecting individuals to help and services- <b>congregations, schools, etc.</b> (SI)</li> <li>• Denied <b>long-term disability</b> based on past work history, assessed that I am well enough to work. Need other support and follow up. There’s a gap between making too much to qualify for services but too little to sustain. (VR)</li> <li>• Services for those in retirement age (50-62) that are not mentally ill enough for <b>SSI</b> but have PTSD, depression, they fall through the cracks (PSW)</li> </ul>
<b>2. Cultural Competence/ Humility</b>	<ul style="list-style-type: none"> <li>• Workforce Education and Training Plan, Lived Experience Academy, Internship and Cultural Competency Stipend</li> <li>• Cultural Competence Policy</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of diverse and bilingual staff/providers (HEI)</li> <li>• Increased training to providers on active listening (CS-CSA)</li> <li>• Lack of appropriate tracking of clients ethnicity and LGBTQQI2S (HEI)</li> <li>• Need to incorporate cultural comp and cultural humility at all service levels and community events (HEI, NCOC, EPABHAG)</li> <li>• County-hosted events need to be culturally sensitive to population (NCOC)</li> <li>• Transparent, welcoming in all meetings/events to diverse communities (NCOC)</li> <li>• Sometimes when a Latino parent calls ACE and is asked how things are going, they say “everything’s fine”... they minimize things, it’s a cultural thing. Their situation is then not considered severe enough to get services.(FP)</li> <li>• Tongan client who has mental illness and drinks every day – doesn’t want services, need to approach this in a culturally appropriate manner (FP)</li> <li>• Need more open minded staff at access points, was told “you talk too well to need help” and “you don’t look like you have a disability.” (VR)</li> <li>• Therapist said she was “playing the victim,” need sensitivity and anti-stigma training (VR)</li> </ul>



**San Mateo County Behavioral Health and Recovery Services (BHRS)  
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<b>THEMES (in order of times mentioned)</b>	<b>What resources are available to address these needs/gaps?</b>	<b>Comments (Stakeholder Group)</b>
<ul style="list-style-type: none"> <li>• Language Access</li> </ul>	<ul style="list-style-type: none"> <li>• Cultural and Linguistic Standards and Policies</li> <li>• BHRS Interpretation, translation services</li> <li>• Chinese community outreach worker</li> <li>• Workforce Education and Training Plan</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of materials and info in other languages (HEI, NCOC, EPABHAG)</li> <li>• Services for diverse, non-English speakers in North County are still lacking (PSW)</li> <li>• Continue to address language barriers (EPA-CSA)</li> <li>• Staff at psych emergency hospital use children for language interpretation ... need continuing training and support for language access (FP)</li> <li>• At times it takes 5 hours to get ASL interpretation services, need better support for ASL community (FP)</li> </ul>
<ul style="list-style-type: none"> <li>• Relationships/ Trust</li> </ul>		<ul style="list-style-type: none"> <li>• Relationships with the community vary widely ( CSA, HEI, NCOC, C-CSA)</li> <li>• Inconsistency – things changing frequently leads to distrust (NCOC)</li> <li>• Need for capacity building and developing trust in the community (HEI, NCOC, EPABHAG)</li> </ul>
<p><b>3. Education, Outreach and Engagement</b></p>	<ul style="list-style-type: none"> <li>• Office of Diversity and Equity – Health Equity Initiatives</li> <li>• NCOC and EPABHAG</li> </ul>	<ul style="list-style-type: none"> <li>• Need more outreach for programs like Parent Project or other groups – families don’t know about them unless they are connected to schools or referred by BHRS (FP)</li> <li>• Need improved outreach and education for underserved populations (HEI, NCOC, EPABHAG, S-CSA, C-CSA)</li> <li>• Information is not getting out, need better way to inform on what’s available (H&amp;S)</li> <li>• Need menu of available services and programs (e.g. Parent Project) in the community so students, staff and parents know who/where to go to (SWC)</li> </ul>
<ul style="list-style-type: none"> <li>• Parent and Family Education and Engagement</li> </ul>	<ul style="list-style-type: none"> <li>• NAMI trainings</li> <li>• Parent Project</li> <li>• Community Interventions for School Age and TAY</li> </ul>	<ul style="list-style-type: none"> <li>• Improve family (children, siblings, partners, etc.) support, education and engagement in treatment (all CSAs)</li> <li>• There are a lot of services for youth but fall back when their families don’t change, need education for parents on how to deal with a child with a mental illness, e.g. Parent Project, NAMI basics. (FP)</li> <li>• Need support for families and parents of TAY with how to deal with the transition to being independent and able to make own choices about meds and other services. AVATAR tracks age, can flag a transition (FP)</li> </ul>



**San Mateo County Behavioral Health and Recovery Services (BHRS)  
MHSA Three-Year Program and Expenditure Plan FY 14/15 through FY 15/16**



<b>THEMES (in order of times mentioned)</b>	<b>What resources are available to address these needs/gaps?</b>	<b>Comments (Stakeholder Group)</b>
		<ul style="list-style-type: none"> <li>• Need more mental illness basics training – what to do with family with a diagnosis, understanding a diagnosis - e.g. NAMI basics. (FP)</li> <li>• More communication and education for families (e.g. NAMI family to family classes, family partners for adult clients, orientation and welcoming), there are not enough family partners in the adult system (FP)</li> </ul>
<ul style="list-style-type: none"> <li>• Media and Social Media</li> </ul>	<ul style="list-style-type: none"> <li>• Wellness Matters</li> </ul>	<ul style="list-style-type: none"> <li>• A lot of negative press that leads to misperceptions yet, positive events don't get as much press... Tony Hoffman Awards, Caminar graduation. (H&amp;S)</li> <li>• For youth, social media is an important venue to learn of services (SI)</li> <li>• Need to use social media and other ways to reach more people (PSW)</li> </ul>
<p><b>4. Coordination and Integration*</b></p>	<ul style="list-style-type: none"> <li>• Total Wellness</li> </ul>	<ul style="list-style-type: none"> <li>• Improve integration of services within schools (C-CSA, CS-CSA)</li> <li>• Lack of care coordination and integration (HEI)</li> <li>• There is a disconnect between Aging &amp; Adult Services providers and BHRS services, individuals may be referred to the TIES line but no direct connection (SI)</li> <li>• Better integration with alcohol and other drug services, including family member engagement (EPA-CSA)</li> <li>• Better healthcare integration with community services, a primary doctor or nurse to visit places like Heart and Soul and other drop-in centers (H&amp;S)</li> <li>• Need a better connection to VRS – client keeps rescheduling appointments “due to work” and in the meantime is not taking meds and has a severe diagnosis (FP)</li> <li>• For someone that is experiencing a breakdown but still high functioning, there is nothing available, they don't qualify for most services (H&amp;S)</li> <li>• There are students that need psychiatric services but not “seriously mentally ill,” what services are available to them (SWC)</li> <li>• Need to provide core services and health insurance to mental health clients (C-CSA)</li> <li>• Additional supports and integration of core services to assist with transitions – jobs, housing, etc. (C-CSA)</li> </ul>



**San Mateo County Behavioral Health and Recovery Services (BHRS)  
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<b>THEMES (in order of times mentioned)</b>	<b>What resources are available to address these needs/gaps?</b>	<b>Comments (Stakeholder Group)</b>
<b>5. Collaboration</b>		<ul style="list-style-type: none"> <li>• Shift to a more collaborate approach – we’re all in this together (CS-CSA)</li> <li>• Need to strengthen collaboration with community providers (HEI, NCOC, EPABHAG)</li> <li>• Individuals in board and care homes have no support or control over what meals are provided to them -e.g. frozen burritos and coffee (PSW)</li> <li>• Better engagement of faith community (S-CSA, C-CSA)</li> <li>• Clients in room and board, not licensed, not connected to services (PSW)</li> <li>• More partnering between schools and parents (SWC)</li> <li>• Students having access to services when needed (SMCOE)</li> <li>• Schools knowing what services are available (SMCOE)</li> <li>• Psychoeducation for families at shelters– parenting, intervention, domestic violence (FP)</li> <li>• Time is an issue for school staff, with Common Core and other requirements, trainings such as Mental Health First Aid that are 8 hrs long, need stronger collaboration (SWC)</li> </ul>
<b>6. Housing</b>	<ul style="list-style-type: none"> <li>• MHSA Housing</li> </ul>	<ul style="list-style-type: none"> <li>• Housing continues to be a challenge (EPA-CSA)</li> <li>• Stable housing – mental health beds, motels, dual-diagnoses housing, shelters for clients that are in and out of addiction (PSW)</li> <li>• Was looking for housing, contacted mid-peninsula and couldn’t get a hold of anybody, HUD was closed, took 2.5 years to get housing (VR)</li> <li>• Criminal history leads to added challenges in accessing housing (EPA-CSA)</li> <li>• Not enough housing options for individuals with varying degrees of mental illness (H&amp;S)</li> <li>• It’s difficult to make ends meet with bills and expensive housing, even cordilleras is expensive. Need vouchers and more housing support (H&amp;S)</li> <li>• Housing, stable place to live is needed first... before anything else (H&amp;S)</li> </ul>



**San Mateo County Behavioral Health and Recovery Services (BHRS)  
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<b>THEMES (in order of times mentioned)</b>	<b>What resources are available to address these needs/gaps?</b>	<b>Comments (Stakeholder Group)</b>
<b>7. Consumer Voice</b>	<ul style="list-style-type: none"> <li>• CSA Planning Committees</li> <li>• Lived Experience Academy</li> <li>• Office of Consumer Affairs</li> <li>• Stigma Free San Mateo County – Faces of Hope</li> </ul>	<ul style="list-style-type: none"> <li>• Consumer/clients and family members have limited presence (HEI, EPABHAG)</li> <li>• Process for individuals to voice their experiences and grievances anonymously (NCOC)</li> <li>• Need improved soliciting of input through non-traditional avenues and those we don't typically hear from or reach (S-CSA, EPA-CSA)</li> <li>• System assessment- how are we doing, better listening of consumer voice (CS-CSA)</li> <li>• Place for people to regularly tell their stories (EPA-CSA)</li> <li>• We are not reaching out to and hearing from marginalized communities - working parents, people struggling economically, in recovery, with mental health illness, or incarceration and also those affected -parents, children, family, etc. (PSW)</li> </ul>
<b>8. Transportation</b>		<ul style="list-style-type: none"> <li>• Need a regional approach, all services should be localized, difficult to get to service (VR)</li> <li>• Transportation as a barrier to access (EPABHAG)</li> <li>• Transportation to clinics and services, some (e.g. 1950 Alameda) are not in easy to access and not in friendly neighborhoods (PSW)</li> <li>• Transportation to services (VR)</li> <li>• Lack of transportation and childcare services (NCOC)</li> <li>• Transportation – 80% of families can't get to a particular location for services(FP)</li> </ul>
<b>9. Stigma</b>	<ul style="list-style-type: none"> <li>• Stigma Free San Mateo County</li> <li>• Stamp Out Stigma</li> <li>• Health Equity Initiatives</li> </ul>	<ul style="list-style-type: none"> <li>• Need more stigma awareness with low income and diverse communities (VR)</li> <li>• Stigma is still a big issue (PSW)</li> <li>• Need more open minded staff at access points, was told “you talk to well to need help” and “you don't look like you have a disability.” Was told by therapist that she was “playing the victim”, need sensitivity and anti-stigma training (VR)</li> <li>• Stigma is still a big issue – it takes a lot of effort to ask for help, there's fear of leaving your place and when you call law enforcement for help you get shot. (H&amp;S)</li> <li>• Stigma is a big issue for many students including International Baccalaureate students who are under a lot of stress and not dealing with it (SWC)</li> </ul>



**San Mateo County Behavioral Health and Recovery Services (BHRS)  
MHSA Three-Year Program and Expenditure Plan FY 14/15 through FY 15/16**



<b>THEMES</b> (in order of times mentioned)	<b>What resources are available to address these needs/gaps?</b>	<b>Comments (Stakeholder Group)</b>
<b>10. Meaningful Employment</b>	<ul style="list-style-type: none"> <li>• Family and Peer Partners</li> <li>• Lived Experience Academy</li> <li>• Health Ambassador Program</li> </ul>	<ul style="list-style-type: none"> <li>• Need more opportunities for employment with organizations that give back, meaningful employment - eg. VRS (VR)</li> <li>• Meaningful employment options – for those that don’t want to work as baggers. Peer opportunities, way to give back and get paid (H&amp;S)</li> <li>• Need more peer support, one-on-one support training (e.g. through Cañada or San Mateo College) and paid positions, not just volunteer (VR)</li> </ul>
<b>11. Undocumented</b>		<ul style="list-style-type: none"> <li>• Challenges in serving undocumented (EPA-CSA)</li> <li>• Services for the undocumented are not sufficient (PSW)</li> <li>• Undocumented status is a huge barrier – they have access to ACE and emergency medical, but it’s difficult to stay engaged when have minimal core support and resources, they give up, then come back when in crisis... it’s a cycle (FP)</li> </ul>
<b>12. Additional Service Needs</b>		<ul style="list-style-type: none"> <li>• More freedom to get a job, go to school or take our meds, more rights - more <b>supportive services</b> to help with this (H&amp;S)</li> <li>• Need a <b>tracking system</b> to track engagement when not getting services (FP)</li> <li>• Need <b>counselors and therapists on campuses</b>. Local Control Funding Formula plans have provided that sustainability for some schools. (SWC)</li> <li>• For borderline personality disorders, need <b>Dialectic Behavior Therapy (DBT)</b>, cognitive behavior therapy to teach us how to live (H&amp;S)</li> <li>• <b>Individual therapy</b> in adult system (C-CSA)</li> <li>• Increased <b>individual treatment</b> services (CS-CSA)</li> <li>• Need more <b>one-stop shops</b> to get information and services needed (H&amp;S)</li> <li>• <b>Parent with a mental illness</b> they may not have the cognitive ability to follow through if they don’t first get accepted for services for their children (FP)</li> <li>• Respite/<b>support for caregivers</b> (S-CSA)</li> <li>• There are no <b>trauma and PTSD treatment specialists</b>, this is a big gap (PSW)</li> </ul>



**San Mateo County Behavioral Health and Recovery Services (BHRS)  
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THEMES (in order of times mentioned)	What resources are available to address these needs/gaps?	Comments (Stakeholder Group)
		<ul style="list-style-type: none"> <li>• Youth system clinic in the coastside (OCFA)</li> <li>• Increase support roles (<b>case managers</b>) to free up clinicians for counseling (CS-CSA)</li> <li>• There is a large turnover in <b>case managers</b>, more support is needed (H&amp;S)</li> <li>• <b>Family Partners for adults</b>/families at clinics (OCFA)</li> <li>• <b>“warm line”</b> open to all BHRS clients (VR)</li> <li>• Increased community <b>peer support</b> (CS-CSA)</li> <li>• More peer mentoring – <b>peers</b> know how to identify signs and symptoms, they have been through it (H&amp;S)</li> <li>• A call center or more intensive support where someone can deal with <b>complicated situations</b> is needed (FP), examples:               <ul style="list-style-type: none"> <li>– triplegic client or serious brain injury... APS can’t find him services</li> <li>– needs... husband puts his wife under his insurance, has a high deductible (\$3K) because they can’t afford to pay more into it and ACCESS can’t help if they are insured, no way to help them</li> <li>– Adult son doesn’t take meds, calls police, keeps repeating same thing over and over, in and out of PES. Mom has cut hours to support her son, difficult not to help son – there are a lot of clients stories like this</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• Parents and children with developmental disabilities</li> </ul>		<ul style="list-style-type: none"> <li>• Need better support for parents with a developmental disability or mental illness – parenting classes, staff capacity (FP, OCFA)</li> <li>• Puente-type clinic in GGRC for children with developmental disabilities (FP)</li> <li>• Services for developmental disabilities, autism, mentally retarded (OCFA)</li> </ul>
<ul style="list-style-type: none"> <li>• Drop-in Centers/ self-help</li> </ul>		<ul style="list-style-type: none"> <li>• Need more support for self-help centers (e.g. Heart and Soul), drop-in centers, they have a huge potential in providing meaningful access and outreach (VR)</li> <li>• Longer hours, staff for Heart and Soul-type centers (H&amp;S)</li> <li>• Need more groups, staff, open doors in drop-in centers (H&amp;S)</li> </ul>



**San Mateo County Behavioral Health and Recovery Services (BHRS)  
MHSa Three-Year Program and Expenditure Plan FY 14/15 through FY 15/16**



<b>THEMES (in order of times mentioned)</b>	<b>What resources are available to address these needs/gaps?</b>	<b>Comments (Stakeholder Group)</b>
<b>13. Warm handoff and follow up</b>		<ul style="list-style-type: none"> <li>• We need to make changes to expectations/culture that staff have of individuals and their ability/follow up to complete and apply for services (PSW)</li> <li>• Warm hand off and follow up / communication among staff (EPA-CSA, EPABHAG)</li> </ul>
<b>14. Recovery</b>		<ul style="list-style-type: none"> <li>• Need to broaden and deepen focus on whole health and recovery (HEI)</li> <li>• Clarify goal of treatment – keep people on medication, prepare them for life (EPA-CSA)</li> </ul>
<b>15. Childcare</b>	Office of Diversity and Equity childcare contracts	<ul style="list-style-type: none"> <li>• Childcare when providing trainings (FP)</li> <li>• Lack of transportation and childcare services (NCOC)</li> </ul>
<b>16. Homeless</b>		<ul style="list-style-type: none"> <li>• Improve work with homeless population (CS-CSA)</li> </ul>
<b>17. Poverty</b>		<ul style="list-style-type: none"> <li>• Poverty continues to be a barrier to accessing services (S-CSA)</li> </ul>
<b>18. Staff Wellness</b>		<ul style="list-style-type: none"> <li>• Self-care and wellness policies for capacity building activities and workforce development (PSW, OCFA)</li> </ul>
<b>19. Suicide Prevention</b>	Mental Health First Aid (MHFA) and Youth MHFA	<ul style="list-style-type: none"> <li>• Need evidence-based suicide prevention programs in schools (SWC)</li> </ul>



## APPENDIX 2. Participant Demographics

San Mateo County Behavioral Health & Recovery Services

MHSA Three-Year Program and Expenditure Plan for FY 14/15 through FY 16/17



Community Program Planning (CPP) Process – Strategy Development Meeting  
July 16, 2014

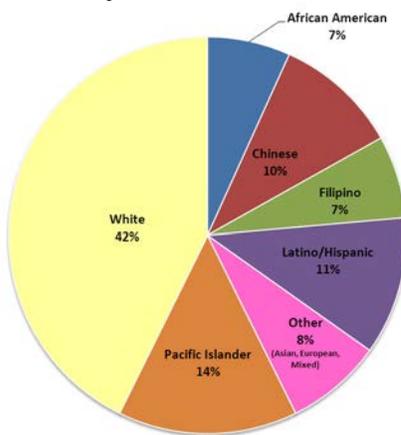
### PARTICIPANT DEMOGRAPHICS

San Mateo County is committed to hearing from diverse communities. Participant demographics help us understand who we have heard from and who we still need to reach out to. 96 participants were in attendance and of these 72 were non-BHRS staff. 21 stipends were provided to consumers/clients and family members. Childcare was provided to 4 families.

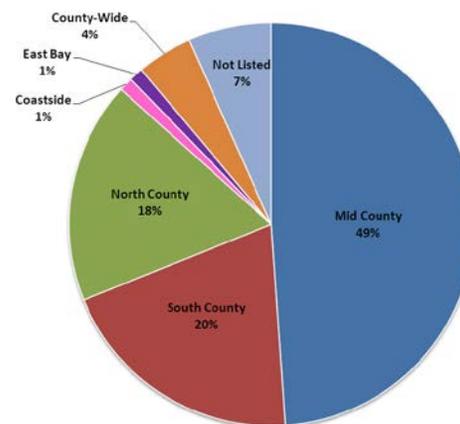
Gender:	Female	Male	Transgender
	77%	22%	1%

Age:	0 – 15 years	6 – 25 years	26 – 59 years	60+ years
	2%	3%	64%	27%

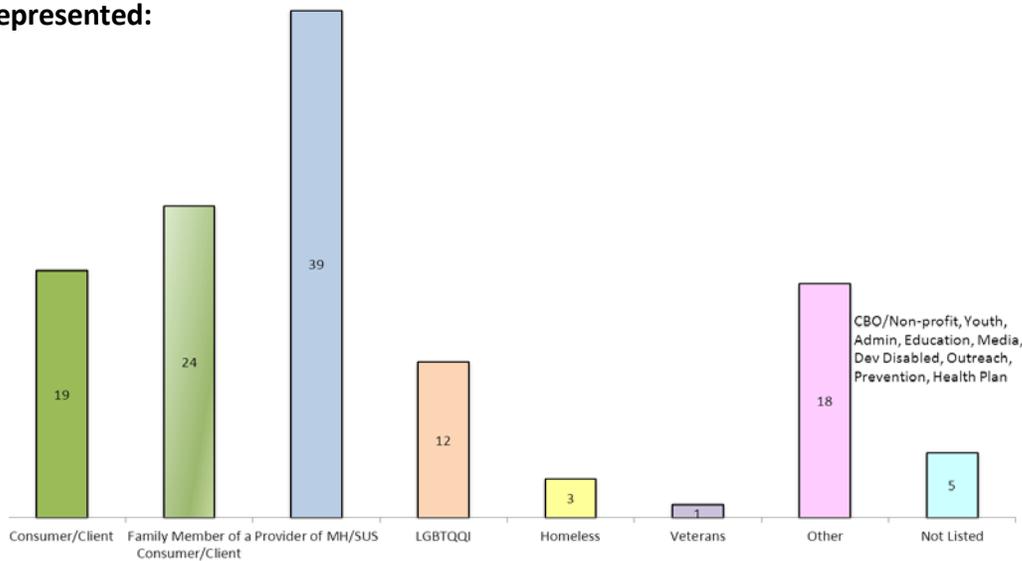
#### Race / Ethnicity:



#### Region:



#### Groups Represented:



## APPENDIX 3. Strategy Development Summary of Input

### MHSA Component - Community Services and Supports (CSS) Adult Treatment and Services

CSS serves individuals of all ages living with serious mental illness with a focus on un-served and underserved populations. There are three different service categories within CSS:

- o Full Service Partnerships (FSP): around the clock, intensive wraparound services to most acute clients
- o System Development (SD): strengthen and expand internal capacity to respond to service demands
- o Outreach and Engagement (O&E): outreach and engage individuals in services, with a focus on underserved and unserved populations

Strategy, program or enhancement to existing program	Comments / Notes	Need Addressed	Input
Total Wellness	<ul style="list-style-type: none"> <li>o Expansion of total wellness type program but with focus of building capacity for psych med prescribers in the community and the program could provide transition from regional clinic level and short term case management/ nursing</li> <li>o Idea to expand on Total Wellness 's Success: Funding of "health worker" type of positions at each regional clinic to track results of intake health screening results (smoking, subs/...(?), sugar/ lipid level, BP, weight, nutrition habit etc.) and outreach to those client with risk to promote further wellness/ PC linkage (treatment, groups, coaching)</li> <li>o Expand total wellness to entire San Mateo County, North County and Coastside have been requesting TW services</li> <li>o Total Wellness in non-county clinics maybe FSPs</li> </ul>	Integration	Community Session 7/16/14 (9 votes)
Peer and Family Partner Support Expansion	<ul style="list-style-type: none"> <li>o Increase in peer consumer and family partners</li> <li>o Consumer and family partner to collaborate with EPABH outreach support</li> <li>o I'd like to see an emphasis on more senior peer counselors. Senior are isolated, constantly have major losses &amp; physical disabilities. It's a strong end-of-life issue.</li> <li>o We need these resources and services in EPA for our residents</li> <li>o Increase self-help services including peer support at sites not in clinics but at stand-alone site</li> </ul>	Add'l Svcs - Peer and Family Support	Community Session 7/16/14 (7 votes)
Supportive Services for Recovery	<ul style="list-style-type: none"> <li>o Increase evidence based practices that support recovery-resiliency in the FSPs and clinics. E.g. IMR, WRAP, Supported employment</li> <li>o After an outreach program or finishing a mental health program, a program that can help patients with mental health illnesswith provides job assistance</li> <li>o More support for people to get employment or vocational training</li> <li>o Provide employment placement services for high functioning individuals (higher level jobs)</li> </ul>	Supportive Services for Recovery (employment, vocational training)	Community Session 7/16/14 (7 votes)
Mateo Lodge Expansion (including FAST team)	<ul style="list-style-type: none"> <li>o Increase in services provided by Mateo Lodge specifically in their ability to provide outreach and community-based services</li> <li>o Provide more resources for FAST team/ crisis management</li> <li>o Provide support or educate family members with outreach programs</li> <li>o More supported housing (with 24 case management and med support on site)</li> </ul>	Housing	Community Session 7/16/14 (6 votes)
Nursing staff in clients homes	Nursing staff to work with clients in their home/ housing situations	Integration	Community Session 7/16/14 (5 votes)

Intensive Day Treatment and Support	<ul style="list-style-type: none"> <li>o Intensive day treatment for adults</li> <li>o Day programming after treatment</li> <li>o Additional pragmatic support &amp; assistance for individuals living in community ; particularly isolated individuals</li> <li>o Support in getting people &amp; connecting to volunteer, work, friendship centers</li> </ul>	Recovery	Community Session 7/16/14 (4 votes)
MH Professionals with EMS	MH professionals to be called when 911 sends CIT	Collaboration	Community Session 7/16/14 (3 votes)
Enhance Psychiatrists	More time spent with psychiatrist to talk face to face	Add'l Svcs - Psychiatrist	Community Session 7/16/14 (3 votes)
Alternative Tx	Non-traditional treatment modalities	Add'l Svcs - Alternative Tx	Community Session 7/16/14 (3 votes)
Alternative Tx	Organize an outing, transport, lunch, etc... ongoing basis (weekly) such as adaptive sailing, equine therapy or any type of recreation therapy	Add'l Svcs - Alternative Tx	Community Session 7/16/14 (2 votes)
Crisis Residential	Larger crisis residential program with an intensive educational component	Recovery	Community Session 7/16/14 (2 votes)
Expansion of Peer Support	Expansion of peer supportive services	Peer Support Svcs	Community Session 7/16/14 (2 votes)
Improve Electronic Records	Update and improve electronic records: better coordination between care givers	Technology	Community Session 7/16/14 (2 votes)
Capacity Building for dealing with MH crisis	Education for individuals with mental health issues families and general public – who to call for help before and during a mental health crisis – to eliminate the need for the police. Public service announcements, Internet, billboards, buses, etc.	Capacity Building and Coordination	Community Session 7/16/14 (2 votes)
Screening in other languages	Providing screening treatment classes in languages other than English	Language Access	Community Session 7/16/14 (1 votes)
Tele-health	Tele-health in primary care settings for homebound/transportation-challenged	Transportation	Community Session 7/16/14 (1 votes)
Support for Pres Drug Abuse	More support for those suffering from prescription drug abuse, difficult to get into treatment	Prescription Drug Abuse Support	Community Session 7/16/14 (1 votes)
Terminally ill consumers	Also like to see some assistance for terminally ill mental health consumers to deal with increased depression and suicidal ideation.	Add's Svcs - assistance for terminall ill	Community Session 7/16/14 (1 votes)
Coordination of services for stigma	BHRS needs to oversee incorporation dealing with stigma from both NAMI and 5150 committee	Stigma	Community Session 7/16/14 (1 votes)
Friendship Center	Friendship Center needs is a little more funding for more healthy lunches provided for clients	Add'l Svcs - healthy meals	Community Session 7/16/14 (1 votes)
	Why is too much or too many services lead to automatic incarceration, seems to me to be counter productive	System Change	Community Session 7/16/14 (1 votes)
Warm drop off	Clients/community members coming from jail dropped into community – need to sllear – warm drop off.	Warm drop off	Community Session 7/16/14
Discharge Coordinator	A discharge/ placement coordinator	Transitional Support	Community Session 7/16/14

## MHSA Component - Community Services and Supports (CSS) Youth Treatment and Services

CSS serves individuals of all ages living with serious mental illness with a focus on un-served and underserved populations. There are three different service categories within CSS:

- o Full Service Partnerships (FSP): around the clock, intensive wraparound services to most acute clients
- o System Development (SD): strengthen and expand internal capacity to respond to service demands

Strategy, program or enhancement to existing program	Comments / Notes	Need Addressed	Input
Development Disabilities	Reduce stigma for persons with disabilities (physical, health, developmental, behavioral). Required anti-stigma activity for students especially elementary school to promote understanding and prevent bullying	Stigma- DD	Community Session 7/16/14 (10 votes)
Drop-in Center for Youth	Drop-in center for youth and young adults for mental health and alcohol and other drug services in East Palo Alto	Addl Svc - Drop in center	Community Session 7/16/14 (7 votes)
Services for Youth with Autism	How can we develop services for high functioning youth with autism	DD	Community Session 7/16/14 (5 votes)
Support Groups	Support groups for kids/ youth/ teens	Add'l Svcs -support groups	Community Session 7/16/14 (4 votes)
Youth Wellness Center in Nth/Sth	Youth wellness center North/South County, EPA please, yoga, meditation, counseling, case management, referrals, laundry, kitchen	Youth recovery and supportive services	Community Session 7/16/14 (4 votes)
Yth Therapy Groups	Culturally-based therapy groups for youth	Addl Svcs - cult therapy groups	Community Session 7/16/14 (3 votes)
LGBTQQI Youth Svcs	LGBTQQI youth services: peer support, adult mentors, safe spaces, support with families rejecting their sexual orientation	Peer support	Community Session 7/16/14 (3 votes)
Stipends	Stipends for youth to better engage & educate	Youth supportive services	Community Session 7/16/14 (3 votes)
Counseling Svcs	More counseling services that are accessible locally in East Palo Alto for non-served cases –	Services for EPA	Community Session 7/16/14 (3 votes)
GGRC support	Support for recognition or acceptance into Golden Gate Regional	DD	Community Session 7/16/14 (3 votes)
Texting crisis line	Integration of technology into existing support services, ex: ability to text crisis line	Technology	Community Session 7/16/14 (3 votes)
Vocational Programs for Youth	New Idea – Needs a vocational program or programs which are designed specifically for youth and TAY: skill building, job, coaching, job attainment and maintenance, job/ internship programs	Youth Capacity Building and Prevention	Community Session 7/16/14 (3 votes)
Tx for Youth with Co-occurring	Inpatient or intensive outpatient treatment for youth with MH & SA	Add'l Svcs- tx for youth with co-occurring	Community Session 7/16/14 (2 votes)
Family and Peer Support	Family members & caregivers (including housing program managers) need more peer support	Add'l Svcs - Peer and Family Support	Community Session 7/16/14 (2 votes)
Supportive Housing for Youth	More supported housing for youth	Housing	Community Session 7/16/14 (2 votes)

Support for youth with parents with MI	Support for youth with challenging parents (i.e. borderline personality disorder)	Add'l Svcs- parents with MI	Community Session 7/16/14 (2 votes)
Family and Peer Support	More mental health treatment & support for parents/ caregivers prior to their children/ youth entering the system – their child's team is often the first to formally identify a mental health need for caregivers	Add'l Svcs - Peer and Family Support	Community Session 7/16/14 (2 votes)
IDV education	Interpersonal dating violence education for adolescents and teens	IDV	Community Session 7/16/14 (1 votes)
School-based AOD svcs	School-based AOD services –	School-based AOD services	Community Session 7/16/14 (1 votes)
Therapeutic foster homes	Increase in qualified therapeutic foster/ respite homes available	Housing	Community Session 7/16/14 (1 votes)
Support Svcs during transition	Need for services & support after leaving program (graduation) family partners & support groups like turning point is trying to provide	Transition services	Community Session 7/16/14 (1 votes)
Youth Mentorsip Program	More mentorship programs – no wait list	mentorship	Community Session 7/16/14 (1 votes)
Care for DD	Address more effectively the gaps between mental-physical development disabilities. We have youth who are not getting effective care in a holistic way	DD	Community Session 7/16/14
Programs for non SMI	Address youth who don't fit criteria & need real support	Youth Capacity Building and Prevention	Community Session 7/16/14
Single Parent Support	Clients that are single with no kids have hard time getting into programs. Why is that? Even if you're homeless, no job, etc.	Add'l Svc- single parents	Community Session 7/16/14
Parent and teacher support	Increased counseling (both identification & direct services – individual & group ) family therapy to prevent issues escalating concerns regarding poor self-esteem, aggressive behavior & parents & teachers need more support	Add'l Svcs- counseling	Community Session 7/16/14
	1 unified program throughout the county		Community Session 7/16/14
Capacity Bld for staff	How do we do a better job of recruiting and retaining great staff, so we & our kids don't keep needing to rebuild therapeutic relationship	Cult Comp	Community Session 7/16/14
Gang Prevention	Gang prevention	Youth Capacity Building and Prevention	Community Session 7/16/14
Family Support	Involve family members by educating them on knowing their alternatives of support systems.	Family Engagement	Community Session 7/16/14
Supportive Svcs	Do we have services to TAY to get jobs, housing and living skills.	Youth Capacity Building and Prevention	Community Session 7/16/14
Youth Center	More age specific youth centers (teen centers)	Youth recovery and supportive services	Community Session 7/16/14
Youth Drop-in Center	There is a need for a drop in/ resource center in South County for Transition Age Youth ages 18-25: Food nightly, socialization, workshops, internet, referrals, resources, activities	Add'l Svc - Drop in center	Community Session 7/16/14
Youth Center	Mouton Center for young individuals	Youth recovery and supportive services	Community Session 7/16/14
Programs for non SMI	Where do non-severe MI youth receive svcs	Youth Capacity Building and Prevention	Community Session 7/16/14

Drug Prevention	Drug prevention programs	Youth Capacity Building and Prevention	Community Session 7/16/14
Youth Programs	Have a lot of youth programs, etc. e.g. activities.	Youth Capacity Building and Prevention	Community Session 7/16/14
Link providers and schools	Improved linkages with providers and schools to improve integration into school setting	Integration	Community Session 7/16/14
Capacity Bld for staff	Capacity building for outreach & youth programs and orgs. Whom are doing outreach	Capacity Bldg	Community Session 7/16/14

## MHSA Component - Prevention & Early Intervention (PEI)

PEI interventions target individuals of all ages prior to the onset of mental illness, with the sole exception of programs focusing on early onset of psychotic disorders such as schizophrenia. San Mateo has focused its PEI dollars primarily on evidence-based interventions that have proven track of success and reliable evidence of their efficacy

Strategy, program or enhancement to existing program	Need Addressed	Input
Clubhouse	Supportive Services for Recovery (employment, education and housing, relationships)	Community Session 7/16/14 (20 votes)
Culturally specific outreach & engagement	Outreach and Engagement	Community Session 7/16/14 (11 votes)
Law enforcement – MH education	Cross-sector collaboration	Community Session 7/16/14 (10 votes)
Intimate Partner Violence (policy, emergency housing, restraining orders, school prevention)	IPV	Community Session 7/16/14 (7 votes)
Clubhouse 9-5 supportive/ rebuilding program (Holistic model) (TAY & older adults)	Recovery and Support Svcs for Youth	Community Session 7/16/14 (6 votes)
School-based teacher training , local resource guide for teachers	Integration	Community Session 7/16/14 (6 votes)
Immigration support (health care coverage, etc)	Undocumented	Community Session 7/16/14 (6 votes)
Using technology for education/ crisis hotline	Technology	Community Session 7/16/14 (4 votes)
Increase education ( disabilities, behavioral health)	DD Education	Community Session 7/16/14 (3 votes)
Schools- pro-social, suicide prevention	Integration	Community Session 7/16/14 (3 votes)
Youth services – drop-in grief	Drop-in	Community Session 7/16/14 (3 votes)
Parenting support	Parenting	Community Session 7/16/14 (3 votes)
Transportation support	Transportation	Community Session 7/16/14 (2 votes)
Cultural-based stigma, LGBTQ, MHFA	Stigma	Community Session 7/16/14 (2 votes)

Suicide prevention	Suicide Prevention	Community Session 7/16/14 (2 votes)
Community needs assessment	Needs Assessment	Community Session 7/16/14 (1 votes)
Anti-stigma - Elementary School	Stigma	Community Session 7/16/14 (1 votes)
Creating more peer support, outreach and education	Peer Support	Community Session 7/16/14 (1 votes)
Mandatory MHFA – staff/ faculty	Capacity Bldg for Svc Providers	Community Session 7/16/14
Respite care for caregivers/ parents	Family Support	Community Session 7/16/14
Outreach/ engagement for families of black youth	Outreach and Engagement	Community Session 7/16/14
Suicide prevention curriculum	Suicide Prevention	Community Session 7/16/14
Youth & school	Integration	Community Session 7/16/14
More funding for project success	Youth Capacity Building and Prevention	Community Session 7/16/14
Immigration services – how to help people to work	Immigration	Community Session 7/16/14
LGBTQ support for younger children	Add'l svcs - LGBTQQI support services	Community Session 7/16/14
O/EI Asian/ Chinese community	Outreach and Engagement	Community Session 7/16/14
Timely access/ outreach for CH	Outreach and Engagement	Community Session 7/16/14
Drop-in center TAY-SOCO	Add'l Svcs- Drop in center for youth	Community Session 7/16/15
Venue for PI leaders to talk about important topics with the community	Space	Community Session 7/16/16
Services regardless of health coverage provide	Svcs	Community Session 7/16/17
Assessment tools	Assessment	Community Session 7/16/18

Culturally relevant suicide prevention education (AA, PI, Latino)	Suicide Prevention	Community Session 7/16/19
Community needs assessment	Assessment	Community Session 7/16/20
Grief groups/ crisis prevention for youth	Add'l Svcs - grief and crisis groups	Community Session 7/16/21
IPV – school-aged youth education	IPV	Community Session 7/16/22
LGBTQQIZs services across the board	Add'l svcs - LGBTQQI support services	Community Session 7/16/23
Increase collaboration project success & partnerships (PI)	Youth Capacity Building and Prevention	Community Session 7/16/24
Cultural specific outreach programs (PI)	Outreach and Engagement	Community Session 7/16/25
Cultural pro-social skills	Youth Capacity Building and Prevention	Community Session 7/16/26
Family support – PI Families	Family Engagement	Community Session 7/16/27
IPV services (Policy rev. emergency housing education – schools prevention, address barriers of restraining o	IPV	Community Session 7/16/28
Immigration support – family education and awareness	Immigration	Community Session 7/16/29
Increase community education re: services – beyond providers ( community members/FBOs)	Outreach and Engagement	Community Session 7/16/30
Support for families/ respite/ care givers	Family Support	Community Session 7/16/31
Peer counseling to Chinese & LGBTQ adults, seniors – train volunteers	Add'l svcs cult relevant peer counseling	Community Session 7/16/32
Cultural competence medical outreach – AA/CH	Add'l svcs cult relevant outreach	Community Session 7/16/33
Culturally-based medical training	Add'l svcs cult relevant medical training	Community Session 7/16/34
Resources to work with GSAs (grants)	Capacity Bldg for Svc Providers	Community Session 7/16/35
O/E to LGBTQ who have BH needs	Add'l svcs - LGBTQQI outreach and education	Community Session 7/16/36

Education regarding LGBTQ issues	Add'l svcs - LGBTQQI outreach and education	Community Session 7/16/37
Increase care for Asian community	Add'l svcs cult relevant outreach	Community Session 7/16/38
Space for (18-24) forum- community issues/ bonding	Space	Community Session 7/16/39
Project Success	Youth Capacity Building and Prevention	Community Session 7/16/40
Peer consumer family partners	Peer and Family Support	Community Session 7/16/41
Transportation services	Transportation	Community Session 7/16/42
College success programs for people with physical disabilities	DD Education	Community Session 7/16/43
Texting to crisis hotline & language services	Technology	Community Session 7/16/44
Mandatory MHFA – staff/ faculty	Capacity Bldg for Svc Providers	Community Session 7/16/45
Resource guide for local providers on MH/sub/LGBTQ resources	Resources Guide	Community Session 7/16/46
Immigration support	Immigration	Community Session 7/16/47
Help in navigating MH system	Peer and Family Support	Community Session 7/16/48
Increase cultural specific services	Cult Comp	Community Session 7/16/49
Community-based parenting classes	Parenting	Community Session 7/16/50
Services for trauma-exposed youth and parents	Add'l Svcs - trauma	Community Session 7/16/51
Increase education – CH edu, ECE	Education	Community Session 7/16/52
Increase education regarding disability (physical/BH) bullying, depression	DD Education	Community Session 7/16/53
Cultural specific programs (individually & together)	Cult Comp	Community Session 7/16/54

## MHSA Component - Innovations (INN)

Innovative programs introduce a behavioral health **practice or approach that is new** to the overall behavioral health system; it has not demonstrated its effectiveness; and

- o Makes a **change to an existing practice** including application and adaptation to a different population; or
- o Applies a **promising community-driven practice** or approach that has been successful in non-behavioral health settings, to the behavioral health setting

Strategy, program or enhancement to existing program	Comments / Notes	Need Addressed	Input
<b>Clubhouse</b>	<ul style="list-style-type: none"> <li>o For stable adults in treatment – Clubhouse is a place with a work ordered day – open to those who want to resume their lives, learn new skills, actually run the program</li> <li>o Financial support to “start-up” Clubhouse in san Mateo County</li> <li>o We need Clubhouse. What can I do for my son when he is out of hospital and make him busy that he stay out of the street.</li> <li>o Clubhouse: on innovative program for San Mateo that’s been proven worldwide. It fills the gap for people searching for a program to support them getting back to work, having a social community + friends – at no cost and with no time limit</li> <li>o Clubhouse: social vocational program</li> <li>o Program to outreach difficult to engage residents – in treatment &amp; in social activities</li> <li>o Motivate to participate in society</li> <li>o Outreach to hard-to-engage</li> <li>o For those without a program/ place to go, provide a productive hang out place where socialization; appropriate computer skills, team works skills – and a choice to do more learning skills (reading, writing, creative writing, basic print, job interview skills and recreation opportunities not just movies. Hang out place 5 days possibly 7 days</li> <li>o A place where adults with a serious mental illness can make lasting friendships and learn more about the services that are out there that can help them improve their lives</li> <li>o A safe productive place adults with a serious mental illness to go during the day and be given opportunities to learn and incorporate new skills into their lives</li> <li>o A productive place to go during the day that has consistent caring staff &amp; peers that provides them with a feeling of belonging in the community</li> </ul>	Supportive Services for Recovery (employment, education and housing, relationships)	Community Session 7/16/14 (21 votes)
<b>"The Club"</b>	After hour Services facility to provide services Friday and Saturday nights especially evenings and weekend nights, holidays	Supportive Services for Recovery (employment, education and housing, relationships)	Community Session 7/16/14 (10 votes)

<b>Community-based models to address racial/cultural groups underutilization of services</b>	<ul style="list-style-type: none"> <li>o Addresses underutilization among racial/cultural minority populations</li> <li>o Bring researched based (developed through community-based participatory approaches) practices that are community models of prevention + care into practice for each major ethnic racial group; conducted in community org's in partnership with them</li> <li>o Program to develop community advocacy in Chinese culture specific community – extreme stigma issue is asking for help and in advocating for services</li> <li>o Develop service capacity in community for Chinese culture specific population in BHRS and community based organizations – specific to their cultural needs/ linguistic needs</li> </ul>	Access for underserved groups	Community Session 7/16/14 (10 votes)
<b>Music Center</b>	Singing, play instruments (all), high tech, recording	Alternative Therapy Approaches	Community Session 7/16/14 (7 votes)
<b>Bridge faith-based communities and BH</b>	<ul style="list-style-type: none"> <li>o Develop program of outreach to bridge faith-based communities and mental health providers and MH consumers (goal to reduce stigma)</li> <li>o Develop to train trainers to facilitate spirituality groups</li> </ul>	Collaboration	Community Session 7/16/14 (6 votes)
<b>BH staff in community setting</b>	Out stationed mental health and behavioral health staff in community health clinics, senior center, family support centers, schools	Coordination and Integration	Community Session 7/16/14 (5 votes)
<b>Venue for networking</b>	Venue for community leaders to break bread and have dialogue on their own topics, needs while introducing services and making connection	Collaboration	Community Session 7/16/14 (5 votes)
<b>Prevention Program Expansions</b>	<ul style="list-style-type: none"> <li>o Provide grants in 5 year cycles to minimize turnover and disruption</li> <li>o Spend more on prevention services overall</li> <li>o Improve 511 system substantially</li> </ul>	Prevention	Community Session 7/16/14 (4 votes)
<b>Capacity Building for Outreach Organizations</b>	Capacity building: For organizations/ contracts who are doing a lot of leg work, outreach needs more support access to better county benefits/ programs – and health/life navigation! Outreach needs support; more resolution for clients.	Capacity Building	Community Session 7/16/14 (3 votes)
<b>Leadership Site Visits with Outreach Workers</b>	<ul style="list-style-type: none"> <li>o Innovations and reinventions</li> <li>o Staff from county/ supervisors visit with families/cases/clients thru outreach workers to experience/feel/see/hear what actual process are not working, what's working and to be able to reflect on needed changes</li> </ul>	System Changes	Community Session 7/16/14 (2 votes)
<b>Integrate MHFA with Lived Experience Academy</b>	Expand on the great experience of the Lived Experience Training Academy. Integrate with the mental health first aid in schools and community for outreach	Lack of diverse staff	Community Session 7/16/14 (2 votes)
<b>Bridge Recovery Stages</b>	Bridging all gaps from transitional stages of recovery (totally tailored) (No one size fits all)	Recovery	Community Session 7/16/14 (2 votes)
	<ul style="list-style-type: none"> <li>o Mindfulness groups for clients and other community members</li> <li>o Long term psychodynamic approach treatment</li> </ul>	Additional Svc Need	Community Session 7/16/14 (2 votes)
<b>Mobile Dental Clinic</b>	Provide more mobile dental clinics	Additional Svc Need	Community Session 7/16/14 (2 votes)
<b>Recreation Therapy</b>	Recreation therapy, socialization skills ongoing programs i.e.: equine therapy, adaptive sailing, Paralympic pre trials / Introduce what others call “alternative approaches” e.g. yoga, meditation, etc. but only for people with mental illnesses.	Alternative Therapy Approaches	Community Session 7/16/14 (2 votes)
<b>Transitional Housing Support</b>	Short term (1-4 weeks) transitional housing for clients on waiting list for inpatient programs	Housing Support	Community Session 7/16/14 (1 votes)



## Additional Input

Comments / Notes	Need Addressed	Input
Employment coaching, job training, case management to help with this	Supportive Svcs for Recovery	Change Agents
Housing for co-occurring illnesses with transitional case management, it's difficult to hold on to housing	Housing	Change Agents
Requirements for housing are a big barrier, need more support. Too many limitations, too expensive, minimum wage is not enough to cover rent	Housing	Change Agents
Need transitional living/sober living communities, more support/funding for these	Housing	Change Agents
Look at Albuquerque example of apt buildings for this population, if they can afford it CA should be able to as well.	Housing	Change Agents
Enhancing funding for co-occurring providers, should have more than 9 contracts	Add'l Svcs - co-occurring providers	Change Agents
AOD component for FSPs, an ARM FSP	Add'l Svcs - co-occurring FSP	Change Agents
Funding for Recovery Month	Recovery	Change Agents
Outreach and services team made up of a clinician, social worker or case manager and a community worker	Cult Comp Outreach and Engagement	Chinese Health Initiative
The team would provide services where people are at and congregating (church, community centers, etc.) because of the stigma associated with seeking behavioral health services. OASIS is a great example of this and they have the highest penetration of Chinese community	Cult Comp Outreach and Engagement	Chinese Health Initiative
A staff position that would help with flow and coordination of clinicians and mental health workers	Coordination	Chinese Health Initiative
Clients don't have transportation or means to get to services available	Transportation	Chinese Health Initiative
The Chinese community values education and awareness but, programs are not culturally sensitive o MHFA is a 2 day training- the advocacy community among Chinese is not strong enough they will not attend a 2 day training o The Parent Project curriculum is not appropriate for the Chinese community – Chinese children tend to not have behavioral issues at school. Currently were told the curriculum is not adaptable	Cult Comp Outreach and Engagement	Chinese Health Initiative
Lack of CBO's/core places in San Mateo County for the Chinese community so they go to SF for services	Cult Comp Services	Chinese Health Initiative

<p>For High School students</p> <ul style="list-style-type: none"> <li>o There are counselors on site but they are not Asian and Asian youth often don't feel comfortable disclosing to their counselors</li> <li>o There are also bicultural and assimilation issues with parents that are immigrants</li> <li>o They have pressure from parents and get pushed to excel in school, counselors don't know how to talk to and connect with Chinese parents who may be limited in language and afraid/worry that any conversations about their children's mental health issues may impact their school record and chances of attending college.</li> <li>o Often they do not have behavioral issues at school but suffering internally and at home</li> </ul>	Integration - Cult Comp Services in schools	Chinese Health Initiative
<ul style="list-style-type: none"> <li>• At the College of SM and Skyline there are no Chinese speaking therapists yet 32% and 60% Chinese students respectively</li> </ul>	Integration - Cult Comp Services in schools	Chinese Health Initiative
The title of this legislation, MHSA, excludes AOD services. We need to figure out a way to strategically address integration within MHSA	Integration	Diversity and Equity Council
Timely access aligns with crisis intervention, not just a call center or law enforcement training, need system-wide effort (mobile support like FAST)... this may be a perfect place for AOD integration	Timely Access	Diversity and Equity Council
Need MH providers at all clinics	Cross Sector Collaboration and Integration	Diversity and Equity Council
Mobile and online tools/resources that provide daily support and assessment (ex. MyStrength.com a partnership with the National Council for Behavioral Health)	Technology	Diversity and Equity Council
Outcome informed services tool to measure how MHSA services are doing (used in engagement and retention)	Evaluation	Diversity and Equity Council
Transportation is a big issue in North County, separates services and providers... a shuttle to coordinate and take clients to providers	Transportation	Diversity and Equity Council
Integrate services with regional centers (state-funded nonprofit like Golden Gate Regional Center) to serve individuals with developmental disabilities.	Integration - DD	NAMI
There is a growing population of children with autism, which overlaps with behavioral issues, it's important to consider what happens when they become transition age youth	Integration - DD	NAMI
Psychiatric Emergency Services does not contract with a lot of private insurance providers, clients are left with overwhelming bills if they go to a hospital that doesn't accept all insurance providers	Integration	NAMI
Need interface with county, state and federal office and advocacy for coordination of services, there are people dying because they are not receiving the care they need	Coordination	NAMI
Housing- when people get discharged they get no housing support, shelters bump them out because of behavioral issues	Housing	NAMI

FSP is good but there is a missing piece with housing, shelters are not the place, need supportive housing with services, need to address substandard housing (infested, dirty conditions)	Housing	NAMI
Therapeutic Day School - need better behavioral health integration with schools	Integration with Schools	NAMI
There are group of teens with eating disorders and cutting that have very limited services unless they get to the point of getting involved with the law	Integration with Schools	NAMI
Need more drop-in centers. Australia has implement gathering places (Fountain House) for people to go to get support and services, develop skills and socialize ... a place to go every day after treatment. The Clubhouse model is an example of this here in the states as well as Community Friend in Santa Cruz and Heart & Soul in San Mateo County	Add'l Svcs - Drop in Centers	NAMI
A lot of staff in the schools don't know how to recognize mental health issues, kids fall through the cracks. Need courses offered to teachers at schools to teach them how to read the signs and help students with mental health needs	Integration with Schools	NAMI
MHFA-type training for registered cosmetologists, cab drivers and other non-traditional points of contact with STIPENDS, difficult to have them attend a training for free	Capacity Bldg	Coastside CSA
Expansion of Crisis Intervention Training/Teams (CIT)...sheriff's department paid for some in the coastside, need continuity not just one time training	Capacity Bldg	Coastside CSA
CIT needs to be periodic, refreshers and targeting alumni, maybe add an expiration date to it like CPR certifications. Bob Cabay is leading an emergency response effort	Capacity Bldg	Coastside CSA
QPR training (like CPR) for immediate response to suicidality... Question, Persuade, Refer	Capacity Bldg	Coastside CSA
AOD providers need support to qualify for drug Medi-Cal... technical assistance with application and requirements (having AOD staff on board, etc)	Integration	Coastside CSA
Long-term treatment and smoother continuum of care, step down services for co-occurring care	Supportive Svcs for Recovery	Coastside CSA
Need Club House and Heart & Soul- type organizations to reach out to the community and help connect people to supportive services during recovery	Supportive Svcs for Recovery	Coastside CSA
Need a hospitality center for the homeless population (Redwood City and SSF have shelters, none in the coast) that would provide basic needs like support services, showers, clothing, food and resources to community services	Homeless	Coastside CSA
Respite Services in the coastside for single parents in need, provide childcare and a warm line. There is a current effort to develop a respite center in the Coast, waiting on location	Timely Access	Coastside CSA
MH waiting room in ER to provide de-escalating, be inviting and not as sterile and structured as the ER waiting area. The medical center in the coastside has one	Timely Access	Coastside CSA
The Peninsula Library Services resource guide will no longer be published, only available online... this excludes a population group that doesn't have access to the internet	Information	Coastside CSA
Communications – having current and updated information helps with same day access	Information	Coastside CSA

Transportation – bus to connect people to services	Transportation	Coastside CSA
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## APPENDIX 4. Priority Strategies - Summary of Voting Results

San Mateo County Behavioral Health & Recovery Services (BHRS)

MHSA Three-Year Program and Expenditure Plan for FY 14/15 through FY 16/17



### Priority Strategies, Program or Expansions - MHSA Steering Committee Voting Results

Please rate the priority of the following strategies for MHSA funding:

1 – Not a Priority, 2 – Low Priority, 3 – Somewhat Priority, 4 – Moderate Priority, 5 High Priority, 6 – Essential Priority

MHSA Component	PRIORITIZED Strategy, program or enhancement to existing program	% VOTED 4 – Moderate Priority 5 – High Priority 6 – Essential Priority
<p><b>Community Services &amp; Supports (CSS)</b></p> <p>CSS provides direct service and treatment to individuals of all ages living with serious mental illness with a focus on un-served and underserved populations.</p>	1. Support and assistance program for isolated individuals living in community to get them connected to volunteer opportunities, work, friendship centers, etc.	<b>100%</b>
	2. Expand meaningful employment opportunities for individuals with lived experience (family and peer support workers, etc.)	<b>96%</b>
	3. Drop-in/wellness center for youth and TAY that provides a broad range of psycho social and health services and supportive services	<b>93%</b>
	4. Center for adults with serious mental illness in recovery that provides psycho social services, vocational and other support services and skills development	<b>89%</b>
	5. Expansion of Total Wellness program <i>*revote</i>	<b>88%</b>
	6. Increase nursing staff that can work with mental health clients where they are (home, drop-in centers, etc.)	<b>86%</b>
	7. Support and assistance services for isolated older adults	<b>86%</b>
	8. Housing for co-occurring illnesses with support and transitional case management	<b>85%</b>
	9. Expansion of supported housing for transition age youth	<b>82%</b>
	10. Increase evidence based practices that support recovery-resiliency in the FSPs and clinics.	<b>81%</b>
	11. Expansion of co-occurring services by BHRS AOD providers	<b>79%</b>
	12. Increase support services for clients and families with developmental disabilities	<b>79%</b>
	13. Short term (1-4 weeks) transitional housing for clients on waiting list for inpatient programs	<b>79%</b>
	14. Supported housing for 18-35 year olds with multiple needs including developmental disabilities who aren't eligible for services	<b>75%</b>
	15. Expand resources for specialty clinics (e.g. Puente clinic serves MH needs of clients with developmental disabilities)	<b>63%</b>
	16. Increase therapeutic foster/respice homes available	<b>42%</b>
	17. Intensive day treatment for adults	<b>12%</b>

<b>MHSA Component</b>	<b>PRIORITIZED Strategy, program or enhancement to existing program</b>	<b>% VOTED 4 – Moderate Priority 5 – High Priority 6 – Essential Priority</b>
<b>Prevention &amp; Early Intervention (PEI)</b>  PEI interventions target individuals of all ages prior to the onset of mental illness, with the sole exception of programs focusing on early onset of psychotic disorders such as schizophrenia.	1. Expansion of Crisis Intervention Training/Teams (CIT)	<b>96%</b>
	2. Increase researched based (developed through community-based participatory approaches) practices that are community models of prevention + care into practice for cultural groups	<b>88%</b>
	3. Media campaign on mental health and stigma specific to different cultural groups (e.g. Out and Well in SMC)	<b>88%</b>
	4. Increase culturally relevant efforts and programs for outreach and education (e.g. Team of outreach and services to provide services where people congregate; Parent Project curriculum is not culturally appropriate for Chinese community; anti-stigma activities in schools for persons with disabilities)	<b>87%</b>
	5. Increase community outreach efforts and education re: services – beyond providers (community members and faith-based organizations)	<b>83%</b>
	6. Increase on-site culturally appropriate resources for schools (e.g. MH counselors)	<b>81%</b>
	7. Question, Persuade, Refer (QPR) training, like CPR, for immediate response to suicidality.	<b>80%</b>
	8. Expansion of MHFA training to medical providers, staff and including to non-traditional points of contact (e.g. registered cosmetologists, cab drivers, etc.)	<b>54%</b>
	9. Expand YMHA training for teachers and school administrators	<b>17%</b>
	10. Therapeutic Day School to provide support services including mental health therapy	<b>4%</b>

## **APPENDIX 5. All Public Comments Received**

Three-Year Program and Expenditure Plan  
FY 2014-2015 through FY 2016-2017 & Annual Update FY 2014-2015

### **PUBLIC COMMENT RECEIVED**

#### **Raja Mitry, California Stakeholder Process Coalition – email (6/14/14) in response to the June 10, 2014 MHSA Steering Committee meeting**

1. I strongly urge that the MHSA Steering Committee actively promote and monitor the crafting and implementation of strategies to expand the diversification of community representation from still unreached and underrepresented ethnic and age populations: such as aging single adults, especially aging single males who may be disregarded or somewhat isolated; single parents with young children and youth, and in particular single custodial dads. BHRS can also reach out to people from the local Iranian community, Japanese community and Burmese community, among others, who can be involved in the planning process and needs assessment. The online list of MHSA Steering Committee members, "updated" April 2014, reflects a lack of needed representation.

Inclusive outreach and welcoming could be more robust. If welcoming is embedded in BHRS policy that you developed, it must be heard, seen, and felt by underrepresented or underserved communities, individuals and families. Values of cultural humility and welcoming of the underrepresented voice and more diverse community members could be re-energized across the agency and by the MHSAR Commission. Trust and building relationships with cultural groups, including transition-age youth and young adults, parents and caregivers from various ethnicities -- are key to their involvement. The Mental Health & Substance Abuse Recovery Commission and BHRS must take timely, effective, and responsive steps to engage those who have been unreached among these groups, ensuring that their mental and behavioral health needs are assessed and met with the goal of reducing health disparities.

*Answer: Thank you for your input and recommendations to help us ensure that the MHSA Steering Committee and process has diverse community representation. During the Community Program Planning process we heard from close to 300 stakeholders including consumers/clients, family members, the general public representing various ethnic communities and community partners and leaders. Diversifying the MHSA Steering Committee membership was an item on the agenda for our first meeting on the Three-Year Plan and the committee actively engaged in providing input on this topic. To date we have increased the membership from 13 to over 30 members of diverse background. Both the list of stakeholders involved, demographics and the updated MHSA Steering Committee member roster is available on our webpage at [www.smchealth.org/bhrs/mhsa](http://www.smchealth.org/bhrs/mhsa).*

2. Although there are several local cultural and linguistic gaps unaddressed, BHRS has begun to identify Arab backgrounds. San Mateo is in the top 5 California counties with the largest Arab populations. Your current data system does not collect information on Arab ancestry; however, you said that you've recently initiated a request with your internal system support staff to put in place a workplan for this need. Please gather relevant information about the distinct heritage and faith backgrounds such as Christian Palestinian, Lebanese, Syrian, Islamic and other Arab cultural identity. Most Arabic translation requests have come from the North region. You've informed me that you cannot commit to an Arab outreach worker at this time, but the Office of Diversity and Equity will commit to hosting an event in North County to bring together providers, community and others with the goal of identifying recommendations for addressing the outreach and education needs of the "Arab community" (as you state it). I've mentioned numerous times that there is not a singular Arab community but rather distinct communities with different heritage and religious backgrounds. This is important when crafting broader outreach efforts and engagement of our folks because we congregate within our gatherings of common heritage and faith.

*Answer: Thank you for your recommendations on addressing the needs of communities of Arab and Middle Eastern ancestry and the distinct heritage and religious backgrounds. We hope that we can continue to count on your expertise and commitment to the outreach of these communities as we move forward with plans to address the needs of emergent and underserved communities in San Mateo County. Numerous staff from the Office of Diversity and Equity are currently beginning a dialogue with numerous individuals of Arab ancestry on how to develop outreach goals for this fiscal year.*

3. Statistical data from the California Department of Public Health show that the number of suicides in California hit a peak (about 4,000) in 2011 -- largely occurring among ages 45 to 64. This particular age group, to which I refer as "transitional aging adults," is not seen as a priority in either public or private health plans and funding can be set aside to develop some analysis and recommendations. I've shared in the past this is an unattended-to vulnerable group of adults. That vulnerability is especially true for aging single adults and males in particular. I hope the department and the MHSA Steering Committee will understand the importance of addressing this issue.

*Answer: Thank you for your feedback. Our Suicide Prevention Committee is actively planning for the current year and one priority population is older adults. This Committee is collaborating with Aging and Adult Services to provide trainings such as Mental Health First Aid to the TIES Line and In-Home Support Services staff. The Mental Health Services Act funds a San Mateo County crisis hotline for all ages. In addition, the Senior Peer Counseling is free for San Mateo County adults age 55 and older and available in English, Spanish, Tagalog and Mandarin and provides support for LGBTQ residents as well.*

4. There had been recent lost opportunities to reach and involve many local stakeholders in MHSA-funded evaluation projects for the community planning process (the Client Stakeholder Project) and the UC Davis Reducing Disparities Report (its draft released for a 30-day public comment period on Feb. 15, 2014). I acknowledge this was not willful and the BHRS' Director gave assurance that now there is an MHSA Coordinator on board tracking the activities of the OAC and updating the MHSAR Commission so they have direct input and can help facilitate seeking broad stakeholder input. Vacancy of a staff position (i.e., MHSA Coordinator), however, should not relieve the county from ensuring that at all times our stakeholders are informed and have their input heard for any participatory efforts, including evaluation especially. Your Office of Consumer & Family Affairs and the Office of Diversity & Equity -- as well as the CALMHB liaison were likely aware of either one or both of these projects and could have been vigilant about dissemination of the information for active stakeholder participation and their comments.

*Answer: Now that we have Doris Estremera, MPH, our MHSA Manager on board we are confident that we will be able to facilitate meaningful input for MHSOAC activities. Doris helps in prioritizing both local and statewide requests and feedback.*

5. As you consider evaluations, please give consideration for looking at relationship status, whether being a single person or in a spousal or committed partnership, to determine any level of risk for depression, anxiety, substance use, suicidal ideation. It impacts MHSA values of having hope, building resilience, and wellness over the long-term -- particularly for those going through critical life transitions, disenfranchised and homeless individuals, or those at-risk for medical conditions. Relationship with another, with family, with one's cultural community is key for ethnic cultural groups and LGBTQ among others. Social connections and peer relations matter, but not having that one meaningful relationship with a partner or spouse in a person's life matters even more. A trustful and reliable relationship contributes tremendously to well-being throughout the lifespan, increasing with importance as one ages, especially for single adults. Counties generally have not assessed closely or at all whether clients have a committed relationship nor how this contributes to their recovery/success in therapy or, how therapy contributes to relationship success, which then improves well-being. I encourage making efforts to include how relationship status affects overall health and prevention of more serious emotional, mental and physical conditions. Populations that need to be looked at are those incarcerated or beginning re-entry, young adults, aging and vulnerable older adults, LGBTQ. One can have housing, work status, some financial resources -- but without security of one loving individual to share with, it could turn pointless or lead to risky behavior. Single folks, single parents, aging males, and many others, if not everyone, will tell you that a healthy relationship blessing is life-giving.

*Answer: Thank you for your recommendations on the importance of looking at impact of relationship status on recovery and well-being as we evaluate our programs. Meaningful evaluation and outcomes are a top priority for the MHSOAC at this point in MHS implementation. We will continue to work with the MHSOAC to improve and expand our evaluation activities. Through the implementation of the Community Service Areas (CSAs) we are stressing the importance of identifying key individuals who are supportive of consumers. Recently, we also developed and passed a family (broadly defined and consumer/client driven) inclusion policy to help guide providers engage family members into treatment.*

**Raja Mitry, California Stakeholder Process Coalition – email (7/15/14) in response to the July 16, 2014 Strategy Development – Community Input Session**

Many of the stakeholder comment findings shared for the MHS Strategy Development - Community Input Needs Assessment remind me of the time prior to MHS and similar input from the stakeholder meetings held when the MHS rolled out in 2005. It's troubling that almost a decade later we're hearing these same concerns.

Some examples of those issues/comments are:

- Building Community Relationships/Trust - need for capacity building and developing trust in the community
- Need more outreach for programs or other groups – families don't know about them
- Need improved outreach and education for underserved populations
- Language Access/Education, Outreach and Engagement
- Services difficult to access in a timely manner; all service providers need to know what resources are available
- Need to incorporate cultural competence and cultural humility at all service levels and community events; county-hosted events need to be culturally sensitive to population
- Lack of appropriate tracking of clients' ethnicity
- Transparent, welcoming in all meetings/events to diverse communities
- Lack of care coordination and integration - there is a disconnect between Aging & Adult Services providers and BHRS services, individuals may be referred . . . but no direct connection
- Better integration with alcohol and other drug services, including family member engagement
- Consumer/clients and family members have limited presence
- Need improved soliciting of input through non-traditional avenues and those we don't typically hear from or reach
- We are not reaching out to and hearing from marginalized communities - working parents, people struggling economically, in recovery, with mental health conditions, or incarceration and also those affected - parents, children, family, etc.

In your groups I'm unable to find a place where an individual community person might fit under the listed "Source of Input;" although you have CSA's (Community Service Areas), it appears they don't ensure closing the gaps so that individuals from the community and from cultural groups that are not involved in any of your identified arenas can have their input heard. It requires diligent wider outreach and engagement efforts. Arab communities,

one of the larger constituencies in this county, have no knowledge that this planning process is going on nor how to be involved, and you must reach the broader communities of this population, as one example, beyond just the clients you serve.

*Answer: Thank you for your input, though the concerns may sound similar to what was presented in years prior to MHSA, we have had years of progress since MHSA implementation in many of these fronts and have documented the numerous programs, efforts, activities and positive outcomes since MHSA implementation through our annual updates, presentations, regular newsletters, evaluation reports and other communication means. Your observations are an acknowledgment that there is still more to do and we are committed to continue improving and expanding our work to address the continuing gaps and needs.*

*During the Community Program Planning process we heard from close to 300 stakeholders including consumers/clients, family members, the general public representing various ethnic communities and community partners and leaders. The list of stakeholders involved and the demographics of our Strategy Development participants are available on our webpage at [www.smchealth.org/bhrs/mhsa](http://www.smchealth.org/bhrs/mhsa).*

**Mitch Eckstein LCSW, Social Worker III – email (7/17/14) in response to the July 16, 2014 Strategy Development – Community Input Session**

I appreciated the opportunity to attend the San Mateo County Mental Health Service Plan Strategic Planning Meeting last night. I'm writing to summarize the input I provided at the meeting. During general comments I requested that BHRS identify children with physical disabilities and major health challenges along with their families be recognized as an under-served population. In the small groups I provided written suggestion that services be provided at elementary schools to help students (and teachers) better understand the experience of their classmates who may have physical disabilities, health challenges, behavioral health issues, intellectual/learning challenges and, or identify as LGBTQI. I explained that the need is to reduce stigma and thereby reduce bullying and resulting depression/suicidality/aggression. I also recommended more individual, group, and family therapy for this population, along with support for teachers. I agreed with comments that Mental Health First Aid Training would be one avenue to provide support/training to teachers. I connected with Maisoon Sahouria of Center for Independence of Individuals With Disabilities who is interested in partnering with CCS and BHRS to address this need. Thanks again for all you are doing to gather public input as you take on the difficult task of deciding how to allocate funding and support services for persons with behavioral health needs in San Mateo County!

*Answer: Thank you for taking the time to attend the Strategy Development meeting and submit your comments. We agree that it is important to recognize children with physical*

*disabilities and major health challenges along with their families are an underserved population. Mental Health First Aid was recently funded through Measure A and there is enough funding to provide trainings to every public and private middle and high school in San Mateo County. We will continue to use this as an avenue to reach teachers and other school administrators. We have reached out to Maisoon Sahouria and she decided to join the MHSA Steering Committee as a member. We look forward to working with her to address this need.*

**Emails (received 8/11/2014 through 8/29/2014) in support of MHSA funding for California Clubhouse in San Mateo County**

**Cheri Hahne – email (8/11/14)**

Dear Doris Estremera:

As a survivor of a near-fatal suicide attempt, I can attest firsthand how very difficult trying to rebuild your life from the ground up is. I wish I'd had the support and assistance. The California Clubhouse will be able to provide others do just that. Coping with the aftermath of suiciding (19 out of 20 survive an attempt,) and juggling to find the right combination of medicines is a huge effort. But harder still is trying to find out what one is capable of NOW--the changed person that any form of mental illness creates. A therapist or support group is helpful and necessary; but neither can provide the hands-on, "real time," and focused assistance that The Clubhouse offers the opportunity to do.

Before I became ill with the mental condition that changed the course of my life, I'd had a decades-long and very successful professional career. I was not capable to returning to any version of that, not even part-time. My first attempts to go back to working did not end well. I was let go, or had to leave because I didn't have the support and assistance so badly needed to successfully accomplish "re-entry" into that world. Ultimately, I ended up rehospitalized full-time and then in a partial program to get the re-stabilized and prevent further decompensation.

My story is not unique; and that's why The California Clubhouse and the "underpinning" it offers "consumers" (I personally dislike that term) and employers is such necessary component to help those of us living with mental illness daily. The intrinsic and cognitive positives of proving to yourself employment is doable, the obvious financial benefits, and the potential to prevent or reduce re-hospitalization make The Clubhouse both costeffective and a truly crucial "win-win" for all involved.

The BHRS receives many requests for funding and has limited resources. Yes, there are start-up costs and grants are also being sought. The California Clubhouse is unique; and is an already-proven cost-effective and successful component toward achieving a good outcome for those of us living daily with mental illness.

Thank you for your consideration of my request. If I can help you in any way or if you'd like additional information, please contact me.

Cheri Hahne

**Carol Labarthe – email (8/11/14)**

Dear Ms. Estremera,

Please fund the effort to open a Clubhouse in San Mateo County with MHSA dollars.

Tragically last year, my daughter took her own life. It is too late to help her but I believe Clubhouse could save someone else's life with the support it give to people in deed. We need this social vocational program in our community. There is no program that does what Clubhouse can do. At the same time Clubhouse will compliment our current programs, bringing further options and expanding hope.

Clubhouse is a proven program we desperately need in this county. Please fund it today.

Thank you for your consideration.

Sincerely,

Carol Labarthe

**Tina Truong – email (8/11/14)**

Dear Ms. Estremera ,

My sister's journey with mental illness has been a brutally long and discouraging one. She had her first psychotic break while getting ready to transfer to a four-year university. We were blindsided by this event and had no idea what was going on. We later found out she was diagnosed with Schizophrenia.

My family watched in horror as she transformed from a once beautiful, outgoing and charismatic young adult to a depressed, paranoid, and psychotic person, barely recognizable to any of us. While we were devastated by her diagnosis, we remained optimistic that we would be able to find a place where she could connect with others who had a similar plight. Unfortunately, we discovered over and over again that there really is no such resource for those with severe mental illness – not only in our county but in those surrounding counties we had tried to find help for her in. My sister doesn't want to go to a support group. She wants to feel like she is doing something productive, learning a new skill, producing something valuable, or helping others. She wants to feel valued.

Like most diagnosed with a serious mental illnesses, my sister fell into the repeated cycle of going off her medications and back into the hospital over and over, and over again – only to be sent back home or to a homeless shelter without any resources once she stabilized and no predictable place to go during the day where she would feel like she was part of the community.

My sister currently spends her days keeping herself entertained in front of a television screen, or listening to the radio, or sitting in a coffee shop where there are other people. I believe she goes into public areas in order to feel "normal" again. To feel like she is making connections with other people. She is very artistic, loves to write poetry, and has a great

sense of humor. Sadly she has nobody to share her experiences with or fill the immense void that she continually feels.

While I'd like to think that my sister's story is unique, I know it is not. She represents a large majority of our mentally ill family members who end up lost in the system and alone and isolated from their very first psychotic break at a young age and are sadly never given the opportunity to do anything but continue on this downward spiral and live an unacceptably poor quality of life.

When I heard about the Clubhouse model, I was immediately relieved to know that someone was trying to do something about the clear lack of services for this population. We clearly need a program that can relieve unnecessary feelings of isolation and allow this population to, once again, feel like they are contributing members of society.

Please strongly consider getting a Clubhouse here in San Mateo County. I understand this model has been successful in many parts of the world – even third world countries. Our County should strive to become an example of what an excellent mental health system could look like. I believe with the addition of a Clubhouse, we would be working toward meeting that goal.

Thank you for your consideration of my request.

Sincerely,  
Tina Truong

**Ingrid Leslie Manzano – email (8/11/14)**

Dear Estremera,

I currently work for the Emergency Room at the San Mateo County hospital and often enough I see families in desperate need for a program such as the Clubhouse, which will bring hope to patients and their families to prevent them to continue getting isolated from our society and will open better opportunities to succeed. Please fund the effort to open a Clubhouse in San Mateo County with MHSA dollars. We need this social vocational program in our community. There is no program that does what Clubhouse can do. At the same time Clubhouse will compliment our current programs, bringing further options and expanding hope.

Clubhouse is a proven program we desperately need in this county. Please fund it today.

Sincerely,  
Ingrid Leslie Manzano

**Marsha Mayer – email (8/12/14)**

To whom it may concern,

I have a 30 year old son who has been suffering with mental illness since his first year of college. Although it has been diagnosed as depression, all the professional help we have sought says there are undefined elements that can't be identified. Kevin has now been

missing since Nov. 10, 2013 when he left his grandmother's home where he had been staying. He left everything behind and has no friends. We did find him on Jan. 3, 2014, with the help of our Missing Person's Report, but he made it clear he was not going to return. We think he is living in his car.

During the years Kevin willingly said yes to any treatment and help we could find, what this essentially meant were hours here and there in the offices of psychiatrists and counselors. No one could provide a real life for him. He would sleep a lot, skip meals, have zero social contact and the last couple of years, almost no conversation with my husband and myself. I sought out any kind of program that would put him back into the routine of a regular life, and could find none.

I believe the Clubhouse is a defined program that would give those who have had varying degrees of recovery a place to go during the day - a place where they had something to look forward to during regular daytime hours, a job or purpose once they were there, interaction with other people, a sense of worth, and then maybe a chance of some type of employment.

I see the Clubhouse as a positive addition to what services are currently available - a place of contentment and hopefully moments of bonding with others to raise self esteem. I do hope financial support will bring the dream of a Clubhouse to this area to improve the quality of life and happiness not only for those people troubled with mental illness, but their families.

Thank you for your support,  
Marsha Mayer

**Jane Clark – email (8/12/14)**

Dear Ms. Estremera,

My name is Jane Clark and I am writing to encourage San Mateo County to fund California Clubhouse.

Six years ago my 20-year-old daughter was diagnosed with bipolar disorder which plunged our family into something I can only describe as, "Alice's rabbit hole." It took almost all of our family's emotional and financial resources to help her recover. How I wished at the time that there was someplace for her to go to rebuild her life with the help of her peers and others who understood the unique challenges of mental health conditions. But there wasn't.

At the present time, I am the facilitator of a weekly mental health support group at Menlo Park Presbyterian Church. I have seen first-hand what the power of peer support and the feeling of contributing to something outside of yourself can do for people who suffer from mental health challenges. California Clubhouse is a proven model of support and wellness for people who suffer from the stigma of brain illness and it deserves the county's investment of resources.

I urge you and others who have the opportunity to make a difference to spend money on a program that will benefit our entire community.

Thank you very much,  
Jane Clark

**Angela Su – email (8/12/14)**

Dear Ms. Estremera,  
My son had mental illness for 19 years. He's been in and out of hospital ever since. While San Mateo provides critical support service, there's very little for him to do once released from hospital.

He is very aware of his illness and is trying so hard to recover. He needs a productive place to go during the day, where he can make friends and get the kind of support that he needs. Please fund the effort to bring a CLUBHOUSE to San Mateo County. It will help keep people like my son out of the hospital, out of a dark solitary bedroom, and into the light of friendship and support.

This is something we desperately need in this county.

Yours truly,  
Angela Su

**Paula Kravitz – email (8/13/14)**

Dear Ms. Estremera,  
I am a San Mateo resident, a Senior Director at the Skoll Foundation and a person living with mental illness. I am writing to seek your support in bringing a Clubhouse to San Mateo County. While we have many good services, we have a huge gap in providing ongoing, consistent support to those who are trying to rebuild their lives. The kind of support that provides increasing levels of opportunity, encouragement and progress for those struggling to reclaim their lives.

25 years ago I was admitted on a 51/50 to Sequoia Hospital. Following my diagnosis of bipolar disorder and psychosis, I was released only to spiral again. I lost my job, my apartment and dropped out of school. My mental health deteriorated further and I was again hospitalized – this time for 3 months. Upon release, it was advised that I seek SSI. Luckily I found a psychiatrist and mentor who supported my desire to work rather than sign up for a life of disability and marginalization. While it has been an uphill climb, I have been successful in recovering a life of richness and opportunity. I went back to school, have an esteemed career, have traveled the world, and cultivated a network of wonderful friends and family -- things no one around me believed would be possible for my life.

I now work at the Skoll Foundation in Palo Alto and am part of an international team that surfaces and supports innovative models that are working to solve pressing social problems. Clubhouse is one of those models. It is recognized internationally, is scaling and replicating in communities all over the world, and is a true beacon of hope in an otherwise

challenging landscape. In my direct experience with Clubhouse, I see the principles and practices at work that were key to my own recovery. For this reason, I have joined the Board of California Clubhouse and am committed to seeing that others faced with the same challenges I faced 25 years ago, also get the same opportunities to recover.

Please support the dedicated team of individuals and professionals who are working to make this a reality and open doors to a Clubhouse in San Mateo County this year! If you have any questions, please feel free to contact me directly.

With sincerest regards,  
Paula Kravitz

**Polly & Terry Flinn – email (8/13/14)**

Dear Ms. Estemera,

We are writing to ask that BHRS help bring the proven Clubhouse model to our county. Our son has been dealing with his bi-polar illness since he was 27, for over 18 years now. He has basic services made available to him by the county. We want to be clear that he and we are grateful, and proud of our county for its awareness of the necessity of providing these services. Additionally, we are facilitators for a NAMI sanctioned support group that meets twice a month in the County Hospital board room. We have participated for years. The distraught family members who attend have been asking us the same question for these many years: Tell us where our son/daughter can go during and after recovery? They isolate, hardly coming out of their childhood rooms, never feeling comfortable in society, never feeling a part of the flow of life that we all require for good mental health. We have never had an answer to this question until now. We have observed Clubhouse in action in several national cities. Members are able to socialize, feel productive and heal, in an atmosphere of commonality and empathy. They can be themselves, and still feel valued. They are in a healing place, a sharing place, a safe place, a place where they are welcome and they know it. We would be gratified to tell our support group members 'We know a place!'

Thank you for your efforts to bring Clubhouse to San Mateo County.

Sincerely,  
Polly and Terry Flinn

**Tanya Rinderknecht, MD – email (8/13/14)**

Dear Ms. Estemera,

I am 31 years old, and work as a surgery resident in 5 local hospitals via Stanford's general surgery graining program. As a physician who serves members of our community day in and day out, I cannot underscore enough the gap that exists for patients between acute care in the hospital and 'normal life'. Many, many patients are discharged from our hospitals in a state of being 'healthy enough' to not need a hospital, but not well enough to thrive back at home. Very often, they don't have the support, resources or network that they need to help them transition to their daily environment and stay well. This situation is somewhat easier

to address with tangible injuries and acute illnesses, where the healing process is more obvious and transparent, but with mental illness, it is tremendously challenging.

Mental illness is chronic and can often be debilitating. That said, it can be managed successfully, if patients have the medical, social, and community support that they need. If we do not provide the necessary resources to help patients with mental illness STAY well when they are in their daily settings, they will inevitably require hospital-level care more frequently and for longer periods of time. Re-admissions are not only costly, but are demoralizing, stressful, and disruptive for patients and their families. Everyone is better off if we can support patients to help maintain their best level of functioning, and help them avoid the hospital.

Please fund the effort to open a Clubhouse in San Mateo County with MHSA dollars. We need this social vocational program in our community. There is no program that does what Clubhouse can do. At the same time Clubhouse will complement our current programs, bringing further options and expanding hope.

Clubhouse is a proven program we desperately need in this county. Please fund it today.  
Sincerely  
Tanya Rinderknecht, MD

**Rosemary and Bruce Field – email (8/13/14)**

Dear Doris,

Please the fund the effort to open a Clubhouse in San Mateo County with MHSA dollars. We need this social vocational program in our community. There is no program that does what Clubhouse can do. At this time clubhouse will compliment our current programs, bringing futher options and expanding hope.

We will never give up Hope.

My brother was ill with Schizophrenia and presently my stepson is ill with Schizophrenia. For him to be included in a community and learn life skills us hope that he could survive us and have an independent life.

Please fund the Clubhouse today.

Thank you,  
Sincerely,  
Rosemary and Bruce Field

**Alan and Gloria Stickle – email (8/13/14)**

Dear Ms. Estremera,

Our youngest and beautiful daughter had a mental breakdown when she was 25 years old. Please stay with me and read her story. Learning was always difficult for her during her school years and she struggled to graduate from high school and from a two year program of business school.

Although she had a degree she could not keep the jobs she was hired for. She was not able to concentrate due to the constant voices she kept hearing. This time in her life became so stressful due to loss of employment and loss of personal relationships. Her friends went on with their life and she could not advance like they did. After a while she became isolated from friends and went into a deep depression and total mental breakdown. She was like a revolving door in and out of hospitals. It is too much to tell, but I must say she desperately needs friends around her. At the present time she is at Cordilleras Telecare Mental Health Center. She told us recently that she loves being there. We believe it is because she has a roommate, someone she can talk with a little. Just sharing a room with another human being brings her some comfort. She was living with us before and spent most of her days in her bedroom praying mostly and listening to music at times. She also stopped taking short walks like she once did. We realize she needs others besides her parents.

The Clubhouse in our San Mateo community would be a dream come true not only for her, but for so many others like herself. It would be like another home where she could visit and help out doing something with support from her friends there. I urge you to please help fund the effort to bring the Clubhouse to San Mateo County. Thank you for your attention.

Sincerely,  
Alan and Gloria Stickle

**Margie Renault – email (8/14/14)**

Dear Ms. Estremera:

Please lend your support to fund a Clubhouse here in San Mateo County. It will provide social and vocational opportunities to the mentally ill of our county. The camaraderie, group support and having something of meaning and value to fill one's time on a daily basis will benefit these people in terms of their emotional well being and in many cases prevent costly emergency services and hospitalizations.

Also for those who benefit from the vocational services offered it will be an avenue to become self supporting and the opportunity to pay taxes and be less dependent on social services in the county.

An investment in Clubhouse is a humanitarian gesture which benefits the recipients as well as the County. Support for Clubhouse is consistent with our image as a progressive, educated and quality of life County! Thank you so much for your consideration in this matter.

Sincerely,  
Margie Renault

**Diane Warner – email (8/14/14)**

Dear BHRS decision makers,

As a parent of a son, Douglas Warner, who has been in care and treatment with San Mateo

Behavioral Health Services for 30 years, I am writing to ask you to support the California Clubhouse in the funding decisions for 2015 and beyond.

Quoting from E. Fuller Torrey, M.D. from his recent book, American Psychosis, 2014  
“Continuity of care, especially continuity of caregivers, is essential for good care of individuals with serious mental illness.” p 154

The best model that combines access to decent housing, vocational opportunities, and opportunities for socialization is the clubhouse model according to Dr. Torrey. Despite the success of this model there are still only 200 of them in the United States since Fountain House of New York opened over 60 years ago. It is time we added San Mateo County and the support of BHRS would be a feather in the cap of the already excellent care services for persons with severe, chronic mental illnesses. My son is looking forward to becoming a club member.

Thank you,  
Diane Warner

**Rabbi Paul Shleffar – email (8/14/14)**

Dear Ms. Estremera,

I am a long time resident of San Mateo County, a former San Mateo County fire fighter and medic of 20 years, and now the Jewish Chaplain at the California Healthcare Facility, California Department of Corrections. In my current role, I serve a large inmate population on a daily basis, many of whom are suffering from severe mental illness. It is my belief and experience that far too many of these men do not belong in prison, and would not be here if they had received care as well as opportunities to recover and rebuild their lives. As you know, this is a huge problem and growing concern nationally as well as for California and San Mateo County.

I have become personally involved as an Advisor to the California Clubhouse team. I have been impressed with the model and approach to rehabilitation, and have seen firsthand the enthusiasm of potential members who would like to participate in the Clubhouse. For this reason, I am encouraging you to fund this program which I believe will improve outcomes for people living with severe mental illness.

Sincerely,  
Rabbi Paul Shleffar

**Robert Labarthe – email (8/14/14)**

Dear Ms. Estremera,

It is my understanding there now is Mental Health Services Act (MHSA) funding available for San Mateo. Currently a group is attempting to provide a place called California Clubhouse for the mentally ill who are undergoing outpatient treatment to go during the day. At the present time the treated patients do not have a safe place to congregate during the daytime hours and soon fall back into the inpatient/release treatment cycle.

Tragically last year my daughter took her own life. Although it is too late to help her, I believe California Clubhouse could save someone else's life with the support it give to people in need.

We need this social vocational program in our community.

There is no program that does what Clubhouse can do.

California Clubhouse will compliment our current programs, bringing further options and expanding hope for both patient and family members.

California Clubhouse is a proven program we desperately need in this county. Please fund it today.

Thank you for your consideration.

Sincerely,  
Robert Labarthe

**Margrit Rinderknecht – email (8/14/14)**

Dear Ms. Estremera,

I lost a close friend to suicide after beeing diagnosed with Schizophrenia. I have a cousin struggling with bipoar disorder. Mental illness is a reality, and San Mateo County has a great opportunity to provide a much needed piece of the puzzle of re-integrating patients into a regular life style.

Please fund the effort to open a Clubhouse in San Mateo County with MHSA dollars. We need this social vocational program in our community. There is no program that does what Clubhouse can do. At the same time Clubhouse will compliment our current programs, bringing further options and expanding hope.

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lubhouse is a proven program we desperately need in this county. Please fund it today.

Sincerely,  
Margrit

**Pamela Reitman – email (8/14/14)**

Dear Ms. Estremera,

Please fund the effort to open a Clubhouse in San Mateo County with MHSA dollars. We need this social vocational program in the community. There is no program that does what Clubhouse can do. At the same time Clubhouse will compliment our current programs, bringing further options and expanding hope.

My son suffers from serious mental illness and is a resident of San Mateo County. He receives some county services, but he keeps going in and out of the hospital and jail. When he is stable, he wanders the streets and gets involved with people who do not benefit his recovery. He needs solid, wholesome social support, where he can make real friends and

have a better quality of life. The Clubhouse is a proven program and will fill a gap for desperately needed social and vocational programming to supplement county services. Please fund it today.

Sincerely,  
Pamela Reitman

**Kristi Stickle-Trybus – email (8/14/14)**

Dear Ms. Estremera,

My sister has suffered from severe mental illness for many years as a young adult. Although she has had the support of family, she has suffered the consequences of being a victim of her illness, with regard to isolation and lack of community support that could make a significant difference in her recovery and maintaining the balance she needs to stay stable.

Having a Clubhouse in San Mateo County would mean a world of difference for countless mentally ill people, and their ability to either recover or continue with a cycle of recurrent mental breakdowns. Having a supportive place to go during the day and being given the opportunity to make friends in an environment that supports those with severe disabilities such as mental illness, is a crucial aspect to their recovery.

We are asking that you please fund the effort to bring a Clubhouse to San Mateo County.

Thank you for all of your efforts.  
Yours truly,  
Kristi Stickle-Trybus

**Lynda M Frattaroli, EdD, LCSW – email (8/15/14)**

Dear Ms. Estremera,

I write to advocate using MHSA funding to help launch and support bringing California Clubhouse to San Mateo County.

The County has already been provided a great deal of information regarding Clubhouse Inc, however, I wish to highlight some important points as to why this is a good investment in services for members of our community.

The Clubhouse program is specifically developed to meet the needs of Adult members our County who have serious and persistent mental illness, The early seeds of the program model comes from the early, early days of the recovery movement. Individual discharge back to their communities identified what they needed in order to stabilize and live in recovery post-hospitalization. These pioneering individuals provided the foundation of what has been incorporated into Clubhouse International today. Clubhouse International holds firm to core values that individuals have four guarantees of Clubhouse membership:

- A right to a place to come;
- A right to meaningful relationships;
- A right to meaningful work; and
- A right to a place to return.

These rights are unconditional for Clubhouses. And while Clubhouses are independent of Clubhouse International, in order to identify as a Clubhouse organization, the program must adhere not only to the above core values, there are very specific guidelines and programming. For example, all Clubhouses have work-ordered days, where staff and members work side by side to make plans and structure the day's activities.

A Clubhouse is a complicated living organism made up of its members with the support of a very small staff. For individuals with serious mental illness, Clubhouse have been found to become a place where individuals can own their recovery. A place to slowly connect with peers and to feel self-worth. A place where one belongs, can connect and begin to break the social isolation that many with severe mental illness in our communities live with.

SAMHSA has identified Clubhouse programs as a best practice for breaking isolation and promoting acceptance, dignity and social inclusion for individuals with severe mental illness. A Clubhouse in San Mateo can fill what is currently an unmet need.

MHSA funding of Clubhouse would fit with the BHRS commitment to support of community based services and addressing the needs of underserved populations. There are a number of individuals with severe mental illness live at home with family member(s), unwilling to come to any clinic, and remain unconnected to any behavioral health service. Then there are those individuals seen only by the shelter and Mobile support people. Clubhouse offers the possibility of a connecting place; a place to belong; and that can be a very big step.

I believe a Clubhouse program in San Mateo County can enhance Behavioral Health services already in place, as well as, provide options and expand hope to Community members with mental health illness and their families. These are the reasons I advocate for MHSA funding to support establishing a San Mateo Clubhouse.

Please feel free to contact me if additional information would be helpful.  
Thank you for your consideration,  
Lynda M Frattaroli, EdD, LCSW

**Sonbol Nickravesh – email (8/15/14)**

Dear Ms. Estremera,

My son Cameron finished high school 4 years ago and after that he start having a mental Health problem , is been very hard on family to manège this issue , my son can not go to school or work , if San Mateo county help our family to make this clubhouse happen , I would be great for My son , that he has somewhere to go since his is hopeless of to do anything in his life ,

He is suffering from this illness very much. I hope our wish come true.

Thank you  
Sincerely  
Sonbol nickravesh

**Patricia Urbina – email (8/17/14)**

Dear Ms. Estremera,

I enthusiastically support the effort to open a Clubhouse in San Mateo County with MHSA dollars. We need this social vocational program in our community. Clubhouse will compliment our current programs, bringing further options and expanding hope for people living with mental illness, such as my son whose choices for daily, meaningful activity are limited even in this forward- thinking county which strives to provide the best of care to its residents.

Clubhouse is a proven program and one which can only enhance San Mateo County's mental health services.

Respectfully submitted,  
Patricia Urbina

**Elizabeth Marstall – email (8/29/14)**

Ms. Destremera,

I work as a Fine Gardener and often work closely with my clients. We discuss many things while out gardening and more than a few times, the subject of mental illness involving a family member has come up. In one case, I have spent time with the son of a client and have seen him at all stages of his disease. I see the heartbreak and anxiety of the family as the son gets better and then gets worse due to the lack of any available programs to support the mental stability of the son. He is an intelligent, convivial, handsome young man and it is a very difficult situation for all involved when he is well enough to not need hospital care but not quite well enough to function in the 'real world'. Without support, he spirals downwards and the whole cycle begins again. San Mateo County needs a program like the Clubhouse in order for there to be someplace for this young man and his peers to go and receive the support they need. Please use MHSA dollars to fund the Clubhouse in San Mateo County.

Sincerely,  
Elizabeth Marstall

*Answer: Thank you for taking the time to write and submit your support for the funding of California Clubhouse in San Mateo County.*

*The MHSA Three-Year Plan development and funding decisions involve various steps including a Community Program Planning process that involves a needs assessment, strategy development and plan development phase where stakeholders (consumers/clients, family members, service providers, community members and leaders) input is gathered. The MHSA Steering Committee members prioritize strategies to close the needs and gaps identified throughout the process and make recommendations for inclusion in the plan.*

*The MHSA Three-Year Plan is developed taking specific priorities identified through stakeholder input from previous years, new priorities identified through the current process,*

*and the fiscal landscape and projections for the next three years. Any expansions or new programs prioritized are implemented as revenue becomes available and through a Request for Proposal process, a competitive bidding process.*

*While the Clubhouse cannot be included in the MHSA Three Year Plan as a specific program that will be funded, it is evident from the plan development process that a place for adults with serious mental illness in recovery that provides psycho-social services, vocational and other support services and skills development is a priority in terms of filling a much needed gap in service for San Mateo County. The priority recommendations from the MHSA Steering Committee for inclusion in the MHSA Three Year Plan can be found on our webpage, [www.smchealth.org/bhrs/mhsa](http://www.smchealth.org/bhrs/mhsa)*

**Raja Mitry, California Stakeholder Process Coalition – email (9/6/14) in response to the August 27, 2014 MHSA Steering Committee meeting**

The different Health Initiatives (i.e., African-American, PI, Latino, Chinese, Filipino, Pride, Native American) are structured in distinct ways that signal exclusion for anyone not of those identities. I believe the Diversity and Equity Council is comprised mostly of staff and providers and the chair/co-chairs from the Initiatives, but my last interaction with the Council is that it lacks many community folks being involved. Some community people attend the Initiative meetings but they and others outside of the Initiatives do not have a voice on the Council that can fully reflect the views of wider diversity and other stakeholders representative of the county's multi-cultural constituencies (which would also include transition-age youth, single parents/dads, older adults and caregivers, veteran/veteran families, etc.). There are numerous individuals and groups affected by mental health disparities who are left out. More unrepresented diverse community individuals and groups are needed to enhance cultural and linguistic competence that ensures involvement in planning processes and services development, evaluation and quality improvement. Better and broader reach to our folks and their involvement are extremely slow to materialize, even non-existent in certain areas. Please ensure that efforts to improve this be given priority. Not to discount the importance of the Initiatives, I encourage that the idea of some sort of Multi-Cultural Community Committee be given consideration.

*Answer: Thank you for your comment. The Diversity and Equity Council (DEC) has grown to include community members and providers that represent various ethnic, linguistic and cultural groups including African American, Latino, Chinese, Pacific Islander, Middle Eastern, Caucasian, Filipino and Native American. Other attendees also identify as part of the youth, LGBTQ, faith-based, consumers and/or family members and the disability communities. The DEC meets every first Friday and the meetings are open to all. Programs such as Mental Health First Aid, Parent Project and Stigma Free San Mateo also serve diverse individuals and*

communities. In addition to the DEC and the Health Equity Initiatives, there are numerous ways for community members to participate in planning processes from seeking membership on the Mental Health and Substance Abuse Recovery Commission, attending monthly Commission subcommittee meetings, to annual Mental Health Services Act community planning meetings. We continue to invite diverse stakeholders to our meetings and activities which are open for all to attend.

## **San Mateo County Mental Health and Substance Abuse Recovery Commission (MHSARC) Meeting (10/1/14)**

### **Questions regarding Full Service Partnerships**

Question 1: That number, underneath Adult, you served 260 Adults? So, 73% of those Adults are no longer homeless?

*Answer: The question refers to the presentation and FSP Outcomes through 2013 presentation slide, which noted a 73% decrease in homelessness. FSP partner/enrollee data is collected on assessment forms then tracks the dates of key event/status changes related to residential, education, employment, legal issues, and emergency intervention. Regarding a significant decrease in homelessness, this reflects FSP partners/enrollees change in housing/residential status at some point in the FSP program compared to the 12 months prior to being enrolled in the program .*

Question 2: How do you evaluate levels of FSP satisfaction?

*Answer: In addition to annual client satisfaction surveys, BHRS engaged Davis Y. Ja and Associates to implement a one-year qualitative evaluation of the Child/Youth/TAY and Adult FSP programs that included interviews/focus group with FSP consumers and caregivers. The full report completed in July 2014 may be found at <http://www.smchealth.org/bhrs/mhsa>*

### **Public Comment**

**Randall Fox:** On Page 9, Housing, we already have the Mental Health Association project in place and going. I'm not sure how that fits into a Three-Year Plan since it's already underway. And also, what's left in that Housing bucket and what are the plans? I know there is always a request for projects or however you want to call it for the Housing part. I am wondering how we are going to address \$1.3 million left or something like that.

*Answer: Originally, we had over \$6 million in the Housing fund. With the Waverly Project, we have approximately \$1.5 million left in the fund. There was recent legislation that requires*

*release of MHSA program funds currently held by the California Housing Finance Agency (CalHFA), upon request of counties, that will provide additional flexibility in providing housing assistance for people with mental illness. Other than the Waverly Project we do not have any other specific housing projects that meet MHSA housing requirements.*

**Randall Fox:** Is Total Wellness going to end in 2015?

*Answer: We will fund Total Wellness this year under Innovation funding. After this year, it is our intent to fund the program under the Community Services and Supports component. We will then develop a new Innovation project to fund in that category, beginning in January 2015.*

**Emily Chandler:** Thank you all for your very hard work. I hope I can say this clearly. I don't really understand where the person who is not decompensated to the point that they need shelter and they can't function on their own. I wasn't clear where the services are for the person who is ambulatory, verbal, functional but can't keep a job, can't find a place to live so they are supported by their families and, therefore, in our case, for instance, we are using our retirement to provide housing for our loved ones. I am just not exactly clear where they fit in. They are ambulatory. Thank you. You can record that it is not visible to me where the services that provide services to these people who are functioning a little bit above the level of desperate.

*Answer: Services for the type of person you describe are provided in our BHRS adult clinics and through contract providers. When someone is a client within our system, their case manager will include housing as part of their assessment. If housing is an issue they will work to achieve the best available option. Assessment, supported employment and financial education was a previous priority expansion that has been implemented. Proposed funding in the Three-Year Plan includes expanded supports for Transition Age Youth as well as Older Adults.*

**Juliana Fuerbringer,** California Clubhouse and NAMI: Can we ask a process question? The timing was mentioned there would be the 30-day comment period, and then you mentioned there would be some money, there would be RFPs that would go out based on some of the new priorities. Is that correct? Is that going to happen sooner or later? I am just curious about the timing of when an RFP might go out.

*Answer: The Three-Year Program and Expenditure Plan must be approved by the Board of Supervisors, and we anticipate the Plan going to the Board December-January. Once the Board approves it, then we can begin the process for implementation of the new priorities*

*when we are confident we have the financial resources to sustain them. From a budget perspective, we projected out a quarter of the year's spending for new projects. That would anticipate a potential start date of April for new projects.*

**Wanda Thompson**, MHSARC member: I just have a suggestion. I don't know if it's related to what we are talking about right now. I want to suggest getting a payee rep for the housing which they would take over paying your bills. They would help out with paying your rent, then that way you wouldn't have to be so stressed about it all being taken care of, of being homeless, or whatever. I was on the verge of being homeless. Then my family member took over. Now they have that to worry about because they are taking over everything. (Inaudible) For each month, it's all taken care of. You are not stressed out. I would suggest that and getting family involved in different situations. Does that make sense?

*Answer: Thank you for your suggestion. For more information about the Representative Payee Program, please see <http://www.ssa.gov/payee/faqrep.htm>*

**Judy Schutzman**, MHSARC: I would also like to comment that I am very pleased to see that there are funds for reducing older adult isolation. This was something that was initially missing in the original Proposal. I am very pleased it's has been added.

*Answer: Our proposed expansions include expanded supports for Older Adults. We also fund Senior Peer Counseling (provided by Peninsula Family Service) through our Prevention and Early Intervention component. This is a free service provided by trained volunteers that has Spanish, Chinese and Tagalog capacity as well as LGBT support.*

**Randall Fox**: I would put forth that perhaps you would think about moving the November 5<sup>th</sup> hearing into a full hearing rather than coming here and spending only an hour on the end and closing of public comment and try to include the full Steering Committee in that process because we won't have another meeting. I realize everybody can put in their comment, public, everybody else, at anytime over the 30 days. However, I think it is shortchanging the process if we spend an hour with your business as the Commission and spend an hour, if we are lucky, on the business of the MHSA. I put it forth to the Commission to rethink that and if we can find another location to have a full blown two-hour discussion and hearing to close it up. I don't know the statutory regulation but if we do have to discuss some of the comments as a Committee, and as the Commission all being part of the Steering Committee. I can show you the statue, if you would like, Judy. As a Commission, we are supposed to go over and as part of the Steering Committee, we are supposed to talk about some of the changes that might be put forth by the public. I put that on the table, and I hope I get positive feedback on that. Thanks.

*Answer: At this time the Mental Health and Substance Abuse Recovery Commission will hold a Public Hearing on the MHSA Three-Year Program and Expenditure Plan FY 2014-2015 through FY 2016-2017 & Annual Update FY 2014-2015 on Wednesday, November 5<sup>th</sup>, 3:00-5:00 p.m. at:  
Room 100, 225 37<sup>th</sup> Avenue  
San Mateo, CA 94403*

**Juliana Feurbringer**, California Clubhouse and NAMI: Just another clarification on public comment. So that would be sending emails, correct?

*Answer: You may submit public comment by November 5<sup>th</sup> by email to [mhsa@smcgov.org](mailto:mhsa@smcgov.org), or by post to:  
MHSA  
San Mateo County BHRS  
225 37<sup>th</sup> Ave., 3<sup>rd</sup> Floor  
San Mateo, CA 94403*

[Jei Africa, Director, BHRS Office of Diversity and Equity, read additional public comment received so far]

### **Public Comment received via email during the 30 Day Public Comment period**

#### **Leslie Muennemann - email (10/2/2014)**

Doris Estremera, MHSA Manager  
Behavioral Health and Recovery Services Division, San Mateo County Health System

Hello,

I searched for the issue that concerns me most in our county Crisis Intervention Training/Team for law enforcement and could not find any mention. I see there are EMTs that are sent out to evaluate an individual. But I'm thinking about the rare occasions, thank goodness they are few and far in between, but nonetheless tragic, where law enforcement responds and over reacts for lack of training, often killing the mentally ill person. Our county does not have what other communities, like Las Vegas have

<http://www.lvmpd.com/CommunityPrograms/CrisisInterventionTeam/tabid/146/Default.aspx>

What will it take for our county to get this kind of expertise? Let's not wait for a tragedy to act.

Thanks,  
Leslie Muennemann

*Answer: Thank you for your input. San Mateo County provides Crisis Intervention Training (CIT) training twice a year and is looking into opportunities to expand the training. The training is a collaborative effort between the San Mateo County Sheriff's Department, Behavioral Health and Recovery Services and NAMI San Mateo County and is designed to help law enforcement deal with individuals with mental illness in our community. BHRS and the Sheriff's Office will be implementing a pilot project based on the Psychiatric Emergency Response Team model early next year.*

**Ned Brasher, MFT, FAST Clinical Director - email (10/9/2014)**

Attached is the concept of ROLES as a service that will likely be well received by clients and families alike.

The concept for ROLES occurred to me prior to knowing about the "proposed strategies, program or enhancement to existing program" of the "Stakeholder Input - Strategy Development Priority Expansions for next 3 years FY 14/15 thru FY 16/17." The stakeholders chose as Priority 1 "Support and assistance program for isolated individuals living in community to get them connected to volunteer opportunities, work, friendship centers, etc."

Priority 3 of the stakeholders was "Expand employment opportunities for individuals with lived experience (family and peer support workers, etc.)"

ROLES fits under priorities 1 & 3.

RELATIONSHIPS  
OPPORTUNITIES  
LIVE LAUGH LOVE  
EMPOWERMENT  
SERVE OTHERS

Close and enduring relationships and meaningful roles in the family and community are clearly linked to a life worth living. We feel empowered when employed, volunteering, learning and giving loving attention to family members and friends as well as showing kindness and respect to people encountered daily.

This is an idea for peer provided, Mental Health Services Act-funded, support out in the community. It grew out of our *FAST* experience. The *FAST* team has been able to make referrals to BHRS clinics and other providers for psychiatry and clinic-based services. We need to have a team of peer counselors and family partners who can offer ongoing support to help clients stay on track with recovery goals. **ROLES** will offer this type of support so that clients achieve a more meaningful life without stigma.

**ROLES** one-on-one peer counseling support will

- Increase connections in the community

- Explore employment, education and volunteer opportunities
- Strengthen healthy roles and relationships in their lives

**ROLES** family partners will provide family members and friends the needed support to be most helpful in supporting their loved one's recovery.

*Answer: Thank you for your recommendations. Your input/feedback will be brought to the MHSA Steering Committee (includes MHSARC) when they meet in February, and [SK1] they may consider recommending adding this to the proposed expansion. BHRS has a strong commitment to consumer/family employment and peer support and through the MHSA has funded such opportunities.*

**Kerry Lobel, Executive Director, Puente – email (10/30/2014)**

Hello friends, as always, we appreciate your hard work on the MHSA Three-year program and expenditure plan.

We were excited when our region participated in the week-long CSA process and are now very distressed to find that not one of the findings from our group were included the MHSA materials that we had the opportunity to review. Here are our concerns:

*1) Not one of the findings from our group were included the MHSA implementation plan. See report out: <http://www.smchealth.org/sites/default/files/docs/BHS/Redesign/CoastsideReportOut.pdf>*

The Coastside CSA emphasized the importance of supporting comprehensive community centers – one stop hubs – for health and wellness, hospitality, groups and resources in HMB and the South Coast. Providing resources and support for existing hubs like Puente and increasing the level of staffing and presence from Coastside Mental Health on the South Coast was a key strategy for the Coastside CSA. Without childcare and transportation, Puente is an important resource for local community members with behavioral health issues.

*2) The document does not include farmworker input nor are there any specific strategies included to address farmworker trauma.*

i) This is despite the fact that indigenous farmworkers are believed to face higher amounts of anxiety, depression and post-traumatic stress disorder than the general population. Studies show that stressors inherent in farm work and the farmworker lifestyle have long been believed to undermine mental health.

ii) Environmental stressors, such as limited social mobility and discrimination, as well as hazardous working conditions, pose significant risks to farmworker mental health.

iii) The document does not reflect the special needs of this population or allocate specific funding to support or expand services for these important communities and the support services needed such as childcare and transportation.

*3) The document does not provide strategies for addressing the unique needs of the County's rural South Coast population*

i) While recent studies indicate that the prevalence and incidence of behavioral health problems are similar in rural and urban areas, a notable exception is the significantly higher rate of suicide

and suicide attempts in rural America. For rural elderly residents in some regions, the rate is 3 times higher than the national average in non-rural settings.

ii) In addition, rural residents experience many more obstacles to obtaining behavioral health services, which results in distinct mental health disparities.

iii) The document does not address the specific needs of the South Coast rural community including needs for transportation, childcare, and locally accessible services.

*4) The document does not provide a sustainable strategy for addressing the needs of South Coast residents which is essential to meet behavioral health disparities.*

i) As described in the document, Puente de la Costa Sur provides nearly all individual, group and school-based behavioral health services on the South Coast. Puente bears a disproportionate responsibility for finding funding for culturally appropriate services for South Coast residents and no MHSA monies are specifically available to support the services Puente provides over the long-term. While grants for programs like Project Success are essential, these funds do not provide support for the overall crisis intervention and long term interventions needed to address the needs of our rural community.

ii) Utilizing models developed by the UC Davis Center for Reducing Health Disparities, Puente:

(1) Develops a mental health-care workforce prepared to address the cultural and linguistic needs of Latinos.

(2) Provides mental health services where other health-care and social services are offered.

(3) Instills in mental health providers the importance of communicating with mental-health consumers in ways that acknowledge their unique beliefs about mental health, spirituality and traditions.

(4) Promotes mental health utilizing the strengths of Latino communities, including families, religious leaders, indigenous community leaders, community *pláticas* or conversations and *promotores*.

Thanks for the opportunity to share my concerns.

Yours sincerely,

Kerry Lobel

Executive Director, Puente

*Answer: Thank you for your feedback. We are continuing to fund Project SUCCESS provided by Puente with MHSA Prevention and Early Intervention (PEI) funding. In addition, one of the proposed PEI programs is the expansion of culturally aligned and community-defined outreach and engagement with a focus on emerging racial/ethnic/cultural and linguistic communities and outcomes and replicable practices (Outreach Team). This outreach includes the farmworkers and rural communities. When we determine there is sustainable funding for this effort we will be defining the specific components through a request for proposals process. The suggestions identified through the Coastside CSA planning process will be considered at that time. We encourage your continued advocacy for the Coastside region through the Coastside CSA and other BHRS planning processes.*

**Public Comment emails in support of MHSA funding for California Clubhouse in San Mateo County**

**Carol Labarthe – email (10/13/2014)**

Dear Ms. Estremera,

Last year, my beloved daughter took her own life. Clubhouse, if one had been available, would have been instrumental in helping her overcome her depressive mental state by giving her support, options, and hope for a better future. It is too late now to save her but Clubhouse will assist someone else's son or daughter with the same kind of illness. That give me comfort and hope for their future.

I am requesting that you fund the effort to open a Clubhouse in San Mateo County with MHSA dollars. We know we've achieved Step One by getting the social vocational program idea behind the Clubhouse model to the top of the Priority List.

Step Two is for Clubhouse to receive MHSA funding. We are writing to ask your help to make this a reality.

There is no program that does what Clubhouse can do. At the same time Clubhouse will partner collaboratively with our current programs, bringing further options and expanding hope. Clubhouse already has a location and active team. We are awaiting permanent staffing and work-ordered day.

Clubhouse is a great model program, with over 330 Clubhouses worldwide, helps over 100,000 people a year living with mental illness lead productive lives. This July, Clubhouse International, won the Conrad N. Hilton Humanitarian Prize of \$1.5 million, the world's largest humanitarian prize.

Please fund the effort to bring a Clubhouse to San Mateo County. This is something we desperately need in this county. Clubhouse will bring support, hope, and more meaningful lives to the mentally ill members of our community. That means everything to the people who live with these debilitating illnesses and their families.

Yours truly,  
Carol LaBarthe<sup>[sk2]</sup>

*Comment: We are very sorry for your loss and would like to express our deep sympathy for you and your family.*

**Cameron Quanbeck MD – email (10/13/2014)**

Dear Ms. Estremera,

Please fund the effort to open a Clubhouse in San Mateo County with MHSA dollars. We

know we've achieved Step One by getting the social vocational program idea behind the Clubhouse model to the top of the Priority List.

Step Two is for Clubhouse to receive MHSA funding. We are writing to ask your help to make this a reality.

There is no program that does what Clubhouse can do. At the same time Clubhouse will partner collaboratively with our current programs, bringing further options and expanding hope. Clubhouse already has a location and active team. We are awaiting permanent staffing and work-ordered day.

Clubhouse, with over 330 Clubhouses worldwide, helps over 100,000 people a year living with mental illness lead productive lives. This July Clubhouse International won the Conrad N. Hilton Humanitarian Prize of \$1.5 million, the world's largest humanitarian prize.\*\*\*

As Medical Director of Cordilleras Mental Health Center, our County's main sub-acute psychiatric facility, I see a Clubhouse as being a very important element in our efforts to ensure our seriously mentally ill clients can make a full recovery. We at Cordilleras would partner with the Clubhouse and include them in our client's Recovery Plan.

Thank you for considering the Clubhouse Model in San Mateo County.

Sincerely,  
Cam

Cameron Quanbeck MD  
Medical Director,  
Cordilleras Mental Health Center

**Patricia Urbina, M. D. – email (10/13/2014)**

Dear Ms. Estremera,

Please fund the effort to open a Clubhouse in San Mateo County with MHSA dollars. With the social vocational model at the top of the priority list for proposed MHSA projects, Clubhouse uniquely fulfills the description of this type of entity. With over 330 Clubhouses worldwide, this community based organization helps over 100,000 people a year living with mental illness lead productive lives.

There is no program that does what Clubhouse can do. At the same time Clubhouse will partner collaboratively with our current programs, bringing further options and expanding hope. Clubhouse already has a location and active team. We are awaiting permanent staffing and work-ordered day.

Clubhouse is an important source of hope for me as my son, now 36, a talented artist and musician, and a young man with dreams who is still desirous of engaging in meaningful work, lives with a serious mental illness.

While San Mateo provides critical support services, there's very little for him to do once released from intensely therapeutic and structured settings. My son is very aware of his illness and is trying so hard to recover. He needs a productive place to go during the day, where he can make friends and engage in activity that is absorbing and rewarding for him.

Please fund the effort to bring a Clubhouse to San Mateo County with MHSA dollars. It will help keep people like my son stay out of the hospital, out of a dark solitary bedroom, and move him into the light of friendship, absorbing activity and support. Thank you for your kind attention in this critical matter.

Sincerely,  
Patricia Urbina, M. D.

**Polly and Terry Flinn – email (10/14/2014)**

Dear Ms. Estemera,

We are writing to ask that BHRS help bring the proven Clubhouse model to our county. Our son has been dealing with his bi-polar illness since he was 27, for over 18 years now. He has basic services made available to him by the county. We want to be clear that he and we are grateful, and proud of our county for its awareness of the necessity of providing these services. Additionally, we are facilitators for a NAMI sanctioned support group that meets twice a month in the County Hospital board room. We have participated for years. The distraught family members who attend have been asking us the same question for these many years: Tell us where our son/daughter can go during and after recovery? They isolate, hardly coming out of their childhood rooms, never feeling comfortable in society, never feeling a part of the flow of life that we all require for good mental health. We have never had an answer to this question until now. We have observed Clubhouse in action in several national cities. Members are able to socialize, feel productive and heal, in an atmosphere of commonality and empathy. They can be themselves, and still feel valued. They are in a healing place, a sharing place, a safe place, a place where they are welcome and they know it. We would be gratified to tell our support group members 'We know a place!'

Thank you for your efforts to bring Clubhouse to San Mateo County.  
Sincerely, Polly and Terry Flinn

**Ruth Parson - email (10/15/2014)**

I am writing to encourage MHSA to provide funding to California Clubhouse, as soon as possible. The Clubhouse model is an innovative, evidence-based Mental Health Program that has a long history of helping people living with persistent mental health challenges to build on their strengths and be part of an on-going and available community of like-minded people.

Though there are many great programs and mental health workers in San Mateo County, there is yet to be a program that can be used daily, for free, during working hours and socially in the evening and weekends for as long as its participants care to and as they choose. Programming is created by all participants in the clubhouse community according to its needs and the needs of its members. Attendance is voluntary to ensure that motivation for growth and direction is created by each individual.

The Clubhouse model has been endorsed by the United Nations and Brigadier General (ret) Loree Sutton, MD formerly of the Veterans Administration, as the program they deem most highly effective for long-term recovery. This year the Conrad N Hilton Humanitarian Award went to the first Clubhouse, Fountain House in NYC and Clubhouse international.

I am both a family member and a retired Clubhouse veteran. I have seen the remarkable difference this supportive community makes in thousands of lives. It would be a shame for San Mateo County to miss this opportunity and resource.

Sincerely yours, Ruth Parson

**Pamela Gehrke, Ph.D. - email (10/15/2014)**

Dear Ms. Estremera,

I understand that the social vocational program idea on which the Clubhouse concept is based has achieved a deservedly high ranking on the Priority List, and I write to express my support for funding California Clubhouse, specifically, with MHSA dollars.

A program of recovery, hope, and dignity that empowers people who live with mental illness through friendship, meaningful work, and cultivation of strengths will go a long way toward relieving the suffering of many individuals and families who struggle to cope. At the same time, the program will help restore to the community the special gifts and talents of Clubhouse members. People will move toward recovery through work and work-mediated relationships, which studies show are restorative and provide a foundation for growth, self-respect, and success.

In addition to the improved well-being of people with mental disorders, benefits of the program to San Mateo County will include higher employment, reduced hospitalization, reduced incarceration

My mother, who died in 2003, suffered from bipolar affective disorder. Since the time when our family struggled with her illness, I've become aware of many others close to me whose lives are impacted in this way. It breaks my heart.

In California Clubhouse, I see the potential for more people to pursue the full and productive lives we all deserve. I urge you to fund this program.

Sincerely,  
Pamela Gehrke, Ph.D.

**Julie Zhao , Gorden Yang - email (10/15/2014)**

Dear Ms. Estremera,

Please fund the effort to open a Clubhouse in San Metro County with MHSA dollars. There is no program that does what Clubhouse can do, Clubhouse is an important source of hope for me as my son. He needs a productive place to go during the day, where he can make friends and get the kind of support that keeps him to afloat. But there is very little for him to do once released from the hospital.

This predictably means he spirals downward, becomes isolated and in some number of months, is back in the hospital. This is a very bad cycle again and again.

Please fund the effort to bring a Clubhouse to San Metro County. It will help people like my son stay out of hospital, out of a dark solitary bedroom and into the light of friendship and support.

This is something we desperately need in this county.

Your truly,  
Julie Zhao , Gorden Yang

**Marsha Mayer - email (10/16/2014)**

To all those that have the power to use MHSA funding to help establish Clubhouse:

Please consider the impact that the MHSA funding can make on our community. Our population includes people suffering with mental illness and depression issues who have nowhere to go during the day to anchor their lives. Clubhouse is a known successful model

that fills a big gap. It is a very big thing to have a place that offers the potential for our young adult children to engage in socialization and purpose and meaningful interaction.

My own 30 year old son who suffers from depression was missing for almost a year. He chose to separate himself from our household because he felt he was a burden to us.

He contacted us last week, came over for one hour and then left again. We have no way to reach him. How wonderful it would have been if I could have suggested Clubhouse as a place to spend his time during the day. Maybe it would have helped the loneliness and isolation he feels.

I look forward to Clubhouse becoming a reality and appreciate any help you can give in financial support in getting it started.

Sincerely,  
Marsha Mayer

**Doug Warner – email (10/16/2014)**

Dear Ms. Estremera,

There is an organization that is opening up and it has a lot of potential. As a client, I can see what it offers to me and other people in my situation. Mental health workers are happy to see this program opening up and there is no difference of functioning. Hopefully your potential will keep growing through this program. California Clubhouse offers many jobs and opportunities of growth to the mentally ill, that is seen to the public, and to your family, and to yourself esteem.

So I hope to see you there, at California Clubhouse

Signed Douglas

**Randi Hackbarth, RN – email (10/16/2014)**

Dear Ms. Estremera,

I am writing you in support of MHSA funding to be used to support a Clubhouse in San Mateo County. You may be aware that the Clubhouse program follows the Clubhouse International Model and Standards which operates in 28 countries. The Clubhouse International Model is included in the US Substance Abuse and Mental Health Services Administrations' (SAMHSA) National Registry of Evidence Based Practices and Programs.

There is documented research on Clubhouse International programs that communities with a Clubhouse benefit from higher employment rates, a decrease in hospitalization, reduced incarceration, reduced costs in services, and improved well-being by those suffering from a serious mental illness in comparison to other programs.

As Board President of Putnam Clubhouse in Contra Costa County, an RN, and former Director of Nursing at John Muir Behavioral Health Center I have witnessed significant recovery in Members after joining the Clubhouse. Through the work ordered day Members perform meaningful jobs and develop the skills, self-esteem, and confidence to work or return to school again.

Clubhouses assist Members with Transitional Employment (supporting Members at jobs) as a starting point and then assist Members in gaining employment in the community. I know many Members who have gained employment, furthered their education, formed friendships, serve on the Board of Directors or who complete productive work at the Clubhouse daily. Putnam Clubhouse has demonstrated that Members have reduced hospitalizations since attending the Clubhouse program.

This Friday we are conducting our 7th annual fundraiser and the Member's are providing the program for 340 guests with music performed by the Clubhouse "Rockers" band, songs written by and performed by Members as well as assistance throughout the evening, with raffle sales, welcoming guests, etc. Many of the Members who are participating in these activities would not have been able to do any of this a few years ago. Every year I witness dramatic development in each Member in re-integrating back into their community and being so proud to do so.

I hope that you do provide funding in support of the California Clubhouse in San Mateo County and are able to reap the benefits that we are experiencing in Contra Costa County, and which assists persons suffering with serious mental illness in their recovery.

Sincerely,  
Randi Hackbarth, RN  
Board President, Putnam Clubhouse

**Cheerfield Wong - email (10/17/2014)**

Dear Ms. Estremera,

Please fund the Clubhouse in San Metro County with MHSA dollars. Clubhouse is an important place for someone with special need to feel being accepted as part of the community. A place that they can connect and to go during the day, where he can make friends, train to do simple daily core and get the kind of support that keeps him to afloat as well as getting some recreation activity. A safe place for them to keep in touch with the society once released from the hospital instead of spirals downward, becomes isolated and return back in the hospital again. This place can even help the borderline patient to be productive again.

Please make the effort to fund and bring the Clubhouse to San Metro County. It will help people stay out of hospital, out of a dark solitary bedroom and into the light of friendship and support.

This is something we desperately need in this county.

Your truly,  
Cheerfield Wong

**Shelley Rintala - email (10/17/2014)**

Dear Ms. Estremera,

Please fund the effort to open a Clubhouse in San Mateo County with MHSA dollars. We know we've achieved Step One by getting the social vocational program idea behind the Clubhouse model to the top of the Priority List.

Step Two is for Clubhouse to receive MHSA funding. We are writing to ask your help to make this a reality.

There is no program that does what Clubhouse can do. At the same time Clubhouse will partner collaboratively with our current programs, bringing further options and expanding hope. Clubhouse already has a location and active team. We are awaiting permanent staffing and work-ordered day.

Clubhouse, with over 330 Clubhouses worldwide, helps over 100,000 people a year living with mental illness lead productive lives. This July Clubhouse International won the Conrad N. Hilton Humanitarian Prize of \$1.5 million, the world's largest humanitarian prize.\*\*\*

Clubhouse is an important source of hope for me as my son had to drop out of college four years ago because of a serious mental illness. He's been in and out of hospitals ever since. Each time he leaves the psych unit, he's left to his own initiative to keep himself stabilized and in recovery mode.

While San Mateo provides critical support services, there's very little for him to do once released from the hospital. This predictably means he spirals downward, becomes isolated, and in some number of months, is back in the hospital.

He is very aware of his illness and is trying so hard to recover. He needs  a productive place to go during the day, where he can make friends and get the kind of support  that keeps him afloat.

Please fund the effort to bring a Clubhouse to San Mateo County. It will help keep  people like my son stay out of the hospital, out of a dark solitary bedroom, and into the light of friendship and support. This is something we desperately need in this county.

Sincerely,  
Shelley Rintala

**Mark Christian – email (10/18/2014)**

Dear Ms. Estremera,

My son Kevin was born and raised in San Mateo County. He was diagnosed 10 years ago with a serious mental illness.

Our son has utilized many services, including emergency hospital visits, and we believe a Clubhouse would be a place that could help bring him out of his dark room to advance on his way to recovery and hopefully employment and independence .

Thank you for your time.

Sincerely,  
Mark Christian

**Dorothy Christian – email (10/18/2014)**

Dear Ms. Estremera,

My son was born and raised in San Mateo County. He was diagnosed 10 years ago with a serious mental illness. We have utilized many services for him and believe a Clubhouse as another support would be invaluable.

The Clubhouse would be a way of helping with stability in his life and to advance him on his way to recovery and hopefully employment and independence.

Please fund the San Mateo County Clubhouse with MHSA dollars.

Thank you for your time.  
Sincerely,

Dorothy Christian

**Dr. Joe and Diane Haggerty – email (10/18/2014)**

Dear Ms. Estremera,

I just heard from a dear friend about this wonderful clubhouse possibility. My goodness, mental health issues are in all families, thus, we all have a need for this house. I, myself, have 2 children with issues like this, alcohol addiction and bipolar out of 4 children. My children do not live in this county, but, I wholeheartedly support all and every effort to find a place for these dear members of our community. This would be a benefit not just to them, but their families. Not just them and their families, but the whole of society.

And, most gratefully, thank you for all your work on this behalf.

Dr. Joe and Diane Haggerty

**Angela Su - email (10/19/2014)**

Dear Ms. Estremera,

Please fund the effort to open a Clubhouse in San Mateo County with MHSA dollars. Clubhouse is an important source of hope for my son. He needs a productive place to go during the day, where he can make friends and get the kind of support that keeps him afloat. Please fund the effort to bring a Clubhouse to San Mateo County. It will help people like my son stay out of hospital.

This is something we desperately need in this county,

Sincerely,  
Angela Su  
Dear Ms Estremera,

**Peggy McLaughlin - email (10/19/2014)**

I am writing in support of funding to open a Clubhouse in San Mateo County with MHSA dollars. This social vocational program is now at the top of the Priority List but we need your support to receive MHSA funding. I hope you will help us make this a reality.

Clubhouse, with over 330 Clubhouses worldwide, helps over 100,000 people a year living with mental illness lead productive lives. This July Clubhouse International won the Conrad N. Hilton Humanitarian Prize of \$1.5 million, the world's largest humanitarian prize. ([http://iccd.org/documents/ClubhouseIntl\\_HiltonPrizeRelease\\_07-17-14.pdf](http://iccd.org/documents/ClubhouseIntl_HiltonPrizeRelease_07-17-14.pdf)) Clubhouse partners collaboratively with current programs and we already have a San Mateo location and active team. We are awaiting permanent staffing and work-ordered day.

I have several friends whose children needed a resource like Clubhouse due to serious mental illness. While we have some critical immediate support services, there's little for these patients once they are released from the hospital. This gap begets an endless cycle back into the hospital, or worse, a suicide.

Please fund the effort to bring a Clubhouse to San Mateo County. We need this resource in our community.

Best regards,  
Peggy McLaughlin

**Diane Warner - email (10/20/2014)**

Mental Health and Substance Abuse Recovery Commission  
San Mateo County, California  
Dear Commissioners,

I am writing in support of MHSA funding for California Clubhouse as an additional recovery model for persons living with mental illness in San Mateo County

My son has benefited from the many Mental Health services within San Mateo County for the 30 years of his chronic and debilitating Schizoaffective Disorder and I am grateful to all his caregivers.

Now my son needs help to develop and appreciate his abilities. He is already an involved and valued member in the new California Clubhouse community. The clubhouse philosophy gives him a place to shine.

One of the values addressed by prop 63 funding is the willingness of the wealthy to be taxed at 1% of their income over 1,000,000 for the treatment and rehabilitation of persons with mental illness. Many of their own family members suffer from severe behavioral disorders. Most are also intelligent with other parts of their brain being underused due to the stigma and misunderstanding of their symptoms. People with mental illness are much more than their mental illness.

The International Clubhouse model is a proven starting place throughout the world for persons with mental illnesses capable of more meaningful lives. The work-day environment where they can choose tasks according to their needs and abilities in the now helps each individual grow self confidence through the guidance and relationship of trained mentors.

The leadership for California Clubhouse is coming from within the grass roots of San Mateo County. Respected, educated family members have stepped up to make the California Clubhouse a reality. Already they have proven their organizational abilities and commitment to launch the clubhouse by donating time, money and motivational drive. Currently they have secured a place at 2205 Palm Avenue in San Mateo.

The California Clubhouse is fully endorsed by NAMI of San Mateo County and is very deserving of the next three year (2015-2017) funding plan.

Sincerely,

Diane Warner

NAMI San Mateo member for 30 years. Board member and Editor of the newsletter.

Co-Founder NAMI Family to Family and NAMI Peer to Peer programs in San Mateo

Board Member of Mental Health Association San Mateo County for 6 years.

Parent and Consumer

**Jane Gomery - email (10/21/2014)**

Dear Ms. Estremera,

Please fund the effort to open a Clubhouse in San Mateo County with MHSA dollars. We know we've achieved Step One by getting the social vocational program idea behind the Clubhouse model to the top of the Priority List.

Step Two is for Clubhouse to receive MHSA funding. We are writing to ask your help to make this a reality.

There is no program that does what Clubhouse can do. At the same time Clubhouse will partner collaboratively with our current programs, bringing further options and expanding hope. Clubhouse already has a location and active team. We are awaiting permanent staffing and work-ordered day.

Clubhouse, with over 330 Clubhouses worldwide, helps over 100,000 people a year living with mental illness lead productive lives. This July Clubhouse International won the Conrad N. Hilton Humanitarian Prize of \$1.5 million, the world's largest humanitarian prize.\*\*\*

Clubhouse is an important source of hope for many young people. I have a friend who had to drop out of college because of a serious mental illness. He's been in and out of hospitals ever since. Each time he leaves the psych unit, he's left to his own initiative to keep himself stabilized and in recovery mode and it has been a nightmare keeping him stable.

While San Mateo provides critical support services, there's very little for him to do once released from the hospital. This predictably means he spirals downward, becomes isolated, and in some number of months, is back in the hospital. This is a costly cycle and not productive for him or the community.

He is very aware of his illness and is trying so hard to recover. He needs <sup>L</sup><sub>SEP</sub> a productive place to go during the day, where he can make friends and get the kind of support <sup>L</sup><sub>SEP</sub> that keeps him afloat. This will be the bridge to allow him to become a successful member of society.

Please fund the effort to bring a Clubhouse to San Mateo County. It will help keep <sup>L</sup><sub>SEP</sub> people out of the hospital, out of a dark solitary bedroom, and into the light of friendship and support. This is something we desperately need in San Mateo county.

Thank you,  
Jane Gomery

**Rosemary and Bruce Field - email (10/21/2014)**

Dear Ms. Estremera,

Please fund the effort to open a Clubhouse in San Mateo County with MHSA dollars. We know we've achieved Step One by getting the social vocational program idea behind the Clubhouse model to the top of the Priority List.

Step Two is for Clubhouse to receive MHSA funding. We are writing to ask your help to make this a reality. There is no program that does what Clubhouse can do. At the same time Clubhouse will partner collaboratively with our current programs, bringing further options and expanding hope. Clubhouse already has a location and active team. We are awaiting permanent staffing and work-ordered day.

Please fund the effort to bring a Clubhouse to San Mateo County. This effort is very dear to my husband and I as parents of a young person who has a mental illness. Isolation is our biggest concern, we feel that a Clubhouse would give us hope that he will have a place to socialize.

Sincerely,  
Rosemary and Bruce Field

**Shirley Eigenbrot LCSW – email (10/22/2014)**

Dear Ms. Estremera,

Please fund the effort to open a Clubhouse in San Mateo County with MHSA dollars. We know we've achieved Step One by getting the social vocational program idea behind the Clubhouse model to the top of the Priority List.

Step Two is for Clubhouse to receive MHSA funding. We are writing to ask your help to make this a reality.

There is no program that does what Clubhouse can do. At the same time Clubhouse will partner collaboratively with our current programs, bringing further options and expanding hope. Clubhouse already has a location and active team. We are awaiting permanent staffing and work-ordered day.

I am a Licensed Clinical Social Worker in San Mateo County who has a professional interest in seeing this clubhouse become a reality. I also have a close personal interest in that I have friends who have brothers, sisters, sons, daughters, parents.....who would/would have benefited from such a facility. This is such an important step forward for our county.

Clubhouse, with over 330 Clubhouses worldwide, helps over 100,000 people a year living with mental illness lead productive lives. This July Clubhouse International won the Conrad N. Hilton Humanitarian Prize of \$1.5 million, the world's largest humanitarian prize.\*\*\*

Please fund the effort to bring a Clubhouse to San Mateo County.

Yours truly,  
Shirley Eigenbrot LCSW

**Judith Moore – email (10/23/2014)**

Dear Ms. Estremera,

Please fund the effort to open the Club House in San Mateo Co. with MHSA dollars making this a reality for those living with mental illness.

So often the mentally ill are underserved in our communities. Having a Club House with support and friends would mean so much to the recipient's and their families.

Thank you for your consideration,  
Judith Moore

**Fely Rodriguez - email (10/23/2014)**

Dear Ms. Estremera,

Please fund the effort to open a Clubhouse in San Mateo County with MHSA dollars. We know we've achieved Step One by getting the social vocational program idea behind the Clubhouse model to the top of the Priority List.

Step Two is for Clubhouse to receive MHSA funding. We are writing to ask your help to make this a reality.

There is no program that does what Clubhouse can do. At the same time Clubhouse will partner collaboratively with our current programs, bringing further options and expanding hope. Clubhouse already has a location and active team. We are awaiting permanent staffing and work-ordered day.

Clubhouse, with over 330 Clubhouses worldwide, helps over 100,000 people a year living with mental illness lead productive lives. This July, Clubhouse International won the Conrad N. Hilton Humanitarian Prize of \$1.5 million, the world's largest humanitarian prize.

Please fund the effort to bring a Clubhouse to San Mateo County. It will help keep <sup>isep</sup> people like my son stay out of the hospital, out of a dark solitary bedroom, and into the light of friendship and support. This is something we desperately need in this county.

Best Regards,  
Fely Rodriguez

**Maggie Smith, PhD, MFT - email (10/23/2014)**

To: Doris Estremera:

I am writing to support the funding of the opening of a Clubhouse in San Mateo with MHSA financial backing. Having a Clubhouse in San Mateo would be a tremendous help for mental health services in San Mateo. It is especially encouraging to know that the possibility of a San Mateo Clubhouse already has a location and an active team and are ready to move forward with permanent staffing.

As a mental health professional in the area for 25 years, I wholeheartedly endorse the funding of Clubhouse in San Mateo for those mental health patients who are so in need of ongoing support.

Sincerely, Maggie Smith, PhD, MFT

**Diane Heditsian – emails (10/23/2014)**

I am writing to request that MHSA fund the effort to open a Clubhouse in San Mateo County. The proven social vocational program idea that is the backbone of the Clubhouse model is already at the top of the Priority List. Now the goal is to actually receive funding and I am asking for your help to make this happen.

Clubhouse is a proven successful model worldwide. There are more than 330 Clubhouses helping over 100,000 people a year living with mental illness to lead productive lives. And this July Clubhouse International won the Conrad N. Hilton Humanitarian Prize of \$1.5 million, the world's largest humanitarian prize.

There is just no other program that does what Clubhouse can accomplish. And Clubhouse will partner with current programs to provide more options and expand hope. Clubhouse already has a location and an active team. Funding is what is now needed to make this a reality.

While San Mateo County currently provides critical support services for the mentally ill, there is nothing currently available that fills this vocational/social need.

Please fund the effort to bring a Clubhouse to San Mateo County. It will help keep  mentally ill people out of the hospital, out of isolation and into a productive life filled with friendship and support. This concept makes sense for the mentally ill of San Mateo County and their families.

Thank you.

Sincerely,  
Diane Heditsian

**Debra S. Mechanic – email (10/26/2014)**

Dear Ms. Estremera,

As you know our NAMI (National Alliance for the Mentally Ill) board members have been working diligently to secure a social and vocational center here in San Mateo County called The Clubhouse.

With your help, we will be able to provide Support, Education and Resources that will help improve the lives of those who suffer from mental illness and provide a crucial and necessary component to their recovery and survival.

Please help us make the Clubhouse a reality by providing us with MHSA dollars; and help us to succeed.

On behalf of myself and other families of the mentally ill, thank you for considering to fund our journey and for helping us to make a difference!

Sincerely,  
Debra S. Mechanic

**Kathy Sampognaro – email (10/26/2014)**

Dear Ms. Estremera,

Please fund the effort to open a Clubhouse in San Mateo County with MHSA dollars. We know we've achieved Step One by getting the social vocational program idea behind the Clubhouse model to the top of the Priority List.

Step Two is for Clubhouse to receive MHSA funding. We are writing to ask your help to make this a reality.

There is no program that does what Clubhouse can do. At the same time Clubhouse will partner collaboratively with our current programs, bringing further options and expanding hope. Clubhouse already has a location and active team. We are awaiting permanent staffing and work-ordered day.

Clubhouse, with over 330 Clubhouses worldwide, helps over 100,000 people a year living with mental illness lead productive lives. This July Clubhouse International won the Conrad N. Hilton Humanitarian Prize of \$1.5 million, the world's largest humanitarian prize.\*\*\*

Clubhouse is an important source of hope for me as my son had to drop out of college four years ago because of a serious mental illness. He's been in and out of hospitals ever since. Each time he leaves the psych unit, he's left to his own initiative to keep himself stabilized and in recovery mode.

While San Mateo provides critical support services, there's very little for him to do once released from the hospital. This predictably means he spirals downward, becomes isolated, and in some number of months, is back in the hospital. He is very aware of his illness and is trying so hard to recover. He needs a productive place to go during the day, where he can make friends and get the kind of support that keeps him afloat.

Please fund the effort to bring a Clubhouse to San Mateo County. It will help keep people like my son stay out of the hospital, out of a dark solitary bedroom, and into the light of friendship and support. This is something we desperately need in this county.

Best Regards,  
Kathy Sampognaro

**Ingrid Leslie Manzano – email (10/26/2014)**

Dear Ms. Estremera,

Please fund the effort to open a Clubhouse in San Mateo County with MHSA dollars. We know we've achieved Step One by getting the social vocational program idea behind the Clubhouse model to the top of the Priority List.

Step Two is for Clubhouse to receive MHSA funding. We are writing to ask your help to make this a reality.

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Clubhouse is an important source of hope for me as my son had to drop out of college four years ago because of a serious mental illness. He's been in and out of hospitals ever since. Each time he leaves the psych unit, he's left to his own initiative to keep himself stabilized and in recovery mode.

While San Mateo provides critical support services, there's very little for him to do once released from the hospital. This predictably means he spirals downward, becomes isolated, and in some number of months, is back in the hospital.

He is very aware of his illness and is trying so hard to recover. He needs <sup>L</sup><sub>SEP</sub> a productive place to go during the day, where he can make friends and get the kind of support <sup>L</sup><sub>SEP</sub> that keeps him afloat.

Please fund the effort to bring a Clubhouse to San Mateo County. It will help keep <sup>L</sup><sub>SEP</sub> people like my son stay out of the hospital, out of a dark solitary bedroom, and into the light of friendship and support. This is something we desperately need in this county.

Regards,  
Ingrid Leslie Manzano

**Maryclaire Sampognaro – email (10/27/2014)**

Dear Ms. Estremera,

Please fund the effort to open a Clubhouse in San Mateo County with MHSA dollars. We know we've achieved Step One by getting the social vocational program idea behind the Clubhouse model to the top of the Priority List.

Step Two is for Clubhouse to receive MHSA funding. We are writing to ask your help to make this a reality.

There is no program that does what Clubhouse can do. At the same time Clubhouse will partner collaboratively with our current programs, bringing further options and expanding hope. Clubhouse already has a location and active team. We are awaiting permanent staffing and work-ordered day.

Clubhouse, with over 330 Clubhouses worldwide, helps over 100,000 people a year living with mental illness lead productive lives. This July Clubhouse International won the Conrad N. Hilton Humanitarian Prize of \$1.5 million, the world's largest humanitarian prize.

I have a niece with mental illness who lives in San Mateo County and she needs this type of facility to give her support and purpose in her life.

Please fund the effort to bring a Clubhouse to San Mateo County to help keep people with mental illness out of the hospital and out of isolation, and into an atmosphere of friendship and support.

Thank you.

Yours truly,  
Maryclaire Sampognaro

**Molly Wantuch - email (10/27/2014)**

Dear Ms. Estremera,

I am asking for MHSA dollars to help fund the Clubhouse in San Mateo. I am excited for this program to go in place as it has a proven track record and with cutbacks in mental health, what would be more beneficial than a place for people who have come out of a hospital setting and to have an actual supportive environment that assists in people remaining stabilized, productive, free from isolation, and in a safe space to be themselves to get their confidence back on track.

So many people dealing with mental health remain isolated, which is the worst thing for them in order to recover and feel productive. It makes total sense to me that a program that has had a very successful track record and has won awards would not only benefit the individuals who attend, but also the family and friends and the community as a whole.

Mental health is being talked about more, but we have a long way to go. Wouldn't it be great to have a positive, safe environment where it can be discussed and community members can be involved and see at last that it is not something to hide, but something to embrace?

The sad part is many of these people are intelligent beings who have a lot to offer our community and if given the opportunity to grow, heal, and feel productive, may in fact create miraculous benefits for our community and in the mental health field.

Thank you for your consideration in helping to fund Clubhouse in our county. Let us step out and be the shining example of how it can be done, to support those with mental health issues, and to be an example of a community that accepts and embraces difference.

Thank you,  
Molly Wantuch

**Parveen Bourne, RN, MSN – email (10/27/2014)**

Dear Ms. Estremera,

I would like to strongly advocate my support for the Club House in San Mateo County. Please fund this much needed service with MHSA dollars. Being someone who works in the inpatient mental health setting and having spent my entire career with this population, I can assure you that such a program would provide a valuable service to the community. Many of our patients return to the inpatient settings because they do not have such programs to attend. Support systems are the primary reason a patient is able to successfully manage their symptoms and avoid being re-hospitalized. There are so few resources for our patients. Many of our patients have lost their support system because of their illness and desperately need to be connected to a support system. Many people come in and out of psychiatric hospitals because they have nowhere to go. The Club House has had international success and a proven track record. This service gives people a sense of purpose and belonging which is essential to their well being.

I look forward to being able to refer our patients to the Club House in the near future. Thank you so much for your support and consideration.

Sincerely,  
Parveen

**Deanna Rodenbeck – email (10/27/2014)**

Dear Ms. Estremera,

I am in complete agreement that San Mateo needs a Clubhouse.

I believe it will not only enrich the lives of the individuals with Mental Health issues, but also the lives of those involved in running the program.

We humans are meant to be social creatures, yet so often the stigma of Mental Health causes us to isolate ourselves from others and waste away. How sad to think of our family and friends, or even people we don't know in a room alone all day. Clubhouse is a place to belong, a safe community where people can come and share their lives, talents, interests and hobbies as well as learn from each other. We have an opportunity to make a difference here, I think we owe it to those who can't do it for themselves, to step up and make it happen.

Thank you for your time,  
Deanna Rodenbeck

**Nancy Compani – email (10/28/2014)**

Dear Ms. Estremera,

Please fund the effort to open a Clubhouse in San Mateo County with MHSA dollars. We know we've achieved Step One by getting the social vocational program idea behind the Clubhouse model to the top of the Priority List.

Step Two is for Clubhouse to receive MHSA funding. We are writing to ask your help to make this a reality.

There is no program that does what Clubhouse can do. At the same time Clubhouse will partner collaboratively with our current programs, bringing further options and expanding hope. Clubhouse already has a location and active team. We are awaiting permanent staffing and work-ordered day.

Clubhouse, with over 330 Clubhouses worldwide, helps over 100,000 people a year living with mental illness lead productive lives. This July Clubhouse International won the Conrad N. Hilton Humanitarian Prize of \$1.5 million, the world's largest humanitarian prize.\*\*\*

Clubhouse is an important source of hope for me as I have a dear friend whose daughter is in need for someplace to go where she can lead a productive live and find friends to be with. There are so many others that would also benefit from this.

Please help.

Thank you  
Nancy Compani

**Denise Grotle, RN – email (10/28/2014)**

Dear Ms. Estremera,

Please fund the effort to open a Clubhouse in San Mateo County with MHSA dollars. As a psychiatric nurse, I can assure you that Clubhouse is a much needed program in our community.

People with mental illness need encouragement and support to live successful lives. Funding a Clubhouse in San Mateo County can provide the support they need. Please give hope to those challenged with the struggles of living with mental illness.

Sincerely,  
Denise Grotle, RN

**Melinda Henning - email (10/28/2014)**

Dear Ms. Estremera,

I'm writing to encourage funding for California Clubhouse by MHSA funds.

In San Mateo County, California Clubhouse will fill a critical gap in mental health care. Right now, so many of our loved ones have no place to go where they can feel accepted and find the social support they need as a base as they figure out how to manage their lives.

My adult son is one who could have benefitted very much from a local clubhouse. He would have appreciated the "work-ordered day" at the clubhouse so he could feel (and be) productive, and he would have appreciated companionship with others who are living with similar challenges but who are not just sitting around smoking all day. Meaningful activities which bring self-respect, a sense of membership, opportunity to practice work and social skills - these are absolute essentials for wellness. Individual families alone cannot provide this for their loved ones, but Clubhouse will.

Clubhouse is a proven and sustainable model, shown in other communities for many years to bring hope, community, and meaningful activities to people living with mental health conditions. The team leading the California Clubhouse initiative is dedicated, determined, smart, and well informed through connection with the clubhouse in Concord and with the Clubhouse organization. Once California Clubhouse opens, I'm certain more community members will actively support it.

Funding California Clubhouse is an excellent and totally appropriate use of MHSA funds. I'm urging you to approve MHSA funding for California Clubhouse.

Sincerely,  
Melinda Henning

**William Persh- email (10/28/2014)**

Dear Ms. Estremera,

Please support the effort to provide a facility with MHSA funds where the mentally challenged can socially gather in San Mateo county. This will provide the chance for meeting and possibly making the lasting friendship that they need and desire.

Thank you for your consideration of this request in helping the mentally challenged in the community of San Mateo county.

William Persh

**Elizabeth Marstall – email (10/28/2014)**

Ms. Estremera,

Please fund the effort to open a Clubhouse in San Mateo County with MHSA dollars.

People with mental health issues are part of our daily news. The stories never end well and often share a common theme of a family member trying and trying to help the person who is mentally ill. Failure to help should not be a burden placed solely on the family. There needs to be a program for the mentally ill that extends beyond a hospital stay and the resources of family members and friends. The number of mentally ill is growing as the population grows and the environment we live in becomes more stressful. People with mental health problems can not continue to be ignored or passed off to family members to take care of them. Programs like the Clubhouse are needed to help them live happy productive lives and to not end up as incredibly sad news stories.

Sincerely,  
Elizabeth Marstall

**Jasmine Arapeles Dolar – email (10/30/2014)**

Dear Ms. Estremera,

I am reaching out to you today in hopes that the efforts to open a Clubhouse in San Mateo County can be assisted by MHSA funds.

Clubhouse, with over 330 Clubhouses worldwide, helps over 100,000 people a year living with mental illness lead productive lives. This July Clubhouse International won the Conrad N. Hilton Humanitarian Prize of \$1.5 million, the world's largest humanitarian prize.

Clubhouse would be an invaluable resource for my family that has been affected in multiple ways by mental illness. I have recently lost my older sister to suicide due to mental illness. I still have two younger sisters with mental illness that have been in and out of hospitals for many years. My hopes are that my family will never have to endure another suicide and I believe that Clubhouse could greatly help my younger sisters with establishing support and stability.

Please fund the effort to bring a Clubhouse to San Mateo County. It will help keep people like my sisters stay out of the hospital, out of a dark solitary bedroom, and into the light of

friendship and support. This is something we desperately need in this county.

Sincerely,  
Jasmine Arapeles Dolar

**Anne Tunnell – email (10/31/2014)**

Dear Ms. Estremera,

I am a mother of two children, now adults, raised in San Mateo County. Of their numerous friends from childhood, two have been stricken with schizophrenia. It is so sad to see how it has affected their lives and the lives of the families. Due to the ups and downs of their medication, these two have been unable to hold down steady jobs. It would be so wonderful for them to have a place to go to feel worthwhile and part of a community.

Please fund the effort to open a Clubhouse in San Mateo County with MHSA funds and make the Clubhouse a reality. It is something that young adults and their families in our county desperately need.

Sincerely,  
Anne Tunnell

**Evangelina (Lily) Arapeles – email (11/3/2014)**

Dear Ms. Doris Estremera,

I am writing this letter as a follow up to my request, along with multiple families and friends, to please, fund the effort to bring our own San Mateo Clubhouse. Clubhouse in Mateo is a much needed service for our people who are affected by mental health challenges/illness. Although we have services available for them through MHSA, Clubhouse has its unique role to play as a source of HOPE. I know for sure what HOPE can do for our mentally health challenged people.

Personally, my HOPE for the funding of Clubhouse in San Mateo is motivated by my own personal experiences. I have two adult children, Eva and Angeline, who are both battling mental illness who can benefit the services that Clubhouse in San Mateo can offer. Eva and Angeline have been in these struggles for 15 years. Eva got sick when she was 17 years old and Angeline had been sick two years earlier than Eva. They just had their birthday last October 15. Now they are 30 years old. They are identical twins with multiple diagnoses of mental illness. I look forward to the days that they could go and be members of Clubhouse in San Mateo. You see right now, both live in separate group homes, go to separate day programs and still looking for common places/ services to go to meet their needs that will be bridged by the clubhouse.

I have high HOPE, for Eva and Angeline, and our people in San Mateo and for all the people affected by mental health challenges/illness as long as we continue to provide services, support, compassion for them. Sadly to say, me, my husband, my other 3 children have already lost a member, my eldest daughter, KathyLee, from mental illness. I know the

struggle. I know the pain. I know the HOPE. let's bring Clubhouse in San Mateo.

Please, fund the effort to bring a Clubhouse to San Mateo County. Thank you for all the dedications and hard work that goes with all the work in MHSA.

Sincerely,  
Evangelina (Lily) Arapeles

*Answer: Thank you for taking the time to write and submit your support for the funding of California Clubhouse in San Mateo County.*

*The MHSA Three-Year Plan development and funding decisions involve various steps including a Community Program Planning process that involves a needs assessment, strategy development and plan development phase where stakeholders (consumers/clients, family members, service providers, community members and leaders) input is gathered. The MHSA Steering Committee members prioritize strategies to close the needs and gaps identified throughout the process and make recommendations for inclusion in the plan.*

*The MHSA Three-Year Plan is developed taking specific priorities identified through stakeholder input from previous years, new priorities identified through the current process, and the fiscal landscape and projections for the next three years. Any expansions or new programs prioritized are implemented as revenue becomes available and through a Request for Proposal process, a competitive bidding process.*

*The proposed Three Year Plan does include as a priority for funding a program that offers a place for adults with serious mental illness that supports their recovery by providing psycho-social services, vocational and other support services and skills development. BHRS will follow County policies related to program development and support. Sustainable funding for programs remains a priority for BHRS.*

*The priority recommendations from the MHSA Steering Committee for inclusion in the MHSA Three Year Plan can be found on our webpage, [www.smchealth.org/bhrs/mhsa](http://www.smchealth.org/bhrs/mhsa)*

### **Public Comment emails in support of MHSA funding for Chinese Outreach Worker Pilot**

#### **Saori Miyazaki – email (10/27/2014)**

Hello, My name is Saori Miyazaki and I would like to submit my comment on San Mateo county 3-year draft plan.

I am glad that there is Chinese Health Initiative and Sunny Choi, the Chinese Community Health Worker is there to help under serviced community with a huge stigma on mental health. I work at middle school in Daly City and I often encountered with the parents who didn't want their children to access on-campus counseling/therapy services since they felt that there is "nothing wrong with" their kids and mental health services are for those "crazy ones".

It was impossible for me to communicate with them without the language capacity to let them know that it is not about “being crazy” when people access therapy. I had several students in the past that want to see the therapist on a regular basis but they know for sure that their parents won’t sign the consent. We still lack Chinese speaking providers in North County (and there is not much resources up in North County), what Sunny Choi has been doing is much needed services for this particular population with a stigma. I hope the county will continue supporting the Chinese Health Initiative/Sunny and also expand this type of programs to other Asian and Pacific Islanders communities.

Thank you very much!!!  
Saori

**Philip – email (10/29/2014)**

To Whom It May Concern,

I would like for formally request continued Chinese outreach and engagement support in the San Mateo county. This service is much needed

Best Regards,  
Philip

**Mei-Hsia Tan – email (10/29/2014)**

To whom it may concern,

I am a volunteer with NAMI Santa Clara and would like to express my support for continued provision of mental health/substance abuse services to the local Chinese community. The availability of such services to those who are in need of them is a valuable asset. I have seen the relief and appreciation of family members seeking more information about the condition of their loved ones when I inform them of services provided by the Chinese Health Initiative of BHRS, San Mateo. I hope we can continue to provide them with access to timely and culturally-appropriate resources.

Many thanks,  
Mei-Hsia Tan

**Beauty by Nature – email (10/28/9/2014)**

To whom it may concern:

I am writing to express my support for continued Chinese and Asian outreach programs. The community needs more culturally and linguistically competent outreach workers to help overcome the barriers for this population to take advantage of mental health services.

If these fledging programs cease we will continue to see a lack of usage of those services until it's too late in the cycle.

It's great to see the pilot program and we should continue and expand on the success of that program.

Thank you for the opportunity to express my concern. I hope these valuable programs can be retained and expand.

Regards,  
B by N

**Russell C. Leong email (10/29/2014)**

Colleagues:

It is vital to continue Chinese support social services in the San Mateo County outreach area. I qualify my views as a professor at UCLA and now at Hunter College, New York. In both locales I also volunteered for Asian Pacific social work agencies that dealt with vulnerable and high risk populations because I believed that being an academic had to be coupled with hands-on knowledge and a community oriented work ethic.

Russell C. Leong 梁志英

**Loi Trinh - email (10/29/2014)**

Dear MHSA,

I would like for the Chinese outreach/engagement program to be continue because it has provided my family with wonderful help, and I know that they are also a big support for the Chinese community.

Sincerely,  
Loi Trinh

**Rick Leong - email (10/30/2014)**

Re: Chinese Outreach

I used the community service at the Central Park San Mateo location last week. Learning about new services and existing programs like Walgreens etc...was very helpful in one location.

Thank you for making this available to our community in many languages.  
Rick Leong

**Minnie M. Fok, PT - email (10/30/2014)**

Good morning,

The San Mateo County Chinese Community Outreach/engagement program is an invaluable link to the under served Chinese Community in our County. I have used the service in different capacities and with good outcome. The examples are as follows:

1. In our church run support group for care givers. A young man who stayed in his room for one year was finally able to come out and seek medical attention due to the help of the

community worker. The parents were extremely grateful and could not say enough about the merits of this program. The family has been encouraging people to use the service.  
2. In my role as a therapy case manager for CCS, I was able to refer the community worker - Sunny Choi's names to families who may need support.

I sincerely hope that this outreach program will continue to be available for families, since it generally takes a long time for Chinese families to trust outsiders to help their loved ones with behavioral health issues.

Sincerely,  
Minnie M Fok, PT  
Therapy Case Manager/ MTU PT  
San Mateo County CCS

### **Steve Sust – email (11/3/2014)**

The Chinese Health Initiative outreach pilot program briefly mentioned on page 26 under the Office of Diversity and Equity Programs is an **absolute must** for the residents of San Mateo County. With the recent spike in mental health problems leading to 5150 involuntary commitments among the youth of San Mateo county's schools, the need for more and more outreach resources to local teens and their parents is more important than ever. I would argue that these programs are vastly underfunded and that an ounce of outreach prevention is far far cheaper than the cost of psychiatric hospitalizations. You should be adding more funding/resources to this program if you are truly looking to save money in the long term.

Also, this word document is an incredibly antiquated way of soliciting feedback on the proposal and likely to decrease the likelihood of people leaving any feedback at all. Would it be possible to implement a website comment system or discussion forum in the future?

### **Mental Health Provider – comment form**

As president of San Mateo OCA, a chapter of the national OCA organization dedication to furthering the social, emotional, and economic well-being of Asian Americans, and as a mental health provider in San Mateo County, I applaud the creation of the pilot Chinese Outreach Worker, and urge that it continue. The Chinese population is often overlooked because it is seen as the “model minority,” tends to be quiet and not seek help, and attention is more frequently focused on those whose difficulties are more easily seen and heard.

This outreach worker has begun to establish himself in the Chinese Community and providing training in cultural sensitivity. He has also begun to build trust in the Chinese Community and is making his position and services known. During this process, he has

been receiving requests for his services and this is only growing. All this has happened during a very short period of time – only 3 months!

His position should grow with the needs it uncovers and I urge the continuation and even expansion of his services to this very underserved population.

As a mental health provider, it is difficult to find either Cantonese or Mandarin speaking mental health providers, as well as *appropriate and correct translations* of materials into Chinese. It is critical to provide this service, and the outreach worker can assist in this effort.

Please continue the Pilot Chinese Outreach Worker position and make it permanent; thank you.

*Answer: Thank you for your feedback regarding our Chinese Outreach Worker pilot project funded through the MHSA Prevention and Early Intervention component. Through the Chinese Outreach Worker, the Chinese Health Initiative (one of eight BHRS Health Equity Initiatives), and Stigma Free San Mateo County, we work to eliminate stigma and end discrimination against people with mental illness and substance use issues in San Mateo County, especially for our underserved and most vulnerable communities.*

### **San Mateo County Mental Health and Substance Abuse Recovery Commission (MHSARC) Meeting – Public Hearing/Close of Public Comment (11/5/14)**

**Carol Labarthe** - My beloved daughter, my only child, committed suicide. It's too late to help her but I'm here to support the Clubhouse because I don't want any other parent to have to go through what I went through.

**Juliana Feurbringer** - I am also here to support Clubhouse . I have a son who just left Cordilleras he is doing quite well, he's stable and now he is living in Daly City in a residential program but he has nothing to do all day so I am hoping that we can get this Clubhouse so that people like my son have a program that they can go to.

**Doug Warner** - I'm a volunteer at the California Clubhouse, I'm learning that there's work that's offered at the California Clubhouse there's options that your psychiatrist can get you into work in the community and get lunch for \$1.50 and it's a good opportunity to get you out of the house. You be there when you want to be, you be there as much or a little as you want to be. The Putnam Clubhouse up in Concord and it seems like a good program up there and it might be a good program down here in San Mateo.

**Diane Warner** - Doug is my wonderful son. I have been a NAMI member for 30 years and very active in bringing educational programs to the county (like family to family and peer to peer) and now I am really anxious to see the CA Clubhouse succeed. It's a wonderful model and it's been proven effective. It has a group that is initiating it that is very effective and professional. I have been working with some of these people and I'm very impressed with their ability to carry this through and make it a wonderful addition for our program.

**Lori Pastorelli** - I have a 33 year old daughter who was diagnosed with schizophrenia 12 years ago and there's a significant gap where there is not anything like the Clubhouse in san mateo county and I would definitely like to see one here.

**Ruth Parson** submitted the following letter to Jei Africa, Director, Office of Diversity and Equity, San Mateo County Behavioral Health and Recovery Services.

November 5, 2014

Dear Ms Estremera and Mental Health and Substance Abuse Recovery Commission,

We are here today because we represent a mental health program called California Clubhouse and are applying for Mental Health Services Act funding.

Clubhouse is a whole-life approach community, which has been the hub of service in mental health for 67 years in 330 cities around the world. Clubhouse is evidence-based and endorsed by SAMSHA, the World Health Organization, the United Nations, the World Innovation Summit on Health, and most recently received the Hilton Humanitarian Award.

Clubhouse Members (known as consumers in other venues) work as colleagues with peers and a small staff to achieve personal goals and to run the clubhouse. The community focus is applying each individual's talents and skills to achieve health, growth, and wellbeing.

Becoming a part of the clubhouse community is voluntary; membership is for life and free. Individuals will determine what work they participate in and what hours they chose to volunteer. The Clubhouse will be open during business hours five days a week. A social program will be offered some evenings and weekend days, every week of the year. Members will participate in every type and level of work the clubhouse has to offer, as outlined in the International Clubhouse Standards, which provide a "Bill of Rights" for members and a "Code of Conduct" for staff.

California Clubhouse currently has a location in San Mateo, just a block away from El Camino Real and 25<sup>th</sup> Avenue. We have an interim leadership team that is dedicated to fully opening a Clubhouse for San Mateo County and has many years experience in successful Clubhouse development and longevity. A mission of Clubhouse, is being a strong, reciprocal partner to the wide variety of proven and innovative programs that already exist and will be developed in San Mateo County.

California Clubhouse meets all five of the MHSA Principles:

- 1) focus on wellness, recovery and resilience
- 2) cultural and linguistic competency
- 3) consumer/client and family-driven services
- 4) integrated service experience
- 5) community collaboration

California Clubhouse is a group of families, potential members, service providers, and San Mateo County community members who appreciate a solution to the rising number of people with mental illness who need a community to belong to and a better chance at living a purposeful and fulfilling life. We each have a personal story that motivates us to move this project forward with a heartfelt tenacity. We have raised enough money from the community and foundations to begin the seed of a clubhouse, where those interested in learning more can come to ask questions, those interested in partnering can come to inform us, and to receive those who care to help us open a fully functioning Clubhouse. MHSA funding can be the catalyst to this hope and promise.

Thank you, Ruth Parson, California Clubhouse  
2205 Palm Avenue, San Mateo, CA 94403  
650-342-5849 info@californiaclubhouse.org



## **APPENDIX 6. WET Three-Year Plan Update**

### **MENTAL HEALTH SERVICES ACT (MHSA) WORKFORCE, EDUCATION, AND TRAINING THREE-YEAR PLAN UPDATE (FY 2014/2015 to 2016/2017)**

#### **Introduction**

This document serves as an update to the already established MHSA Workforce, Education, and Training (WET) Plan that was approved by the Mental Health Oversight and Accountability Commission (MHSOAC) and enacted in 2009. For this update the previous plan was reviewed, and outreach to multiple stakeholder groups across San Mateo County was conducted to verify that the directions and goals of the previous plan still align with the current training needs of our county and promote the fundamental concepts of the Mental Health Services Act. The core features of the previous plan will be continued for the 2014/15 to 2016/17 MHSA cycle with some minor changes based on the community stakeholder process that was completed.

#### **Stakeholder Participation Summary**

This WET Plan update was guided by a meaningful community stakeholder process, which included diverse groups of San Mateo County community members, clients/consumers and family members of behavioral health services, Behavioral Health and Recovery Services (BHRS) and contract agency staff (including peer and family positions), and Health Equity Initiatives. The input process consisted of 2 surveys, 14 meetings with specific stakeholder groups, and 2 community meetings that occurred between May 2014 and October 2014. Over 600 stakeholders participated in this input process. The chart below lists the forums by which information was collected. The data was analyzed in September and October 2014 in order to create this update.

<b>Date</b>	<b>Group</b>	<b>Type</b>
5/21/2014	Chinese Health Initiative	Health Equity Initiative
5/27/2014	Latino Collaborative	Health Equity Initiative
6/6/2014	Spirituality Initiative	Health Equity Initiative
6/25/2014	South County Youth Clinic Staff	BHRS Staff
07/16/2014	MHSA Community Meeting	Community Members
07/17/2014	Filipino Mental Health Initiative	Health Equity Initiative
07/25/2014	Workforce Development and Education Mtg.	BHRS/ Contract Agency Staff
07/29/2014	Pacifica Community Meeting	Community Members
08/01/2014	Diversity Equity Counsel Meeting	Health Equity Initiative
08/05/2014	Parent Project in Daly City	Clients/Consumers and Community Members
08/07/2014	Change Agent Meeting	BHRS/Contract Agency Staff and Lived Experience Advocates
08/18/2014	Client Walking Group at EPA Clinic	Clients/Consumers
08/26/2014	Family Partners	BHRS/Contract Agency Family Partner Staff and Supervisors
09/03/2014	Suicide Prevention Committee	BHRS/Contract Agency Staff and Lived Experience Advocates
09/2014	Staff Training Survey	BHRS and Contract Agency Staff
09/2014	Lived Experience Client/Consumer Survey	Clients/Consumers with Lived Experience
09/24/2014	NMT Provider Meeting	BHRS/ Contract Agency Staff
10/07/2014	Pacific Islander Initiative Meeting	Health Equity Initiative

## **Stakeholder Process Results Related To Training**

Following the guidelines of the previous WET Plan stakeholder process, a survey was administered to all BHRS and contract agency staff in all positions (i.e. clinical, administrative, managerial, peer positions, etc.) in September 2014; and 351 staff completed the survey. Also, 43 lived experience client/consumers and family members of behavioral health services completed a survey about what areas/topics they would like their providers to be trained in and what areas/topics they would like to receive skills training in. The data from these surveys, along with the input from the community and stakeholder meetings are being used to develop the staff training priorities for the next three years. As with the previous training plan, there are 4 major emphases of training—foundational knowledge, specific populations, core clinical competencies, and specific treatment practices.

### Foundational Knowledge

Foundational knowledge areas represent the practices and values of San Mateo County behavioral health programs that all employees, regardless of position, should know and understand. The following list represents the foundational knowledge areas that were emphasized in the stakeholder process.

1. Trauma-Informed Care (ability to address and understand the impact of trauma on individuals/systems)
2. Crisis Management and Safety
3. Co-Occurring-Informed Care (ability to address both mental health and substance abuse conditions)
4. Knowledge of BHRS and Partner Programs and Services (and how to access them)
5. Cultural Competence (including cultural humility and cultural responsiveness)
6. Partnering and Collaboration with other providers and systems
7. Support and Integration of Families in Treatment (including education and training of family members)
8. Integration of Primary Care and Behavioral Health
9. Self-Care
10. Wellness and Recovery
11. Welcoming and Engagement

### Specific Populations

The stakeholder groups and surveys identified specific populations and cultural groups for whom behavioral health staff are in need of more training to effectively treat and serve. These populations/groups include but are not limited to:

1. “At-risk” Youth and Transitional Age Youth
2. The LGBTQQI2S Community (with an emphasis on the transgender population)
3. Individuals with Co-Occurring Mental Health and Substance Abuse Conditions

4. The Latino/Hispanic Community
5. Immigrant Communities (with a focus on undocumented immigrants)
6. Individuals with Developmental Disabilities (with an emphasis on Pervasive Developmental Disabilities)
7. The African-American Community
8. Individuals in the Criminal Justice System
9. The Pacific Islander Community
10. The Aging and Older Adult Population
11. The Chinese Community

#### Core Clinical Skill Areas and Competencies

The stakeholder groups and surveys identified key areas of clinical competency that should be prioritized for staff training. These areas include:

1. Assessing and Treating Suicide Risk/Harm
2. Trauma-Informed Care
3. Working Effectively with Complicated Families
4. Assessment and Diagnosis of Mental Health and Substance Abuse Conditions
5. Assessing/Managing Assaultive Behavior
6. Crisis Management/Safety
7. Client-Centered Treatment Planning and Documentation
8. Cultural Competence, Humility, and Responsiveness (including incorporating clients'/consumers' spirituality into treatment)
9. Self-Care
10. Motivational Enhancement  
Professional Ethics  
Partnering and Collaboration
11. Clinical Case Management (related to benefits, housing, employment, school)

#### Specific Treatment Practices

The stakeholder processes identified a number of specific treatment practices and modalities to emphasize in our clinical care of clients/consumers. This list of Evidenced-Based Practices and promising theoretical approaches will be used to promote the wellness and recovery of clients/consumers.

1. Trauma-focused Cognitive Behavior Therapy (TF-CBT)
2. Dialectical Behavior Therapy (DBT)/DBT informed services
3. Seeking Safety
4. Mindfulness Based Interventions
5. CBT for Psychosis (CBTp)
6. Relapse Prevention Therapy
7. Motivational Interviewing
8. Cultural Humility
9. Brief Family Therapy models
10. NeuroSequential Model of Therapeutics (NMT)

### Information about Administrative Staff/Managers

Administrative staff who participated in the survey included front office, reception, fiscal/billing, support, contracts, quality management, and information technology staff. Clinical program managers, health program managers, executive directors, and other senior-level administrators made up the managerial group who participated in survey. The sections of the training survey completed by both of these sets of staff reflected many of the foundational knowledge areas identified above. Administrative staff also emphasized training on:

1. How to respond to a behavioral health crisis
2. Self-care
3. Communication skills with clients and other staff
4. Managing crisis phone calls
5. De-escalation of conflict
6. Asking difficult questions (i.e. sexual orientation, gender identity, race, age)

Managerial staff emphasized:

1. Legal and ethical issues for supervisors
2. Increasing staff motivation and engagement in the change process
3. Evaluation of staff's clinical competence
4. Providing effective feedback
5. Continuous quality improvement
6. Self-care

### Summary of Top Training Priorities

From reviewing the above categories and noting overlapping and repeated themes, 7 major areas of training have been identified as the foci for training for the next 3 years. They are:

1. Trauma-Informed Care
2. Cultural Competence and Humility
3. Crisis Management and Safety
  - Assessing and treating suicide risk and harm
  - Assessing and managing assaultive behavior
4. Self-Care
5. Co-Occurring-Informed Care
6. Support and Integration of Families in Treatment
7. Partnering and Collaboration with Other Providers and Systems

Most BHRS implemented trainings will focus on these subject areas to ensure that BHRS and contract staff are effective in providing services to our San Mateo clients/consumers and their families. Also, trainings that are required for maintaining licensure will continue to be provided (i.e. Law and Ethics, Supervision, etc.) on a yearly basis.

### Accessibility and Sustainability of Trainings

Ensuring accessibility and sustainability was another significant theme of the WET stakeholder process. Stakeholders recommended that trainings be held in different regions of the county rather than being focused primarily in the center of the county

to improve accessibility. They also highlighted the need for effective outreach to community partners to inform them about what trainings are available. Also, the survey results showed that half-day trainings that start in the morning are the preferred structure and length of trainings. In terms of sustainability, stakeholders requested that certain foundational trainings be presented in frequent rotation (i.e. trauma 101, self-care, etc.), and they also recommended creating webinars of trainings, as a way to continue to disseminate information after an in-person training has concluded. We will work to implement these accessibility and sustainability strategies over the next 3 years.

### Evaluation and Outcome

During the next 3 years of this training plan, special emphasis will be placed on evaluation and outcomes of the trainings. We will explore ways to effectively measure training outcomes through consultation and research. Participants will complete an evaluation at the end of the training event in which they participate. They will also be administered a survey 3 months later to find out if and how they are integrating what they have learned into their work and to identify potential obstacles to integration. This data will be used to make trainings lead to substantive change in work practice.

### **Stakeholder Process Results Related To Workforce Development**

The following workforce development issues and objectives were highlighted during the stakeholder process. These were the same general areas of workforce development need that were identified in the stakeholder process for the original 2009 plan.

1. Develop and expand career pathways and empowering activities for clients/consumers (including youth).
2. Better integrate peer support/lived experience positions (i.e. Family Partners and Community Workers) into behavioral health programs. Provide specific training and support for lived experience staff to enhance skill and promote career development.
3. Increase the cultural competence of the behavioral health workforce with emphases on training and hiring more bilingual and bicultural staff/providers who reflect the racial/ethnic communities of San Mateo County and represent special populations in San Mateo County (i.e. LGBTQQI2S, individuals with disabilities, etc.).
4. Create behavioral health pathways for youth to help foster their interest in behavioral health careers. Specifically, conduct outreach to students who reflect the diversity of San Mateo County communities who are under-served or inappropriately served by behavioral health services currently.

### **Incorporation of Stakeholder Process in 3-Year Training Plan Update**

In keeping with the MHSa guidelines, this WET Plan update addresses the following areas: 1) Workforce Staffing and Support, 2) Training and Technical Assistance, 3) Mental Health Career Pathways Programs, and 4) Financial Incentive Programs.

This section will outline our plans for the next 3 years in each of these domains and will also review what was done in each area in fiscal year 2013-2014.

### **Workforce Staffing and Support**

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

The WET Coordinator performs the following duties:

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

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

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

### **Training and Technical Assistance**

This section addresses the following MHSA WET training guidelines: 1) Targeted Training for and by Consumers and Family Members, 2) Trainings to Support

Wellness and Recovery, 3) Cultural Competence Training, and 4) Evidenced-Based Practices Training for System Transformation.

### Targeted Training for and By Consumers and Family Members

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

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

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

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

#### *CBT for Psychosis (CBTp) Project with Stanford University*

In the fiscal year, 2013-2014, BHRS worked with Stanford University to provide a training for family members on CBTp. It was a well-attended and highly valued training. Approximately 60 family members attended and reported that the information and skills learned would help them support clients/consumers and family members with psychosis. Because of this training's success, BHRS is again working in partnership with Stanford University to apply for a grant that focuses on training family members in the CBTp treatment model. If we are awarded the grant,

a large-scale training will be conducted by Dr. Kate Hardy for family members of individuals with psychosis. This training will be followed by a train-the-trainer program for identified family partners who will develop the skills to continue to train San Mateo County family members in the CBTp model. An advisory board of family partners will help create, develop, and implement the program.

### Training to Support Wellness and Recovery

#### *Wellness Recovery Action Planning (WRAP) with Inspired At Work*

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

### Cultural Competence Training

#### *Cultural Humility*

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

#### *Working Effectively with Interpreters in a Behavioral Health Setting*

This mandatory training aims to enhance the cultural competency and humility of BHRS staff as well as to help providers learn to effectively communicate with clients when they don't speak the client's language. The training was conducted once in 2013-2014, but will be conducted twice each year for the next 3 years of the MHSA WET training plan. This training is typically well attended, highly regarded, and is known to improve staff competence and knowledge on the appropriate use of

interpreters. In 2013-2014, 52 people attended. The average pre-test score was 58% correct and the average post-test score was 80% correct; hence, the average increased by 22% from pre to post training.

### *Spirituality 101*

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

### *Cultural Competence Trainings Addressing Specific Populations*

Over the next 3 years of the WET training plan, trainings addressing the issues, needs, and strengths of particular cultural groups (as identified by the community stakeholder process) will be developed and implemented. Some of the cultural groups/populations that will be addressed with these trainings include but are not limited to the LGBTQI2S community, undocumented immigrants, and the Chinese community in San Mateo County.

### Evidenced-Based Practices Trainings for System Transformation

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

Over the next 3 years of the MHSA WET Training Plan, we will continue to provide the above evidenced-based and promising practices trainings as they all reflect the 7 priority areas of training identified from the stakeholder process. We will also continue to train BHRS and contract agency staff on DBT-informed care and Seeking Safety as those are evidenced based practices that reflect our priorities of trauma-informed and co-occurring informed care. We will also research other evidenced based practices that reflect the 7 priority areas such as Trauma-Focused CBT and Brief Family Therapy and provide trainings on these treatment modalities based on approval from our BHRS Evidenced-Based Practice Committee and budget capacity. The Evidenced-Based Practice Committee is a diverse and multidisciplinary group of staff that reviews proposals from clinicians who want to implement a particular evidenced-based, promising, or community-defined treatment modality to ensure parity and cultural humility in deciding what treatment practices BHRS endorses.

## **Behavioral Health Career Pathways Programs**

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

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

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

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

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

Another BHRS WET effort to address hard-to-fill positions and increase staff diversity is participation in the Behavioral Health and Human Resources Forums put

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

### Goal 3: Promote the Behavioral Health Field

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

#### *Intern/Trainee Program*

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

#### *Behavioral Health Career Pathways Program*

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

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

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

Goal 4: Career Pathways and Ongoing Development for Clients and Family Members  
*Lived Experience Education Workgroup/Lived Experience Academy*

As stated above in the Training and Technical Assistance section of this document the LEEW/LEA programs will be enhanced to expand the skills of and provide more opportunities for clients/consumers and family members to present/teach at trainings as well as develop advocacy skills for participation on committees and commissions.

*Support for Lived Experience Workforce*

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

*Lived Experience Scholarship*

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

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

The application process is ongoing. This scholarship can be used to help students purchase computers and books and/or pay for tuition fees. This scholarship program was not funded in 2013-2014, but it will be reinstated in 2014-2015 and will continue through 2016-2017.

Also, other possible avenues for work and civic responsibility for lived experience clients and consumers will be explored during the course of this 3-year plan update. Possible plans include creating a pathway for BHRS clients to become In Home Support Service (with Aging and Adult Services) workers for other BHRS clients, and/or a BHRS intern program for lived experience individuals who are pursuing their peer specialist certification at community college.

## **Financial Incentive Programs**

### Cultural Competency Stipend Intern Program

The Cultural Competency Stipend Intern Program (CCSIP) aims to support behavioral health graduate students (i.e. social workers, marriage and family therapists, psychologists, alcohol and other drug counselors, etc.) who are completing their internships in BHRS clinics/programs. \$5,000 stipends are given to students who can contribute to the cultural competence/responsiveness of BHRS through linguistic capability, cultural identity and experience, and/or identification with or experience working with and advocating for special populations represented in San Mateo County (i.e. LGBTQQI2S, individuals living with disabilities, etc.) All students who receive a stipend participate in one of the county Health Equity Initiatives by attending the monthly initiative meetings and helping organize events and activities. They also conduct a cultural competence project during the year that is aimed at improving the cultural responsiveness of our services and educating our staff. In 2013-2014, 19 behavioral health interns and 1 Office of Diversity and Equity intern were awarded the stipend. 20 stipends will continue to be awarded each year for the next 3 years of the WET Plan update.

## **Other Projects to Enhance Workforce Retention and Development**

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

### BHRS New-Hire Orientation

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

### BHRS College

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

### Mentoring

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

learn what aspects of the last program worked and what adjustments need to be made to create a sustainable mentoring program.

## APPENDIX 7. FSP Evaluation Executive Summary



San Mateo County Health System  
Behavioral Health and Recovery Services Division

# Full Service Partnerships

## Final Evaluation Report: Executive Summary

July 2014 (revised 7.25.14)

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# Executive Summary

## History: Full Service Partnerships (FSPs)

In 2004, the Mental Health Services Act (MHSA) (Proposition 63) was approved by California voters and enacted in January 2005 as an avenue to comprehensively reform California's mental health treatment system. Under MHSA, Community Services and Supports (CSS) was created as one of five program components offering three different types of funding streams: **1)** Full Service Partnerships (FSP); **2)** General System Development Funds; and **3)** Outreach and Engagement Funds. At least 51% of CSS funding is required to be allocated for FSPs, which are designed to meet the specific needs of un-served or underserved children, transitional age youth (TAY), adults, older adults, and their families through an expanded range of services and supports within a recovery framework (Gilmer, 2010; Brown, 2010; CA-DMH, 2009).

California's FSP model was developed following the pilot of various recovery-oriented programs, including Assembly Bill 2034 (AB2034), with a modified version of the Wraparound Model implemented for child/youth/TAY consumers and Assertive Community Treatment (ACT) services for adults and older adult consumers. Both models seek to provide individualized integrated services, flexible funding, intensive case management, and 24-hour access to care.

## San Mateo County FSP Programs

Within San Mateo County, the initial FSP programs (Edgewood, Fred Finch, and Telecare) have been fully operational since 2006. A fourth site (Caminar's Adult FSP) was added in 2009. According to San Mateo County's Behavioral Health and Recovery Services Division (BHRS), approximately 250 adults and 90 children, youth, TAY, and their families utilize FSP services through four service providers. Edgewood and Fred Finch use the Wraparound model to serve children, youth, TAY, and their families, while Caminar and Telecare offer Assertive Community Treatment (ACT) services to adults, older adults, and their families.

**Edgewood** is the contracted provider for child/youth FSP services within San Mateo County, running the *ISIS* program. The program targets seriously emotionally disturbed children/youth



who are at-risk of being moved to a higher level of care (including residential placement, incarceration or hospitalization) and their families. The Wraparound model is used to emphasize the strengths of consumers and their families and to actively engage them in the treatment planning process. An afterschool intensive services component was added in 2010.

Edgewood's Turning Point program targets transitional-aged youth between 16 and 25 years of age who have serious emotional disorders and/or serious mental illnesses and are at-risk of being moved to a higher level of care. Besides using a Wraparound model to work with TAY consumers and their families, Turning Point also utilizes a Drop-in Center located in the community to engage with and provide services to TAY.

**Fred Finch** is the contracted provider for serving San Mateo children, youth, and TAY placed in temporary out-of-county placements within a 90-mile radius of the Center's Oakland location. Wraparound services are provided to youth between 6 and 17 years of age, as well as supportive services for older adolescents transitioning out of care.

**Telecare** is the contracted provider for providing FSP services to severely mentally ill adults, older adults, and medically fragile consumers and their families. This program uses an Assertive Community Treatment (ACT) approach to provide services to consumers and their families within the community. Additionally, Telecare also operates housing for adult FSP consumers.

In 2009, **Caminar** was added as a fourth FSP site for providing comprehensive FSP and housing support services to adults, older adults and medically fragile consumers and their families. Caminar's R.E.A.C.H (Recovery, Empowerment, and Community Housing) FSP program provides intensive case management services.

**Table 1. SMC FSP Providers and Contracted Consumer Slots**

FSP program	Contracted Consumer slots
<b>Edgewood ISIS (In-County children/youth)</b>	40
<b>Edgewood Turning Point (In-County TAY)</b>	40
<b>Fred Finch (Out-of-county TAY)</b>	20
<b>Telecare (In-County Adult/Older Adult)</b>	198
<b>Caminar (In-County Adult/Older Adult)</b>	30



## Summary of Evaluation Findings

In May 2013, Davis Y. Ja and Associates, Inc. (DYJA) was subcontracted by BHRS to implement a one-year qualitative evaluation of the child/youth/TAY and adult FSP programs. The evaluation was comprised of the following 5 phases:

- 1) Planning (BHRS convened planning committee, consumer evaluation panel, document and literature review)
- 2) Interviews/Focus Groups with FSP Systems-Level Administrators (including BHRS)
- 3) Interviews/Focus Groups with FSP Service Providers (Administrators/Staff) (including two housing site visits)
- 4) Interviews/Focus Group with Consumers and Caregivers
- 5) Data Analysis/Reporting

The following brief summary highlights some of the common themes that emerged during this qualitative evaluation. It is important to note, though, that these findings only reflect the four FSP programs as a snapshot in time. Due to time, resource, and budget limitations, it was not feasible for us to interview all stakeholders nor capture every nuance and context associated with four very different FSP programs serving complex, diverse, and challenging populations in two BHRS systems.

### **Perceptions of FSP services**

Overall, Edgewood and Fred Finch reported a high level of satisfaction with the Wraparound model for serving FSP child/youth. A strength-based approach, individualized treatment planning, flexibility, team-based approach were cited as advantages of the Wraparound model, particularly in contrast to other treatment modalities.

However, a peer-driven and recovery-oriented model may be more appropriate for TAY populations. TAY consumers also found individual DBT to be the most helpful service provided by the FSPs, while caregivers cited Edgewood's auxiliary family support (including family partners) and focus on the family as a whole unit as invaluable to the family and consumer's success. Challenges specific to implementing the Wraparound model with TAY include family participation and wide gradations in the developmental level of TAY served.



Similarly, Telecare and Caminar also positively perceived the current model of providing FSP services to adults/older adults using an ACT framework. The emphasis on teamwork, creativity, and unity while offering consumers flexibility were cited as advantages of the model. Adult FSP consumers identified support groups, classes, transportation access, and health care access to be the most helpful aspects of FSP services.

### **Funding/Fiscal Issues**

Throughout the FSP system, all four providers reported struggling with funding levels, which have led to challenges with staffing consistency and providing an ideal spectrum of services. However, BHRS was unable to extend a Cost-of-Living Adjustment (COLA) to any provider between FY 2007 and 2013 due to the local recession and reduced availability of funds. A 3% increase is being offered during FY 2014.

### **Capacity Challenges/Referrals**

Universally, all four providers agreed that capacity was an issue due to greater community demand than available slots. Child/youth providers and caregivers also felt that certain populations could benefit from earlier identification and referral to FSP services, especially those with Autism Spectrum Disorder and developmental delays. Competing stakeholder priorities was another highlighted challenge (including length of treatment). Child/youth providers experienced difficulty in meeting the expectations of referral sources while adhering to fidelity of the Wraparound model and family priorities.

### **Service Delivery/Linkages**

Service gaps between the Child/Youth/TAY and Adult systems, as well as between all FSP programs and community resources, were especially highlighted by consumers, families, and the child/youth/TAY providers. There are not enough linkages between the two BHRS FSP systems as consumers needing adult FSP services transition out of the TAY system. Insufficient community resources/linkages/support exist for consumers leaving FSP services, whether due to step-down or program discharge. Multiple caregivers of former TAY FSP consumers also expressed feeling that their family member was either prematurely discharged or there was a lack of clarity and communication around the termination reason.

The lack of a systemic approach and resources for monitoring potential consumer decompensation in the community was a substantial concern of caregivers with a consumer either residing in the community (TAY/adult) or discharged/graduated from FSP services.



Integrated substance abuse treatment services was also cited as a critical missing component of child/youth/TAY FSP services, along with additional resources to meet the unique needs of juvenile-justice involved youth and those with psychotic disorders.

Edgewood also discussed the challenges of engaging TAY at its Drop-in Center following changes in the legal mandate to provide services separately for TAY minors and those over 18 years of age, along with new reporting requirements to caregivers. Currently, MHSA's definition for TAY is 16-24 years of age. Staff and administrators emphasized the importance of using the Drop-in Center for outreach and treatment services, with many feeling that a negotiated solution was essential to the program's success.

Among the adult FSPs, providers have noticed an increasing level of acuity among medically fragile consumers and those with severe substance abuse and co-occurring disorders. Expanding resources for integrated medical care capacity was one solution offered by Caminar administrators. However, a dearth of integrated treatment options still exists for consumers with dependency issues.

Caregivers were also concerned about the high level of staff turnover within the adult FSPs and its impact on consumers' therapeutic relationship.

### **Caregiver/Family Involvement**

A basic orientation to the FSP program and services (by either the provider or BHRS) was a common request mentioned by both child/youth/TAY and adult caregivers and family members. Many families new to FSP services reported being overwhelmed at program entry, not fully understanding the FSP program, or feeling that they needed to navigate "the system" on their own.

Additionally, within the adult FSP system, engagement of family members and caregivers remains challenging for both providers. By the time adult consumers arrive at a FSP, most are already "divorced from their families." Among adult caregivers who are involved, a lack of clarity and consistency seems to exist within the adult FSP system. For example, "whatever it takes" often means different things to different stakeholders and lacks any specific standard definition across the system. Consistent and regular communication from providers was also another challenge mentioned by caregivers, including staff not returning/answering calls or showing up to scheduled meetings. Despite these concerns though, caregivers overall described positive



outcomes from past collaborations with providers and expressed a desire for continued collaborations with treatment teams.

## Housing

Availability of safe, accessible, appropriate, and affordable housing for TAY and adult FSP consumers was a consistent concern universally raised by providers, consumers, and their families. Caregivers also identified on-site housing and life skills support services to be critical for monitoring consumer decompensation in the community. Many expressed concern regarding the lack of clarity around whether supportive services are supposed to be available on-site and if they are, what they actually entail.

## Summary

In conclusion, this report is intended to provide a snapshot-in-time of the four FSP programs currently contracted by BHRS to serve severely mentally ill children, youth, TAY, adults, and older adults in San Mateo County. As such, the findings presented here need to be interpreted within that context, for it was not feasible to capture every nuance nor talk with every stakeholder affiliated with the FSPs within the allocated timeframe and scope of work of the evaluation.

Overall, the sense from providers, administrators, consumers and caregivers is that while challenges exist in serving the complex populations targeted by the FSPs, the programs are generally perceived to have a positive impact on the lives of those served. BHRS' award of a COLA for FY 2014 will help address some of the funding concerns. The main challenges, as identified by those interviewed, surround:

- reviewing current referral criteria for child/youth/TAY (BHRS/providers)
- addressing the service gaps (between TAY and adult FSP systems, community supports)
- exploring options for a more integrated model of dependency treatment and medical care, especially for TAY, medically fragile, and older adults
- needs assessment for specific youth populations, especially those with justice involvement, co-occurring, and psychotic disorders
- provider or BHRS-initiated orientation for new families entering FSP services



- identification of safe, accessible, appropriate, and affordable housing options for TAY and adult consumers
- clarification of whether supportive services are available at housing sites; if not, develop plan for monitoring consumer progress/decompensation

Study limitations include being unable to convene focus groups/interviews with specific sub-populations (older adults, child/youth consumers, out-of-county families/youth, and medically fragile adults), as well systems-wide stakeholders peripherally involved with the FSP program. Recruiting family members and caregivers of adult consumers to participate in this study was especially challenging. Despite working closely with the adult FSP providers and BHRS, we were unable to successfully recruit a culturally diverse and representative sample.



## Appendix A: Bibliography

- Bremer, R. W., Scholle, S. H., Keyser, D., Knox Houtsinger, J. V., & Pincus, H. A. (2008). Pay for Performance in Behavioral Health. *Psychiatric Services*, 59(12): 1419-1429. doi:10.1176/appo.ps.59.12.1419.
- Brown, T. T., Chung, J., Choi, S., Scheffler, R., Adams, N. (2012). The impact of California's full-service partnership program on mental health-related emergency department visits. *Psychiatric Services*. doi: 10.1176/appi.ps.201100384
- Bruns, E. J., Sather, A., Pullmann, M. D., & Stambaugh, L. F. (2011). National trends in implementing wraparound: Results from the state wraparound survey. *Journal of Child and Family Studies*, 20(6), 726-735.
- Bruns, E. J., Suter, J. C., Force, M. M., & Burchard, J. D. (2005). Adherence to wraparound principles and association with outcomes. *Journal of Child and Family Studies*, 14(4), 521-534.
- Burns, B. J., Schoenwald, S. K., Burchard, J. D., Faw, L., & Santos, A. B. (2000). Comprehensive community-based interventions for youth with severe emotional disorders: Multisystemic therapy and the wraparound process. *Journal of Child and Family Studies*, 9(3), 283-314.
- Burchard, J. D., Bruns, E. J., & Burchard, S. N. (2002). The wraparound approach. *Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders*, 2, 69-90.
- California Department of Mental Health. (2009). *Clarification on Requirements for Full Service Partnerships (FSP) under the Mental Health Services Act (MHSA)*. Retrieved from [http://www.dhcs.ca.gov/services/MH/Documents/FSP\\_FAQs\\_04-17-09.pdf](http://www.dhcs.ca.gov/services/MH/Documents/FSP_FAQs_04-17-09.pdf).
- Chen, Fang-Pei. (2008). Working with Families in Assertive Community Treatment (ACT) The Case Manager's Perspective. *American Journal of Orthopsychiatry*, 78(4): 456-465.
- Dale Jarvis & Associates (2012). "Public Behavioral Healthcare Payment Reform Principles" (Draft). Retrieved from <http://www.djconsult.net/resources-1/case-rate-info>



- Doran, T., Fullwood, C., Gravelle, H., Reeves, D., Kontopantelis, E., Hiroeh, U., & Roland, M. (2006). Pay-for-performance programs in family practices in the United Kingdom. *New England Journal of Medicine*, 355(4), 375-384.
- Druss, B. G., & Mauer, B. J. (2010). Health Care Reform and Care at the Behavioral Health – Primary Care Interface. *Psychiatric Services*, 61(11): 1087-1092. doi: 10.1176/appi.ps.61.11.1087.
- Druss B., & von Esenwein, S. (2006). Improving primary medical care for persons with mental and addictive disorders: systematic review. *General Hospital Psychiatry* 28:145—153
- Dudley, R. A., Frolich, A., Robinowitz, D. L., Talavera, J. A., Broadhead, P., & Luft, H. S. (2004). Strategies to Support Quality-Based Purchasing: A Review of the Evidence. Rockville, MD: Agency for Healthcare Research and Quality; 2004. Technical review.
- Felton, M., Cashin, C., Brown, T. (2010). What does it take? California County funding requests for recovery-oriented full service partnerships under Mental. Health Services Act. *Community Mental. Health Journal.*, 46, 441–451. DOI 10.1007/s10597-010-9304-6.
- Ferguson, C. M. (2012). The implementation of wraparound in California's Title IV-E child welfare waiver demonstration project. *Children and Youth Services Review*, 34(7), 1331-1336.
- Friedberg, M. W. & Damberg, C. L. (2012). A Five-Point Checklist to Help Performance Reports Incentivize Improvement and Effectively Guide Patients. *Health Affairs*, 31(3): 612-618.
- Friedberg, M. W., Damberg, C. L., McGlynn, E. A., & Adams, J. L. (2011). *Methodological Considerations in Generating Provider Performance Scores for Use in Public Reporting: A Guide for Community Quality Collaboratives* (White Paper). Agency for Health Research and Quality, No. 11-0093: 107. Retrieved from <http://www.ahrq.gov/legacy/qual/value/perfscoresmethods/perfscoresmethods.pdf>
- Garland, A. F., Haine-Schlagel, R., Brookman-Frazee, L., Baker-Ericzen, M., Trask, E., & Fawley-King, K. (2013). Improving community-based mental health care for children: Translating knowledge into action. *Administration and Policy in Mental Health and Mental Health Services Research*, 40(1), 6-22.



- Gilmer, T. P., Stefanic, A., Ettner, S., Manning, W. G., Tsemberis, S. (2010). Effect of full-service partnerships on homelessness, use and costs of mental health services, and quality of life among adults with serious mental illness. *Archives of General Psychiatry*, VOL 67 (NO. 6).
- Gilmer, T.P., Ojeda, V.D., Hiller, S., Stefanic, A., Tsemberis, S, Palinkas, L.A. (2013). Variations in Full Service Partnerships and Fidelity to the Housing First Model. *American Journal of Psychiatric Rehabilitation*, 16: 313-328.
- “Health Policy Brief: Pay-for-Performance,” *Health Affairs*, October 11, 2012
- Holden, E. W., Friedman, R. M., & Santiago, R. L. (2001). Overview of the national evaluation of the comprehensive community mental health services for children and their families program. *Journal of Emotional and Behavioral Disorders*, 9(1), 4-12.
- Jarvis, D. (2009). Healthcare Payment Reform and the Behavioral Health Safety Net: What’s on the Horizon for the Community Behavioral Health System. *National Council for Community Behavioral Healthcare*. Retrieved from <http://www.djconsult.net/resources-1/case-rate-info>
- Kirsh, B. & Cockburn, L. (2007). Employment Outcomes Associated with ACT: A Review of ACT Literature. *American Journal of Psychiatric Rehabilitation*, 10: 31-51.
- Kreindler, S. & Shalom, C. (2010). Housing Histories of Assertive Community Treatment Clients: Program Impacts and Factors Associated With Residential Stability. *Canadian Journal of Psychiatry*, 55(3): 150-156.
- Manteuffel, B., Stephens, R. L., & Santiago, R. (2002). Overview of the national evaluation of the comprehensive community mental health services for children and their families program and summary of current findings. *Children’s Services: Social Policy, Research, and Practice*, 5(1), 3-20.
- Mehrotra, A., Damberg, C. L., Sorbero, M. E., & Teleki, S. S. (2009). Pay for performance in the hospital setting: what is the state of the evidence? *American Journal of Medical Quality*, 24(1), 19-28
- Mehrotra, A., Sorbero, M. E., & Damberg, C. L. (2010). Using the Lessons of Behavioral Economics to Design More Effective Pay-for Performance Programs. *The American Journal of Managed Care*, 16(7): 497-503.



Morrissey, J., Meyer, P., & Cuddeback, G. (2007). Extending Assertive Community Treatment to Criminal Justice Settings: Origins, Current Evidence, and Future Directions. *Community Mental Health Journal*, 43(5): 527-544.

National Alliance on Mental Illness. Fact Sheet: Assertive Community Treatment: Investment Yield Outcomes. Retrieved from: [http://www.nami.org/Template.cfm?Section=ACT-TA\\_Center&template=/ContentManagement/ContentDisplay.cfm&ContentID=52382](http://www.nami.org/Template.cfm?Section=ACT-TA_Center&template=/ContentManagement/ContentDisplay.cfm&ContentID=52382)

National Alliance on Mental Illness. Treatment and Services: Continuum Model Housing Options. Retrieved from: [http://www.nami.org/Template.cfm?Section=About\\_Treatments\\_and\\_Supports&Template=/ContentManagement/ContentDisplay.cfm&ContentID=144020](http://www.nami.org/Template.cfm?Section=About_Treatments_and_Supports&Template=/ContentManagement/ContentDisplay.cfm&ContentID=144020)

Nelson, G., Aubry, T., & Lafrance, A. (2007). A Review on the Literature on the Effectiveness of Housing and Support, Assertive Community Treatment, and Intensive Case Management Interventions for Persons with Mental Illness Who Have Been Homeless. *American Journal of Orthopsychiatry*, 77(3): 350-361.

Petersen, L. A., Woodard, L. D., Urech, T., Daw, C., & Sookanan, S. (2006). Does pay-for-performance improve the quality of health care? *Annals of internal medicine*, 145(4), 265-272.

Pratt, S. I., Van Citters, A.D., Mueser, K.T., Bartels, S.J. (2008). Psychosocial Rehabilitation in Older Adults with Serious Mental Illness: A Review of the Research Literature and Recommendations for Development of Rehabilitative Approaches. *American Journal of Psychiatric Rehabilitation*, 11: 7-40.

RAND (2010). Health Care Pay for Performance. *RAND Corporation*.

Ryan, A., & Blustein, J. (2012). Making the best of hospital pay for performance. *New England Journal of Medicine*, 366(17): 1557-1559.

Ryan, A. M. & Damberg, C. L. (2013) What Can the Past of Pay-for-Performance Tell Us About the Future of Value-Based Purchasing in Medicare? *Healthcare*, 1: 42-49.

Salyers, M., Tsemberis, S. (2007). ACT and recovery: Integrating evidence-based practice and recovery orientation on Assertive Community Treatment teams. *Community Mental Health Journal*, 46, 619-641. DOI: 10.1007/s10597-007-9088-5



- Schneider, E. C., Hussey, P. S., & Schnyer, C. (2011). Payment Reform: Analysis of Models and Performance Measurement Implications. *RAND Technical Report*. Retrieved from [http://www.rand.org/pubs/technical\\_reports/TR841.html](http://www.rand.org/pubs/technical_reports/TR841.html)
- Stambaugh LF, Mustillo SA, Stephens RL, Baxter B, Edwards D, & Dekraai M. (2007). Outcomes from wraparound and multisystemic therapy in a center for mental health services system-of-care demonstration site. *Journal of Emotional and Behavioral Disorders*. 15(3):143–155.
- Strobbe, J., Wierdsman, A., Kroon, A., Rossenchron, B., Depla, M., Mulder, C. (2014). The effectiveness of assertive community treatment for elderly patients with severe mental illness: a randomized controlled trial. *BMC Psychiatry*, 14 (1) :42.
- Suter, J. C., & Bruns, E. J. (2009). Effectiveness of the wraparound process for children with emotional and behavioral disorders: A meta-analysis. *Clinical Child and Family Psychology Review*, 12(4), 336-351.
- University of California Los Angeles Center for Healthier Children, Youth and Families. (2012). Full Service Partnerships: California’s Investment to Support Children and Transition-Age Youth with Serious Emotional Disturbances and Adults and Older Adults with Severe Mental Illness. Retrieved from: [http://mhsoac.ca.gov/Meetings/docs/Meetings/2012/Nov/OAC\\_111512\\_Tab4\\_MHSA\\_Cost\\_Offset\\_Report\\_FSP.pdf](http://mhsoac.ca.gov/Meetings/docs/Meetings/2012/Nov/OAC_111512_Tab4_MHSA_Cost_Offset_Report_FSP.pdf)
- Unutzer, J., Chan, Y., Hafer, E., Knaster, J., Shields, A., Powers, D., & Veith, R. C. (2012). Quality Improvement with Pay-for-Performance Incentives in Integrated Behavioral Health Care. *American Journal of Public Health*, e1-e5. doi:10.2105/AJPH.2011.300555
- Van Herck, P., De Smedt, D., Annemans, L., Remmen, R., Rosenthal, M. B., & Sermeus, W. (2010). Systematic review: effects, design choices, and context of pay-for-performance in healthcare. *BMC Health Services Research*, 10: 247. Brown, T. T., Choi, S., Chung, J., Felton, M. Scheffler, R. M. (2010). A comparison of satisfaction, services characteristics and outcomes in the full service partnership programs relative to usual care. *Petris Report*. Nicholas C. Petris Center on Health Care Markets and Consumer Welfare School of Public Health, University of California, Berkeley.



Weisbrod, B. (1983). A guide to benefit-cost analysis as seen through a controlled experiment in treating the mentally ill. *Journal of Health Politics, Policy and Law*, 4, 808-845.

Winters, N. C., & Metz, W. P. (2009). The wraparound approach in systems of care. *Psychiatric Clinics of North America*, 32(1), 135-151.

Yoon, J., Chung, J., Brown, T. T., Felton, M., Choi, S., Scheffler, R. M., (2010). The impact of the full service partnership programs on independent living: A Markov analysis of residential transitions. Petris Report. Nicholas C. Petris Center on Health Care Markets and Consumer Welfare School of Public Health, University of California, Berkeley.