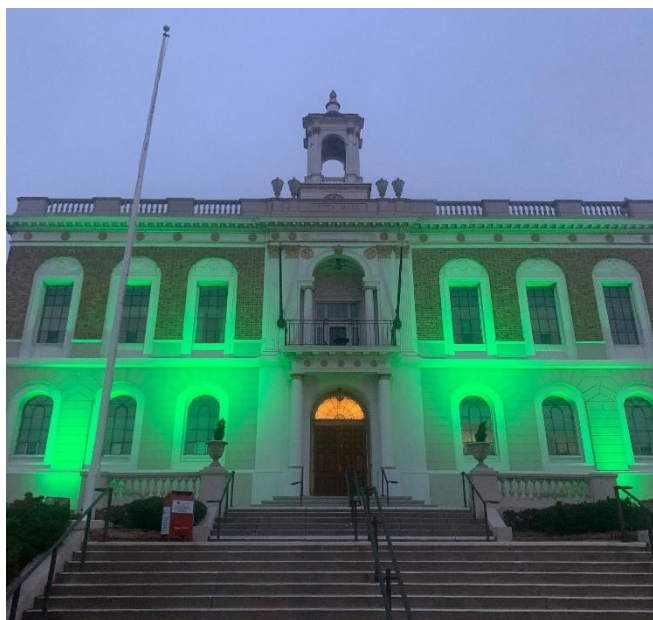# MENTAL HEALTH SERVICES ACT

Annual Update for Programs & Expenditures, Fiscal Year (FY) 2022-23

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

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MHSA COUNTY COMPLIANCE

This section to be completed after Board of Supervisor approval

This section to be completed after Board of Supervisor approval

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

MISSION

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

We are committed to:

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

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

SAN MATEO COUNTY DEMOGRAPHICS

The estimated population of San Mateo County is 770,038, a 7.2% jump over the 2010 Census. Daly City remains the most populous city followed by the cities of San Mateo and Redwood City.   The median age of residents is 39.9 and a median household income of $136,562. While The town of Portola Valley has the highest median age of 51.3 years, East Palo Alto a much less affluent community has the lowest at 28.1 years; an indicator of existing inequities in health.

Total Population	Median Household Income	Bachelor's Degree or Higher	Employment Rate	Total Housing Units
770,038	$136,562	49%	66.8%	283,693

Without Health Care Coverage	Total Employer Establishments	Total Households	Hispanic or Latino (of any race)
4.6%	21,528	265,003	188,316
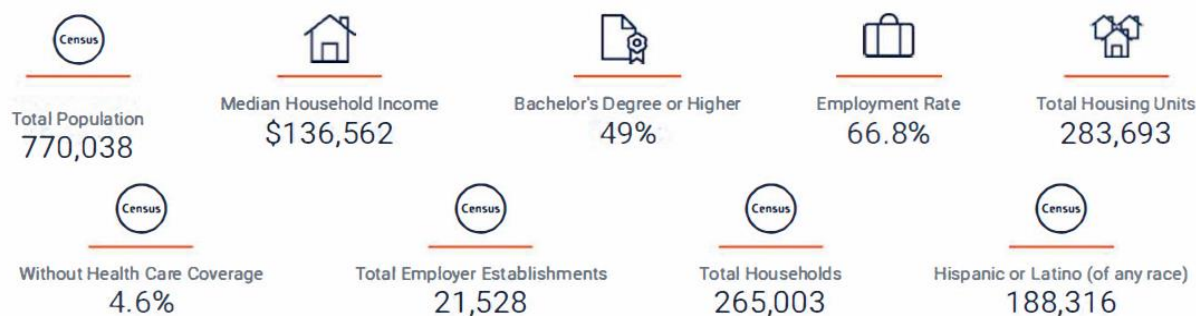
As the County's population continues to shift, it continues to grow in ethnic and cultural diversity. 46.3% of residents speak a language other than English at home, and 34.8% are foreign born. San Mateo County's threshold languages are Spanish, Chinese (Mandarin and Cantonese), Tagalog and Russian (as identified by Health Plan of San Mateo). Tongan, Samoan have been identified as priority languages based on a growing number of clients served and emerging languages as Arabic, Burmese, Hindi, and Portuguese.

San Mateo County Population by Race/Ethnicity
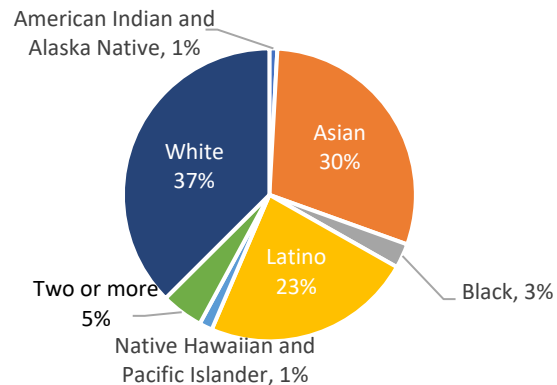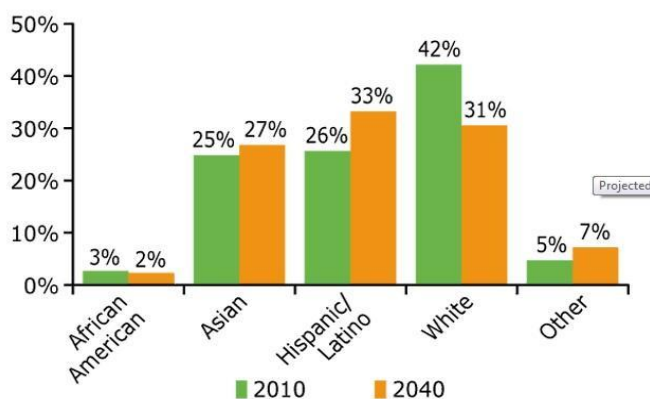
In 2018, growth projections estimated that by 2040 San Mateo County would have a majority non-White population. The White population is projected to decrease by 11%. The Latinx and Asian communities are projected to increase by 7% and 2%, respectively[1]. Additionally, the projected population by age group shows that residents 65 and older is projected to almost double.

Data Source: State of California, Department of Finance
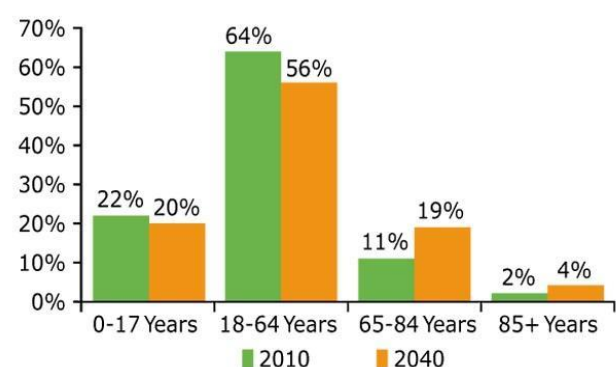
Data Source: State of California, Department of Finance

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[1] sustainablesanmateo.org

BEHAVIORAL HEALTH AND RECOVERY SERVICES

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

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

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

Our Values
- *Person and Family Centered*: We promote culturally responsive person-and-family centered recovery.
- *Potential*: We are inspired by the individuals and families we serve, their achievements and potential for wellness and recovery
- *Power*: The people, families and communities we serve and the members of our workforce guide the care we provide and shape policies and practices.
- *Partnerships:* We can achieve our mission and progress towards our vision only through mutual and respectful partnerships that enhance our capabilities and build our capacity
- *Performance*: We use proven practices, opportunities, and technologies to prevent and/or reduce the impacts of mental illness and additions and to promote the health of the individuals, families and communities we serve.

Proposition 63, the Mental Health Services Act (MHSA), was approved by California voters in November 2004 and provided dedicated funding for mental health services by imposing a 1% tax on personal income over $1 million dollars. San Mateo County received an annual average of $34.3 million, in the last five years through Fiscal Year 2020-21. MHSA emphasizes transformation of the behavioral health system, improving the quality of life for individuals living with behavioral health issues and increasing access for marginalized communities. MHSA planning, implementation, and evaluation incorporates the following core values and standards:

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

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

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

Community Services & Supports
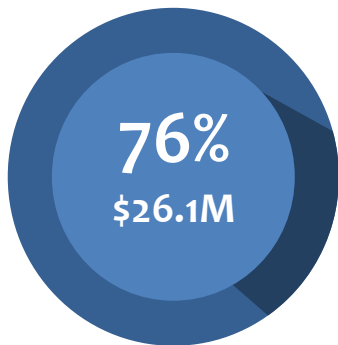
76%
$26.1M

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

Prevention & Early Intervention (PEI)
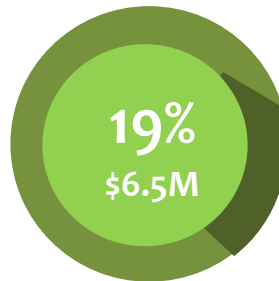
19%
$6.5M

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

Innovation

5%
$1.7M
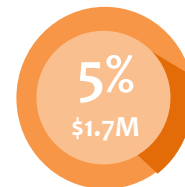
INN funds projects to introduce new approaches or community-drive best practices that have not been proven to be effective.

COMMUNITY PROGRAM PLANNING PROCESS

COMMUNITY PROGRAM PLANNING (CPP) PROCESS

The San Mateo County Behavioral Health and Recovery Services (BHRS) promotes a vision of collaboration and integration by embedding MHSA programs and services within existing infrastructures. San Mateo County does not separate MHSA planning from its other continuous planning processes. Given this, stakeholder input from system-wide planning activities is taken into account in MHSA planning. The Mental Health and Substance Abuse Recovery Commission (MHSARC), the local "mental health board", is involved in all MHSA planning activities providing input, receiving regular updates as a standing agenda item on their monthly meetings, and making final recommendations to the San Mateo County Board of Supervisors (BoS) on all MHSA plans and updates.

MHSA STEERING COMMITTEE MEETING

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

MHSA Steering Committee Roles and Responsibilities were developed to strengthen the representation of diverse stakeholders by including member composition goals related to stakeholder groups (e.g. at least 50% represent clients/consumers and families of clients/consumers; at least 50% represent marginalized cultural and ethnic groups; maximum of two member representatives from any one agency, etc.). In response to ongoing feedback from stakeholders the MHSA Steering Committee was established as a Standing Committee of the Mental Health and Substance Abuse Recovery Commission (MHSARC), which requires the appointment of 1-2 chairperson(s) to the committee. The MHSA Steering Committee meets four times per year in February, May, September and December. See Appendix 1 for MHSA Steering Committee meeting materials for meetings held in September 2021, December 2021 and February 2022.

2021-22 MHSA Steering Committee Members

Stakeholder Group	Name	Title (if applicable)	Organization/Affiliation (if applicable)
Family Member	Jean Perry	Chairperson	MHSARC, Lived Experience Education Workgroup (LEEW)
Public	Leticia Bido	Chairperson	MHSARC
Client/Consumers	Jairo Wilches	Program Coordinator	BHRS, OCFA
Client/Consumers	Michael S. Horgan	Program Coordinator	Heart & Soul, Inc.
Cultural Responsiveness	Maria Lorente-Foresti	Director	BHRS, Office of Diversity & Equity
Cultural Responsiveness	Kava Tulua	Executive Director	One East Palo Alto
Education	Mary McGrath / Molly Henricks	Administrator	San Mateo County Office of Ed
Family Member	Chris Rasmussen	Commissioner	MHSARC

Family Member	Judith Schutzman		
Family Member	Juliana Fuerbringer	Board Member	California Clubhouse
Health Care	Eddie Flores	Director of Youth Behavioral Health	Peninsula Health Care District
Other - Peer Support	ShaRon Heath	Executive Director	Voices of Recovery
Provider of MH/SU Svcs	Adriana Furuzawa	Division Director	Family Service Agency
Provider of MH/SU Svcs	Clarise Blanchard	Director	StarVista
Provider of MH/SU Svcs	Melissa Platte	Executive Director	Mental Health Association
Provider of MH/SU Svcs	Michael Krechevsky	Family Support Specialist	Family Service Agency
Provider of Social Svcs	Mary Bier	Coordinator	North County Outreach Collaborative
Public	Michael Lim	Commissioner	MHSARC, LEEW
Public	Paul Nichols	Commissioner	MHSARC
Public	Sheila Brar	Chair	MHSARC

STAKEHOLDER ENGAGEMENT

MHSA Steering Committee meetings are open to the public and diverse stakeholder participation is promoted through various means, including flyers, emails, announcements, postings, community partners, clients/consumers, community leaders, and the general public. The following demographics represents unique participants in MHSA Steering Committee meetings. When comparing race/ethnicity demographics to San Mateo County census data, all but Asian (underrepresented by 15%) are comparable. Communities of color are engaged in MHSA planning via the Office of Diversity and Equity's Health Equity Initiatives, which represent 9 cultural and ethnic groups including: African American Community Initiative, Chinese Health Initiative, Filipino Mental Health Initiative, Latino Collaborative, Native and Indigenous Peoples Initiative, Pacific Islander Initiative, PRIDE Initiative, Spirituality Initiative, and the Diversity and Equity Council.

San Mateo County Census Race/Ethnicity		Steering Committee Participation Race/Ethnicity	
Asian	30%	Asian Indian/South Asian, Chinese, Filipino*	15%
Black or African American	3%	Black/African-American	6%
Hispanic or Latino	23%	Hispanic/Latino/x	15%
Native Hawaiian or Pacific Islander	1%	Native Hawaiian or Pacific Islander	4%
White alone, not Hispanic	37%	White/Caucasian	35%
Two or More	5%	Two or More*	15%
		Another Race/Ethnicity	8%

* combined to allow for comparison as per MHSA legislation but, represented uniquely below

MHSA Steering Committee Participant Demographics (Combined for Sep '21, Dec '21 and Feb '22)

Age Range	
16-25	2%
26-59	66%
60+	32%

Gender Identity	
Female/Woman	71%
Male/Man	27%
Genderqueer/Gender Non-Conforming	2%

Race/Ethnicity

Pacific Islander	2
Chinese	2
Black/African-American	3
Another Race/Ethnicity	4
Asian Indian/South Asian	5
Hispanic/Latino/x	7
White/Caucasian	24

Stakeholder Group

Decline to state	2
Community member (no affiliation)	4
Provider of other social services	5
Consumer/client	8
Family member of a consumer/client	16
Provider of behavioral health services	17
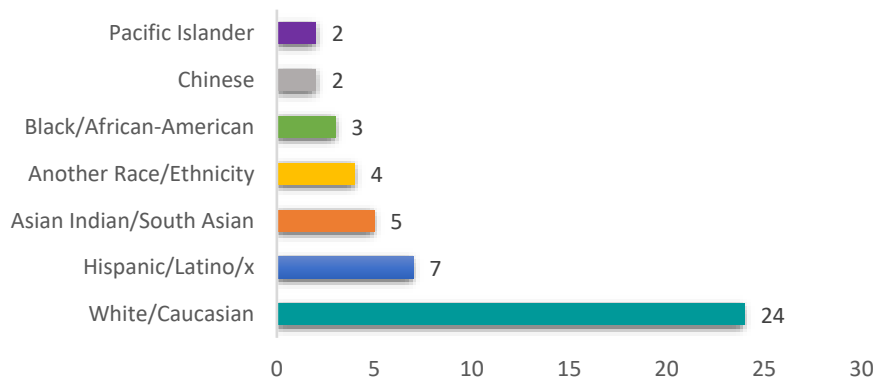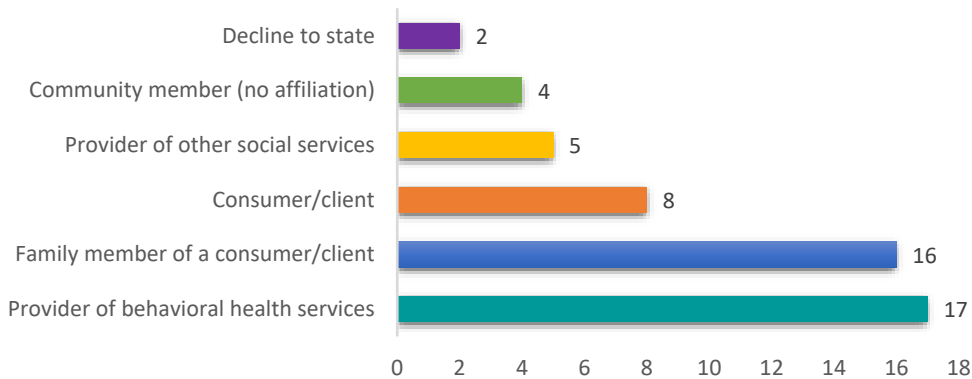
County Region Represented

- South County 10%
- North County 14%
- Central County 34%
- East Palo Alto/Belle Haven 5%
- County-wide 32%
- Coast 5%

12
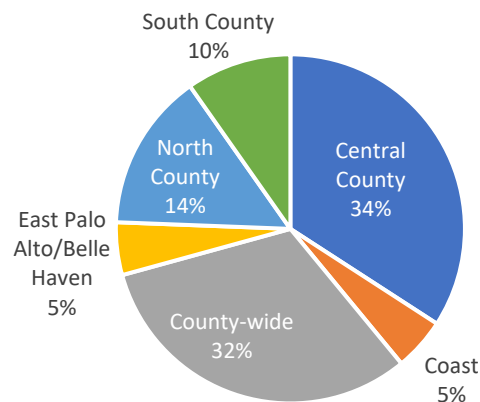
Peer, Client/Consumer and Family Engagement in MHSA

MHSA is committed to engaging individuals with lived experience in planning, implementation and evaluation. Participation and expertise of individuals with lived experience is promoted and compensated with stipends. For the FY 2020-21 reporting year of this MHSA Annual Update, the following stipends were provided to clients and family members of clients participating in MHSA-funded activities.

Activity (FY 2020-21)	Stipend $ Amount Distributed	# unique recipients /activity
Health Equity Initiatives	$4,015	30
Help@Hand	$925	16
Housing Taskforce	$300	7
Lived Experience Education Workgroup	$3,315	21
Mental Health Awareness Month	$315	8
MHSA Steering Committee	$190	6
Photo Voice	$1,200	10
Suicide Prevention Planning	$760	10
TOTAL	$11,120	

30-DAY PUBLIC COMMENT AND PUBLIC HEARING

MHSA legislation requires counties to prepare and circulate MHSA plans and updates for a 30-day public comment period for stakeholders and any interested party to review and comment. The San Mateo County MHSA Annual Update FY 2021-22 (covering data from FY 2020-21) was presented to the MHSARC on March 2, 2022 where it was voted to open a 30-day public comment period and closing with a Public Hearing on April 6, 2022. A special meeting was held on April 20, 2022 where the MHSARC voted *unanimously* to submit the plan to the Board of Supervisors for approval. Please see Appendix 2 for the MHSA Annual Update presentation to the MHSARC and all public comments received.

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

Various means are used to circulate information about the availability of the plan and request for public comment and include:
● Announcements at internal and external community meetings;
● Announcements at program activities engaging diverse families and communities (Health Ambassador Program, Lived Experience Academy, etc.);
● E-mails disseminating information to an MHSA distribution list of over 2,200 subscribers; and the Office of Diversity and Equity distribution list of over 1,900 subscribers;
● Word of mouth on the part of committed staff and active stakeholders,
● Posting on the MHSA webpage smchealth.org/MHSA, the BHRS Blog, smcbhrsblog.org, and the BHRS Wellness Matters Newsletter, smchealth.org/WM, which reaches over 2,400 subscribers.

PROGRAM PLANNING HIGHLIGHTS

NEW INNOVATION PROJECT LAUNCH

San Mateo County has three Innovation projects approved in FY 2020-21, listed below. The Social Enterprise Cultural and Wellness Café for Filipino/a/x Youth, now known as the Kapwa Kultural Center, was awarded to the Daly City Peninsula Partnership in collaboration with the Daily City Youth Health Center. The other two projects are pending a Request for Proposal process, which launched in December 2021.

1. Social Enterprise Cafe for Filipino/a/x Youth - *Kapwa Kultural Center*
   Approved August 27, 2020; Launched October 2021
   Estimated Project Amount & Length: $2,625,000 / 5 years
   The proposed project is a cultural arts and wellness-focused Social Enterprise Cafe that offers youth development and mental health programming on site. The Social Enterprise Cafe will hire and train at-risk youth from northern San Mateo County and serve as a culturally affirming space for Filipino/a/x youth and community. The social enterprise model has proven to be a more sustainable funding approach.
   Annual projected number of participants served: 2,000 unique visitors; 300 referrals; 150 receive behavioral health services; 90 participate in services; 40 in full programming

2. Co-location of Prevention and Early Intervention Services in Low-Income Housing
   Approved November 17, 2020; Pending RFP process
   Estimated Project Amount & Length: $925,000 / 4 years
   The proposed project will provide prevention and early intervention services including behavioral health resources, supports, screening, referrals and linkages to young adults, ages 18-25, on-site at affordable housing properties, minimizing stigma and reducing barriers to accessing behavioral health care.
   Annual projected number of young adults served: 150

3. PIONEERS Program
   Approved December 10, 2020; Pending RFP process
   Estimated Project Amount & Length: $925,000 / 4 years
   The proposed project, Pacific Islanders Organizing, Nurturing, and Empowering Everyone to Rise and Serve (PIONEERS) provides a culturally relevant, behavioral health program for NHPI college-age youth that prioritizes the mental wellbeing of students and their respective communities through empowerment, leadership and advocacy.
   Annual projected number of NHPI youth served: 45 direct; 30 through community projects

MHSA WORKGROUP – FULL SERVICE PARTNERSHIPS

The MHSA Steering Committee hosts up to two small workgroups per year focused on a specific MHSA topic that is aligned with MHSA planning needs and may require more intensive planning, improvements, evaluation and/or other recommendations (e.g. housing, full service partnerships, innovation, community program planning, etc.). The workgroups are open to public participation, are time-limited and 10-12 participants are selected via an interest survey.

Between September-November 2021, a Full Service Partnership (FSP) Workgroup made up of clients, family members, adult and children and youth FSP providers and stakeholders, was convened to provide input on FSP service requirements and outcomes that would support continuous improvement planning. The FSP Workgroup was intended to build off of the Multi-County Full Service Partnership (FSP), a partnership between six counties including, Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura. The multi-county partnership is intended to transform how behavioral health systems use data to continuously innovate and improve FSP services across California. Locally, an independent consultant, Third Sector, conducted two rounds of interviews and focus groups with FSP clients and providers to help inform decisions, see Appendix 3 for the client and provider FSP Focus Group Summaries and Appendix 4 for the FSP Workgroup Recommendations and Materials.

FSP programs are evidence-based and incorporate a "whatever it takes" approach to supporting adults living with serious mental illness and children and youth living with serious emotional disturbance, in achieving their individual recovery goals and needs. The full spectrum of FSP services include therapy, psychiatric services, peer supportive services, housing supports, case management and life skills development. Since the launch of the Multi-County FSP project, Third Sectors has provided BHRS with technical assistance to support the development of eligibility criteria that ensures FSP services are prioritized to the highest-need clients; minimum service requirements of FSP programs; and standardized step-down guidelines for clients. The FSP Workgroup concluded with recommendations across nine areas of FSP improvement, listed below; see the FSP Workgroup Recommendations document in Appendix 4 for the full details on input received and how these will be addressed by BHRS moving forward.

1. Set Minimum FSP Service Requirements
2. Identify Additional FSP Client/Family Resources
3. Support Staff Retention and Appropriate Contractor Rates
4. Develop Trauma-Informed FSP Providers
5. Prioritize Substance Use Integration
6. Strengthen Peer and Family Supports
7. Ensure Housing Access and Retention Services
8. Incorporate Step Down Services Within FSP Programs
9. Enhance Ongoing Data Collection

FSP Workgroup Members Attended (12 were selected, 8 attended)

Participant	Organization and/or Affiliations	Stakeholder Group
Lanajean Vecchione	Help@Hand Advisory, Suicide Prevention Committee, Spirituality Initiative, Lived Experience Education Workgroup (LEEW)	Client/Consumer of mental health services
Jean Perry	Solutions for Supportive Homes, LEEW Advocacy Council, MHSARC, NAMI	Families of clients/consumers of mental health services
Linder Allen	Solutions for Supportive Homes (S4SH)	Families of clients/consumers of mental health services
Suzanne Moore	NAMI and S4SH, Healthcare for the Homeless and Farmworkers	Families of clients/consumers of mental health services
Rosario Gonzalez		Families of clients/consumers of mental health services
Kevin Jones	Telecare	Providers of mental health and substance use services
Amanda Russell	Caminar; San Mateo Contractors Association	Providers of mental health and substance use services
Jamila McCallum	Edgewood Center for Children and Families	Providers of mental health and substance use services

BHRS staff included Doris Estremera, MHSA Manager; Doug Fong, BHRS Youth Clinical Services Manager; and Mariana Rocha, BHRS Adult Clinical Services Manager. The FSP Workgroups were facilitated by Third Sector consultants.

HOUSING INITIATIVE TASKFORCE – AN UPDATE

A Housing Initiative Taskforce made up of diverse stakeholders including clients, family members, service providers and County departments convened between March and May 2021, to prioritize and make recommendation related to funding for housing resources and supports; a full spectrum of housing services for individuals living with mental health challenges was developed. The details of this taskforce were reported in the previous MHSA Annual Update. The following table is intended to report on the progress since the 11 Housing Taskforce Recommendations were released in May 2021.

	Funding Recommendations (May 2021 - listed in order of priority)	Progress	Notes
1.	Establishment of an ongoing Housing Fund with Department of Housing for the development of Supportive Housing Units for clients	Year 1 Completed	Year 2 – targeted for 2022
2.	Housing locator contract: a) Maintenance of BHRS Housing website with real-time housing availability information; b) Linkages to BHRS case managers; c) Landlord engagement; d) Community mental health 101; and e) housing locators (MH counselors) and peer navigators	In Progress	Input sessions + Request for Proposal process (items 2, 6, 7 combined) targeted for Spring 2022
3.	Supportive services for new housing units	Not Yet Started	For new housing units being developed
4.	Mental health workers for Homeless Outreach	In Progress	
5.	Transitional housing supports and training to adequately serve SMI population, including special populations	Not Yet Started	Target TBD
6.	Outreach and field-based services to support ongoing and long-term housing retention; a team of Occupational Therapist and Peer Counselor with co-occurring capacity to support independent living skills development	In Progress	Input sessions + Request for Proposal process (items 2, 6, 7 combined) targeted for Spring 2022
7.	Development of an online BHRS Housing webpage with comprehensive one-stop housing information (including data dashboard for unmet need) for clients and staff	In Progress	Input sessions + Request for Proposal process (items 2, 6, 7 combined) targeted for Spring 2022
8.	Flexible funds for housing related expenses (moving costs, deposits, first month rent)	Not Yet Started	The revenue for this item is highly inconsistent; will propose for FY 22-23
9.	Increase FSP housing funds	In Progress	Current FSP housing rate increased; Third Sector consultants to support cost modeling
10.	Incentives and supports for licensed Board and Cares to improve quality of services	In Progress	
11.	Increase Full Service Partnerships (FSP) slots for children/youth and transition-age youth	Completed	10 Children/Youth and 5 TAY FSP slots

ISSUE RESOLUTIONS

MHSA Issue Resolution Process (IRP)
The purpose of the MHSA IRP is to resolve process-related issues with 1) the MHSA Community Program Planning (CPP) process; 2) consistency between approved MHSA plans and program implementation; and 3) the provision of MHSA funded programs.

In San Mateo County, the MHSA IRP (BHRS POLICY: 20-10) is integrated into the broader BHRS Problem Resolution Process facilitated by the Office of Consumer and Family Affairs (OCFA) to support clients in filing grievances about services received from BHRS or contracted providers, ensuring that client issues are heard and investigated. BHRS clients receive client rights information upon admission to any program, which includes information on the right to a problem resolution process and how to file a grievance, appeal or request a state fair hearing after exhausting the internal problem resolution process.
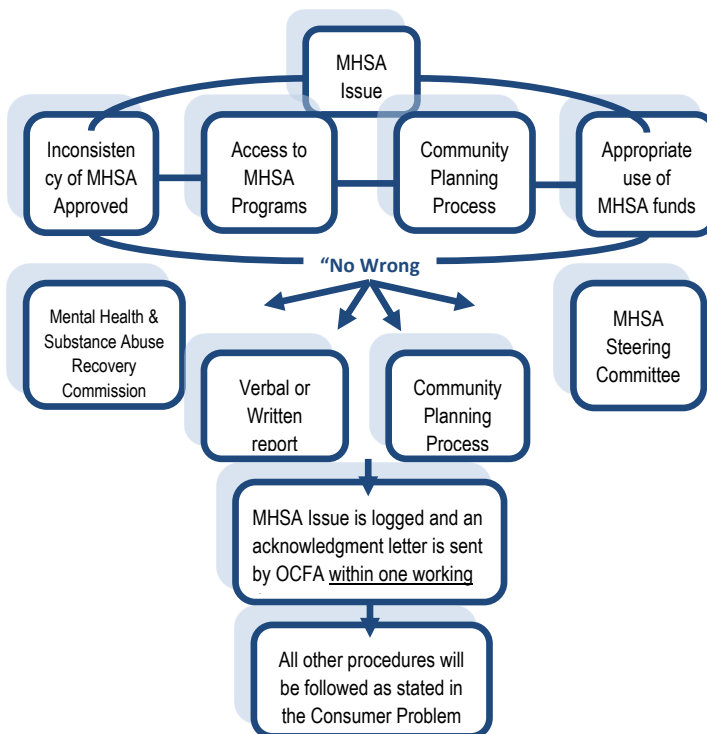
For the FY 2020-21 reporting year of this MHSA Annual Update, there were 14 quality of care-related grievances filed with the BHRS Office of Consumer and Family Affairs (OCFA) for MHSA funded programs.   There were 0 MHSA process-related grievances.

Category of grievance (FY 2020-21)	# of grievances filed	From the client's perspective: Was the outcome Favorable, Partially Favorable, Not Favorable?
Other: Financial	1	Favorable
Other: Lost Property	1	Not favorable
Other: Peer behavior	1	Favorable
Other: Physical environment	2	2 Partially favorable
Medication concerns	2	1 Favorable, 1 Partially favorable
Staff behavior	6	3 Favorable, 3 Partially favorable
Treatment concerns	1	Favorable

FUNDING SUMMARY

FUNDING SUMMARY

The Funding Summary includes MHSA funding requirements and locally-developed guiding principles, revenues and expenditures, available unspent funds, reserve amounts and any updates to the approved MHSA Three-Year Plan for FY 2020-23. See Appendix 5 for the FY 2022-23 Funding Summary by component.

MHSA FUNDING REQUIREMENTS

MHSA funded programs and activities are grouped into "Components" each one with its own set of guidelines and rules:

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

Additionally, Counties received one-time allocations in three additional Components, listed in the table below. Locally, ongoing annual and one-time allocations are prioritized to sustain the work in these components, as per the following guidelines:
- Up to 20% of the average 5-year MHSA revenue from the CSS Component can be allocated to WET, CF/IT and Prudent Reserve.
- A maximum of 33% of the average Community Services and Supports (CSS) revenue received in the preceding five years maximum of 33% may fund the Prudent Reserve.
- Up to 5% of total annual revenue may be spent on administration and community planning processes.

Component	Amount Received and Expended	Ongoing Allocation	Reversion
Workforce Education and Training (WET)	$3,437,600 FY 06/07 & 07/08	$500,000 per year	10 years
Capital Facilities and Information Technology (CF/IT)	$7,302,687 FY 07/08	$330,000 per year	10 years
Housing	$6,762,000 FY 07/08	$5M One-Time FY 21/22 $5M One-Time FY 22/23	10 years
	Unencumbered FY 15/16		3 years

MHSA FUNDING PRINCIPLES

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

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

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

ANNUAL REVENUE GROWTH

Statewide, MHSA revenue represents a little under a third of community mental health funding. In San Mateo County, MHSA revenue represents about 15% of behavioral health funding at a five-year average annual revenue through fiscal year 2020-21 that totaled $34.3 million.

Annual MHSA revenue distributions are difficult to estimate and volatile. MHSA funding is based on various projections that consider information produced by the State Department of Finance, analyses provided by the California Behavioral Health Director's Association (CBHDA), and ongoing internal analyses of the State's fiscal situation. The following chart shows annual revenue allocation for San Mateo County since inception. Below are factors that have impacted the decreases and increases in revenues throughout the years:

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

Revenue Projections
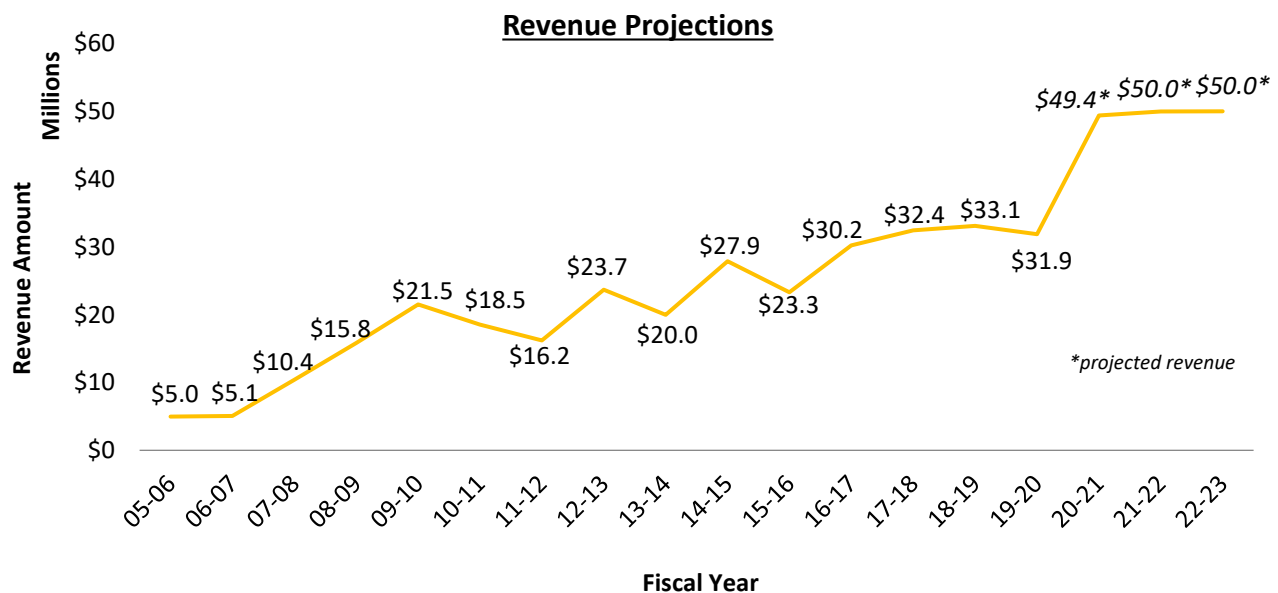
FISCAL CONSIDERATIONS

Excess Revenue and One-Time Spend Plans
The previous FY 2021-22 MHSA Annual Update included an updated and combined $6.9 million One-Time Spend Plan, to be implemented through FY 2022-23; developed with stakeholders to spend down excess MHSA funds. Additionally, given that significant excess revenue due to unanticipated increases in revenue due to the COVID-19 pandemic, the FY 2021-22 MHSA Annual Update also included 1) a new $11.7 million One-Time Spend Plan and 2) increases in the ongoing budget to a slight over-revenue

budget by FY 2022-23. A status update on the new MHSA One-Time Spend Plan is included in the table below and was presented to the MHSA Steering Committee and the MHSARC.

Priority	Item	FY 21/22 Allocation	FY 21/22 Status	FY 22/23 Allocation
Housing Initiative Taskforce	BHRS Housing Webpage	$100,000	Delayed	$0
	Development of Supportive Housing Units	$5,000,000	Completed	$5,000,000
Post-COVID Supports (Prevention and Early Intervention)	Community mental health and substance use education	$50,000	Delayed	$50,000
	Community wellness and recovery supports	$50,000	Delayed	$50,000
	Field and group supports	$100,000	Delayed	$100,000
	Older adult supports	$50,000	In Progress	$50,000
	Health Equity Initiative capacity development	$30,000	Delayed	$30,000
	School mental health supports	$46,000	Completed	$46,000
	Racial Equity and Multicultural Organizational Development	$125,000	In Progress	$125,000
Mental Health Surge Needs	Workforce Development	$200,000	In Progress	$200,000
	Workforce Wellness	$100,000	In Progress	$100,000
	SMI Private Provider Network (SSPN) incentives	$125,000	In Progress	
	Grand Total			$11,727,000

The increases to the ongoing budget have also been updated given even higher revenue than anticipated, as of the latest projections from the State. This includes increased funding to Full Service Partnerships as recommended by the FSP Workgroup to improve FSP services and supported by a new FSP cost modeling conducted by independent consultants, Third Sector, as part of the Multi-County FSP partnership. FSP services will be increased by a total of $2.8 million overall. MHSA increases include the following:

- FSPs by $807,734 (MHSA portion only; FSP's are funded by a number of revenue including MediCal, AB109 for criminal justice FSP slots, realignment funds and others)
    - $2,087,656 increase to adult/older adult FSP services ($522,378 MHSA)
    - $756,240 increase to child/youth/transition-age youth FSP services ($285,356 MHSA)
- PEI by $420,000 to meet 19% requirement

MHSA Revenue & Expenses
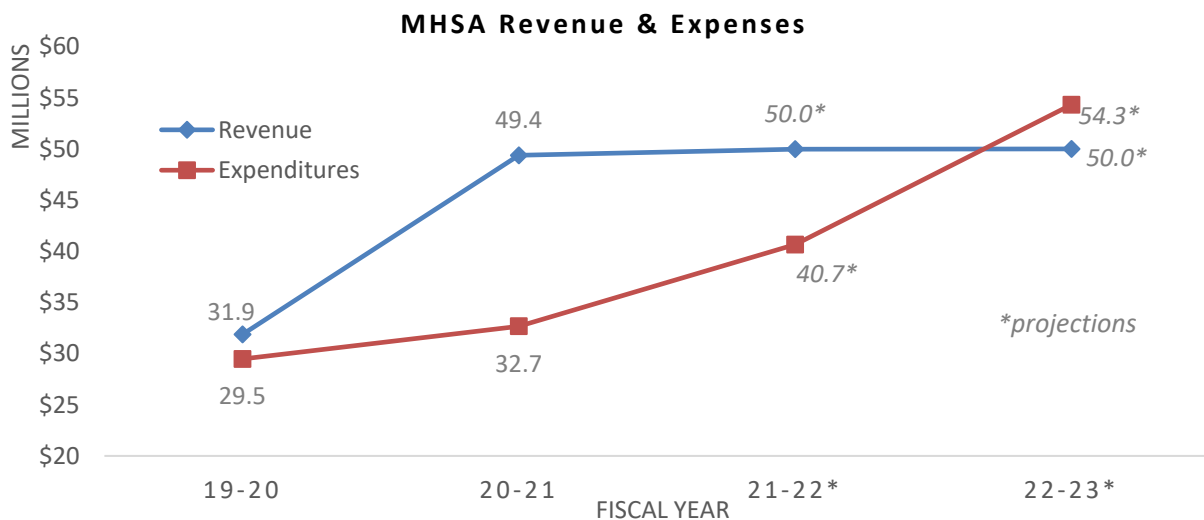
On April 6, 2022, the MHSARC reviewed the public comments received and held a public hearing. The vote to submit the updated expenditures to the Board of Supervisors for approval along with the MHSA Annual Update was held on April 20, 2022 during an MHSARC special meeting. See Appendix 5 for the FY 2022-23 Funding Summary by MHSA component.

Prudent Reserve
Counties are required to establish a Prudent Reserve to ensure the County programs will be able to serve clients should MHSA revenues drop. The California Department of Health Care Services (DHCS) Info Notice 19-017, released on March 20, 2019, established an MHSA Prudent Reserve level that does not exceed 33% of the average Community Services and Supports (CSS) revenue received in the preceding five years. For San Mateo County, this corresponds to $8,879,780, which was $8,279,780 was transferred to the Prudent Reserve in FY 2021-22 as per the stakeholder reviewed and recommended FY 2020-21 MHSA Annual Update. $600,000 was previously transferred in FY 2008-09.

Additionally, as per the FY 2019-20 MHSA Annual Update, the MHSA Steering Committee, the local mental health board and Board of Supervisors, reviewed and approved a recommended Total Operational Reserve of 50% (Prudent Reserve + additional operating reserve), of the highest annual revenue for San Mateo County, which currently equals $24.7 million. The additional Operational Reserve is in a local MHSA Trust Fund. This allows the flexibility in budgeting for short-term fluctuations in funding without having to go through the State's administrative process to access the Prudent Reserve, in the event that revenue decline is less than the State's threshold or funding is needed in a timely manner.

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

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

AB 114 and a SB 192 allowed Counties to submit a plan by January 1, 2019 for expending funds by June 30, 2020 that were deemed reverted as of July 1, 2017. San Mateo County submitted plans for INN in the amount of $3,832,545 and WET in the amount of $423,610. The INN plan was approved through June 30, 2022 and is on target to be expended. The WET funding was expended as proposed.

At the wake of the COVID-19 pandemic, AB81 allowed for some flexibilities in MHSA regulations including reversion of FY 2019-20 funds. In San Mateo County, $922,534 were subject to reversion as of FY 2019-20. Since then, three new MHSA Innovation projects were approved for San Mateo county. These projects will encumber and spend the reverted funds. Therefore, San Mateo County will not be subject to return any INN funds to the State.

Unencumbered Housing Funds
DHCS Info Notice 16-025 required Counties to complete *Ongoing Fund Release Authorization* for both existing and future unencumbered San Mateo County MHSA Housing Program funds (e.g. funds that are no longer required by a housing project, accrued interest, and/or other funds receive on behalf of the counties). Funds will be released annually to Counties. The *Ongoing Fund Release Authorization* was approved by the Board of Supervisors on April 7, 2020. San Mateo County received $105,039 in accrued interest and loan payments in September 2020 and $4,040 in July 2021.

The MHSA Housing Initiative Taskforce prioritized these funds to support ongoing "housing assistance" in the form of flexible funding for clients for housing related expenses (moving costs, deposits, first month rent). These unencumbered housing funds will be used to support the flexible fund.

SUMMARY OF UPDATES TO THE THREE-YEAR PLAN, FY 2020-23

In summary, the following strategies are being implemented in FY 2022-23 to align MHSA expenditures with the increased projected revenue. See Appendix 5 for the updated FY 2022-23 Annual Update Funding Summary by component.
1. Continue implementing one-time spend plan
2. Increase the ongoing budget by $1.23 million to about $4.3 million over-revenue budget.

ANNUAL UPDATE

FY 2022-23

(Includes program highlights and data from FY 2020-21 services)

Welfare and Institutions Code Section (WIC) § 5847 states that county mental health programs shall prepare and submit an Annual Updates for Mental Health Service Act (MHSA) programs and expenditures. Previously, data for the most recent full fiscal year was not readily available by the deadline to submit Annual Updates to the State in December. This Annual Update includes an attempt to collect and report on the most recent data, therefore program highlights and data include FY 2020-2021.

COMMUNITY SERVICES & SUPPORTS (CSS)

COMMUNITY SERVICES AND SUPPORTS

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

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

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

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

FULL SERVICE PARTNERSHIPS (FSP)

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

The cost figures below do not speak to the span or quality of services available to clients either through BHRS or through contracted providers and may overlook important local issues such as the cost of housing, supported services provided, etc.

Program	FY 20/21 FSP slots	FY 20/21 Clients Served	Cost per client*
Children/Youth (C/Y) FSP's	75	182	
Out-of-County Foster Care Settings FSP	10	7	$34,683
Integrated FSP "SAYFE" FSP	25	71	$46,599
Comprehensive FSP "Turning Point"	40	104	$63,318
Transitional Age Youth (TAY) FSP's	45	124	
Comprehensive FSP "Turning Point" FSP	45	124	$63,318
Adult/Older Adult FSP's	302	354	
Adult and Older Adult/Medically Fragile FSP	207	233	$19,901
Comprehensive FSP	30	35	$32,600
Assisted Outpatient Treatment "Laura's Law" FSP	50	66	$27,406
South County Clinic Embedded FSP	15	20	$9,184

*Calculated based on # of contracted FSP slots and total cost of FSP services (not including housing, which is contracted separately); there are reimbursements and other revenues sources associated with FSP's that decrease the final MHSA funding contribution.

FSP RACE/ETHNICITY DEMOGRAPHICS

Child/Youth and Transition Age Youth FSP Client Demographics
FY 20/21 (total clients = 96)

Percent of FSP Clients by Ethnicity	
Hispanic or Latino	55%
Not Hispanic or Latino	39%
Unknown / Not Reported	6%

Child/Youth/TAY FSP by Race
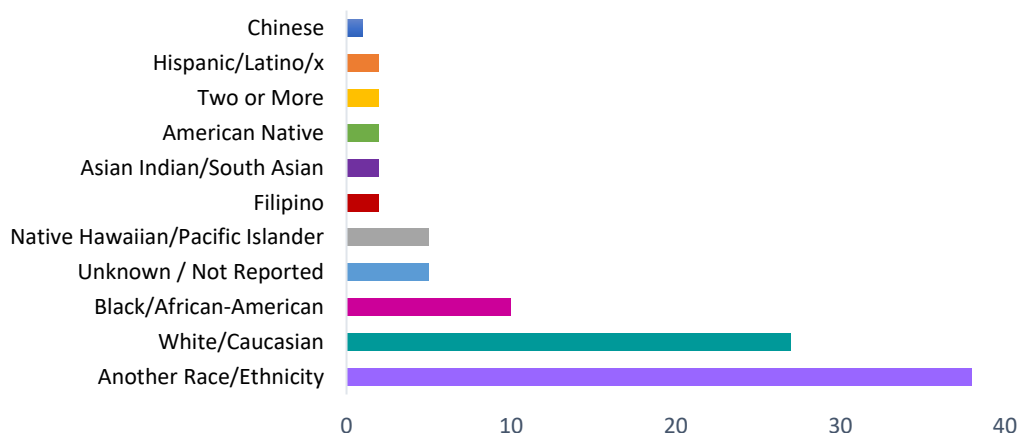
Adult and Older Adult FSP Client Demographics
FY 20/21 (total clients = 334)

Percent of FSP Clients by Ethnicity	
Hispanic or Latino	27%
Not Hispanic or Latino	64%
Unknown / Not Reported	9%

Adult/Older Adult FSP by Race

FSP PERFORMANCE OUTCOMES BY AGE GROUP

As part of San Mateo County's implementation and evaluation of the FSP programs an independent consultant analyzes FSP data to understand how enrollment in the FSP is promoting resiliency and improved health outcomes of clients living with a mental illness.

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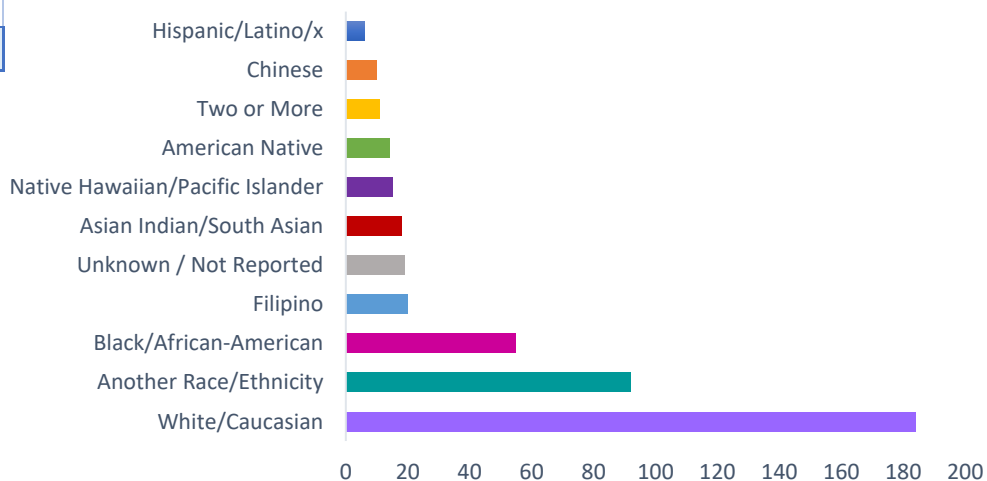tion (e.g. school enrollment and graduation, completion dates, grades, attendance, special education assistance), employment, financial support, legal issues, emergency interventions, health status, substance use, and for older adults, activities of daily living and instrumental activities of daily living.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

See Appendix 6 for the full FSP Evaluation Report for FY 2020-21, which includes client demographics and outcomes. The tables below present a highlight of the percent improvement between the year just prior to FSP and the first year with FSP, by age group.

Fiscal Year 2020-21 FSP Outcomes*	Child (16 years & younger)	TAY (17 to 24 years)	Adult (25 to 59 years)	Older adult (60 years & older)
Self-reported Outcomes (Survey data)				
Homelessness	-33%	-3%	-26%	N/A*
Detention or Incarceration	0%	-16%	-37%	N/A*
Arrests	-84%	-83%	-83%	N/A*
Mental Health Emergencies	-88%	-78%	-65%	-80%
Physical Health Emergencies	-93%	-91%	-65%	N/A*
School Suspensions	-55%	-79%		
Grade Ratings	-10%	-2%		
Attendance Ratings	-11%	3%		
Employment			N/A*	N/A*
Active Substance Use Problem			-8%	N/A*
Substance Use Treatment			22%	N/A*
Healthcare Utilization (EHR data)				
Hospitalization	-70%	-38%	-54%	-33%
Mean hospital days per partner	-91%	-57%	-66%	-48%
Psychiatric Emergency Services (PES)	-57%	-38%	-28%	-40%
PES admissions per client	-56%	-31%	-38%	-49%

Note: The self-reported outcomes do not include Telecare FSP. Telecare FSP changed its EHR system and is currently in the process of converting its data to the original analytic format. Healthcare utilization outcomes are calculated based on the San Mateo County EHR data system, thus it captured all FSP clients including Telecare FSP.

*N/A means insufficient sample size (fewer than 10 observations). Red font indicates outcomes worsened, such as lower lower grade ratings for TAY and Children.

INTEGRATED FSP "SAYFE"

The Short-Term Adjunctive and Family Engagement (SAYFE) program is designed to support the county's most vulnerable youth and their families to maintain and improve the youth's placement. In congruence with Edgewood Center's mission and values, the Full-Service Partnership (FSP) work is informed by a core belief that children, youth, and families are best served and supported in the context of their unique family system, culture, and community. SAYFE serves 25 of the highest risk children/youth living in San Mateo County at any one time by augmenting and extending the clinical work and existing treatment plan within: (1) the outpatient and Therapeutic Day School (TDS) programs and (2) clients who are currently being served by Behavioral Health and Recovery Services (BHRS) in a county clinic.

Youth are primarily referred to the SAYFE program through Human Services Agency (HSA – child welfare), Juvenile Probation, San Mateo County Clinics, and Schools (typically with an IEP for emotional disturbance in place). The treatment is provided to help stabilize youth in their home environment and prevent (or transition back from) a higher level of care (e.g., psychiatric hospital, residential facility, juvenile hall, etc.). All programs under the umbrella of the Youth FSP are guided by a strong belief in:
1. Service Integration: Communities are strengthened by a family-centered network of services and providers that partner with children, youth, and families and
2. Local Focus: Children, youth, and families receive the highest quality of care when services are provided and accessible within their community.

The Youth Full-Service Partnership (FSP) Program services are open to all youth meeting the population criteria below. However, it is specifically targeted to Asian/Pacific Islander, Latino, and African American Children and Youth. Identified San Mateo County resident populations to be served by the program are:
- Severely Emotionally Disturbed (SED) and dually diagnosed children and youth (ages 6 to 21, including 16/17 old when it is developmentally appropriate and/or best meets the needs of the client and family) with multiple psychiatric emergency services episodes and/or frequent hospitalizations with extended stays.
- SED and dually diagnosed children and youth who are at risk of out-of-home placement or returning from residential placement, with juvenile justice or child welfare involvement.
- SED and dually diagnosed homeless children and youth / Transitional Aged Youth (TAY).
- Children and youth / TAY exiting school-based or IEP driven services.
- Youth who are experiencing a "first break" and have been recently diagnosed with a psychotic disorder. This target population may or may not have had prior involvement with the mental health, juvenile justice, and/or child welfare systems.
- Youth and their family who are willing and able to participate in the treatment process.

Additionally, all enrollees in SAYFE are ages 6-18 years old; must be enrolled in, or at-risk of placement in an intensive school-based program (12 plus slots); or are currently being served in a Regional County clinic and are at-risk of out-of-home placement (12 plus slots).

PROGRAM IMPACT

SAYFE	FY 20/21
Total clients served	71
Total cost per client	$16,408
Cost per contracted slot	$46,599

The SAYFE program utilizes the Wraparound model of care for children, youth, and families engaged in its program. The SAYFE program provides a variety of services to youths and her/his/them families. All treatment is voluntary, individualized, strengths-based, and actively engages the youth and family. These services may include: Family Therapy focuses on the care and management of client's mental health condition within the family system; Group Therapy with the client's goals for more than two or more family members that focus primarily on symptom reduction as a means to improve functional impairments; Collateral services provide
support to one or more significant persons in the life of the client which may include consultation and training to assist in better utilization of services and understanding mental illness; and Rehabilitation Services assist in improving, maintaining or restoring functional skills, daily living skills, medication compliance, and access to support resources. The SAYFE program is unique because the team works alongside the Behavioral Health and Recovery Service (BHRS) Primary Clinician.

Also, the families and youths have access to the Crisis Response Services, which is available twenty-four (24) hours on the weekends and after hours during the week. The program has access to Behavior Coaching Services, Psychiatry services, and/or External TBS program.

Additionally, wraparound plans are more holistic than traditional care plans. They are designed to meet the identified needs of caregivers and siblings and address a range of life areas. Through the team-based planning and implementation process, wraparound also aims to develop youth and family members' problem-solving skills, coping skills, and self-efficacy. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network.

The Youth FSP Programs works in collaboration with the other County Staff and contract to assure implementation of each enrollee's Care Plan. The Youth FSP Clinical Intake Coordinator contacts the referent party no later than five (5) business days following authorization by County Designated BHRS representative and opens the Admin Reporting Unit (RU) within 24 hours of receiving the referral from the Interagency Placement Review Committee (IPRC) team.

During the FY 2020-21, Edgewood FSP Programs continue working on the Plan of Corrections to improve timely access, linkages and increase the Units of Services. Edgewood Youth FSP Programs successfully met the convenient access and linkages expectations for FY 2020-2021. The Youth FSP Programs created a system to reflect "true numbers" and track all referrals/engagement before the current MIS opening dates. SAYFE continues to meet the Units of Service requirement from the Plan of Correction.

- The Youth FSP Clinical Intake Coordinator will contact the referent within five (5) businesses within receiving notification from the IPRC representative

- All (non-billable) services before "Treatment opening" will be captured in the "Administrative RU".
- The Youth FSP Clinical Intake Coordinator will work with the referring party to obtain the referral packet as quickly as possible.
- Upon receiving the referral packet containing the necessary and sufficient information, the "Administrative RU" episode will be closed and then opened as a "Treatment RU" episode.
- If the youth does not open in the "Treatment RU", there will be documented efforts of attempts and rationale for not opening.
- The SAYFE Case Manager contacts the Primary Clinician for a provider's meeting before contacting the family no later than five (5) business days from receiving the completed packet.
- The SAYFE treatment team contacts the family for initial intake no later than five (5) business days for commencement of treatment.

The SAYFE program utilizes the Wraparound model of care for children, youth, and families engaged in its program. Wraparound is an intensive, holistic, evidence-based method of engaging with individuals with complex needs (most typically children, youth, and their families) so that they can live in their homes and communities and realize their hopes and dreams. The wraparound process aims to achieve positive outcomes by providing a structured, creative, and individualized team planning process that, when compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family. The wraparound principle of voice and choice impacts the goals and interventions by including the perspectives of youth and family members during treatment. The care plan prioritizes the youth, the families, or other caregivers' strengths and perspectives.

The SAYFE program has started providing Family Conferencing in the care planning process. The Family Conference is family-driven, strength-based, and promotes self-reliance. The Family Conference is a process that brings together the youth, the family/caregiver, and their natural resources. The focus of the Family Conference is to explore Decision-Making and Problem-Solving for multi-needs families and develop an integrated and comprehensive plan for youth and their families/caregivers.

During the FY 2020-2021, Edgewood has been improving and integrating The Family Conferencing throughout all Youth FSP programs. The SAYFE program is integrating more Family Conferencing in treatment to increase engagement and bring forward their voices and choices. The BHRS Oversight team will continue exploring this. During this Reporting Period, there was a pause on integrating Family Conferencing. The SAYFE Program hopes to continue exploring this in the next Fiscal Year.

The Youth FSP programs address the whole family and support parents/caregivers when they have their mental health or substance use needs. The SAYFE Family Partners and Case Managers facilitate access to services, interfacing with Adult Mental Health Services (MHS) or Alcohol and other Drug Services (AOD) of the BHRS Division. The SAYFE team will provide crisis/brief intervention services to those not meeting criteria and refer them to primary care or community resources, as needed.

The SAYFE's treatment team provides peer support and encouragement to the parents/caregivers to enhance the family's community and natural support, transportation services. It supports identified in the individualized action plan. The SAYFE Family Partners provide educational support to the parents/caregivers focusing on mental illness, co-occurring disorders, and finding resources. During FY

2020-2021, the SAYFE Family Partners successfully provided the monthly Parenting Newsletter to the SAYFE program and BHRS families due to COVID-19 Shelter in Place.

Edgewood operates the only program in San Mateo County focused on kinship families- those in which youth are being raised by a relative caregiver independent of the foster care system. Kinship families present additional unique strengths and challenges. When TPCY serves kinship families, they also connect them to the Kinship Support Network to enhance wrap-around services, including caregiver counseling, couple's counseling, community health nursing and case management, support groups, and respite.

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

Support for the Latino and Spanish Speaking Community: Several BHRS partners, families, and bilingual/bicultural staff members highlighted challenges to providing culturally and linguistically matched services.

- The challenges:
  - ✓ There are limited community resources (and literature) that are available in Spanish.
  - ✓ Cultural barriers may include being afraid to ask for assistance, issues with legal status, and/or personal beliefs regarding mental illness.

- The strategies:
  - ✓ During FY 2020-2021, SAYFE Program had a full-time Bilingual Clinician. All the mono-lingual families were served by the bilingual clinician.
  - ✓ Bilingual/bicultural treatment team members invest time and energy into explaining services, translating documents, and interpreting for meetings.
  - ✓ The SAYFE Family Partners provide literature and resources in Spanish to the families.
  - ✓ The Parenting Newsletter was in Spanish.
  - ✓ The Behavioral Health Director hired a Bilingual Clinical Intake Coordinator to provide support to monolinguals families during the orientation meetings.
  - ✓ The Bilingual/Bicultural Behavioral Health Director provides support and advocacy during providers' meetings to advocate for Spanish Speaking families in the system.

The Youth FSP, the SAYFE program utilizes the Wraparound Model of Care, which engages children, youth, and their families through four phases of treatment:
- Phase I (Discovery) - Engagement, assessment, stabilization, and planning
- Phase II (Hope) - Build skills and family connectedness
- Phase III (Renewal) - Strengthening and expanding formal and informal community support systems, affirm and support self-reliance strategies, prevent relapse, and leadership training
- Phase IV (Constancy) - Individualized aftercare planning to promote stability and permanence

The Youth FSP programs provide harm reduction, Stages of Change model for youth with co-occurring disorders. The SAYFE team will consult with the BHRS contractor where substance use is determined to be life-threatening and will implement more assertive interventions.

SUCCESSES

During the FY 2020-2021, all the services were provided via Telehealth due to COVID-19 Shelter in Place.

- Even during these circumstances, SAYFE was able to celebrate multiple celebrations such as "Mother's Day" by delivering packages to all the mothers in the program, Turkey Trot Gift Cards and Family Activity packages, and multiple successful graduations.
- The SAYFE Case Manager's team provided packages for Back-to-School to the families.
- The SAYFE Family Partners have distributed monthly newsletters with various parenting topics (communication, routine after COVID-19, building healthy relationships). The Parenting Newsletter was in both Spanish and English.
- The SAYFE Case Managers have distributed items to families to encourage bonding and self-care (planting flowers, journaling, flying a kite, spa day, pie-making), and have been working tirelessly to support virtual learning and the return to in-person school.
- SAYFE had a full clinical, Case management, and Family Partners team throughout the fiscal year.
- The Youth FSP Leadership team build a system of support to increase the efficiencies of all the Youth FSP programs.
- The SAYFE Program maintains a full Census throughout the Fiscal Year.
- The Youth FSP Family Partners are participating in weekly Peer Credential Training.
- The Youth FSP programs were trained in telehealth services successfully.
- The Crisis Support Team successfully provided interventions via phone to all the FSP youth, families, and TAY.
- Edgewood adapted a new Electronic Health Record successfully.
- The Youth FSP programs provided equipment to families who needed laptops to increase access to Telehealth Services.
- The Youth FSP Leadership team build a system of support to increase the efficiencies of all the Youth FSP programs
- Youth FSP Programs had a full Behavioral Coach Specialist Team.

The following qualitative success stories highlight the work that the SAYFE Treatment Team (the Family Partner, the Case Manager, and the Family Therapist) provides. The SAYFE Treatment Team would usually work jointly with the External Primary Clinician, the Behavioral Coach Specialist, Psychiatrist Team, and/or External TBS program.

Story #1:

The Youth is a 16-year-old, Latino, Bilingual Family who was referred to the program due to aggressive behavior towards his mother, history of incarceration due to violence with mother, significant trauma history, and mother's lack of ability to support her children's needs.

The family struggled to utilize services for the first year or so. They would cancel appointments, refuse to meet with service providers (especially the youth), and their mother struggled to implement any of the strategies suggested by the team.

This family experienced many transitions throughout their time with the program – CPS case closed, the transition of psychiatrists, individual therapists, case managers, and family therapists (bilingual to English only), therefore, the program decided to keep trying to work with this family to help create stability and safety.

We reached out to the youth's probation officer to help increase engagement, tirelessly tried to build rapport with both the youth and his mother (who lack trust due to their trauma history).
Almost 2 years later, the youth is now engaged with his treatment team, the mother can set boundaries and limits with her children without being fearful, and they have started to process their trauma together in family therapy. The team has commented that this case is a reminder that some families need more time than others to engage, and he is a good reminder of how important consistency, patience, and support truly are when doing this work.

Story #2:

The Youth is a 14-year-old, Spanish Speaking Family who was referred to the program due to significant depressive symptoms, active self-harm, and suicidal ideation.

There were struggles in the youth's relationship with their mother, and there was no communication. The Youth isolated in their room for most of the day struggled to get up to participate in school and refused to interact with the family.

The family has engaged in family therapy, case management, and family partner services consistently for the last year. The mother has used family partner services to reflect on her parenting, try different techniques and strategies, and ask for assistance with parenting resources. The Case Manager has helped the family connection to resources to support the family's basic needs, provide psychoeducation regarding mental health, and has developed a positive rapport with the youth to support their talents and interests. Family therapy has also been positive.

Mother and youth can share similar experiences, they report that the communication has improved, and the mother has gained understanding regarding the youth's symptoms and diagnoses. Youth has not report
ed self-harm or suicidal ideation for over 6 months and will be graduating from the program in a few months.

Story #3: Share client with Behavioral Coach Specialist:

Sofia engaged in aggressive behaviors ranging in intensity from mild to severe. At home, Sofia frequently stole random items and told lies to her mother, ignored directives, or talked back to avoid non-preferred tasks, and raised her voice or screamed when she didn't get her way. When Sofia was extremely escalated, she tends to engage in mild self-harm such as biting, scratching, pinching herself, digging her

fingernails into her skin, or headbanging. Sofia also occasionally threw soft objects (ex: stuffed animals, water, pillow) across the room or at her mother.

These behaviors were putting home placement at risk. Per the Youth's mother, the youth's main triggers include being asked to complete a non-preferred task (ex: schoolwork, cleaning room), not getting what she wants, being caught lying or stealing, and wanting attention taken away from her younger sibling. Per the youth's clinician, triggers include disagreeing with someone, feeling guilty or embarrassed, being asked to do something she does not want to do, or perceiving something as unfair.

In the school setting, the Behavior Coach Specialist has assisted the school case manager in implementing a points rewards system to motivate youth to complete work and stay focused in class. The behavior Coach Specialist has also offered the client's mother suggestions on how to support youth in completing work by sitting next to her during assignments and helping youth manage her schedule of work. In the home setting, the Behavior Coach Specialist has implemented a routine chart with daily activities youth need to complete that normally cause aggression (exercising, brushing teeth, putting away dishes, etc). While initially, the chart was not effective due to the client's mother not implementing it, once the chart was implemented daily, the youth has been able to complete the chart on most days. For the session with youth, the Behavior Coach Specialist has done a variety of activities ranging from practicing different coping skills, expressing feelings, communication skills practicing, "I statement", dysregulation strategies, processing difficult feelings of loss, anger, and anxiety, problem-solving, and self-esteem building activities.

For the session with the client's mother, the Behavior Coach Specialist has implemented with the youth's mother using an ABC chart to monitor the client's behavior, discussing appropriate rewards and consequences, self-care/grounding techniques for the mother, de-escalation techniques, modeling appropriate behavior, and using a lockbox to lock up potential safety hazards for when youth is escalated. The behavior Coach Specialist has had difficulty helping the client's mother implement strategies due to having to tell the client's mother multiple times
the same strategy before some progress is made in using strategies.

Within the last year of treatment, the youth's engagement in the mild, moderate, and severe forms of the target behavior has significantly decreased. Sofia made progress on being able to identify and share her feelings as well as being able to ask for emotional support. Sofia has increased her ability to problem-solve. Sofia has coping activities in place that the youth can utilize on her own and with support from her mother such as taking space, listening to music, asking for hugs, or doing activities with her mother to de-escalate. Due to progress the youth
sessions have decreased from 2x a week to 1x a week and will soon transition to every other week as progress continues to move toward graduation. The youth's mother has made progress in retaining and implementing tools such as talking and processing feelings with youth, empathizing and problem-solving with Sofia as well as praising and putting consequences in place.

*The name and some identifying factors have been changed to protect the youth's identity. Quantitative data were provided through the submission of documentation to the state database and unfortunately, do not receive the aggregate results of these data.

CHALLENGES

There were a handful of challenges during the previous fiscal year (2019-2020), which followed through Fiscal Year (2020-2021). While continuing to assess and address ongoing challenges around the ever-increasing cost of living and lack of qualified candidates to fill open positions, the FSP Programs were put on a Plan of Correction. Due to the Plan of Correction and Financial reduction in the contract, The After School Intensive Services Program and the Therapeutic Behavioral Services Program were closed during this ranking period.

The Youth FSP Behavioral Health Director and the Program Manager were able to turn around the leadership instability, maintain consistent staffing throughout the FY 2020-2021, and build positive relationships with external providers and BHRS partners. By improving the relationship with external providers and BHRS contractors, the SAYFE program maintains a high volume of Census throughout FY 2020-2021.

These challenges, their impact, and possible solutions are highlighted below:

Cost of living in the Peninsula and consistent staffing: The high cost of living continues to present a challenge for families (and staff) who are unable to locate affordable and suitable housing.

- The challenges:
    - ✓ Families are frequently living in households with multiple members, impacting quality of life, privacy, and safety.
    - ✓ Families are frequently relocating out of the county which results in an abrupt termination of services.
    - ✓ Families experienced several provider changes, as different members of their treatment team transitioned to/from the team.
    - ✓ Edgewood's salary rates do not match the astronomical cost of living in the county. This is not unique to Edgewood.
    - ✓ Due to COVID-19 Shelter in Place, the families who were already experiencing difficult challenges due to living in the Peninsula, such as cost of living, housing, etc., experienced further challenges, such as loss of work, financial stress, access to equipment, and Wi-Fi to participate in services via telehealth, etc.

- The strategies:
    - ✓ The county is working to create more affordable housing and increase living wages.
    - ✓ As providers of community-based services, staff meets outside of the home, to ensure that youths have the emotional and physical space to engage in treatment. Due to the Covid-19 mandate, the staff provided services via telehealth.
    - ✓ When families relocate to other counties, the staffs work with them to ensure that there are resources in place before their move, to ensure continuity of care.
    - ✓ Staffs continue utilizing satellite offices to do their paperwork, to cut down the time that they are commuting and driving between community-based appointments. During the Covid-19 mandate, the staff has been providing services via Telehealth.

- ✓ As a Trauma-Informed System (TIS) agency, the Youth FSP programs encourage and attempt to incorporate self-care regularly to avoid burnout.
- ✓ In times where SAYFE was unable to meet the language capacity of a family (e.g., Spanish), SAYFE used Edgewood translation services.

During the FY-2020 to 2021, The BHRS Contract Mangers extended the Plan of Correction to improve timely access, access to treatment, and volume of services. The Youth FSP programs continue working closely with the BHRS oversight team in monthly and quarterly meetings to improve the volume of services requirements. The SAYFE Program successfully met most of the Plan of Corrections, except the volume of service. SAYFE is continuing to work on completing the Units of Services expectations.

Volumes of Services (units of service – billable and non-billable):

- Challenges:
  - ✓ To ensure that all the services being documented by staff
  - ✓ What the barriers are to the wraparound team providing billable vs. non-billable services.
  - ✓ The learning curve about documentation varies among staff.
  - ✓ The nature of the SAYFE Program is to have the treatment goals and decision-making with the BHRS primary clinician.
- The strategies:
  - ✓ The FSP conducted a full analysis of the units of the service component.
  - ✓ Provided staff documentation training to ensure staff is:
    - o Up to date on medical documentation standards.
    - o Appropriately capturing billable services (compared to non-billable services).
  - ✓ Provide support to staff to be able for documentation to be done on time.
  - ✓ Created a system of support to motivate staff to document timely.
  - ✓ Runs monthly efficiency data to all staff in the Youth FSP Programs.
  - ✓ The monthly incentive for high "Goal Getters."

COMPREHENSIVE FSP "TURNING POINT"

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

The Turning Point Child and Youth (TPCY) Program is a comprehensive program for 40 of the highest risk children/youth living in San Mateo County. TPCY is designed to help children and youth achieve independence, stability, and wellness within the context of their culture, community, and family.

Youths are primarily referred to the TPCY program through Human Services Agency (HSA – child welfare), Juvenile Probation, San Mateo County Clinics, and Schools (typically with an IEP for emotional

disturbance in place). The treatment is provided to help stabilize youth in their home environment and prevent (or transition back from) a higher level of care (e.g., psychiatric hospital, residential facility, juvenile hall, etc.). All programs under the umbrella of the Youth FSP are guided by a strong belief in:
1. Service Integration: Communities are strengthened by a family-centered network of services and providers that partner with children, youth, and families and
2. Local Focus: Children, youth, and families receive the highest quality of care when services are provided and accessible within their community.

The Youth Full-Service Partnership (FSP) Program services are open to all youth meeting the population criteria below. However, it is specifically targeted to Asian/Pacific Islander, Latino, and African American Children and Youth. Identified San Mateo County resident populations to be served by the program are:
- Severely Emotionally Disturbed (SED) and dually diagnosed children and youth (ages 6 to 21), including 16/17 old when it is developmentally appropriate and/or best meets the needs of the client and family) with multiple psychiatric emergency services episodes and/or frequent hospitalizations with extended stays.
- SED and dually diagnosed children and youth who are at risk of out-of-home placement or returning from residential placement, with juvenile justice or child welfare involvement.
- SED and dually diagnosed homeless children and youth / Transitional Aged Youth (TAY).
- Children and youth / TAY exiting school-based or IEP driven services.
- Youth who are experiencing a "first break" and have been recently diagnosed with a psychotic disorder. This target population may or may not have had prior involvement with the mental health, juvenile justice, and/or child welfare systems.
- Youth and their family who are willing and able to participate in the treatment process.

Additionally, all enrollees in C/Y:
- Are ages 6-21 years old.
- Are at risk for placement in a level 10-14 residential facility or "stepping down" from a level 10-14 residential facility: and
- Must be currently involved in Child and Family Services (Child Welfare) or Probation.

The TPCY program utilizes the Wraparound model of care for children, youth, and families engaged in its program. In the Youth FSP, the TPCY program provides various services to youths and their families. All treatment is voluntary, individualized, strengths-based, and actively engages the youth and family. These services may include: individual therapy with the client's goals that focus primarily on symptom reduction as a meant to improve functional impairments; Group Therapy with the client's goals for more than two or more family members that focus mainly on symptom reduction as a means to improve functional impairments; Family Therapy focuses on the care and management of client's mental health condition within the family system; Collateral services provide support to one or more significant persons in the life of the client which may include consultation and training to assist in better utilization of services and understanding mental illness; and Rehabilitation Services assist in improving, maintaining or restoring functional skills, daily living skills, medication compliance, and access to support resources.

Also, the families and youths have access to the Crisis Response Services, which is available twenty-four (24) hours on the weekends and evenings during the week. The program has access to Behavior Coaching Services and Psychiatry services.

Additionally, wraparound plans are more holistic than traditional care plans. They are designed to meet the identified needs of caregivers and siblings and address a range of life areas. Through the team-based planning and implementation process, wraparound also aims to develop youth and family members' problem-solving skills, coping skills, and self-efficacy. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network.

PROGRAM IMPACT

Comprehensive FSP	FY 20/21
Total clients served	104
Total cost per client	$24,353
Cost per contracted slot	$63,318

The Youth FSP Programs works in collaboration with the other County Staff and contract to assure implementation of each enrollee's Care Plan. The Youth FSP Clinical Intake Coordinator contacts the referent party no later than five (5) business days following authorization by County Designated BHRS representative and opens the Admin Reporting Unit (RU) within 24 hours of receiving the referral from the Interagency Placement Review Committee (IPRC) team. During the FY-2020 to 2021, Edgewood FSP Programs participated in a Plan of Corrections to improve timely access and linkages and increase the Units of Services. Edgewood Youth FSP Programs successfully met the convenient access and linkages expectations for FY 2020-2021. The Youth FSP Programs created a system to reflect better "true numbers" and track all referrals/engagement before the current MIS opening dates. The TPCY Program completed the Units of Service requirements from the Plan of Correction.

- The Youth FSP Clinical Intake Coordinator will contact the referent within five (5) businesses within receiving notification from the Interagency Placement IPRC representative.
- All (non-billable) services before "Treatment opening" will be captured in the "Administrative RU".
- The Youth FSP Clinical Intake Coordinator will work with the referring party to obtain the referral packet as quickly as possible.
- Upon receiving the referral packet containing the necessary and sufficient information, the "Administrative RU" episode will be closed and then opened as a "Treatment RU" episode.
- If the youth does not open in the "Treatment RU", there will be documented efforts of attempts and rationale for not opening.
- The TPCY Care Coordinator contacts the family for initial intake no later than five (5) business days for commencement of treatment.

Reduces stigma and discrimination
The TPCY utilizes the Wraparound model of care for children, youth, and families engaged in its program. Wraparound is an intensive, holistic, evidence-based method of engaging with individuals with complex needs (most typically children, youth, and their families) so that they can live in their homes and communities and realize their hopes and dreams. The wraparound process aims to achieve positive outcomes by providing a structured, creative, and individualized team planning process that, when

compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family. The wraparound principle of voice and choice impacts the goals and interventions by including the perspectives of youth and family members during treatment. The care plan prioritizes the youth, the families, or other caregivers' strengths and perspectives.

In addition, TPCY provides Family Conferencing in the care planning process. The Family Conference is family-driven, strength-based, and promotes self-reliance. The Family Conference is a process that brings together the youth, the family/caregiver, and their natural resources. The focus of the Family Conference is to explore Decision-Making and Problem-Solving for multi-needs families and develop an integrated and comprehensive plan for youth and their families/caregivers.

During the FY 2020-2021, Edgewood has continued improving and integrating Family Conferencing throughout all Youth FSP programs. However, The COVID-19 Pandemic influenced how Family Conference is delivered. For most of the time, the families and youth could utilize the telehealth meetings. There were technical struggles for some families when meeting via Zoom.

Increases number of individuals receiving public health services
The Youth FSP programs address the whole family and support parents/caregivers when they have their mental health or substance use needs. During the FY 2020-2021, the nation experienced the COVID-19 Pandemic. The TPCY Family Partners, Clinicians, and Care Coordinators facilitated access to services via telehealth. The Youth FSP Programs advocated and assessed equipment needs (i.e., Laptops, Wi-Fi, etc.) to ensure all families had access to the Telehealth services. The TPCY Family Partners and Case Managers facilitate access to
services, interfacing with Adult Mental Health Services (MHS) or Alcohol and other Drug Services (AOD) of the BHRS Division. The TPCY team will provide crisis/brief intervention services to those not meeting criteria and refer them to primary care or community resources, as needed.

The TPCY's treatment team provides peer support and encouragement to the parents/caregivers to enhance the family's community and natural support, transportation services. It supports identified in the individualized action plan. The TPCY Family Partners provide educational support focusing on mental illness, co-occurring disorders, and finding resources. During COVID-19 Shelter in Place, the Family Partners have been instrumental in
sending the resources and information via mail and email.

Edgewood operates the only program in San Mateo County focused on kinship families- those in which youth are being raised by a relative caregiver independent of the foster care system. Kinship families present additional unique strengths and challenges. When TPCY serves kinship families, connection to the Kinship Support Network enhances the wrap-around services, including caregiver counseling, couple's counseling, community health nursing and case management, support groups, and respite.

Reduces disparities in access to care
Due to COVID-19 Pandemic, the Youth FSP Programs provided tools to the families in need to access telehealth services. All the families could have access to equipment to participate regularly via telehealth.

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

Support for the Latino and Spanish Speaking Community: Several BHRS partners, families, and bilingual/bicultural staff members highlighted challenges to providing culturally and linguistically matched services.
- The challenges:
  - ✓ Some monolingual's families reported having difficulties with utilizing telehealth and having interpreters in the zoom meetings.
  - ✓ Cultural barriers may include being afraid to ask for assistance, issues with legal status, and/or personal beliefs regarding mental illness.
  - ✓ One of the TPCY bilingual clinician positions is still vacant. This position is hard to fill.

- The strategies:
  - ✓ Increase recruitment of bilingual/bicultural direct line staff to provide services to monolingual Spanish Speaking families.
  - ✓ The Behavioral Health Director hired a Bilingual Clinical Intake Coordinator to provide support to monolinguals families during the orientation meetings.
  - ✓ Bilingual/bicultural treatment team members invest time and energy into explaining services, translating documents, and interpreting for meetings.
  - ✓ The Family Partners provide literature and resources in Spanish to the families.
  - ✓ The program hired a bilingual Youth Specialist to provide services to Latino/Hispanic families.
  - ✓ The bilingual/Bicultural Behavioral Health Director provides support and advocacy during providers' meetings to advocate for Spanish Speaking families in the system.
  - ✓ In times where TPCY is unable to meet the language capacity for the monolingual's families, TPCY uses Edgewood translation services.

Implements recovery principles
The Youth FSP, TPCY program utilizes the Wraparound Model of Care, which engages children, youth, and their families through four phases of treatment:
- Phase I (Discovery) - Engagement, assessment, stabilization, and planning
- Phase II (Hope) - Build skills and family connectedness
- Phase III (Renewal) - Strengthening and expanding formal and informal community support systems, affirm and support self-reliance strategies, prevent relapse, and leadership training
- Phase IV (Constancy) - Individualized aftercare planning to promote stability and permanence

The Youth FSP programs provide harm reduction, Stages of Change model for youth with co-occurring disorders. TPCY team will consult with the BHRS contractor where substance use is determined to be life-threatening and will implement more assertive interventions.

SUCCESSES

During the FY 2020-2021, all the services were provided via Telehealth due to COVID-19 Shelter in Place.

- The TPCY program successfully met the Plan of Corrections goals.
- Even during these circumstances, the TPCY was able to celebrate multiple celebrations such as "Mother's Day" by delivering packages to all the mothers in the program, Winter Holidays Donation Drive, Turkey Trot Gift Cards and Family Activity packages, Staycation Kits from the Youth Specialists during Spring Break, and multiple successful graduations.
- Due to COVID-19 Shelter in Place, the Youth Specialists team created Video Interventions for the youth in the program and created a Back-to-Schools kit for the youth and children.
- The Family Partners provided support to the families for Back-to-School needs.
- The TPCY program was able to hire and onboard the Care Coordinators team successfully.
- The TPCY program was able to maintain a full Census throughout the Fiscal Year.
- The TPCY program was able to promote staff to the role of Care Coordinator.
- The Youth FSP Family Partners are participating in weekly Peer Credential Training.
- The Youth FSP programs were trained in telehealth services successfully.
- The Youth FSP programs provided equipment to families who needed laptops to increase access to telehealth services.
- The Crisis Support Team successfully provided interventions via phone to all the FSP youth, families, and TAY.
- Edgewood adapted a new Electronic Health Record successfully.
- The Youth FSP Leadership team built a system of support to increase the efficiencies of all the Youth FSP programs.
- Youth FSP Programs had a full Behavioral Coach Specialist Team.

The following qualitative success stories highlight the work that the TPCY Treatment Team (the Family Partner, the Care Coordinator, the Clinician, and/or the Youth Specialist) provides: The TPCY Treatment Team would usually work jointly with the Behavioral Coaching Specialist, Psychiatrist Team, and/or External TBS program.

Story #1:
Dante is a 15-year-old Vietnamese young man referred to the Turning Point CY Wraparound program by county mental health providers. He was living in an apartment with his mother and mother's boyfriend at the time of referral. The mother primarily spoke Vietnamese, and her boyfriend was bilingual, as was Dante. Dante was referred by his individual therapist after concerns about his explosive behaviors and moderate depression. He was described as having verbal aggression towards his mother several times per week and over the previous six months had three behavioral outbursts that destroyed property at the home including cutting his mother's clothes up with scissors, destroying bedroom furniture with a hammer, and breaking his mother's phone. Dante was very triggered by even slight comments made by his mother. He was functioning poorly at school even though he was receiving therapeutic services onsite. Dante was unable to make friends and displayed behaviors that made him stand out from his classmates such as murmuring to himself, having an empty gaze, low voice, and dissociation. Dante had poor school attendance, was chronically late, and at times refused to go at all. He also expressed explosive behaviors at school such as throwing chairs in response to mild frustrations such as another

student grazing his leg or staring at him. The mother also reported Dante had run away from home several times in the last six months and had made suicidal statements following an incident at school. His mother also reported explosive arguments between her and her boyfriend in the home, regularly. Dante entered the Turning Point CY Wraparound program and engaged with the Care Coordinator and Clinician to complete an initial screening tool which prompted immediate referrals to be given to the family. The mental health Clinician completed a comprehensive mental health evaluation and a CANS (child and adolescent needs and strengths) assessment. At the end of the assessment phase, the clinician co-created a treatment plan with Dante and his mother.

The Care Coordinator met with the family to create an initial plan of care document. This was used at the monthly family conferencing meetings with the youth, parent, and treatment providers to guide everyone's support of the family toward their family's vision of health.

Dante's mother worked very closely with the Family Partner throughout treatment in Wraparound services. Psychiatry was involved to support the youth with a psychiatric evaluation and medication management. It was important to use interpretation services throughout various treatment meetings to ensure the wraparound staff could communicate directly and effectively with Dante's mother. Crisis response services were engaged regularly and supported the family after hours and on weekends during conflicts at the home. Crisis response staff worked off the safety plan created by the clinician and family.

During treatment, Dante was hospitalized for the threat of harm to self and others. Several reports were made to child welfare services regarding neglect, and the wraparound treatment team worked very closely with child welfare workers and the family to address the reported issues. The clinician and Care Coordinator worked with Dante on coping skills, self-regulation, and effective communication. He responded well to treatment and continued to work with the Psychiatric Nurse Practitioner on his medication treatment. During these crises with the youth and family, what was uncovered was a deeper issue in the family home that the wraparound team was able to identify. The issue was that Dante's mother was in an abusive relationship and due to her limited English, she could not properly advocate for herself with law enforcement or properly work with the child-serving agencies. Dante's mother was in a position where her child and an abusive partner were acting as intermediaries with outsiders and it served to keep her in this abusive relationship and living situation. This domestic violence greatly contributed to her son's rapidly declining mental health.

Once the abusive situation in the family home was identified, the wraparound team was able to more effectively support Dante's mother. Planning was done to assist her with leaving the family home, which was what she had wanted to do for herself and her children. The wraparound team partnered closely with Dante's mother for safety planning, and to assist her with locating a safer situation where she could relocate herself, Dante, and her younger child. The mother was able to do so during one of Dante's inpatient hospitalizations. She was immensely grateful for all the help and support provided by the wrap-around team, and particularly for the support provided by her Family Partner. Because Dante's mother moved out of the county, she was unable to continue with Edgewood's wraparound program. However, the wraparound team did provide referrals to services in the new county of residence. Although this was not graduation from the program, this was an incredible success and that the wraparound team had a tremendous positive impact on the life of Dante and his family.

Story #2:

Eberto is a 16-year-old, the Latino young man referred to the Turning Point CY Wraparound program by County Mental Health providers. He was living in an apartment with his parents and younger brother at the time of referral. The family is primarily Spanish speaking, however, Eberto is bilingual in Spanish and English.

Eberto was referred by a Youth Case Manager at the time. due to an overdose with prescription pain medication. Following his overdose, the youth was transferred to a psychiatric hospitalization however he was non-compliant with treatment and medication during his stay at the hospital. Eberto was diagnosed with major depressive disorder and reported to have attempted suicide following a breakup with his girlfriend. During his evaluation with
county mental health and hospital staff, it was reported that Eberto had been isolated, had low energy, was irritable, evasive, had somatic complaints, and often broke items in the home when he was angry and upset. His parents were concerned about his reckless behavior such as riding his bike on the freeway and leaving the home for hours in the middle of the night. It was also reported that he was abusing alcohol, cannabis, cocaine, and other street drugs. This misuse of alcohol and drugs had begun the previous school year and escalated rapidly. Eberto had been hospitalized several times for psychiatric concerns before his referral to wraparound services and his parents were deeply concerned about his welfare and his future.

Eberto joined the Turning Point CY Wraparound program and engaged with a Family Partner, Care Coordinator, and Clinician to complete an initial screening tool. All members of the assigned treatment team were bilingual Spanish-speaking staff which helped to make the client and family comfortable with services and the wraparound program. A comprehensive mental health evaluation was completed by the Clinician and a treatment plan was developed with Eberto and his parents.The Care Coordinator met with the family to create an initial plan of care document. This was used at the monthly family conferencing meetings with the youth, parent, and treatment providers to guide everyone's support of the family toward their family's vision of health.

Eberto's parents engaged quickly and very well with the wraparound treatment team. His father was very vocal and tearful about the state of his son's mental health and his significant concerns about where his life was headed. A psychiatric referral was made immediately. The wraparound treatment team, and care coordinator specifically, worked to connect with county mental health providers as well as alcohol and other drug specialists who had previously evaluated and supported Eberto and his family. The wraparound team wanted to gather as much information as possible regarding the history so they could determine the best plan moving forward.

Eberto's family contacted the crisis line staff numerous times throughout his treatment in the program. Eberto regularly left the home without permission. As his treatment occurred during the COVID-19 pandemic, this was concerning to the family for multiple reasons. They were very concerned about his exposure in the community to the COVID-19 virus. Additionally, the behaviors he was engaging in were extremely distressing. Eberto was leaving the home late at night and often gone for several hours or did not return until the morning. Often, he was
found spending time in a local park drinking alcohol. The father would regularly go out to try to find him there or to go and throw away the alcohol he was hiding in certain areas of the park. It was of great

concern how he was getting money to purchase the alcohol or if he was stealing it. The family was receiving phone calls and messages from community members looking for Ebert. His parents were very worried about his safety and speculated he may be involved in selling drugs as this may have been the reason unknown adults were calling and looking for
him. Crisis response staff regularly supported the family when they called for support in the evening or early morning hours. Crisis response staff worked off the safety plan created by the clinician and family.

During treatment, Eberto was assigned to work with a behavior coach, a youth specialist, and a mental health clinician. A care coordinator and family partner primarily supported the parents. Due to the severity of symptoms, Eberto was experiencing, his typical presentation with staff was to be intoxicated or high on substances. His frequent absences from the home led to much of the work being provided to the parents for collateral support, education, skill-building, and resourcing. The treatment team provided significant education around strategies and skills to help keep Eberto safe and healthy. Along with managing the safety issues, the family was also facing food insecurity and major financial issues. Eberto's father had left his job because he felt unable to both work and provide the care and supervision his son required. The wrap-around team supported the family with finding financial resources, food donations, and other needed supplies.

School officials were very concerned about Eberto's lack of attendance and functioning at school. Eberto's father appealed to the IEP team to place his son in residential treatment. The wraparound team was very supportive of the IEP process and located several key support services to recommend at the IEP meeting. The father was extremely grateful to present a plan to the school district to have his son placed in residential care. The parents advocated quite strongly for residential treatment as they were so concerned that their son may not survive in the community given the severity of his substance use and mental health issues at this time. Residential treatment eventually was approved. Although this is typically not a sign of success for the wraparound program, viewing this as a positive outcome. Eberto was approved for residential treatment at a location in Utah. The services were approved and there was a rapid turnaround time to place him on a flight to the center. The wrap-around team quickly supported the family by purchasing many of the specific clothing items needed for a much
colder climate. The team also assisted with the specialized hygiene products and daily clothing he was required to bring since the family had no means of purchasing these items, so flex funds were used, and a family partner traveled to several stores to purchase everything. She then delivered the items to the family home so the youth could be prepared to leave on his flight within just a few days.

"We feel proud of the work and support provided to this family through the wraparound team and were thrilled to help support Eberto and his family as he transitioned into residential treatment. We are hopeful as well as optimistic he will be re-referred to Wraparound services once he completes his program and returns home to his family. We look forward to supporting him in his next stage of healing."

Story #3 – Share client with Behavioral Coach Specialist:
Robin was referred to TPCY due to engaging in aggressive and tantrum-like behaviors ranging in severity from mild to severe. In both the home and school, Robin was verbally aggressive, ignored directions, and acted out aggressively when limits were put in place that he did not agree with. In the severe form of behaviors, the youth would become physically aggressive with others in the home and at school, often

resulting in tantrum-like behaviors. These behaviors consisted of the client yelling, kicking, hitting, pushing, pulling hair, and spitting at others. At this point, the youth was easily provoked and difficult to console. In the home, Robin had tantrums in response to following his Mother or Father's direction. Robin had a hard time controlling these behaviors when rules or limits were set in place for him. The youth also had difficulty concentrating on tasks that required his full attention (schoolwork). The youth could not self-regulate when triggered. The TPCY treatment was assessed for support, such as Behavior Coach Services (BCS). The team submitted a referral for BCS.

Throughout treatment, the youth was able to utilize various coping skills introduced to him throughout the session when supported by the Behavior Coach Specialist and his caregivers. These coping skills consisted of utilizing breathing techniques, stretching, using mindfulness techniques such as art exercises, and taking space when needed. The youth was able to identify and vocalize when he needed to take a break from an activity or intervention. The behavior Coach reviewed coping and mindfulness tools throughout sessions to help the client engage in relaxation techniques when becoming triggered. The youth was able to utilize various fidgets as a way to regulate when needed. The behavior Coach introduced healthy vs unhealthy coping tools to the youth.

Robin learned the importance of using healthy coping strategies vs unhealthy ones (engaging in aggressive behaviors). The behavior coach modeled how to use these strategies in conflicting situations in his own life and the client role-played scenarios in which the client was using unhealthy coping strategies, to then introduce how to use healthy ones. The behavior Coach supported the youth in identifying his early anger warning signs. The client showed the ability to recognize his physical and behavioral responses to anger. The behavior Coach also worked with the youth on understanding the importance of using "safe hands" with himself and others.

Within the last year of treatment, the youth's engagement in the mild, moderate, and severe forms of the target behavior has significantly decreased. The youth continued to display the ability to remain focused throughout the session and manage impulsive behaviors by utilizing coping tools learned throughout treatment. The youth made progress in utilizing coping skills when identifying he is feeling overwhelmed or upset. The youth showed the ability to understand and remember the meaning of safe hands, safe boundaries, and kind words during the session. The youth showed progress in developing his replacement behaviors, consisting of verbalizing his feelings in place of engaging in aggressive behaviors, using fidgets to self-regulate and engage in art activities as a form of mindfulness exercises. The youth will vocalize when he needs a break to take space away from an activity or task when becoming too overwhelmed.

During treatment, Behavior Coach worked closely with Robin's caregivers to provide her with tools and information to help manage the client's behaviors within the home (taking space, redirection, appropriate consequences). By the end of treatment, the youth's caregivers showed the ability to support him in managing behaviors in the home by implementing tools and interventions modeled for them by the treatment team.

Behavioral coaching services moved towards closing as a result of the youth having successfully made progress in treatment with the writer, reducing his engagement in target behaviors, and displaying the ability to utilize interventions and tools learned in treatment on his own and with support from

caregivers. The behavior Coach and treatment team met with the youth's caregivers for the final closing session and with the youth respectively. Robin and the caregiver reflected on all the progress during the time at TPCY.

*The name and some identifying factors have been changed to protect the youth's identity. Quantitative data were provided through the submission of documentation to the state database and unfortunately do not receive the aggregate results of these data.

CHALLENGES

There were a handful of challenges during the previous fiscal year (2019-2020), followed through the Fiscal Year (2020-2021). There was a high turnover of clinicians in the program in the mid-fiscal year (2019-2020). While continuing to assess and address ongoing challenges around the ever-increasing cost of living and lack of qualified candidates to fill open positions, TPCY could not fill the bilingual clinician position and the Clinical Program Manager position. These challenges, their impact, and possible solutions are highlighted below:

Cost of living in the Peninsula and consistent staffing: The high cost of living continues to present a challenge for families (and staff) who cannot locate affordable and suitable housing. The COVID-19 Shelter in Place and business closure brought the loss of salary to some families. The TPCY program struggled to recruit and retain qualified staff (e.g., had the language capacity, lived experience, or necessary credentials) to adequately treat the families served.

- The challenges:
    - ✓ Families are frequently living in households with multiple members, impacting quality of life, privacy, and safety.
    - ✓ Due to COVID-19 Shelter in Place, the families who were already experiencing difficult challenges due to living in the Peninsula, such as cost of living, housing, etc., experienced further challenges, such as loss of work, financial stress, access to equipment, and Wi-Fi to participate in services via telehealth, etc.
    - ✓ At the beginning of the pandemic, the low-economic households were having difficulties with getting WiFi accessible.
    - ✓ Families experienced several provider changes, as different members of their treatment team transitioned to/from the team.
    - ✓ Due to Shelter in Place, access to previous benefits, such as Food Pantry, was not available.
    - ✓ Edgewood's salary rates do not match the astronomical cost of living in the county. This is not unique to Edgewood.
    - ✓ Staff are unable to afford to live in the county, this has resulted in them moving out of the county, which resulted in a turnover in the TPCY program for this reporting period.

- The strategies:
    - ✓ The county is working to create more affordable housing and increase living wages.

- ✓ Edgewood got COVID-19 grants to be able to provide resources to families in need of food, equipment, and any other immediate need.
- ✓ The Youth FSP Family Partners created a resource handbook to provide resource information to all the Edgewood families.
- ✓ As providers of community-based services, the staff provided services via Telehealth due to Covid-19 Shelter in Place.
- ✓ When families relocate to other counties, staff work with them to ensure that there are resources in place before their move, to ensure continuity of care.
- ✓ As a Trauma-Informed System (TIS) agency, Youth FSP encourages and attempts to incorporate self-care regularly to avoid burnout.
- ✓ TPCY successfully hires three Case Coordinators to reduce workloads to Clinicians to be more reasonable.
- ✓ In times where TPCY was unable to meet the language capacity of a family (e.g., Spanish), TPCY used Edgewood translation services.

During the FY-2020 to 2021, The BHRS Contract Managers extended the Plan of Correction to improve timely access, access to treatment, and volume of services. The Youth FSP programs continue working closely with the BHRS oversight team in monthly and quarterly meetings to improve the volume of services requirements. TPCY Successfully met all the goals, including the Units of Service requirements from the Plan of Correction.

Strategies to maintain high documentation strategies:
- The FSP conducted a full analysis of the units of the service component.
- Provided staff documentation training to ensure staff is:
  - ✓ Up to date on medical documentation standards.
  - ✓ Appropriately capturing billable services (compared to non-billable services).
- Provide support to staff to be able for documentation to be done on time.
- Created a system of support to motivate staff to document timely.
- Runs monthly efficiency data to all staff in the Youth FSP Programs.
- A monthly incentive for high "Goal Getters."

OUT-OF-COUNTY FOSTER CARE SETTINGS FSP

Through the collaborative relationship between San Mateo County and Fred Finch Youth & Family Services (FF), the East Bay Wraparound (EBW) formed a Full-Service Partnership (FSP) in 2010. The EBW-FSP program provides a full spectrum of community-based services to enable participants to achieve their identified goals. FF provides a wraparound services model to promote wellness, self-sufficiency, and self-care/healing to San Mateo County Court dependents (foster youth) who currently live outside of the county. When foster youth live outside of their court-dependent county, they often have difficulty accessing mental health services. The wraparound model helps provide intensive community-based care rooted in a strength-based approach. The youth and family receive individualized services to maximize their capacity to meet their child's needs and reduce the need for residential placement.
EBW-FSP serves youth in foster care placements outside of San Mateo County who risk losing their current residence and/or at risk for placement in a higher level of care. This program services youth ages

six to 21 and their foster parents/caregivers and parents/family members. Typically, this youth population has experienced some crisis or safety issue in their home or has had a history of multiple placements.

Services include community-based, in-home, individual, and family therapy; personal rehabilitation; case management, linking participants and families to natural and community resources; psychoeducation; integrated medication support services; and crisis intervention. Services are available to participants and their families 24 hours a day, given a target population prone to significant emotional and behavioral disruptions resulting from family stress, extreme behaviors, and care fatigue. Typically, service delivery occurs in the afternoon and evening. Staff otherwise tailors service delivery schedules for each participant's convenience. Participants can access services on weekends and after-hours through the on-call service.

A central part is establishing the Child and Family Team (CFT). Key team members include the youth, caregiver/family, FSA worker, FF team, and interested parties. The CFT meets at least every 90 days to develop the coordination plan. The family is instrumental in voicing their needs and priorities. The hope is to get the youth and family invested in the change they express as urgent and help the family meet those needs.

PROGRAM IMPACT

Out-of-County FSP	FY 20/21
Total clients served	7
Total cost per client	$49,547
Cost per contracted slots	$34,683

The EBW FSP program does many things to improve timely access and linkage for underserved populations, such as meeting youth/families in the community at convenient locations. The team consists of youth and parent partners who have "lived experience," and sometimes having a staff team member with similar struggles breaks down some barriers to cautious service participants. Attempting to reduce stigmatization through thoughtfulness and respect is an approach to service. The EBW FSP program tries to educate the youth and family on typical child development and help youth and parents better understand the impact of trauma on how symptoms manifest. Helping youth and parents better understand the function that trauma might be playing can reduce the sense of being alone in their struggles.

Staff is currently getting training and support on racial equity through racial affinity groups. The staff attends these groups monthly to address privilege and racial issues. The hope is that staff are better equipped to understand race's impact on youth, caregivers' and their own lives. The program hopes to have more meaningful discussions and be more thoughtful and culturally responsive in their actions so that families feel safe and valued in their care.

Wraparound services are not commonly offered throughout the Bay Area. The EBW FSP program has been proud to provide this evidence-based approach to families. Many of the youth served would not have had success in traditional counseling services. This approach certainly helped increase the number of individuals receiving public health services. All referred youth have been screened and approved for services and "do what it takes" to help start a positive engagement process. The program aims to treat all youth referred with equal enthusiasm and professional care.

All staff is trained in Motivational Interviewing strategies and philosophy. MI is helpful for staff to recognize the different ways a youth displays their readiness for change. Staff meet the youth where they are at and help them see the positives and negatives of their choices. Validating the youth and hearing them out are powerful tools for implementing recovery principles. Encouraging staff to get a different perspective helps prevent staff burnout.

SUCCESSES

"We are very proud of the youth who we served for several years in the program. "J" came to us with many trauma related issues. "J" was expressing suicidal ideation, had hygiene issues and would tantrum regularly. The EBW FSP provided funds for a tutor through the flex funds to help him catch up with schoolwork. "J" expressed an interest in ROTC and playing sports at the school. The foster parents expressed reservation in "J" doing these activities because "J" would often start things and give up on those activities. EBW FSP staff gave him encouragement, picked "J" up from the activities and even went to the sport events to show "J" that we believed in his dreams. "J" eventually asked to move and found a more supportive living arrangement with his resource parents. Over time, "J" called them "mom and dad" and was able to talk to them about his emotional pain. "J" was able to graduate and is pursuing his dreams of being in the military."

CHALLENGES

The main challenge is the shrinking population in the program. The program predicted that the start of AB 1299 would reduce enrollment, which is currently evident. EBW FSP program continues to meet with program partners and reach out to past staff who made referrals. Staffing is a significant challenge for this program, especially during the current workforce shortage in the field. The agency increased salaries, and has a sign-on bonus to attract new job applicants. The agency recently hired a job recruiter and hoped to see some improvements in bringing new staff to the department/agency.

TRANSITION AGE YOUTH (TAY) FSP

COMPREHENSIVE TAY FULL SERVICE PARTNERSHIP

The TAY FSP program is a specialized mental health program designed to meet the unique needs of high risk and highly acute 16-25-year-olds in the county. The program receives referrals from San Mateo County BHRS and can serve 45 transition age youth clients at any given time. The TAY FSP program seeks to assist young adult clients to achieve stability and wellness within the context of their culture and community. The program assists young adults to strengthen their network of chosen family and support people and to develop the skills to manage their needs independently. A scaffolding approach is employed to incrementally remove the formal supports in place for the clients and replace them with natural supports to ensure their recovery can be sustainable.

The multidisciplinary team identified several areas of need for the transition to adulthood which include prosocial behavior development, independent living skill acquisition, career and education guidance, and housing support. The team includes specialists in each of these areas who can be added to a client's wraparound team to provide one-on-one support in achieving their independence goals, ensuring a holistic lens is applied to clients and their lives. The program applies a person-centered approach, employing "whatever it takes" to engage and support TAY clients in addressing their needs and meeting their identified goals. Specialized services include case management, clinical treatment (psychiatry, individual therapy, and family therapy as needed), skill-building, crisis prevention/intervention, support network building and engagement, medication management, housing support, community engagement, career and employment exploration, and linkage to a wide array of community resources.

PROGRAM IMPACT

Comprehensive TAY FSP	FY 20/21
Total clients served	60
Total cost per client	$42,212
Cost per contracted slot	$63,318

During the 2020-21 reporting period, Edgewood's TAY FSP provider staff were charged with the very challenging task of ensuring timely access and linkages during the mandated COVID- 19 shelter-in-place. Edgewood's policy during shelter-in-place was to provide solely telehealth services for all outpatient clients, which includes the TAY program. This created a barrier to both client intake and engagement. Providers addressed this access barrier by employing methods including face-to-face Zoom, voice-only Zoom, telephone calls, and shorter but more frequent check-ins. Because providers' schedules were freed up significantly due to the reduction in drive-time, they were able to reach out more frequently and consistently to attempt client engagement. The Drop-In-Centers also went virtual, offering delivery of hygiene supplies and food, care packages including craft supplies, Zoom chats with Peer Partners, craft classes, and game nights. During times of normal operations, there are numerous strategies for timely access and linkages including:

- Hiring bilingual and bicultural case managers and clinicians to create a workforce that is representative of the demographics of San Mateo County;
- Employing creative strategies for locating and engaging young adults including searching for youth at known hangouts in the community, connecting through the Edgewood Drop-In Centers, searching system databases (ex. court or incarceration systems), using incentives such as meals, donations of necessities like clothing and toiletries, or providing technology supplies for better access to services; and
- Creating flexibility in the staff's work hours to accommodate TAY client schedules that often include school, work, childcare, treatment for co-occurring disorders, etc.

Throughout the 2020-2021 fiscal year, the TAY FSP was engaged with San Mateo Behavioral Health and Recovery Services (BHRS) on a Plan of Correction to address areas of improvement in Full-Service Partnership program services. Specific to the TAY FSP, this program worked closely with BHRS partners to improve timely access and linkage. Together, a streamline referral process shortened the time from the FSP accepting a client's referral to the time that the client is seen for intake. TAY FSP also worked

with BHRS to address challenges that were delaying clients from gaining timely access to internal psychiatric services. BHRS has been a valuable partner in ensuring that the referral documents are filled completely and include pertinent medication and diagnostic information facilitating a smoother transition from the County's psychiatric services to TAY FSP.

Edgewood's values of family, community, hope, and diversity are infused throughout staff onboarding and training. While in new hire training, providers are oriented to the history of behavioral health stigma and discrimination. Edgewood seeks to ensure that all providers have extensive training in modalities that seek to address these systemic issues related to behavioral health. Edgewood's ongoing staff development yields practitioners who are adept at utilizing a hybrid model of harm reduction, trauma-informed care, and wraparound principles. TAY FSP staff and leadership are aware that mental health treatment and evidenced-based practices may serve as a mechanism of cultural oppression rather than recovery, therefore the program continues to evaluate practices and request feedback from clients regarding how services are experienced by them. Another way stigma and discrimination is addressed is by offering staff in-depth training on gender-affirming treatment as well as multicultural therapeutic practices have also been instrumental in meeting the needs of the increasingly diverse transition age youth population. Providers build engagement and access to services by taking time to learn about a client's preferred methods of skill-building and wellness practices. It is standard practice for providers to create or adapt interventions to best serve each unique TAY in the program.

Edgewood as an agency leans heavily on Ecological Systems Theory to train providers how to holistically engage and work with clients and their families. In alignment with that approach, the TAY FSP encourages its staff to engage in ongoing behavioral health education and supports providers to develop flexible, individualized approaches to treatment that address every system that impacts a client's life.

Each client is considered independently; FSP does not operate under a one-size-fits-all model. At the outset of services, this includes setting the pace for rapport-building and engagement in clinical work based on each individual client's readiness to participate in services. At the point that TAY come into the program, they often have been victimized by and are untrusting of programs or systems they have been involved with in the past. Often these systems have served to stigmatize their mental illness and have limited their hopes for the future. Taking the time to prove the investment in their vision of the future engages TAY in a way that typically helps them reach beyond where they or others have ever thought they could go in their own wellness and functioning.

Microsystems work includes offering psychoeducation to a client and their support network about serious mental illness. Special consideration is given to naming the intersectionality of factors that contribute to the complexity of each client's behaviors and treatment. Some of those factors could include gender expansiveness, identification with the LGBTQ community, neurodiversity, differences in physical ability, past experiences of trauma, and racial identity.

Ecosystems work includes encouraging TAY to expand their support networks to include chosen family, community members, and local resources as well as helping them practice reaching out for support. Prioritizing outreach to local police jurisdictions and hospitals to partner around improving collective response to mental health crises. This level of systems work also includes offering space for staff to participate in workgroups, committees, and community initiatives that affect TAY in the community.

Edgewood values the agency's engagement with the communities that they serve and seeks to have a presence at local events such as the *Soul Stroll, Pride Fest, and Transgender Day of Remembrance*. Community involvement helps advocate and give voice to clients in spaces that they may not feel welcome or seen. TAY values the role in maintaining visibility for the TAY population and championing higher standards of behavioral healthcare for TAY.

Macrosystems work means the agency and FSP provide advocacy on the county, state and federal level for policies and funding that will positively impact TAY, especially those experiences serious mental illness. Each TAY client is unique, and this includes their individual barriers to receiving public health services. Every client's treatment team is tailored to their specific needs. The providers on the team collaborate extensively to connect the TAY with services available in their community that are the best fit for their personal goals, be it achieving sobriety, earning a GED, or a myriad of other activities.

To ensure the facilitation linkage to needed resources, TAY FSP Case Managers stay abreast of what resources are available to the clients and how to access them. This can include Medi-Cal or other health insurance coverage, Social Security Income, and other health and wellness services available in the county. To further assist with this effort, Behavior Support Specialists help clients decrease behaviors that may get in the way of accessing or engaging with health services. Finally, the Independent Living Skills specialists are available to work on the logistical components related to accessing services such as using public transit, obtaining and maintaining important documents (e.g., identification cards), or managing an appointment calendar. The program's chief strength in reducing disparities is the ability to maintain a flexible programmatic structure that can be easily adapted to meet the changing needs of the caseload at any given time. One excellent example of this was the nimble response to the COVID-19 pandemic, which ensured the continuation to reach the vulnerable clients even as they operate under increasingly restrictive conditions. TAY FSP takes pride in the value that there is no "one way" to receive treatment and no predetermined course in the program. The providers are not easily discouraged by behaviors that others may label as "resistant" or "unengaged." TAY FSP celebrates engagement on any level and works hard to build upon it. This helps the team establish trust that supports further engagement and progress through treatment.

TAY FSP also employs a culturally and ethnically diverse workforce with a wide variety of educational and experiential backgrounds. Diversity in the workforce brings diversity to the understanding of each unique client and creates space for "out-of-the-box" approaches to treatment. Commitment to being a trauma-informed program means the employment of very broad definitions of what constitutes engagement and recovery, among other aspects of treatment. This illustrates another facet of the wraparound principle of meeting clients "where they are." Edgewood's TAY FSP integrates trauma-informed practices and a harm reduction stance with a strong foundation in the principles of wraparound to support TAY through their treatment with the program. Utilization of a recovery-oriented approach that allows TAY to set their own vision and build agency to reach their goals. Partnership with other programs in the county that treat co-occurring disorders as needed to support all facets of a client's recovery.

SUCCESSES

Edgewood's TAY FSP is proud of the work the team has been able to do with clients over the past year, despite many challenges and hardships. From a year fraught with challenges, several bright spots have emerged in the program.

Annie (pronouns she/her) is a transgender TAY who received services through the FSP from 2018 until mid-2021. Annie's family narrative at the time of her intake into the program was that she was not capable of making independent decisions for herself (e.g. - she had a chauffeur to take her to all her appointments). Her parents were highly involved in her treatment and their relationship was marked by poor boundaries and enmeshment She presented with symptoms related to a trauma tied to her gender identity and sexuality. She also experienced high anxiety as well as relationship and boundary issues. She was also using a significant amount of marijuana. The FSP team used harm reduction techniques to help Annie curb her marijuana use. She learned how to evaluate her finances to determine how much she could afford to smoke. When she learned to budget, she cut back out of necessity. The team also helped her build independent living skills such as how to take public transportation and connect her with the Drop-In Center. Her parents also received support from the Family Partner to better understand Annie's mental health needs. During the course of treatment, Annie became more open to examining her relationships and engaged with her team to learn how to create healthy relationships and to set appropriate boundaries. While she was in the program, Annie became homeless by choice, due to her unhealthy relationship with her parents. The team provided housing resources and she was eventually moved into her own apartment unit with rental assistance from Edgewood. She was extremely successful in this setting and within the past year, she was able to take over the lease and graduate successfully from the program (as of May 2021). We referred her to a step-down program to continue therapy and case management services, which she continues to participate in.

Byron (pronouns he/him) has been in the program since 2017. At the time of referral, Byron was highly symptomatic; his diagnoses are ADHD and MDD. At the time, he was experiencing extreme paranoia and abusing opiates regularly. Byron had experienced rifts in several family relationships, including his mother. He was also distrustful of the mental health system and was challenging to engage. His treatment team developed and executed a long-term plan for engagement employing scaffolded interactions at the Edgewood Drop-In Center designed to develop trust and rapport before initiating higher-intensity services. Once engaged in services, a primary goal of Byron's was to get clean and maintain his recovery. He worked closely with his team to learn the skills necessary to reach this goal. He developed a habit of thinking critically about how to reach his goals. For example, he was having trouble with cravings and staying sober and identified that hanging with his old friend group was triggering him to use it. With this knowledge, he could make concrete plans to avoid that triggering situation. He worked with the Guidance and Career Specialist to register for college courses. She coached him on how to interact with academic advisors and navigate the higher education system. They also completed a resume, did mock interviews, and explored career paths. Byron successfully acquired the education and employment-related skills he had identified for himself. He also worked with a Behavior Support Specialist to support his recovery and develop social skills, and a Residential Support Counselor to acquire housing knowledge and navigate his occasional housing insecurity. The team supported him in adjusting his treatment goals each time he graduated from an adjunct service. Today, he is living with his mother, and they are doing well. In reflecting on his treatment, the team noted his significant achievements: he is maintaining his recovery, he is successfully managing his symptoms, he has secured stable housing, he has repaired some of his family ruptures, he has improved his relationship skills, he is

attending school, and has been able to secure employment. The team is currently helping Byron plan for graduation sometime this year.

In addition to client successes, the program was able to respond quickly to the pandemic and was able to continue providing services despite widespread shutdowns. The implementation of telehealth in response to the COVID-19 pandemic yielded mixed results, however for those clients who responded well it has proven highly successful. From the outset of the shelter-in place mandate, all providers were equipped with agency-issued cell phones and laptops and deployed videoconferencing technology. For some TAY clients, especially those suffering from severe anxiety or who are housebound, the use of telehealth has improved access to services. Further, it is not uncommon for TAY to prefer meeting with their team via video or phone versus in-person and the use of telehealth has resulted in more frequent service delivery contacts to some clients. Considering these findings, TAY saw the need to enhance its telehealth delivery with an eye toward expanding the program's offerings to include virtual service provision even after shelter-in-place. To that end, the program employed grant funding to purchase telehealth supplies that can be distributed to clients in need.

CHALLENGES

On the opposite side of the coin, there have also been some significant challenges with moving to a primarily telehealth model during the pandemic. Program providers report they have difficulty keeping clients engaged for a full session and lack the resources to provide quality content for virtual sessions. In the past, interventions could be provided on a long car ride, sitting together over coffee, or on a walk. In this new virtual world, the therapeutic work is much more direct and can be overwhelming for clients who have significant trauma to process or those who do not respond well to talk therapy. And then, of course, there are the universal challenges of internet service overload in multi-person households, unreliable tech equipment, and crowded living spaces that do not offer quiet or privacy for individuals to hold teleconference sessions. For TAY specifically, having parents, siblings, or friends in the same room can be a considerable barrier to their ability to discuss private topics such as past traumas or current suicidal ideation. Appearing on camera has also been particularly challenging for TAY experiencing body dysphoria, those with social anxiety, or those experiencing severe paranoia.

TAY has attempted to mitigate these challenges in several ways. The program has purchased telehealth supplies for clients, including tablets, charging blocks, and headphones to give them the ability to create privacy for their sessions. Staff also have access to a seven-part training series, "Increasing Engagement Utilizing Telehealth," which covers topics from addressing trauma to utilizing spiritual practices to acknowledging mental health stigma and implicit bias through the medium of telehealth. Finally, with guidance from the Medical Director and per local and state guidelines, returned to community-based work using a hybrid model of in person and telehealth services. TAY continues ongoing efforts to plan for and monitor how to safely conduct in-person services for clients in their communities.

An important component of the TAY FSP is the Family Support Team, consisting of two Family Partners and a Family Support Manager. All people with lived experience. Maintaining this team has been extremely difficult for the past several years. Part of the reason is the staunch commitment to hiring staff with lived experience who can provide invaluable support and validation for often-stressed caregivers. The pool of potential candidates who are interested in this work is small.

Additionally, TAY cannot pay a competitive salary due to agency budget restrictions. This makes it especially difficult to hire in San Mateo County, where the cost of living is very high. The difficulty is further compounded by the fact that many potential applicants would need to balance their full-time position with their work as primary caregivers to a youth, TAY, or other family members who may be participating in intensive treatment themselves.

The TAY FSP Leadership team is actively looking to fill these positions posted on the Edgewood website. The program has also "put out feelers" with county partners, and one manager even actively recruited a potential applicant she encountered in her work. Finally, the Leadership team is strategizing ways to build more robust caregiver support into the current program structure. This has included bringing in a trainer to help providers learn how to talk to TAY about engaging their caregivers in treatment and ways to strengthen those relationships. They have also begun to cross-train current provider staff to allow more flexibility within their roles, including offering caregiver support. Finally, TAY is looking at ways to facilitate connections within the current caregiver census to support one another sustainably.

Staff turnover has presented yet another programmatic challenge that has worsened during the COVID-19 pandemic. Low salaries, Zoom fatigue, pandemic-related challenges in working with clients, and the high cost of living in San Mateo County are all factors that have contributed to staff turnover in the past year. The program is currently looking at ways to address these issues, including offering a hybrid workplace (virtual v. in-person) that allows staff to live out of the county in more affordable areas. One of the most pervasive program issues is housing. The TAY FSP struggles with housing on several fronts. As mentioned previously, San Mateo County is one of the more costly areas in the state to live in, which impacts both staff and TAY clients. The program addresses this by allowing staff more flexibility to work from home than before the pandemic. TAY has also partnered with the Mental Health Association (MHA) of San Mateo to provide housing subsidies for clients and offer several apartment units that the agency manages. However, even when housing units and rental assistance exist for TAY clients, there often remain safety and risk management challenges for young adults experiencing serious mental illness. The program is currently exploring ways to expand supportive housing placements, including licensed facilities and emergency beds, within the county utilizing the partnership with MHA.

ENHANCED SUPPORTED EDUCATION

Caminar's Supported Education program at the College of San Mateo has been highly successful in supporting individuals with mental health/emotional needs in attending college and achieving academic, vocational, and/or personal goals. This program was established in the spring of 1991 from collaboration with the College of San Mateo, Caminar, and the County of San Mateo's BHRS program. The program's unique approach combines special emphasis on instruction, educational accommodations and peer support to assist students to succeed in college. Traditionally, the attrition rate for individuals with psychiatric disabilities has been exceptionally high as a result of anxiety, low stress tolerance, lack of academic and social skills, and low self-esteem. However, this program has become an innovative leader in reversing this trend. Started in 2016 at Skyline College, Future Views supports potential students with an introductory class and one to one counseling and tutoring.

In Addition to the campus presence, the Supported Education program has an extensive presence in the community, with regular groups at Caminar's residential programs such as; skills groups, self-care groups, activity groups, and processing groups. There is also a weekly Drop-In time for clients to get school and career assistance. The Supported Education program is also a part of the Diversity and Equity committee and the MHB adult and TAY subcommittees.

The Supported Education program strives to reach out and engage individuals who can benefit from engagement in the supported education program. To this end, the supported education program team has reached out to a wide number of community programs throughout the fiscal year, to reach out and engage clients into supported education services, thereby initiating a pathway of recovery, support and empowerment. Once engaged in the supported education program, clients begin to see their potential and the opportunities available to them.

Classes and groups also build on recovery principals such as; WRAP (Wellness Recovery Action Plan), personal and career skills-building, resource education and linkage, empowerment through education and career development, leadership potential, having a peer support group, and engagement utilizing active listening, motivational interviewing, and supportive engagement.

Providing a pathway for clients into a new identity as a student, Peer Counselor, or other career pathway greatly increases personal self-esteem and helps re-write the 'client' narrative, thereby decreasing the stigma commonly associated with persons receiving mental health support and services. Caminar's Supported Education program provides such a pathway of opportunity, and it remains essential that all of San Mateo county clients are given information of and access to the supported education program.

PROGRAM IMPACT

Supported Education	FY 20/21
Total clients served	82
Total cost per client	$2,419

The supported education program focuses on connecting individuals with educational/vocational services and by providing individualized supports. With these supports, the cohort GPA and retention rates are as follows:

Students attending Fall and Spring semesters of the Peer Counseling program:
- achieved an overall GPA of 2.9
- Attained a retention rate of 77%

Additionally, through the development of supports such as staff and student support groups, the individual client benefits from a supportive, nurturing and empowering environment that fosters self-reliance, self-care, and in turn decreases the isolation and stresses that often precipitates an increase in symptoms or a decrease in functioning.
- 100% Reported that their class experience was satisfactory or above

Curriculum Summary

- Peer Counseling Class 1 Fall. Orientation, HIPAA, boundaries, Carl Rogers active listening, hierarchy of needs, Humanistic Psychology, overview of academic programs, group facilitation, communication essentials, WRAP, ACA ethics, self-care, diversity and equity programs, and the models of recovery.
- Peer Counseling Class 2 Spring. Review of active listening, Motivational Interviewing/stages of change, Harm Reduction models, Object Relations model, classical/operant conditioning, Cognitive Behavioral Theory, problem solving, DSM 5, assessment concepts, developing a treatment plan, writing progress notes/BHRS documentation guidelines, and a career project.

- *Fall Semester*- 10 students completed the Peer Counseling 1 class
- *Spring Semester*- 10 students completed the Peer Counseling 2 class
- 6 students are working, 3 are continuing school.
- The program served 82 unduplicated clients, with 20 TAY (transition-age-adults)
- 139 Hours of service were provided (8,380 minutes)
- 64 groups and activities for TAY clients were offered
- 189 engagement activities for TAY were offered (classes, groups, outings, one to one activities)

SUCCESSES

The College of San Mateo has continued with distance learning for most of its classes, except small lab sections for courses with a lab requirement. The Peer Counseling class has continued with the RingCentral Zoom online format, which seems more accessible to those students who otherwise have challenges commuting to campus. Additionally, this has also helped them to be able to check in weekly and become more fluent in alternate methods of communication. The entire counseling class needs to be recognized for their inspiring perseverance, adaptability, engagement, and support. Whichever direction they choose, they are sure to not only have a positive impact but also, and most importantly, they will be a support and inspiration to other clients.

CHALLENGES

1. Clients can often need extra assistance and, in some cases, upgraded devices to be able to join on zoom activities. Programs increasingly assist their clients with grant-sourced devices to aid in their connectivity.
2. Referrals/Connecting- Conducting outreach and community activities during covid-19 has been modified. The supported education program has a strong focus on outreach and engagement activities to reach as many clients and programs as possible and offer the support and program opportunities available. The Supported Education program will continue exploring alternative outreach strategies in the coming year.
3. TAY (Transition-Age-Youth) This age group presents challenges in engaging and supporting in life and career goals and the continued housing crisis that directly impacts their stability and overall health and well-being. As age-appropriate, TAY often prefers doing activities with other TAY and does not want to identify with a 'specialized' program. While this is important for connection and self-esteem, it represents challenges for helping professionals in engaging, guiding, and

supporting. Nonetheless, this is a critical area of focus, as helping to guide and support TAY in their growth, exploration, and development is both essential and highly rewarding.

DEMOGRAPHICS

	FY 20/21			FY 20/21
Age			Race/Ethnicity	
0-15	9%		Latino/a	56%
16-25	3%		Pacific Islander	0%
26-59	86%		Asian	2%
60+	2%		Chinese	1%
Unknown	1%		Black/African/-American	2%
Primary Language			White/Caucasian	3%
English	17%		Filipino	3%
Spanish	80%		Asian Indian	1%
Mandarin	1%		Puerto Rican	1%
Tagalog	1%		Samoan	1%
Unknown	1%		Fijian	1%
Gender Identity			South American	9%
Male	24%		Another race/ethnicity	8%
Female	74%		Unknown	10%
Decline to state	1%			
Unknown	0%			
Two-spirited	0%			
Sexual Orientation			Veteran	
Gay, lesbian, homosexual	0%		Yes	2%
Straight or heterosexual	84%		No	95%
Bisexual	0%		Unknown	2%
Decline to state	14%			
Unsure	2%			
Unknown	0%			

TAY DROP-IN CENTERS

Located in San Bruno and Redwood City, the Drop-in Centers are community resource centers catering to individuals between the ages of 18-25 years (up to their 26th birthday). Each peer-led site serves as a safe and confidential space offering free resources, activities and workshops, and opportunities for socialization and peer connection.

The Drop-in Centers provide regularly scheduled programming such as community outings, social activities, personal growth, and wellness workshops, as well as access to computers, the internet, a

clothes closet, and food. Most importantly, Peer Partners lead activities that support 18-25-year-old participants in building the necessary skills to successfully transition to adulthood.

Peer Partners, young adults who have been through similar life experiences, are an invaluable resource to the Drop-in Center participants. Employing people with lived experience in peer worker roles to support others brings a tremendous range of benefits. Peer workers know what it is like to go through uniquely difficult situations and life experiences and can share their experiences of recovery, growth, and resilience. Peer Partners who are living well represent hope that is often missing in the Drop-in Center participant's lives. Peer Partners facilitate a safe and welcoming environment using empathy, validation, constructive feedback, and unconditional support; Peer Partners are trained in Youth Development, Harm Reduction, and peer counseling techniques. Peer Partners offer support and peer mentorship; give resources; and plan, implement, and co-facilitate groups and activities.

Success at the Drop-in Centers is measured individually and is fluid according to how each transition age youth participant defines self-efficacy. The primary focus is on building quality relationships with all individuals, so each may feel empowered and capable of voicing their needs and apply what they have learned to all facets of their lives. Due to the COVID 19 pandemic, both locations suspended in-person activities and pivoted to providing services over the phone, through video-conferencing platforms like Zoom, and provided basic needs and health related services through on site grab and go distributions and home deliveries. Goals of the Drop-in Centers are:
- Promote socialization and community connectedness
- Support academic and/or vocational exploration and growth
- Encourage the development of independent living skills
- Empower rising leaders and advocates

Additional Goals During the COVID-19 Pandemic:
- Provide basic needs to overcome financial challenges and promote emotional/physical well-being
- Provide a virtual safe space for TAY to connect and decrease feelings of isolation

PROGRAM IMPACT

TAY Drop-In Center	FY 20/21
Total clients served	124
Total cost per client*	$16,944

Funding for the C/Y and TAY FSP includes drop-in center services and is not separated out

The Drop-in Centers (DICs) continue to address the basic and higher-level needs of transition-age youth. Basic needs include food, hygiene products, and clothing. When in-person services resume (TBD), dinner is served nightly, snacks and food are available for take away, hygiene products and clothing are available, as well as free computer and printer access. The DIC South provides laundry access as well.

Higher-level needs may include referrals for mental health treatment, linkage to a community health clinic and other health-related resources, support in understanding their benefits, and someone to talk

to (usually a peer) to problem-solve a difficult situation. All that is offered is free. Peer partners help participants identify resources and services that will best fit their needs. Peer Partners model how to make calls to health care providers, locate resources via the internet and make direct links to community providers. When a participant or group of participants has a need not currently being met by one of the Drop-in Center sites, the staff will reach out to community partners, identify resources, and ensure participants' needs are met.

Given the nature of who they serve, young people who are marginalized or living outside of the normative young adult experience, it is fair to say most of the participants are impacted by stigma and/or discrimination. Recent undocumented immigrants face discrimination daily and see the Drop-in Centers as one of the few safe places they can go for their physical and psychological wellbeing. Young people of color have reported the comfort they felt upon learning many Peer Partners share a similar background, ethnicity, or language; these same individuals reported a sense of shame and discomfort that held them back from asking for help in other settings. Participants also report feeling Peer Partners accept them for who they are, empathizing with their experiences, and not judging their past or current behaviors (i.e., harmful to self or others) or who/what they represent (i.e., LGBTQ+, foster, immigrant youth).

There is one specific but direct intervention they apply which the Drop-in Centers are particularly proud of - their welcoming culture. This intervention includes creating an inclusive environment and training Peer Partners in engagement practices. Instead, it embodies welcoming to ensure a visual and visceral experience of acknowledgment, appreciation, belonging, and unconditional positive regard. We see this as the core intervention upon which all others are built. The intended impact of this welcoming culture is to meet the needs and interests of transition-age youth at this critical stage of life. The unintended impact of the welcoming culture includes the broad spectrum of resource requests made by the participants and the need for continuous training of Peer Partners in facilitating sensitive conversations (i.e., race, discrimination, power and privilege, politics).

The Drop-in Centers do not collect this data due to the nature of the DIC model and philosophy. Unlike other services that have restrictive rules, lengthy intake processes, and eligibility criteria, the Drop-in Centers welcome anyone who meets the age requirement. The program is designed to reduce barriers and instead acts as a core center for transition age youth. While mental health services or emergency housing may not be available at the Drop-in Centers, the staff are well informed of processes for accessing services and will provide a high level of support to participants to ensure as few obstacles arise in their effort to address their needs. The data collected is represented in the demographics section below. The information collected while minimal is the least invasive and often still, difficult to attain from a young person.

SUCCESSES
- Monthly on-site basic needs and food distribution at both North and South locations
- Home deliveries of basic need items to TAY with lack of transportation support and resources
- Partnerships with local organizations
- Additional funding support from private foundations and local health district
- Online activities for TAY to connect and DIC Peer Partners

- Launched DIC Social Media page on Instagram

Positive Youth Development continues to be the approach in working with the San Mateo County TAY community. The holistic, positive, and preventative nature of the youth development philosophy has given us positive outcomes, including feeling valued and included in what happens at the Drop-in Center. Participants are encouraged to give feedback on programming, giving them a sense of ownership of the weekly groups and activities.

They also continue to establish partnerships with community organizations and businesses. Without partnerships with local educational institutions and community-based organizations, they would not hold its annual events, including the Back to School Fair and Career Fair. Representatives from Bay Area colleges and universities spread throughout the DIC sites on fair days. Food, raffle items, and new backpacks filled with school supplies result from donations from individuals and local entities, including Help One Child, Jersey Mike's, and EA Sports.

As the COVID-19 pandemic continued to restrict in-person support, staff developed alternate ways to reach clients, offering multiple avenues of connection, including one-on-one support via phone, Game Nights through Zoom, and the Centers' Instagram Page. This effort included a dramatic increase in content aimed towards TAY on connecting with the help they need around food banks, housing, unemployment support from the government, and staying connected to local community colleges for academic support and services. They also worked to increase the visibility of the page and the number of followers to reach more TAY in the county and provide them with updated information on the virtual support services and activities and the ongoing basic need distributions.

Towards the end of the reporting period, due to support from the Sequoia Healthcare District and the Chan Zuckerberg initiative, they provided health-related tools and equipment at the on-site grab-and-go distribution at the DIC South location. Items like yoga mats, stress balls, fidgets, and massagers were available to any community TAY who came to the site. They also partnered with the Stanford Teen Health Van to provide TAY with drop-in health services, including free COVID testing and sensitive services. The TAY Healthy event was just one of the many services that have had to adapt to the circumstances of the pandemic. In addition to their accomplishments this year, below are individual stories that demonstrate the impact of the services (names changed for confidentiality):

Michelle, is a 24 year old TAY and the mother of three young children. She did not have a job and feared finding one due to the COVID 19 pandemic, making it extremely difficult for her to meet the needs of her family. Desperate for support, she reached out to the Drop-in Centers for assistance. With team collaboration, the Drop-in Centers team were able to provide her with immediate basic needs such as hygiene and munchie bags, clothes, diapers, and wipes, as well as recreational items such as activities and activity kits, and Chats with a Peer Partner. Michelle participated in many of the plethora of activities offered at Drop-in Centers. Michelle stated that the Drop-in Centers have been helpful for her to manage everyday stressors and feels that she would not have been able to support her children if it were not for the Drop-In Center.

Angie (She/her) is a 19-year-old living in Daly City with her family. Angie is on the autism spectrum and struggles with depression and anxiety. She reached out to the Drop-in Centers on the Instagram

account. Due to low family income and inability to find a job, Angie needed help with obtaining food, hygiene items, and other necessities. She participated in game nights and weekly Chat's with Peer Partners where she worked with staff to help manage her depression and anxiety. As Angie continued her job search, she reached out to the Drop-in Centers for support when it came to resume and application help. Angie also utilized other Drop-in Center services such as deliveries, hygiene/munchie bags, activity kits, and clothes. These services relieved financial stress and burden. Eventually Angie's confidence grew and was able to find a job. Angie reduced her engagement in Drop-in Center services on a regular basis but, is thankful that the support she received made her become a more independent young adult.

CHALLENGES

Many of the challenges faced in this reporting year were due to the COVID-19 pandemic, having to suspend on-site activities, which affected the amount of TAY served throughout the year. Below is a list of obstacles that will be continued to be addressed in the next reporting year.

- Re-establishing connections with regular TAY community members due to lack of contact info.
- Communication and outreach to TAY community providers for collaboration and resource support
- Holding in-person events amid COVID-19 uncertainty
- Capacity to deliver services to monolingual Spanish speaking TAY
- Reaching more Community TAY who are isolated during this time and lack the communication resources to connect with their DIC team

DEMOGRAPHICS

	FY 20/21
Age	
16-25	100%
Sexual Orientation	
Gay, lesbian, homosexual	0%
Straight or heterosexual	35%
Bisexual	5%
Queer	0.01%
Questioning or unsure	0.02%
Another sexual orientation	0%
Decline to state	55%
Gender Identity	
Male/Man/Cisgender	15%
Female/Woman/Cisgender woman	29%
Transgender male	0.01%
Transgender woman	0%
Decline to state	54%
Race/Ethnicity	

American Indian/Alaska Native/ Indigenous	0.01%
Asian	0.01%
Latinx	31%
Pacific Islander	0.01%
Eastern European	0%
European	0%
Arab/Middle Eastern	0.01%
Black/African/-American	4%
White/Caucasian	7%
Asian Indian/South Asian	0%
Central American	0%
Chinese	0%
Mexican/Chicano	0.01%
Filipino	0%
Japanese	0%
South American	0%
Another race/ethnicity	0.02%
Decline to state	52%

ADULTS AND OLDER ADULTS FSP

ADULT AND OLDER ADULT/MEDICALLY FRAGILE FSP

The FSP program, overseen by Telecare, Inc., provides services to the highest risk adults, highest risk older adults/medically fragile adults. Outreach and Support Services targets potential FSP enrollees through outreach, engagement and support services. These programs assist consumers/members to enroll and once enrolled, to achieve independence, stability and wellness within the context of their cultures and communities. Program staff are available 24/7 and provide services including: medication support, continuity of care during inpatient episodes and criminal justice contacts, medical treatment support, crisis response, housing and housing supports, vocational and educational services individualized service plans, transportation, peer services, and money management. Services specific to Older Adult/Medically Fragile include maximizing social and daily living skills and facilitating use of in-home supportive agencies.

Telecare FSP, via the integrated teams model uses daily morning huddles to assertively coordinate and track the various service needs for every individual the teams serve. Including benefits acquisition, psychiatric appointments and medication, case management and evidence-based rehabilitation and other promising practices, the teams proactively identify needs and gaps in service and provide, broker or advocate for those necessary services or resources. The concentrated effort of each team affords the opportunity to engage in continual improvement for clients lives by circling back on progress made in all the areas identified.

Telecare delivers excellent and effective behavioral health services that engage individuals with complex needs in recovering their health, hopes and dreams. Utilizing a team-based approach, clients have 24/7 access to a team member that has working knowledge of their hopes and dreams, treatment plan goals, interventions that have worked and those that do not. Furthermore, each team incorporates titrated services ranging from the most intensive (FSP level) through Case Management and into Wellness.

These levels allow members to progress in their recovery journey while keeping their support team intact and allows for aging members to move back into higher levels of support, again, keeping their support team intact.

All service recipients are adults or older adults that are in their recovery journey from complex behavioral health challenges including serious and persistent mental illness, co-occurring medical issues, substance use, criminogenic profiles and more.

Activities, services and interventions include but are not limited to: assessment and treatment planning, psychiatry, case management, medication support, vocational development/brokerage, supported education brokerage, numerous evidence based and promising practices such as Motivational Interviewing, Wellness Recovery Action Plans (WRAP), Seeking Safety, Recovery Centered Clinical Systems (RCCS), Screening, Brief Intervention and Referral to Treatment (SBIRT), etc.

PROGRAM IMPACT

Telecare Adult/Older Adult FSP	FY 20/21
Total clients served	233
Total cost per client	$17,681
Cost per contracted slots	$19,901

Improves timely access & linkages for underserved populations
With very few exceptions, initial meetings with new clients occur in less than three business days of the referral. Engagement, assessment, and collaborative treatment plan development start in that initial meeting.

Reduces stigma and discrimination
The multi-disciplinary teams are comprised of varying professions (Case Managers, Licensed Clinicians, Nurses, and a Prescriber). Still, they also comprise a high number of individuals with lived experience. Approximately 80% of the Telecare teams are individuals on their recovery journey. This normalizes the process, establishes rapport, and reduces stigma.

Increases number of individuals receiving public health services
The program takes almost all client referrals, with few exceptions. They refer, link, and connect clients with various public health providers. Within the first two weeks of working with a new member, the team searches for benefits to which the member is entitled and helps establish those benefits for the member.

Reduces disparities in access to care

Daily team huddles are conducted, and members' circumstances are reviewed to ensure that all members have access to but are not limited to the following: psychiatric and medical care, financial benefits, access to housing options, food security, vocational and educational resources. Furthermore, as part of San Mateo County's system-wide effort to improve care coordination for individuals with complex needs, Telecare FSP participates in cross-over collaborative efforts and has representation at the planning level.

Implements recovery principles
Telecare's clinical model, Recovery Centered Clinical Systems (RCCS), is at the core of operations. The staff focus on recovery in the aspects of the care provided.

SUCCESSES

Telecare FSP continues to provide excellent services and interventions to the individuals served. Over the past several years, the Telecare FSP's have focused on:

- Using intentional service delivery (based on a member's stated preference of goals in their treatment plan, staff know what behavior they want to address and what interventions they will use prior to going out to see the member)
- Observing clinical efficacy in addition to capturing outcomes other than MHSA (meaning, did the intervention work in addressing the behavior and did the member get the outcome they preferred)
- Sharing these observations with the individual member
- Further partnering with the member using Motivational Interviewing (MI) and Recovery Centered Clinical System (RCCS) conversations to highlight their choice in both interventions and hoped for outcomes

#1 James has been a client with Telecare on and off since 2015.   When first enrolled James struggled greatly. He presented as extremely symptomatic, delusional, and aggressive. He was inconsistent in his engagement with the team and was not participatory in his recovery. He was unable to remain in the community for more than a few months at a time. He would frequently get new criminal charges and end up incarcerated. During his last incarceration James reports that he had a realization that things needed to change. Upon his release, he requested to come back to Telecare. This was in April of 2019. Over the last few years James has had his ups and downs. James has struggled with his finances and has had to figure out how to make his own way financially after being denied for social security benefits. He has faced homelessness and had to find new housing on numerous occasions. He re-engaged with his family but learned that he needed to part ways from his father due to the toxicity of their relationship. Through all of these issues he has been able to continue to make positive progress in his recovery, engage with his treatment team and voice his needs, and partner with his case managers to obtain needed support and resources.
Currently James is living in the community independently, meeting with his treatment team on a weekly basis, and has been working a full-time job at the same location for the last three years. He continually gets positive feedback from his employer and they have stated he is one of their best employees. He has truly turned his life around and is living proof that with proper support and dedication to recovery amazing things can happen.

#2 "Before coming into Telecare, I felt like I didn't have an identity. In those moments, I didn't care about my life, I didn't care about the choices I was making and how they were hurting my family. I was in a dark place. I felt like I was just treading through mud and just going through the motions. It seemed as though no one believed in me, no one was able to see my inner struggle, and no one could see the evolution of changes going on within me. My family, especially my mom, has been a huge influence on helping reawaken me to live the best life I can. She believed in me when I didn't believe in myself, and so did Telecare. Working with Telecare has given me that truth serum I needed, in the sense that they pushed me to see that I was better than whatever was going on in my life and conflict internally. They worked with me on goals and more and more doors opened. I was able to change my perspective to be more realistic and more understanding and I began to feel like somebody out there does see my worth, even if I couldn't. Telecare, and more importantly my family's support in my journey has also helped me muster that last seed of hope I was holding onto, this hope that I wasn't able to see before in my life but now I AM ABLE TO SEE that I am more loving, caring, and I carry a can do it attitude. The biggest part of my journey has been figuring out who I am and would like to be, and I know now I am more than my diagnosis. I am who I am and I am a good person. Both telecare and my family have helped me see the strength I have within me, and I didn't realize I had so much more to offer. I feel like I am finally able to exhale, and that means a lot to me."

#3 Bradley has been with Telecare FSP for just over a year. When he was first enrolled he was struggling with living in an environment that was not supportive to his mental health. Bradley was psychiatrically hospitalized almost on a weekly basis while living in this environment with his previous domestic partner and due to consistent symptoms of mania and non medication compliance, which was hard for his partner to understand. Bradley would choose shelters over returning home and would self present to PES for a break from home. When initially enrolled, within the first 3 days he resided at safe harbor, an independent supported living placement, & was arrested before returning "home" with his domestic partner.

Bradley was discharged from his last psychiatric hospitalization in May 2021 and has since become estranged from a 20 year domestic partnership, lived in a group home setting, and then signed the lease for his own apartment. Upon his discharge, Bradley was faced with many challenges such as living in a group setting and having to start from scratch with his belongings and lifestyle. Bradley exhibited immense maturity, respect and responsibility throughout these moments and turned from a "hot client" to someone who had a new accomplishment to share during his interactions with the team. Bradley continues to engage with FSP multiple times a week and has become medication compliant along with

discovering how to live independently at 72 years old. He has engaged with his peer mentor and enjoys outing in the community during his meetings. Bradley has developed many social skills such as learning how to communicate with staff at his bank, grocery stores and within his apartment complex. Bradley continues to draw "doodles" to show his team what his life is like through his eyes. Bradley will tell you "this is all because of Telecare" and constantly reminds his team of his appreciation to turn "a creep into a prince".

In addition to the individual clinical interventions such as those above, Telecare is also deeply proud of community interventions, particularly during the various crises (pandemic, fires, civil unrest). Whereas some of the competitors closed their entire operation for two weeks for the holidays during these times, Telecare did the following:

- Worked with Public Health to include non-licensed but congregate living homes in the county wide COVID-19 testing and contract tracing (there are many dozens of these and several hundred people with disabilities and health complications residing in such homes)
- Developed cohorting, cleaning, quarantine protocols for such homes and shared these with the greater community
- Partnered with Public Health to get PPE's to such sites
- Developed an Acute Step Down home for 5 long term patients on the acute psychiatry floor (average length of stay was between 2-2 ½) to prepare for COVID surge. This home was opened within 9 days of the request and all the residents are still in the community 1 ½ years later.
- Worked with CVS pharmacy to run COVID-19 vaccination clinics for members at the congregate housing locations getting over 75% of members vaccinated.
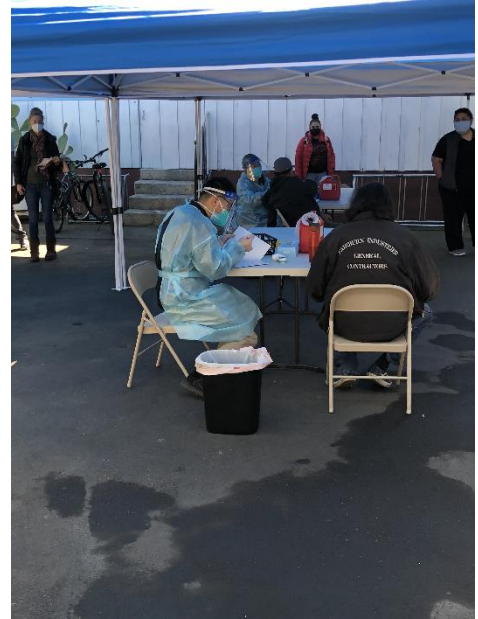
CHALLENGES

The challenges during this reporting window were severe. With the COVID-19 pandemic, fires, and civil unrest, there were plenty of opportunities to rise to the occasion and be of service to members and the community at large. Challenges included: testing, contact tracing, access to PPE, teaching and reinforcing the use of PPE's, providing services to members while managing shelter in place, quarantines, etc. Telecare FSP teams aggressively pursued measures to continue services to the members. Staff learned to connect with members via phone, mobile platforms (e.g., Skype, Zoom, MS Teams, etc.), and socially distanced contacts. Telecare even developed a low bandwidth virtual TelePsych app for virtual doctor's visits.
 A non-pandemic but long-standing concern for Telecare is the contract and that it's been extended many times with no accurate adjustment for service costs. This has led to significant challenges in several areas, most notably in staff recruitment and housing for members. Due to salary limitations, the program remains significantly understaffed by more than 20%, with one Team Lead role open for 1 ½ year. While housing costs did stabilize in the region during COVID, costs remain well beyond the means of those they serve. Additional resources for solutions such as the congregate homes offer a significant

opportunity for members to have a place to call home. As the Community Interventions narrative above highlights, Telecare's ability to act proactively, swiftly, and competently to serve members is well on display. They are deeply committed to the mission of excellence in San Mateo and welcome the opportunity to increase this mission in the coming contact cycle.

COMPREHENSIVE FSP FOR ADULTS AND OLDER ADULTS

Caminar's FSP program is designed to serve the highest risk adults and highest risk older adults / medically fragile. Most adults with SMI served by FSP have histories of hospitalization, institutionalization, and substance use, are not engaged in medical treatment and have difficulty participating in structured activities and living independently. Older adults have cognitive impairments and medical comorbidities. The purpose of this program is to assist clients in enrolling and achieving independence, stability, and wellness within the context of their culture and communities. This program aims to divert clients from the criminal justice system and acute, long-term institutional levels of care and help them succeed in the community. In addition, the program strives to help them achieve their wellness and recovery goals, maximize their use of community resources, integrate clients' family members or other support people into their treatment, achieve wellness, independence, and improved quality of life.

FSP has a staffing ratio of staff to consumers, with a ratio of 10:1. FSP can serve 30 clients. There are frequent team meetings to discuss clients in crisis, hospitalizations, incarcerations, med non-compliance, and homelessness. A psychiatrist is assigned to the client to provide medication evaluation and psychoeducation. Case managers assist clients with needs related to mental health services, rehabilitation, housing, employment, education, social and recreational activities, and health care. Consumer treatment includes a variety of modalities based on consumer needs, including case management, individual, group, or family therapy, psychiatric medication prescription, and general medication support and monitoring. Consumer self-help and peer support services include money management, employment opportunities, social rehab, and assistance with referrals and housing.

Caminar also provides community based-nursing to assist clients with improving medication compliance. FSP services are delivered by a multidisciplinary team, which provides 24/7 crisis response support, including in-home support services and services at other consumer locations as appropriate. Case managers help plan for linkage to and coordination with primary care services to strengthen the client's ability to access healthcare services and ensure follow-up with detailed care plans.

PROGRAM IMPACT

Caminar Adult/Older Adult FSP	FY 20/21
Total clients served	35
Total cost per client	$27,943
Cost per contracted slot	$32,600

Caminar reduces suicide by rapid and consistent engagement with clients and their collateral providers, case conferences, increasing contact with clients who may be decompensating, 24/7 availability, and CPI protocol and training. The program limits school failure and dropout through the Supported Education program. It helps lower unemployment by utilizing the Jobs Plus program, which provides skills training and referrals to employers looking for workers. Homelessness is a pervasive problem in the Bay Area and San Mateo County, in particular. Caminar provides housing options to clients in need of independent

apartments and shared apartments through the Supported Housing program. In collaboration with BHRS, FSP links clients to multiple housing options: Licensed Board and Cares, SRO rooms, shelters, and unlicensed room and boards.

By utilizing the social rehabilitation model, which provides a non-judgmental, normalized environment that emphasizes the client as the lead in their care, Caminar works to reduce the stigma and discrimination their population often faces. They further ensure linkage to outside community providers for primary care and ensure ongoing collaboration with said providers and staff; this helps ensure that clients receive public health services. By partnering with other non-profit agencies, Caminar helps reduce the disparities in access to care. Finally, they utilize Harm Reduction, MI, DBT, and WRAP to help strengthen clients' gains and implement the principles of recovery throughout all of their programs.

SUCCESSES

Covid-19 Pandemic response measures:
As a result of the Covid-19 Pandemic, Caminar FSP has put safety measures of PPE and outdoor meetings in place to continue providing face-to-face services to the clients. This last year Caminar received a Cares funding grant and provided 14 clients with technology to keep them connected and provide the ability for them to engage in Caminar and community virtual groups. The program has equipped staff with technology to support clients who now have the resources to engage in telehealth. The Wellness Support Specialist (Peer Partners) has created and implemented groups for clients to attend to engage in group activities safely. The clinic offers in-person, phone, and video psychiatric services.

Caminar has successfully supported clients in receiving the covid vaccination, with 26 of 30 clients being vaccinated and encouraging the remaining clients to receive the vaccine.

To support clients during the holiday season, Caminar provided clients with gift baskets containing items to increase coping skills, activities to increase moods during the holidays, and gift cards for grocery stores to encourage clients to purchase nutritious foods.

To support the safety and connectedness of staff, Caminar has developed staggered schedules to allow for in-office work. The program has also implemented daily morning huddles for the team to check in, gauge their level of burnout, discuss the support needed, and identify specific goals for the day.

Cultural responsiveness training and addressing inequalities in the community:
As a response to the need to increase staff's competency of structural racism in the community and be culturally responsive to provide the best quality of services to FSP's diverse population, Caminar has continued a monthly Diversity and Equity Committee. Caminar has continued to hold an Organization-Wide Committee –on Structural Racism, Diversity, Equity, and Inclusion. Weekly Staff meetings continue to include time to discuss staff's personal experience with racism and biases and allow space for staff to share their own culture with their team to celebrate its diversity. Caminar also provided training by Nancy Khan on Training: Part 1& 2 Race, Class, Culture & Gender: "The Conversation." And Part 1 &2 Giving and Receiving Transformative Feedback by Alejandra Siroka/Mary Vargas.

Training and Evidence-based practices:
Since early 2021 Caminar has been implementing a Feedback Informed Treatment (FIT) pilot. Established research has shown the alliance with the provider and early positive change to be the best predictors of successful outcomes. FIT uses routine provider alliance monitoring (Session Rating Scale)

and routine outcome monitoring (Outcome Rating Scale), which in the FIT evidenced-based practice model can double reliable, clinically significant positive change (the "effect size"). FIT provides the opportunity to surface and correct problems with engagement and the alliance (including any issues related to culture or diversity) and/or lack of progress to reduce adverse outcomes such as poor engagement and early dropouts. This pilot has created a more unified, effective, empowering, inclusive, and equitable service model while enhancing a healthy organizational culture of feedback. Early aims/goals for outcomes are being tracked per the FIT Charter document.

Weekly labs have been implemented to increase ongoing and consistent training to new and current staff. These labs are guided by suggestions from staff in areas where they want to review processes or increase clinical knowledge. Topics range from documentation, treatment planning, crisis intervention and planning, and recording of client key events.

Succession and Retention Planning:
As part of the commitment to foster growth and development of staff and retention for consistency of services to client care. Caminar has begun meeting regularly to discuss succession and retention of staff. During this year, the program created a Lead role for Case managers to foster the development of leadership skills, increase skill building with new responsibilities, and provide increased compensation. Regarding retention, they have surveyed staff on what provides joy in work. Senior management is meeting on integrating the suggestions into the benefits provided to staff. They have already provided staff with monthly lunches, daily snacks in the snack room and began planning a flexible schedule to be piloted in the FY 20/21.

Client Story #1:
During COVID-19 shelter-in-place, Sally has been able to successfully secure and maintain housing for the first time in years due to her mental health disability (schizoaffective disorder) and has been doing a great job at maintaining it. Sally was at risk of homelessness and disengaged with both her physical health providers and mental health treatment services for a period of time. Due to the persistence of FSP staff and Sally's hard work and dedication to improving her well-being, Sally has maintained stable housing for almost a year now and communicates with both her case manager regularly and meets with her therapist at least once a week for the full clinical hour. She is now also attending her appointments with PCP and maintaining active communication with her nursing team at Landmark each week as well.

Client Story #2:
Sam has made a tremendous progress in terms of improving her mental health. In the past, Sam struggled with periods of unemployment, at risk of homelessness, inability to maintain activities of daily living, and substance use. More recently, Sam has been able to successfully secure part-time employment for the first time in years due to her mental health disability (bipolar disorder) and has been doing a great job at maintaining it. Sam has also maintained stable housing for over a year now and she has been able to utilize positive coping skills to prevent substance use relapse. Sam is successfully now able to independently complete ADLs such as maintaining personal care (bathing, dressing,

toileting, and grooming). She is now successfully managing her own money and completing housework independently. Finally, Sam has been engaged with the treatment team which includes communicating with her case manager regularly and attending her psychiatry appointments.

CHALLENGES

Impact of Covid on community connections: COVID impacted the community connectedness that many clients gained from Caminar and other community organizations to go virtual for their groups. Clients were isolated at home for safety and struggled to connect with family, friends, or community groups for support in person. Caminar has implemented virtual support systems and connected many clients to other community based virtual resources; however, the program sees the continued impact through increased use of emergency services, reports from landlords or behavioral issues, and reports from housing inspections, which have now resumed, showing an increase in infestations and hoarding.

Housing: Given the continued increase in housing costs in the Bay Area and their low incomes, the limited housing options for clients continue to be the biggest challenge for FSP. The closure of more Licensed Board and Cares over the past year has increased the waitlist for clients to access appropriate levels of housing. In addition, clients reflect an aging population and increased medical needs, and their medical issues become a dominant component of their lives.

Housing subsidies: Housing subsidies linked to FSP have been barriers to stepping down several clients. If they are stepped down to a lower level of care, they lose their housing subsidy, which means they lose their housing. Caminar seeks alternate forms of non-program-dependent housing subsidies and/or vouchers not tied to the FSP program.

Comorbidity: Clients are continuing to experience major medical concerns in the FSP program. These clients will need long-term medical assistance but are currently being managed in the community or temporarily placed in SNFs in the hopes of returning to the community. All FSP clients continue to be seen weekly for at least two hours by their case managers, nurses, psychiatrists, assistant case managers, and/or wellness support specialists. Many of these clients may need to be assessed for IHSS services to continue to live independently, live safely, and ensure their needs are met.

ASSISTED OUTPATIENT TREATMENT "LAURA'S LAW" FSP

The purpose of Assisted Outpatient Treatment Full Service Partnership {AOT FSP) is to provide services to individuals with serious mental illness who currently are not receiving treatment and may or may not require court intervention to receive treatment. AOT FSP services are based on the Assertive Community Treatment model (ACT).

AOT target population are adult San Mateo County residents living with serious mental illness who meet the eligibility criteria listed below as specified in Assembly Bill1421 : Clients unable to "survive safely" in the community without "supervision;" History of "lack of compliance with treatment" as evidenced by at least one of the following : a. Hospitalized/incarcerated two or more times in the last 36 months due to

a mental illness; or b. Violent behavior towards self or others in the last 48 months. Clients who were previously offered treatment on a voluntary basis and refused it or are considered "deteriorating."

Program activities include engaging Individuals who have not had a successful and lasting connection to treatment and recovery services. Diversion from the criminal justice system and/or acute and long term Institutional levels of care (locked facilities) SMI and complex Individuals with multiple co-morbid conditions that can succeed in the community with sufficient structure and support. Caminar offers a "whatever it takes" to engage complex adults and older adults with SMI in a partnership to achieve their Individual wellness and recovery goals, using alternative models of care which offer greater benefits to them, increasing the likelihood that they will experience positive outcomes.

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AOT has a staffing ratio of staff to consumers, with a ratio of 10:1. With a capacity to serve 50 clients. There are frequent team meetings to discuss clients in crisis, hospitalizations, incarcerations, med non-compliance and homelessness. A psychiatrist is assigned to the client to provide medication evaluation and psychoeducation. Case managers assist clients with needs related to mental health services, rehabilitation, housing, employment, education, social and recreational activities, and health care. Caminar maximizes use of community resources as opposed to costly crisis, emergency, and institutional care. Utilize strategies relating to housing, employment, education, recreation, peer support and self-help that will engender increased collaboration with those systems and sectors. AOT establishes and solidifies linkages to medical, health care coverage, social services, and income benefits.

Clinically Caminar provides interventions from evidence-based practices such as Assertive Community Treatment (ACT), Motivational Interviewing, Cognitive Behavioral Therapy (CBT), Harm Reduction, Seeking Safety, Trauma Informed Services, Stages of Change, Crisis intervention and management, Medication benefits, (MAP) medication assistance program, WRAP, recovery-based treatment.

PROGRAM IMPACT

AOT (Laura's Law) FSP	FY 20/21
Total clients served	66
Total cost per client	$20,762
Cost per contracted slot	$27,406

Caminar reduces risk by rapid and consistent engagement with clients and their collateral providers, case conferences, increasing contact with clients who may be decompensating, 24/7 availability, and its CPI protocol and training. When indicated, all management staff are trained and certified to initiate involuntary hospitalization. Caminar limits school failure and dropout through the Supported Education program and helps lower unemployment by utilizing the Jobs Plus program, which provides skills training and referrals to employers looking for workers. Homelessness is a pervasive problem in the Bay Area and San Mateo County, in particular. The Supported Housing program provides housing options to clients who need independent apartments and shared apartments. In collaboration with BHRS, FSP links clients to multiple housing options: Licensed Board and Cares, SRO rooms, shelters, and unlicensed room and boards.

Once a client is referred to Caminar services, staff attempts to initiate contact within two (2) business days for case management and psychiatric services within five days. Clients are assessed rapidly and comprehensively by case managers, the psychiatrist, and Clinic Manager/RN. The Clinic Manager/RN completes a Nursing Assessment for all clients admitted to the program. Furthermore, AOT also utilizes a Mediation Assistance Program (MAP) to increase medication compliance and reduce the risk of clients overtaking or undertaking their medications.

By utilizing the social rehabilitation model, which provides a non-judgmental, normalized environment that emphasizes the client as the lead in their care, Caminar works to reduce the stigma and discrimination the population often faces. AOT further ensures linkage to outside community providers for primary care and ensures ongoing collaboration with said providers and staff; this helps ensure that clients receive public health services. By partnering with other non-profit agencies, AOT helps reduce the disparities in access to care. Finally, the program utilizes Harm Reduction, MI, DBT, and WRAP to help strengthen clients' gains and implement the principles of recovery throughout all programs.

SUCCESSES

Covid-19 Pandemic response measures:
As a result of the Covid-19 Pandemic, Caminar AOT has put safety measures of PPE and outdoor meetings in place to continue providing face-to-face services to clients. This last year AOT received a Cares funding grant and provided 22 clients with technology to keep them connected and provide the ability for them to engage in Caminar and community virtual groups. The program has equipped staff with technology to support clients who now have the resources to engage in telehealth. The Wellness Support Specialist (Peer Partners) has created and implemented groups for clients to attend to engage in group activities safely. The clinic offers in-person, phone, and video psychiatric services.
AOT has successfully supported clients in receiving the vaccination, with 35 of the clients being vaccinated and encouraging the remaining clients to receive their vaccine.
To support clients during the holiday season, Caminar provided clients with gift baskets containing items to increase coping skills, activities to increase moods during the holidays, and gift cards for grocery stores to encourage clients to purchase nutritious foods.

To support its staff's safety and connectedness, staggered schedules have been developed to allow for office work. AOT has also implemented daily morning huddles for the team to check-in, gauge their level of burnout, discuss the support needed, and identify specific goals for the day.

Cultural responsiveness training and addressing inequalities in the community:
As a response to the need to increase staff's competency of structural racism in the community and be culturally responsive to provide the best quality of services to AOT's diverse population, Caminar has continued a monthly Diversity and Equity Committee. Caminar has continued to hold an Organization-Wide Committee –on Structural Racism, Diversity, Equity, and Inclusion. Weekly Staff meetings continue to include time to discuss staff's own experience with racism and biases and allow space for staff to share their own culture with their team to celebrate staff's diversity. Caminar also provided training by Nancy Khan on Training: Part 1& 2 Race, Class, Culture & Gender: "The Conversation." And Part 1 &2 Giving and Receiving Transformative Feedback by Alejandra Siroka/Mary Vargas.

Training and Evidence-based practices:
Since early 2021 Caminar has been implementing a Feedback Informed Treatment (FIT) pilot. Established research has shown the alliance with the provider and early positive change to be the best predictors of successful outcomes. FIT uses routine provider alliance monitoring (Session Rating Scale) and routine outcome monitoring (Outcome Rating Scale), which in the FIT evidenced-based practice model can double reliable, clinically significant positive change (the "effect size"). FIT provides the opportunity to surface and correct problems with engagement and the alliance (including any issues related to culture or diversity) and/or lack of progress to reduce adverse outcomes such as poor engagement and early dropouts. This pilot has created a more unified, effective, empowering, inclusive, and equitable service model while enhancing a healthy organizational culture of feedback. Early aims/goals for outcomes are being tracked per the FIT Charter document.

Weekly labs have been implemented to increase ongoing and consistent training to new and current staff. These labs are guided by suggestions from staff in areas where they want to review processes or increase clinical knowledge. Topics range from documentation, treatment planning, crisis intervention and planning, and recording of client key events.

Succession and Retention Planning:
As part of the commitment to foster growth and development of staff and retention for consistency of services to client care, AOT has begun meeting regularly to discuss succession and retention of staff. During this year, AOT created a Lead role for Case managers to foster the development of leadership skills, increase skill building with new responsibilities, and provide increased compensation. Regarding retention, the program has surveyed staff on what provides joy in work. Senior management is meeting on integrating the suggestions into the benefits provided to staff. They have already provided staff with monthly lunches, daily snacks in the snack room and began planning a flexible schedule to be piloted in FY 20/21. Caminar San Mateo region AOT Program Director and Director of Case Management met with Caminar Santa Clara region and Santa Clara county representatives to present the SMC AOT program function, structure, successes, and barriers to assist in the SCC decision to open an AOT program in Santa Clara County.

Client Story #1:

"Historically, Jane had spent much of her time homeless and intoxicated in a local town in San Mateo County cycling in and out of jail multiple times a week due to disruptive, threatening, assaultive behaviors in addition to being drunk and disorderly conduct. It is worth noting that her numerous local incarcerations occurred at a time when the local jail system was only taking violent offenders due to the pandemic. She has suffered with Schizoaffective disorder for most of her life. She has resisted accessing mental health services for many years. Her AOT case manager, in collaboration with several other county resources has been able to get her stabilized in a hotel room, provided her new, clean clothes and have worked on getting her General Assistance benefits as well as an ID and helped her with substantially reducing her disruptive behavior in the community where she lives. She has had a substantial improvement in reducing incarcerations to one every several weeks instead of an average 3times a week. She is happier and a better member of the community. Businesses and residents have reported being amazed by how appropriate she has been lately. AOT services have reduced the client's adverse impact upon various businesses in the area during this time, reduced the substantial cost to the county and taxpayers in San Mateo County when you consider: police response, arrest, booking, jail, public defender, court costs. We continue to provide intensive services to this client as she progresses in her mental health recovery."

Client Story #2:

"John has struggled with Schizoaffective Disorder and PTSD for a number of years. Prior to referral to AOT, John decompensated and was smoking marijuana, which exacerbated his symptoms. He went for a drive with the hood of his car up. This led to him having no vision over the road; the police thought he was fleeing and then they tased him once they got him to stop. He was sentenced to jail. He then developed trauma from the interaction with the police, was speaking in tongues, paranoid, hearing things, and very disorganized. He was eventually placed in Napa State Hospital. Once stabilized, and restored to competency, he was referred to Caminar AOT. Currently, he is stably housed in an apartment, adheres to medication, psychiatric appointments, and case management services 100% of the time. He remains in contact with his mother every other day, utilizes grounding techniques, mindfulness practices, and his connection to his faith as strong coping mechanisms. He effectively manages ADLs. The client meets with his case manager 1-2x every week to review coping mechanisms (i.e., going for walks, practicing his religion, utilizing AA services, and identifying healthy socialization opportunities). The client is motivated to maintain his sobriety through multiple AA meetings per week and personal faith."

CHALLENGES

Impact of Covid on community connections: Covid impacted the community connectedness that many clients gained from Caminar and other community organizations to go virtual for their groups. Clients were isolated at home for safety and struggled to connect with family, friends, or community groups for support in person. AOT has implemented virtual support systems and connected many clients to other community based virtual resources; however, the program sees the continued impact through increased use of emergency services, reports from landlords or behavioral issues, and reports from housing inspections, which have now resumed, showing an increase in infestations and hoarding in units.

Reducing the high utilization of crisis services: AOT has received new clients who have been unusually high users of judicial and hospital emergency services. There has been a challenge in reducing

unnecessary utilization due to lack of engagement and refusal to participate with staff. Due to a lack of community connections, the program sees overutilization by some clients who use these services as a support system when not meeting the criteria for acuity or risk.

Housing: Given the continued increase in housing costs in the Bay Area and their low incomes, the limited housing options for clients continue to be the biggest challenge for AOT. The closure of three Licensed Board and Cares over the past year has increased the waitlist for clients to access appropriate levels of housing.

Housing subsidies: Housing subsidies linked to AOT have been a barrier to stepping down clients. If they are stepped down to a lower level of care, they lose their subsidy, which means they lose their housing. The program seeks alternate forms of non-program-dependent housing subsidies and/or vouchers not tied to the AOT program.

MATEO LODGE: SOUTH COUNTY INTEGRATED FSP

The South County Adult Behavioral Health Outpatient Clinic located in Redwood City and serves complex serious mental illness (SMI) adult client population. Due to the location of the clinic the program serves as the catchment area providing services to individuals from the women's and men's county jail, Redwood House crisis residential, Cordilleras MHRC, three inpatient SUD treatment programs, and two homeless shelters. The typical client served are considered at risk of self-harm or neglect, recently hospitalized for mental health, poorly engaged in treatment, have co-occurring SUD disorders, often homeless, have trust issue stemming from mental health diagnosis, and have limited community resources.

Mateo Lodge is contracted to provide 50 hours of Intensive Case Management (ICM), services per week for 3 different levels of intensity (A - Task oriented case management 1-2 months, B - Supplemental case management 4-6 months, and C - FSP clinical case management 6 -12months). The clients within the program receive 1–3 hours of contact per week based on level of care needed and/or need identified to support client. ICM is a clinic referral-based program. The referring party completes a referral form indicating 'ICM Service Requested'. The ICM engages with the client within one week of the referral to complete a client focused needs assessment based on clients' stated need. The best outcomes for ICM clients exist when there is a warm handoff from the referring clinical team. The ICM collaborates with the treatment team to ensure targeted service that is based on client and referring party identified needs are addressed. Full Service Partnership (FSP) level C is utilized for clients that are high risk of self-harm, loss of placement, or poorly engaged with outpatient services. The FSP level of care is initiated prior to referring clients to other FSP providers in attempts to service clients within BHRS outpatient clinics and to evaluate mental health level of care needed.

Mateo Lodge also provides evening and weekend coverage on an as needed basis from the mobile support team. ICM staff support additional needs for voucher-based clients and provide quarterly home

visits, monthly phone check in, and assistance with negotiation with landlords, etc. in preparation for annual housing inspections, relocation if needed and redetermination paperwork/ appointments. The housing voucher programs include Permanent Supported Housing (PSH), Housing Readiness Program (HRP), Moving to Work (MTW), and Mainstream Voucher Program. Case management staff makes every attempt to meet their clients in the community to ensure they have the basic needs of food, access to mental health services/primary care, and to further support their housing needs. Engagement strategies used are home visits (both scheduled and unscheduled), use of natural family support, case conference with outpatient community partners, hospital, jail, and joint home visits with a member of the treatment team.

During FY 2020 - 2021, Mateo Lodge has been contracted to provide 50 hours of service per week for 3 different levels of intensity (A - Task oriented case management 1-2 months, B - Supplemental case management 4-6 months, and C - FSP clinical case management 6 -12months).

During this period, a total of 20 unduplicated clients were served. Of which, 11 clients were carried over from FY 2019-2020, 8 new referrals, and 1 voucher-based clients. Of the 20 clients, 8 were closed during this reporting period. The housing voucher programs supported include Permanent Supported Housing (PSH), Housing Readiness Program (HRP), Moving to Work (MTW), and Mainstream Vouchers.

Clients receive 1–3 hours of direct CM contact per week and carry a weighted caseload of 10-12 clients as FSP level clients receive 3 – 5 hours or weekly support. There are currently 12 Embedded Intensive Case Management (ECM) clients, of which 3 also receive voucher support. The voucher-based clients receive quarterly home visits, monthly phone check in, and assistance with negotiation with landlords, etc. in preparation for annual housing inspections, relocation if needed and redetermination paperwork/appointments. At the close of the fiscal year, there was no waitlist for services.

Each ECM client meets with their embedded case manager and completes a "Needs Assessment" to facilitate client goals to targets case management tasks/activities and updates LOCUS bi-yearly for evaluation of level of care.

PROGRAM IMPACT

Integrated FSP – South County	FY 20/21
Total clients served	20
Total cost per client	$6,888
Cost per contracted slot	$9,184

ECM serviced 20 clients,' and the demographics represent the total population served.

Client demographics indicate a 450% increase of clients receiving services over 59 from the last reporting in FY 2019-2020. ICM referrals remain flat. Under Covid 19 precautions starting in March 2020, CM did not provide in-person services and transitioned to remote telephonic support throughout this reporting.

The level of care for (B) supplemental case management remains flat with a 30% increase for (C) FSP level of service from previous reporting in FY 2019 -2020.

Level of Care Provided	# of Clients FY 21-22
A - Task Oriented	1
B - Supplemental	8
C - FSP	11

SUCCESSES

Staffing/Staff Training
During this reporting period, ECM hours were impacted by staff shortages. The ICM program was staffed with 40 hours of the 50 hours budgeted weekly hours during this fiscal year. Under Covid 19 precautions, Mateo Lodge has not secured new staff identified for this ICM program.

ECM staff are bilingual in Spanish and participate in professional development, including Cultural Competency, SOGI, Assaultive Behavior, Motivational Interviewing, BHRS required documentation, and compliance training. Additionally, ECM CM attends quarterly meetings with Mateo Lodge, weekly county supervision, and bi-weekly staff meetings at South County Clinic. Staff development is targeted to further strengthen ECM awareness of community services, improve culturally appropriate services, and deepen clinical knowledge of the population of clients served to employ best strategies/practices.

Outcomes
Embedded CM closed 8 cases during this reporting period. Mateo Lodge also provided evening and weekend coverage on an as-needed basis from the mobile support team as part of their agency to further support at-risk client needs.

Remarkable outcomes are noted related to Covid-19 precautions, concerns, and impact. Four clients declined services over safety concerns, and two client deaths due to medical conditions. Clients referred to ICM reflect higher acuity clients, which is congruent with the clinic population.

Outcome	# of Clients FY 20/21
Declined ICM services	4
Deceased	2
Higher level of Care – FSP/Locked/BEAM	1
Moved to lower-level Care	1

CHALLENGES

South County has complex impaired SMI clients as the catchment area services the county jails, Redwood House crisis residential, Cordilleras, three social rehabilitation board & care placements, three inpatient SUD treatment programs, and two homeless shelters. The main barrier for the clients served

through Embedded Case Management is limited housing, communication by telephone due to homelessness, co-occurring SUD disorders, trust issues stemming from mental health diagnosis, and limited resources for undocumented clients.

Most of the referrals for the ECM program are to improve clients' engagement with their treatment teams (not making it to appointments) and/or are not stable. All new client referrals were to reduce hospital and PES encounters in this reporting. The difficult-to-engage client is typically medication non-compliant and/or homeless with limited family/social support. The use of culturally appropriate community agencies (faith-based, Club House, pride center) has helped support recovery when limited financial and family support exists. Assisting clients with task activities such as obtaining cell phones, assistance to coordinated entry, and other community resources improves client outcomes through building a working rapport and trust with the Case Manager. The Case Manager makes every attempt to meet clients in the community, assess for food insecurity, link to mental health services/primary care, and support their housing goals/needs. Engagement strategies used are home visits (both scheduled and unscheduled), natural family support, case conferences with outpatient community partners, and joint home visits with a treatment team member. The best outcomes for ECM clients exist when there is a warm handoff from their clinical treatment team and collaboration with valued community partners.

DEMOGRAPHICS

	FY 20/21
Age	
16-59	55%
60+	45%
Race/Ethnicity	
White/Caucasian	50%
Latino	30%
African American	10%
Laotian	5%
Vietnamese	5%

HOUSING INITIATIVE

FSP SUPPORTED HOUSING (TAY)

The FSP Supported Housing Program for Transition-Age Youth (TAY) provides housing supports, housing and property management for up to thirty (30) TAY ages 18-25 and emancipated minors ages 16-18, in various sites, units in scattered sites, assisted living, board and care and locations throughout San Mateo County. The housing services were provided by Mental Health Association to Edgewood's TAY FSP - Turning Point.

The Mental Health Association offers integrated housing and support services geared toward achieving maximum levels of residential stability and improved health outcomes for TAY. Services provided include:

- Locate and obtain needed units of housing.
- Ensure that leased housing remains in clean, safe, and habitable condition.
- Collaborate on a regular basis with the FSP provider
- Utilize creative, harm reduction-based techniques beyond standard property management practices and activities.
- Manage relationship with property owners including timely payment of rent, monitoring and enforcement of lease provisions, and problem solving.
- Occupational Therapist services to support the TAY resident

PROGRAM IMPACT

TAY Supported Housing	FY 20/21
Total clients served	30
Total cost per client	$13,644

Client demographics and outcomes are those of Edgewood's Comprehensive FSP program for TAY listed above. Mental Health Association is also able to provide ongoing support to youth as needed, once they end FSP services, through their Support and Advocacy for Young Adults in Transition (SAYAT) program, which offers intensive case management and support services to facilitate successful independent living.

Month of Service	Housing	# and Type of Housing Placement for TAY
Jul-20	LifeMoves	2 Emergency Shelter Beds
	Private Landlord	4 One-Bedroom Apartment Plus Utilities
	Private Landlord	1 Four-Bedroom Apartment Plus Utilities
	Board and Care Operator	4 Board and Care Beds
Aug-20	LifeMoves	2 Emergency Shelter Beds
	Private Landlord	4 One-Bedroom Apartment Plus Utilities
	Private Landlord	1 Four-Bedroom Apartment Plus Utilities
	Board and Care Operator	4 Board and Care Beds
Sep-20	LifeMoves	2 Emergency Shelter Beds
	Private Landlord	4 One-Bedroom Apartments Plus Utilities
	Private Landlord	1 Four-Bedroom Apartment Plus Utilities
	Board and Care Operator	4 Board and Care Beds
Oct-20	LifeMoves	2 Emergency Shelter Beds
	Private Landlord	4 One-Bedroom Apartments Plus Utilities
	Private Landlord	1 Four-Bedroom Apartment Plus Utilities
	Board and Care Operator	4 Board and Care Beds

Nov-20	LifeMoves	2 Emergency Shelter Beds
	Private Landlord	4 One-Bedroom Apartments Plus Utilities
	Private Landlord	1 Four-Bedroom Apartment Plus Utilities
	Board and Care Operator	4 Board and Care Beds
Dec-20	LifeMoves	2 Emergency Shelter Beds
	Private Landlord	4 One-Bedroom Apartments Plus Utilities
	Private Landlord	1 Four-Bedroom Apartment Plus Utilities
	Board and Care Operator	4 Board and Care Beds
Jan-21	LifeMoves	2 Emergency Shelter Beds
	Private Landlord	4 One-Bedroom Apartments Plus Utilities
	Private Landlord	1 Four-Bedroom Apartment Plus Utilities
	Board and Care Operator	4 Board and Care Beds
Feb-21	LifeMoves	2 Emergency Shelter Beds
	Private Landlord	4 One-Bedroom Apartments Plus Utilities
	Private Landlord	1 Four-Bedroom Apartment Plus Utilities
	Board and Care Operator	4 Board and Care Beds
	Wally's Place	I bed
Mar-21	LifeMoves	2 Emergency Shelter Beds
	Private Landlord	4 One-Bedroom Apartments Plus Utilities
	Private Landlord	1 Four-Bedroom Apartment Plus Utilities
	Private Landlord	1 One-Bedroom Apartment Plus Utilities
	Board and Care Operator	4 Board and Care Beds
	Wally's Place	I bed
Apr-21	LifeMoves	2 Emergency Shelter Beds
	Private Landlord	4 One-Bedroom Apartments Plus Utilities
	Private Landlord	1 Four-Bedroom Apartment Plus Utilities
	Board and Care Operator	4 Board and Care Beds
	Wally's Place	I bed
May-21	LifeMoves	2 Emergency Shelter Beds
	Private Landlord	4 One-Bedroom Apartments Plus Utilities
	Private Landlord	1 Four-Bedroom Apartment Plus Utilities
	Private Landlord	1 Four-Bedroom Apartment Plus Utilities
	Board and Care Operator	4 Board and Care Beds
	Wally's Place	I bed
Jun-21	LifeMoves	2 Emergency Shelter Beds
	Private Landlord	4 One-Bedroom Apartments Plus Utilities
	Private Landlord	1 Four-Bedroom Apartment Plus Utilities

	Private Landlord	1 Four-Bedroom Apartment Plus Utilities
	Board and Care Operator	4 Board and Care Beds
	Wally's Place	I bed

AUGMENTED BOARD AND CARES

The purpose of the 13 contracted Board and Cares (B&C) is to provide a supported living environment for clients with severe mental illness (SMI). These placements are needed to afford SMI client's an opportunity to live in the community in a supported living environment.

There is one BHRS staff member that is the designated B&C Liaison. The B&C Liaison processes referrals to B&C, completes assessments, provides care coordination with the treatment team and any issues related to their placement, and oversees admissions to and discharges from BHRS contracted B&C.

The Target population served are adults with severe mental illness that have completed a social rehabilitation program, are stepping down from a locked setting, or coming from the community. They are psychiatrically stable, compliant with medications and in need of a supported living environment. Clients are Health Plan of San Mateo members, and either have SSA or GA benefits.

The B&C provides three meals a day, medication management which includes storing and administration of medications. They regularly collaborate with the client's treatment team and conservator (if there is one) about the client's progress and address any issues that impact the client's placement. The B&C Operators work in close collaboration with the BHRS B&C Liaison. The role of the B&C Liaison is to support the client's transition into the B&C, oversee and coordinate their care, and ensure they address issues that impact placement. The B&C Liaison develops and coordinates a training schedule for the B&C Operators. The training increases the B&C Operator's capacity to address the needs of the SMI clients in their care as well as fulfilling their CEU requirements. In addition, they have been providing and facilitating a series of mental health groups for clients at the B&C facilities. Curriculums for these groups have included Seeking Safety, Illness and Recovery Management, Dual Diagnosis, and Wellness Recovery Action Plan (WRAP). We were able to obtain Chrome Tablets through the use of MHSA funding, for the virtual mental health groups when the facilities were in shelter in place. This was a source of emotional and social support when in-person contact was not possible.

PROGRAM IMPACT

Board and Cares	FY 20/21
Total clients served	80
Total cost per client	$30,810

Board and Cares report reduced incarcerations by 18% and homelessness by 72%.

Improving timely access and linkages for underserved populations:
Referrals are promptly processed and screened for the appropriate level of care. When placements open, the B&C Liaison links and prepares the referred client for transition to their placement. The program keeps track of the referred clients and the barriers impacting placement. The B&C Liaison regularly contacts and coordinates with the B&C Operators, treatment team, and the conservator (if there is one) to address and meet the clients' needs.

Reducing stigma and discrimination:
The assessment procedure goes through a 15-item checklist to determine eligibility for a B&C placement and ensure that they do not reflect any bias. Once they are considered eligible for the B&C level of care, the program makes every attempt to review and problem-solve barriers. If there is any indication of discrimination or expressed concerns by clients, this is taken seriously, and appropriate steps are taken to address the issues promptly. Additionally, the B&C Liaison contacts the B&C regularly to check in on and evaluate clients' care and makes monthly in-person visits to the facilities. At times, complex case conferences will be needed. All parties involved, such as the conservator, treatment team, and case managers, discuss support/ resources needed to successfully transition a client to placement or address any challenging situations. The program also addresses any forms of stigma and discrimination brought to their attention. Through training and close coordination with the B&C Operators, it is shown how disruptive behavior often stems from mental health challenges and not because they are "bad." B&C provides training to B&C Operators on Diversity and Equity topics such as Cultural Humility, Implicit Bias, Sexual Orientation, Gender Identity, NMT, Trauma and Trauma-Informed Care, and Recovery Model. As a County, the program makes it a priority to be a Multicultural Organization and make every effort to ensure clients are treated with respect and dignity.

Reduces disparities in access to care:
The BHRS contracted B&C facilities are specifically for clients with mental illness and or co-occurring substance use issues. All clients placed at the B&C are connected to BHRS regional clinics or a Full-Service Partnership Program, and thus their psychiatric and medical needs are attended to. If they are determined to need a higher level of mental health services, then appropriate steps are taken to access such services quickly. The B&C Liaison is regularly working with B&C Operators and the treatment team to assess that clients are getting the appropriate level of care services and accessing the needed services.

Implements recovery principles:
Clients with substance use problems are appropriately referred to Substance Use Disorder (SUD) programs. The B&C Operators are trained on the possibility of relapse and work with the client's treatment team and the B&C Liaison to develop a plan to support the client based on Recovery principles. We have one B&C specializing in serving clients with substance use issues. Interventions are considered and implemented based on the Recovery Model. The training module for B&C Operators also includes training around Recovery principles. BHRS Clinicians offer recovery-oriented groups at different Board and Care facilities throughout the program. The groups have included Seeking Safety, Illness Management and Recovery, Wellness and Recovery Action Plan, and a Dual Diagnosis Group.

SUCCESSES

This year there was a very scary experience before the vaccine was readily available. In January of 2021, a resident became positive with COVID-19 at one of the B&C facilities. It is a small, close knit facility of staff and residents. Staff at the B&C are one family that has been caring for consumers with serious mental illness for many years. Within a week, all the staff and all the residents had tested positive and become very ill. The Administrator, his wife, and one of the residents had been hospitalized, and the

original resident who became ill passed away. This was a very trying and scary period for the facility staff, families, and the residents. Fortunately, they were all able to make a full recovery, with the assistance of the State of California who supplied staff support, and San Mateo County who supplied necessary resources and health/clinical support.   BHRS support included weekly meetings and coordination with the State, Public Health, the facility, families, the residents, the treatment teams, and the B&C Liaison. Resources included a food vendor for daily meals, Personal Protective Equipment (PPE), and a vendor for ongoing COVID-19 testing. Treatment teams provided ongoing mental health support to residents. The B&C Liaison was in constant contact with the facility to monitor and address any concerns, and ensure a safe, coordinated process toward recovery.

The B&C Liaison spoke with the facility administrator, who said, "he had no idea how bad COVID-19 was," that he was "grateful for all the support." The B&C Liaison also spoke with a resident, who has lived at the facility for many years and is in conservatorship, about his well-being and recovery experience. He was hospitalized and became gravely ill from COVID-19. He said, "it was very scary." Initially the resident was unable to walk and had to undergo a lot of rehabilitation before he could return to the facility. Today he is completely healthy and back at the B&C. He says, "I was really sick, I'm glad to be alive." Through a coordinated, multi-level response and collaboration by many parts of the Community – the B&C family, residents, the State, Public Health, the County/BHRS Department – we were able to join forces and come together toward a safe and healthy recovery."

CHALLENGES

The continuation of the COVID-19 pandemic has affected the B&C, especially the older adult clients, who are most vulnerable. A couple of facilities could not take new admissions due to COVID-19. In addition, one of the B&C facilities had to go into quarantine due to the number of clients and staff who became sick with COVID-19 and in which one of their clients passed away from COVID-19. Also, the prolonged impact of the pandemic has affected the mental health well-being of clients. Due to limits on person-to-person contact and gatherings, many of the community groups and activities, social outlets, and mental health support groups were not available in person. This has been very challenging and has caused much stress for some clients. For some, it has meant a change to a higher level of care placement and several 30 day-notices. When any concerning issues arise, the B&C Liaison organizes and facilitates case conferences on a regular, continuous basis with all relevant parties such as treatment providers, conservator (if there is one), facility operator, hospital staff, client if possible, etc. to address and resolve these issues. Recovery and trauma-informed principles and interventions are used to address such mental health challenges. There has been an increase in the case of conferences due to the continuing stressors for clients.

With the increase in vaccinations and lifting of shelter in place measures, treatment providers have had in-person contact, whether in the field or at the facility. In-person appointments with treatment providers may be offered, and remote modes of contact such as Telehealth. Additionally, B&C has implemented three therapy groups in person at the facilities, taking precautions to provide the needed service in a safe, supportive manner. Also, peer mentoring services have been made available to all B&C clients, especially those who are struggling and in need of peer support. As a result of making this service available, peer mentors have regularly provided on-site, in-person support, which is a huge source of emotional support, connection, and a social outlet. The B&C Liaison has continued to contact

the B&C Operators weekly to check in on how clients are doing, address any concerns promptly, and make monthly in-person visits to all B&C facilities.

Lastly, the San Mateo County Behavioral Health and Recovery Services (BHRS) Department has provided ongoing updates, information for resources, vaccination centers, etc. to B&C Operators. B&C Liaison assisted in evaluating the needs of the B&C facilities and clients and coordinating B&C facilities to community vaccination sites such as local pharmacies.

DEMOGRAPHICS

	FY 20/21
Age	
26-59	59%
60+	41%
Race/Ethnicity	
Chinese	1%
Filipino	15%
Black/ African- American	10%
White/Caucasian	55%
Latino/Mexican/Chicano	19%
Japanese	1%
Another race/ethnicity	2%
Unknown	4%
Sex assigned at birth	
Male	75%
Female	25%
Primary Language	
English	85%
Spanish	13%
Tagalog	1%
Arabic	1%
Intersex	
No	100%
Gender Identity	
Male/Man/ Cisgender	79%
Female/ Woman/ Cisgender Woman	21%
Sexual Orientation	
Gay, lesbian, homosexual	2%
Straight or heterosexual	98%

GENERAL SYSTEM DEVELOPMENT (GSD)

General Systems Development (GSD) in San Mateo County has been primarily focused on supportive services for individuals with mental illness through integration of peer and family partners throughout the behavioral health system of care, and community peer run and peer focused wellness centers; system transformation strategies that support integration of services across various sectors impacting individuals with mental illness' lives including co-occurring substance use, dual diagnosis intellectual

disability, criminal justice, child welfare, aging; and integrating evidence-base practice clinicians throughout the system.

OLDER ADULT SYSTEM OF CARE

OLDER ADULT SYSTEM OF INTEGRATED SERVICE (OASIS)

The OASIS Program purpose is to provide outpatient field based mental health services for home-bound elderly individuals with severe mental illness and co-occurring medical diagnoses and functional limitations. The program assists elderly individuals to live in the community independently with improved quality of their lives. The targeted population served is the elderly ages 60+ with severe mental illness and co-occurring diagnosis due to mobility issues and functional limitations. Primary program activities provided include interventions such as psychiatric assessment and treatment, psychiatric medication evaluation and on-going monitoring, clinical case management, rehabilitation counseling, individual or family therapy, peer support, psychoeducation, and collateral support with other community services.

PROGRAM IMPACT

OASIS	FY 20/21
Total clients served	221
Total cost per client	$3,460

During this 2020-2021 fiscal year, OASIS total serviced 221 clients, include 26 new enrolled and 21 discharged from program. The data indicated there were 75% female clients and 25% male clients, age range included 3% under age 60, 17% age between 61-70, 44% between 71-80, 29% between 81-90, 6% between 91-100, and 1% above age 100.

Among the discharged clients, the data indicated 52% died from medical complexity, 19% had moved out of San Mateo County because of high cost of living and limited care home placement, 14% were placed at SNF due to health declining and need high level of care, 5% were stable and were transferred to PCP for continually care, 5% were with dementia diagnosis that condition had taken over mental health symptoms, and 5% declined the services.

The languages and races provided to clients, the date shown 14% of Latino American with monolingual in Spanish, 14% of Chinese American with monolingual in Chinese, 48% of Caucasians, 17% of African American, and 6% of combination of Polish, Indian, Farci, Korean, Germany, Russian, Filipino, Arabic and Vietnamese.

In the fiscal year of 2020-2021, with the COVID pandemic, OASIS continually serves elderly clients of aging, increasingly physically fragile, and medically complex. Most of the clients enrolled in the program with multiple co-occurring conditions related to physical health, cognitive impairment due to mental health issues or age-related, long history of substance use, prescription addiction, functional limitations, social isolation, and serious mental health challenges. These conditions required more hands-on clinical case management and emotional support and assistance to enable these clients to remain in community-based settings, especially for the monolingual Spanish and Chinese-speaking older adults. It

also necessitates greater collaboration among the OASIS psychiatrists and primary care providers due to the number of medications these clients take for their multiple conditions and concerns about side effects and medication interactions.

Similar to previous years, the support provided by the OASIS team is continually enhanced by the strong commitment and dedication of the direct service staff that regularly go the extra mile to ensure that the clients not only get the essential care they need but to have the quality of the emotional and concrete support needed clients to need and to have the highest quality of the elderly life as possible and to remain to reside in the community for as long as for the safety and the wishes that elderlies can in accordance with.

During the COVID pandemic year, OASIS continually provided mental health services to elderly populations with mental health challenges in addition to the factors of physical mobility issues due to medically fragile and aging declining. The services were provided via weekly phone-call check-in, bi-weekly home visiting, or Telehealth to monitor elderly clients' overall mental health disabilities. As the pandemic continues, the services also moved from assisting the clients' overall health. They included the linkage of food or groceries supplies and interventions on clients with their family members' dynamic encounters as properly needed.

There were increased 8% of APS reports for emotional, physical, and financial involved matters. The pandemic also limited clients' routine social activities; they became more isolated at home without a daycare program to join in person, which became a huge loss for the elderly population. Lack of regular face-to-face contacts made the case managers more and sole support to them. As a result, the stigma and discrimination for mental health services have reduced because of the eagerness and motivations of the needs of human contacts, and their elderly clients became more initiate themselves to accept the phone check-in, the visits, etc. The public services, such as food bank, meals on the wheels, friendship support line, suicidal hotline, etc., also became more acceptable by their elderly clients because of the pandemic isolation and stress in general.

Because of the service principle of "no door is wrong door" for medically fragile and mentally challenged elderly clients in the OASIS program, case managers and psychiatrists made every effort to maintain their clients at their residential location and not end with severe hospitalization or became homelessness or long-term disability. They continually compiled the treatment in the OASIS program.

SUCCESSES

Jei is a ninety-three-year-old Korean speaking female who was seen in her apartment home by OASIS case manager and Korean speaking interpreter. Jei was referred to the program due to presenting depressive symptoms of sad mood, irritable at times, hopelessness, social isolation, thoughts of death, lack of enjoyment for activities. Jei was at the time tearful and struggled with accepting the changes to her overall health caused by the factors of aging, as well as adapting to her diminished eyesight. She accused her IHSS caregiver of stealing money from her, and an APS report was made by the case manager. Jei also often had arguments and conflicts with caregiver; she had also fired several caregivers within a short period of time.

OASIS case manager was able to form a therapeutic relationship with Jei with tireless efforts in the first three months. Also taking consideration of cultural factors and differences, the case manager was able to contact the Korean speaking Catholic Church and facilitate visits from priests and peers from church to Jei's home to reduce Jei's anxiety of struggles that she always had regarding her spirituality and mortality. After one year of treatment with her depression, Jei had reported feeling supported by the

OASIS case manager, and agreed to continually work with the OASIS team, and received visits once a month from a Korean speaking priest. Jei also reported feeling new motivation to become more involved with family activities and visited with her grandchildren often. Jei reported feeling grateful for her life turning around, and for the efforts and support she received from the Oasis team. Earlier this year, Jei was placed at SNF because of her physical decline. She was no longer able to live independently with IHSS provider's assistance and needed a higher level of care.

CHALLENGES

As in the pandemic year and the State went through lockdown and shelter in place orders, the services were not stopped, only changed the way from home-visit to phone or telehealth providing the same support and care as much as possible for this vulnerable population in the community. The challenges were the services through tech-supplies, phones with apps in different platforms, the elderly clients were facing difficulties to utilize those tech-supplies, not even understanding the app function to utilize properly fully, that also created more frustration and irritated to receive the mental health services, especially if with language barriers. The county provided free smart cell phones or tablets to clients. Still, during the telehealth, clients encountered either dropped calls due to internet access limitations in their living area, the equipment malfunction, or client push on the wrong key, ending with anger and upset feelings. With memory issues for some clients, the tech-knowledge requirement became even harder on the elderly.

Housing or placement for OASIS clients in a community setting with the necessary supportive services has continually become an increasing challenge. There is a minimal supply of licensed board and care providers willing to care for these clients with their multiple health issues and needs and limited financial resources. As there is no Intermediate Care Facility level of service in San Mateo County, placement became challenging to maintain these clients in the community as their care needs had increased. Even with the minimal resources of Assisted Living facilities in the county, the high cost of placement also became a significant financial burden for the elderly and their families to bear with.

DEMOGRAPHICS

	FY 20/21
Age	
26-59	3%
60+	97%
Primary Language	
English	65%
Spanish	14%
Chinese	14%
Russian	1%
Tagalog	2%
German	1%
Another language	2%
Sex Assigned at birth	
Male	25%
Female	75%
Decline to state	0%

SENIOR PEER COUNSELING

Senior Peer Counseling (SPC), Peninsula Family Service is comprised of specially-trained volunteer counselors, more than 100 in total, to provide weekly visits to older adults to help manage transitions and life changes such as health concerns, mobility issues, caregiver needs, and grief. Special care is taken to connect participants with someone who shares similar life-experiences and perspectives, with support offered in languages such as English, Mandarin, Cantonese, Spanish, and Tagalog, and to participants who identify as LGBTQ+.

Senior Peer Counseling provides peer to peer support by trained and supervised older adult volunteers. The program serves older adults, 55 years and older, who reside in San Mateo County who are isolated, depressed, and anxious. The program targets underserved older adult population who may be monolingual in Spanish, Mandarin, Cantonese, Tagalog and to participants who identify as LGBTQ+.

SPC provides 36 hour training, in-services and monthly clinical supervision to peer volunteers. These volunteers provide weekly one on one or group peer counseling to participants throughout San Mateo County. They also link participants to needed resources in the community.

PROGRAM IMPACT

Senior Peer Counseling	FY 20/21
Total clients served	410
Total cost per client	$419

Peninsula Family Service conducts an annual program evaluation to determine if the program is meeting the established goals and to determine where improvements can be made. Program participants and peer volunteers complete either an online, paper or phone interview survey. The survey is available in English, Spanish and Mandarin. A copy of the most recent survey results is attached.

Some of the highlights from the 20/21 survey were:
- 89% of the volunteers were satisfied with the program
- 86% of the participants said the program was very valuable to them
- 89% of the volunteers who responded to the survey said that training on meeting the needs of the participants was great. "We learn from others and it benefits us". "I thought the initial training was terrific and the staff is always available for questions".

The Senior Peer Counseling Program is a program that is preventative. When a participant needs a higher level of care, program staff make a referral to an appropriate resource. Volunteers attend monthly clinical supervision where they receive oversight and guidance in working with their clients. In supervision, Peer Counselors discuss clients who may be suicidal, at risk of homelessness, abuse or neglect. Referrals are made to the proper resource and follow ups are conducted to make sure the resource was accessed.

Improves timely access & linkages for underserved populations:

Program referrals are received via phone, in-person, or secure fax. The Program Director who reviews each referral may contact the participants or the referral source for more information or determine program suitability. Once determined appropriate, the Director will send the referral to the peer counseling Coordinators to find a match between peer counselor and participant. The program Coordinators speak Spanish, Mandarin, Tagalog, English and are from the LGBT+ population.

Coordinators will contact their volunteers to find a match. If a match is not found, the Director keeps the referred participant on a waiting list until one can be found. The Program Director reviews the waiting list monthly. We also offer many drops in the community, affiliated with older adult housing, the Pride Center, community centers, etc. The groups are currently held on Zoom, so participants county-wide may join any group, regardless of where they reside. When a new participant joins a group, an intake is completed.

Reduces stigma and discrimination:
Many older adults have a stigma about receiving mental health support from a licensed provider and find that talking to someone who has lived through similar experiences, share a similar age, or share a similar culture does not have the same stigma. Because of stigma, the support groups are not called counseling groups; they are instead called Let's Talk, Platica, or Kapihan. Platica in Spanish means Chating, and Kapihan means getting together for coffee and chatting.

Increases number of individuals receiving public health services:
Peer Counselors refer participants to public health services when appropriate.

Reduces disparities in access to care:
The Peer Counseling Program is free and available to all San Mateo County residents, 55 years and older, who can benefit from the program. Those who need a higher level of care are referred to other resources.

Implements recovery principles:
Many peer counselors help participants establish goals to become less isolated, lonely, or anxious.

SUCCESSES

SPC program have now conducted two 36 hour trainings for new volunteers via zoom and 27 new counselors have been trained this year. Switching to an online training platform was challenging but worth the extra work. The program now has recordings of each training session. Staff and volunteers felt safe learning in their own homes and many staff and volunteers' computer skills have improved as a result. Through a special grant with San Mateo County Behavioral Health and Recovery Services, 27 tablets were distributed to volunteers and participants so that they could attend clinical supervision, training or connect with each other. The tablets have a free data plan that will be covered by the County through December, 2021.
BHRS funding supported recruitment and ongoing support and training of 145 counselors and the addition of 4 new groups. We know that these services have been even more critical since Covid-19

emergence. The stress levels, anxiety and isolation that many people are feeling right now are very high. We continue to outreach to those in need.

SPC will continue to offer training and in- services and monthly clinical supervision via zoom. The program wants to make it easier for volunteers to attend these meetings. SPC is planning a different type of evaluation process this year. Last year it contacted many of the participants via telephone to conduct its annual survey. Many participants were unfamiliar with the phone numbers so did not answer the call. This year the bulk of the evaluation will be done via focus groups. SPC worked hard to serve its participants and modifications to the program included:

- Continuing to provide well-being calls to all participants on its wait list. During the year, 987 well-being calls were made to older adults in the community. The program continued to provide telephonic peer counseling, Zoom and phonebridge training, distribution of tablets to enable participants to access needed socialization and stimulation, distribution of masks and other needs that arose due to sheltering in place.
- Conducted meeting of all Clinical Consultants to discuss clinical issues of older adults
- Coordinated a meeting of California SPC program managers and shared best practices
- Conducted the following In-service trainings for volunteers and staff:
  1) Motivational Interviewing
  2) San Mateo County Community Resources - 65 attended
  3) Spirituality as we Age – 40 attended
  4) HICAP – 33 attended
  5) Ombudsman Services of San Mateo Co – 43 attended
  6) Self-Care – 38 attended
  7) Ageism Part 1 – 17 attended
  8) Ageism Part 2 – 15 attended
  9) Affordable Housing – 8 attended
  10) Rituals re: Death and Grief from diverse perspectives-14
  11) Stroke 101 – 29 attended
  12) Cultural Humility – 43 attended
  13) Zoom Recognition Event-32

Four new groups have begun, with one of them supporting Mandarin- speaking individuals in a local senior housing facility. The others include a Men's group, an English-speaking Coastside group and an LGBTQ+ Women's group.

A participant reports:

"The Peninsula Family Service has been wonderful for me. I used it after my father died. I am usually an organized person but grief got in the way of that. I did a lot of talking to my peer counselor, telling her my problems. She helped me to prioritize my responsibilities and gave me good suggestions. We met regularly. I was completely comfortable with her. She was understanding and supportive. Visie would listen carefully and make sure she understood. I was very glad I could meet with her! Visie helped me when I was quite upset several times. When I followed her suggestions I felt better.

In addition, she reports about her husband: Sometime after this, I realized my husband could benefit from having a peer counselor. I contacted the Peninsula Family Service. My husband is a scientist. He works from home and has done some important physics work. He recently started to work on a related biology project. It's lonely to do this and it's so helpful to have support. Peninsula Family Service found an excellent peer counselor for him, a man with a scientific background. My husband is thrilled about

that. He looks forward to his talks with his counselor. His counselor encourages and supports him. This is very, very important to my husband. It means so much to him. This past week when he finished speaking with his counselor he said, as he often does, 'What a great call! It was sensational.'"
Another participant talks about the diverse cultures of staff, volunteers and participants. Language is the means of communication with everyone in the world. It is an important asset in helping the community. The Kapihan group (means Coffee break) is a Tagalog term in the Filipino culture which I joined recently. The flow of sharing by group members is joyfully expressed in Tagalog and I think one hour is not enough to end the conversation. Tessie Madrinan, is a Filipina, and she is an accomplished moderator and coordinator of this group. There are other groups like Chinese, Spanish, English and could expand in the future.

CHALLENGES

SPC had a change in staffing for the Spanish-speaking component of the program. The program moved a Spanish-speaking staff person from another program into the position part-time to fill in until the right person was found. By doing this, SPC was able to maintain current volunteers and participants but could not recruit enough new volunteers to run Spanish-speaking training for new volunteers. The program has finally found a new Spanish-speaking Coordinator. She is due to start on August 16, 2021. They hope to have more success in finding new volunteers with her on board.

The Chinese Clinical Consultant left and has not been able to fill the position. Currently, the Program Director is providing clinical support to the group with the help of a bilingual staff member.

DEMOGRAPHICS

	FY 20/21
Age	
0-15	0%
16-25	0%
25-59	2%
60+	71%
Decline to State	27%
Primary Language	
English	52%
Spanish	20%
Mandarin	3%
Cantonese	2%
Tagalog	9%
Another language	7%
Race/Ethnicity	
American Indian/Alaska Native/Indigenous	1%
Asian	18%
Black/African American	0.1%
White/ Caucasian	40%
Central American	8%
Chinese	12%
Mexican/Chicano	12%

Filipino	9%
Japanese	0.7%
South American	1%
Korean	0.3%
Another race/ethnicity	7%

CRIMINAL JUSTICE INTEGRATION

PATHWAYS COURT MENTAL HEALTH PROGRAM + HOUSING

Pathways is a partnership of the San Mateo County Superior Court, Probation Department, District Attorney, Private Defender Program, Sheriff's Office, Correctional Health, National Alliance on Mental Illness, and Behavioral Health and Recovery Services. Pathways is an alternative path through the criminal justice system for those with serious mental illness. Pathways participants may have a co-occurring substance use disorder as long as a functionally impairing major mental illness is also present. The criteria for eligibility include statutory eligibility for probation, San Mateo County residency, diagnosis of a functionally impairing major mental illness, voluntary agreement to participate, and age 18 or older.

Primary program activities include intensive case management (treatment and recovery plan services, medication linkage, supportive housing services, treatment and recovery support for co-occurring mental health/substance use, psycho-educational/recovery services, service coordination including assistance/linkage with health care services, peer support/mentoring, family education and support) and intensive monitoring and probation supervision.

During this reporting period, Pathways was staffed by four case managers, two full-time clinicians, and one mental health program specialist who helped facilitate psychoeducational, support, and rehabilitation skills groups: Pathways Clubhouse is socialization and skills group co-facilitated by the Pathways lead clinician and peer support worker. This weekly group includes socialization activities and group outings with a focus on increased communication skills and symptom reduction through peer support. Pathways Men and Women's process-oriented groups also meet weekly for participants to further reinforce natural support systems and coping skills. Lastly, Pathways runs a Cognitive Behavioral Therapy group facilitated by two clinicians. This group utilizes evidence-based cognitive behavioral therapy interventions from the model Thinking for a Change, a manualized intervention that concentrates on cognitive interventions and criminogenic thought processes.

While Pathways also generally hosts annual events in which members of the community, program alumni, and current clients and staff join to participate, much of FY2020-2021 was overshadowed by the COVID-19 pandemic. As such, the program has maintained its community through small and safe events. Prior to the pandemic, they held a small client appreciation party open to current clients, alumni, and their families. This was an opportunity to showcase clients' success to one another and included giving out client-specific awards. In response to the pandemic, Pathways have leveraged technology and virtual platforms, such as Teams to host virtual game sessions in its Clubhouse group as well as engaged in socially distanced small outings when advisable by county guidelines. Despite having to cancel larger events, Pathways remain in coordination with community partners including Correctional Health

Services, National Alliance on Mental Illness, Sheriff's Office, Private Defender Program, the District Attorney's office, and community alcohol and drug treatment providers.

PROGRAM IMPACT

Pathways	FY 20/21
Total clients served	65
Total cost per client	$4,860

In this reporting period, Pathways served 65 clients, including 12 program graduates, 12 new admissions, and 3 exclusions. Pathways graduates receive certificates signed by its judge and get their court costs deleted in recognition of their work. Some graduates also receive expungement of their legal charges. Since Pathways began in 2006, 142 participants have graduated. The program invites Pathways Alumni to picnics and other events as role models for current Pathways' participants.

Most Pathways' clients represent traditionally underserved populations; all have experience with the criminal justice system and a mental health diagnosis. The four Pathways case managers work with clients individually and intensively to ensure they are connected promptly with a warm handoff to needed services. Each clinician develops an individually driven treatment plan to address client-specific needs sensitive to a history of minimal access to resources. Services accessed include public health services (e.g., Medi-Cal enrollment, benefits applications, linkage with a regional mental health clinic and primary care provider) and additional services with partner programs based on individual needs (e.g., chemical dependency treatment, housing agencies). Pathways' clinicians also provide direct clinical services to all clients, including group and individual therapy and crisis management, to ensure low barriers to access needed care. Pathways also proactively combat stigma and discrimination, particularly concerning mental health diagnoses and difficulties. Pathways encourage participants to speak openly about their experiences and partner with organizations such as the National Alliance on Mental Illness to participate in the annual NAMI awareness walk, mental health month, and suicide prevention initiatives. Further, Pathways utilizes the peer support worker model to reinforce the recovery and human-centered approach to treatment.

In this reporting period, all 65 of current clients were able to reduce the duration and severity of mental illness through their active participation in Pathways support and treatment groups as well as through intensive case management. Specifically, many clients also addressed concrete negative outcomes that result from untreated mental illness:

- Pathways is an alternative to incarceration, meaning that all enrolled clients are in Pathways and thus able to avoid incarceration by obtaining mental health treatment. Over the reporting period, 1 client were booked into custody on probation violations. 1 of those were readmitted to the program without future violations, and 3 were excluded
- 11 clients obtained employment
- 8 clients newly obtained stable housing; of those, 1 obtained permanent housing vouchers, 5 joined sober living environment homes, and 2 are in social rehabilitation or board and care
- 1 client newly obtained employment
- 2 clients enrolled in school and have continued via online learning during the pandemic
- 1 client were able to maintain children in their homes, and 0 without previous contact with their children have been able to resume contact

SUCCESSES

Pathways' support far extends to being on probation and successfully dismissing a case, and bringing families together. One case that denotes this to be true is a current case of a young Latin man who recently was diagnosed with schizophrenia and had no way to answer some of the many questions they had about cared for a loved one. Watching his family coming together and embracing him after he was released from custody speaks volumes on the positive benefit that the program brings to the community.

Pathways have made it possible for this family to see their son return home again. It is admirable that the Pathways program proudly offers true cultural competence in the services. Another case involved a client who had just been released from custody and was rejected from several shelters because of his mental health diagnosis, which caused him to be overly aggressive. While in Pathways care, he thrived. He completed Pathways successfully and was welcomed at the Industrial Hotel, where Pathways holds a room. He got a job designing systems to help people with disabilities at a local nonprofit and became an entrepreneur while successfully attaining permanent housing.

CHALLENGES

Restrictions related to the pandemic have been the primary area impacting client care and timely access to treatment. Specifically, clients needing access to Residential Treatment Programs (RTPs) have encountered delayed admissions due to quarantine requirements needing to be met before entering the RTP facility. When an unvaccinated client is released from custody and/or prematurely leaves an RTP, they must be quarantined for 10-days before they are admitted. While the county can provide temporary housing to ensure the client quarantines appropriately, there is little support available to help a client trying to remain sober doing that time. Pathways have found that many clients ultimately relapse during their quarantine period, increasing rates of rearrest and hospitalization.

BHRS is actively working on increasing vaccination rates, which will help waive the quarantine requirement placed by many RTPs. Additionally, Correctional Health Services (CHS) has effectively administered vaccinations to clients while incarcerated, which directly mitigates wait times related to this specific challenge.

DEMOGRAPHICS

	FY 20/21
Age	
16-25	13.85%
26-59	80%
60+	6.15%
Primary Language Spoken	
English	86.15%
Spanish	4.62%
Russian	1.54%

Cantonese	1.54%
Tagalog	1.54%
Unknown/Not Reported	4.62%
Race/Ethnicity	
White/Caucasian	55.38%
Latino/Hispanic	23.08%
Black/African-American	12.31%
American Indian or Alaska Native	4.62%
Asian	3.08%
Guamanian	1.54%
Asian Indian/South Asian	3.08%
Laotian	1.54%
Other Pacific Islander	1.54%
Chinese	3.08%
Mexican/Chicano	1.54%
Filipino	9.23%
Samoan	1.54%
Not Hispanic or Latino	58.46%
Other Hispanic	3.08%
Not of Hispanic Origin	3.08%
Mixed Race	6.15%
Another race/ethnicity	41.54%
Unknown/Not Reported	10.77%
Declined to state	4.62%
Sexual Orientation	
Gay, lesbian, homosexual	3.08%
Straight or heterosexual	53.85%
Bisexual	1.54%
Decline to state	40%
Veteran	
Yes	0%
No	23.08%
Unknown/Not Reported	76.92%

PATHWAYS, CO-OCCURRING HOUSING SERVICES

Pathways still has 2 contracted beds at Maple Street Shelter. 1 is dedicated for male identified clients, and 1 for female identified clients.

In this FY2020-2021:
- 6 clients occupied male beds
- 3 clients occupied female beds

GIRLS PROGRAM

StarVista's GIRLS (Gaining Independence and Reclaiming Lives Successfully) is an intensive outpatient program for female clients aged 12-18. Participants learn how to deal with significant substance use and mental health issues. Adolescent girls are valuable and worthy of community support. Sustainable resources and programs are provided that promote the process of healing, educating and empowering each girl to achieve her greatest potential in her community. Services include: Individual counseling, Family counseling, Adolescent group counseling, Multifamily group counseling.

StarVista is a well-established nonprofit based in San Mateo County. Their mission is *to deliver high impact services through counseling, skill development, and crisis prevention to children, youth, adults and families.* StarVista has provided services to youth involved in the justice system for over 20 years, and has a long history providing evidence-based mental health services to youth and families. StarVista staff also have extensive knowledge of the gender-specific, developmental, neurological, psychological, and social impact that trauma has on adolescents.

StarVista has lengthy experience serving juvenile justice involving youth at Camp Kemp (GIRLS) and the Youth Service Center (YSC). Note that services provided at YSC have a separate funding source through Youth Offender Block Grant (YOBG). The programs have shown to promote youth resiliency, prosocial behavior and emotional wellbeing and to decrease juvenile justice system involvement.

The GIRLS Program has provided high-level behavioral health services to youth with co-occurring mental health and substance use issues at Camp Kemp. The GIRLS Program is based on gender-responsive principle, restorative justice philosophy, and strength-based approach. The program centers on the belief in blending accountability and treatment to repair harm and heal personal and interpersonal relationships while forming positive connections.

The program services youth incarcerated at Margaret J. Kemp Camp (Camp Kemp) and youths attending Camp Kemp but reside at home (Girls Empowerment Program – GEP). Youths that enter the program typically have a range of issues including mental health disorders, trauma and substance use. The program is designed for at-risk, multi-recidivist adolescent girls with significant alcohol and drug and mental health problems, who have a current charge or serious probation violation. The program seeks to admit youths who have:

1) Have multiple other risk factors including mental health issues
2) Have an offense history placing them at risk for an out of county placement
3) Are likely to participate in activities that present at significant risk to themselves and the community
4) And in many cases, have a significant history of running away.

Each youth receives intensive mental health services, including a comprehensive assessment, individual therapy, crisis services, group therapy, family therapy, and case management. Mental health services focus on family dynamics, communication, trauma, substance use and relationship dynamics.

GIRLS offers groups on communication skills, anger management, anti-bullying, mindfulness, sexuality, and healthy vs. unhealthy relationships, and has utilized a wide range of modalities to engage clients (e.g., drama, poetry, music, and journaling). Emotional Regulation/Coping Skills have specifically been

addressed through the Expressive Arts and Mind, Body, Spirit groups as they can elicit personal connections amongst participants that directly impact their ability to regulate their emotions and cope with life stressors. StarVista also provides multi-family groups that focus on youth development, impacts of substance use on the family, communication, relationship dynamics, and at-risk behaviors.

PROGRAM IMPACT

GIRLS Program	FY 20/21
Total clients served	12
Total cost per client	$7,448

The primary short-term outcome is a demonstrated increase in engagement for both clients and their families. Additionally, clients are engaged in school and have made academic progress, increase in cooperative family unit, increase in positive peer relationships, and increase in pro-social activities. Outcomes are measured by self-report, family report, probation report, school report, and client surveys. Outcomes-based on girls completing the 6-12-month GIRLS program indicate:

- Increase in positive individual engagement   93%
- Increase in positive family unit   60%
- Increase in positive academic engagement   73%
- Increase in positive peer relationship   80%
- Increase in pro-social activities   73%

Timely access and linkage for underserved population & reduce disparities in access to care:
This year, to improve access to services for clients who would struggle to get to Camp Kemp services, the program provided individual and family therapy both in the office in San Mateo and at other community locations such as BHRS offices close to a client's home. They refer clients to various providers, including Rape Trauma Services, other StarVista programs, such as Your House South, Daybreak, Insights, and the Counseling Center. The program also refers to other nonprofit community agencies, such as Teen Success, Outlet, the Prep team, Family Partners, or Pre to Three through BHRS. Additionally, GIRLS reached out to StarVista Early Childhood Department to provide resources for pregnant youths at GIRLS. StarVista worked closely with collaborators to successfully transition services to a telehealth platform while COVID-19 and Shelter-In-Place ordinances were in place. To minimize the disruption to access to care, StarVista began providing phone and telehealth treatment to youths and their families. StarVista is delighted with the collaboration that has taken place between San Mateo Probation, BHRS, and other collaborators to support youths. They value these relationships as they continue to support work in providing high-impact services to clients.

Reduces stigma and discrimination:
GIRLS Program works closely with other collaborators such as The Art of Yoga Project, BHRS, and Rape Trauma Services to provide high-impact services to clients. To normalize mental health services to youths and their families, each family/youth participate in individual, family, case management, and group therapy. As mentioned above, StarVista offers mental health services that focus on family dynamics, communication, trauma, substance use, and relationship dynamics. Moreover, StarVista's

groups emphasize communication skills, anger management, anti-bullying and use various modalities to engage clients.

Increases number of individuals receiving public health services:
Juvenile Court makes referrals to the GIRLS program. When a youth is identified as a GIRLS program participant, StarVista and other mental health providers actively support the youth. Due to the specific referral process of GIRLS programming, StarVista is limited to providing services to youth specifically assigned to Camp Kemp or GEP programming. As mentioned above, the program provides intakes, assessments, collaborative treatment planning for each client together with individual therapy (weekly), group therapy (two groups per week), family therapy (weekly), and multi-family groups (twice a month), utilizing educational and psycho-educational and process models as well as case management including extensive collaboration with the multi-disciplinary team (weekly).
During their time at GIRLS, StarVista has observed a demonstrable increase in engagement for clients and their families. Additionally, clients are engaged in school and have made academic progress, increased cooperative family units, increased positive peer relationships, and increased pro-social activities.

Implements recovery principles:
The GIRLS program serves juvenile justice youth and provides trauma-informed, culturally responsive treatment to youth and families. StarVista implements culturally and linguistically appropriate services. GIRLS program provides high-level behavioral health services to youth with co-occurring mental health and substance use issues at Camp Kemp. GIRLS utilizes strength-based, gender-specific, trauma-informed, culturally responsive approaches. The groups provided at Camp Kemp utilize the Girls Circle curriculum to support healthy relationships, strengthen their sense of self, build self-esteem, make connections to position role models/peers, develop resiliency, and teach skills training that builds on positive connections and personal, collective strengths and competence. Specifically, the Expressive Arts and Mind, Body, Spirit groups elicit personal connections amongst participants that directly impact their ability to regulate their emotions and cope with life stressors. The StarVista Management Team and the GIRLS Program staff remain fully committed to providing excellent evidence-based programming and services to the clients they serve.

SUCCESSES

StarVista is proud to support youth in the GIRLS program at Camp Kemp. This year, 12 youths successfully participated in the GIRLS Program. This year, a solid team reflected the efforts made to recruit interns that can thrive within the Camp Kemp environment and improve the training program. It was also helpful that the multidisciplinary team was welcoming and supportive of the new interns. Generally, interns fit very well into the Camp Kemp environment and built rapport with the youth, families, and the multidisciplinary team.
The collaboration within the multidisciplinary team is at the highest point they have seen. The MDT meetings are now a space where each client's situation is discussed with all parties involved. Also, the clinical collaboration between B.H.R.S., Rape Trauma Services, and StarVista is at a high point, as reflected by how they have co-facilitated groups together.

StarVista continued to provide Alcohol Other Drugs (A.O.D.) group therapy (funded by probation) which has been well received by the clients who have been highly engaged. Additionally, A.O.D. individual therapy was provided to six youths (funded by probation)—the integration of A.O.D. In collaboration with the individual, family, and group counseling services, individual counseling services provided significant support to youths struggling with substance use. They successfully utilized the GIRLS Circle curriculum. They now provide healthy snacks as part of their group therapy sessions. They have increased sensory tools such as stress balls, tactile objects, and rocking chairs in group therapy to support self-soothing and emotional regulation.

In March 2020, COVID-19 and Shelter-in-Place ordinance greatly impacted StarVista's ability to provide services to youths. StarVista worked diligently with Probation and B.H.R.S. to quickly provide services to youths. StarVista provided all mental health services via phone and video therapy to best support youths during these unprecedented times. Moreover, StarVista was ready and provided group therapy services via video conferencing when this possibility became available. StarVista has worked collaboratively with probation to smooth the transition to remote services.

CHALLENGES

During FY 2020-2021, StarVista navigated the transition to virtual service delivery due to COVID-19 and Shelter-in-Place ordinance. Although StarVista was ultimately able to transition to virtual services, they encountered challenges such as youths not having internet, phone, or computer access, youths no-showing to schedule sessions, and pauses on group therapy meetings. The GIRLS program has continued to build relationships with BHRS and SMC Probation to coordinate mental health treatment for youths and their families. During COVID-19, the GIRLS program shifted all mental health services to phone or video sessions and provided additional meetings depending on family/youth need.

DEMOGRAPHICS

	FY 20/21
Primary Language	
English	100%
Age	
0-15	41.7%
16-25	58.3%
Race/Ethnicity	
African-American	8.3%
White/Caucasian	8.3%
Latino	83.3%
Filipino	5%
Sexual Orientation	
Decline to state	100%

The GIRLS program plans to collect data for Disability/Learning Disability, Intersex, and Gender Identity from youth in the upcoming fiscal year. It is important to note that during youth's time at GIRLS program, one youth did disclose desire to transition from female to male, however this continues to be a state of exploration.

CO-OCCURING RECOVERY SUPPORT SERVICES

Voices of Recovery San Mateo County (VORSMC) is a non-profit 501©3 peer-led organization established in 2010 to advocate for and support the recovery community: people overcoming drug and/or alcohol addictions. VORSMC creates peer-led opportunities for education, wellness, advocacy, and support services for individuals who need long-term recovery from alcohol and other drug addictions, equally sharing these opportunities and support services with impacted families. We coordinate local, state, and federal advocacy efforts. VORSMC partners with treatment providers, government entities and officials, community non-profits, faith-based organizations, and other organizations that provide recovery support services to individuals and impacted families.

VORSMC targets the most disenfranchised community members and offers critical support services to persons recovering from a wide range of addictions. VORSCMC provides recovery support services to San Mateo County (SMC) residents from the urban core of San Mateo and Redwood City to the historically underserved coastal regions, geographically isolated from services and long-standing networks of support. SMC is home to 769,545 residents, and the Census reports a significant percentage of the population as persons of color (46.6%), including 24.8% Asian, 25.4% Latino, 2.8% African American, 1.4% Pacific Islander and 11.8% Other/Mixed Race. The South County Cities Redwood City and East Palo Alto are home to immigrants from Latin America.

The agency works to prevent relapse, sustain long-term recovery, and support family members affected by addiction. The agency also helps develop employment opportunities and community outreach to promote addiction-free lifestyles. VORSMC's Wellness Recovery Action Plan (WRAP) program is an evidence-based, peer-led practice nationally recognized by SAMHSA as an effective way to help marginalized populations, including people of color and persons reentering the community from incarcerated settings, maintain their recovery from addiction and mental health issues.

WRAP is based on the premise that everyone is an expert on self, and there is no judgment on people. People sharing their lived experience within the group diminishes stigma's effect by helping others disclose their experiences with mental illness, treatment, and or recovery. The program understands that self-stigma has a pernicious effect on the lives of people with addiction and mental illness. Although medical perspectives might discourage patients from identifying with their illness, at WRAP, they encourage public disclosure, promoting empowerment and reducing self-stigma.

PROGRAM IMPACT

Voices of Recovery	FY 20/21
Total clients served	295
Total cost per client*	$390

VORSMC program is mostly offered at partner organizations across the county. Thus, directly accessing their target population. During the Covid-19 pandemic, all groups and communication are offered virtually, through Zoom, website, Facebook, YouTube, and other media avenues. This access allows improvement in the access and linkages to the populations they cannot serve before the pandemic. Virtual presence allows them to provide convenient, accessible, and acceptable services in a culturally appropriate setting.

VORSMC offer groups designed and implemented in ways that reduce and circumvent stigma, including self-stigma and discrimination related to being labeled as an alcoholic/addict or diagnosed with a mental illness, having a mental illness, or seeking mental health services, and making services accessible, welcoming, and positive having groups facilitated by peers with lived experience. VORSMC facilitators use non-stigmatizing and non-discriminatory approaches by sharing personal stories that are positive factual messages and tools they have learned to use to focus on recovery, wellness, and resilience; using culturally appropriate language, practices, and promoting positive attitudes.

VORSMC provides free services to all individuals, which helps to increase the number of individuals seeking service. They also provide mentorship from WRAP facilitators, referral to residential treatment providers, and public health services if required. The online resource presence helps individuals access other services; housing, transportation assistance, referrals to health clinics to address chronic conditions, and other educational, social, and recovery services, as identified by participants in their groups.

Disparities in access to care is a significant issue with the peers that VORSMC service. Most of the participants do not have insurance and have difficulties seeking care, especially during the pandemic, because they lack the technology for use. VORSMC aids in reducing disparities by allowing the use of computers and aiding with application processes. VORSMC's partnership with the different minority initiatives helps increase awareness of racial disparities and advocate for more minority physicians and therapists in San Mateo County. VORSMC prioritizes the elimination of racial and ethnic health disparities as a top priority.

VORSMC implements recovery principles by adhering to the 10 core principles of recovery.
1. Self-direction: WRAP participants are encouraged and guided to set their path to recovery.
2. Individualized and person-centered: WRAP helps their participants to set their own individualized recovery pathway based on their own strengths, needs, preferences, experiences, and cultural backgrounds.
3. Empowerment: WRAP participants are empowered to choose among options and participate in all decisions that affect them.
4. Holistic: WRAP has a very holistic approach to a participant's recovery and helps participants focus on their life, including mind, body, spirit, and community.

5. Nonlinear: WRAP sets a Non-linear tone to discussing and approaching recovery by emphasizing the importance of continual growth despite occasional setbacks.
6. Strengths-based: WRAP helps participants think about their own strengths and empowers them to use their strengths in their recovery journey.
7. Peer support: In an 8-week WRAP program, the participants receive mentorship from their WRAP facilitators and continue to receive peer support for up to one year after completion of the program. While in these groups, peer coordinators offer support in accessing services and help create links to housing, transportation assistance, referrals to health clinics to address chronic conditions, and other educational, social, and recovery services, as identified by participants in their groups.
8. Respect: The WRAP groups are facilitated by facilitators to provide participants with a space to be themselves and positively share their experiences.
9. Responsibility: The program emphasizes the importance of personal responsibility in approaching one's recovery.
10. Hope: This is the central to WRAP programs, and the majority of the participants in the post-completion survey, agree they have hope after completing the WRAP groups.

SUCCESSES

Unedited Personal Recovery Stories:
"Hello my name is Yraes Ycenet Guerrero. I am a single mother of 3 amazing children but most of all I am also their best friend. I am dedicated to my sobriety because it is the only way I know that everything in my life will and can work! Before getting clean I had 5 years of darkness in my life, and I barely came out of it alive. It literally took my life to be threatened and my organs to begin to shut down for me to make the choice of getting clean and living a clean and sober life. With the help of my sister, HR360, and Women's Recovery Association (WRA), I began my journey of Hope. My sister and HR360 guided me into WRA ensuring I would get the help I needed and WRA got me through the 1st 90 days of my recovery. It was at WRA that I came to know who Voices of Recovery San Mateo County (VORSMC) is and how I could use Wellness Recovery Action Plan (WRAP) in every part of my life. It was during the Voices Open House event where I heard a woman's story, her perseverance, and her hope to be the vehicle that drove her to live a sober and clean life. It was during the few minutes that she told her story, I wanted to be her. I wanted what she had and that was where I gained more motivation to live a mentally, physically, spiritually, and emotionally healthy life. My recovery has become the first in my life today. I know today that I can handle LIFE and all the hits that it can throw my way in a positive and productive manner. When I began to attend WRAP, I had my 90 days of sobriety,
and I had a tool belt where I could put the tools WRA had taught me to use but I needed more. Once home and out of the safe walls WRA had provided for me, I needed to begin to fill my tool belt with the tools I would need to live my life in a healthy manner. Voices of Recovery provided me with a safe place. A place where I could be myself, where I can talk about my struggles and my imperfect self without being judged or feeling less of myself. I began to explore myself and build confidence about the woman I am. After attending WRAP for several months, I was given the opportunity to work for them and I never thought I would be given the gift to get paid while working on my recovery. Today when I facilitate a

WRAP group, I do it with confidence because I truly believe in the ethics and values of WRAP. I believe in it because I use WRAP in my everyday life, and it is what keeps me in my wellness. Today because of my recovery, my health is on the right track. My physical, mental, spiritual, and emotional health are all on the right track. I feel ready to return to school and finish my education, to go back and finish so I can receive my bachelor's degree and continue to work in recovery. I have a great support system with my family, my friends, and my co-workers. I believe in Hope......and all the blessings it brings to my life. I believe in Education....in order for me to better my life and that of my children. I believe in Personal Responsibility and making the right choices. I believe in Self-Advocacy and asking for the things I need to make my life right. And most of all I believe in Support. Without support I do not know if I would have made it out of my addiction alive. I owe all the people in my life for supporting me through my journey. A journey I am enjoying today because of how I am living my life I can enjoy it more even through my struggles."

"My name is Eric Love. My recovery story begins not with my willingness to get clean but rather from a story of tragedy turned into a life of hope. I was in my addiction for over 20 years and along with that some criminal activity. Due to the lifestyle, I was living, I was involved in a very bad motorcycle accident that left me paralyzed. The accident that left me paralyzed happened 3 1⁄2 years and not only was I paralyze but I was in a dark place. I was physically in bad shape but so was my mental, emotional, and spiritual being. It was the lowest point of my life. Then I was introduced to someone at Voices, and they invited me to attend WRAP. I began to attend daily, and I began to develop my WRAP. WRAP is something I use daily today, and wellness tools is what I use to keep my recovery strong. WRAP has provided me with tools I can use in my recovery. WRAP has allowed me to view my circumstance as a positive thing that happened to me because without that accident, I may not have found recovery. I am grateful for all the resources that San Mateo County has to offer. Some of those programs are transportation to attend Health and Wellness and WRAP before Shelter in place. I used and continue to use Redi wheels. This resource is valuable to me because it provides transportation for disabled individuals and/or in a wheelchair, as I am. It would be near impossible for me to get to my appointments or any place I need to go. I also live in an assisted living hospital where I get help to get myself ready each day. I am provided with meals each day and they help me with just about everything. If this resource did not exist I do not know where I would be because I have no family that would take on such tasks and my mother is physically unable to care for me this way. Today I have hope and every day I am improving physically, mentally, emotionally, and spiritually and what that means to me is that I have hope, that someday I may be able to walk again. Today I look forward every day to move forward and I strive to be a better person. I am excited at what the future has in store for me, and I owe that to my recovery and this journey of recovery."

CHALLENGES

In 2020, the loss of Executive Director Raymond Mills was a devastating trauma for the organization. COVID-19 has created new challenges for VORSMC, and technology upgrades have been required for the facility and staff to provide services virtually. The participants and partners in the community have needs as well. These challenges make it difficult to implement programs and hold events typically done in person.

Mitigating solutions to these problems include upgrading and purchasing new technology and offering participants tablets for staff to hold virtual events remotely to ensure the participants have the best experience and receive needed services.

In addition to having virtual events and holding groups and services, the need for participants to have the appropriate technology to attend groups is also a challenge. Many participants lack the funds and experience to source or even utilize the necessary equipment. Also, purchasing the necessary technology to train participants at the office can increase the availability of services and participation numbers. The loss of groups that were previously operating due to the technology gap and the aforementioned challenges continue to be a challenge for Voices to provide the needed recovery services. The in-person requirements and restrictions have lowered the groups that are still operating and continue to be a challenge for starting new groups within the community.

DEMOGRAPHICS

	FY 20/21
Primary Language	
English	65%
Spanish	35%
Age	
0-15	0%
16-25	13%
26-59	84%
60+	3%
Race/Ethnicity	
Asian	6%
Black/African-American	10%
White/Caucasian	21%
Mexican/Chicano/Hispanic/Latin X	42%
South American	9%
Another race/ethnicity	21%
Sex Assigned at Birth	
Male	60%
Female	40%
Gender Identity	
Male/Man/Cisgender	25%
Female/Woman/Cisgender Woman	70%
Transgender Woman	1%
Decline to state	3%
Sexual Orientation	

Gay, lesbian, homosexual	7%
Straight or heterosexual	90%
Bisexual	3%
Veteran	
Yes	0%
No	100%

RECOVERY SUPPORT SERVICES (GIRLS PROGRAM)

Refer to the program outcomes included in the section above, under Criminal Justice Integration programs.

CO-OCCURRING CONTRACTS & STAFF

MHSA co-occurring funds support nine substance use providers and BHRS staff to support integration of substance use and mental health services. Additionally, two clinical contractors provide co-occurring capacity development trainings to BHRS staff and multiple agencies, consultation for complex co-occurring clients and system transformation support for relevant programs.

PROGRAM IMPACT

Clients served by Co-occurring Staff	FY 20/21
Total clients served	1436
Total cost per client*	$196

The Treatment Perception Survey (TPS) was administered to Alcohol and Other Drug (AOD) Treatment Programs during one week in November 2020 in all threshold languages. The TPS measures impact of services in 5 domain areas: Access, Quality, Outcomes, Care Coordination, General Satisfaction

- 175 TPS completed
- 18 Treatment programs participated
- 7.4% TPS surveys completed in Spanish, 92.6% in English
- 66.8% of respondents were 26-55 years of age, 10.3% 18-25, and 16% 56+
- 41.7% of respondents were White, 29.1% Latinx, 6.9% Asian, 6.3% Black and 3.4% NHPI
- 58.3% of respondents were male, 33.7% female, 1.1% transgender and 1.7% other gender identity

Quality Measures
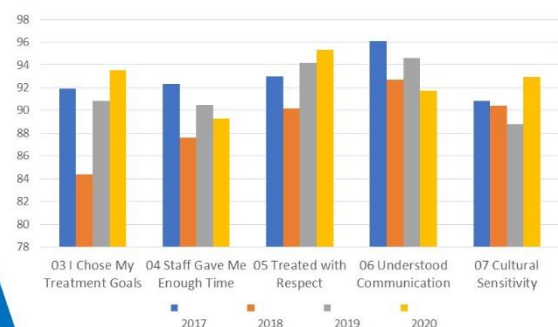
Outcome Measure

> " As a direct result of the services I am receiving, I am better able to do the things I want to do."
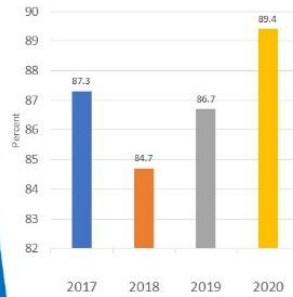
Care Coordination Measures
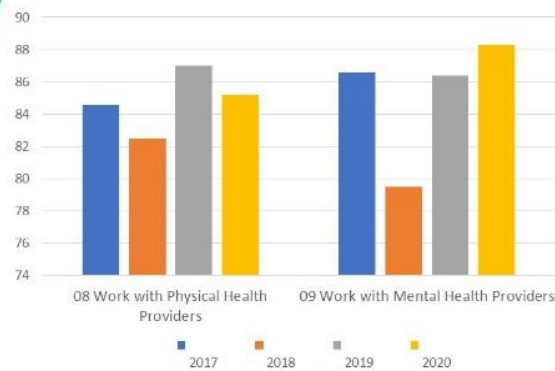
Access Measures

SUCCESSES

Client quotes
"I enjoyed sharing and learning how to manage my life as an adult. I learned coping skills, communication style, critical thinking and living in the present and the future and not get stuck on the past. To move forward and forgive myself and be a better and kinder person to myself. Learn the path to sobriety and live a richer, fuller, and healthier life. I love it and would love to do it more."

PEER AND FAMILY PARTNER SUPPORTS

PEER SUPPORT WORKERS & FAMILY PARTNERS

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

PROGRAM IMPACT

Peer and Family Partners	FY 20/21
Total clients served	82
Total cost per client	$18,951

There are currently 9 Peer Support Worker and 9 Family Partner positions across BHRS.

Peer Support Worker Team:
- 6 Peer Support Workers on the Adult Clinical Services Teams (full time positions)
- 1 Peer Support Worker is in the Older Adult System of Integrated Services (OASIS) Team (part time civil service position)
- 1 Senior Community Worker on the Adult Services Teams (full time civil service position)
- 1 Senior Community Worker on the Pathway Team (full time civil service position)

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

They inspire clients through sharing their personal experience with mental health and/or substance use services which helps clients realize the benefits of such services. They also help them overcome barriers to participation in mental health and substance use services. Support clients with developing and maintaining treatment goals and plan.

Peer Support Workers also supported clients by:
- connecting to housing services, applying for housing assistance, locating housing, completing referral, finding housing, and maintaining housing;
- linking to mental health and substance services and counseling;
- facilitate the transition to a higher level of care;
- connecting to vocational resources;
- applying for benefits, process with Medi-Cal, SSI, Unemployment SSDI, DOR, general assistance, food stamps;
- providing transportation support in order to acquire medical or mental health services;
- connecting to Peer Support Services as Heart and Soul, California Clubhouse, Voices of Recovery and The Barbara A. Multicultural Wellness Center.

Peer Support Worker Trainings: This fiscal year has been mostly dedicated to the implementation of SB803 – Peer Support Specialist Certification. BHRS contracted with CASRA to provide a 60-hour training for peer support staff consisting of:
- 2-hour - Recovery, Wellness and Resiliency Part 1
- 2-hour - Recovery Wellness and Resiliency Part 2
- 2-hour - Nothing About Us Without Us - History of the Treatment of People with Mental Health Challenges
- 2- hour-The Values of Peer Providers
- 2-hour -The Role of Peer Providers
- 2-hour - Listening
- 2-hour - Harm Reduction and the Three E's
- 2- hour - Harm Reduction Part 2
- 2-hour - Culture and Worldview
- 2-hour - Trauma-Informed Care
- 2-hour - Boundaries and Ethics 1
- 2-hour - Boundaries and Ethics 2
- 2-hour - Honest Open Proud: Self-Disclosure and Sharing Your Story
- 2-hour - Honest Open Proud: Self Disclosure and Sharing Your Story Part 2
- 2-hour - An Overview of Psychosocial Rehabilitation
- 2-hour - Being a Navigator and Making Good Referrals
- 2-hour - Supported Education
- 2-hour - Supported Employment

In addition, the Peer Support Workers also completed:
- 10-hour documentation training for Peer Support Workers and Family Partners
- COVID-19 Prevention Program (CPP) Training

- Digital Health Literacy Training & Technical Support; Introduction to Digital Peer Navigation/ Smartphones; Email Set-up and Maintenance; Online Security and Privacy; and Telehealth during COVID-19
- Painted Brain's Community Tech Café to learn about today's most important uses of technology to stay connected with work, family, and friends.
- Working Effectively with Limited English Proficient Clients & Interpreters Training
- 2020 Annual Update - BHRS Confidentiality and HIPAA
- NMT - 14 hours Training
- Compliance Training for BHRS
- Fraud, Waste, & Abuse Training for BHRS

Peer Support Workers bring their lived experience to the broader community by participating in community groups and County BHRS Health initiatives such as:
- African American Initiative,
- Lived Experience Speakers Academy,
- Lived Experience Education Workgroup,
- Housing Operations and Policy Committee,
- Housing Change Agent Meeting
- MHSA Steering Committee

Family Partner Team:
- 7 Family Partners are embedded in the youth clinical services teams. (full-time civil service positions
- 1 Family Partner is on the Adult Pathways Mental Health court team. (full-time civil service position)
- 1 Family Partner on the Pre-3 Program. (part-time civil service position).

Family Partners represent diverse cultural and linguistic experience including bicultural and bilingual Spanish and Tongan, as well as English speaking African American. BHRS Family Partners can be referred to provide support for families who are not receiving services on the teams that they are embedded on. Cultural and linguistic matches are a key factor in making these assignments. Family Partners provide individual support to parents of youth and young adults, sharing their lived experience with the families they serve. Some case management is part of their support of families. They also provide group support to parents/caregivers by providing educational activities around children and their mental health.

Family Partners also bring their lived experience to the broader community by participating in the following community groups and initiatives: African American Initiative, Latino Collaborative, Pacific Islander Initiative, North County Outreach Committee, Immigrant Forum, Pride Initiative, and Pacific Islander Taskforce. Groups co-facilitated by Family Partners during 2020-2021 include:
- 2 virtual *Nami Basics* in Spanish - 6-week Psycho-educational program weekly (36 parents/caregivers)
- 7 virtual Monthly Support Groups in Spanish for Parents/Caregivers of adult clients (6 participants)

- 24 by-weekly virtual Parent Café's in Spanish - Coastside Clinic with (3-5 parents/caregivers per group)
- 21 by-weekly virtual Parent Café's in Spanish - South Youth Shasta Clinic (4-6 parents Per group)
- 4 virtual by-weekly Parent Café Groups in English for parents/caregivers of youth. (2 parents per group)
- Virtual *Educate, Equip, and Support (EES)* group, a 5-week group meeting weekly to educate parents about common childhood mental health issues and symptom management techniques. Provide information on local resources to help address their children's mental health needs (3-4 participants per group)
- 3 Virtual Parent Project "the essence of Mana" 12-week course meeting weekly to support parents/caregivers develop communication skills and tips leading to more love and nurturing family relations (20 participants per group)
- 2 Suicide Prevention "Know the Signs" presentations: one in English and one in Spanish

Some Presentations by Family Partners during 2020-2021 include:
- 1 Parent Café group model Presentation for the BHRS Pre-three clinical team
- Family Partners participated in the BHRS Interns Orientation in a panel to share their lived experience to educate interns about family integration in the treatment
- Community and Family Engagement Café for Providers Working with Families

Some of the trainings/conferences the Family Partners participated in during 2020-2021:
- Conversations about institutional racism
- Trauma-Informed Leadership in Times of Crisis
- Antiracist practice/ALLYSHIP
- Working through the IEP Process
- Digital Health Literacy Training & Technical Support; Introduction to Digital Peer Navigation/ Smartphones; Email Set-up and Maintenance; Online Security and Privacy; and Telehealth during COVID-19
- Painted Brain's Community Tech Café to learn about today's most important uses of technology to stay connected with work, family, and friends.
- Managing Assaultive Behaviors Training
- Office of Consumer and Family Affairs collaborated with NAMI San Mateo County to bring two NAMI Basics Facilitator Trainings. One in English and one in Spanish. Four Family Partners, one Peer Support Worker, and ten community caregivers were trained.
- Working Effectively with Limited English Proficient Clients & Interpreters Training
- 2020 Annual Update - BHRS Confidentiality and HIPAA for Mental Health and Alcohol and Other Drugs
- NMT - 14 hours Training
- Compliance Training for BHRS
- Fraud, Waste, & Abuse Training for BHRS
- "Café entre Mujeres": Group for woman about challenges, solutions, and self-care in the face of the pandemic
- Documentation for Peer Support Workers and Family Partners, 10-hour training

- COVID-19 Prevention Program (CPP) Training
- 2-hour - Recovery, Wellness and Resiliency Part 1
- 2-hour - Recovery Wellness and Resiliency Part 2
- 2-hour - Nothing About Us Without Us - History of the Treatment of People with Mental Health Challenges
- 2- hour-The Values of Peer Providers
- 2-hour -The Role of Peer Providers
- 2-hour - Listening
- 2-hour - Harm Reduction and the Three E's
- 2- hour - Harm Reduction Part 2
- 2-hour - Culture and Worldview
- 2-hour - Trauma-Informed Care
- 2-hour - Boundaries and Ethics 1
- 2-hour - Boundaries and Ethics 2
- 2-hour - Honest Open Proud: Self-Disclosure and Sharing Your Story
- 2-hour - Honest Open Proud: Self Disclosure and Sharing Your Story Part 2
- 2-hour - An Overview of Psychosocial Rehabilitation
- 2-hour - Being a Navigator and Making Good Referrals
- 2-hour - Supported Education
- 2-hour - Supported Employment

Some of the committees for outreach and support to the community the Family Partners participated during 2020-2021:
- 6 monthly Immigrant Forum
- Integrating Families into the Treatment Plan (Virtual Training for Interns)
- 12 monthly Pacific Islander Initiative Committee
- California Systems of Care (CSOC) Bay Area Regional. Meetings held quarterly with behavioral health directors and Family Partners
- SB803 State Stakeholders Workgroup Meetings twice a month
- 3 Service Provider Virtual Roundtables with Vision and Compromiso. This group was to address cultural values and beliefs of Latinx immigrants and/or refugees

Some of the outreach efforts to the clients and community during COVID-19:
- Supporting the San Mateo County Health Department COVID Testing sites. Providing interpretation in Spanish and Tongan. Assisting with scheduling appointments and on-site registration.
- *"How to Support our Families and Kids to Have a Successful School Year,"* Facebook Live event to support families prepare better for distance learning due to COVID-19
- *"My Body, my Mind, My Wellness, My Community."* Facebook Live community outreach forum in Spanish with interpretation in English for the Latinx community to provide education about the COVID-19 vaccine.

- Family Partner supported First 5 San Mateo with a focus group to obtain feedback from parents/caregivers a youth 0-5 to gather information in finding resources to support the families through the COVID-19 crisis
- Pacific Islander Task Force, Taulama for Tongans outreach & support for the communities during COVID-19

SUCCESSES

Peer Support Worker Team
- Continue facilitating client engagement with virtual services, reaching out to clients between appointments, assessing their needs, and providing resources.
- Support in getting consumers/clients to vaccination clinics.
- Support and distribution of electronic devices to consumers/clients to continue engaging in their treatment goals and participate in activities provided by San Mateo County Peer Run Organizations.
- BHRS has contracted and provided a 60-hour Peer Support Specialist Training for Peer Support Workers in preparation for implementing SB803 in July 2022 with CASRA.
- BHRS also has contracted and provided a 6-hour training for Peer Support Workers' Supervisors to implement SB 803 in July with CASRA.
- A subgroup of Adult Leadership is creating the Scope of Practice for Peer Support Workers within the BHRS clinic.

Family Partner Team
The Family Partner Team served over 80 unduplicated families, primarily underserved communities. Some family support transitioned from virtual meetings during the pandemic to case-by-case in-person services. All support groups and educational workshops were held virtually to support these families with emotional support and essential community resources to survive COVID-19. Family Partners assisted families with the financial support applications for rental assistance, and over 20 families received rental assistance support.
Due to Family Partners' bilingual skills, it was possible to reach out to the Tongan and Spanish-speaking community in the county efforts for clients and the community to get vaccinated.

Due to COVID-19, most of the challenges the families have faced in accessing mental health services for their children are due to the lack of community resources to access a sustainable device with internet access for them to have their virtual therapy sessions. In addition, several families from underserved communities are technology illiterate and have difficulties helping their children with medical appointments, therapy appointments, and education support. San Mateo County BHRS, in collaboration with ODE, coordinated a program to provide cellphones/tablets with a data plan for these clients to access telehealth.

The following are three of the parents/caregiver's personal stories about family support:

"My granddaughter has been receiving mental health services for a few years. I moved to Redwood City two years ago to take care of my granddaughter. I have been receiving support from my Family Partner in Spanish for almost two years and she has been a great support to me and my family. She listens to my concerns and supports me at all times. She has helped me navigate the systems and resources in Redwood City since I recently came from out of state to care for my granddaughter. She has provided emotional support and always has a word of encouragement during difficult times. She invited me to a NAMI Basics group where I learned many skills to support my granddaughter better, and I enjoy the Parent Café groups where I feel supported by other parents. Thanks to my Family Partner who connected me with community resources during Covid that helped me maintain my home and financial stability during Covid-19." -Rosalba, Redwood City, CA*

"I have been receiving support from my Family Partner for six months. I am a mother of three young children. My Family Partner has guided and educated me on how to navigate CPS and mental health. Before I met her, I was very worried when I had the CFT meetings. Dealing with CPS is frustrating. But now my Family Partner has listened to my concerns, she has thought me some wellness tools and has guided me to better advocate for my family's needs. We meet weekly and I finally feel heard, I know I have a voice." -Anonymous, Redwood City, CA*

"I am a mother of three children. I have been receiving support from my Family Partner for 6 months. My son is 14 years old, and he has been receiving therapy for over a year. I have been trying to support his treatment but it's very frustrating as he is dealing with addiction and mental health issues. When I first met my Family Partner, it was very difficult for me to talk about my family's problems. I felt lonely and hopeless. But she has listened to me and guides me on how to better communicate with my son. My family Partner has been a great support for me and my family." -Ramona, East Palo Alto, CA*

CHALLENGES

- A high percentage of unvaccinated BHRS clients and youth 12 and over, despite the outreach efforts to raise awareness on the importance of getting vaccinated.
- Effects of isolation and fear of getting sick during COVID-19 on the mental health of clients and families.
- Housing - keeping their housing, and supporting clients to meet and get requirements for a mainstream voucher or other housing vouchers—food resources and applying for government grants for those qualified, such as Immigrant Families Fund.
- The biggest challenge was keeping clients engaged during covid, especially groups, answering calls, and keeping them connected.

DEMOGRAPHICS

	FY 20/21
Primary Language	

English	17%
Spanish	80%
Mandarin	1%
Tagalog	1%
Another language	1%
Age	
0-15	9%
16-25	3%
26-59	86%
60+	2%
Decline to state	1%
Race/Ethnicity	
Asian	2%
Black/African-American	2%
White/Caucasian	3%
Mexican/Chicano/Hispanic/Latin X	56%
Asian Indian/South Indian	1%
Fijian	1%
Central American	14%
Chinese	1%
Filipino	3%
Puerto Rican	1%
Samoan	1%
South American	9%
Another race/ethnicity	8%
Sex Assigned at Birth	
Male	24%
Female	74%
Decline to state	1%
Gender Identity	
Male/Man/Cisgender	25%
Female/Woman/Cisgender Woman	70%
Transgender Woman	1%
Decline to state	3%
Sexual Orientation	
Gay, lesbian, homosexual	0%
Straight or heterosexual	84%
Questioning or unsure	2%
Decline to state	14%
Veteran	
Yes	2%
No	95%
Decline to state	2%

CALIFORNIA CLUBHOUSE

California Clubhouse is a community-centered organization where adults (18 years and older) with mental health challenges can go every day during business hours to work on overcoming obstacles they face. It offers support, training, education, employment, healthy social interactions and positive reinforcement through collegial relationships and work. California Clubhouse is currently hosting 40 plus hours of Hybrid Programming, Monday thru Friday from 8:30am to 5pm as well as weekly virtual and in-person social gatherings.

Members (program participants) share ownership and responsibility for the success of the organization. They work and socialize in a unique partnership with small and dedicated staff, building on their strengths. Clubhouse program also builds and supports its members' social and emotional skills and well-being. This community-centered approach meets individuals in their path of recovery and has proven to support successful outcomes.

Due to continued COVID-19 restrictions in the county and state, California Clubhouse restructured their programming to allow for in-person and virtual formats. We focused the efforts on Membership, Wellness Works, Young Adult Program and Career Development using the principles of the Work-Ordered Day. The work-ordered day is a structured format that provides meaningful work for all members.

Colleagues (members and staff) work together to run the programs and do the day-to-day work associated with maintaining a meaningful and productive program. The work-ordered day highlights the talents and abilities of members and utilized within the Clubhouse. Members can participate in consensus-based decision-making regarding all important matters relating to the running of the Clubhouse. They have opportunities to obtain paid employment in the local labor market through a Clubhouse-created Transitional Employment Program. In addition, members participate in Clubhouse-supported and Independent employment programs; assistance in accessing community-based educational resources; access to crisis intervention services when needed; evening/weekend social and recreational events; and assistance in securing and sustaining safe, decent and affordable housing.

At California Clubhouse, the work includes, but is not limited to, orientation of colleagues, tours for potential members, administering employment programs, assistance with educational goals, fundraising, marketing, reach out, planning social activities, and conducting evaluation of Clubhouse effectiveness and policies. The community-centered approached provides members the opportunity to build long-term relationships that, in turn, support them in obtaining employment, education and housing as well as creating a social community.

PROGRAM IMPACT

California Clubhouse	FY 20/21
Total clients served	142
Total cost per client*	$2,354

California Clubhouse is affiliated and accredited by Clubhouse International, a psychiatric rehabilitation model recognized worldwide. Affiliating to Clubhouse International allows them to connect with Clubhouses around the nation regarding best practices around the model and Standards. Clubhouses have shown that participation naturally leads to reduced hospital visits, shorter hospital stays, reduced recidivism, fewer incarcerations, and reduced suicides. Clubhouse aligns well with an individuals' path to recovery and meets the members where they are at. According to the Substance Abuse Mental Health Services Administration (SAMHSA), the definition of recovery is as follows, "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potentials." Apart from that, SAMHSA has delineated four major dimensions that support a life in recovery, all of which Clubhouse provides. The four dimensions are health, home, purpose, and community.

The clubhouse provides a work-ordered day that is purposeful and person-driven. Members have a guaranteed right to a place to come, a place to return, meaningful work, and meaningful relationships. Members have shown and expressed an increase in self-confidence and sense of achievement through their ongoing participation in Clubhouse programming. Membership is voluntary and without time limits. Therefore, members are empowered to make decisions regarding participation in the program. Participation in the work-ordered day prepares many members to take the next step toward workforce re-entry, aligned with their skills and interests and prepares them to participate in the Career Development program. The Career Development program focuses on job readiness skills such as resume building, applying for the job, writing a cover letter, and weekly job search opportunities. This program encourages members to pursue employment in San Mateo County – something many members don't see as a possibility. The program invited Caminar to present on Supported Education to encourage members to pursue further education. They also encouraged members to join the Lived Experience Academy by San Mateo County.

Clubhouses' engaging program allows member to be part of something bigger than themselves. As a member of the community, they look after each other, advocate for each other when needed and conduct meaningful reach out to all members. This was especially crucial this last year through the pandemic stressors experienced. Clubhouse community supported various members in managing symptoms and staying on their steady path of recovery. Through the Evening Chats, safe spaces were created a for peer connections where members connected with each other and built supportive relationships. We rallied around members that were particularly struggling with symptoms of depression by creating a reach out tree. We planned a weekend of reach out calls to the member and hand-delivered a lunch for them to eat. Through work-ordered day conversations, members expressed that the Clubhouse program kept them out of the hospital this year and, if they went in, the visit was much shorter.

California Clubhouse conducts a yearly Member Satisfaction Survey that evaluates the Clubhouse effectiveness. The survey includes questions pertaining to the Clubhouse Standards and Model as well as membership satisfaction in the program. This survey allows the program to self-assess and make changes where appropriate. Apart from that, Clubhouse attends bi-annually a two-week comprehensive training that is geared towards accreditation for the Clubhouse. We also send colleagues (members and staff) to Clubhouse International and National conference.

Key outcome indicators from the Member Satisfaction Survey are as follows:

I belong to a supportive community at California Clubhouse.

Answered: 39   Skipped: 0
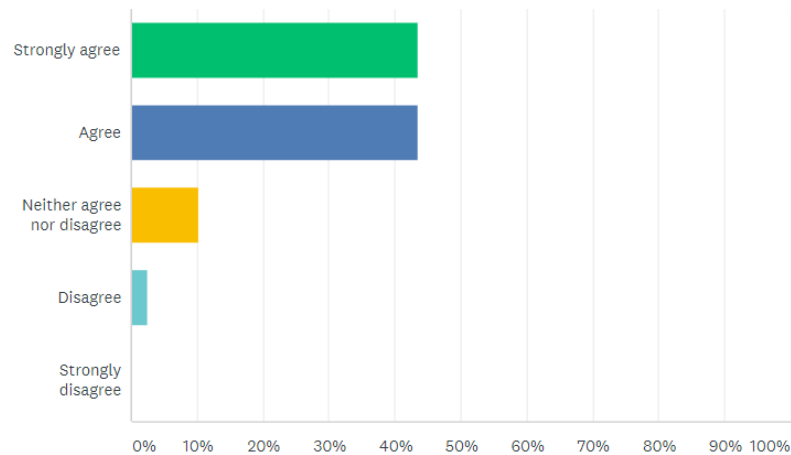
ANSWER CHOICES	▼	RESPONSES	▼
▼ Strongly agree		43.59%	17
▼ Agree		43.59%	17
▼ Neither agree nor disagree		10.26%	4
▼ Disagree		2.56%	1
▼ Strongly disagree		0.00%	0
TOTAL			39

California Clubhouse assists members in securing, sustaining, and improving their employment outcome.

Answered: 39   Skipped: 0
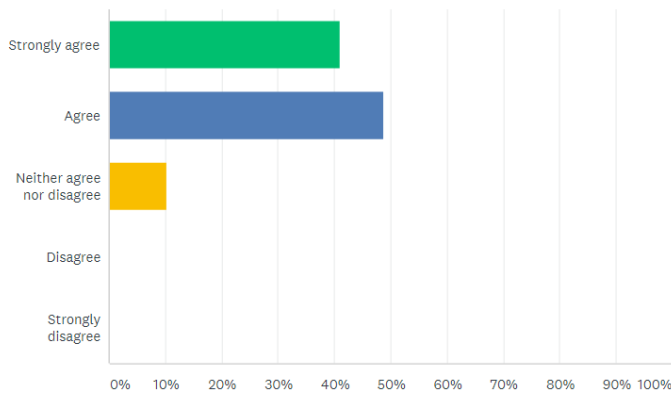
ANSWER CHOICES	RESPONSES	
Strongly agree	41.03%	16
Agree	48.72%	19
Neither agree nor disagree	10.26%	4
Disagree	0.00%	0
Strongly disagree	0.00%	0
TOTAL		39

I have noticed an improvement in my mental health after attending California Clubhouse regularly.

Answered: 39   Skipped: 0
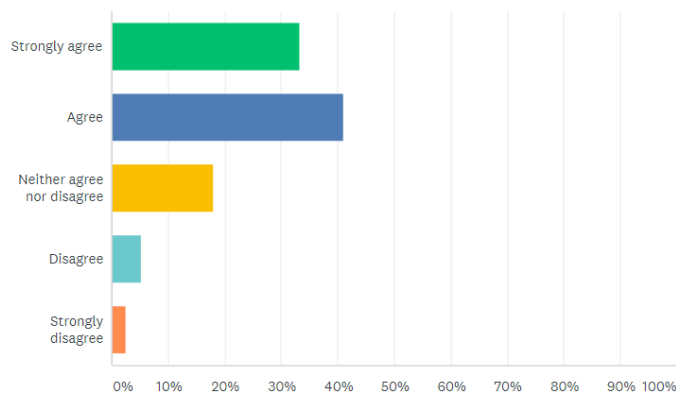
ANSWER CHOICES	RESPONSES	
Strongly agree	33.33%	13
Agree	41.03%	16
Neither agree nor disagree	17.95%	7
Disagree	5.13%	2
Strongly disagree	2.56%	1
TOTAL		39

Since joining the Clubhouse, my quality of life has improved in the following ways (check all that apply):

Answered: 39   Skipped: 0
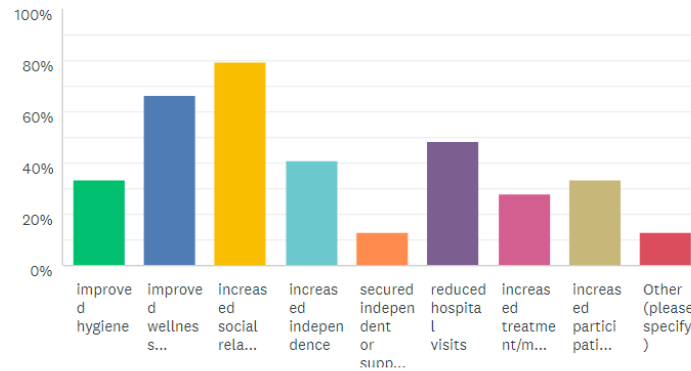
ANSWER CHOICES		RESPONSES	
improved hygiene		33.33%	13
improved wellness (exercise, mindful of what I eat, practice self-care)		66.67%	26
increased social relationships (peer support system)		79.49%	31
increased independence		41.03%	16
secured independent or supported housing		12.82%	5
reduced hospital visits		48.72%	19
increased treatment/medication compliance		28.21%	11
increased participating in other community programs		33.33%	13
Other (please specify)	Responses	12.82%	5

RESPONSES (5)   WORD CLOUD   TAGS (0)   🔒 Sentiments: OFF ⬤

☐ Add tags▼   Filter by tag▼   Search responses 🔍   ❓

Showing **5** responses

☐ increased my self-esteem!!
8/19/2021 4:56 PM   View respondent's answers   Add tags▼

☐ support group,negative passed
8/18/2021 3:29 PM   View respondent's answers   Add tags▼

☐ more social
8/13/2021 9:20 AM   View respondent's answers   Add tags▼

☐ Hellp me not to isolatie.
8/9/2021 2:26 PM   View respondent's answers   Add tags▼

Total Respondents: 39

125

SUCCESSES

The California Clubhouse community survived the pandemic to a thriving Hybrid Program. The Hybrid Program has allowed the community to connect and work side-by-side (screen-to-screen) in the work-ordered day through a virtual format. Members and staff designed this format to provide robust Clubhouse programming successfully. The program opened virtual doors weekly Monday-Friday 8:30 am – 5:00 pm with an additional 2 hours (5-7 pm) for daily Evening Chat – a warmline for members and guests. Members had the opportunity to join the program from the comfort of their own homes. They found that those that struggled with getting out of bed or leaving home had the opportunity to join the program– inactive members started joining regularly. They were mindful that there were still many hurdles for members to cross and that access to the virtual program had its challenges. Therefore, the program tackled this challenge by providing technology such as tablets, laptops, and phones to members who had technological hardships.

This new format challenged the community to push past the regular programming they offer and create something new, engaging, and meaningful that could be easily adapted virtually. They took a creative approach in organizing the work-ordered day by providing virtual Socials and Holidays such as Thanksgiving and Christmas, hosting virtual employment dinners, and a project-oriented program. They utilized member talents and skills when organizing its programming. An excellent example of this is the Spanish class created, implemented, and facilitated all by members. Below is an excerpt from the newsletter highlighting the importance of utilizing member talents and skills in the work ordered day. A member, Nelly, shares the impact that feeling wanted, needed, and expected by Clubhouse can have on members in the community.

CHALLENGES

CALIFORNIA CLUBHOUSE CHANGED MY LIFE
–Natalie (Nellie) San Juan

This sounds melodramatic, but it's true! Throughout my life from pre-K through professional college, I have been bullied. It took a tremendous toll. I have lived through physical and emotional trauma that even today I am in physical pain each day. I grew up feeling ashamed of myself and of my feelings. I became a master at hiding my emotions in order to get through each day.
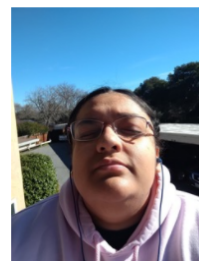
Luckily, I have a loving and caring family who have always been there for me. I was privileged enough to grow up in a bilingual background where I mastered English and Spanish – which I now teach to Clubhouse members – and get a lot of pleasure being able to pass along my heritage. I graduated Woodside High School's Business & Technology Academy and went on to Heald College to become a Medical Assistant. Unfortunately, due to the traumas I experienced I became homebound for a little over six years.

I found California Clubhouse through a former social worker who knew of the benefits of the Clubhouse model from a past position she held also in California. She just said one day, "I wonder if there is a Clubhouse in San Mateo County?" – and the rest is history! I've been a member since 2017, and my life has not been the same – in a very good way!!!

The support and care I received from my care team at San Mateo County's Behavioral Health & Recovery Services prepared me to flourish even more at California Clubhouse. During my long days of despair, I never thought I would get this far.! I am most proud of teaching Spanish to members who wish to learn a new language or refresh what they remember from high school. I have also found a hidden talent in writing poetry (see my poem below); and special birthday greetings and composing letters to seniors who are in hospice care.

What I like best about California Clubhouse: I finally feel accepted and welcomed for whom and what I am. I love the give and take of working together with others and having people to talk to about anything, not just our lived experience. I enjoy the variety in the programming, and I love that members and staff see me as me, not just my disability.

My goal I have set myself for the future is, in time, to be able to become a Peer Support Specialist and help others as I have been helped.

California Clubhouse community experienced various challenges this past year because of pandemic restrictions. While they can pivot and find opportunities for growth through any challenge, it was challenging to pause the daily meal program and in-person holiday celebrations. The Clubhouse community found ways to "be together while apart" by catering and delivering holiday meals to active members this last year. Members and staff came together to plan the meals, order, and deliver all over San Mateo and Santa Clara County. The program was also mindful that many members rely on the Clubhouse daily meal program to obtain nutritious meals. Therefore, the program connected with those members and supplied various options for food such as blue apron boxes, Safeway gift cards, and/or perishable goods from the Clubhouse pantry. They created a Care Package program where members and staff packaged essential items and delivered them personally to member homes – they were able to deliver to active and inactive members.

The Clubhouse tends to be an active community that constantly moves around working on various projects around the Clubhouse building. It was a drastic change to move to a more sedentary work environment. They found ways to remedy this by incorporating Wellness Time into daily routines, such as virtual walks, Sit & Be Fit, and Tai Chi. The program ordered and delivered yoga mats and resistance bands. However, while the intent was there, the reality was that there were hurdles for members to have an active lifestyle. They wanted to plan more in-person, safe, physically-distancing park gatherings as a community, but transportation was a huge barrier. Many members live in living situations with very strict protocols that prevent them from joining wellness meetups. The program hopes to find better ways to engage members in more active lifestyles even when asked to shelter in place.

DEMOGRAPHICS

	FY 20/21		FY 20/21
Primary Language		**Sex Assigned at Birth**	
English	98%	Male	67%
Spanish	1%	Female	32%
Another language	1%	Decline to state	1%
Age		**Gender Identity**	
0-15	9%	Male/Man/Cisgender	67%
16-25	4%	Female/Woman/Cisgender Woman	31%
26-59	73%	Transgender Male	2%
60+	24%	Genderqueer/Nonconforming	2%
Race/Ethnicity		**Sexual Orientation**	
Asian	10%	Gay, lesbian, homosexual	1%
Black/African-American	7%	Straight or heterosexual	80%
White/Caucasian	60%	Queer	1%
European	7%	Pansexual	2%
Mexican/Chicano/Hispanic/Latinx	6%	Bisexual	9%
Asian Indian/South Indian	1%	Another sexual orientation	2%

Central American	1%	Decline to state		9%
Filipino	4%			
Puerto Rican	1%	Veteran		
Samoan	1%		Yes	4%
Togan	1%		No	96%
Japanese	1%			
Korean	1%			
Vietnamese	1%			
Another race/ethnicity	1%			

THE BARBARA A. MOUTON MULTICULTURAL WELLNESS CENTER

The Mouton Center provides behavioral health clients and their family members, culturally diverse community-based programs, support and linkages to services and resources as needed in the East Palo Alto community. To that end, the program creates a safe and supportive environment for adults with mental illness and/or co-occurring addiction challenges and their families who are multiracial, multicultural and multigenerational through various strategies.

The Mouton Center:
- Reduces stigma and discrimination - Through the Mental Health First Aid program, culturally responsive peer support groups, WRAP groups, etc., participants engaged in these programs reduce stigma and discrimination towards themselves and others by facilitating open and sharing discussions about mental health, which understanding resulting in empathy and authentic concern for those suffering with a mental illness and empowers them to speak-up on behalf of others.
- Increases number of individuals receiving public health services - The Mouton Center staff facilitate connections between people who may need mental health and/or substance use services or other professional services to relevant programming and/or treatment by conducting the following:
  - Performing initial screening and engaging potential clients
  - Providing brief interventions to motivate more extensive assessment and intervention
  - Referring members who may need behavioral health services to appropriate agencies in the behavioral health system of care for assessment and follow up treatment as needed.
- Reduces disparities in access to care- The Mouton Center opened its doors in June, 2009 to reduce the disparities in accessing mental health services in East Palo Alto as well as to reduce the stigma associated with mental health. To this end, The Mouton Center has been a safe haven for consumers to gather, pursue leisure activities and be in community with one another without judgement. The program has been the connection to mental health services for the consumers and through its programs, services and classes reduce disparities in access to care and the stigma associated with being identified as one needing mental health services.

PROGRAM IMPACT

Mouton Center	FY 20/21
Total clients served	107
Total cost per client	$1,817

Outreach activities at the Mouton Center:

- Were conducted in English (59.8%, n=64), Mandarin (18.7%, n=20), Tongan (17.8%, n=19), Samoan (1.9%, n=2), Spanish (0.9%, n=1), and Cantonese (0.9%, n=1).
- Resulted in 107 mental health referrals and 0 substance use referrals.
- Resulted in 12 social services referrals. (See Exhibit 2). An individual outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Referrals were made for food (58.3%, n=7), other services (33.3%, n=4) and form assistance (8.3%, n=1).

Outreach event attendees:

- Most often were female (56.1%, n=60). Forty-four percent were male (43.9%, n=47).
- Identified their gender as female (55.7%, n=59), male (44.3%, n=47).
- Identified as heterosexual (95.3%, n=102) or gay/lesbian (3.7%, n=4). One percent (1%, n=1) declined to state their sexual orientation.
- Were adults (26-59 years, 45.8%, n=49), older adults (60+ years, 40.2%, n=43) and transition-age youth (16-25 years, 14.0%, n=15).
- Were primarily White (29.0%, n=31), Tongan (26.2%, n=28), or Chinese (19.6%, n=21). (See Exhibit 3).

DEMOGRAPHICS

	FY 20/21		FY 20/21
Age		Disability/Learning Difficulty	
16-25	5.4%	Difficulty seeing	1.5%
26-59	75.8%	Difficulty hearing or having speech understood	1.5%
60+	18.3%	Developmental disability	1%
Decline to State	0.5%	Learning disability	2%
Primary Language		Chronic health condition	1%
English	75.7%	I do not have a disability	93%
Spanish	13.3%		
Samoan	9.4%		

Tongan	1.5%		
Sex at Birth		**Veteran**	
Male	25.5%	No	100%
Female	74.8%		
Race/Ethnicity		**Gender Identity**	
American Indian/Alaska Native	0.5%	Male/Man/Cisgender	25%
White	29%	Female/Woman/Cisgender Woman	74%
Black	14%	Transgender Woman	0.5%
Mexican	20%	**Sexual Orientation**	
Asian Indian/South Asian	1%	Gay, lesbian, homosexual	2%
Chinese	3%	Straight or heterosexual	90%
Filipino	2%	Bisexual	3.5%
Fijian	05%	Decline to state	3%
Japanese	1%	Queer	0.5%
Korean	2%	Questioning or unsure	1%
Central American	1.5%		
Vietnamese	1%		
Samoan	12%		
Tongan	8%		
Native Hawaiian	0.5%		
Another race/ethnicity	3%		
Unknown	%		

OTHER SYSTEM DEVELOPMENT

Other System Development efforts help improve the behavioral health service delivery system across various sectors and areas of focus.

CHILD WELFARE PARTNERS

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

Child Welfare Partners	FY 20/21
Total clients served	69

Total cost per client*	$7,179

PUENTE CLINIC

Puente Clinic was created in 2007 under the Behavioral Health & Recovery Services (BHRS) of San Mateo County Health System to accommodate the sudden increase of psychiatric service need due to the closure of Agnews Developmental Center and relocation of many intellectually disabled adults to San Mateo County. The word "Puente" means "Bridge" in Spanish, and it implies helping clients bridge what could be a life of dependence and isolation to a life of independence and integration with the whole community. Clients with intellectual disability have higher comorbid psychiatric disorders, face more stressors and traumatic exposure in life, and experience more stigmatization and discrimination. But limits in communication/cognitive ability and aberrant brain development/function make it challenging for behavioral health providers to assess, diagnose, and treat these clients.

Clinical staff at the Puente Clinic are trained and experienced in working with adult clients with both intellectual disability and psychiatric conditions. In carrying out this unique function, Puente Clinic collaborates closely with the San Mateo County Branch of the Golden Gate Region Center (GGRC), which coordinates essential benefits (daily living, housing, etc.) for County residents with intellectual disabilities. Puente Clinic serves as the lead clinical team in BHRS to receive psychiatric service referrals from GGRC. The team provides assessment, psychotherapy, medication management and coordinates case management with GGRC social worker/case managers. Currently, Puente Clinic has one Full-Time Marriage & Family Therapist, two Half-Time Psychiatrists, and one Half-Time Nurse Practitioner. A typical client referred to Puente Clinic is someone having mild to severe intellectual disability, often with significant limits in communication ability, with one or more of the following conditions:

1. Client is returning to the community from a developmental center or a locked or delayed egress facility.
2. Client is at risk for a higher level of care.
3. Client requires in-home services as clinically determined.
4. Client has had multiple psychiatric emergency services contact.
5. Client has complex diagnostic issues or poly-pharmacy.

PROGRAM IMPACT

Puente Clinic – Dual Diagnosis	FY 20/21
Total clients served*	275
Total cost per client	$1,321

increase of 15 from the year before

One of the outcome data Puente Clinic continues to track is the utilization of Psychiatric Emergency Services (PES) at the San Mateo Medical Center, which is the triage center for acute psychiatric emergency in the county. One Puente Clinic's tasks is to ease the transition of intellectually disabled

clients with aggressions that endanger self or others from a locked or highly structured institutional setting to the much less restricted community environment. To achieve this, individual psychotherapy, medication management, and close collaboration with GGRC and its support teams are needed to reduce disruptive and aggressive behaviors and to maintain stability in high-risk clients.

In FY 2020-2021, 4 unique Puente clients had PES episodes, with a combined total of 12 episodes. This was 1% of the total caseload, and 2% less compared to last fiscal year. These continuously low percentage numbers indicate that Puente Clinic has been able to provide effective outpatient-level services to avoid the use of higher-level interventions, such as PES, and to maintain the stability of most clients in its caseload.

Improves timely access & linkages for underserved populations:

Puente Clinic and GGRC have jointly created a "Referral Form" to facilitate the recording and transmitting comprehensive referral information. This special arrangement allows dedicated attention to clients diagnosed with intellectual disability and mental illness. This client population often gets ignored and underserved due to limited self-advocacy and self-refer. A GGRC social worker sends this "Referral Form" to the Puente Clinic to initiate a screening process to identify Medi-Cal clients who meet medical necessity criteria. Over time, the Puente Clinic and GGRC continue to improve this form to make the referral process streamlined. Once the Puente Clinic receives this form, the case is quickly reviewed for the appropriate level of service and treatment provider. Clients with limited communication ability tend to stay with the Puente Clinic providers, but other BHRS regional clinics could also serve clients with appropriate communication skills. When a client's symptoms are in the Mild-to-Moderate range, referral to Private Provider Network will be made.

Reduce stigma and discrimination:

The establishment of Puente Clinic was meant to create a special workforce with expertise in treating clients with both intellectual disability and severe mental illness in a timely fashion. By removing barriers to care, this clinical team helps to reduce stigmatization and discrimination that clients with intellectual disabilities often experience. Co-location of Puente Clinic and several other BHRS clinical teams helps normalize a sense of being welcome when these clients come to the clinic location, as they are treated with the same attention and respect as others. In addition, the Puente Clinic providers regularly offer training to other BHRS teams to inform skills and knowledge that help to work with clients of this population. Puente Clinic also actively participates in the training of LMFT/LCSW interns and nurse practitioners on best practices in working with intellectually disabled clients to reduce the resistance of mental health providers in serving this client population.

Increases number of individuals receiving public health services:

Over the past few years, the census of the Puente Clinic continued to increase annually. But in addition to enhancing referral pathways to help with access to behavioral health treatment, the Puente Clinic providers also facilitate connecting clients with primary care providers and other specialty services covered by Medi-Cal benefits. In addition, there is a communication channel among the leadership of Puente Clinic, GGRC, and the Health Plan of San Mateo (HPSM) to resolve conflicts that cause barriers to care. Minimally every quarter, these three entities meet to discuss improving public health services to the intellectually disabled population.

Reduces disparities in access to care:
Puente Clinic clients come from diverse social backgrounds. Each provider has received numerous Cultural Humility training and applies the learning to clinical care and service coordination involving clients, families, caretakers, and parallel professionals. The Puente Clinic providers constantly help clients who can't advocate for themselves to pursue ancillary services that cover needed social benefits. In clinical sessions, interpretation services are provided as needed through phone or in-person arrangements, including sign-language interpretation.

Implements recovery principles
The Puente Clinic providers infuse hopefulness in clients, families, and caretakers to help each client to achieve the highest level of functioning one could get. The successful outpatient treatment model that Puente Clinic provides helps the client live in the least restrictive setting in the community. Many Clinic clients came out of an institutional setting, such as a Development Center, where clients often experienced multiple types of trauma of verbal and physical nature. Still, Puente Clinic helps these clients process their trauma experiences and recover over time. When a client is cognitively capable, supportive psychotherapeutic treatment is always provided to enhance personal agency in achieving life goals. The Clinic works closely with GGRC and the Department of Rehabilitation to find the best educational and vocational opportunities for clients. It works with local community groups to promote social connections and increase educational resources for clients.

SUCCESSES

CC - 39 y/o Chinese American non-verbal male GGRC client residing at group home with nursing facilities, for past 2 years. Client has severe intellectual disability, seizure disorder and life-long maladaptive behavior. Client is on tube feeding via gastric tube. No history of psychiatric diagnosis. Client was referred to Puente clinic at the request of the home staff due to insomnia and chronic self-injurious behavior (SIB). Client required 1:1 staffing solely to prevent hitting self, throwing self on the floor. Puente clinic MD collaborated with neurology and primary care. Puente clinic MD changed seizure medication and added sleep. SIB has stopped and client sleeps through the night. MD is now working on transferring care back to primary care as Client has no psychiatric needs. This is an example of how Puente MDs and NP take a leadership role in care coordination, resulting in positive outcomes.

KB- 34 y/o non-verbal Caucasian woman with anxiety disorder, OCD traits and autism living with parents, presenting symptoms include irritability, physical aggression, and hoarding. Over the last 10 years she has had multiple medication trials under private providers and with Puente Clinic, none seemed to be beneficial, and she could not tolerate antipsychotics. Typically, severe OCD and hoarding are difficult to treat with medication. Parents were close to giving up on medication interventions and did not wish to try behavioral interventions. We decided on a final trial of clomipramine, an older antidepressant used for OCD. KB still has maladaptive behaviors when she might not get her way but is much calmer, redirectable and appears happier. Parents are now able to enjoy time with their daughter.

CHALLENGES

CG – 25 y/o verbal, white-Caucasian, conserved GGRC client with autism, oppositional defiant disorder, antisocial personality disorder, ADHD, and chronic maladaptive behaviors, resides in an apartment funded by GGRC. Client requires 24-hour support and supervision. Due to pandemic-related day program closure, Client has no structure to his day. He is up all-night playing video games, and sleeps during the day. He stopped attending to his hygiene. Client had 1 episode of false 911 call telling police '2 black guys are threatening me'. This was in response to Client demanding staff cook him a second full meal from scratch at 11pm; staff had offered to make a snack instead. Client is threatening and verbally abusive towards staff when they try to set limits. Behavioral consultant who has been training staff, has retired. This is an example of lack of behavioral support and inadequate staff training.

TB - 63 y/o verbal non-conserved Filipino American woman has been residing in family homes for past 2 decades. Her previous caregiver, with whom TB was attached, developed cognitive impairment and therefore unable to provide appropriate care. Since leaving that home, TB has not been able to settle in with other family homes due to behaviors including stealing caregivers' belongings, hoarding, dumping urine and fecal matter in her bedroom closet. When TB is asked to stop these behaviors, she may respond by yelling, pushing, and tantrums. TB has been transferred from one family home to the next. Caregivers at family homes lack the professional training and experience to work with maladaptive behaviors. This is an example of need for proper placement by GGRC, in this case a higher level of care in a behavioral group home.

DEMOGRAPHICS

Plans to collect data currently not collected: Last FY, 45% of clients had unknown/not recorded race. The goal for this year was to reduce this to 5%, which was surpassed, reducing it to 0%. The unknown/not recorded ethnicity was 32.99% and reduced it to 5.82%. The goal for next year is to reduce unknown/not recorded ethnicity to 0%. To achieve this, the referral form has been revised to include race and ethnicity. The following tables include any client who had an episode open for at least one day during FY2021. Clients were counted in multiple race groups if they indicated belonging to multiple race.

	FY 20/21
Age	
10-19	0.36%
20-29	13.45%
30-59	56.19%
60+	21.09%
Sex at Birth	
Male	58.55%
Female	41.45%
Race/Ethnicity	
American Indian/Alaska Native	1.82%
White/Caucasian	52.73%
Black/African American	13.09%
Chinese	6.55%
Filipino	4.00%
Hispanic	6.55%

Korean	1.82%
Other Asian	0.73%
Other Race	9.82%
Unknown	5.82%

TRAUMA-INFORMED INTERVENTIONS (NMT)

San Mateo Behavioral Health and Recovery Services (BHRS) implemented the Neurosequential Model of Therapeutics© (NMT) within the Adult System of Care. NMT is an alternative approach to addressing trauma, that is grounded in development and neurobiology. NMT is not a single therapeutic technique or intervention. Rather, NMT uses assessments to guide the selection and sequence of a set of highly individualized therapeutic interventions (e.g., therapeutic massage, drumming, yoga, expressive arts, etc.) that best match each NMT consumer's unique strengths and neurodevelopmental needs. The Primary Purpose was to increase quality of mental health services, including measurable outcomes to consumers in the Adult Mental Health System that have experienced severe trauma. The program serves the following population:

- General adult consumers (ages 26+) receiving specialty mental health services
- Transition age youth (TAY) consumers (ages 18-25)
- Criminal justice-involved consumers re-entering the community following incarceration.

Primary program activities include assessment, brain mapping, and the development of individualized treatment recommendations. NMT-trained providers collect information pertaining to the consumer's history of adverse experiences—including their timing, nature, and severity—as well as any protective factors. This information is used to estimate the risk and timing of potential developmental impairment. The assessment also includes an examination of current functioning and quality of their relationships. Clients can then be connected to appropriate interventions through MHSA funded contracts such as Trauma Informed Yoga, Intensive Speech therapy, Equine therapy or are provided with regulating tools as determined by the assessment outcome. NMT providers are also equipped in the clinics with supports for clients such as sensory tools, art activities, glider chairs, weighted blankets, clay, and other regulating materials. Yearly training is provided to clinicians to expand the training in the Adult System of Care.

PROGRAM IMPACT

Trauma-Informed Interventions (NMT)	FY 20/21
Total clients served*	35
Total cost per client	$5,714

The NMT Adult program provides clients with SMI access to a more in-depth assessment and trauma-informed care. A better understanding of the client's history, including trauma or experiences of neglect, can help reduce the stigma of specific mental health disorders and potentially misdiagnose a client. The NMT program also provides clients with access to interventions in the community that Medi-cal doesn't pay for, such as Trauma-Informed Yoga, Intensive Speech Services and Equine Therapy, and

community resources that clients may not be able to afford as gym memberships and recreational classes. NMT interventions also support clients to increase resources, build a supportive community and address alcohol and other drug issues from trauma and relationally informed lens.

In a focus group conducted in Oct 2020, consumers shared that NMT felt different from other mental health services they had received. Some consumers also felt that other providers were more focused on identifying a diagnosis and the appropriate medication. In contrast, the individualized approach of NMT helped consumers feel respected and heard. Several consumers observed that it was easier for them to discuss their feelings and trauma when engaging in regulating activities during their therapy sessions and that it helped them feel safe. Consumers appreciated that providers tailored activities to consumers' specific interests, and providers' willingness to participate in the activities with consumers helped build rapport and trust. Another consumer stated,

"I've worked with [my NMT provider] longer than anyone else in the past. Past therapists would try to diagnose me, and then give me some form of medication to 'treat' me. I don't think that actually addressed any of my issues... I've never had a therapist that's like let's do yoga, I'll do it with you. Let's do meditation, or this Qigong video together. Sometimes we do sit down and have a serious conversation. But I think developing a bond through doing activities like yoga made me feel more comfortable. [My NMT provider] is very relatable."

SUCCESSES

Adult NMT Yoga: A trauma informed yoga provider is currently serving patients at the pain clinic in the medical center and currently seeing an individual client at one of the regional mental health clinics.   At the pain clinic, various patients have shared their experiences:

- "It all works for me."
- "I feel better. I sleep better. The pain is reduced and my mind chatter is down."
- "I think this is helping my depression."
- "Yoga brought more mobility to my ankle."
- "This uplifts my spirit and prepares me for meditation."
- "There's been no pain in my leg for two weeks."
- "Without afternoon yoga I would not be dealing with my pain nearly as well mentally."

The client receiving one on one yoga at one of the mental health clinics has benefitted from yoga to manage social anxiety and improve social/relational functioning. Her therapist reported that the client has now been practicing yoga on her own on a regular basis and has reconnected to her support system which she hadn't accessed in many years. The client reported:

"It [*yoga*] helps me relax. When things go wrong, I just do yoga and I feel better. With yoga, I feel stronger and more confident. I've been doing yoga almost everyday and made it a part of my daily life."

Adult Equine Therapy: Equine therapy supports natural, outdoor and rhythmic movement that aligns with the NMT interventions that San Mateo County Health provides clients. Square Peg Foundation specifically follows the developing brain science to support individuals with trauma and neuro differences. Expected outcome from services provided from this contract is to increase regulation of the client's nervous system, thereby supporting positive behavioral outcomes. Below is a quote from a therapist who assisted his client during an equine session:

"The client had some weariness with the male horses since her experiences with males have been painful. Upon finding out the horse she was working with had also been through traumatic experiences, the client was able to identify differently with the horse and even began to reflect on her own son's experience, opening up more understanding for him."

CHALLENGES

Many of the challenges clients have faced have been due to the pandemic, as some community resources were closed or unavailable for a period of time. Some of the NMT trained providers also don't have the space in their work settings to support doing more therapeutic activities in line with NMT interventions with clients onsite. During the shutdown, many clients were seen through telehealth which prevented access from therapeutic items they had when they would see their therapist in the clinic. Some clients have struggled financially as they have lost their jobs during the pandemic or have experienced higher stress levels due to crowded housing situations, supporting children with online school, or limited access to transportation to go out. As resources have started to open up again, Clinicians have started to help clients reaccess therapeutic supports in the community, and clients are re-engaging in these supports. Increased funding may be helpful to expand contracts, and access to recreation in the community as more clients require these services due to experiencing increased stressors during the pandemic.

DEMOGRAPHICS

		FY 20/21
Age		
	10-15	0.00%
	16-25	62.86%
	26-59	31.43%
	60+	5.71%
Language		
	English	80.00%
	Spanish	20.00%
Sex at Birth		
	Male	25.71%
	Female	74.29%
Ethnicity		
	Hispanic or Latino	57.14%
	Not Of Hispanic Origin	28.57%
	Unknown/ Not Reported	14.29%
Race		
	Other Race	57.14%
	White or Caucasian	20.00%
	Unknown / Not Reported	11.43%
	Filipino	5.71%
	Black or African American	5.71%

EVIDENCED-BASED PRACTICE (EBP)

Evidence-Based Practice Clinicians	FY 20/21
Total clients served	438
Total cost per client	$3,471

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

CONTRACTOR'S ASSOCIATION

The Contractor's Association Grant Funding program exists to fund organizations that contract with BHRS to be able to:

1. Improve capacity to provide integrated models for addressing trauma and co-occurring disorders;
2. Improve its capacity to incorporate evidence-based practices into day-to-day resources;
3. Improve its cultural competency; and
4. Improve its capabilities to collaborate, partner and share resources and information with other Association Members.

Caminar acts as the fiscal agent, oversight and accountability to this program. See Appendix 7 for the data on each funding recipient and what needs were met.

OUTREACH AND ENGAGEMENT (O&E)

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

MATEO LODGE: FAMILY ASSERTIVE SUPPORT TEAM (FAST)

FAST is an in-home outreach and support services program. FAST's purpose is to assess, educate, assist, support, and link families and adult mental health/substance use consumers that are living with their family (two or more people with close and enduring emotional ties) to appropriate mental health and substance use services and a myriad of other resources and opportunities suitable to the individuals' needs and goals.

PROGRAM IMPACT

Pre-Crisis (FAST)	FY 20/21
Total clients served	67
Total cost per client	$4,720

In FY 2020-21, 67 unduplicated clients and 67 families were served by FAST, 100% diagnosed.

- Most referral sources were families followed by other providers (BHRS, GGRC, Law Enforcement/Courts, and Adult Protective Services).
- Of the 67 clients, 52 had zero contact or connection with behavioral health services. The remaining 15 had some history of mental health services ranging from months/years/decades before contact with FAST but had dropped out of treatment;
- 45 were successfully connected to outpatient mental health services. The majority of others were connected to some level of social services, benefits, housing, medical, etc.;
- The collected locus scores indicate a majority of clients were SMI with significant disability and need for intensive treatment and adjunct Case Management post FAST;
- The region, ethnicity of clients served would appear to reflect demographic distribution not far from the averages of San Mateo County.
- The adverse outcomes and concomitant suffering for individuals and families alike were diminished from contact with FAST.
- The rate of hospitalization and incarceration were higher pre-contact with FAST and Reduced-Post contact with FAST;

Pre/Post Hospitalization and/or jail

Category	Value
Kaiser Pre-Contact	3
Kaiser Post-contact	0
Mills Peninsula Pre	7
Mills Peninsula Post	4
3AB/PES Pre-Contact	8
3 AB Post-contact	3
Jail pre contact	8
Jail post contact	3
Cordilleras Pre	0
Cordilleras Post	0
Napa Post	0

Diagnosis

Diagnosis	Number of Clients
Delusional Disorder	1
Spectrum	6 / 0
Body Dysmorphia	7 / 0
PDO	2 / 2
Substance induced psychosis	0 / 2
Eating DO	29 / 2
ADHD	4 / 0
Schizo-Affec	15 / 11
Psychosis NOS	21 / 2
Schizophrenia	11 / 13

(Chart: bars at Delusional Disorder=1; Spectrum=6, label 0; Body Dysmorphia=7, label 0; PDO=2, label 2; Substance induced psychosis=0, label 2; Eating DO=29, label 2; ADHD=4, label 0; Schizo-Affec=15, label 11; Psychosis NOS=21, label 2; Schizophrenia=11, label 13)

Number of Clients (axis 0–35)

DEMOGRAPHICS

Age	FY 20/21
18-30	34%
31-45	27%
46+	39%
Sex	
Male	52%
Female	48%

Ethnicity

Ethnicity	Number of Clients
Asian	7
PI	1
Arab/Middle East	4
Persian	0
Cauc	28
Hisp	21
Filipino	4
Amer Indian	0
AA	3

Number of Clients (axis 0–32)

THE CARIÑO PROJECT

The purpose of the Cariño Project/MCWP is founded on the opportunity to create new models of mental health and wellness wrap-around services that are grounded in cultural frameworks of intervention. The program opens pathways for increased services on the Coastside, limited in services. MCWP has allowed growth in programming and staff to increase wellness support services across the Coast.

ALAS is centered on honoring the client and their cultural wealth. The program believes that each person and family is rooted in a history of tradition and culture that strengthens who they are, which should be honored and valued. Operating from a strengths-based and cultural wealth perspective, ALAS values each person, family, and child, embracing each person's identity, sexual orientation, race, ethnicity, and cultural background/s. The Cariño project strengthens opportunities to work closely with expanded community groups.

PROGRAM IMPACT

Cariño Project	FY 20/21
Total clients served	1221
Total cost per client	$315

ALAS's program has an open-door process for the community to enter or call in for services. ALAS works to engage the community in available programs. For example, the program doesn't limit the services offered to just one area; they invite them to participate and connect them to other areas and what they are requesting. They use a wrap-around approach to services which has been impactful. For mental health, they work to limit the amount of time they are waiting to receive treatment. They have increased the opportunities for direct wellness services.

ALAS is both a service provider and an advocate for racial equality and is committed to reducing racial trauma and increasing equity and access. With MCWP funding, the program has increased bilingual, bicultural staff from the community committed to supporting the most vulnerable community on the Coast. With ongoing staff training, ALAS has implemented best practices for staff in reducing stigma and being allies to increase support for the Latino community. In addition, they have done workshops, outreach, and individual educational support to change negative narratives and practices that impact discrimination. In ALAS's practice, they are aware of using cultural models of practice that include the narratives, history, and traditions to engage the community they work with. ALAS's counseling practices are culturally centered with mental health practices that expand mental health from a whole person model.

MCWP has allowed ALAS to enter into spaces to grow the much-needed work to provide services in areas that have been limited. ALAS has provided direct support out in the community during times of COVID, reaching Seniors and Farmworkers. ALAS has provided mental health to these groups and increased the numbers of those receiving public health. This summer ALAS offered their first intensive summer program to sixty children and their families, which increased access for a new group of children to have public health services. In addition to their general community outreach and work, they are also

working closely with Moonridge to support folks who cannot come into their clinic for care. The MCWP program has also expanded its access to Pescadero and has made its services available.

Thanks to MCWP, all of ALAS's services are free. ALAS's system includes outreach, self-referral, linkages to County and community agencies. In addition to their specialized counseling clinic, their ALAS Cariño casa and the Sueño Center are all part of ALAS community programming; they go directly into the community to provide direct resources. They also are integrated into the schools as part of MCWP. ALAS is working closely to support models of health and wellness that recognize each individual's strengths. They believe in the power of each individual to be an active part of their treatment and healing. ALAS uses a hope model of support for clients and integrates the whole person into treatment and services.

SUCCESSES

The MCWP Cariño project has been successful on many levels. A few highlights include
Creating Stronger outreach to the community with increased resources and services. The case manager has been able to support an increase in clients during this difficult time of COVID to provide direct support for triage of services, connections to resources in the community, medical insurance sign up and wellness care.

One quote from a client shared the following:
"No se que haría durante este tiempo. No se cómo agradecer todo lo que han hecho por mi y mi familia. No estoy trabajando hamos pasando por un tiempo muy difícil. Gracias a todos por ser esté ayuda posible"

Another exciting success is the creation of a mother's group that began through mcwp. This group has had up to 30 members ranging from Montara to Pescadero. The group provides support to mothers that have found comfort in coming together especially during the difficult time of COVID and the stress they have had of the pandemic. The group has provided them a space of community, educational classes, nutrition classes, arts and crafts and mental health support.

"Para mí el grupo de mamás me ha salvado durante éste crisis con mi familia, me siento relajada y estoy contenta de estar juntas cada semana"

Mental health counseling has increased, and it's been a significant source of free counseling to the community- thanks to MCWP. One parent shared, "we have been looking everywhere for counseling for my daughter who really needed it. ALAS opened the doors for us and she really likes it. It's so important because we are seeing a change in her behavior. I don't know what we would have done".

DEMOGRAPHICS

	FY 20/21			FY 20/21
Age			Race/Ethnicity	
0-15	9%		Asian	2%
16-25	3%		Black/African-American	2%
26-59	86%		White/Caucasian	3%
60+	2%		Asian Indian/South Indian	1%
Decline to state	1%		Fijian	1%
Sex			Central American	14%
Male	24%		Chinese	1%
Female	74%		Mexican/Chicano	56%
Decline to state	1%		Filipino	3%
Language			Puerto Rican	1%
English	10%		Samoan	1%
Spanish	46%		South American	9%
Mandarin	1%		Another race/ethnicity	8%
Tagalog	1%			
Another language	1%			

RAVENSWOOD FAMILY HEALTH CENTER

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

The intent of the collaboration with Ravenswood FHC is to identify patients presenting for healthcare services that have significant needs for mental health services. Many of the diverse populations that are now un-served will more likely appear in a general healthcare setting. Therefore, Ravenswood FHC provides a means of identification of and referral for the underserved residents of East Palo Alto with SMI and SED to primary care based mental health treatment or to specialty mental health.

Ravenswood	FY 20/21
Total clients served	544
Total cost per client	$78

PREVENTION & EARLY INTERVENTION (PEI)

PREVENTION AND EARLY INTERVENTION (PEI)

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

- Early Intervention programs provide treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence. Services shall not exceed eighteen months, unless the individual receiving the service is identified as experiencing first onset of a serious mental illness or emotional disturbance with psychotic features, in which case early intervention services shall not exceed four years.
- Prevention programs reduce risk factors for developing a potentially serious mental illness and build protective factors for individuals whose risk of developing a serious mental illness is greater than average and, as applicable, their parents, caregivers, and other family members. Services may include relapse prevention and universal strategies.
- Outreach for Recognition of Early Signs of Mental Illness to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.
- Access and Linkage to Treatment are activities to connect individuals with severe mental illness as early in the onset of these conditions as practicable, to medically necessary care and treatment, including, but not limited to, care provided by county mental health programs.
- Stigma and Discrimination Reduction activities reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or seeking mental health services.
- Suicide Prevention programs are not a required service category. Activities prevent suicide but do not focus on or have intended outcomes for specific individuals at risk of or with serious mental illness.

PEI ANNUAL AND THREE-YEAR EVALUATION REPORTING

MHSA Prevention and Early Intervention regulations require that counties prepare and submit an Annual Prevention and Early Intervention report, this current section and a Three-Year Prevention and Early Intervention Evaluation Report. The current PEI Three-Year Evaluation Report is in Appendix 8; it is due with this Annual Update and covers Fiscal Years 2018-19, 2019-20 and 2020-21.

PEI AGES 0-25

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

EARLY CHILDHOOD COMMUNITY TEAM (ECCT)

The Early Childhood Community Team (ECCT) aims to provide targeted, appropriate, timely responses to the needs of underserved families with children ages 0 through 5 or pregnant mothers in the Half Moon Bay community. ECCT focuses on the parent/child relationship as the primary means for intervention. Team members also focus on child development and strive to individualize services to ensure each child and family's unique needs are met. Identifying challenges early and providing families with the proper assessments, interventions and supports can make a difference in a child's earliest years and for many years thereafter.

ECCT is made up of three interconnected roles that support the community and families in different ways. The Community Worker provides case management and parent education to the families, facilitates play groups and support groups, and develops and maintains partnerships in the Half Moon Bay community. The Mental Health Clinician provides Child Parent Psychotherapy (CPP) informed therapeutic support to families as well as using other attachment/relationship based clinical modalities as appropriate. CPP is a specific intervention model for children ages 0-5 who have experienced at least one traumatic event and/or are experiencing challenges related to attachment, and/or behavioral problems, including posttraumatic stress disorder. The primary goal of CPP is to support and strengthen the relationship between a child and his/her caregiver as a vehicle for restoring the child's cognitive, behavioral, and social functioning. The Mental Health Consultants provide ongoing support to childcare providers in preschool settings with the goal of establishing a safe and trusting relationship that supports teachers in building their capacity of self-reflection, understanding of the child's experience and fostering an inclusive classroom where all children can receive high quality care. Consultation services also provide more intensive case support for children who have been identified with significant needs or who are at risk of losing placement at their site. For this more intensive work, ongoing support is provided for parents in hopes of bridging the child's home and school experience and creating a feeling of continuity of care. The ECCT model allows for a collaborative and team-based approach.

PROGRAM IMPACT

ECCT	FY 20/21
Total clients served	29
Total cost per client	$15,528

Activities/Interventions:
Mental health consultation services were provided to 4 childcare programs in the Coastside region serving 38 children and 21 staff. It is important to note that these numbers differ greatly due to previous years due to COVID-19 restrictions and state guidelines reducing the number of children allowed to be enrolled in classrooms. It is also important to mention that one of the programs consulted to at Children's Coastside Program was also closed during the pandemic until the month of March. Due to the reduced slots and serving one less program, the numbers for more intensive consultation services was also impacted. This year, "Light Touch" services were provided, which are more intensive services for

families with more specific needs, to 1 family and 4 children received "Case Consultation" services. Consultation activities include individual and group consultation meetings with childcare providers, meetings with parents, observations of classrooms and individual children and assistance with resources and referrals. Consultation was provided through tele-health for the entire school year due to COVID-19 restrictions. Virtual meetings were held on a weekly or monthly basis in group and individual meetings depending on the specific needs and availability of each center and staff members. Meetings with parents also were delivered via tele-health or phone.

Weekly Child-Parent Psychotherapy was provided to 24 children and their families in the Half Moon Bay community. Weekly services include child/parent therapy, family therapy, collateral individual sessions with caregivers and additional collateral contacts such as school communications, participation in IEP meetings, etc. Most participants receive psychotherapy services for at least one year.

The Community Workers provided support and services to 16 children and their families, which includes case management, providing activities supporting the caregiver/child relationship and child's development, parent education and assessment. The Community Worker was also contacted by 3 former caregivers who reached out this reporting cycle for COVID-related resources and referrals. Groups this fiscal year have proven challenging on the Coast. Three groups were coordinated, and outreach done, however there was minimal attendance despite efforts to offer different times and collaborating with different co-facilitators to offer a variety of topics. For those groups coordinated for caregivers (feedback at the time was that groups for caregivers- only was requested), there were 4 caregivers who attended the Back-to-School Workshop and 1 caregiver attended a group co-facilitated with Ability Path Family Resource Center. An additional 1 caregiver participated in a workshop on Self-Care. In response to lower than usual group attendance overall, outreach was done in the Half Moon Bay community for a Facebook Live event where ECCT was represented by the Half Moon Bay Community Worker and Department Director on the panel. This Facebook Live event engaged approximately 130 clients and videos were viewed about 5,500 times in total.

The Mental Health Consultants, Mental Health Clinicians and Community Workers all meet as a team twice per month at a minimum. Ongoing communication and collaboration occur regularly, as needed, to assure that each family's needs are known, addressed and supported by the team members working with each family.

ECCT staff work together to support families and their overall needs, in order to enable families to live in stable environments. ECCT Mental Health Consultants work with caregivers and teachers to support and maintain children's placements to prevent suspensions or expulsions in preschool settings. Mental Health Clinicians work with families around traumas, mental health issues, family discord and child/caregiver relationship repair and building capacity while the Community Worker provides support around housing needs, financial support resources within the community and employment resources.

The Child Behavior Checklist (CBCL) assessment tool is completed by the Mental Health Clinicians and looks at a variety of subset categories related to stressors on the caregiver/child relationship. This is the tool that was previously the primary assessment tool used by ECCT Clinicians. Given the length and challenges in completion of this tool with families, this is now a supplemental assessment tool for ECCT Clinicians. The Mental Health Clinicians switched the middle of this fiscal year to using the primary

assessment tool Parenting Stress Index (PSI), which is completed every six months after the initial pre-test. The PSI establishes a measurement for the stress within the parent-child relationship as well as subsets measuring stress related to: child characteristics, parent characteristics and environmental/situational life stressors. In part because the training and beginning implementation of this tool occurred in the middle of the reporting year, there are only pre-PSI data for review at the time of this report. It is also important to note that the inability of clients and families to remain engaged and consistent during this reporting period has impacted being able to administer assessment tools. The team anticipates more consistent engagement overall as the threat and impact of COVID-19 lessens. Of the 24 families receiving mental health services, the pre-test PSI was able to be completed with 8 families (the rest are in-process at time of this reporting cycle) and the CBCL was completed with 1 family. There will be pre- and post- tests available for comparison the next reporting cycle. By enhancing parenting skills and promoting healthy child development, providing early childhood home visiting and treatment to prevent problem behavior, ECCT aims to reduce child abuse and neglect.

The Community Workers provided 16 families with linkages to community resources, parenting education and assessment, case management, providing activities supporting the caregiver/child relationship and child's development, parent education and assessment. The resources provided by these services helps reduce parent stress which increases a parent's protective capacity. There were 3 former families that reached out to the Community Workers during the pandemic for referrals and updates on available community resources. The Community Workers coordinated and completed outreach for 3 groups/workshops. There were 4 caregivers who attended the Back to School Workshop and 1 caregiver attended a group co-facilitated with Ability Path Family Resource Center. An additional 1 caregiver participated in a workshop on Self-Care. In response to lower than usual group attendance overall, outreach was done in the Half Moon Bay community for a Facebook Live event where ECCT was represented by the Half Moon Bay Community Worker and Department Director on the panel. This Facebook Live event engaged approximately 130 clients and videos were viewed about 5,500 times in total.

Improves Timely Access & Linkages for underserved populations:
One of the goals of ECCT is to keep existing partners and ECCT families aware of how to make new referrals, the schedule of upcoming groups, and new resources, as well as being strategic to reach new families within the communities served. This fiscal year the Intake Coordinator has worked closely with another Early Childhood Services Program to stay up to date regarding groups offered for caregivers via telehealth. Offering a variety of groups open to caregivers at Intake has allowed parents to connect with parent support groups offered at various times. The Intake Coordinator, Mental Health Clinician, Mental Health Consultants, and Community Worker are primarily bilingual in Spanish and English. Staff is required to complete eight annual hours of diversity training to integrate a more culturally responsive approach to their work. In addition to outreach efforts, families often self-refer after hearing about supports and services from other families that have worked with ECCT themselves. Referrals also come from schools, community partners, and internal referrals within Star Vista. Once a referral is received, the Intake Coordinator connects with the caregivers within two-three business days and completes a detailed phone Intake. The phone Intake involves listening to caregivers' immediate concerns, gathering information on what supports/services they are interested in, and what risk factors are known. Depending on what the caregiver shares, the family may be referred right away to community resources

outside of ECCT in addition to being connected with either the appropriate Community Worker and/or the Mental Health Clinician so that either of them can begin their work with the family immediately. For any families on the Wait List, the Intake Coordinator follows up with them regularly to check in, assess for any changes in needs, and provide any new information on available groups and/or resources that may be relevant to their needs.

Mental Health Consultants also support families in linking with Light Touch or intensive case consultation services. Consultants support teachers in identifying children who might benefit from Early Intervention services and support linkages to developmental screenings or psychological evaluation. Through this process, teachers and families come together and work hand in hand in completing assessment tools that paint a richer and broader picture of what is happening at home and school.

Mental Health Consultants also help families support children identified by teaching staff as needing more intensive services due to behavior concerns. Meeting consistently with teachers allows for constant communication about children in the classroom and families served, especially those demonstrating behaviors that might require more attention and/or families sharing specific needs that might benefit from the consultant's support. This allows for early identification and timely referrals. Once a child has been identified as needed by staff, they can check in with parents around bringing in a consultant to support them in better understanding the child within the classroom context. With parent consent, consultants conduct individual classroom observations and meet with teachers and parents to better understand what may be happening for the child and, in turn, implement more attuned strategies at home and school that support the child in their development. Through this process, teachers and families come together and work hand in hand in completing assessment tools that paint a richer and broader picture of what is happening at home and school. If necessary, children are also referred to further assessments and/or services that target their specific developmental needs. Consultants also link identified families with services through Light Touch consultation services. If a family has been identified or has requested additional support, consultants are there to support them in linkages to community resources. This year, they could refer families to services including rental assistance, diapers, housing, and mental health services.

Reducing stigma & discrimination and Increasing individuals receiving public health services: Beginning at Intake, the staff of ECCT meets caregivers where they are in terms of how they feel about the referral being made and their level of comfort with engaging in services. Families are encouraged to talk about what worries or hesitations they might have in engaging in services, which sometimes includes caregivers sharing negative experiences they have had in seeking support in the past and stigma around mental health support within their own culture and/or family. ECCT staff is thoughtful and intentional in providing a safe space for families to explore any hesitations to connect with ECCT services. ECCT staff work within this trusted relationship to support families in connecting with various public health services core agencies and other programs within the community as appropriate and as caregivers are ready.

Remaining connected within the community and being available for 1:1 introductions and answering questions is a foundation of the success of ECCT. To decrease the stigma around mental health, ECCT staff attend events held in the community, which provides the opportunity to begin and build

relationships and connect with families about ECCT services. Community partnerships are an integral part of the ECCT model, so the team feels part of the community and is aligned with what is happening specific to the area. Part of the goal within ECCT is to support and empower caregivers to be aware of and able to access resources within their community, a piece that will last long after their work with ECCT services end.

The presence of a Mental Health Consultant on-site as a familiar face for parents within the community has proven, over the years, to be an effective way for parents to be willing to connect with a consultant for Mental Health Services. The program finds parents who are accessing services for the first time and those who have not had a positive experience with mental health services in the past. For many families, the Preschool is a safe and trusted place thanks to their relationships with staff. This makes parents much more willing to sit with a Mental Health Consultant when the service is offered by a trusted teacher of family support staff. The "Light Touch" services often lead to parents being connected to more comprehensive services, including community resources or mental health support for themselves or someone within the family systems. This flexible approach allows consultants to "sit" with parents for several sessions and assess their needs thoughtfully and with intention. At the same time, prepare them for the possibility of therapy or other services that may be valuable. They can also explore the possible barriers of accessing services and try and find ways to break through them. Once services are accessed, this unique model allows for a warm handoff to the Clinician, which highly increases the likelihood of parents being more committed and engaged with the Clinician from the start of treatment. This is also true when parents are referred out to therapy with partnering agencies. Consultants are, for many, the first point of contact and one that "meets clients where they are at," allowing them the space and taking the time for them to be ready to connect with more intensive services. In the same way, Consultants, who all are trained clinicians, can "hold" the family using a therapeutic approach while they are on any waitlist for services. Once they are linked, the Consultants can continue working with the clients within the school and collaborate closely with Clinicians, Community Workers, Early Intervention supports, Social Workers, or any other provider that works with the family.

Reducing disparities in access to care & implementing recovery principles:
At the core of the work within ECCT is the relationship staff has with family members. Treating the family with respect, cultural humility, and within the family's preferred language. Central to the work is the belief that the relationship between ECCT staff and caregivers is parallel to the relationship between child and caregiver. Beginning at Intake, the intent is to gather information from the caregivers and allow their input to guide the services, treatment goals, and pace of the work using strength-based language. Meeting caregivers where they are and genuinely allowing their family's needs, concerns, culture, and beliefs to drive the work is at the heart of the ECCT program. For this to occur, communication and respect are key. ECCT staff work focuses on remaining curious with families and allowing the work to follow the family's needs, not the ECCT staff's determination. At regular points throughout the work, within all the roles of ECCT, there is time set aside to reflect on the work, progress, and challenges. This allows the opportunity to evaluate the caregiver's experience and make any adjustments as needed. Being placed in the community is also essential since it provides staff with a deeper understanding of its needs. Understanding the resources, trends, and challenges that families encounter daily allows ECCT staff to have a more holistic approach and provide support in a way that feels responsive to the client and the community. Due to the ongoing political climate, many families

have remained hesitant to connect with some services due to fear of deportation or that accessing services, even emergency COVID-19 relief programs, may impact the family's eligibility to apply for a green card. The Community Worker has made herself available to support families with any appointments they were concerned about to help relieve some of the families' anxiety.

The Consultation Framework ensures that services be tailored to the specific needs of the programs served. To achieve this, consultants check in consistently with staff and inquire about services being delivered and meeting the needs of the program, classrooms, and families. Through weekly, bi-monthly monthly Mental Health staff meetings and 1:1 meetings (when requested by teachers), Consultants can have a deep understanding of the program and its functioning. At the forefront of this approach is a culturally sensitive and social justice-oriented framework, a lens used to conceptualize the issues within the community, the system, the classroom, and the individuals served. This lens allows them to think with staff about language barriers, cultural differences, and their impact on the caregiver's connection to the child and the families served. These themes are consistently talked about within the safe and non-judgmental consultation relationship. It is also within the context of this trusting relationship that consultants can support teachers in exploring their own implicit biases and how they inform their understanding of a child and a family's experience. Through this exploration and, ultimately, awareness, teachers hope that they become aware of their unconscious assumptions and better understand how they play out in their relationships within and outside the classroom. Once teachers can safely explore and understand these beliefs, they can respond in a much more informed and sensitive way to the children under their care. This, in turn, creates a much more inclusive classroom.

This year, in particular, this approach of ensuring that Mental Health Consultation services are uniquely tailored to the needs of the programs served was particularly important. Through the consistent checking in with sites, Consultants learned about COVID policy updates that impacted the staff constantly and the families served. Regular Mental Health staff meetings are a way of ensuring constant communication with staff about their own needs and the needs of the children and families they serve. This year was filled with challenges, uncertainty, fears, and chronic stress. Even those within the same system, every program had very different comfort levels and different ways of needing Consultation support. This led to Consultation services looking very different depending on the site. Due to teachers also experiencing significant stress, burnout, and fatigue, the Consultation space was significant for them to "unpack" and work through their feelings and thus be better able to show up for the children and families in their care. For many teachers, the therapeutic space offered in consultation is the main place to check their mental and emotional health. Through an attachment lens, the program can ensure that needs of the caregiver are met so that, in turn, they can show up for the children under their care and be better able to meet their needs.

Mental Health Consultation services have supported children with challenging behaviors, reducing their risk of expulsion and increasing the school's capacity to sustain these children in their programs. Out of the 4 cases for intensive case consultation services, none were expelled or suspended. In Consultation meetings, Consultants think with teachers about the meaning behind these behaviors and work with teachers to develop an understanding of the child's needs to develop a more attuned response aligned with the need the child might be expressing. Consultants offer consistent meeting space with teachers as discovering which type of intervention will work with a particular child often takes multiple tries and

tremendous effort on the teaching staff. Consultants support teachers in these efforts by witnessing the teachers' specific classroom experiences and offering a reflective space where teachers share what was happening in their classrooms. Through a reflective approach, teachers were invited to develop an awareness of their own experience in a particular moment and be more grounded and intentional in their work. Consultants provide encouragement and guidance to teachers while holding onto the hope for change. In light of the overwhelming work, they manage teachers may not be able to hold onto themselves.

Lastly, one of the most effective components of the program is to work with community partners to identify gaps in families having access to services. The ECCT team makes efforts to connect families with programs that could provide ongoing support for families, or in some cases, that gap is filled short term by the ECCT team. Having regular conversations as providers with other community providers allows for consideration and coordinated attempts to fill identified gaps and establish a commitment to continuing to address needs and challenges as they arise. The Community Worker maintains strong relationships within the community with both community members and community providers. These relationships have been crucial to getting families connected with much-needed services.

SUCCESSES

The Half Moon Bay client story is of a family who worked closely with the Community Worker initially, and later with the Mental Health Clinician. Mother has been the primary caregiver involved in the work with ECCT for her and her now 3-year-old son (client). The referral was initially made to ECCT from Pre-to-Three. This is a family with a significant history of trauma. Mother grew up in a home with cycles of parental interpersonal violence and has a history of her own similar relationship patterns. Through her work with ECCT, Mother is working hard to break this cycle for herself and for her family and to strengthen her relationship with her son.

The Community Worker supported Mother for a period when she was pregnant client, connecting Mother with much needed concrete resources such as a car seat and diapers. The Community Worker supported Mother in considering the importance of her own self-care as she anticipated having her baby and taking care of her newborn. Mother moved abruptly with the Father, who had been inconsistent regarding his support and involvement in the pregnancy, out of the area for a period of time. Mother was very isolated during the early years with client, and the family ended up moving back to Half Moon Bay. Mother reached out to the Community Worker for support upon their return. The Community Worker has supported Mother with understanding child development and providing parent-child activities in addition to assisting in referrals and making connections to Coastside Hope for determining eligibility for assistance programs, to Mariner's Church in the community for financial assistance during the pandemic, to Bay Area Legal Aide for legal assistance, as well as connecting Mother to local preschools for client.

The Community Worker referred Mother and client for dyadic work with the ECCT Mental Health Clinician as Mother began sharing concerns of increased family/partner stressors in addition to her description of her son having behavioral outbursts of hitting. Mother began describing increased stressors at home and began presenting as more depressed and having less energy to engage and

interact with her son. Because of the trusted relationship with the Community Worker, Mother was open to adding another support person for herself and client.

The Mental Health Clinician began working with the family shortly before the COVID-19 pandemic, so they started out with their assessment phase and then dyadic in-person sessions. Family stressors and a history of family trauma on the maternal side were shared, as well as current significant stressors gathered regarding Mother's older children living in Mexico with her parents. Soon after the change to telehealth during the pandemic, Mother and child unfortunately witnessed physical violence between extended family members. Police and Child Protective Services (CPS) were involved as a result, with the CPS investigation ultimately being closed. Witnessing this traumatic event in addition to being fearful of the CPS process resulted in Mother being triggered from her past experiences and led to her being less available for her son. Mother became more anxious and less involved with client. Client became anxious overall and was scared to leave his Mother's side. He expressed fear that another incident could happen again. Mother became less communicative and supportive, and she became sterner and more stressed/rigid in her interactions with client. The Mental Health Clinician focused the treatment using the Child Parent Psychotherapy model to address this specific, recent trauma. This work required Mother to have her own collateral sessions as well as being available for the dyadic sessions with client. Through this model of treatment, Mother was able to work through her own trauma response and to build capacity to support client through his experience. During the dyadic work, client played out the trauma involving the police cars, ambulance, family members, and used both play and language to express his worries and fears. The Mental Health Clinician was able to support Mother in hearing her son as well as to respond to him with reassurance of her love and commitment to keep him safe. Mother has developed the capacity to again be more communicative and interactive, and to calm herself in the moment when she notices herself becoming stressed.

Both the Community Worker and Mental Health Clinician have made attempts to engage Father, but he has not been open to participating himself. He has, however, shown more support for the ECCT work by supporting Mother and client to be able to engage in sessions. For example, he began spending time with client outside the home so that Mother would be available for scheduled collateral sessions with the Mental Health Clinician. Should Father express an openness/willingness to participate, the work would shift in order to support his involvement.

Due to what has come up for Mother during her collateral sessions, the Mental Health Clinician and the Community Worker are supporting Mother in connecting with her own individual therapy to allow her own space to work on her own history of trauma. This has taken time, given that Mother has expressed concern around the stigma of therapy in her culture. She has expressed that it feels different seeking help for her son than seeking this type of support for herself. Both the Community Worker and Mental Health Clinician have supported her thinking and readiness for this referral. They have worked with her to think of therapy for herself as part of her own self-care. Mother was also hesitant for this referral because, as it happens for families in the small community of Half Moon Bay, she knows someone who works at the mental health clinic. Both the Community Worker and Mental Health Clinician have listened to Mother's concerns and talked with her about confidentiality and options to look for services outside the community. Mother is currently on the Wait List at the Coastside Clinic for individual therapy.

Recently, client began preschool and is off to a good start. He is adjusting to the routine, making new friends and his Mother feels good about how he is doing. Mother is able to work more hours with him in preschool, which will help ease financial stressors. Mother continues to check in with the Community

Worker at least every other week (or as needed, if something comes up), and Mother and client meet with the Mental Health Clinician weekly. There is a Mental Health Consultant available for support at the new preschool, should any concerns arise. Mother has demonstrated a commitment to breaking the cycle of violence in her family and to protecting her son. Mother has remained dedicated to engaging in reflection of her own experience and to what her son's experience is, and to work in therapy with her son to make sure he is heard, understood and supported. While the family is not yet at the termination point, they have shown such commitment and resilience. Through the dyadic work, Mother and client are working on strengthening their relationship and ultimately supporting client's overall development and functioning.

Mother gave permission to share the following feedback about her experience with ECCT (translated from Spanish):

"I have felt supported, assured, and very comfortable. I am very grateful for their work and commitment to me. Thanks to (Community Worker), I met (Clinician). She inspires a lot of confidence in us. She has been with us in the most difficult times of our lives. I am very happy with them both because they have motivated me to move forward with my life and that of my son. Thank you for these great people. We love them!"

CHALLENGES

Challenges defined this fiscal reporting year as a result of the COVID-19 pandemic. COVID-19 led to unemployment, housing instability, families dealing with the illness and loss among their family members, caregivers struggling to support their preschool and school-aged children in their distance learning school models, as well as supporting the transition back to in-person school. Engagement in services has been inconsistent for many clients and families during this period of instability due to the pandemic. All services and supports through ECCT were via telehealth during this reporting period. Staff worked with families through the telehealth option caregivers were most comfortable and dependent on what has been accessible for families. There has been a theme of changing schedules and working/not working scenarios and stressors for families, so setting regular and consistent meetings/check-ins with caregivers has proven difficult. Some caregivers can only reach out during times of significant stress for immediate support. Due to the various stressors related to the pandemic, Clinicians have had more Collateral sessions with caregivers to support them in their experience of stressors, loss, and grief. During the pandemic, the work shifted to supporting families in re-establishing stability through meeting concrete needs and providing support regarding parental/familial discord due to the extreme stressors in the home. Dyadic work via telehealth platforms has proven challenging with this age group, despite efforts of Clinicians to offer engaging and interactive activities for sessions. Previous participants of the parent groups remained in contact with the Community Worker individually to stay connected and share up-to-date resources, despite not being able to meet as a group in the same way. The team anticipates more consistent engagement and availability of caregivers as the fear and impact of COVID-19 lessens.

A separate impact on the work resulting from COVID-19 has been related to ECCT staff. ECCT has experienced a turnover of Clinical staff towards the end of this reporting period. Most staff leaving cited the need for higher salaries and sought employment at other agencies. To mitigate this issue, management is working on a restructuring of the Team and Department allowing for higher salaries to help retain staff and continue to meet the level of need in the ECCT communities.

One of the ongoing challenges for ECCT has been office space. As ECCT anticipates returning to providing services in person, this challenge must be considered. One of the impacts of the Bay Area economy on the families served by ECCT, in addition to related COVID-19 factors, has led to multiple families moving in with other families to mitigate the cost of the rent. This has not only increased stressors in the home but has limited the family's level of comfort and availability to meet for in-home visits. The current ECCT office space is shared with a non-mental health non-profit program, and confidentiality is a significant concern. There is no private office space available for ECCT staff to meet with families. Efforts had been made to adjust schedules to hold sessions after work hours of the other program, but given that there are 3+ ECCT staff working on scheduling families in a tiny shared office area, this has proven challenging in the past. ECCT staff attempted to hold meetings in the Half Moon Bay Library pre-pandemic. Still, confidentiality remained a concern as caregivers were often not comfortable meeting for therapy sessions in such a public space within the small community. Team members have looked into other possibilities for office space, but these options have not been pursued due to limited funding. It would be to the benefit of the clients if a small, confidential meeting space were able to be secured. ECCT Management is currently communicating with District staff to determine if another office space might be available for the program.

Another ongoing challenge is supporting those who age out of the ECCT program. There have been significant challenges within Half Moon Bay and La Honda/Pescadero communities in terms of programs available for continued mental health and case management support post- ECCT. They are assisting families in transferring to Coastside Mental Health, Puente, and School-based services. ECCT has provided extended services for some families as necessary, and the team is able; however, this is not always possible. ECCT staff are in ongoing conversations with other Community Providers to look at this gap and better understand services available and supporting referrals/linkages made.

As anticipated, the COVID-19 licensing regulations greatly impacted the number of children served at the sites served by ECMHC consultants. Schools were enrolled at half capacity due to licensing regulations, and one of the agencies served closed one of its sites for half of the year. This, of course, reduced the number of both children and staff served. It also decreased case consultation services and "light touch" services. This year, classrooms will return to full capacity by January 2022 (per the State of California). Although sites have reported enrollment has been challenging due to some parents still being fearful of sending children back to school in person, an increase is expected of children at the sites.

One of the programs they consulted to unexpectedly lost their Executive Director mid-way through the year in a very abrupt manner and left no other person to take the lead. Therefore, getting consultation services again was challenging as teachers were overwhelmed, short-staffed, and highly anxious. This also resulted in this agency closing one of its classrooms until staffing was solidified and enrollment was up. This situation prevented them from connecting with a consultant as they tried to navigate change and uncertainty. Thankfully, a new ED has been assigned, and they are now working closely with her to ensure services are delivered regularly to staff. They have also been asked to support their after-school staff, who also report needing a space to receive support.

Another challenge that impacted referrals was that teachers reported very high levels of stress, fatigue, and burnout due to COVID-19. Fears of getting sick, caring for unvaccinated young children, constant classroom closures, shortage in staffing, intense cleaning guidelines on top of their many duties and responsibilities caring for young children contributed to teachers struggling to think more deeply about children's behaviors. For most teachers, the consultation space was one where they shared and reflected on their experience and sought emotional support for themselves. Though this is an integral

part of the consultation work, it was evident that this year, this part took precedent over slowing down and thinking about what is happening for children in the classroom. Being in a state of crisis and survival mode highly impacts the caregiver's capacity to think about the deeper meaning of behaviors. Therefore, referrals were limited to families already in crisis and needing more concrete services. Although they anticipate that stress will still be high for providers due to continued threats of COVID and its variants, they are hopeful that as teachers feel more comfortable, their capacity to "hold" children in their minds will also increase.

This year deemed difficult for consultants to be a "friendly face on-site" as they have been historical, something that has proven to be an effective way for parents to connect with services in a manner that feels safe and convenient. Due to consultants not being allowed on-site physically, it was left up to staff to connect us with families that expressed interest in services and/or were identified as needed by school staff. Many parents started feeling unsure of or even refusing the referral for consultation services. Their inability to be present on-site and build connections with parents was a barrier that impacted the referral process. This confirms what they have known about this "stance" and approach; for many families, the school is a safe and trusted place, which makes parents much more willing to sit with a Mental Health Consultant when the service is being offered by the teacher of Family Support Staff and seeing the consultant as a regular "face" every week does make a positive impact on their willingness to connect with them.

Another essential barrier faced due to not being present at the sites was not having access to observations. When a child was referred for more intensive services, usual assessment tools could not be implemented at the start of services. These two tools, the Devereux Early Childhood Assessment for Infants and Toddlers (DECA) and the Arnett, are pre and post-assessments used to show outcomes and require observation of the child and the child/teacher interactions. Without sitting in classrooms and observing closely, the data could not be collected this year. At the start of the 21-22 school year, sites informed that formal observations of children referred for more intensive consultation services, will be possible. Therefore, it is anticipated that the Pre and Post assessment tools necessary to report back qualitative data will be implemented once again.

DEMOGRAPHICS

	FY 20/21		FY 20/21
Age		Race/Ethnicity	
0-15	9%	Asian	2%
16-25	3%	Black/African-American	2%
26-59	86%	White/Caucasian	3%
60+	2%	Asian Indian/South Indian	1%
Decline to state	1%	Fijian	1%
Sex		Central American	14%
Male	24%	Chinese	1%
Female	74%	Mexican/Chicano	56%
Decline to state	1%	Filipino	3%
Language		Puerto Rican	1%
English	17%	Samoan	1%
Spanish	80%	South American	9%
Mandarin	1%	Another race/ethnicity	8%

Tagalog	1%		
Another language	1%		

COMMUNITY INTERVENTIONS FOR SCHOOL AGE AND TAY

PROJECT SUCCESS

Project SUCCESS, Schools Using Coordinated Community Efforts to Strengthen Students, is a research-based program that uses interventions that are effective in reducing risk factors and enhancing protective measures. Project SUCCESS is a SAMHSA model program that prevents and reduces substance use and misuse and associated behavioral problems among high risk multi-problem youth ages 9-18.

Project SUCCESS is designed for use with youth ages 9-18 and includes parents as collaborative partners in prevention through parent education programs. Clinical staff trained in culturally competent practices ran all the groups. All of Puente's Behavioral Health and Recovery Services (BHRS) staff are either licensed or pre-licensed by the Board of Behavioral Sciences (BBS). Project SUCCESS groups are offered to all three school campuses in the La Honda-Pescadero Unified School District (LHPUSD). The school district's small size provides an opportunity for every student in the district, ages 9 to18, to participate in one or more Project SUCCESS activities.

Each academic school year, a passive consent letter explaining the Project SUCCESS curriculum is sent to all parents with children ages 9 to 18. There is an opportunity for parents to have their child opt out of the workshops with a signature at the bottom of the consent letter. Project SUCCESS activities include:
- Social Emotional Learning and Psychoeducation workshops with students, parents, and community members
- Individual and family counseling services
- Parent and Teacher consultation
- Mental health community awareness and education
- Project SUCCESS services were provided to participants primarily via telehealth due to the COVID-19 pandemic. When possible and safe, services were provided in person.

PROGRAM IMPACT

Project SUCCESS	FY 20/21
Total clients served	208
Total cost per client	$1,529

For FY 20-21, COVID-19 related alterations to school programming meant that standard programming was not possible. Puente clinicians were quick to adjust and offer services through the telehealth platform. Clinicians partnered with teachers to provide social emotional learning workshops called "wellness time" via Zoom in all elementary school classes at Pescadero Elementary. Puente also

provided community drop-in sessions in both English and Spanish for adults and parents via the zoom platform.

In spring of 2021, a teen who lived in another city in San Mateo but who had close ties to the La Honda community overdosed and passed away. Puente's BHRS team, parents, and educators collaboratively decided an in-person Project SUCCESS group for the La Honda 5th grade students would support community healing. This group was provided in person at La Honda Elementary School to all 5th grade students. Pre-group and post-group quantitative data were collected for this 8-week group using the Developmental Assets Profile (DAP). Given the low number (N), a proper statistical analysis could not be conducted. These data will be combined with future data to inform practice.

Total Individuals provided 1:1 counseling services	208
Total Group participants	223
Total Number of Community Psychoeducation & Support Groups (virtual)	7
Total Number of SEL workshops "wellness time" at Pescadero Elementary (virtual)	8
Total Number of in person SEL workshop "wellness time" at La Honda Elementary (in person)	8
Total Number of Teen drop-in groups in La Honda (in person)	7
Timely Access to Services	All counseling referrals were linked to a clinician within 1 week of being received

Improves timely access & linkages for underserved populations:
Puente's service region is home to San Mateo County's most underserved population. Participants face numerous challenges to accessing health care, including behavioral health care. South Coast residents with low socioeconomic status are more likely than higher-status groups to have access issues, such as the absence of health insurance and inadequate transportation to medical appointments. Moreover, individuals who do not receive health insurance subsidies, such as undocumented immigrants, often lack the means to pay for health care. In addition to working physically demanding low-wage jobs, many participants are non-English speaking immigrants who have experienced multiple stressors and trauma.

All students and their families (ages 9-18) in the school district have access to Project Success. There is no barrier to accessing this program or participating in Puente treatment. Every youth, family member, and school staff member has complete access to consultation, a direct referral to therapy, and treatment with a trained mental health clinician at Puente. By providing free behavioral health care to all residents in the service area, Puente ensures that vulnerable SMC community members have access to the mental health services they need. Services were primarily accessed via telehealth over the 20/21 fiscal year due to the COVID-19 pandemic. Puente mitigated access issues by offering the community hotspots and tablets when necessary. A major challenge in this area was the lack of connectivity (internet or cellular) in some regions of the South Coast, adding challenges to reaching participants. The

Puente clinical team was creative in connecting with participants by making multiple attempts through various means (text, WhatsApp, email, and voicemail). The online nature of services may also have hindered some access for individuals who felt uncomfortable with the new technology.

Reduces stigma and discrimination:
Project SUCCESS is an opportunity for students (ages 9 to 18) and their families to engage with trained mental health clinicians in an educational format, workshop format, and therapeutic sessions to build relationships that break down the stigma of mental health issues and reduce the stigma for seeking treatment. The Puente BHRS team promotes mental health awareness, provides education in accessible formats, and makes access to mental health services easier through a simple referral process. By embedding mental health awareness and mental health clinicians in existing community forums such as the weekly farmworker La Sala program, the vaccine, and food distribution sites, and in classrooms, the mental health team is seen "as part of" and not "separate from" the community and in this way directly able to reduce stigma.
Puente's BHRS services are provided to anyone residing or working in the geographic region of Pescadero, La Honda, Loma Mar, or San Gregorio The South Coast is a multicultural community. Sixty-six percent of the BHRS staff are bilingual in English and Spanish. All BHRS clinicians are culturally competent and trained through a diversity, equity, and inclusion framework, which reduces language barriers and cultural biases. During the 20/21 fiscal year, all Puente staff participated in four 2-hour bilingual (Spanish/English) training on stress and conflict management. Trauma Transformed 101 training was also held via zoom platform for the community in Spanish over fiscal year 20/21.

Increases number of individuals receiving public health services:
Project SUCCESS provides students and families with referral services for physical health, behavioral health programs, safety net services, and education programs.
Puente's health programs address social determinants of health such as access to health care services, transportation limitations, limited social support, language barriers, and cultural biases. Puente's health program recognizes the social determinants that affect a participant's ability to access healthcare and maintain their health. In addition to working physically demanding low-wage jobs, many participants are non-English speaking immigrants who experience multiple stressors and trauma. Each social determinant increases participants' cumulative barriers to healthcare and their overall wellness. Puente enrolls participants in health insurance programs, arranges transportation to medical services, and facilitates and hosts mobile medical and dental clinics in conjunction with the San Mateo County Health System and other providers. When a member of the behavioral health team notices a public health need, Puente's internal referral process allows for seamless linkage to health services as needed.
Reduces disparities in access:
Behavioral Health is a high priority need area for San Mateo County (Stanford Community Health Needs Assessment Report, 2019). Through Project SUCCESS, all La Honda-Pescadero Unified School District students have access to this program. Puente aims to eliminate health disparities and improve access to healthcare services for vulnerable populations on the South Coast, including behavioral health care. By providing greater access to behavioral health care services, Puente seeks to improve participants' mental health and decrease long-term mental health problems. Puente improves individual and family mental health by providing on-site individual and group behavioral health services, and Puente significantly reduces the disparities in the behavioral health system. During the COVID-19 Pandemic, the

Puente BHRS team initiated services with all participants referred (by self or other) within one week of the referral being received.

Implements recovery principles:
Project SUCCESS is an early prevention and intervention program designed to mitigate the need for recovery services. Puente provides alcohol and other drug referral services as needed.
Puente also recognizes that recovery is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential. Puente's service continuum promotes the four major dimensions that support recovery:

- Health is defined by overcoming or managing one's disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being. Puente's Behavioral Health and Community Health teams make physical and mental health care accessible to the community. In partnership with San Mateo County, Puente offers free medical clinics, has championed the vaccination effort on the San Mateo South Coast, and offers free and accessible health services.
- Home is defined as having a stable and safe place to live. Puente's financial assistance programs provide rental assistance to those struggling with housing stability. Puente's easy internal referral system makes participants' access to these services seamless.
- Purpose is defined by conducting meaningful daily activities and having the independence, income, and resources to participate in society. Puente's education programs and safety net services support participants in attaining purpose. Services including but not limited to tutoring, financial planning, individual tax return preparation, and technical assistance for job seekers are all accessible to all Puente participants.
- Community is defined by having relationships and social networks that provide support, friendship, love, and hope. Community is at the center of Puente's mission and vision; empowering community members and being a local resource is a sense of pride for Puente. Puente seeks to reduce health disparities in the community through access to services.

SUCCESSES

The Puente BHRS team adjusted and continued services without interruption during the COVID-19 pandemic and CZU fires. Being able to creatively deliver high-quality mental health services to the community during this unprecedented time is the biggest success.

During the 2020-2021 school year, Puente offered virtual behavioral health services via the telehealth platform to adhere to CDC COVID-19 health and safety guidelines. Puente's BHRS team served 208 unduplicated participants and offered 30 prevention, early intervention, and psychoeducation support groups reaching 223 group participants. The team utilized innovative techniques such as creating a "virtual therapy room" and mailing "telehealth kits" to participants to support the virtual therapy sessions. Telehealth kits included self-soothing tools, therapeutic activities, and psychoeducation. When necessary and safe, the BHRS team conducted outdoor therapy sessions with high-risk youth who needed to be seen in person.

Puente BHRS staff also continued to provide teacher and school consultation regarding mental health support throughout the pandemic. The team was able to streamline the process should the school feel a youth needed crisis services by outreach to Star Vista's crisis support team and educating the school about available crisis services.

To support community mental health and wellness, the BHRS created Wellness kits provided to 250 families distributed during Puente's food distribution program that included psychoeducation about wellness, information on how to access mental health services, and tangible tools for practicing mindfulness and self-care.

CHALLENGES

In 22 years of service, the COVID-19 pandemic and the CZU fires have been the biggest challenge for Puente. As a result of the shelter-in-place order, most staff have worked remotely since March 2020. Puente teams adapted, provided support for participants, and provided as many services as possible, including behavioral health programs. Puente as a whole saw a 41 percent increase in the number of participants during this time as there was a greater need - including mental health needs. It has been challenging to provide more services with less direct in-person contact to protect staff and participants.

The BHRS team also experienced a leadership transition in October 2020, with an interim director stepping in to manage the team until a permanent director could be hired. Given the current hiring challenges in mental health, filling this position took almost an entire year. Puente continues to experience the challenges of hiring for open clinical positions as the mental health services demand outweighs the number of eligible clinicians looking for employment, especially bilingual and willing to work on the remote South Coast.

There has been an increase in mental health services because of the COVID-19 pandemic. BHRS clinicians continue to provide services to clients and facilitate support groups via Zoom and by phone. Remote telehealth has long been suggested as a strategy to provide greater access to mental health care. Although there are challenges to providing remote therapy, it allowed the BHRS staff to continue to provide critical mental health care during this time while keeping participants safe.

In August 2020, the South Coast communities were evacuated because of the CZU wildfire. There is an even greater need for mental health services with the wildfire trauma and the evacuation. The BHRS team provided services to the community during the fires by staffing evacuation sites. The BHRS team supported individuals who lost their homes or were temporarily displaced.

Ten to 30 percent of wildfire survivors develop diagnosable mental-health conditions, including Post-Traumatic Stress Disorder (PTSD), depression, and anxiety (National Center on PTSD). Feelings such as overwhelming anxiety, constant worrying, trouble sleeping, the desire to self-medicate with drugs and alcohol, and other depression-like symptoms are common responses after experiencing the trauma of a wildfire (SAMHSA 2020). These symptoms are a natural response to an emergency, such as fleeing a

wildfire. Having access to mental health care is one strategy to help alleviate mental-health conditions that develop after natural disasters (Hrabok et al., 2020).

DEMOGRAPHICS

	FY 20/21			FY 20/21
Age			Race/Ethnicity	
0-15	31%		White/Caucasian	30%
16-25	29%		Mexican/Chicano	54%
Adult	28%		Other/data not available	16%
60+	3%			
Decline to state	9%			
Primary Language			Gender Identity	
English	54%		Male/Man/Cisgender	34%
Spanish	21%		Female/Woman/Cisgender Woman	64%
Another language/unknown	25%		Decline to state	2%

TEACHING PRO-SOCIAL SKILLS (TPS)

Beginning FY 2020-21, Human Services Agency decided to no longer provide the Teaching Pro-Social Skills (TPS) evidence-based training program designed to improve elementary school students' behaviors, replacing less productive ones. The program is part of a larger Trauma-Informed Co-Occurring Services for Youth strategy, described in the following section. The funding for TPS will be rolled into this strategy for the next Request for Proposal (RFP) process to allow agencies to propose culturally responsive evidence-based and/or community defined best practices.

TRAUMA-INFORMED CO-OCCURRING SERVICES FOR YOUTH

Trauma-Informed Co-occurring Prevention Services for Youth target youth and transitional age youth (TAY) ages 15-25 who are at greatest risk for adverse childhood experiences; children of color and children who grow up in poverty show the greatest risk for ACEs. Other groups can include juvenile justice involved, immigrant youth, homeless youth, youth in foster care, etc. In San Mateo County, African American, American Indian, Latinx, and Native Hawaiian and Pacific Islanders, are more likely to live in high poverty areas (15.2%, 24.2%, 12.7%, and 10.9% respectively).

Trauma-Informed Co-occurring Prevention Services for Youth consists of three required components: Group-Based Intervention; Community Engagement; and Social Determinants of Health (SDOH) Screening and Referrals.

1. The Group-Based Intervention component utilizes evidence-based or promising practice intervention or curriculum to address trauma and co-occurring substance use issues with youth. Agencies can opt to provide the Mindfulness-Based Substance Abuse Treatment (MBSAT), which was piloted with youth throughout San Mateo County or an alternate culturally-relevant intervention/curriculum. Examples of alternate interventions/curricula include, but are not limited to, the National Compadres Network curricula; Keepin' it R.E.A.L.; Teaching Transformative Life Skills to Students: A Comprehensive Dynamic Mindfulness Curriculum; and Mission Possible 360. Agencies providing Trauma-Informed Co-occurring Prevention Services for Youth target at least 8 youth per cohort and each cohort consists of at least eight sessions for the intervention and one session for BHRS staff to present on youth engagement opportunities.

2. The Community Engagement component address systemic and community-level challenges that are necessary for positive youth development and behavioral health outcomes. Agencies provide at least two foundational trauma-informed 101 training for adults and other members of the community that interact with their youth cohort participants (parents, teachers, probation officers, service providers, community, etc.) to create trauma-informed supports for youth. This component also encourages agencies to connect the cohort youth to leadership engagement opportunities such as the BHRS Office of Diversity and Equity (ODE) Health Ambassador Program for Youth and the Alcohol and Other Drug (AOD) youth prevention programs.

3. The SDOH Screening and Referrals component acknowledges that social determinants of health (e.g., food insecurity, housing, transportation, medical treatment, etc.) can account for up to 40 percent of individual health outcomes, particularly among low-income populations. Agencies screen youth participants at intake for social determinants of health impacts to support appropriate referrals and identifying community-based social service resources and social needs and/or gaps. A screening tool will be developed by BHRS and made available to the selected provider.

Four agencies provide Trauma-Informed Co-occurring Prevention Services for Youth interventions:
*   Mindfulness-Based Substance Abuse Treatment (MBSAT)
    o   StarVista provides 6 cohorts per year in North County and South County
    o   Puente de la Costa Sur provides 2 cohorts per year in the South Coast region
    o   YMCA Bureau of San Mateo County provides 2 cohorts per year in South San Francisco

*   Panche be Youth program
    o   The Latino Commission provides 2 cohorts per year; 1 cohort of the indigenous and culturally-based Xinachtli for girls and 1 cohort of El Joven Noble curriculum for boys in Half Moon Bay.

MINDFULNESS-BASED SUBSTANCE ABUSE TREATMENT (MBSAT)

MBSAT is a group-based curriculum incorporating mindfulness, self-awareness, and substance use treatment strategies with adolescents dealing with substance use/misuse. MBSAT provides adolescents with the ability to improve their decision-making skills and reduce unhealthy behaviors such as

substance use through learning emotional awareness and choosing how to respond (versus react) to stressful situations, how specific types of drugs affect the body and the brain, and how family, peers, and the external environment can contribute to drug use. MBSAT strives to offer youth an empowered approach to substance use prevention, rather than the norm that adolescents typically meet; programs that teach "just don't do (drugs)." MBSAT is designed for use with adolescents, broadly defined, and uses adult facilitators as group leaders to model authenticity and build healthy relationships.

MBSAT – PUENTE DE LA COST SUR (PUENTE)

Puente clinical staff trained in cultural humility and trauma-informed care ran this group. All Puente Behavioral Health Recovery Services (BHRS) staff are either licensed or pre-licensed by the Board of Behavioral Sciences (BBS). MBSAT is offered at high school students in the La Honda-Pescadero Unified School District (LHPUSD).

PROGRAM IMPACT

MBSAT - Puente	FY 20/21
Total clients served	208
Total cost per client	$144

The primary program activities this fiscal year included three-day training for all clinical staff provided by Dr. Sam Himelstein. Dr. Himelstein addressed the unique challenges posed by the pandemic in offering the MBSAT curriculum and provided alternative implementation strategies that included utilizing the curriculum in individual sessions as well as modifying the curriculum by either combining modules or only including modules that seemed particularly applicable to the youth being served. The MBSAT program was provided to Puente clients individually and in small group format.

Program activities included a combination of experiential, didactic (psychoeducation), and process-based interventions. These included formal meditation (mindful breathing, body-scans, noting/labeling, and compassion-based meditations), emotional awareness/processing activities, informal mindfulness activities, and the dissemination of information to youth (defining mindfulness, exploring the relationship between drugs and the brain, etc.), as well as processing with youth how their environments influence them and vice-versa. The 12 sessions in the MBSAT curriculum manual were covered in the following order: Introduction to the Program, Mindfulness of Drugs and their Health Effects, Reacting Vs. Responding, Mindfulness of Delusion, Emotional Awareness, The Brain and Drugs, Mindfulness of Cravings, Mindfulness of Triggers, The Family System and Drugs, Mindfulness of the Peer System, Mindfulness of the External Environment, and Closing Ceremony.

For FY 20-21, COVID-19 related alterations to school programming meant that standard programming was not possible. Puente clinicians were quick to adjust and offer services through the telehealth platform. The principles and practices of MBSAT were incorporated into individual sessions with adolescents.

In spring of 2021, a teen who lived in another city in San Mateo but who had close ties to the La Honda community overdosed. Puente's BHRS team, parents, and educators collaboratively decided that in order to address need an in person drop-in group for the La Honda teens would support community healing. This 1.5 hour group was provided in person at the La Honda office every Wednesday evening for 8 weeks. The team adjusted the group format to include both MBSAT curriculum and grief support. Survey data was not collected due to the sensitive nature of the group and to encourage attendance. Community parents also provided dinner each week to encourage attendance. A small stipend ($15/per group) was also offered for attendance.

Total Individuals provided 1:1 counseling services	208
Total Teen Drop-In Group participants	12
Timely Access to Services	All counseling referrals were linked to a clinician within 1 week of being received

Improves timely access & linkages for underserved populations:
Puente's service region is home to San Mateo County's most underserved population. Participants face numerous challenges to accessing health care, including behavioral health care. South Coast residents with low socioeconomic status are more likely than higher-status groups to have access issues, such as the absence of health insurance and inadequate transportation to medical appointments. Moreover, individuals who do not receive health insurance subsidies, such as undocumented immigrants, often lack the means to pay for health care. In addition to working physically demanding low-wage jobs, many participants are non-English speaking immigrants who have experienced multiple stressors and trauma.

All students and their families (ages 9-18) in the school district have access to Puente counseling services. There is no barrier to access for participating in treatment at Puente. MBSAT is provided to those youth who would benefit from psychoeducational and support around substance use.

By providing free behavioral health care to all residents in the service area, Puente ensures that vulnerable SMC community members have access to the mental health services they need. Services were primarily accessed via telehealth over the 20/21 fiscal year due to the COVID-19 pandemic. Puente mitigated access issues by offering the community hotspots and tablets when necessary. A major challenge in this area was the lack of connectivity (internet or cellular) in some regions of the South Coast, adding challenges to reaching participants. The Puente clinical team was creative in connecting with participants by making multiple attempts through various means (text, WhatsApp, email, and voicemail). The online nature of services may also have hindered some access for individuals who felt uncomfortable with the new technology.

Reduces stigma and discrimination:
Puente's BHRS services provide an opportunity for students and their families to engage with trained mental health clinicians in an educational format, workshop format, and therapeutic sessions to build relationships that break down the stigma of mental health issues and reduce the stigma for seeking treatment. The Puente BHRS team promotes mental health awareness, provides education in accessible

formats, and makes access to mental health services easier through a simple referral process. By embedding mental health awareness and mental health clinicians in existing community forums such as the weekly farmworker La Sala program, the vaccine, and food distribution sites and classrooms, the mental health team is seen "as part of" not "separate from" the community and in this way directly able to reduce stigma.

The MBSAT curriculum provides psychoeducation and a harm reduction model for substance use services. The non-stigmatizing and non-pathologizing aspect of the curriculum supports inclusion and exploration of issues versus an abstinence model, which can deter some individuals from seeking support.

Puente BHRS services are provided to anyone residing or working in the geographic region. The South Coast is a multicultural community. Sixty-six percent of the BHRS staff are bilingual in English and Spanish. All BHRS clinicians are culturally competent and trained through a diversity, equity, and inclusion framework, which reduces language barriers and cultural biases.

Increases number of individuals receiving public health services:
Puente's BHRS services provide students and families with referrals for physical health, behavioral health programs, safety net services, and education programs.
Puente's health programs address social determinants of health such as access to health care services, transportation limitations, limited social support, language barriers, and cultural biases. Puente's health program recognizes the social determinants that affect participants' ability to access healthcare and maintain their health. In addition to working physically demanding low-wage jobs, many participants are non-English speaking immigrants who experience multiple stressors and trauma. Each social determinant increases participants' cumulative barriers to healthcare and their overall wellness. Puente enrolls participants in health insurance programs, arranges transportation to medical services, and facilitates and hosts mobile medical and dental clinics in conjunction with the San Mateo County Health System and other providers. When a member of the behavioral health team notices a public health need, Puente's internal referral process allows for seamless linkage to health services as needed.

Reduces disparities in access:
Behavioral Health is a high priority need area for San Mateo County (Stanford Community Health Needs Assessment Report, 2019). Through Puente's BHRS services, all La Honda Pescadero Unified School District students have access to this program. Puente aims to eliminate health disparities and improve access to healthcare services for vulnerable populations on the South Coast, including behavioral health care. By providing greater access to behavioral health care services, Puente seeks to improve participants' mental health and decrease long-term mental health problems. Puente improves individual and family mental health by providing on-site individual and group behavioral health services, and Puente significantly reduces the disparities in the behavioral health system. During the COVID-19 Pandemic, the Puente BHRS team initiated services with all participants referred (by self or other) within one week of the referral being received.

Implements recovery principles:
Puente's BHRS team provides a continuum of services from prevention, early intervention, and treatment. The MBSAT curriculum is psychoeducation and skill-building substance use intervention

program that supports recovery services. Puente provides alcohol and other drug referral services as needed.

Puente also recognizes that recovery is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential. Puente's service continuum promotes the four major dimensions that support recovery:

- Health is defined by overcoming or managing one's disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being. Puente's Behavioral Health and Community Health teams make physical and mental health care accessible to the community. In partnership with San Mateo County, Puente offers free medical clinics, has championed the vaccination effort on the San Mateo South Coast, and offers free and accessible health services.
- Home is defined as having a stable and safe place to live. Puente's financial assistance programs provide rental assistance to those struggling with housing stability. Puente's easy internal referral system makes participants' access to these services seamless.
- Purpose is defined by conducting meaningful daily activities and having the independence, income, and resources to participate in society. Puente's education programs and safety net services support participants in attaining purpose. Services including but not limited to tutoring, financial planning, individual tax return preparation, and technical assistance for job seekers are all accessible to all Puente participants.
- Community is defined by having relationships and social networks that provide support, friendship, love, and hope. Community is at the center of Puente's mission and vision; empowering community members and being a local resource is a sense of pride for Puente. Puente seeks to reduce health disparities in the community through access to services.

SUCCESSES

The Puente BHRS team adjusted and continued services without interruption during the COVID-19 pandemic and CZU fires. Being able to creatively deliver high-quality mental health services to the community during this unprecedented time is the biggest success.

During the 2020-2021 school year, Puente offered virtual behavioral health services via the telehealth platform to adhere to CDC COVID-19 health and safety guidelines. Puente's BHRS team served 208 unduplicated participants and offered 30 prevention, early intervention, and psychoeducation support groups reaching 223 group participants. The team utilized innovative techniques such as creating a "virtual therapy room" and mailing "telehealth kits" to participants to support the virtual therapy sessions. Telehealth kits included self-soothing tools, therapeutic activities, and psychoeducation. When necessary and safe, the BHRS team conducted outdoor therapy sessions with high-risk youth who needed to be seen in person.

Puente BHRS staff also continued to provide teacher and school consultation regarding mental health support throughout the pandemic. The team was able to streamline the process should the school feel a youth needed crisis services by outreach to Star Vista's crisis support team and educating the school about available crisis services.

To support community mental health and wellness, the BHRS created Wellness kits provided to 250 families distributed during Puente's food distribution program that included psychoeducation about wellness, information on how to access mental health services, and tangible tools for practicing mindfulness and self-care.

CHALLENGES

In 22 years of service, the COVID-19 pandemic and the CZU fires have been the biggest challenge for Puente. As a result of the shelter-in-place order, most staff have worked remotely since March 2020. Puente teams adapted, provided support for participants, and provided as many services as possible, including behavioral health programs. Puente as a whole saw a 41% percent increase in the number of participants during this time as there was a greater need - including mental health needs. It has been a challenge to provide more services with less direct in-person contact to protect staff and participants.

In October, the BHRS team also experienced a leadership transition, with an interim director stepping in to manage the team until a permanent director could be hired. Given the current hiring challenges in mental health, filling this position took almost an entire year. Puente continues to experience the challenges of hiring for open clinical positions as the mental health services demand outweighs the number of eligible clinicians looking for employment, especially bilingual and willing to work on the remote South Coast.

There has been an increase in mental health services because of the COVID-19 pandemic. BHRS clinicians continue to provide services to clients and facilitate support groups via Zoom and by phone. Remote telehealth has long been suggested as a strategy to provide greater access to mental health care. Although there are challenges to providing remote therapy, it allowed the BHRS staff to continue to provide critical mental health care during this time while keeping participants safe.

In August 2020, the South Coast communities were evacuated because of the CZU wildfire. With the wildfire trauma and the evacuation, there is an even greater need for mental health services. The BHRS team provided services to the community during the fires by staffing evacuation sites. The BHRS team supported individuals who lost their homes or were temporarily displaced.

Ten to 30 percent of wildfire survivors develop diagnosable mental-health conditions, including Post-Traumatic Stress Disorder (PTSD), depression, and anxiety (National Center on PTSD). Feelings such as overwhelming anxiety, constant worrying, trouble sleeping, the desire to self-medicate with drugs and alcohol, and other depression-like symptoms are common responses after experiencing the trauma of a wildfire (SAMHSA 2020). These symptoms are a natural response to an emergency, such as fleeing a wildfire. Having access to mental health care is one strategy to help alleviate mental-health conditions that develop after natural disasters (Hrabok et al., 2020).

DEMOGRAPHICS

	FY 20/21
Age	

0-15	31%	
16-25	29%	
Adult	28%	
60+	3%	
Decline to state/data not available	9%	
Primary Language		
English	54%	
Spanish	21%	
Another language/unknown	25%	
Sex Assigned at birth		
Male	34%	
Female	64%	
Decline to state	16%	
Race/Ethnicity		
White/Caucasian	30%	
Mexican/Chicano	54%	
Other/data not available	16%	

MBSAT - STARVISTA

MBSAT is offered as part of the StarVista Insights Program. The purpose of the Insights Program is to improve the lives of transition-age youth (TAY) who are dealing with issues around substance use, trauma, emotional regulation, family conflict, unhealthy relationships, and/or any other factor limiting their healthy development and overall happiness. Over the last year and a half, the program was adapted during the current COVID-19 pandemic to continue to bring support and emphasize emotional regulation and help youth cultivate and grow their resilience during these uncertain times. To that end, StarVista Insights Program is ramping up the offerings of MBSAT groups for TAY youth by working with various community-based organizations and San Mateo County school districts. Any transition-aged youth (typically ages 15-25) are welcome to participate and any organization serving TAY. The groups focus on skills like self-awareness, enhancing emotional well-being, and reducing substance use through better decision-making. With the right tools, youth can better manage life challenges in the moment instead of allowing emotions to lead to poor judgement, risky decisions, and eventually negative or dire consequences. Group facilitators work with participants to understand practical application of how these tools can improve their quality of life. During the sheltering orders associated with COVID-19 telehealth (remote) service delivery was implemented. Remote sessions have allowed the groups to continue while maintaining safety by adhering to regulations associated with COVID-19 protocols. With the appropriate safety protocols in place, during the last quarter of the fiscal year, in-person services were made optional for clients. This has led to an increase in the number of youth served. Groups are organized to make the setting age appropriate (usually ages 15-17 and 18-25).

Currently, clinicians are traveling to various sites again (as prior to the pandemic).   Program activities focus on drug education, mindfulness techniques, meditation and breathing exercises, skits, role play, and much more through encouraged dialogue and authentic engagement. Topics covered, per the

curriculum, are substance use, emotional awareness and regulation, cravings, triggers, brain function, family systems, peer systems and environmental influences. Each group provides an opportunity to explore multiple meditation interventions focusing on different elements, such as, but not limited to, meditation of the breath, body, and environment.

The intention is that by providing youth the space to calmly explore their own mindful awareness and its potential benefits, they can implement and execute these strategies in their everyday lives. So often, negative experiences come down to split decisions made in a momentary lack of clarity and poor judgement, leading to many more moments of anguish and discomfort. Increasing awareness and acceptance of emotions is the first step towards preventing these momentary lapses that lead to longer term struggles. Continued utilization of these strategies around how youth approach and manage their emotions and their relationships may allow them to make better decisions and lead happier lives.

PROGRAM IMPACT

MBSAT - StarVista	FY 20/21
Total clients served	39
Total cost per client	$2,308

Due to COVID-19 related challenges this year, most group cycles were interrupted due to shelter-in-place orders. The data collected is insignificant for analysis as it is all consisting of "pre" surveys with only a handful of "post" surveys. Though the survey tools have been transferred to online, most youth due to it being telehealth services for the majority of the year was hard to get them to fill out the survey while not physically present. This next fiscal year in person with COVID precautions will be possible, which increases the completion of the pre and post surveys.

The self report throughout the duration with the clients was positive. The group provided them coping skills to increase positive decision making. Connection to mental health services and continued support/ case management. Clinicians for most of the fiscal year have co-facilitated groups in order to increase screening and support for clients individually and prevent mental illness from becoming severe and disabling. We have utilized client's input throughout their services to better support them personally and arrive early and leave late to give them the individual support as needed. The clinicians take part in weekly training in order to recognize and assess untreated mental illnesses. The clinicians also ensure to have regular communication with the program/school representative in order to learn more about what needs/areas of growth the clinicians can benefit from.

Improves timely access & linkages for underserved populations:
By traveling to various facilities in the community where the underserved population congregates, resides, or attends programming, an opportunity is provided for greater accessibility allowing increased attendance by participants in need. StarVista works with partner agencies and participants to determine the best time/access point for participation. Additionally, the program will be provided with an online/at-home format, allowing greater reach and accessibility. Through a special grant, cellular phones with cameras were secured for clients who indicate that they would most benefit from remote services due to transportation issues but do not have a phone of their own.

Reduces stigma and discrimination:
The design of this program does not focus on telling youth what to do and what not to do. This approach helps reduce any shame associated with their actions or community. This program focuses on teaching youth to be more aware of the systems, choices, and myriad factors that contribute to what is always ultimately a choice on their part but can be understood in a greater context. The hope is to make more informed decisions based on desired long-term consequences and outcomes rather than immediate gratification or reactivity. The program encourages a high level of peer engagement, thus creating a more interactive feeling of togetherness and support, less like the typical teacher-student dynamic (perhaps more authoritative or 'one-way') to which they are accustomed. They are teaching youth to be more present in their lives and develop healthier coping skills. These skills are taught in the context of being applied to many life challenges, such as family and peer relationships, past traumas, and addiction. By normalizing the conversation around personal struggles, increasing awareness, and emotional regulation, youth can continue these conversations in their private circles and further normalize the concept of seeking out and receiving support. They aim to reduce societal stigma around emotional or mental health support. Many youths that have been involved in their communities' various systems (juvenile justice, probation, homeless networks, foster care, etc.) have expressed feeling powerless within those systems. As noted above, this program provides TAY with the psychoeducation, skill-building, and decision-making abilities to overcome obstacles, leading to solutions and positive outcomes. Thus, a sense of empowerment and self-definition.

Increases number of individuals receiving public health services:
Pre COVID-19 pandemic, they would travel to meet underserved youth- most of the time, they reach participants through programs where they are already receiving services (whether in-person or virtually). These are individuals that would otherwise not have been receiving public health services. Since having established their online platform due to COVID-19, they can cast their net even farther, reaching homes with already limited accessibility due to schedules and timing of personal lives and/or travel limitations due to financial constraints. Suppose there appear to be any unmet needs, reported or perceived by the clinician, to ensure the youth's health needs are being met. In that case, StarVista collaborates with the partner sites to coordinate the appropriate care level for all participants who engage in the program.

Reduces disparities in access to care:
This program directly increases the number of individuals receiving public health services by targeting underserved populations, thus reducing the disparity in access to care. Transportation can often be a barrier to access and increases these disparities for young people with limited resources. This program travels to the participants, removing transportation as a challenge in accessing services. Additionally, their online platform offers a variety of time slots to accommodate the variety of work schedules, home-life schedules, and school schedules. They can also provide phones for youth who need a cellular device to participate in remote services.

Implements recovery principles:
By emphasizing increased awareness and acceptance as core elements of mindfulness, individuals can patiently implement critical principles to their recovery. Teaching mindfulness encourages the

implementation of self-actualized, self-directed factors that the individual identifies through the recovery process. Mindfulness is rooted in holistic, strength-based, person-centered, and self-directed elements – all key principles of recovery.

SUCCESSES

One of the most notable shifts reported from clients was in their willingness to enjoy and engage in "therapy", they would say. They reported that they thought it would be boring and a poor use of their time, but by the end of the 8-week cycle, they reported having enjoyed learning and would ask how they could continue. Another notable success of this program has been seeing a shift in desire to change by the participants. So often, youth participants are barely "contemplative" in regard to the "stages of change". Most youth, after participating in the full curriculum are much closer to an "action" stage of change. This is where they have identified what they want to work on and are actively working towards goals. This is an enormous step in improving their journey and creating an internal process of awareness and action. Multiple youth reported using the tools learned in group during their daily lives. This further showcased that when provided the encouragement and the space, they would thrive. Youth left the group self-reporting a generally greater ability to express their emotions in a way that was receivable and positive to those around them. It appears groups that holding more open groups with flexible times and online formats has lead to higher levels of interaction and participation. One major difference between the online and in-person group setting is that youth have seemed to appreciate being in their own spaces as opposed to sitting in the group circle. In addition, youth have exhibited very positive bonds with group facilitators.

Daybreak
One of the greatest successes of the program has been the positive progression of one of the groups, a collaboration with Starvista's Daybreak program. Many of the youth who participated in this group had participated previously. This mounted a bit of a challenge; the common attitude and response was "we've already done this before". However, with a fresh and interesting approach to help youth build on what they had already learned from the previous cycle, youth were a lot more receptive. By encouraging youth to chime in with more authority on topics they felt the most comfortable with, there was a palpable shift in interest. Whereas at the beginning youth expressed that their previous experience with MBSAT was "okay", as sessions progressed, one client shared, "I like how we are using the same tools in a more specific way".
The youth went on to share the relevant examples in his life where the tools and examples came to life in his own everyday experience. He shared how the tools and practices were helpful to him in improving his relationships. As an example of this he shared with one of the counselors that what he's learned "helped me with communication and expressing myself better....it helped me with talking to family about figuring out how to get my needs met". This youth had shared that a difficulty in his life revolved around boundaries with his mom. He felt that what he said was more constructive and showed great self-awareness when talking about himself and the important relationships in his life. One of the most rewarding things to hear from this youth was "things are not where I want them to be, but I am getting there". The details he went on to talk about showed great self-awareness but beyond this, future planning and vision. This is the kind of feedback expected from new youth in the future.

CHALLENGES

School partners are having difficulty adjusting to the many changes this school year; distance learning and telehealth have provided challenges for all to adapt, and progress is gradual. Many of their school-partner sites paused groups because there was not enough stability to offer this service to the youth. The need for constant scheduling changes during the pandemic made it challenging to find a time that worked well consistently. Most programs were forced to request that they push the start of these groups back until more safety could be guaranteed for participants and facilitators. This meant waiting to see a drop in COVID-19 cases and increased comfortability of all involved to participate. Programs that attempted to move forward with groups realized that making groups attractive to youth in a virtual setting was difficult. As the fiscal year progressed, the community started to open and ease restrictions. At that time, they held groups in person and increased engagement with the proper protocols.

DEMOGRAPHICS

		FY 20/21
Age		
	0-15	13%
	16-25	87%
Primary Language		
	English	95%
	Spanish	5%
Sex Assigned at birth		
	Male	56%
	Female	44%
Race/Ethnicity		
	Mexican/Chicano	23%
	Black/African/-American	10%
	White/Caucasian	49%
	Asian	10%
	Asian Indian/South Asian	2%
	Another race/ethnicity	5%

MBSAT - YMCA

The Youth Service Bureau is a part of Urban Services YMCA and provides school-based mental health services on three high school campuses in South San Francisco. The high schools served are South San Francisco High School and El Camino High School. The target population served are youths ages 14-18

who attend high school. High School School Safety Advocate (SSA) services are available and open to all youth on campus. YMCA High School SSAs provide the First Stop group which utilizes the MBSAT curriculum for youth referred to school-based services for both prevention and substance use.

The High School SSA staff provides the following services:
- crisis intervention and mediation
- risk and mental health assessment
- on-campus First Stop groups, using Mindfulness-Based Substance Abuse Treatment (MBSAT) curriculum
- on-campus Girls United empowerment groups
- on-campus anger management "CALM groups," based upon Aggression Replacement Therapy
- referrals for further individual and family counseling at the Youth Service Bureaus/YMCA clinics or with other appropriate services in the county
- family case management, including parent support and psychoeducation

Additionally, High School SSA staff provide outreach and education activities with schools to enhance strategies for reducing school violence, criminal justice involvement, and risk factors through discussions with students, workshops, and parent workshops. The purpose of the High School SSA program is to keep young people out of the criminal justice system by addressing critical safety concerns. SSA staff work in partnership with school personnel to create safe environments on campuses by intervening to stop fights, mediating conflicts through restorative justice techniques, and preempting potential bullying, self-harm, suicide, and substance use. SSAs therapeutic program model enables staff to establish relationships that empower young people to work with a safe adult who can guide them through problem-solving and skill-building techniques designed to address challenges, both at school and at home. The overarching goals of the program are to:

- reduce youth violence, gang participation, substance use, and involvement in criminal justice
- identify any risk to self or others, and secure appropriate services to ensure youths' safety
- change at-risk youths' behaviors to increase personal responsibility, risk avoidance, protective behaviors, and resiliency
- provide the following developmental inputs to promote positive behavioral change: safe environments, supportive adults, and a variety of programs and interventions matched to youths' risk levels
- measure the impacts of those developmental inputs as indicators of positive behavioral change

PROGRAM IMPACT

MBSAT - StarVista	FY 20/21
Total clients served	102
Total cost per client	$42

The High School SSA program provided by the YMCA is a valued service on campus. Student referrals can come from teachers, administrators, parents, and students who choose to self-refer. The SSA

completes mental health and risk assessments. Clients can receive continued support on campus, be referred to outpatient clinic services, or be linked with other care providers as needed, including mental health linkages through Care Solace. YMCA High School SSAs can refer to the Youth Service Bureau (YSB) outpatient clinic, ensuring continuity of care for referred clients. YSB outpatient clinic accepts Medi-Cal and provides a sliding scale to accommodate youth and families in the community from any economic level. YMCA High School SSAs are trained in the use and practice of MBSAT for adolescents and can use it both with groups and individually.

The YMCA High School SSA program provides confidential mental health services to students, providing a safe space increases trust in the therapeutic relationship. Trusting therapeutic relationships, providing psychoeducation and resources can reduce stigma and discrimination by normalizing mental health support and increasing opportunities for students to seek supports in the future. Engaging in group work can also help to reduce stigma and discrimination for students by increasing connections and fostering relationships through shared lived experiences. The MBSAT curriculum includes mindfulness, psychoeducation, and self-reflection that also help reduce stigma related to substance use in adolescents by increasing skill-building, self-regulation, and positive coping strategies. The YMCA High School SSA program is currently working with the schools to incorporate the MBSAT as an alternative to suspension for students caught on campus with substances and/or using substances. This can reduce stigma and discrimination by moving toward a less punitive, more supportive, and restorative solution to substance use by youth on school campuses.

YMCA High School SSA's work to get referred students connected to services that are appropriate to the needs of the youth. Work with students also involves parents and caregivers, and referrals and linkages extend to families. The YMCA Community Resource Center (CRC) is a core service agency in South San Francisco located in close proximity to all three high schools. The CRC provides food, information on housing resources, shelter, other homeless services, short-term rental/deposit/mortgage payment assistance, and utility bill financial assistance. The CRC also has annual holiday food drives, toy drives, and backpack giveaways for school-age youth.

Due to the ease of access on the high school campuses, YMCA High School SSA's can provide mental health support to students throughout the school year. Mental health support is also available in an outpatient clinic over the summer if client needs indicate continued treatment is beneficial to client success. YMCA outpatient clinic services have been provided through telehealth since the start of the COVID 19 pandemic in March 2020. Telehealth services have guaranteed that clients already in service could continue without any disruption to services and safely accommodate any new clients. YMCA High School SSA services are free to all high school students, which greatly helps to reduce disparities in access to mental health care.

The YMCA High School SSA program has integrated the MBSAT program curriculum to support youth on campus referred for substance use or youth at risk for substance use due to family or community involvement. The curriculum can be implemented in a group or individual settings. Parent and family support or engagement is also possible. Supporting clients by meeting them where they are at, highlighting strengths and abilities, promoting hope, learning ways to cope and function at school, and building a positive therapeutic relationship with a trusted adult are ways that integrate recovery

principles. Data shown below highlights a range of issues addressed in services provided by YMCA High school SSAs during the 20-21 academic year. Most services addressed depression and anxiety as well as academic stress.

CLIENTS ISSUES ADRESSED 2020-2021

Issue	Percentage
SUICIDAL IDIATION/ATTEMPTS	10%
PHYSICAL AGGRESSION	15%
IMPULSE CONTROL	15%
FAMILY CONFLICTS	18%
DEPRESSIVE SYMPTOMS	21%
ANXIETY/STRESS	25%
ACADEMIC STRESS	25%
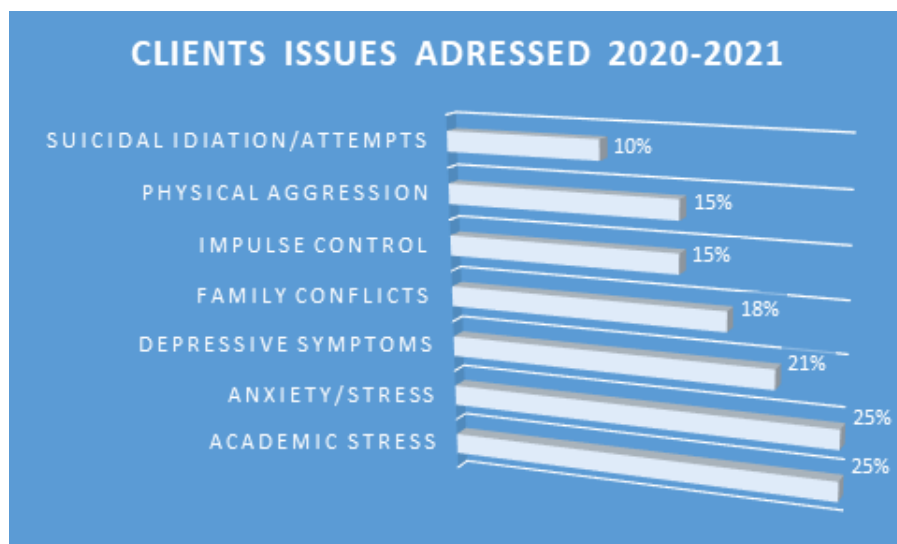
SUCCESSES

Below are two client stories shared by a YMCA High School SSA highlighting work that was done with clients in a virtual online setting during the shelter in place (SIP) that was enacted due to the COVID 19 Pandemic which resulted in the 2020-2021 school year being conducted virtually through distance learning. The highlighted client stories below utilized interventions from the MBSAT curriculum that is part of the First Stop group program as well as other appropriate interventions facilitated by YMCA High School SSAs. The clients were seen individually in a virtual online setting to accommodate needs and adhere to all safety and COVID 19 precautions.

- DG was a 9th grader in high school who was referred for concerns about grades and lack of attendance in the virtual classroom during distance learning due to COVID-19. In check-ins, DG disclosed that he was extremely overwhelmed and stressed out with the overlay of family, work and school responsibilities piling up on him and his family. During the day, he was fully responsible for his younger brother, have to be ready to support his father's food truck business (which was tanking during the lockdown), and maintain a full school load of classes from 8am-3pm with additional hours of homework as well. Because of all of this, he was given a Puff Bar with marijuana from a friend who was attempting to help him with the weight of the stress. DG stated that he eventually came to the point where he was using it and other vaping products regularly and even began selling them to help bring in additional cashflow for his family. DG began to recognize his involvement with these substances as problematic when younger brother would ask to tag along with him, and he would have to refuse in order to keep him from engaging in the selling and distribution. Through the therapeutic work, DG did not decide to stop selling vape and marijuana products but was able to pinpoint the cause of stress, establish a harm reduction schedule, and gain the mental awareness of identifying reactionary behaviors to self-sooth differently when under stress.

- TT was a 9th grader in high school who was referred for concerns of erratic behaviors, a potential assessment for bipolar disorder, and affect discrepancies when discussing recent self-harm and suicidal ideation. In check-ins with the SSA, TT disclosed she had been in multiple relationships since middle school and had suffered a significant amount of emotional and psychological abuse from past boyfriends, peers, and even parents, regarding her weight and self-image. In addition to the regular idolization of self-harm, TT would also obtain ecstasy, vape pens and marijuana products from boyfriends and use them to help stave off food cravings. While parents would regularly discipline once drug products were found, TT would eventually get more by sneaking away with her boyfriends. By engaging in self-exploration and reflection including interventions from the MBSAT curriculum, TT was able to gain awareness to how patterns of continued abuse from self and others stemmed from a sense of unworthiness and failure experienced since elementary school. While treatment did not stymie her continued affect discrepancies, TT was able to make significant changes at times of great motivation and inspiration to move beyond the use of hard drugs and redirect much of her attention to her extremely high 3.8 GPA.outh in the future.

CHALLENGES

Fiscal Year (FY) 2020-2021 was unprecedented since YMCA's services were provided virtually for the entire school year. Since the YMCA High School SSA program relies on being on the campus to allow for walk-ins and immediate interventions when a student is in crisis, the work was restructured as a virtual service. Even though the year before, services had pivoted to a virtual platform. There were more challenges than expected getting referrals and getting engagement in services from the students in the fall of 2020. YMCA staff worked on multiple engagement strategies and were proactive in reaching out to youths struggling in distance learning. Many youths referred to the YMCA were not attending their virtual classes and were already very difficult to engage or non-responsive to outreach strategies.

The First Stop group that utilizes the MBSAT curriculum continued to be the most challenging group to fill due to the difficulty in identifying youths at risk of substance use. They could not rely on referrals from the administration when students were caught with substances on campus. As predicted, there was a decrease in referrals based on behavioral problems due to virtual learning, which reduced the number of First Stop group referrals. Unfortunately, there were no First Stop groups held during the 20-21 academic year due to the lack of substance use-related referrals.

YMCA High School SSAs worked on multiple strategies to outreach to students, teachers, school administrators, and parents. SSAs held drop-in online virtual spaces for parents to learn about services available and facilitate referrals. SSAs attended school staff meetings and school counseling meetings to highlight services and groups. SSAs included "walk-in" opportunities for students in a virtual online setting. SSAs had open office hours, in which SSAs would sit in a zoom room waiting for any student to join. YMCA hoped to provide time for students to interact in the virtual classroom space. The program reported mixed results, believed to be due to zoom fatigue and the ongoing nature of the pandemic. YMCA also ran into some struggles with the school schedule. Some schools were reluctant to have students pulled from virtual class time, wanting YMCA staff to wait until after school to meet with some students. In the previous semester, staff met students after school, but this was not sustainable for what was assumed would be an entire semester.

Challenges with the implementation of Avatar for reporting purposes are also present. YMCA computers and laptops run on an updated Windows platform that is not compatible with Avatar. Solutions include further collaboration with YMCA IT to locate older devices to mitigate any reporting challenges in the future.

Challenges experienced during the 20-21 school year have significantly impacted the program and greatly reduced the number of students referred for substance use on campus. With the return to in-person learning for the 21-22 academic year YMCA High School SSAs are experiencing higher than normal referrals for this time of year. Currently, two First Stop groups utilize the MBSAT curriculum scheduled to begin this month. Due to current guidelines for COVID safety and precautions, smaller groups are being utilized that are running concurrently. Outreach by the YMCA High School SSAs has already begun this school year. SSAs attend school counseling and staff meetings, provide drop-in information sessions online for parents and caregivers and connect with teachers. As mentioned above, YMCA is also working with the schools to incorporate the First Stop group and MBSAT curriculum as an alternative to suspension for students caught with substances on campus.

DEMOGRAPHICS
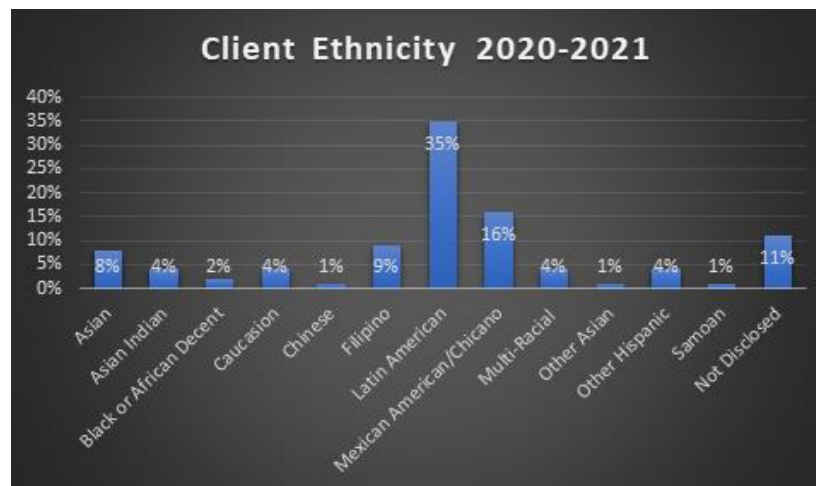
PANACHE BE YOUTH PROJECT

The Latino Commission is the one agency out of the Trauma-Informed Co-Occurring Service for Youth strategy that proposed an alternate culturally relevant intervention/curriculum, The Panche Be Youth Project. The services will still consist of three required components; Group-Based Intervention; Community Engagement; and Social Determinants of Health (SDOH) Screening and Referrals.

The Panche Be Youth Project, which combines El Joven Noble, and Xinachtli programs delivered as an afterschool activity. The Xinachtli program assists teen girls in maintaining self-esteem, self-image and self-confidence to continue on to higher education. It is based on indigenous principals, and provides dialectic process designed to support and build on the strengths of the individual. It incorporates an

educational and organizing process in the development of leadership capacity and personal community responsibility encouraging them to serve as guides for other young women in the community. El Joven Noble program incorporates social-cognitive behavioral skills building activities with culturally sensitive video clips, games, brainstorming, role playing to create group cohesion. The goal is to help prevent young men from participating in gangs, reduce crime, increase numbers of youth attending college, improve prevention and health knowledge.

The Latino Commission will provide two cohorts of group-based interventions per year to an average of eight youth per cohort in North County and Halfmoon Bay. One additional session will be conducted in collaboration with BHRS to present on youth community engagement opportunities.

As of this reporting year, The Latino Commission had not started groups due to the COVID-19 pandemic challenges but, have since started providing services virtually, outcomes will be reported in the next Annual Update

HEALTH AMBASSADOR PROGRAM - YOUTH (HAP-Y)

Health Ambassador Program for Youth (HAP-Y) trains Transitional Age Youth (ages 16-24) to become youth ambassadors. As ambassadors, youth promote awareness of mental health, they educate their community on resources that can be accesses to obtain support and maintain mental health wellness. Having young people talk to other young people will increase the likelihood that their peers in San Mateo County will feel safe in seeking support when needed.

Programming consists of 14 weeks of a psychoeducation curriculum that meets twice/week. To ensure accessibility for youth throughout San Mateo County, each round of HAP-Y is hosted in a different part of San Mateo County, this helps reach a wider geographical representation of youth. Following the training portion, youth have three months to complete three community activities. Youth participate in community activities to educate and engage community members in topics of mental health. Most ambassadors host presentations to educate their peers in topics of mental wellness, other opportunities complete this portion by serving as panelist during panels. To build group cohesion and improve participant retention, HAP-Y programming is hosted two times per week, for 14-weeks, on Monday and Wednesday evenings. Over the last year, all programming has transitioned from in-person to virtual programming. Below is a list of the different training topics of the HAP-Y programming curriculum.

LEADS For Youth - Linking Education and Awareness for Depression and Suicide (LEADS) is an informative and interactive curriculum designed to link schools and educators to conversations about suicide and depression. The LEADS training introduces participants to various mental health terms that reappear throughout the 14 weeks of HAP-Y.

QPR - QPR (Question, Persuade, and Refer) teaches three basic steps anyone can take to prevent suicide. In this two-hour training, participants learn to develop active listening skills and assess for suicide. Afterward, participants will be asked to integrate these skills through role-play and scenarios. Cohort 14 expressed appreciation for the short and straightforward steps to prevent suicide.

LivingWorks Start - LivingWorks is a one-hour online interactive course. Through the course, youth learn to identify signs about suicide, ask about suicide, state that suicide is serious, and connect to resources. Positive feedback for youth, especially about how realistic and relatable the example stories were. Additionally, the youth did feel that those same stories were triggering, and suggested a warning before starting that specific section. The current cohort went through this workshop, and they appreciated that the training was interactive. It included an opportunity for youth to apply suicide intervention in a variety of scenarios to select from, such as texting over the phone, social media, or in-person.

WRAP - Wellness Recovery Action Plan (WRAP) is an 8-week training program in which HAP-Y participants develop an individualized wellness plan. WRAP guidelines do not allow this workshop to be facilitated via online works. For virtual programming, Advanced Level WRAP Facilitator and HAP-Y staff engaged the group in a workshop referred to as Taking Action- Youth Mental Health Recovery Self-Help Educational Program. This workshop has similar guidelines and focuses on self-help and peer support as WRAP. The fall and Winter cohorts were part of this workshop. The summer cohort did not participate in WRAP or Taking Action- Youth Mental Health Recovery Self-Help Educational Program.
Photovoice
Photovoice is a storytelling workshop offered through ODE- it's a way for youth to share empowering stories for themselves and the audience. A Photovoice is a one-page layout with a photo and a short story to go along with the photo. Each cohort spends the last two weeks of HAP-Y working on their own Photovoice project as part of the curriculum. Cohort 11 spent the last night of HAP-Y, sharing their Photovoice
projects. Like past cohorts, the youth found the experience empowering and a positive experience. Below are some direct quotes from participants about their experience with Photovoice.

Additional training topics
- Intro to Mental Health and Stigma
- Brain Development and Medications
- Psychosis, Schizophrenia, Bipolar Disorder, Mood Disorders
- Trauma and Anxiety Disorders
- Substance Use
- Personality Disorders
- Presentation on Advocacy
- Lived Experience Guest Speaker/s

PROGRAM IMPACT

Health Ambassador Program - Youth	FY 20/21
Total clients served	33
Total cost per client	$7,576

In the last fiscal year, 33 youth went through HAP-Y programming in the three cohorts that were hosted. This includes the current group, Cohort 14, who are still going through the training program and will

have their community involvement activities completed by December 2021. Cohort 13 has their deadline for community presentations coming up in July 2021.

As a way to encourage youth to be active mental health advocates in their communities, HAP-Y participants are asked to be involved in three community events to successfully complete the program. This mainly includes conducting presentations in the community where HAP-Y participants aid in educating the community on mental health, suicide prevention, and providing community resources. HAP-Y participants have the option of either conducting these presentations on their own, or with the support of a HAP-Y staff in a classroom setting. One night of the 14-week training is dedicated for presentation preparation. After all community presentations, HAP-Y youth provides the audience with a handout of local resources, and requests that the audience fill out the audience survey. HAP-Y staff provides copies of the audience survey and resource sheet for every presentation conducted, and then reviews the surveys once collected – HAP-Y staff also reaches out to audience members who indicate that they would like a follow up. Since August 2020, ambassadors have reached an audience of 902. Audience survey data is included in the Overall Impact/ Survey Results section of report.

	Number of participants (Start)	Number of participants (End)	Number of participants completed presentations*	Number of presentations
Summer 2020 Cohort 11	14	13	13	32
Fall 2020 Cohort 12	11	11	10	30
Winter 2021 Cohort 13**	14	13	6	12
Summer 2021 Cohort 14**	7	-	-	-

*Number of participants who completed training program and presentations
**Cohort has not yet completed training program and/or community involvement activities

Audience Survey
The first cohort of HAP-Y worked closely with evaluators to create an audience survey that would be administered during community presentations. That audience survey continues to be used by youth during their community presentations. The goal of the survey is to support us in assessing the effectiveness and the impact of the presentations. The survey consists of a 'pre/post' format in which it asks the audience members their knowledge and beliefs before presentation and compares them to their knowledge and beliefs after the presentation- to see if anything changed after having experienced the presentation.

Since August 2020, 930 audience surveys have been administered. Survey results showed an increase in knowledge of available services, after presentations 74% of the audience learned about where to get support if they find themselves emotionally struggling, 72% of the audience could access services that they need, and 69% of the audience learned where to access support during evenings/weekends. There was also a change in ideas and beliefs regarding mental health and people struggling with their mental health, before presentation 48% believed that people with mental health challenges can lead healthy lives, that increased to 69% after the presentation.

In post-presentation part of the survey, 63.86% of audience members said they had an excellent experience with presentation and only 0.15% (one audience member) said their experience with presentation was poor. Additionally, majority of audience members, 55%, shared that the effectiveness of the presentation was excellent.

Exit Survey

To measure impact of programing, HAP-Y staff with support from evaluators, created an Exit Survey that will be completed by youth once they complete the training program and their three community involvement activities. The Exit Survey includes a 'before/after' format to help grasp any change in their ideas/belief on mental health due to their participation in HAP-Y. Additionally, the Exit Survey also asks participants to share their experience with training program, community involvement activities, opportunity for continued engagement, and general feedback on programming. As a way to help youth The Exit Survey has been completed by participants from the fall and winter cohorts. To ensure that youth provide feedback and complete survey, starting with winter cohort, youth will be required to complete Exit Survey before they earn their completion bonus.

"I'm just very thankful for the experience and so glad I was able to be a part of such a bright, welcoming community. I wish I could go back and do it all over again." - Youth from Cohort 11

"I loved the whole experience and how nice everyone was. I learned so much about mental health and it allowed me to practice my presentation and public speaking skills! Thank you so much for this opportunity." - Youth from Cohort 12

Questions on Exit Survey are aimed to capture a change in beliefs and ideas on Mental Health prior and post programming. Through the Exit Survey it was learned that participants comfort in talking about mental health increased, from 50% to 81%, after participating in HAP-Y programming. Additionally, at the end of programming 75% of participants answered that HAP-Y had increased their awareness and understanding of mental health issues. Aside from providing the youth with knowledge and confidence in talking about mental health, HAP-Y gave participants a sense of belonging and community. Before programming only 33% of participants shared that they felt they were part of community, that number increased to 67% post-programming. The majority of participants that completed survey (92%) expressed that HAP-Y gave them knowledge and skills that they continue to use in their life.

"I loved how organized and how well thought out all the lessons were. I learned so much in every class and it was therapeutic for me because it felt like such a safe place." - Youth from Cohort 11

While majority of youth felt that they appreciated and enjoyed the training program as it is, there were some suggestions for improvement: more interactive during virtual workshops, more support around addressing questions during presentations, and a brief study guide at the end of HAP-Y training portion. These considerations will be applied to future cohorts.

Ongoing Participation

With majority of programming in San Mateo County being hosted virtually opportunities for youth to be part engaged and active in advocating for mental health. Since December 2020, three youth worked together to plan and host virtual support groups for hap-y participants. The ambassadors worked on planning and facilitating the groups with the guidance of One New Heartbeat staff. During these groups, youth have facilitated discussions around confidence, self-care, history of Pride Month, among others. Moving forward, these groups will be open to youth through San Mateo County who are seeking a sense of community and support.

In honor of May-Mental Health Month, HAP-Y hosted two events: Youth Led Panel Discussion and *Si Se Puede!* (Spanish presentation). From March-May 2021, a couple of hap-y youth met with HAP-Y staff to plan a Youth Led Panel Discussion: Changing the stigma. As part of this event, youth prepared and delivered presentation highlighting facts and misconceptions around mental health and suicide. Following that conversation, 5 youth were part of a panel in which they took turns answering questions regarding their experience with mental health challenges, getting support, and how their relationships have been affected as they worked towards healing and recovery.

For Spanish presentation, HAP-Y partnered with OneLife Counseling, to host a presentation to engage Spanish-speaking youth through San Mateo County. Though attendance was low, the two presenters were glad to have had the opportunity to host a Spanish presentation and are eager to do future Spanish presentations.

Additionally, a handful of HAP-Y participants worked with StarVista's marketing department to create a blog post for Mental Health Month. As part of the blog, the youth created a toolkit in which they shared vocabulary, wellness tips and routines, book/movies/show recommendations, and resources that they believed to be important to support their mental wellness. On a similar project, a HAP-Y participant was featured as a Spotlight on StarVista's blog.

HAP-Y participants collaborated with youth from other SMC organizations to increase Youth Vaccine Outreach and encourage young people throughout the county to get vaccinated before the start of school year. HAP-Y youth supported this effort by planning and hosting a Youth Vaccine Town Hall in which youth talked about their experience with getting vaccinated: why they decided to get vaccinated, how was it getting vaccinated, and address any hesitations they might have experienced around getting vaccinated.

SUCCESSES

HAP-Y was able to transition into virtual programming smoothly. The Fall and Winter cohorts had more youth start and complete programming than in-person programing. One reason for this may be the accessibility to joining meetings virtually and not stress over finding transportation.

For the first time, youth could plan and host an event for county-wide Mental Health Awareness Month efforts with the Office of Diversity and Equity. Two separate groups, made up of HAP-Y youth, were involved in these projects.

CHALLENGES

A big challenge that HAP-Y staff encountered was outreach for the summer training session. To engage and provide a safe space to youth who identify as LGBTQ+, the summer cohort was LGBTQ+- focused cohort. Another challenge that arose was the limited presentation opportunities for participants to conduct their presentations.

DEMOGRAPHICS

AGE

During the 2020-2021, 14 participants reported they were 16 years old, and 19 participants reported they were between the ages of 17-24.

■ 58% of youth were between the ages of 17-24

■ 44% of youth were 16 years old

42%

58%

RACE

6% 3% 3%

18%

18%

52%

- 52% Hispanic /Latinx/o/a
- 18% Asian
- 18% White/Caucasian
- 6% Black or African American
- 3% American Indian/Alaskan
- 3% Native Hawaiian/Pacific Islander
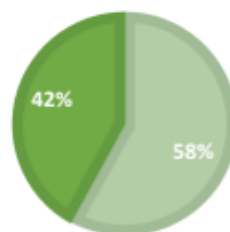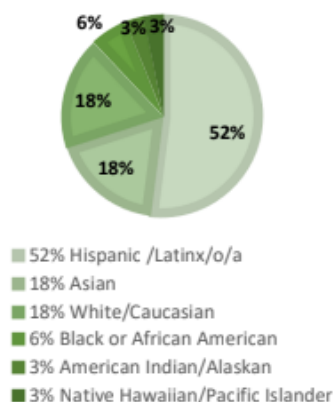
Of the 33 participants, 17 reported they were Hispanic/Latinx/o/a; 6 youth reported their race as Asian; 6 youth reported White or Caucasian; 2 youth reported Black or African American; 1 youth reported American Indian/Alaskan; 1 youth reported Native Hawaiian or Pacific Islander.

ETHNICITY

Of the 33 participants, 2 reported Central American as their ethnicity; 4 reported South American; 2 reported other White/German/Native American; 2 reported Chinese, one reported Asian Indian/south Asian; 1 youth reported Filipino; 1 youth reported Caribbean; and 5 youth did not respond to this question.

3% 15%

6%

6%

6%

6%

46%

12%

- 45% Mexican/ Mexican American/ Chicanax/a/o
- 12% South American
- 6% Central American
- 6% White/German/Native American
- 6% Chinese
- 6% Asian Indian/South Asian
- 3% Filipino
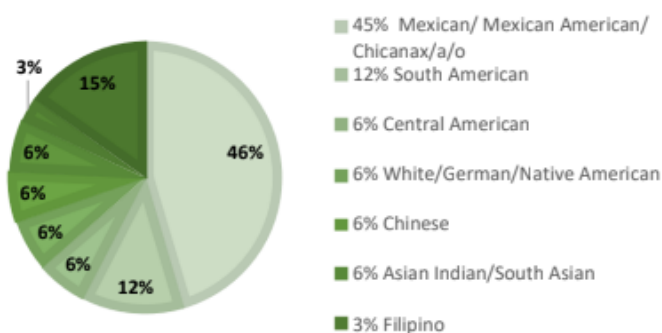
PEI AGES 0-25: EARLY CRISIS INTERVENTIONS

TRAUMA INFORMED 0-5 SYSTEMS

Acknowledgement of the lasting impact of adverse childhood experiences and movement towards providing trauma-informed care has been building for the last decade or more. It is now reaching a tipping point, with many leaders and practitioners from across sectors, including health, education, social welfare, housing, criminal justice, and others, recognizing that their clients and staff are experiencing or encountering trauma regularly. State funding and prioritization of trauma-related work is evident in the passage of AB 340 in 2017 to mandate trauma screening for children on Medi-Cal, and the appointment of Dr. Nadine Burke-Harris, a pioneer in childhood trauma work, as the first California Surgeon General. There is tremendous energy and interest around trauma-informed practices locally. With funding support from San Mateo County Health MHSA as well as additional support from Sequoia Healthcare District, First 5 San Mateo County (F5SMC) has launched a multi-sector initiative to

transform service delivery for young children and their families. The Trauma- and Resiliency-Informed Systems Initiative (TRISI) is a countywide effort to integrate a comprehensive commitment to address trauma and promote resiliency into local programs, structures, and culture with a long-term goal of embedding trauma- and resiliency-informed policies and practices at every level of the system.

The strategies and targets for the Initiative include:
1. Training and support for child- and family-serving organizations to imbed trauma-informed practices in their internal operations,
2. Training and resources on trauma-informed practices for professionals working with children and families, and
3. Education for parents to help recognize the signs and symptoms of trauma

Through an extensive planning process with cross-sector partners, the Initiative has established the following areas of focus:

1. Systems Strengthening: Focused on system leaders, organizational leaders, policymakers
   - Activities include:
     - Coordination with other local, regional, and statewide efforts
     - Promoting common language/ approach
     - Policy and resource advocacy

2. Practice Improvement: Focused on organizational leaders, managers, all staff
   - Activities include:
     - Online trauma and resilience resources
     - Trauma trainings and learning cohorts
     - Trauma-informed organization assessment support
     - Trauma-informed organization implementation support

3. Initiative Evaluation: To measure if organizations have become more trauma- and resiliency-informed based on the Trauma-Informed Organizations Developmental Framework

Progress to date includes:
- *Online Resource Hub*: Development of a local online resource hub targeted at providers and other interested community members;
- *Market Assessment Survey*: Creation, dissemination, and analysis of an online Market Assessment Survey designed to gauge the interest of local stakeholders in family-serving organizations in trauma-informed training and stages of organizational readiness;
- *Countywide Trauma Convening*: Hosting of a full-day Culture of Care Convening focused on supporting trauma-informed organizational practices for child- and family-serving organizations attended by over 150 individuals and 40+ agencies
- *Organizational Assessment Tool**: Identification of an organizational assessment tool to determine stages of readiness and areas for growth for child- and family-focused organizations interested in furthering their TIO practices; outreach/ education to publicize the

tool; linkage and support for completing the tool and disseminating results internally

- *Trauma-Informed Organization Cohorts and Coaching*:* Support the deepening of TIO practices for organizations by offering ongoing training, support, and action plans through group work in cohorts and specific agency-focused goals through coaching

*Activities have taken place within the current funding term.

PROGRAM IMPACT

Trauma-Informed 0-5 Systems	FY 20/21
Total clients served	354
Total cost per client	$424

Though not explicitly focused on the outcomes referenced above, by focusing efforts on providers and the agencies within which they work, TRISI helps to support such results. For instance, supporting and enabling providers to acknowledge that they experience stress and secondary trauma inevitably helps reduce stigma and discrimination around these issues for providers and those they serve.

The common thread for agencies involved in TRISI focuses on underserved populations within San Mateo County. The nine agencies that opted to complete the TIO Assessments in the first round of implementation include those focusing on food insecurity, domestic violence, low-income mothers and children, publicly insured residents with mental health needs, and individuals with developmental disabilities. These agencies have made it their work to meet the needs of underserved populations explicitly, and the assessment, cohort, and coaching work supports greater awareness of, sensitivity to, and deepening of quality service delivery for these agencies and their clients.

Agency-wide efforts to better understand and implement trauma-informed practices ideally lead to reduced burnout for staff and more effective and high-quality services delivery for clients. Strategies like reflective practice, which allow client-focused staff to increase awareness of and explore their triggers and biases, lead to decreases in the incidence of discrimination and a reduction in disparities that can influence access to care.

As noted previously, for the purposes of this project, the "clients" served are, most directly, the staff and providers working within the target agencies that serve children and families in San Mateo County. In this context, the MHSA Intended Outcomes would be sought for providers within the community who work to serve the public. While the TIO Assessment Tool does not ask particular questions about the mental health status or outcomes of agency staff, the overarching intention of building a community of trauma-informed organizations is consistent with supporting positive mental health practices and outcomes for staff of child and family serving organizations.

The data gathered from 346 staff participants within seven of the eight agencies that completed the TIO Assessment Tool and the subsequent analysis is included in the Report Attachment. The data from the eighth agency to complete the assessment was not yet available at the time this analysis was run.

SUCCESSES

TIO Assessment Tool: During the funding term, one of the greatest successes of TRISI was the rollout of the TIO Assessment Tool, completed by eight organizations and over 350 individual participants. It is conceivably the largest combined dataset collected of its kind. There is the intention to share the aggregate data broadly after the conclusion of the cohort and coaching components of the work, both locally and potentially at the state and national levels, to share the learnings.

Additionally, the TIO Assessments were conducted during a global pandemic, with such success adding to the significance of this achievement. All told, the implementation of the first round of TIO Assessments establishes a solid proof-of-concept that illustrates both the interest in and value of the results to support continued organizational growth in this area.

Cohorts: Two TIO cohorts commenced in May of 2021, with six agencies participating and 24 individual participants in total. The cohorts will run through January of 2022.

The cohort model has been successful on numerous levels. First, relationships among people within each organization have deepened as they formed implementation teams to continue the work. They are also building relationships between and among people from other organizations and agencies, which has helped with cross-sector collaboration, learning from and with each other. Sharing experiences and ideas give participants practical and useful information, skills, and practices to apply to their workplace. In a survey to which 11 participants responded, they expressed a desire for more time hearing from others, and have made changes to the meeting structure to allow for that.

The cohort meetings also create space for participants to share their own lived experiences with trauma and secondary trauma. They have realized that secondary trauma is not just something they have to deal with but that their agencies and organizations can take proactive steps to help staff process and heal from secondary trauma. Ultimately, this may positively impact burnout, toxic stress, well-being, and turnover as participating agencies take steps to implement ways to support those with stress and trauma.

As learning has progressed and relationships have deepened, participants can be asked to bring their expertise to the cohorts as presenters. For example, a learning is that in coalition work, it is essential to include clients – people with trauma who have gone through the system – so that their lived experiences can inform change and decision-making. One cohort participant mentioned she was hired to do this very thing, and she is willing to share what she's learned with other cohort members at the next meeting. This kind of volunteerism would not happen without their commitment to meet regularly, share openly and honestly, and deeply listen to each other. Interactions are progressing in ways that equalize the distribution of power and elicit the wisdom of group members.

CHALLENGES

TIO Assessment Tool: While there have been many successes with the rollout of the TIO Assessment Tool as a first step to supporting organizations to understand the experiences of staff and use the information to inform practice, there are also opportunities for learning and growth.

The TIO Assessment opportunity was rolled out with specific recommendations for agencies in order to help the process itself be as trauma-informed as possible. These recommendations included suggestions such as developing an internal implementation team to support the rollout and subsequent activities. As a result, for agencies that may already have had limited bandwidth for staff during COVID and in general, these practices may have resulted in fewer agencies signing on to participate in the TIO Assessment. Efforts were made to mitigate these barriers by supports offered by First 5 SMC staff and consultants,

although these supports were only accessible to those who took the step to initiate interest either by attending an info session or by signing up.

For some larger organizations who did sign on to complete the TIO Assessment, participation rates were lower than desired. This appears to be related to the buy-in from the executive leadership and/or upper management within the agency, since participation rates were higher for those agencies where leadership was directly involved in sending communications about completing the TIO Assessment. In agencies where this wasn't the case and communications may have come from those with less authority or not directly within the chain of command for many staff, this was a barrier.

Cohorts: Turnover within participating organizations creates a challenge. Within the first 3 months of the cohort meetings, 3 of the 26 participants left. Some of those slots remain vacant, while others have been filled with new people. This has required some catch-up and relationship building. However, the intention of agencies to replace people who leave demonstrates an understanding of the importance of the work and the need to have as many people engaged as possible.

Some participants are feeling overwhelmed with the work involved in cohort participation, although there has been intention around limiting the time and content shared. Consultants have validated this and supported participants to do what they can, when they can, and that it's important to keep plugging along even if they cannot do everything. Small changes can make great differences.

From the facilitative standpoint, there is also a feeling that two hours of in-person time a month is not enough for cohort meetings, though there is acknowledgement that this is what is reasonable to expect, given the demands on people's time. The work of becoming a trauma-informed organization is extensive, and people doing the work need support and guidance. Using the feedback from the survey, the consultants shifted the format to allow for more discussion time during the in-person sessions and converted live presentations to recordings.

YOUTH CRISIS RESPONSE & PREVENTION

The Crisis Intervention & Suicide Prevention Center (CISPC) has multiple components with the sole purpose of providing crisis and suicide support to all ages of the San Mateo County community including a 24/7 Crisis Hotline, outreach and training, and mental health services.

CISPC provides the only 24/7 crisis intervention and suicide prevention hotline in San Mateo County. As such, it works extensively with community partners to ensure callers receive support and services that wholly meet their needs. CISPC's range of mental health services are culturally sensitive and offered free of charge across multiple platforms to address and prevent health disparities and promote health equity across San Mateo County. Callers accessing services receive a rage of interventions; brief, emotional support through active engagement and collaboration with lifesaving, emergency services. CISPC also frequently refers hotline callers and other CISPC clients to other StarVista programs (e.g., Daybreak for transitional housing, Insights for co-occurring mental health and substance use challenges, etc.) or outside community resources for additional services needed depending on the caller's needs.

This Crisis Intervention and Suicide prevention center also provides teen crisis services through chat and texting services. Teens can chat anonymously with trained youth peer counselors under Crisis Center staff supervision about various topics. While mainly focused on crisis intervention and suicide prevention, teens can also talk about school stress, relationship issues, and mental health challenges.

While the program is intended to focus on youth ages 13 and up, no youth will be turned away because of age.

To ensure children, youth and their parents/caregivers have the support and resources they need, CISPC also collaborates heavily with schools and tailors its services to each school's unique needs. In the coming months, the Crisis Intervention and Suicide prevention center will expand its services to youth and families in crisis through the Youth Stabilization Opportunity and Support Program (Youth SOS). This team, formerly known as YIT, which Youth Intervention Team, which provides support to schools during crisis. This mobile crisis response team will also respond to the state-wide crisis program for current and former foster youth, as well as their caregivers through the Family Urgent Response System (FURS) program.

StarVista's Crisis Intervention and Suicide Prevention Center program offers educational presentations geared toward students (parent and educator versions also available) covering topics such as depression, anxiety, coping skills, stress, help-seeking, and suicide prevention. The purpose of the program is to increase knowledge, reduce stigma, and increase help-seeking behaviors in youth. Presenters distribute community resources and discuss school resources, providing means to access confidential and flexible mental health and crisis support.

PROGRAM IMPACT

Crisis Intervention & Suicide Prevention	FY 20/21
Total clients served	15,694
Total cost per client	$22

Cost of services include youth interventions, crisis hotline response and outreach

The program diverted 100% of youth from suicide and all youth received counseling and/or referrals to ongoing services. Additional outcomes are listed in the table below.

PROGRAM OUTCOMES	
	total
% of youth seen by Crisis Staff who are diverted from suicide	100%
% of youth seeking crisis counseling that receive it	100%
% of individuals seeking crisis counseling that received counseling or referrals	100%
% of youth who score 100% on outreach presentations	93%
CRISIS HOTLINE	
	total
total number of calls	12476
% of calls related to covid-19	17%
average length of call	14 min
CASE MANAGEMENT/FOLLOW UP	
	total

total number of follow ups requests	55
total number of sessions provided	90
total number of in-person ADULT crisis response	7
TEEN CRISIS SERVICES	
	total
number of individual chats	163
total site views	10565
YOUTH INTERVENTIONS	
	total
number of initial interventions	4
number of follow up sessions with youth	219
number of follow up sessions with collateral contacts	46
SCHOOL AND COMMUNITY PRESENTATIONS	
	total
total number of presentations	151
number of adults served	794
number of youth served	2067
number of youth requesting follow-up after presentation	0
CLINICAL TRAINING/SUPERVISION	
	total
total number of phone consultations (community provider, school provider)	27
training hours provided (including preparation time)	288
number of trainings attended	44

Improves timely access & linkages for underserved populations:
CISPC staff provides connection and linkages to other StarVista programs as well as outside partners. Callers will receive resources and referrals from crisis phone counselors upon request.

Reduces stigma and discrimination:
Each presentation collects a pre and post survey from participants. In these surveys, participants are asked to identify their improved knowledge and awareness of suicide intervention and prevention. For example, that it is okay to ask others about suicide.

Increases number of individuals receiving public health services:
All individuals who attend presentation are invited to receive follow up services from presenter, or other staff member on CISPC team to support connecting to needed services upon request.

SUCCESSES

Mary* attended a virtual school presentation on suicide awareness, education, and prevention through her middle school this year. She was quiet throughout the virtual presentation but responded to all the

presenter's question through the chat feature. During the Q&A, Mary asked several questions about how to best support a sibling that may be thinking about suicide. After some time, she gathered the courage to share with the group that she knows her sister has been struggling with her mental health for a while. Not knowing the best ways to help and support her sister has been difficult for Mary. Mary shared her appreciation for the presentation and shared that she had learned new ways to talk to her sister. After the presentation, Mary requested to speak with the Crisis Center presenter further. During this meeting Mary was very open and shared more about her sister's challenges. The presenter offered additional resources, including the teen chat, where Mary could express her feelings and learn about other ways to support her sister. The Crisis Center team have praised Mary for her bravery and vulnerability to come forward during an educational presentation and share the struggles her and her sister are going through.

Teen Crisis Services:

Ari*, who was seeking support to manage a difficult relationship with their mother and father, began utilizing the texting service. Ari explained to the youth counselor that they have not disclosed to their parents that they identify as non-binary. The youth counselor validated Ari's experiences and provided a non-judgmental space for this chatter to discuss what being non-binary meant to them. Ari and the youth counselor discussed additional resources that might be helpful to Ari – such as the Trevor Project and other counseling services in the county. Ari stated they would text or chat at a later time and was thankful for the services provided. This innovative new youth texting service will expand the services of the online teen chat and increase accessibility to mental health resources for youth in the community.

Names changed to protect confidentiality.

CHALLENGES

The Crisis Center has faced challenges with recruiting, providing training and retaining volunteers. Crisis Center's one-on-one live chat sessions for youth are conducted by youth volunteers; however, due to shelter-in-place regulations and the lack of appropriate technology to train and supervise volunteers from home, the Crisis Center had to place its youth volunteer program on hold. We believe in the power and need for peer-based services and staff worked quickly to acquire the appropriate technology and training for youth to continue operating this service. These new technologies provide the possibility for staff and volunteers to work remotely. With the launching of 988, this ability to respond to callers in remote capacity will become more important and a critical aspect of addressing the expected 30% increase in calls.

DEMOGRAPHICS

	FY 20/21
Age	
0-15	0%
16-25	2%
26-59	6%
60+	4%
Primary Language	
English	35%

Spanish	0.5%
Mandarin	0.04%
Tagalog	0.8%
Russian	0.03%
Another language	0.22%
Sex Assigned at birth	
Male	0%
Female	0%
Race/Ethnicity	
Mexican/Chicano	0.35%
Black/African/-American	0.98%
White/Caucasian	5%
Asian	5%
Asian Indian/South Asian	0.36%
Another race/ethnicity	4.68%

EARLY INTERVENTION:

EARLY CRISIS INTERVENTIONS

SAN MATEO MENTAL HEALTH AND REFERRAL TEAM (SMART)

The SMART program is to provide San Mateo County's residents with a comprehensive assessment in the field and offer an alternative to Psychiatric Emergency Services when appropriate; or if needed to write a hold status and provide secure transportation to the hospital. SMART serve any resident in psychiatric crisis regardless of age as identified by Law Enforcement. Primary program activities include consultation to law enforcement on scene. SMART can write a 5150 hold if needed and transport the person. If the individual does not meet the 5150 criteria the SMART medic can provide support and transportation to an alternate destination, i.e. crisis residential facility, doctor's office, detox, shelter, home, etc.

PROGRAM IMPACT

The highest volume of calls for SMART response is Thursday through Saturdays. The goals of the program include:

- To divert 10 % of calls where a 5150 was not already placed.
- To respond to 75% of appropriate calls for service.

SMART evaluates people in the field and able to connect people to behavioral health services that would otherwise not have occurred. Being able to transport people right on the spot to the appropriate services has increased connectivity and treatment for many people. Many people are more likely to be forthcoming with a psychologically trained medic about what is going on than law enforcement.

SMART Medics are able to evaluate both physical and mental health issues including suicidal ideation and direct people to the appropriate resources. SMART responds to many people under 18 who are in crisis. By addressing the youth's concerns and getting supportive and protective factors in place the youth is much more likely to remain in school. Getting supportive services to the youth's family helps the family unit to stay intact. SMART refers parents to services, so they can provide for their children.

SMART responds to many homeless severely mentally ill adults. By getting them evaluated and getting the right level of medications and placements this assist in reducing homelessness.

SMART	FY 20/21
Total calls received	2615
Total cost per client	$56

EARLY INTERVENTION: EARLY ONSET OF PSYCHOTIC DISORDERS

EARLY PSYCHOSIS PROGRAM- (RE)MIND

The (re)MIND® (formerly PREP) program is a coordinated specialty care model for prevention and early intervention of severe mental illness that specializes in early intervention for schizophrenia spectrum disorders. The BEAM program is an expansion on the (re)MIND® model and specializes in the early intervention of bipolar and affective psychoses. (re)MIND® and BEAM delivers comprehensive assessment and treatment grounded in wellness, recovery and resilience to youth and young adults experiencing early symptoms of psychosis with evidence-based and culturally responsive interventions. The (re)MIND/BEAM aftercare program – (re)MIND® Alumni – was developed to provide program graduates and caregivers with a specialized safety net to sustain gains achieved.

- The (re)MIND® and BEAM programs serve the following regardless of insurance status:
- Residents of San Mateo County -and-
- Between the ages of 14 and 35 -and-
- Identified as being at risk for the development of psychosis (having subthreshold symptoms that do not meet justification for a diagnosis OR having a first degree relative with a history of psychosis AND a recent significant decline in age-appropriate functioning) -or-
- Have developed symptoms of psychosis or bipolar disorder for the first time in the past two years

In addition, (re)MIND® Alumni serves individuals who have graduated from (re)MIND/BEAM and elect to receive active support to maintain engagement in educational or vocational activities, and further

develop skills to self-navigate community resources. (re)MIND® and BEAM provide a wide array of services designed to wrap around the individual and their family members involved in treatment. Services start with an outreach and education campaign that helps members of the community and providers detect early warning signs and reduce the stigma associated with psychosis. Once a youth or young adult has been identified and referred to the program, they receive a comprehensive, research-validated diagnostic assessment to determine their diagnosis with high degree of accuracy and their eligibility for early intervention services. Following assessment, individuals participate in assessment feedback session(s) where they receive psychoeducation on diagnosis and treatment options.

Besides early diagnosis, program services include:

- Cognitive Behavioral Therapy for Psychosis (CBTp)
- Algorithm-guided medication management
- Individual peer and family support services
- Psychoeducational Multifamily Groups (MFG)
- Supported Employment and Education using the Individual Placement and Support (IPS) model
- Strength-based care management
- Community-building activities such as program orientation for new participants and their families

PROGRAM IMPACT

RE(MIND)	FY 20/21
Total clients served	68
Total cost per client	$12,289

The outcome data for all individuals served by the program advances a number of MHSA Intended Outcomes. In particular:

1) Reduction in duration of untreated mental illness (through access to specialized treatment close to onset of symptoms)
2) Prevention of mental illness from becoming severe and disabling (reduction in hospitalization episodes and days hospitalized)
3) Reducing negative outcomes that may result from untreated mental illness such as decrease in prolonged suffering, risk of suicide, school failure or dropout, and unemployment.

Data Collection and Reporting Methods
Program outcome data includes several elements used for direct reporting on program utilization (such as demographic data), as well as outcome measures such as medication adherence, symptom reduction, client satisfaction, and successful engagement in school and/or work.

For example:
- Demographic data collected in CIRCE (Felton's EHR).

- Hospitalization data collected via county database (AVATAR) and external hospital records that are tracked through CIRCE.
- Symptom reduction data was determined using the Adult Needs and Strengths Assessment (ANSA). The ANSA is an annual measure used by the clinicians to evaluate the needs and strengths of individual participants at enrollment, annually, and at discharge. The ANSA is scored on the following 4-point scale:
    - 0 = No Problem/Not Present
    - 1 = Mild Problem/History
    - 2 = Moderate Problem
    - 3= Severe Problem
- California Department of Health Care Services Consumer Perception Survey was used to determine participants service satisfaction and quality of life. This survey is collected semi-annually as part of a statewide effort to incorporate participant and family feedback into services and results are made available after data is independently processed and analyzed.
- Supportive Employment and Education Services (SEES) staff utilize an internal tracker to provide current education and employment data for participants. SEES staff work with program manager to update excel spreadsheets and CIRCE in real time on a monthly basis.

The (re)MIND® and BEAM Programs served 68 youth and young adults during FY 20/21 achieving the following outcomes:

MHSA Intended Outcomes: Preventing mental illness from becoming severe and disabling & reducing negative outcomes that result from life-disrupting hospitalizations (i.e. disruptions in employment and education).

Objective: Reduce Number Inpatient Hospitalization Episodes by at least 50%
- Exceeded - - There were 38 participants enrolled for at least 12 months in FY 20/21. Out of 16 participants with prior hospitalizations within 12 months of enrollment, 15 (94%) experienced a reduction in acute hospitalization episodes as a result of their engagement into early psychosis services. In addition, out of 22 participants with no prior hospitalization history, 18 (82%) continued to have no hospitalizations as a result of their engagement into early psychosis services. This highlights the importance of early intervention for psychosis in preventing mental illness from becoming severe and disabling.

Objective: Reduce Number of Days Hospitalized by at least 50%
- Exceeded - There were 38 participants enrolled for at least 12 months in FY 20/21. Out of 16 participants with prior hospitalizations within 12 months of enrollment, 15 (94%) experienced a reduction in days hospitalized as a result of their engagement into early psychosis services.

MHSA Intended Outcome: Preventing mental illness from becoming severe and disabling & reducing negative outcomes such as school failure/dropout and unemployment.

Objective: Promote satisfactory participation in school, vocational training, volunteering and/or employment activities for at least 75% of program participants

- Not Met (partially achieved) - There were 68 participants enrolled into full program services in FY 20/21. Out of the 68 participants enrolled, 49 (72%) were engaged in personally meaningful part-time or full-time school or work as a result of their engagement into early psychosis services. Due to the challenges with the closing of schools and workplaces during the COVID-19 pandemic, this is an exceptional outcome in extraordinary times.

Objective: Improve the quality of engagement in employment and education activities, 40% of participants will be engaged in new levels of employments or education.
- Exceeded - There were 38 participants enrolled for at least 12 months in FY 20/21. Of these 38 participants, 34 (89%) achieved new levels of employment or education.

MHSA Intended Outcomes: Reducing the duration of untreated mental illness, preventing mental illness from becoming severe and disabling & reducing negative outcomes such as prolonged suffering, school failure/dropout, unemployment, and suicide

Objective: At least 70% of Aftercare Program - (re)MIND® Alumni - participants will sustain improvements on CANS/ANSA domains of Psychosis, Education, and/or Employment.
- Not Met (partially achieved) - Initial and most recent annual CANS/ANSAs were used to evaluate maintenance of improvements on the domains of symptoms, education, and employment for 11 (re)MIND® Alumni participants. Out of 11 individuals, 7 (64%) demonstrated maintenance of improvements with ratings of 1 or lower. Of the 4 clients who did not maintain their scores, all of them had increase in symptoms of depression/anxiety, which is actively being addressed in treatment.

Objective: At least 80% of program participants will stay at current or lower level of care.
- Exceeded - Of the 68 participants served during FY 20/21, 60 (88%) maintained their placement at home or in a lower level of care because of their engagement in early psychosis services.

MHSA Intended Outcomes: Preventing mental illness from becoming severe and disabling & reducing negative outcomes such as prolonged suffering, school failure/dropout, unemployment, and suicide

Objective: At least 90% of participants will report satisfaction with services.
- Unable to evaluate - The semi-annual California Department of Health Care Services Consumer Perception Surveys are typically used to evaluate service satisfaction, but were cancelled due to COVID-19. Due to COVID-19 Shelter-in-Place Order, the May 2021 survey period was conducted directly by San Mateo County Behavioral Health and Recovery Services collecting mail-in responses and the program has not received survey results in time to add them to this report.

Objective: At least 75% of participants will report that they can handle daily life.
- Unable to evaluate - The semi-annual California Department of Health Care Services Consumer Perception Survey are typically used to evaluate service satisfaction, but were cancelled due to COVID-19. Due to COVID-19 Shelter-in-Place Order, the May 2021 survey period was conducted directly by San Mateo County Behavioral Health and Recovery Services collecting mail-in responses and the program has not received survey results in time to add them to this report.

Objective: Provide Opportunities for current participants/families to engage with Alumni to enhance mentorship and hope.

- Not Met - FY 20/21 was conducted exclusively under the COVID-19 Shelter-in-Place Order. The 16 individuals were served through (re)MIND® Alumni received direct care through individual meetings with youth/young adults and families. Group sessions were on hold during this period. All alumni and families were invited to the virtual Open House hosted in May 2021, and a digital Alumni graduation ceremony was conducted

Improves timely access & linkages for underserved populations

(re)MIND® and BEAM are stepped models of care programs designed to detect signs and risk states for severe mental illness at the earliest possible stages. Program eligibility includes individuals at risk for developing severe mental illness (prevention) and those with a recent onset of symptoms (early intervention). This allows program staff to intervene as early as possible, limiting the duration of untreated mental illness and preventing symptoms from worsening by working with the individual and their family toward a path of recovery and ultimately illness remission. State timely access standards are upheld with all clients to expedite intake and services.

Reduce stigma and discrimination

An important function of the program is to equip mental health providers and the community at large to identify early warning signs of psychosis. This function is provided by program staff through targeted community outreach and educational presentations. As a result of these activities, two major goals are achieved: 1) The importance of early intervention in preventing severe mental illness from limiting an individual's potential to achieve their hopes and dreams, and 2) The community broadens their understanding of psychotic experiences existing in a continuum of common human experiences rather than limited to a pathological condition. Due to the COVID-19 shelter-in-place order, their outreach programming was adapted to a digital format through didactic training, community presentations, and open house meet-and-greets over telehealth platforms. Their number of individual outreaches decreased, but participation in community-sponsored committees like Diversity and Equity Council and School-Based Initiatives increased to spread their message further, reducing stigma and discrimination digitally.

Increases number of individuals receiving public health services

(re)MIND® and BEAM work with public partners such as the BHRS YTAC network to support youth transitioning out of high school-based services and otherwise lose contact with the public mental health system. Through these partnerships, youth maintain a safety net within the mental health system until they can access public benefits and get the necessary services directly. This results in a seamless care continuum that benefits the youth and family in need of services and helps to ensure that youth in transition to adulthood do not fall through the cracks.

Reduce disparities in access to care

Prevention and early intervention services for psychosis are not yet widely available, and those in need of these services commonly experience some barriers. One such barrier addressed by the (re)MIND® and BEAM programs is that insurance status is not a factor for accessing care. This eliminates barriers to

specialized treatment at the earliest point in time possible. Another barrier commonly experienced by this population can be access to reliable and safe transportation. The program addresses this barrier with services offered in the community at conveniently accessible locations for program participants. During the COVID-19 shelter-in-place order, the program expanded digital options for accessing care, including phone and telehealth services. The program applied for grant funding to help clients access needed technology and services to access care. Clients had the opportunity to use staff support to set up cell phone plans and data networks and access donated tablets to help them better access care equitably.

Implements recovery principles
At (re)MIND®/BEAM, the power of the participant's goals, dreams, and aspirations guide and drive treatment. The participant's multidisciplinary team uses a holistic, strength-based approach to instill hope, empower the participant's voice, and identify their goals to develop a plan centered around them. Program participants are recognized as having subject-matter expertise about themselves and are an active and central part of their treatment team.

SUCCESSES

Each of the evidence-based practices that are implemented in the (re)MIND® and BEAM Programs are widely adopted as the standard of care for early psychosis coordinated specialty care models. It is not an exaggeration to suggest that each of these interventions are worth noting and taking special pride in as they are effective at contributing to the mutual goals of the programs and the mental health system such as;

- Better family and social connectedness
- Improved engagement in education and employment with a focus on developing a career
- Decrease prolonged suffering with reduction in symptom frequency, severity, duration, and distress
- Preventing mental illness from becoming disabling through reduction in hospitalizations and days hospitalized

Cognitive Behavioral Therapy for Psychosis: A core intervention within the (re)MIND® program is supported by evidence and has demonstrated effectiveness in reducing symptoms (79% reduction this year for individuals enrolled 12 months or more, as recorded utilizing CANS/ANSA domain of psychosis), improving insight and awareness about symptoms, and ultimately setting the therapeutic foundation to maintain remission over time.

Supported Employment and Education Services (SEES): Employment and education outcomes are a central focus each year and it is generally expected by program staff that these outcomes shine. It is not uncommon for staff to see participants that have dropped out of school return and eventually graduate, even transitioning to 4-year universities.
Aftercare Services: FY20/21 marks the second year for the (re)MIND®/BEAM San Mateo aftercare services, (re)MIND® Alumni, which provides ongoing care and support for program participants and

family members who have completed the program and would benefit from additional safety net services as they journey forward into their recovery. The expansion into aftercare services creates an avenue for (re)MIND® and BEAM to further cement the successes and gains that the participants have achieved during their time in the program, setting the stage for sustained recovery, and allows for additional outcome data collection to demonstrate the success of prevention and early intervention services. (re)MIND® Alumni had the pleasure of serving 11 individuals in the program's second year.

Since the Shelter-in-Place Order, staff has worked tirelessly to help clients access quality care safely and securely. This success centers around staff and client resilience in the face of continued uncertainty and being able to provide a safe space for healing. 94% of established clients had a reduction in their hospitalization days and 88% were able to maintain 0 days hospitalized during this period new routines were established with clients, including supporting clients in finding new meaningful activities at home.

Client Success Story: The individual whose story is recounted here is in their first 6 months of treatment, and has already started to make huge changes towards positive community engagement and increasing functioning. This individual came to the program as an emerging adult, having just been hospitalized, and had gone to jail after a manic episode. They were struggling to function (academically, at work, and socially) due to their symptoms. They had been all over the state trying to make music and start businesses, had had a traumatic experience on a trip with friends, and became addicted to several substances before ending up in jail. The participant started and remained engaged with their treatment team (therapist, supported employment and education specialist, peer support specialist, and psychiatric nurse practitioner). As a result of their engagement in services they have gotten back to a regular routine including exercising, making music, and being able to reach out to and meet with friends in a way they had not in years.

CHALLENGES

The biggest challenge experienced by the (re)MIND®/BEAM and (re)MIND® Alumni programs in FY 20/21 were the same challenges experienced systemically, responding to the complexities of operating in the context of a pandemic. COVID-19 and the resulting Shelter-in-Place Order had potential to create a serious negative impact on service accessibility and engagement, participants' well-being and outcomes, and staff's health and wellness among other impacts. Program staff had the challenge of integrating frequent updates (especially technologically), new policies, and changing recommendations into their own lives and clinical care. Program leadership had to work to redefine and reconstruct the program infrastructure to move away from an office and field-based setting to working out of staff's homes successfully.

The program developed a cohesive plan and fell into a routine that kept both clients and staff safe while providing quality care remotely. The participants struggled initially and were hesitant to reach out, but in the end responded well to the support. However, there were aspects to the program that suffered as a result of COVID-19; community outreach efforts were put on hold to allow greater time for availability to participants, the program census growth slowed significantly, and hiring for vacant positions was temporarily halted while program leadership worked to support existing staff and participants.

1. Disruption to community outreach: Spring is a natural time for a big push in terms of community outreach, hosting events (open house, Mental Health Awareness Month), and receiving a healthy flow of referrals from schools that are preparing to enter summer break. As a result of the changing

community landscape in response to COVID-19, the program saw a decrease in the number of referrals generated during this time.

2. Staff Training: As staff were hired and onboarded during the pandemic, they received largely remote training and had to adapt to a different workplace structure. It required much more independence in growth, and with the changing policies and client needs it was difficult to maintain consistency.

3. Limited program growth: Low referrals, graduations, limited outreach, and staff vacancies contributed to slow census growth. All programs were under census for most of the fiscal year with some positive change during the final quarter that coincided with community re-openings in the course of the COVID-19 pandemic in late Spring.

The program is actively addressing the factors that have resulted from the challenge brought on by COVID-19.

1. Outreach plan and impact: Program staff are now engaged in virtual outreach to promote access to the program and educate the community on serious mental illness while simultaneously reducing stigma. Staff are generating presentations for specific populations, including community members, families, students in middle and high school and clinical members to help everyone recognize psychosis signs and refer early.

2. Filled vacancies: Program is now fully staffed and ongoing training is helping to address the trauma impact of the past year on clients and themselves.

DEMOGRAPHICS

	FY 20/21
Age	
0-15	12%
16-25	70%
26-59	18%
Primary Language	
English	97%
Sex Assigned at birth	
Male	56%
Female	44%
Sexual Orientation	
Straight or heterosexual	55%
Gay, lesbian, homosexual	4%
Bisexual	4%
Questioning or unsure	13%

	FY 20/21
Race/Ethnicity	
Asian	4%
Mexican/Chicano	31%
Eastern European	3%
European	3%
Arab/Middle Eastern	1%
Black/African/-American	6%
White/Caucasian	18%
Asian Indian/South Asian	0%
Central American	3%
Chinese	6%
Native Hawaiian	0%
Filipino	13%
South American	3%
Another race/ethnicity	9%

Another sexual orientation	14%		Disability/Learning difficulty	
Decline to state	9%		Developmental disability	4%
Gender Identity			Chronic health condition	0%
Male/Man/Cisgender	52%		Learning disability	4%
Female/Woman/Cisgender woman	34%		I do not have a disability	92%
Questioning/unsure	0%		Another disability	0%
Another gender identity	11%		Veteran	
Decline to state	3%		No	100%

EARLY INTERVENTION: PRIMARY CARE AND BEHAVIORAL HEALTH INTEGRATION

PRIMARY CARE INTERFACE

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

Primary Care Interface	FY 20/21
Total clients served	1041
Total cost per client	$1,285

PREVENTION: COMMUNITY OUTREACH, ENGAGEMENT AND CAPACITY BUILDING

OFFICE OF DIVERSITY AND EQUITY (ODE)

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

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

PROGRAM IMPACT

The Office of Diversity and Equity measures progress along these 5 indicators. These definitions are influenced by (1) public health frameworks and (3) ODE's mission, values and strategy.

1. Self-Empowerment - enhanced sense of control and ownership of the decisions that affect your life
2. Community Advocacy- increased ability of a community (including peers and family members*) to influence decisions and practices of a behavioral health system that affect their community
3. Cultural Humility
   - heightened self-awareness of community members' culture impacting their behavioral health outcomes
   - heightened responsiveness of behavioral health programs and services for diverse cultural communities serve
4. Access to Treatment/Prevention Programs (Reducing Barriers) - enhanced knowledge, skills and ability to navigate and access behavioral health treatment and prevention programs despite potential financial, administrative, social and cultural barriers.
5. Stigma Discrimination Reduction - reduced prejudice and discrimination against those with mental health and substance use conditions

For FY 20-21 ODE's programs had the following impact:

Parent Project: 30 of the 80 participants responded to the end of class evaluation.
- Self-Advocacy
   - 96% feel confident about their parenting skills as a result of taking Parent Project
   - 67% feel overall satisfied with the relationship with their child
   - 63% feel supported as a parent
- Community Empowerment
   - 83% feel they can positively help their community after taking Parent Project
- Access
   - 83% responded knowing where to go to receive behavioral health services
   - 75% are more willing to seek behavioral health services for themselves and/or a loved one if needed

Adult Mental Health First Aid
- Stigma Discrimination Reduction
   - 83% feel that they strongly agree or agree that they are willing to take action to prevent discrimination against people with mental health conditions.
- Cultural Humility
   - 87% feel that spirituality can be a tool for recovery from mental health problems.
   - 80% feel that they strongly agree or agree that the adult mental health first aid training was relevant to them and their cultural background and experiences (race, ethnicity, gender, religion, etc.)

- 70% feel that they strongly agree or agree that they have a better understanding of how mental health and substance use challenges affect different cultures through the adult mental health first aid training.

Mental Health Month: 156 respondents responded to the evaluation survey.
- Stigma Discrimination Reduction
  - 100% strongly agree or agree that they can recognize the signs that someone may be dealing with a mental health problem, substance use challenge, or crisis.
  - 100% strongly agree or agree that they will reach out to someone who may be dealing with a mental health problem, substance use challenge, or crisis.
- Access
  - 100% feel that they strongly agree or agree that they are more willing to seek support from a mental health professional if they think they need it.
- Cultural Humility
  - 90% feel that cultural background influences the way that people seek help for mental health problems.
  - 90% strongly agreed or disagreed that this program was relevant to me and other people of similar cultural backgrounds and experiences (race, ethnicity, gender, religion, etc).

DEMOGRAPHICS

368 demographic surveys were collected from individual served across ODE programs.

	FY 20/21			FY 20/21
Age	%		Sex assigned at birth	%
Age 0-15	4%		Male	23%
Age 16-25	7%		Female	79%
26-59	73%		Decline to state	0%
60+	16%		Intersex	%
decline to state	1%		Yes	2%
Primary language	%		No	87%
English	61%		Decline to state	7%
Spanish	34%		Veteran	%
Mandarin	0%		Yes	3%
Tongan	2%		No	95%
Another language	1%		Decline to state	1%
Bilingual	0%		Disability/ Learning difficulty	%
Race/Ethnicity	%		Difficulty seeing	3%
American Indian/ Alaska Native/ Indigenous	5%		Difficulty hearing or having speech understood	1%
Asian	15%		Dementia	0%
European	0%		Developmental disability	0%
Black/ African- American	9%		Physical/ mobility disability	5%

White/ Caucasian	40%	Chronic health condition	7%
Asian Indian/ South Asian	0%	Learning disability	0%
Hispanic/ Latinx	2%	I do not have a disability	71%
Central American	0%	Another disability	3%
Chinese	10%	Decline to state	7%
Mexican/ Chicano	18%	Gender Identity	%
Native Hawaiian	4%	Male/Man/ Cisgender	21%
Filipino	0%	Female/ Woman/ Cisgender Woman	71%
South American	3%	Transgender Male	0%
Another race/ ethnicity	8%	Transgender Woman	0%
Multiracial	0%	Questioning/ unsure	0%
Decline to state	19%	Genderqueer/ Nonconforming	1%
		Indigenous gender identity	0%
		Another gender identity	2%
		Decline to state	4%

HEALTH EQUITY INITIATIVES (HEIS)

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

HEIs implement activities throughout San Mateo County that are intended to:
- Decrease stigma
- Educate and empower community members
- Support wellness and recovery
- Build culturally responsive services

Through presentations, events, and trainings the HEIs reached the following number of people:

Health Equity Initiatives	FY 20/21
Total clients served	2500
Total cost per client	$117

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

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

DIVERSITY AND EQUITY COUNCIL (DEC)

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

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

Highlights & Accomplishments
In the FY 20/21 the Diversity & Equity Council, in collaboration with San Mateo County Public Health, Policy and Planning, StarVista, Bay Area Community Health Advisory Council, the Office of Diversity & Equity and Health Equity Initiatives, held a total of 4 virtual Town Halls that focused on Race & COVID-19. The events created opportunities for community members and organizations to share collective challenges, growth and experiences this past year. Approximately 516 participants attended and provided input on supports needed, and what are the priorities of communities as response to the pandemic continues. As a result of the information and feedback received: Digital (tablets, county hotspots for internet access) support has been made available, mental health support cards are being provided, PPE was distributed and mask mobile, vaccination equity group for marginalized communities was formed, other supports included: school support, rental assistance, BHRS sponsored workforce wellness month, FB live events with other groups to share resources.

The DEC continues to focus on immediate response to community needs during COVID recovery. Partnerships were strengthened through the town hall collaboration, relationships were strengthened

with SMC Public Health, Policy and Planning, StarVista and Bay Area Community Health Advisory Council. This has broadened opportunity for DEC to be involved in larger equity efforts and provide support for other HEIs and CBOs.

AFRICAN-AMERICAN COMMUNITY INITIATIVE (AACI)

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

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

- Awareness: Increase overall community awareness and involvement of community members in African American Community Initiative
- Utilization/Access: Increase knowledge and utilization of mental health services of BHRS among African American community members in San Mateo County.
- Education/Training: Act as liaison between African American community and BHRS, assisting in linkage to services such as Black Infant Health and community trainings such as Mental Health First Aid, Photo Voice, and Applied Suicide Prevention.
- Employment: To advocate for the staffing of at least one African American clinician or peer-support provider (MFT, LCSW, and other providers) in each Community Service Areas of San Mateo County's Behavioral Health and Recovery Services.
- Research: To provide feedback and inform San Mateo County BHRS regarding African American community as result of surveying through the Office of Consumer Affairs, focus groups, and community-based research.
- Outreach: Conduct at least one annual community-based event, such as in celebration of Black History Month, Juneteenth, or Kwanzaa to build support of AACI and to reach out tothe African American community.
- Partnership: Partner with other organizations and health equity initiatives from the Office of Diversity and Equity to support AACI and AA clients and professionals as well as other diverse groups; link and collaborate with other entities that work in various capacities with African American community members.

Highlights & Accomplishments
One of the goals of The African American Community Initiative is to increase collaborative efforts with other HEI's in order to identify the health needs of communities of color and ultimately decrease

disparities for communities of color. Black History Month events in 2020 & 2021 focused on the mental wellness of African Americans of all ages. It acknowledged the chronic stress of racism and that everyday family challenges (such as securing resources, family stability) can add even more stress. The Initiative offered workshops and activities that provided coping strategies for the whole family to mitigate stress. Participants remarked that the workshops and speakers were very helpful and meaningful. The event planning began in the annual AACI strategic planning facilitated by Leanna Lewis.

In FY 20-21 community members participated in and/or hosted the following AACI events:
- Black History Month Celebration
- Black Lives in Recovery/ Told Through Our Stories of Anti-Racism-BLM
- Suicide Intervention & Prevention for the African American Community
- Race and COVID; Diversity and Equity Townhall meeting

CHINESE HEALTH INITIATIVE (CHI)

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

Mission, Vision, and Objectives

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

Highlights & Accomplishments

During the FY 20-21 the Chinese Health Initiative (CHI) created public spaces where members of the community, BHRS staff and other residents could feel comfortable openly talking about issues they would normally prefer to talk about in a private setting, namely immigration and suicide. With the opportunity to elevate these voices, community members feel more confident and less anxious about these issues. CHI participated in AANHPI Mental Health Day Proclamation, and tabling events in Daly City with Filipino Mental Health Initiative. CHI also planned and facilitated AAPI Hate event, monthly family support groups, an AAPI focused support circle for the county staff, and piloted a behavioral health mentoring program at Mills High School. CHI also collaborated with Millbrae library for the Mandarin Story Time event, and collaborated with Adult and Aging, Self Help for the Elderly and Travonde for series of promoting health education with the elderly population called Asian Be Well. CHI along with FMHI, Pacific Islander Initiative attended SMC API Caucus monthly membership meeting to present on recent hate crime against the API community.

FILIPINO MENTAL HEALTH INITIATIVE (FMHI)

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

Mission, Vision, & Objectives

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

Highlights & Accomplishments

In FY 20-21 the FMHI made efforts consisting of creating a community calendar where people could have access to outlets for social interaction and connection, as well as forming a bi-weekly support group (Kapwa Soul Sessions). This effort began in the fourth quarter of fiscal year 2019-2020 and FHMI was able to continue this through 2020-2021. These efforts aimed to address community needs brought on by the pandemic, but also focused on pointing them to the resources and support in the community. In addition, FHMI made sure the themes of Kapwa Soul touched on current events that were intensifying stress levels. Other COVID-19 responses included collaborating with other Filipinx organizations to create spaces for community, in the form of an open mic, to address both the pandemic and racial injustices that erupted after the death of George Floyd these events attracted 40 to 60 community members at each event: this included events in July, September and October of 2020. These served as vital spaces for expression and touched on topics that included political upheaval and unrest in the Philippines, how community has come together to support one another in the pandemic, addressed mental health issues, and served as a forum for many youth to connect with their culture and community.

FHMI also engaged a number of youth and community members to express themselves creatively through a project that aimed to address the emotions people were feeling about racial injustice and the Black Lives Matter movement. FMHI-SMC, together with the group made up of the COVID Bayanhihan Response (groups involved with open mic showcases, put a call out for community (especially youth) to be a part of this project. Over the course of several months, starting in June, FHMI onboarded a group of 9 youth and community members, and brainstormed, planned and carried out pre-production related activities -- including the script writing. Ultimately due to many scheduling challenges, this project was postponed. Despite the challenges, it was a tremendous learning experience for everyone, as well as an opportunity to share each others' passion, skills, and talents towards this

endeavor; this was especially true for the youth participants, who described the experience as giving them purpose, voice, and opportunities to express themselves.

Overall, FMHI has had to think more creatively about how to continue engaging community and keep them informed, especially among the older adult Filipinx population that does not always access information online. As a result, the initiative created a wellness outreach campaign to called the "Mano Po Project." This included interfacing with elders and other vulnerable community members at places like one of the Daly City food bank distribution centers, where members volunteered to help hand out goods, while also providing important information about COVID-19 safety and mental health/wellness resources available in San Mateo County.

These activities underscore the strengthening of FMHI's approach to create activities that engage community members in a culturally-responsive manner with the goal of building a consistent network of members, partners and collaborators who have successfully been doing this work in the community. In FY 20-21, FMHI participated and/or hosted the following events and activities:

- Filipinx PSA planning/filming (in solidarity and response to BLM Movement) June 2020 - October 2020 – 9 attendees
- MHSAOC Public Hearing for Social Enterprise Cultural Center- 30+ attendees
- Daly City Bayanihan Showcase: Build that Self-Care for Back to School- 40+ attendees
- Daly City Bayanihan Showcase: Fiesta Celebrating Filipinx American History Month- 50+ attendees
- FMHI Co-chair and members speak at the Exceptional Women in Publishing Conference: Our Stories| Our World focused on mental health – 20 attendees
- DCP Volunteers: Mano Po Project – 8 attendees
- Mano Po Kwentuhan Korner Online Space (for sharing wellness and connection stories)- 14 attendees
- Kapwa Soul Sessions between July 2020 to June 2021- 6-10 attendees per session
- Daly City Bayanihan Showcase: People Power in a Pandemic- 40+ attendees
- Engaged in Mobilization for the Justice for Angelo Quinto Coalition (signed letter with 160+ orgs to advocate for Antioch officials to adopt mental health response- 200+ participants
- Two General Assembly/Filipinx in Tech workshops presentation/facilitation- 148 attendees
- CSM and Skyline outreach about Mano Po Project- 76 attendees

LATINO COLLABORATIVE

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

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

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

Highlights & Accomplishments
In FY 20-21 the Latino Collaborative welcomed several presenters sharing local resources into its meetings. Because the majority of members have direct contact with the community via direct services or outreach and prevention, these informational presentations can impact services. Presentations included:

- Stanford Health Care research program on COVID-19 clinical trials
- Catholic Charities on immigration policies
- Immigrant Posada/ Pilgrimage

In addition to resource sharing and promotion, LC members participated in the MHSA Community Program Planning Process. During the input session members provided specific suggestions (prevention, direct services, workforce education and training) to support complex cases in San Mateo County. The feedback and input collected was presented and considered for the MHSA budget. The LC was able to switch all interactions, activities, and documents to a virtual platform.

In FY 20-21, the LC participated and/or hosted the following events and activities:

- Sana, Sana Event over 1,000 views
- Virtual Ofrenda- Dia de los Muertos
- MHSA input session for collaborative
- Native Heritage Month-NIPI

NATIVE AND INDIGENOUS INITIATIVE (NIPI)

The Native and Indigenous Peoples Initiative (NIPI) is one of the newer Health Equity Initiatives, established in 2012. Inherent to their work is building appreciation and respect for Native American and indigenous history, culture, and spiritual healing practices.
Mission, Vision, & Objective
NIPI has defined its mission as generating a comprehensive revival of the Native American and indigenous community by raising awareness through health education and outreach events which honor culturally appropriate traditional healing practices. NIPIs vision is to provide support and build a safe environment for the Native American and indigenous communities. NIPIs goal is to appreciate and respect indigenous history, culture, spiritual, and healing practices. The NIPI strives to reduce stigma,

provide assistance in accessing health care, and establish ongoing training opportunities for behavioral health staff and community partners.

The NIPI has further developed and articulated the following objectives:

- Increase Awareness: Improve visibility of the challenges faced by Native Americans and indigenous people and provide support for indigenous communities.
- Outreach and Education: Outreach to and educate San Mateo County employees and community partners on how better to serve indigenous communities.
- Welcome and Support: Welcome community members, clients, consumers, and family. Assist individuals in accessing and navigating the San Mateo County health care system.
- Strengthen our Community: Provide opportunities for Native Americans and indigenous peoples to strengthen their skills and create collaboration for guidance, education, and celebration of indigenous communities.

Highlights & Accomplishments

The NIPI has not only provided mental health resources to San Mateo County residents but has also contributed to the professional development of providers through trainings and workshops. The collaboration with CBO-Nuestra Casa, Pride Center and Phoenix Garden-BHRS has provided NIPI with the exposure to work in the community. The limited community members that identify as Native/Indigenous are receiving services in sister counties i.e San Jose Indian Health Center and San Francisco Indian Health Center. NIPI has partnered with SMC Libraries to further educate the community. NIPI is in the process of collaborating with San Jose Indian Health Services to increase outreach to San Mateo County and will continue to strengthen the relationship with Nuestra Casa East Palo Alto. NIPI's trainings have increased (via ZOOM) interest with traditional healing practices in a clinical setting as well as in the community. In

FY 20-21, NIPI participated and/or hosted the following events and activities:

- Provider training - Native American Mental Health
- Annual Indigenous Peoples Day: Promoting awareness to communities
- Hosted Virtual Drumming and Spirituality as a Method of Healing and Recovery (with Spirituality Initiative)
- NIPI has partnered with SMC Libraires to further education to the community.
- Alcatraz honoring of Indigenous peoples

PACIFIC ISLANDER INITIATIVE (PII)

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

Mission, Vision, & Objectives

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

- Service Accessibility
- Sustainability & Funding
- Mental Health Career Pipeline
- Community Partnership

Highlights & Accomplishments

The FY 20-21 continued with strengthening its virtual work and outreach to the community due to COCVID-19 restrictions. Partners alike gathered to discuss their hopes and goals for the Pacific Islander Initiative. Several partners who had purposefully disengaged from the group after losing trust in its leadership were able to return, speak about their experiences, and commit to re-engaging. With this tone shift, PII embarked on the third year of long-term planning, building a comprehensive five-year plan that includes a youth leadership and mental health career pipeline program (PIONEER). PII also changed its meeting time from 6pm to 11am and utilized virtual Zoom calls for all its meetings. Trust, engagement, and collaboration has greatly increased over the course of the past year.

The Pacific Islander Initiative engaged with community members directly through events and community trainings throughout the year. PII has continued to focus on reducing stigma and increasing awareness about suicide in Pacific Islander communities.

In FY 20-21 PII participated and/pr hosted the following activities and events:

- Hosted Series of Heal and Paint- Journey to Empowerment
- Leadership Workshop
- Native Heritage Month
- Provided COVID-19 support for PII community

PRIDE INITIATIVE

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

Mission, Vision, & Objectives

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

- Engage LGBTQ+ communities.

- Increase networking opportunities among providers.
- Provide workshops, educational events, and materials that improve care of LGBTQ+.
- Assess and address gaps in care.

Highlights & Accomplishments

FY 20-21 the LGBTQ of San Mateo County has been deeply impacted by COVID19 and COVID-19 delta variant, which has limited-service availability and increased disparities in a community that already faced isolation. This year PRIDE felt it was particularly important to hold a PRIDE event due to the impacts of COVID-19 pandemic, racial injustices and gender inequalities. The initiative decided to have another virtual Pride event, along with the help, of the Pride Initiative members and the LGBTQIA+ community partners, the initiative was able to shift the event from an in-person to a virtual one. The Pride Initiative met and decided to have an entire week of workshops and end the week with a Grand Finale celebration event. This included a Community SOGIE workshop; Transgender/ Nonbinary Inclusive- Resources workshop; Kaiser Gender clinic resources workshop; CORA Healthy LGBTQ relationships workshop; Aging & Adult services Panel; Health Equity Initiatives Outreach workshop; LGBTQIA Biblical workshop; and Coastpride services workshop. PRIDE had their Grand Finale hosted by DJ Ben which featured a diverse line up of entertainment and special guest local poets. Overall, 1,074 participants via social media attended during SMC Virtual PRIDE week 2021 and Grand Finale Celebration 2021. We also collaborated with San Mateo County Fair Grounds and collaborated for a *Pride Day at the Fair 2021* event. And collaborated with SMC County Health for a *Grand Rounds Pride Month presentation* to medical practioners.

In FY20-21, PRIDE participated and/or hosted the following events and activities:
- SMC Virtual PRIDE Week – 1,074 attendees
- Pride Day at the Fair
- SOGIE training
- Pride Grand Rounds

SPIRITUALITY INITIATIVE (SI)

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

Mission, Vision, & Objectives

The SI envisions a health system that embraces and integrates spirituality when working with clients, families, and communities. They have defined three core principles that guide their work:
- Hope. The Spirituality Initiative recognizes that hope is the simplest yet most powerful tool in fostering healing.
- Inclusiveness. The Spirituality Initiative acknowledges that spirituality is a personal journey and that individuals should not be excluded from services based on their spiritual beliefs and practices.
- Cultural humility. The Spirituality Initiative encourages an attitude of respect and openness in order to create a welcoming and inclusive space for everyone.

Highlights & Accomplishments

In FY 20-21 the Spirituality initiatives ongoing monthly meetings have become a place where a cross section of the community comes to learn more about San Mateo County BHRS, community partners/stakeholders, consumers, and family members of those with lived experience, furthermore the opportunity to interact with those who are in leadership positions have been rewarding for all. For instance, the meeting in April Rev. Jane Doty MacKenzie, of the Burling Presbyterian Church, presented highlights from her churches 60-page safety plan of guidelines for staff to reopen. SI members were able to ask questions, learn about the church's successful parking lot services, and the outside worship experiences.

Second, June of 2021, SI featured the community outreach person of the PRIDE Center, Marilyn Fernando, who spoke about the resources that are available for the LGBTQ+ community. The initiative also participated in the PRIDE event on June 8th, by collaborating and attending several celebrations/events through the month which expanded the insights to all those who attended. Since members of different faith communities attend the SI meetings along with family members, clinicians and those with lived experience, there is a healthy dialogue which is ensued. Throughout the year SI brings in speakers who enhance the understanding of BHRS and the surrounding community. During this FY 20-21 the SI held presentations that had impact upon those present as well as the broader community:

- Dr. Rev Janet Bower Care Ministry Seminar – Autism and Strategies for Parents, in January presented about their Feb 10t seminar
- Isaac Frederick, both a BHRS counselor, SI Co-Chair and faith-based leader during February African American Month presented about the role of African American Athletics voice about social injustices and exercising their civil right to peaceful protest.
- Poetry Reading – Poem written and read by Community member Tatiana; "PAUL ROBESON-SPEAK OF ME AS I AM".
- Burlingame Presbyterian Church spoke about their parent's seminar to support children/youth safe transition to in-person learning.
- Clinical Serv Manager Regina Moreno of BHRS presented about Labyrinth at Phoenix Garden.
- Power Meditation and open discussion about Juneteenth.

This year the initiative collaborated with the African American Community Initiative on the first annual "Amazing Souls of Black Folks". This is event recognized the resiliency of African Americans while facing systematic racisms, the historical contents of slavery, and post which included Jim Crow, and the prison-industrial complex, a short-film on the history of misdemeanors and how African Americans became targeted to prosecute at higher rates for free labor.

Lastly, the Spirituality Initiative, along with San Mateo County Health, Office of Diversity & Equity, Office of Consumer and Family Affairs, Adult Resource Management, other county, and community partners/stakeholders put on a series of virtual townhalls during the fiscal year beginning in June 2020 through January 2021. SI was instrumental in creating the Faith Based letter sent to faith leaders throughout the county in support of the COVID vaccine, correspondence about safety protocols, updates about plans to reopen, and resources for testing and vaccination sites throughout the county. Over 50 clergy/faith leaders signed the pledge. In addition, SI found two parishes – Daly City

United Methodist Church and St Matthew Catholic Church who held an onsite clinic for vaccinations for their congregants as well as the surrounding community.

HEALTH AMBASSADOR PROGRAM - ADULT

San Mateo County's Behavioral Health and Recovery Services (BHRS) Health Ambassador Program (HAP) was created in 2014 out of a desire for community members, who are committed to helping their families and neighbors, improve their quality of life, continue learning, and increase their involvement in community services.

Health Ambassadors are individuals who are committed to helping to improve the health and wellbeing of individuals in their community and complete the Health Ambassador Program. To become a Health Ambassador, community members must complete 5 of the 11 courses offered: The Parent Project, Mental Health First Aid (MHFA) and/or Youth Mental Health First Aid (YMHFA), Wellness Recovery Action Plan (WRAP), NAMI Family to Family, NAMI Basics, Applied Suicide Intervention Skills Training (ASIST), Photovoice Project, Digital Storytelling, Stigma Free San Mateo, and the Lived Experience Academy. San Mateo County's Behavioral Health and Recovery Services (BHRS) Health Ambassador Program was created in recognition of the important role that community members serve in effectively reaching out to others. HAP goals include:

- Increase community awareness of services available in San Mateo County and help connect individuals to appropriate care and support.
- Reduce the stigma of mental health and substance use so individuals are more willing to get help.
- Improve the community's ability to recognize the signs and symptoms of mental health and/or substance use issues and implement social change.
- Foster community support and involvement in BHRS' vision to improve services.
- Assist communities in practicing prevention and early intervention, leading to healthier and longer families.

PROGRAM IMPACT

Health Ambassador Program	FY 20/21
Total clients served	10
Total cost per client	$1,997

Highlights in FY 20-21:

- Monthly meetings have continued despite the Program Coordinator position being vacant.
- Health Ambassadors were key in providing COVID-19 support and outreach. These efforts included a Public Service Announcement (PSA) in English and Spanish to promote vaccination and distributing mental health resources at vaccination sites.
- Hosted several online events in Spanish, such as "Familia y Bienestar Durante COVID-19."
- Started a door-to-door canvassing in San Mateo, East Palo Alto, Redwood City and Half Moon Bay, where they distributed masks and flyers with the 5 most important messages that San Mateo County highlights about the COVID-19 vaccine and how to register to receive notifications for the next vaccination clinic. The one-on-one conversations, outreach and distribution of materials continue happening in Spanish at laundromats, grocery stores and food distribution centers.
- Ambassadors also participated in a Stigma Free virtual workshop, a sex trafficking webinar and received training to become NAMI trainers.
- On October 28, 2021, ODE and a consultant group hosted a listening session with the Health Ambassadors and the Project Coordinator, which was recently hired.

SUCCESSES

Ten new ambassadors graduated in May 2020, prior to the Program Coordinator position being vacant. Staff were able to sustain monthly meetings with Health Ambassadors to ensure continuity in services.

CHALLENGES

The biggest challenge during this fiscal year was losing the Program Coordinator, which was a limited-term position. ODE successfully advocated for a permanent position and was able to hire recently.

- Limited staffing support to help with actual course
- Provide trainings in other languages. Some curriculums haven't been translated to other languages yet.

INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS

ADULT MENTAL HEALTH FIRST AID (MHFA)

Mental Health First Aid USA is an 8-hour public education program which introduces participants to the unique risk factors and warning signs of mental health problems in adults, builds understanding of the importance of early intervention, and teaches individuals how to help an individual in crisis or experiencing a mental health challenge. The program targets population served is the community members and partners in San Mateo County. Primary program activities and/or interventions provided is an 8-hour training, outreach and promotion.

PROGRAM IMPACT

Adult Mental Health First Aid	FY 20/21
Total clients served	184
Total cost per client	$382

41 of the 184 graduates responded to the end of the class evaluation due to COVID-19 county shut down. Of the 41 respondents:
- 90% feel that cultural background influences the way that people seek help.
- 87% feel that spirituality can be a tool for recovery from mental health problems.
- 83% feel that they strongly agree or agree that they are more willing to take action to prevent discrimination against people with mental health conditions.
- 80% feel that they strongly agree or agree that the adult mental health first aid training was relevant to them and their cultural background (race, ethnicity, gender, religion, etc.)
- 70% feel that they strongly agree or agree that they have a better understanding of how mental health and substance use challenges affect different cultures through the adult mental health first aid training.

Improves timely access & linkages for underserved populations
AMHFA training incorporates culturally humble questions, examples and resources to help participants to intervene with and refer behavioral health services to underserved populations in a more culturally responsive way.

Reduces stigma and discrimination
AMHFA shares mental health facts and stories of hope and recovery which both help reduce stigma of mental health issues and conditions.

Increases number of individuals receiving public health services
AMHFA training shares local resources participants can refer to for professional behavioral health support, including public health services.

Reduces disparities in access to care

AMHFA partners with agencies that connect marginalized communities to care, including those serving older adults and incarcerated youth.

Implements recovery principles

AMHFA implements the recovery principles of support from others and providing hope since participants become gatekeepers who provide hope and support to those facing mental health issues.

SUCCCESSES

The main success of the program was that Adult Mental Health First Aid was available for virtual training.

CHALLENGES

The main challenge is that National Council of Behavioral Health Wellbeing new learning management system makes it harder to get individual data and makes it harder for limited English proficient participants and limited technology proficient participants to navigate the learning management system.

DEMOGRAPHICS

	FY 20/21		FY 20/21
Age	%	Gender Identity	%
0-15	0%	Male/Man/Cisgender	21%
16-25 (Age collected as 18-25)	8%	Female/Woman/Cisgender woman	76%
26-59	80%	Transgender woman	0%
60+	10%	Questioning/unsure	0%
Decline to state	2%	Genderqueer/nonconforming	1%
Primary Language	%	Another gender identity	0%
English	96%	Decline to state	1%
Spanish	3%		
Decline to state	1%		
Race/Ethnicity	%	Disability/Learning difficulty	%
American Indian/Alaska Native	2%	Difficulty seeing	2%
Asian	17%	Difficulty hearing or having speech understood	2%
Black/African/-American	8%	Developmental disability	1%
White/Caucasian	39%	Physical/mobility disability	3%
Filipino	0%	Learning disability	3%
Puerto Rican	0%	I do not have a disability	74%
Pacific Islander	0%	Another disability	2%
Hawaiian	8%	Decline to state	9%
Another race/ethnicity	6%		
Decline to State	18%		
Sex Assigned at birth	%	Veteran	%
Male	22%	Yes	1%
Female	77%	No	96%

Decline to state	1%		Decline to state	1%
Sexual Orientation	%			
Gay, lesbian, homosexual	3%			
Straight or heterosexual	71%			
Bisexual	8%			
Queer	4%			
Pansexual	0%			
Another sexual orientation	1%			
Decline to state	10%			

RAVENSWOOD FAMILY HEALTH CENTER

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

The intent of the collaboration with Ravenswood FHC is to identify patients presenting for healthcare services that have significant needs for mental health services. Many of the diverse populations that are now un-served will more likely appear in a general healthcare setting. Therefore, Ravenswood FHC provides a means of identification of and referral for the underserved residents of East Palo Alto with SMI and SED to primary care based mental health treatment or to specialty mental health.

Ravenswood	FY 20/21
Total clients served	544
Total cost per client	$78

ACCESS AND LINKAGE TO TREATMENT

Community outreach collaboratives funded by MHSA include the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) and the North County Outreach Collaborative (NCOC). The collaboratives provide advocacy, systems change, resident engagement, expansion of local resources, education and outreach to decrease stigma related to mental illness and substance use and increase awareness of and access and linkages to culturally and linguistically competent behavioral health, entitlement programs, and social services; a referral process to ensure those in need receive appropriate services; and promote and facilitate resident input into the development of MHSA funded services. See Appendix 9 for the full FY 2020-21 Outreach Collaborative Annual Report.

NORTH COUNTY OUTREACH COLLABORATIVE (NCOC)

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

The North County Collaborative is composed of five agencies that reside and serve in the North sector of San Mateo County.

1. Asian American Recovery Services (AARS) - a program of Healthright360 that provides an array of culturally competent services to the Asian and Pacific Islander and other ethnically diverse communities of the San Francisco Bay Area. AARS is dedicated to reducing the impact and incidence of substance use. Programs serve youth, adults, and families in San Mateo county. AARS offers an array of programs and services, each tailored to meet the needs of the clients/participants. Their culturally oriented, gender-responsive approaches are delivered by multicultural and multilingual staff who are a part of the communities they serve. AARS- partners with government agencies, community-based and ethnic-specific organizations to strengthen the support networks available to clients and to engage in research and advocacy. They offer culturally-tailored community-building activities that motivate the populations they serve to be resilient and healthy.

2. Daly City Partnership (DCP) - provides mental health therapy to individuals, families, and groups, their mental health services provide to all ages and they facilitate and organize collaboration with partner agencies for services to all clients.

3. Daly City Youth Health Center (DCYHC) - provides effective, safe and respectful health services to underserved youth and young adults, aged 12-24, in North San Mateo County at no cost to them. DCYHC provides physician led primary healthcare, counseling services from licensed therapists, and sexual health education and social and emotional development from health educators. Every medical and counselling appointment that DCHYC provides to its client base, which is composed of low-income youth, is an example of a reduction of the disparity of access to care and an increase in the number of underserved youth receiving public health services in the community. In addition, DCYHC strives to schedule appointments in a way that the youth are receiving timely access to the care that they need

4. Pacifica Collaborative (PAC) - exists to connect people, share resources and support one another to enrich the community. The Pacifica Resource Center's mission is to support the economic security of Pacifica families and individuals by providing safety net of food, housing critical services, including coaching, and advocacy, information, and referral. PRC's vision is to assure the basic needs of every Pacifican are met so that each member of the community has the opportunity to thrive.

5. StarVista - provide services for all ages, and all populations in San Mateo County and has been providing services for over 55 years. StarVista especially reaches out to underserved, marginalized communities including LGBTQ+, low SES, English as a 2nd language, and undocumented peoples. Provide individualized, client-centered, affordable services for all clients in multiple settings including at home family support, groups, individual services and residential services

The North County Outreach Collaborative's program purpose is to connect people who need services and support around mental health, alcohol and drug treatment, medical and other needed social services. The North County Outreach Collaborative also aims to reduce stigma and discrimination of mental illness along with alcohol and other drug issues by increasing awareness of available resources through education and creating access to care for those in the community who are underserved. The North County Outreach Collaborative continues to establish effective relationships with culturally and linguistically diverse community members to assist in increasing Behavior Health and Recovery Services capacity and performance in addressing the specific needs of various populations that are prominent in the North County of San Mateo such as Chinese, Filipino, Latin, LGBTQ and Pacific Islander.

The NCOC welcomed two new executive directors and these NCOC partners were community based and enthusiastic to connect, which allowed partner agencies to continue to create and build on relationships The collaborative has learned that in order to help create linkages to services, knowing the individuals improves the connection with assisting in a warm hand off. Trust is the key to helping make the connection to services with diverse individuals and the NCOC recognizes that often they are planting the seeds of information in their various communities. The NCOC recognizes that being a consistent presence in the community allows them to then be able to water those informational seeds that were previously planted with reassurance that support is here to help. NCOC also works with service providers to better understand diverse community and their cultural beliefs and practices. This is an area where the Community Outreach Team (COT) often is the bridge, the solid foundation that helps make the connection. When community members recognize a friendly face, a relationship has already been established and they then are more likely to step towards seeking support. During this pandemic this has been a solid fact as NCOC saw an increase of community folks that reached out for resources and connections. They shared that they remembered them from an outreach event or presentation they did.

PROGRAM IMPACT

NCOC	FY 20/21
Total clients served	7254
Total cost per client	$31

Asian American Recovery Services (AARS)
AARS provided mental health services with low to moderate needs through referrals from SMC Access and on a fee for service sliding scale during the beginning of the fiscal year. Sadly, the program sunset and clients were referred out with the hope of being able to do a warm hand off to a partner agency. AARS also has staff that speak Cantonese, Samoan and Tagalog which offers a more cultural setting for clients, especially those who preferred to speak their native tongue AARS provides outpatient programming for Adults in North County to help alcohol and drug users break the cycle of addiction by learning to take responsibility for rebuilding their lives and innating change in attitude, behavior, and lifestyles. The programs utilize culturally appropriate approaches that can facilitate the transition from addiction to recovery. AARS also has programs in prevention and education around reducing youth substance use, building community capacity, reducing the impact of substance use/misuse, hepatitis and HIV/AIDS. AARS also focusses on stigma reduction by providing safe spaces in the community on a regular basis to have guided conversations on taboo topics while sharing available resources and

connecting folks to services. In addressing needs of the Pacific Islander community, AARS provides regular programing by teaching culturally specific parenting classes that aims to increase awareness and share knowledge and resources that can help raise their youth of today in a nurturing environment. Because parents expressed a need for their youth, AARS was also able to create programing for Pacific Islander youth 11-17years old. The 12-week workshop covers topics such as self-identity, self-care, identifying emotions, anger/violence prevention, family & social connection, healthy relationships, substance use, problem solving restorative and social justice and mental wellbeing. AARS believes that it takes a village to raise a child and to create change. Through conversations, education and resource building, all parts of the family begin a healing process to wellness.

Daly City Partnership (DCP)

DCP provides mental health services in a timely manner. Clients needing services are able to obtain appointments within a one-week time span. Working with their partner agencies, they offer discrimination in regard to mental health. Workshops are done within their communities and schools when needed. Due to Covid-19, all workshops were done via Zoom. At DCP, they offer free services to all. The ability to provide this service makes it one less barrier that clients face. All clients are given tools to help them better work with issues that they are facing.

During the 2020-21 fiscal year, Daly City Partnership referred clients to both counseling services and core services. This was greatly increased due to COVID 19. Daly City Partnership referred 10 clients to "Whole Person Care", enabling clients to access much needed resources. 6 clients were placed into recuperative care, connecting with support for acute medical issues. It assists them in getting off the street, while connecting them to resources that can help them in their transition. Many clients were referred to shelters and local hotels. On multiple occasions, Case Workers at the Daly City Community Service Center (DCCSC), have referred the clients to BHRS for services or medications. DCCSC has referred over 200 clients to the Coordinated Entry System for Shelter. In addition, 370 households received emergency rental assistance to keep them stably housed.

This reporting year has been a very interesting year in the field of mental health. Our Second Home (OSH) continued to offer teletherapy. Our Second Home (OSH) has adapted and has managed to continually collaborate with partner agencies such as the school districts and the Daly City Youth Health Center. The mental health program has continued to offer no-cost therapy to their clients. They are in the process of working with insurance companies to process medical payments for future billings. Looking at the total sessions offered this fiscal year, you can see that despite all obstacles, OSH is committed to serving their community.

All departments for the Daly City Partnership were still in full operation and dealing with COVID-19 and Shelter in Place (SIP) or Stay at Home orders. Because of this, all therapy appointments have been via tele therapy or virtual via Zoom. More clients have expressed major anxiety and depression due to Covid 19 job losses, and now having to become their child's at-home teacher. Many students have been unable to access online-tele mental health services as they are required to use their devices for At Home Learning (AHL). Other students have no computers or internet access and are finding it difficult to keep up with their work. Even though the world is in a pandemic, there are many, however, that are finding ways to be grateful. The focus of most of the LMFT sessions have been to alleviate anxiety and help those focus on how to make the best out of this situation. During this time, social injustice continued to take place and rocked America to its core. Most client sessions have been finding ways to deal with the

ups and downs of the pandemic and dealing with their own feelings. Throughout the school year, many of the clients still came from the following locations: General Pershing State Preschool (GP), Fernando Rivera Middle School (FR), FD Roosevelt K-8th (FDR), Daly City Community Service Center (DCCSC), and Our Second Home (OSH). All locations are in Daly City.

Many new clients were added that included teachers, school staff, mental health professionals, medical professionals and many other individuals. Supervision of MFT Trainees began in September with the supervision of 3 trainees. They are expanding their intern program for locations within the DCP. All supervisees are under the license of the LMFT.OSH hired one additional spring/summer intern with weekly supervision. Clients at OSH are referred from all over the school district, but primarily received via Our Second Home, General Pershing State Preschool, Daly City Community Service Center, Fernando Rivera Middle School, Franklin D. Roosevelt Elementary School, Susan B. Anthony School, Daniel Webster Elementary School.

- Measurable Outcome: Provide holistic therapies (yoga, art, music) & programs for children with special needs, & those with ACE factors. Clients are offered individual, group and family therapy in the form of Solution Focused Therapy, Cognitive Behavior Therapy, Emotion Focused Therapy as well as Art and Play Therapy.
- Measurable Outcome: Market and manage a wraparound information and assistance program for families in the community, including community outreach and social media. In addition to postings on Facebook, Twitter, NextDoor and the city's monthly newsletter, known as "Daly Wire", Daly City Partnership and OSH post news of classes and events on a quarterly basis through Constant Contact, which has a list serve of nearly 2,000. This past year, OSH received over 500 inquiries regarding childcare, preschools, and events. Due to Covid 19, OSH's inquiries continue to address the need for food and housing assistance, and OSH continues to be instrumental in clients' accessibility to online rental assistance application and Covid 19 resource page. Check it out on www.dcpartnership.org/covid
- Measurable Outcome: Family and children's group and individual therapy for uninsured, under supported, and underinsured referred families The monthly "Special Needs Support Group" and social/emotional reading workshops at the preschool have taken place the last year via Zoom. Over a dozen families have participated this year and appreciated the connection and the continued efforts to keep this group going virtually.
- Measurable Outcome: Provide Individual and Group Therapy Clients range in age from 4-75 years of age, and come with some presenting issues such as; covid 19, depression, suicidal ideation, suicidal attempts, domestic violence, child abuse, child neglect, social anxiety, anger, post-traumatic stress, marital issues, self-harm, child pornography, cutting, illnesses contributing to anxiety, sexual molestation of minors, and self-esteem. Implementations of safety plans are available to clients. Safety plans will be given to clients after initial assessments have been done. Appropriate resources will also be given to best meet their needs. Some of these resources have been to local food banks, shelters, psychiatric wards, clothing resources, transportation issues, housing issues, and medical information. "Handing a client a phone number is not enough, but rather ensuring them that their needs will be met to the best of our ability."

Client Statements:
- *"I finally realized that I am no longer a victim but am a survivor."*
- *"I realize that I am not alone."*
- *"The world really scares me, but I am glad I have you to talk to."*
- *"I don't know where I would be without therapy each week."*

Daly City Youth Health Center (DCYHC)

DCYHC improved timely access and linkages for underserved populations by having their clinic open and operating throughout the duration of COVID-19. Clients were able to make medical and mental health counseling appointments throughout the past year. Given the increase in mental distress in youth, adults, and elders while sheltering in place and considering COVID related stressors, the behavioral health team strived to take in more clients. Through the mental health clinicians and Project PLAY (Peer Leadership Alternatives for Youth) health educators' efforts, they have worked to reduce the stigma that youth and families feel about mental health. In addition, the program provided valuable insights from youth to build and reduce stigma in the future. To reduce disparities in access to care, mental health clinicians began to offer meeting clients in public spaces, where they felt safe enough to do so for therapy appointments. Additionally, more DCYHC space was arranged with more furniture. Implementing recovery principles include anxiety reducing techniques, mindfulness, meditation, and preparedness.

DCYHC and NCOC MOU Outcomes for 2020-2021:
1. 1-on-1 counseling for 220 people
2. Enroll 20 people per month in benefits via an on-site Benefits Analyst
3. Facilitate 2 Emotional Intelligence workshops and host peer support groups
4. Participate in 12 outreach events per year
5. Participate in 2 nontraditional provider collaborations per month
6. Participate in at least one Strong Provider Collaboration event annually
7. Identify local providers that provide culturally sensitive services
8. Provide education presentations at collaborative meetings, in classrooms, and in the community
9. Provide translation services for ODE forms and flyers (English to Tagalog)
10. Participate in meetings for the Filipino Mental Health Initiative and other collaborations
11. Conduct one anti-stigma event per year at the local high school.
12. Attend HEI meetings to engage with members and promote future events/services
13. Attend quarterly business networking events
14. Participate in the San Mateo County Contractors' and Providers' Monthly Meeting
15. Participate in NCOC quarterly/steering committee meetings
16. Participate in quarterly DCP meetings
17. Participate in monthly COT (Community Outreach Team) meetings
18. Provide training for Outreach Workers
19. Provide oversight and monitor NCOC Blog Site

We have incorporated an AllMinds assessment tool that helps us understand in real-time what the actual needs are to get straight to the point of issues that need to be addressed.

Pre/Post -- AllMinds Report:
- Average Feedback/helpfulness: 92% indicate that their session was helpful.

- Average Feedback/Wellbeing: 85% indicate their overall wellbeing has improved because of sessions.
- Average Feedback/Topics: 91% indicate that the topics discussed are helpful for a change.
- Average Overall: 98% of clients feel the services provided are helpful.

DCYHC mental health therapists use the Patient Health Questionnaire (PHQ)-9 to identify and treat depression, the Generalized Anxiety Disorder (GAD)-7 to monitor anxiety, and the Alcohol Use Disorders Identification Consumption (AUDIT C) and the NIDA Modified Assist for to monitor substance use. During treatment, mental health challenges are both reduced and prevented from becoming more severe as clients receive therapy and then continue to answer the survey questions which relate to their care. Their development is tracked through both the survey data and continued clinical assessments. Through the hard work invested by both the client and therapist, there is a very good chance that improvement will take place and that any existing challenges will not become more severe.

Each DCYHC mental health client receives a therapy plan that is individually tailored to their specific needs and continues to be adjusted through the therapeutic process. These clinic plans are designed and proven to treat and often reduce depression, anxiety, and substance use—all of which can reduce the likelihood of suicide, prolonged suffering, incarceration, homelessness, academic failure, removal of children from their homes, and unemployment.

Youth Vaccination Clinic - Because of everyone's hard work, Youth Vaccine Week was a huge success! It was amazing to watch each group take the lead role on planning activities (BtC for the podcast, HAP-Y for the town hall, YAB for the clinic, and all for social media) and inviting others to join! It made for very manageable events that allowed other groups to participate as they were able! It was evident what young people can accomplish when given the opportunity and support to work together. The vaccine clinic saw about 160 people vaccinated when they usually see 80-100 at that clinic. It is so important in making sure young people get vaccinated for COVID-19 to keep the 2021-2022 school year as safe and healthy as possible!

Pacifica Collaborative (PAC)
PAC works together to ensure that underserved populations receive referrals and timely linkages to services. PRC's Houseless on the Coast team implements consistent outreach to folks living in RV's, vehicles and encampments in Pacifica. The consistency of this outreach, over time, creates a trusting relationship with the outreach workers and allows for information to be shared without fear or mistrust. Reducing Homelessness - HIPPA protected data through the Houseless on the Coast data shows the correlation between the outreach efforts and securing housing for Pacifica families. Data is collected and housed at the Pacifica Resource Center. Data is also collected to show the number of folks who have accessed rental assistance in the past year and have avoided homelessness. (See attached Update from Pacifica Resource Center) Making the connections between regular community outreach and health outcomes of people served is not easily tracked unless the outreach worker has direct access to client information. Outreach conducted through food distribution, libraries, social media and other on the ground efforts are not trackable from outreach to health outcomes. Data is collected thought the Pacifica Resource Center intake questionnaire which asks where did you hear about us? Target Population: Low income, people at risk of or experiencing homelessness, families and children affected

by mental health issues, Chinese, Filipino, Latino, African American/Black, Pacific Islander and LGBTQ communities of all ages.; Faith Community; Business Community

StarVista
StarVista has a well-designed website that is easy to navigate and sends many monthly newsletters out with program updates. StarVista partners with many providers as well as San Mateo County Health Department, BHRS and the Human Services agency, and SV provides flyers on all services to these partners and attends street fairs whenever possible. SV reduces stigma and discrimination through their cultural diversity program work, IDEA, committee, inclusion, diversity, equity and accountability. SV also focuses on hiring a very diverse staff. SV assists clients in signing up for Medi-Cal, Medi-Caid and Medi-Care, to utilize the public health services and to reduce disparities in access to health care. SV also offers a sliding fee scale for all services. Recovery is self-directed, ongoing journey, it will empower you, includes, mental, physical and spiritual needs, ups and down, need to bounce back, respect, hope and responsibility. StarVista Outcomes:
1. Support the implementation of the NCOC components through direct staffing and training.
2. Ensure priority insurance enrollment assistance for individuals and families referred by members of the NCOC.
3. Provide behavioral health services to individuals and families referred by members of the NCOC.
4. Participate in Community Outreach Team activities and project evaluation activities.
5. Participate in Steering Committee & other Collaborative activities.
6. Compile and relay program activities and evaluation data to the program coordinator.
7. Track all referrals for insurance enrollment.

SUCCESSES

Asian American Recovery Services (AARS)
AARS was able to be successful in adapting to the virtual way of doing things during the pandemic while staying connected to the community. They were able to still provide their once-a-month community safe/brave space Journey to Empowerment to meet with Pacific Islanders who needed a place to unpack and feel connected. This gave AARS an opportunity to also share resources electronically with the participants which appeared to be an easier way for them to keep stored. AARS also held their culturally specific Parent Project and were able to connect with 52 individuals who joined their cohorts, AARS also knew there was a need to still connect with the community and share resources and provide spaces to highlight the people in the community. AARS has Talanoa Tuesday where staff host a live program on facebook with a Pacific Islander community person as the highlighted guest speaker. They were able to cover taboo topics which are often not spoke about in the community and it was so powerful to see this platform not only elevate individuals voices but have heart to heart discussions with the speakers that the community could relate to.   They had 45 episodes anx actually replayed a few of those during this fiscal year. Here are some quotes to support the Pacific Islander programming.

- *"Thank you so much for hosting that much needed dialogue and bringing light to mental wellness for everyone"*
- *"Thank you so much for talking story and for being raw and real in your conversation! "*
- *"I wanted to give huge thank you's to organizations like... #EssenceOfMana for creating emotionally & mentally- centering virtual spaces for our NHPI community members during these times."*
- *"Cannot express enough how appreciative I am for Essence of Mana & the safe space you all have created with your Talanoa Tuesday programming."*
- *"I was on three other meetings last night and am so happy I can go back and watch Essence of MANA's Talanoa! I appreciate these important conversations thank you"*
- *"Thank you for making our Tuesday so interesting and showing so much love"*
- *"this is absolutely amazing... keep up the great work essence of mana"*
- Essence of MANA Parenting class - *"The cultural part of Essence of MANA meant many things to me. I remember walking into the first day of class and feeling safe, comfortable and welcomed. Since I felt safe and comfortable during the class, I did not hesitate sharing experiences and stories from my life"* – Tongan Parent
- *"This course is a new approach to child rearing, learning how to show love and how to speak without becoming angry. Culturally we do what we know… now I know different"* – Samoan Great Grandparent

AARS challenges were the same as everyone else's with the increase in needs and less staff to operate. We had some folks who also didn't have transportation to do food pick up. This mother would walk to the neighborhood liquor store and buy her food because she didn't have ethe strength to travel on the bus with her son and then stand in line at a grocery store. COT was able to triage and help set up a pick up where AARS staff was able to pick up some stuff and deliver it to her,. AARS also had a wonderful working relationship with another community partner who was doing deliveries of food and would also drop off boxes, in turn AARS was then able to turn around and support Taulama for Tongans who run a senior program for Tongans with some support and items and also include outreach flyers in their food boxes. Full circle of community helping community and a creative way to outreach.
Daly City Partnership (DCP)
Providing clients with resources to help them during these difficult times have been extremely helpful. One story comes from a family where the father was incarcerated due to alcohol and drug use. During this time, the mother came to receive individual and family therapy to help her and their children deal with this. She was also referred to resources to help with rent and food and clothing. When the father was released, they came for family reunification therapy. Fast forward to present, family is reunited, father is in full recovery, their marriage has been restored, their house was saved from foreclosure!!Both parents state, "We could not have done any of this without the help of mental health therapy and all the other community resources that made all of this possible. "We are so very grateful for all the help we have received and we will take all that we have learned through the experience and we want to help others!"
Daly City Youth Health Center (DCYHC)
DCYHC has an intervention they are proud of. Below, client R.M. speaks on his progress made by going to therapy and how he is grateful for his experience with his clinicians.

"Before, to think of the progress I've made from the many years here would have been hard for me. Throughout my life it's been really easy seeing my mistakes rather than my accomplishments, but I can now say the amazing progress I've made since I first stepped into the clinic. I'm insanely grateful of all the people who helped me throughout the years. All therapists I got felt like the perfect fit, always listening on what I had to say, feeling like they actually cared, them reaching out to me whenever I needed them. The environment that this clinic gave for me was very welcoming for me. Never felt judged or looked down upon. They have helped me through the toughest points in my life and supported me throughout, never giving up on me. Learning not to give up on myself and start seeing those accomplishments, big or small. They've helped me be more myself, and let my greatest traits such as my optimism shine more than it ever has before. I'm glad I've been on this journey of self-growth and have a solid group of people being there with me, and providing me the tools to follow through. I see my future being bright again, I see the good that I can spread. I'd recommend anyone this kind of support, no matter how big or small the issues are. Everyone needs help. And I'm glad I took it."

There was a challenge in implementing Project PLAY program activities due to COVID, but the health educators did their best to ensure that all were safe. Sexual health education instruction followed through online and Zoom efforts. Online programming can be completely different from in person learning; however, the students and health educators were vulnerable to each other about getting through the rough patch together. While there are no solutions to mitigate this issue in the future, strong communication with one another can continue to boost morale, especially during a pandemic.

Pacifica Collaborative (PAC)

Outreach client story #1: "Because of COVID-19, I found myself in a tough financial situation. Thankfully I knew of a friend in the community that I have seen talking about sharing resources on Facebook. I reached out to this person, who is the facilitator of the Pacifica Collaborative, and confided in them about my struggles. She told me about PRC. She told me about all of the services they provide. After many attempts of trying to find the courage to call them by myself, I reached back out to the outreach person. She came to me and sat with me while I made that call. She then walked with me as I went in for my first in person appointment. I was greeted by a woman with a calming nature and the biggest smile. Within a few minutes my nerves had settled, and I scheduled an appointment for a couple of days later. When I left the office, I was no longer trembling inside. The woman who helped me said that things would be okay... that my family & I would be okay. What mattered the most is that I believed her and I believed in myself again. I no longer felt helpless and alone! "

Pacifica Resource Center Shower Program:

"I have lived in Pacifica all my life. I became homeless during the beginning of Shelter-in-place. A friend of mine told me about PRC's shower program. I was cold, dirty and needed a shower really bad. My friend came with me and helped me sign up for the shower program. Little did I know that with the shower program comes so many other resources. I ended up getting connected to a case manager, who connected me with Project Room Key. I was then offered shelter through the program in a hotel in Redwood City. I was able to shelter in place there, escape the intense smoke and rest. Six months later I

received the key to my own apartment and I am so thankful that people knew enough to send me to PRC to get cleaned up!"

StarVista- SV is very proud of the outreach work done with the Homeless community. StarVista staff were able to provide COVID safety packages, COVID food packages, prepaid iPhones and tablets to 200 homeless citizens. The staff made over 250 follow up phone calls to these individuals, providing additional referrals to shelters and to some housing opportunities. 40 homeless individuals did find shelter placement from these outreach phone calls. One of the client's shared that they placed their first phone call to family in 4 years, and their mother cried mand warmly sent her love to him. Another graduated client, recently wrote to StarVista's Marketing and Development Department and stated they wanted to share their story, and StarVista had saved their life. They were clean and sober, and in active recovery, and enrolled in the College of San Mateo Alcohol and Other Drugs Certification program. "We were so happy and positive about this notice, that reached out to this individual with a job offer, and they have accepted work with the First Chance program."

Connecting to the Chinese community – AARS was taking calls for the outreach line, however due to staff changes in schedule- they were able to give the cellphone to Daly City Partnership for the HEART Team to take the calls, AARS staff attended CHI on a regular basis to stay connected. DCP- DCP's Healthy Aging Response Team became the holder of the Chinese Initiative Outreach phone. Incoming calls have been sparse, but the phone was utilized by the Cantonese speaking Case Worker to reach over 50 Cantonese speaking clients who were sheltering in place, some needed food, and all appreciated her caring friendly phone visit. HART works with many of the Chinese community and offers support to them with brown bag deliveries, meal delivery, interpreters, friendly visits and calls. DCYHC will continue to connect and engage with the Chinese community. Their hope is to reach this community when doing outreach for the Social Enterprise Youth café. PAC- Two volunteers from the Pacifica Resource Center are available to translate for both Mandarin and Cantonese speakers. There is set times during the week when they are available, and appointments are scheduled accordingly. Phone appointments have allowed for 6 families to be connected to services through this translation services. Focused Outreach to Chinese faith-based churches: In 2019, Mandarin/ Cantonese speaking volunteer from Pacifica Collaborative (Haolin Zhue) attended service, met with pastor and left translated materials from San Mateo County and Pacifica Resource Center and referral line post card at 太平洋真耶穌教會 610 Edgemar Ave, Pacifica, CA 94044. Haolin then moved out of the area. During 2020 - 2021 COVID, Haolin was able to continue the relationship with the pastor remotely to share information with the congregation about food services, funding for rent, behavioral health services and small business assistance. Promote Chinese Referral Line: Include post card sized cards at food distribution sites and in the curbside book pickups at the Pacifica Libraries. 400 cards printed and distributed throughout the past year. STARVISTA- StarVista has continued to provide clinical services to the Chinese community through work with the Daly City Chinese Hospital. Their clinician speaks both Mandarin and Cantonese and is able to provide services in each client's language of choice.

Outreach and connecting the community to COVID-19 testing and vaccine
AARS was involved in working with other Pacific Islander Community leaders to provide PI testing sites and also share information on vaccine locations. They also were in close contact with the Pacific Islander Covid 19 Response Team and involved in strategic planning on how to not only share awareness about the reality of the pandemic but to offer opportunities for the Pacific Islander to get connected to

support. AARS also outreached and disseminated information regarding covid, safe practices, vaccine information and the growing rate of deaths amounts PI's from the pandemic via social media, and other electronic devices.0.0

DCP had a contract with San Mateo County to provide covid testing at the Daly City Community Service Center from November 2020 to June 2021.Outreach was done through social media, flyers at the DCCSC and partner organizations. The county also set up a vaccine clinic in the parking lot of the DCCSC and Daly City Youth Health Center, enabling the community access the vaccine easily.

DCYHC -Through their partnership with SMMC, DCYHC was able to receive information about COVID vaccination days designated for the community. Outreach for vaccination clinics taking place were shared to additional networks via email, social media posting, and networking.
The DCYHC location also served as a COVID-19 testing site for community members and essential workers to get tested. Specifics on the days that testing was done was communicated through partner agencies and word of mouth. A Youth Online Town Hall (July 15, 2021) and Youth Ambassadors Vaccine Clinic (July 24, 2021) was created in collaboration with Star Vista, SMC of Education, SMC Health, and YAB XII to encourage youth to get COVID vaccinations

PAC-The bulk of the outreach consisted of sharing information about COVID testing, vaccines, and resources. Printed materials were included in food distribution boxes, drive and go senior lunch programs and curbside library pick ups. Links to services were shared during collaborative meetings, on social media and through youth-led Podcasts. STARVISTA- StarVista reached out to the San Mateo County community with Newsletters, flyers, and website, Facebook and Twitter postings listing COVID testing sites and COVID vaccination sites. StarVista also reached out to the homeless community with this information and provided rides, and lyft vouchers and bus tokens for clients to get to testing and vaccination sites.

Partnership
During this year there was more opportunity for the partner's to not only support each other but actually work on projects together. DCP- All of the community partners helped out in various ways, such as Food Bank distributions, Covid testing and vaccine facilitation. All of the agencies, work together in supporting each organizations projects and outreaches. This year, DCYHC was able to partner with Daly City Partnership and the Filipino Mental Health Initiative to complete a proposal for a Social Enterprise Café for Filipina/x/o youth. All three NCOC agencies will be working together for the planning, implementation, and evaluation stages of rolling out this youth café. The Pacifica Collaborative and Daly City Youth Health Center have created a working relationship that included youth outreach in both Pacifica and Daly City. The groups collaborated with SMC on a youth -led campaign to encourage young people to get vaccinated. This included youth-led panel discussions, in person vaccine events and Podcast series on youth and COVID.

North County Outreach Collaborative General & Steering Committee Meetings were Aug 21, 2020, November 20, 2020, Feb 19, 2021 and May 21 2021 via zoom. NCOC takeaway were AARS appreciate that the folks that could be around the table and how COT would intestinally create and agenda for the general meeting DCP -felt that continued collaboration with agencies can help the clients continue to

move forward, especially during these times. These relationships enable us to be able to refer clients to the appropriate resources for the community. DCYHC -appreciated continuous dialogue Covid-19 and partnership strategic planning. PAC-acknowledged during the pandemic it has been hard to get people around the table and it will change with work around the pandemic. SV felt the discussions regarding the COVID pandemic and the many efforts to continue to provide services, especially for many clients with few IT resources and little internet knowledge.

NCOC Community Outreach Team Meetings: For 2020 - July 10, August 14, Sep 11, October 9, Nov 13, Dec 11th. For 2021 it was Jan 8, Feb 12, Mar 12, April 9,May 14, June 11th all via zoom Some Highlights & Outcomes from the COT:

DCP-This monthly meeting is so very beneficial for the team, to come together to talk about what is going on with not just the agencies, but with the goal to support each other with the very hard and oftentimes, sad work.

DCYHC was able to meet with MHSA to negotiate a grant to fund vaccination innovative, and strategic approach

PAC-The COT team is a lifeline to the outreach work in the community. The deep connection and caring relationships between the COT team members allow for a safe space to work out the issues, feelings and experiences that happen whole doing the work. Maneuvering through the pandemic has been extremely challenging for all of us and having the opportunity to discuss this openly is a true gift. Most of what is shared in these meetings are extremely personal and include working through a situation of stalking, illnesses of family members, depression, medical issues and lack of motivation. The highlights of all of these situations is being able to cry it out, talk it out and end in love and laughter

STARVISTA-staff attended the COT meeting on a regular basis and discovered a number of creative ways to continue to build StarVista outreach effort

CHALLENGES

During this fiscal year, navigating the pandemic led to some obstacles the agencies overcame to stay connected to the community were:

AARS – Seeing folks struggle with electronic and the being forced into the virtual world and then to trying to help folks navigate this and the office having wifi issues on a regular basis. In order to expect staff to do more electronically you have to give them materials to do so, it is the same for the community. Through all of the uncertainties and even on the grayest day, being able to help the community find their inner strengths and sharing coping skills like deep breathing exercises to help them get through those hard moments is always a win for the community.

DCP- One main obstacle was funding, as always. The need for mental health became very apparent and there are not enough resources out there to accommodate all those needing services. If agencies were able to receive more funding for those who don't alwaysqualify based on income or insurance, age, or

where they live, then mental health can be made more available to many. There are many therapy services available but almost always with a "Free Trial, etc. This should not be the case!

DYHC Some obstacles faced during this fiscal year includes state sanctioned violence on black and brown communities and racist attacks on Asians and Asian elders. While these acts of hate and bigotry heavily impacted staff, youth, and communities, DCYHC took action to create a brave space for healing. On June 18th, DCYHC, FMHI, and Daly City 4 Black Lives joined forces to create an online community gathering called SOULidarity (Sourcing Our Unified Light). We deemed it was necessary to provide space for community to heal, decompress, and dialogue with one another. In this event, facilitators offered yoga, art therapy, and other forms of healing in solidarity.

PAC- COVID has and continues to create challenges in community outreach. Relationship and trust is built through in person interactions and this has been lacking in the past two years.

Rental Assistance Funds: The COVID Rental Assistance funds come with many barriers, including that landlord must agree to accept the funding. It has been challenging getting landlords to agree to the COVID rental assistance funds. This is a barrier an getting peoples back rent paid. The outreach materials were not clear and did not have enough information to inform the property owners about this program. More focused outreach to large property owners, SAMCAR and the California Apartment Association has mitigated some of this problem. People are still not accessing the funding available to them.

STARVISTA- The COVID Pandemic presented a number of challenges including lack of technology knowledge, and lack of technology resources, and StarVista works very hard to overcome and address these challenges. StarVista recognizes that NCOC agencies that partner and work together learn from each other and build knowledge about the communities served StarVista did find it challenging to stay connected to community as StarVista and clients found zoom and Teams challenging. Clients often do not have technology knowledge, understanding or resources. StarVista filed for several grants to provide resources such as prepaid tablets or iPhones for clients and created a training to demonstrate how to use these items.

DEMOGRAPHICS

Age	FY 20/21	Race/Ethnicity	FY 20/21
0-15	6%	American Indian/Alaska Native/Indegenous	70%
16-25	18%	Black/African-American	8%
26-59	45%	European	1%
60+	30%	Central American	2%
Decline to state	1%	Chinese	2%
Sex		Mexican/Chicano	8%
Male	49%	Filipino	1%
Female	36%	Asian	8%
Decline to state	15%		
Language			
English	70%		

Spanish	25%		
Mandarin	2%		
Cantonese	2%		
Tagalog	1%		

EAST PALO ALTO PARTNERSHIP FOR BEHAVIORAL HEALTH OUTREACH

The East Palo Alto Partnership for Behavioral Health Outreach (EPAPBHO) collaborative is comprised of community-based agencies from the East Palo Alto region of San Mateo County to provide culturally appropriate outreach, psycho-education, screening, referral and warm hand-off services to East Palo Alto region residents. One East Palo Alto (OEPA) served as the lead agency and work in collaboration with El Concilio of San Mateo County (ECSMC), Free at Last (FAL) and 'Anamatangi Polynesian Voices (APV). The program goals are as follows:

- Increase access for marginalized ethnic, cultural and linguistic communities accessing and receiving behavioral health services. The collaborative will facilitate connections between people who need mental health and substance use services to responsive programming (e.g. Parent Project, Mental Health First Aid, WRAP, support services, etc.) and/or treatment. Specifically, looking at how to increase access for children with seriously emotionally disturbed (SED) and adults and older adults with serious mental illness (SMI) or at high risk for higher level of care due to mental illness.
- Strengthen collaboration and integration. Establish effective collaborative relationships with culturally and linguistically diverse agencies and community members to enhance behavioral health capacity and overall quality of services provided to diverse populations. The Collaboration will improve communication and coordination among community agencies involved and with broader relevant efforts through the Office of Diversity and Equity (ODE), Health Equity Initiatives (HEI) and others.
- Establish strong linkages between the community and San Mateo County Behavioral Health & Recovery Services (BHRS). It is expected that there will be considerable collaboration that would include but not be limited to mutual learning. The Outreach Workers will receive trainings from BHRS and the Office of Diversity and Equity to support outreach activities as needed (e.g. Using Cultural Humility in Asking Sexual Orientation Gender Identity Questions, Health Equity Initiative sponsored trainings, etc.) Partnership with the regional clinic(s), ACCESS referral team and many other points of entry to behavioral health services will be prioritized by BHRS. Likewise, the collaborative agencies and outreach workers will work with BHRS regarding strategies to improve access to behavioral health services. They will build linkages between community members and BHRS to share vital community information through the participation input sessions, planning processes and/or decision-making meetings (e.g. boards and commissions, steering committees, advisory councils, etc.).
- Reduce stigma, including self-stigma and discrimination related to being diagnosed with a mental illness, substance use disorder or seeking behavioral health services. The Outreach Workers will

make services accessible, welcoming and positive through community approaches that focus on recovery, wellness and resilience, use of culturally appropriate practices including provision of other social services and engaging family members, speaking the language, efforts that address multiple social stigmas such as race and sexual orientation, and employment of peers. Specific anti-stigma activities can include, but not be limited to, community- wide awareness campaigns, education and training, etc.

The target populations served by EPAPBHO are marginalized ethnic, linguistic and cultural communities in the region including Latino, Pacific Islanders, African American/Black, and Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) communities of all ages.

EPAPBHO services are based on two key models of community engagement, the community outreach worker model and community-based organization collaboration.

- Outreach Workers (also known as promotores/health navigators) connect with and facilitate access for marginalized populations through culturally and language appropriate outreach and education and provide linkage and a warm hand-off of individuals to services. Outreach Workers are usually members of the communities within which they outreach to. They speak the same language, come from the same community and share life experiences with the community members they serve. Outreach Workers use a variety of methods to make contact with the community. From group gatherings in individuals' homes to street outreach and large community meetings, as well as make direct contact with target audiences, warm hand-offs and convey crucial information to provide community support and access to services.
- Strong collaborations with local community-based agencies and health and social service providers are essential for cultivating a base of engaged community members. Organizations leverage their influence, resources, and expertise, especially in providing services that address cultural, social and linguistic needs of the community. Collaboratives benefit from having regular meetings to share resources and problem solve, having a clearly defined infrastructure and consistent strategy and, offering ongoing presence and opportunities for community members to engage in services.

PROGRAM IMPACT

EPAPBHO	FY 20/21
Total clients served	254
Total cost per client	$802

Improves timely access & linkages for underserved populations:
Historically, the population served by EPAPBHO are undercounted and underserved. The partnership's on-going interventions provide timely access and linkages to treatment. For example, during initial screening, outreach workers engage clients when they either come in for services or when they are engaged in the community. During the verbal assessment, outreach workers help clients with presenting needs for which they are seeking services. Outreach workers listen non-judgmentally, assessing for risk of suicide or harm to self or others, give reassurance that there are local programs and services that will

address whatever their specific need or concern may be. If/when appropriate, an immediate referral to the appropriate agencies in SMCBHRS' SoC is made for assessment and follow up treatment. In most cases, partners make warm hand-off referrals by accompanying the consumer member to the agency and depending on their request, participate in the initial assessment appointment. This has become a standard practice for all EPAPBHO partners particularly among monolingual speakers who need translation services and rely on an ambassador that they know and trust.

Reduces stigma and discrimination:
EPAPBHO partners are founding members of the East Palo Alto Behavioral Health Advisory Group (EPABHAG), convened by OEPA. EPABHAG was created as an advocacy group to ensure that quality mental health services are provided to EPA residents. Over the years, it has partnered with SMCBHRS leadership to ensure that programs provided are created by the community and for the community. Major goals of the work have been to raise awareness of mental health issues and reduce the stigma associated with those issues. To this end, EPABHAG has held 12 annual Family Awareness Night events to achieve these goals with the most recent event held May 30th. Since its inception, EPABHAG has served over 1,000 residents through these events and have addressed topics including, but are not limited to mental health vs. mental illness, stigma, trauma, substance use, wellness and faith.

Increases number of individuals receiving public health services:
EPAPBHO partners facilitate connections between people who may need mental health and substance use services or other social services and relevant programming and/or treatment by:
- Performing initial screening and engaging potential clients
- Provide brief interventions to engage clients
- Refer members who may need behavioral health services to appropriate agencies in the SMCBHRS SoC for assessment and follow up treatment as needed.

Additionally, for most clients, continued support is needed to encourage participation in follow-up treatment. On many occasions, this means providing transportation when the services are outside of the East Palo Alto community, making a phone call as a reminder and as needed, accompanying them to sessions.

Reduces disparities in access to care:
(see comments above regarding stigma and discrimination)

Implements recovery principles:
EPAPMHO partners incorporate the five key recovery concepts into outreach efforts as follows:
1. Hope – People who experience mental health difficulties get well, stay well and go on to meet their life dreams and goals.
2. Personal Responsibility – It's up to individual, with the assistance of others, to take action and do what needs to be done to keep themselves well.
3. Education – Encouraging learning all what one is experiencing so they can make good decisions about all aspects of their life.
4. Self-Advocacy – Teaching how to effectively reach out to others so that one can get what it is that one needs, wants and deserves to support wellness and recovery.

5. Support – Allowing others to provide support while working toward one's wellness and giving support to others will help one feel better and enhance the quality of one's life.

MHSA Intended Outcomes:
- Reduce the duration of untreated mental illness
  The EPAPBHO outreach form collects the following data points.
    o Has the individual had a previous outreach contact with this organization?
    o Was the individual referred to Mental Health or System of Care services?
    o Was the individual referred to Substance Use or System of Care services?
- Prevent mental illness from becoming severe and disabling
  The EPAPBHO outreach form collects the following data points:
    o Has the individual had a previous outreach contact with this organization?
    o Was the individual referred to Mental Health or System of Care services?
    o Was the individual referred to Substance Use or System of Care services?
- Reduce any of the following negative outcomes that may result from untreated mental illness
  The EPAPBHO outreach form collects the following data points:
    o Does the individual have any disabilities or learning difficulties?
    o Is the individual homeless or at risk for homelessness?
    o Is the individual a veteran?
    o Has the individual had a previous outreach contact with this organization?
    o Was the individual referred to Mental Health or System of Care services?
    o Was the individual referred to Substance Use or System of Care services?
    o Was the individual referred to other services (Emergency/Protective Services; Financial Employment; Food; Form Assistance; Housing/Shelter; Legal; Medical Care; Transportation; Health Insurance)?

SUCCESSES

FAL continues its strong work with clients in recovery. Their work with clients dealing with behavioral health and/or co-occurring issues is ongoing and consistent. They have a close partnership with the East Palo Alto Community Counseling Center and its staff, meeting once a month or when necessary to go through cases and ensure that treatment is effective. Due to COVID-19, FAL has had to adapt and change their way of doing business on a daily basis. Most appointments or services with therapist or doctors have been via phone and others via zoom. FAL has recently reported that they are grateful to the 3rd Floor for being open to concerns the partnership had a few months ago about same-day access and services. The issue was brought to the partnership which met with BHRS staff and leadership. Following the meeting where protocols were clarified, the partners felt heard and procedures were clear about clinic hours and client referrals process.

ECSMC notes the successes of the program is that "we are able to offer this service in true partnership support with providers and BHRS. The established trust and confidence that allow the clients to open up allows us to reduce stigma that plagues the community and be able to make referrals."

"Some clients who were referred to mental health return to the office for other services, I ask them if they are already going to psychological therapy and some say yes and I ask them how they feel now receiving that therapy and some say they can see the problems and things differently."

"One client came to the office displaying very sensitive behavior as she could not speak without crying. We had spoken to her about mental health services and she barely responded but indicated she was seeing someone. We encouraged it. The next time we saw her she looked better and was grateful for the encouragement. She confirmed she had returned to her counselor. She was happy and looked so much better, we almost did not recognize her. This was a great moment of shared joy."

Anamatangi Polynesian Voices (APV) recognizes that a multi-level approach to addressing the issues experienced by youth and young adults (in-school students and out-of-school) has been the intervention needed to succeed in serving families. As yet another successful intervention provided by Mamadee is her work at the Juvenile system in the County. Mamadee has been working with young people who have been referred to her by County Probation to provide intervention for these young men and their families. With her cultural/linguistic intervention, Mamadee has been successful in serving the young men and their families and connecting them to other programs in the community. A success story reported by APV is as follows:

Fotu Kofutua, a 14 year-old 9th Grader at Menlo Atherton (MA) was referred to APV three weeks ago. Fotu is new to the United States, having immigrated here with his family when he was 10 years old. He attended Ravenswood City School District, the local school district that serves EPA students. Some of the issues experienced by Fotu as a newcomer to the States is culture shock, English language barriers and issues of mental health including anger. He had been suspended from MA three times and was eventually referred to APV for services. Mamadee addressed the issues that Fotu was dealing with by active listening to his issues without judgment and building rapport and trust. Over the course of three weeks, Mamadee has seen great improvement with Fotu as he has been engaged in APV's activities and programs and well as spiritual guidance by Rev. Dan Taufalele. APV has also been working with CORA to support some of the mental health issues that have come up for Fotu. Mamadee and her staff look forward to continued progress as they work to support Fotu as well as many other students that APV works with.

CHALLENGES

FAL describes their biggest challenge this year being COVID-19 and how it has changed everything; adapting to the pandemic to continue pivoting and evolving their way of helping the community.

ECSMC's challenges are similar to years past – "The challenges are still in the belief that only people who are crazy are the ones who go with the signs and job as a community worker is to change that myth. We always tell them that I have the opportunity is that psychological therapy is like going to the Dr. for a disease of the body and that the mind also needs help to be healed."

APV staff have definitely experienced the impact of COVID-19 on their families throughout their pandemic. In-person gatherings and face-to-face meetings are the methods of engaging Pacific Islanders (PI) and young people in the community. Over the years, raising awareness and reducing stigma around mental health have been conducted through creative PI gatherings such as music, song, dance and drumming as well as meals. Home visits have been the way to reach parents about their children, meeting face-to-face, explaining processes of school systems, social service systems, behavioral health

systems and supporting their navigation have been Mamadee and her team's success. However, COVID-19 exacerbated the barriers that families have dealt with, leading to clients and families suffering in silence from the pandemic, depression, unemployment, health issues, undocumented status, etc.
To mitigate the challenges, APV has pivoted their outreach and referral process to include wellness checks via phone and email, delivered wellness packages to homes, referrals and warm hand-offs to community resources and assistance programs. They will continue to develop and adapt programming as the pandemic continues in order to meet the growing need in the community. Since things have been opening up recently, APV has been able to hold in-person social distancing gatherings in their outdoor tent and most recently, have been able to hold a cultural identity event at Cooley Landing, in partnership with St. Francis High School focusing on youth. The event drew over 200 students and families.

DEMOGRAPHICS

Age	FY 20/21	Race/Ethnicity	FY 20/21
0-15	9%	Black/African-American	2%
16-25	3%	White/Caucasian	3%
26-59	86%	Asian Indian/South Asian	1%
60+	2%	Fijian	1%
Decline to state	1%	Central American	14%
		Chinese	1%
Sex		Asian	2%
Male	24%	Mexican/Chicano	56%
Female	74%	Filipino	3%
Decline to state	1%	Another race/ethnicity	19%
Language			
English	17%		
Spanish	80%		
Mandarin	1%		
Another language	1%		
Tagalog	1%		

CARIÑO PROJECT
Refer to the program outcomes included in the section above, under Community Services and Supports (CSS) Outreach & Engagement (O&E).

SENIOR PEER COUNSELING
Refer to the program outcomes included in the section above, under General System Development-Older Adult System of Care.

OUTREACH WORKER PROGRAM

The Outreach Worker program existed under the Office of Diversity and Equity (ODE) to identify existing gaps in service provision that lead to underutilization of behavioral health and substance use recovery services by Lesbian, Gay, Bisexual, Transgender, Queer+ (LGBTQ+) and the Native Hawaiian and Pacific Islander (NHPI) communities. The primary program activities involved: providing trainings and consultation to service providers across BHRS, contract providers, SMC Health division partners and community organizations; connecting community members to culturally responsive services; and strengthening collaboration with partners to create community events to increase opportunities for connection, as well as bring awareness to community issues and challenges.

The program was resourced with limited-term positions that have since termed out and programs terminated. Similar to the Chinese Outreach Worker pilot project under ODE, the funding has been directed to support these communities through ongoing partnerships and contracts serving these communities.

STIGMA AND DISCRIMINATION REDUCTION

MENTAL HEALTH AWARENESS AND #BETHEONESMC CAMPAIGN

#BeTheOneSMC is San Mateo County's anti-stigma initiative and aims to eliminate stigma against mental health and/or substance use issues in the San Mateo County community. #BeTheOneSMC can mean many things to different people. #BeTheOneSMC's main message is that you can be that ONE who can make a difference in reducing stigma and promoting wellness in the community.

Primary program activities and/or interventions provided include:
- Annual May Mental Health Month (MHM) Observance: This is one of the biggest mental health observances of the year for San Mateo County. The 2020 MHM consisted of:
  - o Planning Committee which planned and implemented the 2020 MHM countywide virtual events. Planning committee members included clients/consumers, family members, county staff and community-based organization staff. Planning committee meetings convened from December 2019 to June 2020.
  - o Proclamation which is the opportunity for the Board of Supervisors to officially proclaim and recommit to May MHM. There was a 10-minute presentation followed by public comment.
  - o Event Support & Mini-Grants which is an opportunity for County and community partners to apply for event support and funding for their MHM event. Mini-Grants were distributed to 5 grantee recipients ($200 per grantee). Event support included:

- Input/ideas on event theme, programming, communication/outreach and logistics
- Speakers with lived mental health and/or substance use experience
- Digital stories for screening
- Photo voices for exhibits
- Event flyer template
- Event promotion on website and social media (Facebook, Twitter and blog)
- Evaluation template
- Volunteer to support with day-of event logistics
  - o Communication Campaign which involved Facebook, Twitter and blog posts throughout the month.

- Community Stigma Baseline Survey: San Mateo County launched and completed a Community Stigma Baseline Survey around mental health and substance misuse knowledge, beliefs and behavior. The San Mateo County Behavioral Health & Recovery Services Office of Diversity and Equity commissioned an independent research firm, Strata Research Inc., to implement a baseline survey among San Mateo County residents who were at least 18 years of age. This 15-minute survey was completed by 450 residents in San Mateo County during March 2020. This survey built off of the statewide mental health stigma survey conducted by RAND Corporation.

PROGRAM IMPACT

Mental Health Awareness	FY 20/21
Total clients served	3,000
Total cost per client	$32

The #BeTheOneSMC (Stigma Discrimination Reduction) initiative
- Improves timely access and linkage to treatment for underserved populations (#1) and increases the number of individuals receiving public health services (#3) by raising awareness in the community about behavioral health resources through online communication and outreach.
- Reduces stigma and discrimination (#2) by providing education and sharing stories of those with lived experience through community events and social media.
  Reduces disparities and inequities to access to care (#4) by hosting activities that target specific marginalized communities in different regions of the county. For 2020-2021, specific marginalized communities targeted including youth, older adults, new mothers, Spanish and Mandarin speaking, people of color (including African American and Asian Pacific Islander) and LGBTQ+ community.
  Implements recovery principles (5) by integrating key recovery principles (particularly individualized and person-centered, respect, and hope) in the communication messages and framing of events.

There was a total of over 43 MHM events with collectively about 3,000+ people reached (estimated based on attendees and views of recording). 160 survey responses collected from 20 out of 43 events. Results are shown below. Of the collected responses:

- 94% (149/158) are MORE willing to take action to prevent discrimination against people with mental health conditions.
- 18% (28/158) are MORE likely to believe that people with mental health conditions are never going to contribute much to society.
- 89% (141/158) are MORE likely to believe that people with mental health conditions can eventually recover.
- 94% (149/159) are MORE willing to seek support from a mental health professional if I thought I needed it.
- 90% (143/159) are MORE willing to talk to a friend or a family member if I thought I was experiencing emotional distress.
- 89% (141/159) learned how to better care for my mental health and seek help if need it.
- 90% (142/158) agree that this program was relevant to me and other people of similar cultural backgrounds and experiences (race, ethnicity, gender, religion, etc).

SUCCESSES

Three key successes listed below.
1. For the very first time, four cities in San Mateo County (Brisbane, Hillsborough, Redwood City, and South San Francisco) lit up their buildings in green to symbolize mental health awareness month, and nearly all cities (19 out of 20) proclaimed May as Mental Health Month.

Hillsborough, May 2021

Brisbane, May 2021

South San Francisco, May 2021

2. The May Mental Health Month Livestream Kickoff was also a success with over 2,200 views.
3. After learning about inclusive mental health language, the Mental Health Month Planning Committee Members who were also Mental Health Substance Abuse Recovery Commission proposed to change their Commission name change to be more inclusive and not stigmatizing.

Here is quote about the overall success of 2021 May Mental Health Month from William Kruse, Spirituality Initiative, San Mateo County Behavioral Health & Recovery Services,
"it was the best Mental Health Month that I have been a part of. I have participated in all MHMs except for one over the last decade and it was the best coordinated, the most inclusive and more people were reached than in any other I am aware of. The leadership was excellent for it was supportive, compassionate and yet goal oriented. A wonderful combination to make Mental Health Month of May 2021 the best."

CHALLENGES

As similar to last year, the main challenge and area of growth is to broaden the reach, especially to marginalized communities with greater behavioral health need. Solutions to mitigate the challenge of broader outreach include:
- Create a communication map with special emphasis on marginalized communities with greater behavioral health need (based on available county or state data)
- Media engagement (e.g. print, radio, television) to reach a very wide audience
- Targeted outreach to marginalized communities.

When reaching a broader audience, one of the family members and Mental Health Month Planning Committee members – Michael Lim – gave the following input: "The statewide theme for this year's MHM is #HopeForChange. Appropriately so because Hope is a staple from those working through their Recovery, and Change is an inevitable for things to get better. Political, social, & health events have all raised the consciousness to mental health, and how vital it plays to overall wellbeing. To meet the challenge, this year's BHRS's MHM team have organized about 50 events, and have involved almost all the cities throughout the county to participate in this awareness.
On reaching this level of critical mass, instead of just educating the community on what mental health is and what it is like to live with a mental health challenge, there is readiness to take the next step. The step of providing the tools on how to talk about, how to think about, & what to do about mental health.

A good start was a co-sponsored NAMI-SMC & Menlo Park Library entitled "The Impact of Negative Attitudes, and 5 Things each of us can do to make the community a better place for people experiencing a Mental Illness." It is time to shift the me-them conversation to the we-us conversation. It is time to expand the talk from mental health, to Mental Wellness.'

DEMOGRAPHICS

Age	%	Gender Identity	%
Age 16-25	6%	Male/Man/ Cisgender	20%
26-59	60%	Female/ Woman/ Cisgender Woman	74%
60+	31%	Transgender Male	0%
decline to state	3%	Questioning	1%
Race/Ethnicity	%	Genderqueer/ Nonconforming	3%
Asian	22%	Another gender identity	0%
Black/ African- American	16%	Decline to state	3%
White/ Caucasian	50%		
Asian Indian/South Asian	1%		
Native Hawaiian or Pacific Islander	4%		
Declined to State	4%		
Another race/ ethnicity or Mixed Race	19%		
Sexual Orientation	%	Disability/ Learning difficulty	%
Gay, lesbian, homosexual	N/A	Physical/ mobility disability	N/A
Straight or heterosexual	N/A	Chronic health condition	N/A
Bisexual	N/A	Cognitive Disability	N/A
Queer	N/A	I do not have a disability	N/A
Pansexual	N/A	Another disability	N/A
Asexual	N/A	Decline to state	N/A
Questioning or unsure	N/A		
Indigenous Sexual orientation	N/A		

SUICIDE PREVENTION

SUICIDE PREVENTION COMMITTEE

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

- Suicide Prevention Committee (SPC): The purpose of the SPC is to provide oversight and direction to suicide prevention efforts in San Mateo County. The SPC meets every month. The target population is a diversity of community partners, suicide survivors and the San Mateo County community at large. For 2020-2021, SPC focused on three projects (1) Suicide Prevention Roadmap Public Input, (2) Communication Workgroup (mainly for Suicide Prevention Month) and (3) Data Workgroup (mainly for Health and Quality of Life and Stigma Baseline surveys).

- September Suicide Prevention Month (SPM): The purpose of SPM is to encourage all in the community to learn how everyone has a role in preventing suicide. The 2021 SPM included a: (1) proclamation, (2) event support and mini-grants, and (3) events hosted by community partners. For 2021, SPM focused on the theme #StrongerTogether. Unlike most years, the local crisis center Star Vista was contracted to lead SPM efforts.

- Suicide Prevention Roadmap: The Suicide Prevention Roadmap development started in October 2019 and continues through this reporting period. In August 2020, public input was gathered for the draft plan and, in spring 2021, a graphic designer was confirmed to help finalize the plan which was published September 30, 2021.

PROGRAM IMPACT

Suicide Prevention Committee	FY 20/21
Total clients served	500
Total cost per client	$191

Improves timely access & linkages for underserved populations:
Promote the crisis hotlines and emergency contacts in public events, meetings, campaigns and documents that target the general San Mateo County community, including those targeted specifically

to certain marginalized communities.

Reduces stigma and discrimination:
Provide training/education and communication campaign around suicide and suicide prevention that (1) increase knowledge about suicide and (2) promote stories of hope and recovery.

Increases number of individuals receiving public health services:
Promote the crisis hotlines and emergency contacts in public events, meetings and campaigns that target the general San Mateo County community.

Reduces disparities in access to care:
Target some interventions on groups with high risk of suicide. In 2020-201, specific targeted groups included youth, parents of youth, older adults, people of color, food service workers, veterans and those with mental health and/or substance use issues.

Implements recovery principles:
Integrating key recovery principles (particularly individualized and person-centered, respect, and hope) in the communication messages and framing of events.

SUCCESSES

For the suicide prevention program in 2020-2021, one of the key successes was the Suicide Prevention Roadmap Online Forums in August 2021. Both forums offered Spanish and Mandarin interpretation and promoted the event with a flyer translated in Spanish and Chinese Simplified. There were a total of 40 participants who attended both forums.

Another key success was that the Mental Health Substance Abuse Recovery Commission (MHSARC) recommended person-centered Caltrain Strike Incident Messaging. At the September 2 MHSARC meeting, the San Mateo County Suicide Prevention Committee (SPC) presented recommendations on more person-centered language for Caltrain strike incident messaging (or communications to passengers and the press when someone is struck on the Caltrain tracks). Caltrain has been a member of the SPC since its inception in 2009, when there were clusters of youth suicides by train. Since September 2019, SPC co-chairs and Caltrain staff have been meeting monthly to work on suicide prevention efforts. The SPC has been particularly interested in improving Caltrain strike incident messaging since over half of Caltrain fatalities are intentional (due to suicide) and there has been passenger and public feedback to make the messaging more humane and less stigmatizing. MHSARC unanimously voted to forward SPC's recommendation to Supervisor Dave Pine who sits on both the MHSARC and Caltrain Board of Directors.

CHALLENGES

The main challenge was implementing the Suicide Prevention Committee Docuseries Workgroup. Implementation was challenging possibly because the workgroup project largely depended on decisions of a non-profit film making partner and this partner was not available to be engaged regularly with the

Suicide Prevention Committee. In the future, workgroup projects will be focused on those that the Suicide Prevention Committee has more control and decision-making power over.

DEMOGRAPHICS

Age	%	Sex assigned at birth	%
Age 0-15	4%	Male	40%
Age 16-25	8%	Female	60%
26-59	68%	Decline to state	0%
60+	20%		
Decline to State	0%		
Primary language	%	Gender Identity	%
English	64%	Male/Man/ Cisgender	40%
Spanish	32%	Female/ Woman/ Cisgender Woman	56%
Mandarin	4%	Transgender Male	0%
		Transgender Woman	0%
Race/Ethnicity	%	Questioning/ unsure	0%
European	24%	Genderqueer/ Nonconforming	0%
White/ Caucasian	52%	Indigenous gender identity	0%
Central American	8%	Another gender identity	0%
Mexican/ Chicano	32%	Decline to state	4%
American Indian/Alaska Native/Indigenous	8%		
Filipino	4%	Disability/ Learning difficulty	%
Puerto Rican	0%	Difficulty seeing	8%
Samoan	0%	Difficulty hearing or having speech understood	0%
Japanese	0%	Dementia	0%
South American	8%	Developmental disability	0%
Another race	0%	Physical/ mobility disability	8%
Another ethnicity	0%	Chronic health condition	12%
Decline to state - race	8%	Learning disability	0%
Decline to state – ethnicity	0%	I do not have a disability	68%
Sexual Orientation	%	Another disability	20%
Gay, lesbian, homosexual	4%	Decline to state	4%
Straight or heterosexual	80%		
Bisexual	8%	Veteran	%
Queer	4%	Yes	16%
Pansexual	0%	No	84%
Asexual	0%	Decline to state	0%
Questioning or unsure	0%		

Indigenous Sexual orientation	0%		
Another sexual orientation	0%		
Decline to state	0%		

CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY (CALMHSA)

CalMHSA implements PEI Statewide Projects including Suicide Prevention, Stigma and Discrimination Reduction, and the Student Mental Health Initiative. CalMHSA is a Joint Powers Authority (JPA), formed July 2009 as solution to providing fiscal and administrative support in the delivery of mental health services.

INNOVATIONS (INN)

INNOVATIONS (INN)

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

The development MHSA Innovation Projects is part of the comprehensive Community Program Planning (CPP) process. As mentioned in the planning section of this Annual Update, new INN projects are just getting launched.

The INN projects that were active in San Mateo County through FY 20-21 included:
- The San Mateo County Pride Center
- Help@Hand (Tech Suite)

Please see Appendix 10 for the INN Evaluation Reports.

WORKFORCE EDUCATION & TRAINING (WET)

WORKFORCE EDUCATION AND TRAINING (WET)

WET exists to develop a diverse workforce. Clients and families/caregivers are trained to help others by providing skills to promote wellness and other positive mental health outcomes, they are able to work collaboratively to deliver client-and family-driven services, provide outreach to unserved and underserved populations, as well as services that are linguistically and culturally competent and relevant, and include the viewpoints and expertise of clients and their families/caregivers. WET was designated one-time allocation totaling $3,437,600 with a 10-year reversion period. In the spring of 2017, the BHRS Office of Diversity and Equity (ODE) hired an independent consultant to assess the impact of WET and identify priorities that would shape the future landscape. Ongoing WET activities are funded by MHSA at $500,000 per year.

As part of the mission of the Office of Diversity and Equity, which is "…in collaboration with and for community members, the Office of Diversity and Equity (ODE) advances health equity in behavioral health outcomes of marginalized communities throughout San Mateo county; the WET Team, informed by broader social justice and equity efforts, a wellness and recovery orientation and two advisory committees, strives to equip the workforce, consumers, and family members for system transformation by planning, coordinating, and implementing a range of initiatives, trainings, and program activities for the Behavioral Health and Recovery Services (BHRS) workforce, consumers/family members, and community partners.

There are several distinct populations served directly by the WET Team. The BHRS Workforce, people contracted by San Mateo county to provide behavioral health services, consumers and family members and subgroups of those populations actively participate in the program activities. For example, WET program areas such as the BHRS Clinical Internship/ODE Internship programs are implemented for Interns and other non-licensed/certified staff/community providers to gain knowledge and supervised professional experience in a local government setting. One of the broader objectives of the internship programs is to attract and retain a diverse workforce to better serve the San Mateo County communities.

As a program area of ODE, the WET Team also focuses on providing program activities that are in alignment with the best practices established by ODE and policies implemented by the County and this includes modeling the ODE Team values across the work. For instance, pronouns are disclosed when introducing ourselves at trainings and meetings. The WET Team program areas may be categorized into three broad areas. Training and Technical Assistance, Behavioral Health Career Pathways and WET Workplace Enhancement Projects. The annual training plan and education sessions to provide up-to-date information on practices, policies and interventions approved for use in BHRS is an integral component of the Training and Technical Assistance area. Interns who have obtained an internship in one of the more than 20 clinic and program training sites can collaborate with the County's Health Equity Initiatives in the Cultural Stipend Internship Program which is supported by the Behavior Health Career Pathways program area. As part of the BHRS Workforce Enhancement Projects, the WET team was actively involved in the successful, inaugural BHRS Mentorship Program.

PROGRAM IMPACT

The WET Team of the Office of Diversity & Equity provides programs that build the capacity of the workforce, community providers, and consumers and family members. Primarily providing training/education/development. It is imperative for underserved, marginalized community members and populations to have timely access and links to services, in their many forms provided by the county. Those communities include ethnic/racial communities, communities' members with limited English proficiency and member of the LGBTQ communities. However, there are sometimes barriers which may hinder the timely access. Some of those barriers might include lack of language services, lack of cultural humility, lack of knowledge of trauma informed care practices and/or recovery as a lifestyle. WET activities help to reduce stigma and discrimination by training providers, community members. Most workforce education activities have an indirect impact however, without it, members of the community may suffer lack of access to services or insufficient services. By attending some events as a constant presence, trust is built and communities are more likely to reach out when they or someone they know may need of services. Equity is a core principle in WET trainings.

- Total number of WET Implemented/Supported trainings: 42
- Total number of Attendees: 704
- Total number of ASIST/Suicide Prevention Trainings: 0 (Living works only allowed for in-person training, which was not possible during the 2020-2021 year.
- Total number of Cultural Humility/Working with Interpreters/SOGI: 9 (including Training of Trainers)
- Total number of Trauma/Resiliency Related Trainings: 4 including NMT
- Total number of For/By Consumers & Family Members: 61
- Total number of AOD/Integrated Behavioral Health: 4
- Total number of Health Disparities Trainings: 2
- Other**: 1 (Eating Disorders)

*Many trainings are open to consumers and family members.   Many consumers and family members attend the training that are not directly for or provided by them.

**Other trainings include: ABC's of Child Family Treatment(CFT), Crisis Response Team, (Clinical)Supervisors' Training, Internship orientation, Photovoice, BHRS New Hire Orientation, Prevention & Management of Assaultive Behavior, Child & Adolescent Needs & Strengths (CANS) Training, and Law & Ethics for Behavioral Health Providers.

The WET team was able to successfully implement virtual trainings as a response to the COVID-19 pandemic. One of the main initiatives for the 2020-2021 fiscal year was to implement the Relias Behavioral Health Library Solutions supplement to the San Mateo County LMS in order to extend and expand online courses/trainings for all BHRS staff and providers. The WET team successfully trained the first cohort of the BHRS EMDR Training Program, Mindfulness Based (MBSAT), Eating Disorders Training and continued to virtually provide trainings in Prevention & Management of Assaultive Behaviors, Becoming Visible Using Cultural Humility in Asking SOGI Questions. The WET team has also successfully collaborated with AOD services to structure their service plan for staff members. The team also successfully supported April provider wellness month with deputy directory Xiomara Ochoa through 17 trainings with over 200 participants. CSIP interns successfully conducted and collected data pertaining to COVID-19 vaccine in San Mateo County and its underrepresented, and underserved community. Started

to update all MOU's for internship program. Lastly the WET team participated in the regional WET collaborative.

CHALLENGES

One of the greatest and most consistent challenges to implementing WET program activities was the impact of the COVID-19 pandemic along with the inability to provide ASSIST trainings due to lack of permission provided by contractor for virtual trainings. Additionally, the loss of staff contributed to hurdles faced during the 20-21 fiscal year. Due to these factors the WET team had to reduce the amount of participants per training session, as trainings were virtual. Additionally due to the pandemic, there were fewer applicants for internships within BHRS.

HOUSING

HOUSING

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

Since 2006, the MHSA Housing Program funded 71 housing units across housing developments in Redwood City, South San Francisco, San Mateo and North Fair Oaks community.

Year	Housing Development and Location	Units
2009	Cedar Street Apartments 104 Cedar St., Redwood City	14 MHSA units 14 total units
2010	El Camino Apartments 636 El Camino Real, South San Francisco	20 MHSA units 106 total units
2011	Delaware Pacific Apartments 1990 S. Delaware St., San Mateo	10 MHSA units 60 total units
2017	Waverly Place Apartments 105 Fifth Ave, North Fair Oaks	15 MHSA units 16 total units
2019	Bradford Senior Housing 707-777 Bradford Street, Redwood City	6 MHSA units 177 total units
2019	2821 El Camino Real, North Fair Oaks	6 MHSA units 67 total units
		71 Total MHSA Units

CAPITAL FACILITIES &
INFORMATION TECHNOLOGY (CF/IT)

E-CLINICAL 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 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.

Currently, devices (phones, tablets) and data plans are provided to BHRS clients to support their engagement with telehealth and other online supports. $330,000 per year is allocated to CFTN for client devices and data plans.

APPENDICES

APPENDIX 1. MHSA STEERING COMMITTEE MEETING MATERIALS

Be the one to help

Mental Health Service Act (MHSA)
MHSA Steering Committee

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

The MHSA Steering Committee meets the first Thursday at 3pm in February, May, September and December to provide input, make recommendations and stay up-to-date on new MHSA developments and ongoing programming.

Meeting objectives include:

- Provide final input on the MHSA Steering Committee goals moving forward.

- Learn all about the MHSA Full Service Partnerships, current Statewide FSP evaluation efforts and how to get involved.

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

Please contact us at mhsa@smcgov.org at least 2 weeks in advance to reserve language services.

DATE & TIME

Thursday, September 2, 2021
3:00 pm – 4:30 pm

Zoom Meeting:
https://us02web.zoom.us/j/83216209789
Dial in: +1 669 900 6833
Meeting ID: 832 1620 9789
iPhone one-tap: +16699006833,,83216209789#

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

www.smchealth.org/MHSA

SAN MATEO COUNTY HEALTH
**BEHAVIORAL HEALTH
& RECOVERY SERVICES**

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

Mental Health Services Act (MHSA)
Steering Committee Meeting

Thursday, September 2, 2021 / 3:00 – 4:30 PM
Zoom Meeting: https://us02web.zoom.us/j/83216209789
Dial in: +1 669 900 6833 / Meeting ID: 832 1620 9789

AGENDA

1. **Welcome**   5 min
   Jean Perry, MHSARC Commissioner
   Leticia Bido, MHSARC Commissioner

2. **Logistics & Agenda Review -** *Doris Estremera, MHSA Manager*   5 min
   - Previous meeting minutes available on the MHSA website,
     www.smchealth.org/MHSA

3. **General Public Comment** – *Leticia Bido*   10 min
   - For non-agenda items
   - Additional public comments can also be submitted via email to
     mhsa@smcgov.org.

4. **MHSA Steering Committee Goals & Workgroups** – *Jean Perry*
   - DRAFT MHSA Steering Committee Goals   10min
     o Public Input

5. **MHSA Full Service Partnerships (FSPs) -** *Third Sector consultants*   20 min
   - FSP 101 and Background
   - Statewide FSP Project
   - San Mateo County Client/Families and Provider Input
     o Public Input   30 min

6. **Adjourn**

* Public Participation: All members of the public can offer comment at this public meeting; there will be set opportunities in the agenda to provide Public Comment and input. You can also submit questions and comments in the chat; these will be addressed on a "first-come, first serve" basis. If you would like to speak, please click on the icon labeled "Participants" at the bottom center of the Zoom screen then click on "Raise Hand." The host(s) will call on you and you will unmute yourself. Please limit your questions and comments to 1-2 minutes.

The meeting will be recorded. Questions and public comments can also be submitted via email to mhsa@smcgov.org.

***REMINDER** – Please Complete the Steering Committee Feedback Survey*

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

Mental Health Services Act (MHSA)
Steering Committee Meeting
September 2, 2021

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Before we begin…

- Introductions: your name, pronouns and affiliation in the chat
- Stipends for clients and family members participating
  - You can let us know in the chat (private message) - please provide your email
  - Or, please remain online after the meeting ends and we'll take your information
- Meeting is being recorded
- Quick Poll

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Participation Guidelines

- You can enter questions in the chat box as we go, and we will get to those first
- For each agenda topic there will be public input time – you can use the "Raise Hand" button and unmute yourself when called on.
- If you have a general public comment (non-agenda items), let us know in the chat.
- Share your unique perspective and experience
- Share the airtime; allow every voice to be heard (step up/step back)
- Practice both/and thinking; consider all ideas along with your personal advocacy
- Be brief and meaningful when voicing your opinion

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BEHAVIORAL HEALTH & RECOVERY SERVICES

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Agenda

1. MHSA Background
2. General Public Comments
3. MHSA Steering Committee Goals & Workgroups
4. MHSA Full Service Partnerships (FSPs)
   - FSP 101 and Background
   - Statewide FSP Project
   - San Mateo County Client/Families and Provider Input

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MHSA Background

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

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

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

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

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

1% tax on personal income over $1 million
San Mateo County: $30.7M annual 5-year average through FY 19-20; ~15% of the BHRS budget

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1. General Public Comments
(non-agenda items)

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BEHAVIORAL HEALTH & RECOVERY SERVICES

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2. MHSA Steering Committee Goals & Workgroups

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Proposed Steering Committee Goals

The MHSA Steering Committee:

1. Represents diverse community and stakeholder voices.

2. Engages and supports participation of individuals living with mental health challenges, their families and their direct service providers.

3. Includes equity and inclusion as an active goal of all MHSA processes and priorities.

4. Develops meaningful and simplified input processes.

5. Engages in funding, planning, implementation and evaluation decisions of MHSA services and programs.

6. Are active participants, attending Steering Committee meetings and workgroups and other planning processes as appropriate.

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Workgroup Participation Guidelines

- 10-12 participants to allow for deeper engagement
- "First-come, first-serve basis" based on the completion of an interest survey.
- If we receive more than 12 survey responses, a selection group will review the surveys and prioritize lived experience and cultural and stakeholder diversity.

FSP Workgroup participation survey:
https://www.surveymonkey.com/r/MHSAWorkgroup

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Public Input

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3. Full Service Partnerships (FSPs)

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Public Input

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Announcements

- **Suicide Prevention Month:** https://www.smchealth.org/suicide-prevention-month
- **Digital Literacy for Peers and Community Tech Cafe's**
  - www.smchealth.org/bhrs/mhsa, under "Announcements"
- **Subscribe at MHSA website to stay informed:**
  - www.smchealth.org/MHSA
- **Get Involved:**
  - https://www.smchealth.org/get-involved

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Thank you!

Jean Perry, MHSARC Commissioner
Leticia Bido, MHSARC Commissioner
Doris Estremera, MHSA Manager
Email: mhsa@smchealth.org
Website: www.smchealth.org/MHSA

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

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THIRD SECTOR

Multi-County Full Service Partnership (FSP) Innovation Project

Implementation Report | September 2021

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Project Partner: Third Sector
San Mateo County Learnings & Initiatives
Next Steps
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Executive Summary: Multi-County FSP Innovation Project

Implementing a more uniform data-driven approach to Full Service Partnerships using using one-time CSS unspent funds

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Origins of the Multi-County FSP Innovation Project

The Opportunity for Improvement

California has made significant strides since the creation of the Mental Health Services Act (MHSA). However, client outcomes data and concerns raised by county mental health directors suggests that counties still struggle to achieve the originally intended outcomes of the Full Service Partnership (FSP) program and understand their own impact.

An Initial County Pilot

From 2018 – 2020, the Los Angeles County Department of Mental Health partnered with Third Sector to transform the program into an outcomes-oriented and data-informed FSP that reflects the spirit of "doing whatever it takes."

The Multi-County Collaboration

Six counties -- Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura -- launched the Multi-County FSP Innovation Project to leverage their collective resources and experiences to transform how FSP data is used to continuously innovate and improve FSP services across California. While most counties are using their Innovation Plan funding to support the project, San Mateo County is using one-time CSS unspent funds.

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The Multi-County FSP Innovation Project focuses on five shared goals

Project Goals
Upon completion of the Multi-County FSP Innovation Project, counties will have increased capacity for collecting and using data for FSP services. These improvements will support participating counties' clients in their recovery and improve the statewide system.

1 Develop a shared understanding and more consistent interpretation of FSP's core components across counties, creating a common FSP framework

2 Increase the clarity and consistency of enrollment criteria, referral, and graduation processes through developing and disseminating clear tools and guidelines across stakeholders

3 Improve how counties define, track, and apply priority outcomes across FSP programs

4 Develop a clear strategy for tracking outcomes and performance measures through various state-level and county-specific reporting tools

5 Develop new and/or strengthen existing processes for continuous improvement that leverage data to foster learning, accountability, and meaningful performance feedback

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We are leveraging a multi-stakeholder partnership to accomplish project goals over the course of 4.5 years

2019 — **Phase I Plan:** Counties worked with Third Sector and the MHSOAC to build a new partnership that would encourage peer learning, further improvement to FSPs, and accelerate county collaboration

2020 — **Phase II Landscape:** An 8-month "listening and "learning" (Landscape Assessment) phase allowed us to gather context and feedback from County staff, providers, and consumers

2021 — **Phase III Implement:** 12 months of implementation activities that were informed by a prioritization process that ensures we are meeting government and stakeholder needs

Phase IV Sustain: A 2-month dedicated sustainability period will support counties in cementing collaborative continuous improvement processes

2022

2023 — **Phase V Evaluate:** During the 2.5-year evaluation period, RAND will assess the contributions of this project to statewide learning and improved FSP outcomes

2024

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California's Full Service Partnership (FSP) delivers a "whatever it takes" approach to comprehensive, community-based mental health services

Population

FSP serves over 60,000 individuals and families across California experiencing severe emotional disturbances or serious mental illness.

$ Funding

The County directs the majority of its CSS to fund FSP

Services

FSP providers deliver a diverse range of evidence-based services modeled after ACT and AB2034 (pilot of recovery-oriented approach targeting homeless SMI) including therapy, psychiatric services, peer supportive services, housing services, and a wide range of case management services geared towards developing life skills and coping mechanisms.

Outcomes

As stipulated in the Mental Health Services Act (MHSA) Regulations, FSPs provide **consumer-centric services to achieve goals** identified in individuals' Individual Services and Supports Plans (ISSP).

*California counties are provided **substantial flexibility** in FSP operations, data collection, and approaches. While this local control has supported innovative, community-responsive services, **counties have different operational definitions and inconsistent data processes**, making it **challenging to understand and tell a statewide impact story**.*

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Project counties and the MHSOAC contributed $8.3M of state and local funding to support the multi-year collaboration

Project Roles & Responsibilities

Counties: The participating counties are Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura. Lake and Stanislaus will be joining the project as a Wave 2 in August 2021.

Third Sector: Third Sector is providing project management, outcomes-focused technical assistance, and implementation support.

RAND: RAND is providing data and outcomes technical assistance, data cleaning and quality improvement support, and conducting the overall project evaluation.

CalMHSA: CalMHSA is serving as the project's fiscal intermediary, including contract and fiscal management as well as administrative oversight.

MHSOAC: The CA Mental Health Services Oversight and Accountability Commission (MHSOAC) supported the Innovation planning process as well as the development of statewide project resources and Learning Community events.

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Project Partner: Third Sector

A non-profit advisory firm transforming public systems to advance improved and equitable outcomes

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Third Sector is a non-profit that brings government closer to communities by aligning policy, dollars, data, & services for improved & equitable outcomes

Anatomy of an Outcomes Orientation

Evaluate the effect of services on outcomes to inform policy decisions, improving the efficiency and effectiveness of spending over time

Implement policies that link funding to outcomes, providing increased flexibility and transparency in spending of taxpayer dollars

POLICY

DATA

BETTER OUTCOMES

DOLLARS

Share data to support service delivery focused on outcomes, allowing providers to align services with the needs of their community

SERVICES

Utilize contracts to leverage flexible funding by creating incentives for coordination, innovation, and continuous improvement in services

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Third Sector helps government and communities use data and lived experience to strengthen human services and improve lives

Third Sector Engagements

19

Launched Outcomes-focused Contracting Projects

75+

Consulting Engagements

Since 2011, Third Sector has worked with 40+ communities to deploy more than $1.2 billion in government resources toward improved outcomes

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San Mateo County Initiatives & Learnings

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San Mateo County Implementation Activities

San Mateo County Department of Behavioral Health and Recovery Services collaborated with providers to select the following activities to work on during the Multi-County FSP Innovation Project.

ELIGIBILITY CRITERIA

Revise county-specific FSP eligibility criteria to ensure that counties **prioritize FSP services to the highest-need clients**.

SERVICE REQUIREMENTS

Develop **minimum service requirements of FSP to adopt as official guidance**. E.g.: % of field-based services, telehealth options, housing and employment services offered, peer supports available, etc.

STEP DOWN GUIDELINES

Develop **standardized graduation guidelines** to support staff in making individual stepdown and graduation decisions while considering ISSPs and system-wide outcomes. Guidelines include improved definitions of "stability" and discussion prompts.

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San Mateo County Activities and Next Steps

Activities Under Development	What's Next?
Co-creating Child/Youth/TAY FSP Service Exhibit with San Mateo BHRS staff that will become the basis for the new Request for Proposal to procure for Child/Youth/TAY services in the county	**Finalize** Child/Youth/TAY and Adult Service Exhibits and Requests for Proposal
Sharing best practices from Los Angeles County Department of Mental Health to inform the **revised Adult FSP Service Exhibit** that will become the basis for the Request for Proposal to procure for Adult services	Continue **gathering local input** to prioritize local FSP outcomes and provide input on FSP services for ongoing quality improvement
Using **provider and client interview and focus group feedback to inform Service Exhibits** and RFPs	Developed **standardized graduation/ step-down process** that can now be used across all FSP providers in the county
Developing **standardized graduation readiness guidelines** to be used in conjunction with new graduation / step-down process	

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San Mateo County Stakeholder Engagement Overview

Stakeholder Engagement Overview	Engagement Insights
Third Sector interviewed clients and FSP staff at two points: • **Round 1 (August - September 2020):** to understand FSP programs' strengths & challenges, helping guide the county's selection of implementation activities • **Round 2 (March - April 2021):** to gain more detailed insights that informed the new service exhibits **Client Engagement Summary:** Third Sector interviewed clients (selected by each FSP program) 1-on-1, over the phone. Clients received a $35+ gift card for participating. Third Sector interviewed 13 clients during the landscape phase and 14 during implementation. **Provider Engagement Summary:** Third Sector interviewed front-line FSP staff in focus groups, speaking to 8 staff during the landscape phase, and 12 during implementation.	**Therapy/psychiatry are not provided in-house and are inconsistently available** Providers refer clients out for therapy, but there is not always someone available at no- or low-cost, or there is a lot of turnover in who a client ends up seeing. **Peer and family advocates are essential for both providers and clients** Peer support is very important to clients, but it's sometimes hard to find true "peers" and/or staff attrition is high due to lack of pathways for career advancement **Graduation/step-down should be discussed earlier and more often** Providers could use more standardization and guidance around graduation readiness and process, while clients wish to be more involved in conversations and decisions about their transition

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Questions & Additional Input

*Any additional feedback on **needed improvements** to mental health services in San Mateo County?*

*Any additional **coordination or support** San Mateo BHRS could be providing mental health service providers or clients?*

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Cohort (Multi-County) Updates

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Cohort Implementation Activities

Over the last 10 months, The six participating counties collaborated to achieve the goals below.

DEFINE FSP POPULATIONS

Standardize definitions of FSP populations (e.g., homeless, justice-involved, high utilizer of psychiatric facilities, etc.)

IDENTIFY OUTCOME & PROCESS METRICS

Identify priority outcomes and process measures, and associated metrics, to track what services FSP clients receive and the success of those services

DEVELOP DCR RECOMMENDATIONS

Develop recommendations for revising Data Collection & Reporting (DCR) forms, metrics, and/or data reports to increase the utility of state data

Overarching Impact: **The cohort solutions will enable counties to better understand who FSP serves and how effective FSPs are at achieving outcomes for those focal populations**

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Cohort Accomplishments and Plans

Accomplishments to Date	What's Next?
Developed operational definitions for the following **FSP sub-populations** and associated "at risk" categories: homeless, justice involved, and high utilizers of psychiatric facilities	Determine a strategy for disaggregating the adult FSP outcome metrics by the key FSP sub-populations and other key demographic categories (race, geography, etc.)
Identified priority adult FSP **outcomes** (see below) and **process measures** (frequency and location of services).	Determine which services counties should track as priority process measures
Developed **outcomes metrics** to track the following outcomes: increased stable housing, reduced justice involvement, reduced psychiatric facility utilization/crisis services, and increased social connectedness	Finalize DCR System Enhancement Recommendations Memorandum
Solicited feedback on the areas for improvement related to the Data Collection and Reporting System **(DCR)** and developed recommendations to improve the user experience and inform future system enhancements	Support RAND & counties to design continuous improvement structures

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Cohort Next Steps

DATA QUALITY IMPROVEMENT

RAND will support counties in improving data quality via monthly check-in meetings, ultimately supporting more real-time programmatic improvement the statewide continuous improvement process.

LEARNING COMMUNITY

All involved counties will finalize shared outcomes and population definitions to use in a statewide FSP Learning Community that will allow county behavioral health agencies to promote statewide improvements and advance collective learning.

EVALUATION

RAND conducts quantitative and qualitative analysis using data from each county and stakeholder interviews. Monthly meetings between RAND, counties, Third Sector and CalMHSA continue through 2024 to share evaluation updates and troubleshoot data challenges.

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Updates from Other Participating Counties

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Fresno County Implementation Activities

Fresno County Department of Behavioral health collaborated with providers to select the following activities to work on during the Multi-County FSP Innovation Project.

REAUTHORIZATION PROCESS

Develop a process in which FSP providers communicate to DBH at regular intervals where FSP clients are in their treatment plans in order to assess reauthorization needs

CHILD REFERRAL & ENROLLMENT

Develop a standardized youth FSP referral and enrollment process with enhanced communication between DBH and contracted providers

DATA COLLECTION & REPORTING

Streamline existing and/or develop new data reports or methods so that DBH and providers can more effectively collect, access, and use FSP data to inform care decisions

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Fresno County Stakeholder Engagement Overview

Stakeholder Engagement Overview	Engagement Insights
Purpose of Engagement: Third Sector interviewed clients and staff at two points: • **Landscape Phase** (July - Aug 2020): to understand FSP strengths and gaps, which guided project focus areas • **Implementation Phase** (Feb - May 2021): to understand caregiver experiences with referrals and get targeted feedback on BHS services to inform new Service Exhibits	**Data Access and Usage** FSP providers have mixed experiences with accessing and using DBH data to make program improvements. DBH staff believe the county's new data dashboard platform will improve both accessibility and usability.
Client Engagement Summary: Third Sector conducted one-on-one phone interviews with **32 clients or caregivers of clients**: 16 interviews during the landscape phase and 16 during implementation. Individuals received $35+ gift cards for participating.	**FSP Program Waitlists** Several caregivers of FSP participants pointed to waitlists as a pain point of the referral process. This insight is guiding DBH's commitment to ensure that changes to the county's referral and reauthorization processes improve the waitlist experience.
Provider Engagement Summary: Since July 2020, FSP providers in Fresno County participated in a **digital survey with over 70 responses** as well as **10 focus groups and workgroup meetings** to share their perspectives and help shape the priorities of the Multi-County FSP project, including the redesign of FSP referral and reauthorization procedures and improvements to the county's data sharing practices.	**Data Disaggregation** Providers and DBH staff both want to focus their efforts on high-need areas and high-risk populations and would find it valuable to have client data disaggregated by variables like race, diagnosis, age, etc. to inform FSP improvement efforts.

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Fresno County Accomplishments and Plans

Accomplishments to Date	What's Next?
Developed **new proposed procedures for reauthorizing clients** to receive FSP services and for collecting data on the primary reasons clients participate in FSP	**Determine appropriate staffing structures** to support potential changes to Fresno's FSP reauthorization and referral processes
Developed recommendations to **streamline the Child FSP referral process**	**Pilot changes to DBH's continuous improvement process** (e.g., new meetings and dashboard utilization practices)
Identified high-priority metrics from both providers and DBH to include in Fresno's new data dashboard platform (Domo)	**Gather and incorporate final input from FSP providers** on continuous improvement process and data dashboard changes

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Sacramento County Implementation Activities

Sacramento County Behavioral Health Services (BHS) collaborated with providers to select the following activities to work on during the Multi-County FSP Innovation Project.

CLIENT STEP DOWN PROCESS

Develop a standardized FSP client stepdown readiness review process, supported by tools that help the County more regularly assess whether a client is ready to step-down while centering client needs and desires.

STEP DOWN GUIDELINES

Develop standardized graduation guidelines to support staff in making individual stepdown and graduation decisions while considering ISSPs and system-wide outcomes. Guidelines include improved definitions of "stability" and discussion prompts.

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Sacramento County Stakeholder Engagement Overview

Stakeholder Engagement Overview

Third Sector interviewed clients and FSP staff at two points:
- **Round 1:** to understand FSP programs' strengths & challenges, helping guide the county's selection of project focus areas
- **Round 2:** to better understand the existing step-down & graduation process, as the county considered changes

Client Engagement Summary: Third Sector interviewed clients (selected by each FSP program) 1-on-1, over the phone. Clients received a $35+ giftcard for participating. Third Sector interviewed 15 clients during the landscape phase and 17 during implementation.

Provider Engagement Summary: Third Sector interviewed front-line FSP staff in focus groups, speaking to 8 staff during the landscape phase, and 13 during implementation.

Additionally, 12 director-level FSP staff helped co-create the graduation guidelines during six, 90-min workgroups. 19 staff, from all levels and programs, gave feedback on the completed guidelines and plans for implementing them.

Engagement Insights

Discussions about Graduation

Clients and staff reported that graduation and the temporary nature of FSP services aren't discussed consistently with new clients, and so for some clients later conversations about graduation are a surprise.

Warm Hand-Offs During Step down

Clients and staff value warm hand-offs between FSP and step down programs. Clients want gradual step downs with support from staff they know, while provider staff want the staffing and billing flexibility to offer more of that support.

Client-Staff Relationships

Clients reported making the most progress after they felt connected to staff; many are hesitant to leave FSP, afraid they won't be able to find similar connections with step-down staff. However, some clients struggle in FSP in part because they don't feel staff understand their backgrounds.

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Sacramento County Accomplishments and Plans

Accomplishments to Date	What's Next?
Co-created draft FSP graduation guidelines with provider staff that provider staff & the BHS management team are excited about	Create **graduation guideline reference sheets** for providers, that include discussion prompts they suggested
Developed a training deck to **illustrate the ideal step down process**.	Develop and conduct a **training session for high-intensity provider staff** on the new graduation guidelines
Created a 1-2 year workplan for 3 activities that will **improve the stepdown process** by better incorporating client voice & ensuring more regular review of all client cases	Support BHS on **incorporating the graduation guidelines into policies** and materials

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San Bernardino County Implementation Activities

San Bernardino County Department of Behavioral Health collaborated with providers to select the following activities to work on during the Multi-County FSP Innovation Project.

REFERRAL FORMS & PROTOCOLS	STEP DOWN GUIDELINES	DATA COLLECTION & REPORTING
Create a consistent referral process and form across adult FSP programs and develop protocols for FSP referrals between entities that ensure for warm hand-offs	Develop protocols on how to approach step down in a way that is responsive to clients' individual recovery journeys while ensuring that FSPs focus on building the client skills necessary to successfully step down	Update existing and/or develop new data reports that allow providers and departmental staff to more effectively access and utilize client data to understand outcomes and inform care decisions

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San Bernardino County Stakeholder Engagement Overview

Stakeholder Engagement Overview	Engagement Insights
Client Engagement: Third Sector worked in partnership with Clubhouse & Research & Evaluation staff to interview **24 individuals** receiving services across **4 adult FSP programs**. Third Sector compensated clients for their time with $35+ Visa gift cards. The purpose of these interviews was to seek targeted feedback about what clients' goals are in FSP, what services are most helpful for achieving those goals, and how FSP could better prepare clients to step down. **Provider Engagement:** San Bernardino County embraced a collaborative approach to building solutions in partnership with the provider community. Provider staff and departmental staff jointly participated in Working Groups to build standard referral forms, create step down protocols, and strategize on new data reports. This approach should ensure that the solutions built will effectively meet the needs of both San Bernardino County DBH and the provider community. Third Sector also conducted a focus group with peer staff to obtain their insights on how the step down process could be improved.	**Step down should be discussed early and routinely in a client's FSP journey** Some clients stated that they first discussed step down with their providers a few months before leaving, leading to increased anxiety and unpreparedness for stepping down. Clients who gradually began discussing step down soon after enrollment had the most positive outlook on stepping down. **Additional supports from care teams during step down transitions are very important** Peer staff emphasized the need for care teams to help individuals settle into a new environment and routine before stopping services. This is especially crucial for individuals who need to transition housing during the step down process. **Providers would benefit from more routine data sharing** Providers would benefit from regular outcomes reports to better understand how effective their services are and assess where improvements could be made.

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San Bernardino County Accomplishments and Plans

Accomplishments to Date	What's Next?
Created a standard electronic referral form across all adult FSP specialty programs, streamlining the disparate paper referral forms in circulation	Continue determining the feasibility of **embedding the electronic referral form into AVATAR**
Drafted referral protocols outlining the overall referral process and roles and responsibilities at each step of the process	**Determine an access strategy for external referring sources** that would not have access to the electronic referral form within AVATAR
Drafted step down protocols for each adult FSP specialty program to help care teams balance client needs with a focus on enabling increased independence	**Revise the step down protocols** based on department and provider feedback
Identified outcomes and services data that providers would like to receive on a regular basis	Consult with IT and the Research & Evaluation teams to **determine the feasibility of developing new data reports** that capture relevant outcomes and services data

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Siskiyou County Implementation Activities

Siskiyou County Behavioral Health Services (BHS) collaborated with their provider staff to select the following activities to work on during the Multi-County FSP Innovation Project.

SERVICE GUIDELINES

Develop an FSP Service Exhibit
that includes staffing, caseloads, FSP levels of care, and housing and SUD support guidelines to adopt as official guidance

STEP DOWN GUIDELINES

Define indicators of recovery
(including how those indicators are tracked in data) to lay the foundation for developing FSP graduation criteria

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Siskiyou County Stakeholder Engagement Overview

Stakeholder Engagement Overview	Engagement Insights
Purpose of Engagement: Third Sector interviewed clients and staff at two points: ● **Landscape Phase** (July - Aug 2020): to understand FSP strengths and gaps, which guided project focus areas ● **Implementation Phase** (Mar - Apr 2021): to understand perspectives on recovery and get targeted feedback on BHS services to inform new Service Exhibits **Client Engagement Summary:** Third Sector conducted one-on-one phone interviews with **23 clients**. Third Sector conducted 9 interviews during the landscape phase and 14 during implementation. Clients received $35+ gift cards for participating. **Provider Engagement Summary:** Third Sector conducted 4 focus groups with **30+ staff** over the course of the project. Third Sector will complete a second round of engagement to gather feedback on definitions for and indicators of recovery in September – October 2021.	**Capacity Constraints & Inconsistent Experiences** Clients described inconsistencies in the level of support that they receive and perceived staff as generally overworked. Staff noted that having a new, weighted caseload system. as outlined in the Service Exhibits, will help with these challenges. **Challenges Transitioning to New Care Teams** Staff capacity constraints exacerbated the challenges some clients experience when transitioning to new care team members. Staff see the guidelines outlined in the Service Exhibits as a helpful structure to ensure all clients experience smooth transitions. **Client-Centric, Culturally Responsive Care** Staff believe that BHS' plan to implement Strengths Model Case Management will help make care more culturally responsive and client-centered.

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Siskiyou County Accomplishments and Plans

Accomplishments to Date	What's Next?
Created **Adult and Child FSP Service Exhibits** for BHS to use as official FSP care guidance	**Incorporate new definition and indicators** of recovery into FSP Service Exhibits
Developed a **new tiered system of FSP care** to better serve BHS' highest need clients	**Implement new team meetings** designed to coordinate care for clients in different tiers
Created a **new EHR form** to track changes to clients' FSP tiers while they are in services	**Finalize the process** for assigning and changing client FSP tier designations
Drafted an **initial definition of "recovery"** to guide BHS in transitioning clients out of FSP	**Refine definition of recovery and identify indicators** of recovery for all age groups

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Ventura County Implementation Activities

Ventura County Behavioral Health collaborated with providers to select the following activities to work on during the Multi-County FSP Innovation Project.

ELIGIBILITY GUIDELINES

Revise county-specific FSP eligibility criteria to ensure that counties prioritize FSP services to the highest-need clients.

SERVICE GUIDELINES

Develop minimum service requirements of FSP to adopt as official guidance. E.g.: % of field-based services, housing and employment services offered, peer supports available, etc.

STEP DOWN GUIDELINES

Develop standardized graduation guidelines to support staff in making individual stepdown and graduation decisions while considering ISSPs and system-wide outcomes.

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Ventura County Stakeholder Engagement Overview

Stakeholder Engagement Overview	Engagement Insights
Purpose of Engagement: Third Sector interviewed clients and FSP staff at two points: ● **Landscape Phase** (July - Aug 2020): to understand FSP strengths and gaps, which guided project focus areas ● **Implementation Phase** (Feb - Mar 2021): to inform new guidelines for FSP eligibility, services, and graduation **Client Engagement Summary:** Third Sector conducted one-on-one phone interviews with **32 clients**. Third Sector conducted 19 interviews during the landscape phase and 22 during implementation. Clients received $35+ giftcards for participating. **Provider Engagement Summary:** Third Sector engaged **35 staff** over the project life cycle. Through focus groups and interviews, Third Sector met with 14 direct-care staff during the landscape phase and 11 during implementation. Additionally, 10 director-level FSP staff co-created eligibility and graduation guidelines in a series of six workgroups.	**Programs could benefit from increased consistency** Specialty FSP programs are better equipped to offer a high level of care, with smaller caseloads and more field-based service capability than clinic-based FSP programs. **Clients would like to access additional services** FSP clients expressed a desire for additional support with employment, housing, transportation, and money management. Providers agreed that they would like more resources to implement these services. **Clients and staff develop trusting relationships** While providers are successful at building trusting relationships with their clients, these deep relationships may impede graduation. Many individuals live with trauma and a history of crisis, which makes transitions difficult.

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Ventura County Accomplishments and Plans

Accomplishments to Date	What's Next?
Developed new, clarified guidelines for **FSP services**, including FSP level of care and flex funding access	**Operationalize new service guidelines**, which will involve additional staff hiring and training
Created new guidelines for **FSP eligibility,** building on MHSA-defined criteria with enhanced definitions for focal populations like "homeless" and "high utilizer"	**Integrate with existing data collection**—by modifying referral forms, VCBH can ensure data is available at the time of eligibility decisions, so that focal populations are prioritized for admission to FSP
Created new guidelines for **FSP graduation,** so that programs have a shared standard for "graduation readiness"	**Collect staff feedback** about the guidelines before incorporating them into policy and practice

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Boston · San Francisco · Washington, D.C.
info@thirdsectorcap.org | www.thirdsectorcap.org

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Multi-County FSP Innovation Project

San Mateo County Client
Interview Synthesis

Spring 2021

Client engagement methods

- In March - April 2021, as part of the Multi-County FSP Innovation Project, Third Sector interviewed 8 individuals receiving services across San Mateo County's different FSP programs.

- Third Sector conducted these one-on-one interviews by phone, and compensated clients for their time with $40 Visa gift cards per interview.

- The purpose of the FSP client interviews was to gain deeper insight into potential changes to service design and graduation processes, supporting improvements to current FSP services.

Time in Program (n=8)

	Clients
Chose not to share	1
5+ years	3
3-5 years	1
2-3 years	1
1-2 years	1
6-12 months	1

FSP Age Group (n=8)
- Adult 75%
- TAY 13%
- Older Adult 12%

Participant Race (n=8)
- Black/ African American 25%
- Chose not to share 25%
- Two or more races 13%
- White/ Caucasian 12%
- Asian Amerian/ Pacific Islander 12%
- LatinX/ Hispanic 13%

Participant Gender (n=8)
- Male 63%
- Chose not to share 25%
- Female 12%

Service Guideline Insights

Overall experience

Overall, clients had positive experiences with FSP services

- Six out of eight clients expressed largely positive experiences with their providers in San Mateo County. Most clients gave reasons such as case management support, connection to outside resources, and availability of staff.
- One of the eight clients expressed dissatisfaction and frustration with their family member's provider, citing reasons of inconsistency in appointments and other aspects of service delivery.

"
"It's been very good for me, Telecare has been good to me. I've been with them for 13 years. They have helped me with medication, provided housing, and also helped me get a job."

"Most of my interactions have been really positive. I feel like they really genuinely care."

"Caminar has been really hit or miss. If we get calls for support, great. If not, I don't know who to ask. I don't know who is taking care of my [family member's] case. It's been on and off. There hasn't really been a routine schedule where he [family member] has appointments with different staff."

"I've been stable, not hospitalized for over a year. I feel like Caminar has allowed me to be myself, say how I feel, rather than tell me about how I should feel."
"

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Needed services

Therapy / psychiatry services are not provided in-house and are inconsistently available

- Providers refer clients out for therapy, but there is not always someone available at no- or low-cost, or there is a lot of turnover in who a client ends up seeing.
- Two clients noted that their psychiatry services were provided by individuals still going through school to get their accreditation, who then move-on once they complete their degrees.

"It would be helpful if they provided a therapist. One that doesn't cost me any money because I don't have much money. They give me the pills but won't give me the therapy."

"I keep begging for a DBT program. There is a big demand for it, and very few are offered. Also group therapy, that's another thing not offered. It's impossible for anyone to get that therapy, because they're all booked, and the people who are trained in this are too few. The waitlist is too long."

"A ride to the DMV wouldn't hurt. And if they could cover my behind the wheel classes that would be helpful."

Clients have inconsistent access to transportation services

- Despite being offered bus tokens [*see flex funding section*], one client mentioned that it would be helpful to have more rides directly to certain places from their care provider. However, other clients mentioned that they had received ride to clinics and other places, and expressed gratitude for how helpful they were.

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Team-based collaboration

Clients interact with many different staff

- Six out of eight clients indicated seeing multiple different case workers, psychiatrists, and/or nurses throughout their FSP involvement, mostly due to staff turnover.

"I see a doctor. I saw another doctor, but unfortunately they left. I also work with two different case workers. I worked with another one but she left there. I also got to work with two other case workers and the nurse. But she was being switched around. It made me sad when she told me she was leaving."

"My [family member] had difficulty trusting them, and depending on them to help him get better. He just got more suspicious and it's difficult for him to build rapport with the case managers, and clinicians. Nothing was consistent. It was really hard to keep track of who is who"

"It's good because I can talk to one of them, if I need a different opinion about something, I can talk to another one. They're all working in the same field, giving help you know."

There is collaboration between staff and teams

- Multiple clients were aware that the members of of their teams had meetings about them and always knew what was going on with their case.
- Clients expressed that even when they have to meet or talk with someone who is not usually on their care team, they are still knowledgeable and able to give them the support they need.

Staff capacity and challenges

Clients perceive staff to be busy and overworked, and feel the stress of staff turnover

- Two out of eight clients noticed that staff seemed extremely busy and overworked. Another noted that numerous people on his care team had left, and that some departures were difficult.

"I had a social worker in there and she was super overworked. She had everyone in the hospital. I think she had one other partner."

"I think they're understaffed. They need more support. It's unfortunate but they do... there are a lot of people using their services. I think it's because it's a county program they don't get the support they need."

Clients reported problems filing complaints

- One client described a situation where she wished to file a formal complaint. Despite the county having a designated phone line for clients to call and file a grievance, this client was told that wasn't possible.

"I did want to file a formal complaint, but my case manager told me that I wasn't able to do that. One time I did get a call from a particular staff member, and...it sounded like he was recording the call...I did receive an apology call after that. But there was no way for me to file a formal complaint about something that I was really upset about..so what can I do? We're just being victims and not be allowed to talk to anyone about it. So that was difficult. I think that was the lowest experience with [my provider]."

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Service location, hours, and frequency

FSP staff are able to meet clients where it's convenient for them

- While most meetings are currently still happening virtually (mostly by phone), staff are still dropping things off for clients as needed or having them come into the office or clinic for medication.
- Clients appreciate that prior to Covid staff would meet where it was most convenient for them, often at a client's home, work, or restaurant near them.

"*I preferred to meet with them at the hotel. Because I didn't have to leave. I could come out of my room, talk to them in the lobby, or they could come up to my room.*"

"*Before not [meeting] regularly, but from time to time. Only regular after Covid when the case manager started scheduling a one time per month video conference. But before Covid, we don't have a regular session. To my knowledge we didn't have a routine one time per month session until Covid.*"

Consistent, regularly scheduled meeting times are preferred and boost engagement

- Frequency of services differed a lot amongst clients (from once per week to once every other month).
- The clients who have more frequent touch-points were the ones with recurring meetings scheduled with their caseworkers, therapists, and/or psychiatrists. The clients who said they set up appointments with their caseworker as they go tend to engage with FSP staff less frequently.
- Services are only offered on weekdays, which works well enough, but most clients indicated that some weekend availability would be helpful.

Peer support and cultural relevance

Peer support is very important to clients, but sometimes hard to find true "peers"

- Not all providers offer peer support services in-house, but all clients mentioned that were at least referred to peer support resources (i.e. through their housing, NAMI, AA/NA, ILP, California Clubhouse)

> "My case manager introduced me to my support brothers. They took me in, they've always been there for me, supported me… I'm Black, they're Black. One of them just got married, I went to his wedding. They're good people."
>
> "She taught me about breathing techniques. She wasn't telling me about her personal life, but it related with what we were discussing, and it was something that resonated with me...She could give me good advice on how to help it. Because she had to do it herself... Instead of giving me lessons that she's learned in a class setting, she would give me what worked for her."
>
> "I think it's very helpful [that one of my care team members is Black]...Birds of a feather flock together... But I don't feel that race is the reason that me and my case manager click. I appreciate his [case manager's] guidance and that's why we click. It doesn't matter if he's Black or White." (Black)

Racial dynamics

- Clients had mixed views on whether race impacted their FSP experience
- One client who identified as Black suggested that it would be helpful if their provider connected them with people from the National Association for the Advancement of Colored People (NAACP).

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Translation and language barriers

Clients have been challenged by language barriers and translation competency

- Two out of eight clients shared that their service was hindered by negative experiences with translators, either themselves or for family members enrolled in FSP services.
- One client, a native Spanish speaker, shared that when the translator was speaking, the responses from the care team did not correspond to the questions that the consumer had asked. However, when he spoke to a staff member who was a native Spanish speaker, they had no issue communicating.
- One client shared that translators weren't effective because they were always changing and it was difficult for her family member to build trust or be honest when there was no consistency. She also shared that to her knowledge, no provider staff spoke Korean, her family member's native language. Cultural stigma around receiving mental health services also made it difficult to address these challenges.

"Well, sometimes I lose hope because there is no communication...if I ask them [translators] a question, I'm not sure what they say to the others [doctors]. I'm not sure what they are translating. Sometimes they answer me with something that does not match what I asked."

"Part of the problem is that neither of [them] speak English, they speak Korean. Caminar would try and get translators, but most of the time, translating doesn't really work. Because [he] isn't willing to open up unless the doctor or case manager was the person who spoke the language...His responses were always really the surface level...partly because the translators changed all the time. Each time there had to be an introduction, and I think he felt ashamed of needing to rely on them. That was really stressful."

Flex funding and housing

Clients have benefited from flex funding for a variety of different needs

- Two out of eight clients received bus tokens to support their transportation needs.
- Two out of eight clients received other supports, such as gift cards and outings to restaurants.
- Two out of eight clients had never been offered any sort of supplemental funding.
- One client shared that their housing was covered by their provider. Another client mentioned that he had been offered housing, but he declined it since it was in an area where he didn't know anyone.

> *"I think they offered it to me. I was at the office for a sit down meeting and they asked if I wanted bus tokens because I'd been riding the bus and I said yes, and they gave me a handful."*
>
> *"They got me a burger one time, and a BART card. I got a giftcard for some stuff at Safeway. They try to help me with my passport and the embassy."*
>
> *"I'm in THP, it's funded by MHSA and Caminar. Caminar is supporting me to live here. Now I've got my own room just with that."*

Graduation Criteria Insights

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Graduation readiness: goals and indicators for recovery

Independence is a core goal of San Mateo FSP clients

- Clients defined success in a variety of ways, but everyone all clients interviewed mentioned some form of independence.
- Many clients also mentioned multiple, staged goals: while their initial goals were focused on stabilization and socialization, as they recover, their goals progress to focus on housing, employment, income, and family reconnection.

"*[Success looks like] doing something positive, and proactive for my recovery. Taking things one day at a time.*"

"*My next major goal is really becoming even more independent.*"

Note: some clients indicated multiple goals

Supports clients still need

Clients emphasized wanting to feel equipped with "tools"

- A number of clients wanted to ensure that they had the tools that they needed to succeed without FSP. Examples included family communication strategies, therapy, personal responsibility, and anxiety management strategies.

"*Sometimes people in my family don't understand mental illness...it's easier to, say, call my case manager; he'll tell you how it is. And it's easier for him to explain to them that I'm fine and they don't have to worry. Transitioning to not having case managers like this could make it difficult to handle these conversations and family.*"

"*I fall back sometimes, I get anxiety, but the tools that she's given me, I feel like I'm better equipped to handle it as things get bad. I meet new goals that I've set for myself. So the goals change.*"

Clients also wanted to accomplish concrete goals

- Other clients mentioned that they could not imagine graduating from FSP without accomplishing very specific goals related to employment (e.g., a military job), financial stability, sobriety and health and wellbeing (e.g., primary care / vaccinations).

Conversations about transition

Only some clients discuss transition with their case managers

- Three of the five individuals interviewed on this topic had discussed graduation and stepdown with their case managers, while the other two had not had any conversations about the topic.

- Clients who do not discuss stepdown with their case managers still think about the topic. For those clients, it would be reassuring to know that they won't be asked to transition until they have met their goals or have specific resources (e.g., housing, car, financial stability, etc.)

"

"I see it happening organically as I get close to accomplishing these goals and get the job that gets me off of disability and such. They'll know I'm moving that direction based on what we talk about and stuff and progress I've made and we'll just know."

"Ahead of time, it wasn't a big surprise. She told me, 'As you get better we're going to go to every other week, and then…' So I knew that's how it was going to go to be, so I was ready for that… I agreed 'Yeah, I'm ready for that step.' It wasn't a surprise, they eased me in the entire way, she held my hand the entire way."

"

Ideal stepdown transition

Clear and multi-stage communication is important to clients

- Many clients emphasized the helpfulness of taking things in "steps", whether that is progress towards goals, or a rampdown in support from the FSP program.
- Similarly, clients requested that transitions be planned and carefully communicated so as to avoid surprises or abrupt endings to services.

"Talking about it and having that communication where we're on the same page. I don't want to deal with the stress of all that when they pop out and say we're done with your services as of today."

"[The "support brothers"] took me in, they've always been there for me, supported me, especially if it's positive. They support me in whatever I do. They're nice guys. I'm Black, they're Black."

"It would be cool if there was a BBQ and people showed up. They had an ice cream truck last time; that would be cool."

Clients also valued celebration and peer supports in transitioning from FSP

- Many FSP clients stated that graduating from the program would feel like a cause for celebration and requested an acknowledgement of that.
- Peer and therapeutic supports were also requested as part of the stepdown process, including involvement from the case managers, psychiatrists, and nurses.

About the Multi-County FSP Innovation Project

When the Multi-County FSP Innovation Project is complete, counties will have an improved ability to collect and use data that illuminates **who FSP is serving, what services they receive, and what outcomes are achieved**. Findings from each county will contribute to **statewide recommendations to create more consistent FSPs** that deliver on FSP's "whatever it takes" promise.

Participating Counties

Fresno
Sacramento
San Bernardino
San Mateo
Siskiyou
Ventura

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San Mateo County BHRS FSP Innovation Project
Implementation Phase

Child/Youth/TAY FSP Provider Engagement Synthesis

Method

- Third Sector conducted a two-hour hour virtual focus group with individual providers. In total, perspectives from six (6) staff members across San Mateo County's two (2) **Child/Youth/TAY FSP programs were represented**.
- In the first half of the session, staff were asked forward-looking questions to inform new **service guidelines**, including questions related to staffing specialization, caseload size, frequency of services, service hours, education/employment support, and flex funding. In the second half of the session, staff were asked questions to inform new **eligibility and graduation guidelines**, including questions related to recovery-oriented services, assessing readiness, preparing for transition, and post-graduation support. For each of these topics, providers shared information about their program priorities and offered suggestions for BHRS to support their work. Their feedback is synthesized below.

Takeaways & Key Recommendations

Based on provider feedback, BHRS may be able to support providers in the following ways:

Eligibility criteria:

- *YTAC referral system is missing eligible youth* from drop-in centers, those not currently connected to a mental health provider, and potential self-referrals. Providers recommended there be a better linkage between drop-in centers and the County referral system.
- *Enrollment/intake process* is overwhelming and sometimes retraumatizing due to amount of paperwork, level of detail, and repetition
- *Providers are unable to adequately service youth with psychosis*, and would like resources for/access to more suitable treatment options
- *Mental health and FSP knowledge is limited* among families of eligible youth; families would therefore benefit from in-home services and family education when first establishing care

Service guidelines:

- *Family and peer advocates are invaluable* and need more pathways to promotion to reduce attrition
- *Billing should allow earlier addition of specialist* to the treatment team, as well as in-house substance abuse counselors to be added as available specialists for TAY clients
- *Caseload size and frequency of services* should adjust based on client level of need, not a fixed number
- *Swing shift hours may be more suitable* for the TAY population
- *County employment partnerships* would help providers support TAY in achieving their employment goals
- *More flex funding guidance and support* would help providers strategically utilize all available flex funds

Graduation guidelines:

- *Staff look at several indicators of graduation readiness,* such as meeting treatment goals, family support, etc., and it differs by client, so providers do not wish to use a single standardized readiness assessment tool
- *Staff would like to be able to check on their graduated clients*, which County policy could encourage with appropriate privacy, consent, and billing policies
- *County facilitated communication/partnerships with out of county programs and providers*, would help providers transition care when clients move out of county

Detail

Eligibility Criteria Detail
(+) Assets
+ TAY FSP is great option for youth aging out of foster care + Drop-in centers are open to the community and are a great way to provide knowledge about mental health in a nontraditional setting
(Δ) Opportunities

Δ Referrals, outreach, and engagement all down because of COVID
Δ AB1299 fixed policy issues for out of county foster care placements, but now Fred Finch is not utilized and hard for those staff to find eligible youth
    ○ *"I assume there must be youth who are living out of county who are in foster care. But maybe because it's a small program, it's hard for referral partners to keep it top of mind. We used to have lots of staff meetings with child welfare workers, but when they left, knowledge about the program was gone too."* -FSP Program Director
Δ Child/Youth/TAY with psychosis technically eligible but treatment current providers can provide is very limited
    ○ *"There are options for early intervention and youth psychosis, but nothing available for TAY population"* -TAY, Case Manager
Δ Enrollment process is overwhelming and sometimes triggering, especially for clients from historically marginalized populations
    ○ *"If they make it through that then the process of engagement goes well, but would be good to have a way to smooth the process out and make it less triggering for clients who have had to go through similar processes which have been traumatizing"* -TAY, Enrichment Services Specialist
Δ Lack of community education and awareness of mental health in general and FSP services among eligible populations, but resources and capacity currently limit the ability to provide in-home services and family education when first establishing care
    ○ *"I have youth that would qualify for FSP, but they have never heard of "mental health"...don't understand what the services mean...don't want their child to talk about their trauma"* -TAY, Therapist
Δ Many eligible youth are not being referred because they are not currently connected to a provider and therefore don't have access to the YTAC referral process / committee; no one knows the referral phone number or option for self-referral
Δ Currently, staff and peer partners at drop-in centers do not have enough access/agency to make referrals for youth as needed; there is not enough direct linkage between the drop-in centers and County referral system

Service Guidelines Detail
Specialization
(+) Assets
+ Nurse practitioner, because they are able to follow youth, i.e. at-home, in-school, etc. + Peer and family advocates are critical for their lived experience and could use even more of them
(Δ) Opportunities

- Δ High turnover among peer and family advocates//support specialists due to:
  - ○ No career ladder/opportunity for advancement/pathway to promotion
  - ○ Large amounts of required paperwork
  - ○ High caseloads
- Δ Specialists are not always able to join the treatment team early enough in the treatment plan process due to billing restrictions
- Δ Most TAY clients would benefit from substance abuse counseling, but currently have to refer out for that specialist
  - ○ *"Sometimes there are resources to direct them to, but it would be better for it to be in house for direct collaboration and support of the youth. Co-occurring MH and SUD can get really tricky so in house positions on both sides would be great" -TAY FSP, Behavioral Support Specialist*

Caseload Size

(Δ) Opportunities

- Δ Should be based on client level of need and level of connectedness (to FSP program and other providers/services), not a fixed number

Frequency of Services

(+) Assets

- + Similar to caseload size, number and type of touchpoints per week should be client specific
  - o *"It's a TAY dance on level of engagement; clients are set in what they see they need and then other times they are open to learning about themselves and open to being more engaged" - TAY FSP, Behavioral Support Specialist*
- + Ability to keep cases open during period of no engagement
  - ○ *"Ability of program to go into community and look for people [i.e. in jail and/or in-patient] and ability to stick with people even during long periods of "going dark" is really important" - TAY FAP, Enrichment Services Specialist*

Service Hours

(+) Assets

- + All programs are able to provide 24/7 services by utilizing on-call crisis teams outside of normal business hours

(Δ) Opportunities

- Δ Should have flexibility to provide more TAY services on swing shift basis to accommodate TAY population natural tendencies, i.e. starting office hours later in the day and staying open late

Education/Employment

(+) Assets

- + Specialists are valuable in helping clients achieve education and employment goals, i.e. Guidance and Career Specialist, Youth and Parent Partners

(Δ) Opportunities

- Δ More County employment partnerships

Flex Funding
(+) Assets
+   Being able to spend it on food and other engagement incentives helps built rapport early on
(Δ) Opportunities
Δ   Not exactly sure what to do with the money or how much they have available   Δ   Provide suggestions on how providers should spend the money and more oversight on availability of funds so providers feel encouraged and supported to spend it down

Graduation Guidelines Detail
(+) Assets
+   Providers are talking to clients about graduation from day 1   +   Graduation works best when it is a slow and collaborative process between treatment team and client, not rushed by the County   +   Transition-facilitated CFT team meeting works great   +   Not having to use one standardized readiness assessment tool   o   *"A really interdisciplinary effort goes into assessing readiness - the whole team. It's more nuanced and sensitive than a simple readiness assessment. You see things brought up like a client's natural supports, more subtle aspects of their family life - and those are really important to clients and that can have a deep impact." TAY FSP, Enrichment Services Specialist*
(Δ) Opportunities
Δ   Hard to communicate and work towards graduation in a remote setting during COVID   Δ   Not able to graduate out of county foster youth because there were no other services to refer them to   Δ   Aging out or services being discontinued because child welfare case closes often feels abrupt and without much County follow-up   Δ   There is not much interaction happening post-graduation, but providers feel as if this would be helpful to the clients (i.e. 30 day phone call, etc.)   Δ   It would be helpful if the County facilitated communication/partnerships with out of county programs and providers, because a lot of transitions are because clients move out of county and it can be challenging to coordinate their ongoing care

San Mateo County BHRS FSP Innovation Project
Implementation Phase - April 2021

Adult FSP Provider Engagement Synthesis

Method
- Third Sector conducted a two-hour hour virtual focus group with **8 staff** across BHRS's **3 Adult FSP programs**.
- Staff were asked questions to inform potential changes to **eligibility criteria**, **service guidelines** (including questions related to staffing specialization, caseload size, frequency of services, service hours, housing/jail coordination, and flex funding), **and graduation guidelines** (including questions related to recovery-oriented services, assessing readiness, preparing for transition, and post-graduation support). For each topic, providers shared information about their program priorities and offered suggestions for BHRS to support their work.

Takeaways & Key Recommendations
Based on provider feedback, BHRS may be able to support providers in the following ways:

Eligibility criteria:
- ***The BHRS/Core Service Agency referral system*** is not set-up for eligible adults to self-refer or reconnect directly to services after a period of disengagement. Providers recommended there be a better authorization process for individuals identified as eligible outside of the County process.
- ***Because authorization decisions happen at the County level*** individuals who providers see as eligible are sometimes denied FSP services without citing a reason. This leads to confusion around eligibility criteria.
- ***Providers are unable to adequately service older/elderly with physical health issues*** and would like resources for/access to more suitable healthcare options
- ***Eligible individuals and the community at-large*** have limited knowledge about mental health services in general, the FSP program, and/or how to access FSP services

Service guidelines:
- ***Providers are not currently contracted to provide therapy***, which makes it almost impossible to provide the treatment that each client needs. There are not enough therapists in the county to refer out to so clients are currently going without therapy services.
- ***Peer advocates are invaluable*** and could use more of them
- ***In-house substance abuse counselors*** would be a helpful specialist to add to treatment teams
- ***There is a discrepancy between providers*** as to what the expectation is for number of contacts per week from 1x/week up to 3-7X/week
- ***After hours and crisis care is not always being provided by in-house***, FSP-specific treatment team members
- ***Housing subsidies/vouchers being tied to FSP involvement*** are forcing clients to stay in FSP even after they are ready to step-down
- ***Better coordination with other providers*** would give clients more seamless continuity of care when moving between jail, hospitalizations, residential treatment, and FSP
- ***More flex funding guidance and support*** would help providers strategically utilize all available flex funds

Graduation guidelines:
- ***Staff look at several indicators of graduation readiness,*** such as meeting treatment goals, housing stability, etc. Try to start conversation as early as possible but it differs by client.
- ***County-facilitated communication/partnerships with out-of-county programs and providers*** would help providers transition care when clients move out of county

Detail

Eligibility Criteria Detail
(+) Assets
+ Are able to see clients of any age 18+ and criteria on paper seems to be working
(Δ) Opportunities

Δ Criteria is sometimes at odds with what they are contracted to provide
   ○ *"Have to find higher-functioning person to be able to fully take advantage of the program -- but that is not the only group that should be able to take advantage of the program" -FSP Director*
Δ Older adult/elderly community is more challenging because they have mental and physical health needs that are hard to address under current service model
Δ Some clients who are eligible still get lost in the intake process or do not get approved for services for some reason
Δ Clients having to go through BHRS referral process, Core Service Agencies, or service connect is an access barrier for initial service authorization and for clients trying to reconnect to services
   ○ *"We'll have former clients who are disenrolled because they are in jail or a locked facility for a long time. Sometimes they'll ask if we can just take them back on, but they have to go through a whole reauthorization process and we can't just re-enroll them" -FSP Case Manager*
Δ Everyday individuals do not know what the County has to offer or that the services exist; need more education to general population / community at-large so people know FSP is even a thing

Service Guidelines Detail
Specialization
(+) Assets
+ Peer advocates prior to COVID were essential, but their job scopes have been limited due to COVID quarantine policies + Jobs Plus Program for employment and education + Housing Resource Manager
(Δ) Opportunities

Δ For new clients it would be good if they were introduced to case management earlier in their journey so they are receiving support while getting matched to the right level of service
Δ Providers are not currently contracted to provide therapy, only for case management, which makes it almost impossible to provide the treatment that each client needs.
   ○ Sometimes due to high staff turnover and clinicians getting promoted into manager positions
   ○ Some providers use interns who need academic/licensing hours in order to provide clients with therapy
   ○ Shortage of therapists at a County level, so hard to refer clients out for therapy services
   ○ FSP licensed Clinical Case Managers are able to provide some therapy in-house, but it is hard to hire for and fill those positions
   ○ *"At county level, shortage of therapists and they are not accepting people with suicide attempt or previous psychiatric hospitilizatons. So clients are not being accepted to therapy programs, and there's a limit of therapy programs and a waitlist to begin with. The private provider network isn't accepting clients with SMI and/or suicide attempt in the last year. They say that they cannot provide services to meet those needs." -FSP Case Manager*

Δ   Peer advocates job scopes have been limited during COVID as they are now allowed to come into the office

Δ   More peer advocates

- *"More peer groups would be beneficial and client advisory board that meets more regularly or one that is county-wide and not just organization specific"* - FSP Case Manager

Δ   Reliance on Case Manager to know what specialists and resources are out there and they need more education on the specific services available to them and their clients

Δ   Do not have substance use counselors but would be very beneficial

Δ   Have access to prescribers but if the client isn't enrolled in Medi-Cal it's hard to fill meds

- *"Sometimes we loan clients the funds but that can be expensive/ not possible."* -FSP Case manager

Caseload Size

(Δ) Opportunities

Δ   Maximum caseload size differs by provider, somewhere between 10 to 15. Providers feel 10 is more manageable than 15, which feels very heavy to those with that caseload.

- *"10 is max with still being able to help each client; 8-10 is good load but really depends on the client because 1 client can feel like 3; not just based on numbers"* - FSP Case Manager
- *"12 feels good enough but comes down to frequency of services and that depends on crises; 12 gives that wiggle room to flex if needed"* -FSP Case Manager

Frequency of Services

(+) Assets

+   Having flexibility in what is contracted/expected is key so that care can be adapted and individualized to each client needs

(Δ) Opportunities

Δ   There is a discrepancy between providers as to what the expectation is for number of contacts per week; answers included 1x, 3x, and 3-7x/week

- *"Was told 3 touches per week (either in-person or by phone)"* -FSP Case Manager at organization A
- *"1x/week, can go up to 4X/week if the client is in crisis but it's based on the needs of the client at the time."* -FSP Case Manager at organization B
- *"Contracted to do 3-7 touches per week per client (could be a combo of anyone from the care team) but it seems overwhelming for some clients and challenging for team members. Some clients do not want this level of engagement so mandate is a challenge."* -FSP Director at Organization C

Δ   It is challenging, due to staff capacity and sometimes client engagement, to get more than one contact per week

- *"Challenge is mostly on staff capacity; sometimes it's getting in touch with clients and them picking up the phone but mostly it's my time."* - FSP Case Manager

Service Hours

(+) Assets

+ Providers all providing treatment during normal business hours with clients being able to access care outside of those hours through call-in center, mobile support, or in-house crisis response team

(Δ) Opportunities

Δ Not all 24/7 care right now is being provided by in-house, FSP-specific treatment team members
Δ Might be worth looking at exempt / non-exempt status of FSP staff as one way to expand the flexibility in what hours staff are able to provide care to clients
  ○ *"Would be more advantageous to clients, but clinicians may not like losing overtime"* -FSP Case Manager

Housing & Jail Coordination

(+) Assets

+ Housing is most important thing because not having stable housing leads to other issues and problems

(Δ) Opportunities

Δ Clients have exhausted all housing options by the time they start FSP and the County is not client friendly when it comes to housing
  ○ *"Sometimes they are not even set up on the right benefits to be able to access housing services; especially for AB109 clients coming out of jail."* -FSP Case Manager
Δ Housing is most important goal for most clients, but over 50% of clients are unhappy with their housing situation
Δ Case Managers need more County-wide education and resources about available housing options
Δ Clients are often "stuck" in FSP even though they are ready to be stepped-down because their housing subsidy/voucher is tied to their FSP involvement
  ○ *"If he leaves FSP he loses housing subsidy, but being in FSP and having to meet 2x/week is holding him back. And he is taking someones spot who could really use the FSP level of care."* - FSP Case Manager
Δ Challenging to get housing for people with criminal legal histories, but often clients only want to engage with a provider if it comes with housing benefits
  ○ *"Clients only want to engage if the provider has housing. They won't work with you if you don't have housing to offer them."* -FSP Case Manager
  ○ *"The first thing clients ask is can you get me housing? Coming out of the hospitals, rehab, etc. Had a few successful stories of getting a housing voucher for mental health specifically. Even for the vouchers, it's a challenge to find housing where the landlord will rent the unit to someone who has a voucher and SMI."* -FSP Case Manager
Δ Case Managers need more support going through the housing application process, especially for individuals coming out of jail, as it's a lot of paperwork and bureaucratic barriers
Δ Clients are coming out of jail without benefits and without having had any mental health treatment while incarcerated; some clients and FSP Case Managers are being told that they have to be out of jail for three months and in good standing with the program to even apply for benefits
  ○ *"Coming from jal with no benefits is a big issue. Was able to use AB109 to gain housing with some members but that funding is only temporary and there is a max on the number of AB109 clients and max AB109 dollars our program can accept. Even in those cases, it is still a month long process to apply and get someone into housing. There is also apparently a MediCal change that has resulted in clients being released from jail with no medication. They used to get 2 weeks worth of medication upon release. This is a big issue."* -FSP Case Manager
Δ There is a disconnect when clients are moving between programs, i.e. coming out of hospitals or in/out of residential.
  ○ *"It gets complicated on who is allowed to write what medication for who. We need more coordination so there is a more seamless provision of medication for clients."* -FSP Case Manager

Flex Funding

(Δ) Opportunities

- Δ Has been a useful resource in the past, , i.e. to support purchasing client medication, but was cut because of budget cuts
- Δ Guidance on allowable uses of Flex Funding keeps changing, so it is just not currently getting used
  - ○ *"Think we have Flex Funds and tried to get some funding approved, but then were told not to spend money in that way because it would hinder clients "learning"" -FSP Case Manager*
- Δ Most Case Managers are not familiar with or aware of Flex Funds

Graduation Guidelines Detail

(+) Assets

- + Most providers are talking about graduation at the very beginning and again when a client has met all their goals that were specified in the referral
  - ○ *"Model is to talk about graduation in the very beginning but the reality is that not everyone can tolerate that kind of conversation. Some folks disappear when we talk about graduation which prolongs the graduation." -FSP Case Manager*
- + There is a process and annual packet of paperwork to talk with clients about their status and goals towards graduation. Often internal care team conversations happen internally to determine if it's beneficial before introducing to the client at all
  - ○ *"Goals are identified by the treatment team: psychiatrist, nurse, sometimes social worker. When I feel the client has met the goals, I check with the treatment team for input, where I think the client should be. I always double check with the treatment team. They take my input into account." -FSP Case Manager*
- + There is currently flexibility for providers to determine when graduation is appropriate and not
  - ○ *"There's fluidity in our program. We have flexibility with timing around step-down, it's not formulaic. We're able to accommodate changes in needs and readiness to graduate." -FSP Case Manager*
- + Really good experience when it is slow and client-driven

(Δ) Opportunities

- Δ Referral source has been communicating a 3-12 month program length to clients and Case Manager
  - ○ *"The person who does the referral tells the client that the services are 3-6M or up to a year, depending on client needs. Didn't used to be like that, but now implemented that." - FSP Case Manager*
- Δ Need a more coordinated process for clients who are not ready to graduate or step-down but are moving to a new county so they do not have a lapse in treatment
  - ○ *"It becomes more expensive to live in SMC. For clients who aren't ready to step down from FSP, but are moving to a new county, they have to go through the whole approval process again in a new county. Would be great to have people qualify in one county if they qualify in another county, moving seamlessly." -FSP Case Manager*
- Δ One of the biggest concerns with step-down and why it's sometimes intentionally slower for clients is because of medication and wanting to make sure there is no lapse in care
  - ○ *"Always try to keep them on and implement a warm handoff. Waiting longer usually has to do with meds - not always, but is a big focus. Want to make sure they can start a new service with meds. Clients may not want to change psychiatrist, but they have to if they step-down, so that causes resistance." - FSP Case Manager*
- Δ Case Managers are often focused on more high-need clients and helping clients think about or start the step-down and/or graduation process takes a back seat
  - ○ *"I honestly focus more on the high need clients, when chatting with my supervisor, etc. The process of stepping down starts with me, but it's hard if I have other priorities. Challenge to handle the workload and make sure it's prioritized." - FSP Case Manager*

Mental Health Services Act (MHSA)
Steering Committee Meeting
Thursday, September 2, 2021 / 3:00 – 4:30 PM
Zoom Meeting: https://us02web.zoom.us/j/83216209789
Dial in: +1 669 900 6833 / Meeting ID: 832 1620 9789

MINUTES

1. **Welcome -** *Jean Perry, MHSARC Commissioner & Leticia Bido, MHSARC Commissioner*   5 min

2. **Logistics & Agenda Review -** *Doris Estremera, MHSA Manager*   5 min
   - Introductions (name, pronouns, affiliation) were shared via chat
   - Previous meeting minutes available on the MHSA website, www.smchealth.org/MHSA
   - Stipends available to clients and family members participating; information collected via chat
   - Notice that meeting was being recorded
   - Participation guidelines – enter questions in chat, will address those first, can also use raise hand button during question/answer and unmute when called on, share airtime, practice both/and thinking, be brief and meaningful
   - For General Public Comments (non-agenda items) requested sign up via chat
   - Quick Poll – 12 participants reported demographics, results below:

What is your age range?	
26-59	67%
60+	33%

What is your gender identity?	
Female/Woman	67%
Male/Man	25%
Gender Non-Conforming	8%

What part of the county do you live in OR work in?	
Central County	50%
County-wide	25%
East Palo Alto/Belle Haven	8%
North County	17%

What is your race/ethnicity?
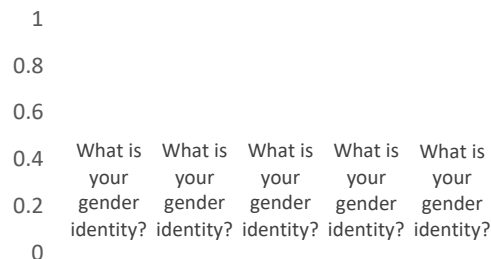
Stakeholder Group
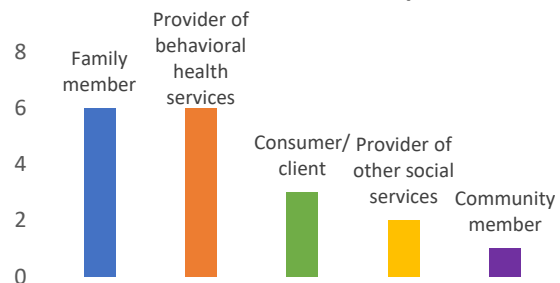
- MHSA Overview
  - 1% tax imposed on personal income over $1M to transform public mental health systems
  - 76% of revenue allocated to direct services and treatment for individuals living with serious mental illness; 51% of this must go to Full Service Partnerships (FSPs)
  - 19% goes to PEI; 5% to INN
  - Two components WET and CFTN do not have automatic allocations but, counties can allocate up to 20% per year to these components. In SMC, we transfer annually to WET

3. **General Public Comment** – *Leticia Bido*   10 min
   - Instructions
     - For non-agenda items; comments limited to 2 minutes
     - Please do not respond to public comments to avoid back and forth, we will respond if we are able to or follow-up after the meeting
     - Requested names of individuals who are interested in providing general public via the chat.
     - Additional public comments can also be submitted via email to mhsa@smcgov.org.

                                                                                    10min

   - Comments
     - Pat: I am very familiar with the police and mental health clinician pilot program [crisis response] between four cities (Daly City, South San Francisco, San Mateo and Redwood City). RWC and SM have not found a clinician to join the pilot program. It is my strong belief that the reason for this is that a certified mental health clinician is not necessary. The San Mateo street mental health program staff are not certified, the Kahoots program are not certified. San Francisco hired Kahoots consultant to help develop their program, Marin County (Santa Rosa) has a similar program that is about to kick off. The Kahoots program manager testified before a senate subcommittee indicating that no Kahoots clinical person has ever been injured or killed, the program has an EMT (not an armed police officers). I wish the County would consider and change the job requirements.
       - Commissioner: thank you very much for this topic, it's certainly something helpful to know and at the Commission we are paying close attention to this
     - Susan (Executive Director, Contractors Association of SMC): we have 23 non-profits that run mental health and substance use programs in our association, and we would gladly partner in this process. StarVista happens to be one of the organizations and we are interconnected but, have other agencies that would be able to

support your needs. If you want to share information with me, I will share with our network. We are your experts in the County.

- Thank you for sharing your services and letting others know you are available as a resource

4. **MHSA Steering Committee Goals & Workgroups** – *Jean Perry*
   - **DRAFT MHSA Steering Committee Goals**
     - At the previous Steering Cmtee meeting we shared that we made a change to the MHSARC by-laws in terms of how the MHSA Steering Committee functions within the MHSARC. This gives more voice and makes it our explicit role to advise the MHSARC.
     - Proposed Goals include:
       1) Represents diverse community and stakeholder voices.
       2) Engages and supports participation of individuals living with mental health challenges, their families and their direct service providers.
       3) Includes equity and inclusion as an active goal of all MHSA processes and priorities.
       4) Develops meaningful and simplified input processes.
       5) Engages in funding, planning, implementation and evaluation decisions of MHSA services and programs.
       6) Are active participants, attending Steering Committee meetings and workgroups and other planning processes as appropriate.
     - This is a more active role than we previously had; workgroups will be subsets of the MHSA Steering Committee and include public members
     - It isn't anticipated that all MHSA Steering Committee members will be able to participate in every workgroup.
   - **Workgroup Participation Guidelines**
     - In previous meeting we shared that there will be two workgroups in the course of a fiscal year (Fall and Spring); the first workgroup starts today and is on Full Service Partnership – shared interest survey link in the chat
     - Guidelines proposed include:
       - 10-12 participants to allow for deeper engagement
       - "First-come, first-serve basis" based on the completion of an interest survey.
       - If we receive more than 12 survey responses, a selection group will review the surveys and prioritize lived experience and cultural diversity
   - **Public Input**
     - Brandi: I filled out the survey [FSP Workgroup Interest Survey] and have not had a follow-up
     - Lanajean: have you picked the participants [of the FSP Workgroup] yet?

- We will be reviewing the surveys next week with a Selection Group (MHSARC Co-chairperson, MHSA Manager and an MHSA Steering Committee volunteer)
- We intentionally did not close the interest survey to allow folks that are not able to attend today for the FSP Workgroup kick-off to still participate; we will make the recording and materials available for folks that could not participate today.
- You will hear from us before the next October workgroup
  - Doris: We currently do not have an MHSA Steering Committee member volunteer for the Selection Group
    - Michael: I also serve on the Commission, can I support the Selection Group? How does the "first-come-first-serve" work if we want to ensure diversity.
    - In this case, because we have over 24 interest surveys, we will take a look at the first 12 that completed the survey and will build off of that to ensure there is diverse representation across organizations, lived experience and cultural perspectives. This means that someone who is on the first 12 list may not be selected.
    - Mary and Juliana also volunteered for the Selection Group via chat; Doris will reach out after the meeting to find a date/time to review interest surveys.

- **MHSA Full Service Partnerships (FSPs) -** *Third Sector consultants*   20 min
- FSP 101 and Background
- Statewide FSP Project
- San Mateo County Client/Families and Provider Input
- Public Input   30 min
- **Introductions**
  - Aurelle Amram, Director with Third Sector, based in San Francisco. Leads mental health work across California and the country. Worked with Los Angeles County on transforming their Full Service Partnerships so that clients aren't falling through the cracks; a three-year project that led to the Statewide work.
- **Statewide Collaborative – Multi-County FSP Innovation Project**
  - Overall goal within SMC is to implement a more uniform data-driven approach to FSPs; using one-time CSS unspent funds in SMC
  - Project originated from the work in LA County; when look at data and anecdotal data on the ground, note that some counties have not been able to meet the full intended outcomes of FSP and there are challenges understanding impact.
  - LA brought in Third Sector to help transform FSP to be outcomes oriented and data informed while still respecting the spirit of doing "whatever it takes" to support clients

- 6 counties came together (Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura) with support from the MHSOAC, CalMHSA and RAND as an evaluator to create consistencies and improve FSPs
- Counties will have increased capacity for collecting and using data to improve FSP services. Clients will receive data-informed and evidence-based services. Lessons and tools can be shared statewide to benefit statewide FSP services. Goals include:
  1) Develop a shared understanding and more consistent interpretation of FSP's core components across counties, creating a common FSP framework
  2) Increase the clarity and consistency of enrollment criteria, referral, and graduation processes through developing and disseminating clear tools and guidelines across stakeholders
  3) Improve how counties define, track, and apply priority outcomes across FSP programs
  4) Develop a clear strategy for tracking outcomes and performance measures through various state-level and county-specific reporting tools
  5) Develop new and/or strengthen existing processes for continuous improvement that leverage data to foster learning, accountability, and meaningful performance feedback
- Timeline: 4.5-year project. Began in 2019 working with MHSOAC and interested counties in developing project plan. Winter 2020 began landscaping assessment to learn about FSPs in each county (differences, similarities and challenges) Fall 2020 started 1-year implementation phase, which is coming to an end now. Sustainability planning will begin soon. 2022-24 RAND will evaluate the impact of this Third Sector process
- Because this project is focused on continuous improvement, there's still a lot of opportunity to gather input and inform direction of SM FSP's moving forward.

- **FSP 101**
  - FSP's deliver a "whatever it takes" approach to community-based mental health services for SMI/SED individuals
  - Serves over 60,000 individuals and families across the California
  - Counties are required to direct the majority of MHSA CSS funding to FSPs
  - FSP providers deliver a wide array of services – many modeled after national Assertive Community Treatment (ACT) and AB2034 (pilot of recovery approach targeting homeless SMI)
    - Services include therapy, psychiatric services, peer supportive services, housing services, and a wide range of case management services geared towards developing life skills and coping mechanisms.

- o Outcomes include consumer-centric services to achieve goals identified in individuals' Individual Services and Supports Plans (ISSP).
- o Statewide challenge: counties have flexibility in how they operate FSPs and clients need a variety of different services at entry and during the course of their journey. How do we build consistency, measure success, and understand statewide impact?

- **Participating agencies**
  - o 6 counties (Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura) + Lake and Stanislaus joined in August 2021
  - o Third Sector is providing project management, outcomes-focused technical assistance, and implementation support.
  - o RAND is providing data and outcomes technical assistance, data cleaning and quality improvement support, and conducting the overall project evaluation.
  - o CalMHSA is serving as the project's fiscal intermediary, including contract and fiscal management as well as administrative oversight.
  - o The CA Mental Health Services Oversight and Accountability Commission (MHSOAC) supported the Innovation planning process, rural Counties and the development of statewide project resources and Learning Community events.

- **Questions**
  - o Is the work only for adult FSP programs?
    - ▪ SMC chose to focus on both youth and adults. Counties got to choose what groups they focused on. The statewide work to define shared measurements strategies are focused on adults but, the second wave will focus on youth.
  - o I would like to receive a PDF copy of this presentation. Can you share the slides with us?
    - ▪ Slides are posted on the MHSA website, under Announcements: www.smchealth.org/MHSA
  - o What is CSS?
    - ▪ CSS is the Community Services and Supports component of MHSA. 76% of MHSA funding must be dedicated to CSS; 51% of CSS must fund FSPs.
  - o Regarding data gathering, I want to understand more about this process: is RAND in the middle of this or do they come in after we are done with the process. What are some of the data that is already available.
    - ▪ Qualitative data – feedback from providers and consumers in the programs have informed a lot of the recommendations. This was conducted by Third Sector. Also looked at MHSA annual updates, three-year plans, cultural competency reviews and from Counties directly

- RAND will receive quantitative data to evaluate the impact of the process, directly from the County. Aggregate data will be shared across counties.
    - What does it mean that we used CSS dollars in our counties? Why did we use CSS funds?
        - Our INN monies were already allocated when this opportunity came to us so, in SMC we used unspent MHSA CSS dollars through a stakeholder process that prioritized a $12M One-Time Spend Plan back in 2019-2020
    - Will SMC retain its individual rights on how we execute FSPs
        - Absolutely. This whole project has been about retaining local flexibility while identifying areas for statewide consistencies
    - Did you say that a goal is if a person in FSP moves from one county to another in California, he/she will be able to get consistent care?
        - Counties are retaining local control while they learn from each other. If someone moves from one County to another, they should receive consistent high-quality care. We have been very thoughtful about what should be consistent and what should be localized. These questions has not been answered before and it's part of the innovation.
- SMC-focus
    - Working on some things at the statewide level (shared outcomes, measurement strategies to compare data)
    - At the statewide level we are not coming up with eligibility guidelines and other local implementation strategies
    - SMC implementation activities have included:
        - Revise county-specific FSP eligibility criteria to ensure that counties prioritize FSP services to the highest-need clients.
        - Develop minimum service requirements (baseline foundation) of FSP to adopt as official guidance. E.g.: % of field-based services, telehealth options, housing and employment services offered, peer supports available, etc. Whether a client accepts the service or provider offers other services, that is the flexibility of this project.
        - Develop standardized graduation guidelines to support staff in making individual stepdown and graduation

decisions while considering ISSPs and system-wide outcomes. Guidelines include improved definitions of "stability" and discussion prompts.

- o SMC activities have included:
    - Co-creating Child/Youth/TAY FSP Service Exhibit with San Mateo BHRS staff that will become the basis for the new Request for Proposal to procure for Child/Youth/TAY services.
    - Sharing best practices from Los Angeles County Department of Mental Health to inform the revised Adult FSP Service Exhibit that will become the basis for the Request for Proposal to procure for Adult services.
    - Using provider and client interview and focus group feedback to inform Service Exhibits and RFPs. What's worked well, what hasn't.
    - Developing standardized graduation readiness guidelines to be used in conjunction with new graduation / stepdown process. Not about forcing anyone out of FSPs but, want to provide consistency in when to consider transitions and provide the supports needed for a warm hand-off (readiness indicators and guidelines for best practices).

- o SMC Next Steps include:
    - Finalize Child/Youth/TAY and Adult Service Exhibits and Requests for Proposal.
    - Continue gathering local input to prioritize local FSP outcomes and provide input on FSP services for ongoing quality improvement. Through upcoming FSP Workgroup
    - Developed standardized graduation/ step-down process that can now be used across all FSP providers in the county.
- o Stakeholder engagement in SMC included:
    - FSP clients and staff interviewed Aug-Sep 2020 to guide selection of implementation activities (13 clients; 8 staff) and Mar-Apr 2021 to inform the RFP (14 clients; 12 staff).
    - Clients were interviewed over the phone and received $25 gift card. Hundreds of clients interviewed across the State
    - Staff focus groups included staff that work with clients directly and heard about services that are working and challenges/barriers

- o The full FSP Focus Group Summaries are available on the MHSA website, under Announcements and our MHSA Steering Committee Meeting Materials, www.smchealth.org/MHSA
- o Learnings/Highlights included:
  - Therapy/psychiatry should be more readily provided in-house and consistently within FSPs
  - Importance of Peer and family advocates; how we could improve staffing issues and making sure we address attrition and career pathways
  - Helpful to leaving FSP earlier in the program, not necessarily a forever program so being able to have graduation conversations sooner. What will it look like when a client is ready to graduate?
- Questions and Input
  - o What does it mean to graduate? To be self-supporting? Or to just be more engaged with the community? I think what it means to "graduate" might vary for each person.
    - "Graduation" is used because it is important to celebrate hard work and thinking about when clients are ready to move to a less intensive level of care; "step-down" is another word used for stepping down to lowers level of care.
  - o Comment: regarding seeking peer opinion about this program reminds me that the law enforcement and mental health pilot program [crisis response] was created completely behind closed doors, no public input was requested nor made available. Santa Clara County spent months getting public input on their mobile mental health pilot program that will roll our and has no embedded police component. The program was designed by local mental health programs and staff.
    - There is so much interesting work across the state and it will be beneficial to share and compare across similar indicators
  - o Were clients interviewed who had "graduated"? Clients who "dropped out"?
    - Yes, we did interview clients who had graduated or stepped down to lower levels of care to find out what worked well. We did acknowledge the inherent bias in the data because couldn't track down clients that dropped out due to negative reasons. Recognized bias in the type of feedback we sought.
  - o Regarding step-down of care and supporting clients in their transition, has Third Sector began that process or are we just

beginning now. Will there be opportunities to share about this and hear about what those indicators currently are?

- We are looking at this in two stages: 1) what is the process for stepping a client down once the decision is made that a client is ready to step down? How is FSP provider coordinating with new provider, are they attending sessions with the client, meeting one-on-one with the provider? What does warm hand-off look like? 2) readiness indicators of how you know when the decision to graduate should be made. This will be explored with the FSP Workgroup in future meetings. So, part of the work has already begun and part of it is happening through the FSP Workgroup. We will share best practices and input from academics and other counties during the October FSP Workgroup.

o Apparently, the schools have major say re: continuing FSP vs graduating. Is this due to funding?

- We have been discussing with the Child/Youth team on how to enhance coordination between the FSP services and the school-based services team, if there are additional services being provided at schools and trying to put more consistency in what it would look like for an FSP team member to coordinate with the school district or school care team and that it's all billable.
- Participant comment: My experience is that schools are fairly uninvolved with the FSP's and they don't tend to impact that decision. Just my experience.

o School districts filed due process to discontinue FSP. Administrative judge ruled "no way". School district discontinued FSP anyway.

- We will follow-up on this comment. I agree that this has not come up in our local conversations but, I will follow-up to make sure we can clarify.

o Did you mention standards for people who may not be in a step-down position... are there going to be standards of continued care for them as well?

- Yes, some of the workflows include looking at readiness indicators every 3 months in partnership with clients and families; review goals and decide collectively using data. If not sure then routine care will continue. Goal-oriented care, FSP services will continue until client is ready; not about a timeline, it's about checking in with the client and the families.

o Older adults – there's an optimism with how we are discussing graduation ("you're not quite there but, you will get there"). But, for older adults, housing may be jeopardized and may not have the

ability to step-down; what would be reassuring for those that may not get better.

- We are focused on giving FSP providers the tools to have those conversations with clients and let them have the judgement about whether someone should or should not move out of FSP; not mandating that clients graduate. If provider is working with an older adult, they will continue services for them.

o There's standard for stepping down, will there be standards for those that don't step-down. Are there enough clients that fall into that category?

- We know that most clients don't step down. The average participation is 1-2 years. Quarterly, there will be conversations about stepping down. We can discuss this further in the FSP Workgroups and especially as it relates to youth vs. adults and older adults.

o I would like there to be some consideration of being able to "step up" where peers can transition from clients into peer providers. . .giving them opportunity to become employed into the field.

o We're talking about transition moving in one direction. Are there conversations about transition moving bi-laterally? What we observed in 05-07 (as part of the AB2034) is that many clients who stabilized and were transitioned down, decompensated rapidly and aggressively. Those that were kept with their agency, even if moved to a lower level of care within that same agency, had a higher success rate in that transition. We (Telecare) held on to some clients within our agency in lower levels of care for years and then age-related decline issues led to moving them back up to higher level of care. Is there conversation statewide about this?

- Transition back and forth comes up in every FSP conversation. We are thinking about how to address it but, in SMC we are not addressing it explicitly.

o In SMC, we have not seen a lot of youth that move from the youth/TAY FSP into the adult FSP. What work is being done in integrating that fluidity?

- There is not good quantitative data being collected about outreach and engagement in any County. Who did or did not get into FSP? Can we get a quantitative foundation of who was enrolled in FSP or who were not eligible, where are referrals coming from and what are they dynamics? WE are starting to gather this data.

- Qualitative data has pointed to confusing service expectations about transferring a client when they turn 26 years of age to the adult FSPs or keeping them if they are

being successful. Where is there flexibility on this and what should outreach look like.

- Participant comment: It's incredibly difficult to track community outreach as most of the outreach in our work happens on the ground and we do not have the capability to follow the person from point of contact to access of care.

o For service requirements, will Third Sector look at requirements from both staff perspective and client's perspective on eligibility requirements? There is a discrepancy between providers and consumers. On the medical side things are still being updated and re-evaluated as to when clients can be graduated.

- We asked this of consumers during the interviews. Did you feel it was easy to get into the FSP program, what questions were you asked, what was the experience like, how did you hear about the program, how would you know when you are ready to graduate, how would you feel, have you talked about this with your clinician, how did you make that decision, how did it feel, did it go well, if not, what can we improve?

5. Adjourn
- Feedback survey for this meeting available here: https://www.surveymonkey.com/r/MHSA_MtgFeedback
- FSP Workgroup interest survey is open through Friday, September 3, 2021
- Next Steering Committee meeting is scheduled for December 10, 2021

* **Public Participation:** All members of the public can offer comment at this public meeting; there will be set opportunities in the agenda to provide Public Comment and input. You can also submit questions and comments in the chat; these will be addressed on a "first-come, first serve" basis. If you would like to speak, please click on the icon labeled "Participants" at the bottom center of the Zoom screen then click on "Raise Hand." The host(s) will call on you and you will unmute yourself. Please limit your questions and comments to 1-2 minutes.

The meeting will be recorded. Questions and public comments can also be submitted via email to mhsa@smcgov.org.

*REMINDER – Please Complete the Steering Committee Feedback Survey

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

ATTENDANCE

There were up to 25 participants logged in to the Zoom app. Below is a list of attendee names as recorded from Zoom; call-in numbers are typically unidentifiable.

MHSA Steering Committee Co-Chairpersons
1. Jean Perry (MHSARC)
2. Leticia Bido (MHSARC)

MHSA Steering Committee Members
3. Jairo Wilches (BHRS OCFA)
4. Juliana Fuerbringer
5. Mary Bier
6. Michael Krechevsky
7. Michael Lim (MHSARC)

Participants
8. Kevin Jones
9. Georgia Peterson
10. Suzanne Moore
11. Tet Madrid
12. Amanda Russell
13. Brandi Machado
14. Eddie Flores
15. Susan Cortopassi
16. Noelle Beaver
17. Lanajean Vecchione
18. Eddie Flores
19. Pat W
20. Chelsea Bonini
21. Claudia Saggese (BHRS OCFA)

BHRS Staff Supports
Doris Estremera (MHSA Manager, BHRS ODE)
Sylvia Tang, she/her (BHRS ODE)

Presenter(s)
Aurelle Amram, Third Sector

Be the one to help

![Proposition 63 MHSA logo]

Mental Health Service Act (MHSA)
MHSA Steering Committee

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

The MHSA Steering Committee meets the first Thursday at 3pm in February, May, September and December to provide input, make recommendations and stay up-to-date on new MHSA developments and ongoing programming.

Meeting objectives include:

- Review and provide input on the Full Service Partnerships Workgroup Recommendations.

- Update on recent MHSA Housing developments

- Learn all about Innovation Planning and get involved in the new MHSA Workgroup.

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

Please contact us at mhsa@smcgov.org at least 2 weeks in advance to reserve language services.

DATE & TIME

Thursday, December 2, 2021
3:00 pm – 4:30 pm

Zoom Meeting:
https://us02web.zoom.us/j/83216209789
Dial in: +1 669 900 6833
Meeting ID: 832 1620 9789
iPhone one-tap: +16699006833,,83216209789#

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

www.smchealth.org/MHSA

![County of San Mateo California seal] ![San Mateo County Health Behavioral Health & Recovery Services logo] **SAN MATEO COUNTY HEALTH BEHAVIORAL HEALTH & RECOVERY SERVICES**

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

SAN MATEO COUNTY HEALTH
**BEHAVIORAL HEALTH
& RECOVERY SERVICES**

Mental Health Services Act (MHSA) Steering Committee Meeting
Thursday, December 2, 2021 / 3:00 – 4:30 PM
Zoom Meeting: https://us02web.zoom.us/j/83216209789
Dial in: +1 669 900 6833 / Meeting ID: 832 1620 9789

AGENDA

1. **Welcome**   5 min
   Jean Perry, MHSARC Commissioner and Leticia Bido, MHSARC Commissioner

2. **Logistics & Agenda Review –** *Doris Estremera, MHSA Manager*   5 min
   - Previous meeting minutes available on the MHSA website,
     www.smchealth.org/MHSA

3. **Announcements**   10 min
   - MHSA membership **–** *Doris Estremera*
   - Infrastructure funding – *Jean Perry*

4. **General Public Comment** – *Leticia Bido*   10 min
   - For non-agenda items
   - Additional public comments can also be submitted via email to
     mhsa@smcgov.org.

5. **Update - Housing Initiative Taskforce Recommendations**   30 min
   - Supportive Housing Units – *Judy Davila*
   - Housing Locator and Field-based Services – *Doris Estremera*
   - Homeless Outreach Teams – *Ally Hoppis*
   - Board & Care Support – *Talisha Racy*
     o Public Input

6. **Full Service Partnerships (FSPs) Workgroup Results** – *Jean Perry*   20 min
     o Public Input

7. **Next MHSA Workgroup: MHSA Innovation (INN) Planning** – *Doris Estremera*   10 min
     o Public Input

8. **Adjourn**

* Public Participation: All members of the public can offer comment at this public meeting; there will be set opportunities in the agenda to provide input. You can also submit questions and comments in the chat. If you would like to speak, please click on the icon labeled "Participants" at the bottom center of the Zoom screen then click on "Raise Hand." The host(s) will call on you and you will unmute yourself. Please limit your questions and comments to 1-2 minutes. The meeting will be recorded. Questions and public comments can also be submitted via email to mhsa@smcgov.org.

*REMINDER – Please Complete the Steering Committee Feedback Survey

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

Mental Health Services Act (MHSA)
Steering Committee Meeting
December 2, 2021

1

Before we begin…

- Agenda, handouts, slides: www.smchealth.org/MHSA, under "Announcements" tab
  - o Past meeting materials/minutes: under "Steering Committee" tab
- Introductions: your name, pronouns and affiliation in the chat
- Stipends for clients and family members participating
  - You can let us know in the chat (private message) - please provide your email
- Meeting is being recorded
- Quick demographics poll

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Participation Guidelines

- You can enter questions in the chat box as we go
  - For each agenda topic there will be time for questions/comments – you can also use the "Raise Hand" button during this time.
- If you have a general public comment (non-agenda items), let us know now in the chat.
- Share your unique perspective and experience
- Share the airtime; allow every voice to be heard (step up/step back)
- Practice both/and thinking; consider all ideas along with your personal advocacy
- Be brief and meaningful when voicing your opinion

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BEHAVIORAL HEALTH & RECOVERY SERVICES

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Agenda

1. MHSA Background + Announcements
2. General Public Comments
3. Update – MHSA Housing Taskforce Recommendations
4. Full Service Partnerships (FSPs) Workgroup Results
5. Next MHSA Workgroup: Innovation (INN) Planning

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MHSA Background

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

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

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

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

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

1% tax on personal income over $1 million
San Mateo County: $30.7M annual 5-year average through FY 19-20; ~15% of the BHRS budget

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Quick Announcements

- MHSA Steering Committee membership
  - Updated Member Roles & Responsibilities: www.smchealth.org/MHSA, under "Steering Committee" tab
    - Includes membership targets to ensure diverse representation
- Infrastructure funding

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2. General Public Comments
(non-agenda items)

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3. Update - Housing Initiative Taskforce Recommendations

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Update - Housing Taskforce Recommendations

	Funding Recommendations (May 2021 - listed in order of priority)	Progress	Notes
1.	Establishment of an ongoing Housing Fund with Department of Housing for the development of Supportive Housing Units for clients	Year 1 Completed	Year 2 – targeted for 2022 *Judy Davila to report out*
2.	Housing locator contract to oversee: a) Maintenance of BHRS Housing website services with real-time housing availability information; b) Linkages to BHRS case managers; c) Landlord engagement; d) Community mental health 101 education to housing agencies; and e) 3 housing locators (mental health counselors) and 3 peer navigators	In Progress	Input sessions + Request for Proposal process (items 2, 6, 7 combined) targeted for Spring 2022
3.	Supportive services for new housing units developed	Not Yet Started	Targeted for new housing units being developed
4.	Mental health workers for Homeless Outreach Teams	In Progress	*Ally Hoppis to report out*
5.	Transitional housing supports and training to adequately serve SMI population, including special populations	Not Yet Started	Target TBD

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Update - Housing Taskforce Recommendations

	Funding Recommendations (May 2021)	Progress	Notes
6.	Outreach and field-based services to support ongoing and long-term housing retention; a team of Occupational Therapist and Peer Counselor with co-occurring capacity to support independent living skills development and recovery	In Progress	Input sessions + Request for Proposal process (items 2, 6, 7 combined) targeted for Spring 2022
7.	Development of an online BHRS Housing webpage with comprehensive one-stop housing information (including data dashboard for unmet need) for clients and staff	In Progress	Input sessions + Request for Proposal process (items 2, 6, 7 combined) targeted for Spring 2022
8.	Flexible funds for housing related expenses (moving costs, deposits, first month rent)	Not Yet Started	The revenue for this item is highly inconsistent; will propose for FY 22-23
9.	Increase FSP housing funds	In Progress	Current FSP housing rate increased; Third Sector consultants will support ongoing cost modeling
10.	Incentives and supports for licensed Board and Cares to improve quality of services	In Progress	*Talisha Racy to report out*
11.	Increase Full Service Partnerships (FSP) slots for children/youth and transition-age youth	Completed	10 Children/Youth and 5 TAY FSP slots

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Public Input

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4. Full Service Partnerships (FSPs) Workgroup Results

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FSP Workgroup Recommendations

- refer to meeting handout for more details

- Set Minimum FSP Service Requirements
- Identify Additional FSP Client/Family Resources
- Support Staff Retention and Appropriate Contractor Rates
- Develop Trauma-Informed FSP Providers
- Prioritize Substance Use Integration
- Strengthen Peer and Family Supports
- Ensure Housing Access and Retention Services
- Incorporate Step Down Services and Guidelines for FSP Programs
- Enhance Ongoing Data Collection and Evaluation

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Public Input

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5. Next MHSA Workgroup: Innovation (INN) Planning

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MHSA Innovation (INN) – New Cycle!

- 5% of MHSA funding must be allocated to innovative ideas
  - Average $2.15M available per year for new projects
- INN Projects must be approved by the State prior to implementation
- INN Projects are 3 to 5-year pilot projects to develop new best practices:
  1. Introduce a <u>new</u> practice or approach
  2. Make <u>a change</u> to an existing practice, including application to a different population
  3. Apply a <u>promising community-driven practice</u> that has been successful in non-behavioral health settings
  4. <u>NOT demonstrated effective</u> in behavioral health setting (in literature, research, etc.)

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New INN Workgroup

- To develop an inclusive and supportive process for submitting and selecting ideas
- Participation survey will open in January
  - 10-12 participants
  - Meet monthly March-May

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INN Planning Timeline

INN Workgroup

Submitting INN Ideas Feb-Apr 2022 → Selection of INN Ideas May 2022 → State feedback on INN Ideas Jun 2022 → DRAFT INN Proposals July- Aug 2022 → MHSA Steering Committee - Stakeholder Input Sep 2022

30-day Public Comment & Public Hearing Oct- Nov 2022 → Board of Supervisors and State approval Dec 2022-Jan 2023 → Procurement of Service Providers Jan – Jun 2023 → Projects Commence July 2023

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Get Involved!

- **Subscribe to receive opportunities to get involved in MHSA planning:**
  www.smchealth.org/MHSA

- **BHRS-wide opportunities:**
  https://www.smchealth.org/get-involved

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Thank you!

Jean Perry, MHSARC Commissioner
Leticia Bido, MHSARC Commissioner
Doris Estremera, MHSA Manager
Email: mhsa@smchealth.org
Website: www.smchealth.org/MHSA

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

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Mental Health Services Act (MHSA) Housing Fund 2021

1

MHSA Funds for Supportive Housing

- MHSA Commission approved 3 year plan. Included funds for housing development.
- 5 million dollars transferred to Dept of Housing for inclusion in AHF 9 NOFA
- BHRS/DOH Review of potential developments
- 3 Projects selected for funding

2

Criteria for Selection

- Interest and Experience of Developer
- Project Feasibility
- Location
  - Services near by
  - Transportation
- Design of building
- Population of building
- Amenities in building

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Proposed Projects

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Week St Apartments

- MidPen Housing & EPA CanDo
- 135 Units Affordable Housing
- 8 MHSA Units
- East Palo Alto
- Completion Date

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North Fair Oaks Apartments

- Affirmed Housing
- 84 Units Affordable Housing
- 11 MHSA Units
- North Fair Oaks
- Completion Date 10/2025

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Fire House Square Apartments

- Eden Housing
- 82 Units Senior Affordable Housing
- 6 MHSA Units
- Downtown South San Francisco
- Completion Date 2/2024

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4. Additional Projects

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Kiku Apartments

- Mid Pen Housing
- 224 Units Affordable Housing
- 9 MHSA Units
- Downtown San Mateo
- Completion Date 2/2024

9

• Light Tree Apartments

- Eden Housing
- EPA Can Do
- East Palo Alto
- 198 Affordable Units
- 9 NPLH Units

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4. MHSA Housing Program Funded Projects

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636 ElCamino

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Delaware Pacific

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Cedar Street

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Waverly Place

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Fair Oaks Commons
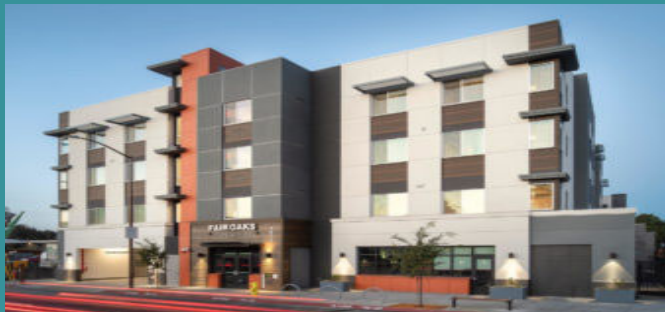
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Arroyo Green

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Questions

- Type in chat or raise hand
- Email Judy Davila: c_jdavila@smcgov.org

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THANK YOU!

Judy Davila

c_jdavila@smcgov.org

Doris Estremera

mhsa@smcgov.org

www.smchealth.org/MHSA

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MHSA FSP Workgroup – Stakeholder Feedback

Recommendation	Workgroup Feedback	How will this be addressed
Set Minimum FSP Service Requirements	General Feedback: - Therapy services need to be offered by providers - Nutrition, physical activity, evidence-based tx (e.g. EMDR) peer support are low-cost services that can have a big impact C/Y/TAY Breakout: - Young adult peer supports is essential - Need family support groups in multiple languages - Important to build independence of client and natural supports Adult Breakout: - Quality FSP services should include food and life skills training	• At minimum, the following <u>FSP requirements</u> (per MHSA legislation) will be included in FSP Request for Proposal (RFP) process and subsequent contracts: 1. Mental health treatment plans (ISSP) 2. Therapy and psychiatric services 3. Co-occurring assessment and referrals 4. Alternative and culturally specific treatment 5. Wrap-around services to children 6. Peer/family supportive services 7. Supports to assist the clients/family to obtain and maintain employment, housing, and/or education and life skills development 8. Case management – Personal Service Coordinator; available 24/7 9. Crisis intervention/stabilization services 10. Non-mental health services (food, clothing, housing supports, supports with cost of health care and co-occurring treatment, respite care) 11. Language capacity/services

Identify Additional FSP Client/Family Resources Needed	General Feedback:
	- Early Psychosis resources are provided by Felton Institute, how can we ensure that providers know?
	- Broaden definition of family to communities of support, providing them with education and supports.
	
	C/Y/TAY Breakout:
	• Community education about SMI and reducing stigma
	• Education for parents on how to advocate for their kids, how to help and connect to resources
		• The following services are contracted out, include separate funding, and provide additional supports for FSP clients, families/communities of support and providers:
		  o Supported education/employment
		  o Early psychosis
		  o Housing units for SMI/SED, peer supports and maintenance
		  o Life skills development
		  o Wellness Centers, Drop-in Centers
		  o Education and outreach for clients, families, and community
		• Interagency collaboration will be an expectation of all contracted providers, to ensure awareness and access to additional supports available to FSP clients; via consults, education and outreach, and other standing committees (e.g. Youth Transition Assessment Committee)

Recommendation	Workgroup Feedback	How will this be addressed
Support Staff Retention & Appropriate Contractor Rates	General Feedback and Breakouts: - Staffing and contractor rates need to be updated to support all activities - Pay rates and benefits of staff impact whether people feel valued - Need ongoing sustainable plan to renew rates to retain staff - Need recruitment/retention of staff of color and bilingual; including monetary hiring incentives - Improve compensation and benefits for peer supports to increase Peer Staff retention - Need supports for peer staff	• Third Sector's contract will be extended for another 6 months to support appropriate cost modeling for FSPs that considers all existing and any new service expectations including retention needs of clinical and peer staff • BHRS' goal is to conduct RFP processes every three years if possible, for FSP services. Three-year FSP contract terms allow for level-setting FSP rates via the RFP process and aligning FSP cost increases with MHSA budgeting. • Upcoming BHRS workforce strategies will include Student Loan Repayment, Undergraduate Scholarship, Graduate Stipends and Pipeline programs, available to both BHRS staff and contracted providers' staff
Develop Trauma-Informed FSP Providers	General Feedback: - Trauma informed capacity across services provided, data collected and staff supports C/Y/TAY Breakout: - More robust assessment of intergenerational trauma, ACEs, etc. in order to match services to family needs from the start	• BHRS Trauma-Informed Systems training will be expanded beyond BHRS to include (and required of) contracted providers

Prioritize Substance Use Integration	General Feedback:
	- Substance se capacity needs to be strengthened and include education on harm reduction
		• The following will be expectations of FSP providers, per California Institute for Behavioral Health Solutions (CIBHS) recommendations:
		  o Service philosophy - trauma-informed, SU/MH integrated care
		  o Trainings and EBPs - baseline knowledge of co-occurring for all staff, Motivational Interviewing, CBT/DBT, strength-based case management, peer supports, harm reduction, etc.
		  o Assessment tools - to support understanding of SUD and impact on MH (coping vs. causal) and appropriate treatment and referrals (e.g. methadone, harm-reduction, residential tx, etc.)

Recommendation	Workgroup Feedback	How will this be addressed
Strengthen Peer & Family Supports	<u>General Feedback</u> - Peers are an essential service and evidence-based but, there are not enough peer specialists available. - Peer supports for family members of both youth and adults - Provide a wider menu of supports for clients and families/community of support (e.g. motivational interviewing, DBT group, etc.).	• FSP providers will be expected to include an increased role of peers (both for clients and family members of youth and adults) to support care coordination and linkages to additional supports and services. • The MHSA Housing Initiative Taskforce prioritized "peer-led housing locator services" and "outreach and field-based services," to support ongoing and long-term housing retention. The planning for this RFP will begin in 2022 and include input sessions with stakeholders. • Training for peers will be expanded via SB 803 Peer Programs, requires continuing education for certified peers. Separate funding has been identified and can include clients, families/communities of support.
Ensure Housing Access & Retention Services	<u>Adult Breakout</u>: • Housing is a bedrock to recovery, as much as therapy or other clinical svc. • SMC should ensure housing is not impacted by graduation • When in housing; need supports (hoarding, meals, managing budget, weekly cleaning routines, etc.) <u>General Feedback</u>: • Need to identify those at risk for homelessness during transition from foster care, incarceration, armed services, in-patient, family caregivers, or other personal circumstances, etc. • It is difficult to adopt a "housing first" model due to cost of living • Individuals at times are not eligible for vouchers (e.g., due to criminal history); U.S. Dept HUD requirement • FSP housing supports are often the only places available to for clients with complex housing histories.	• Housing transition supports and/or linkages (e.g. to new Housing Locator services) will be an expectation of FSP providers. FSP providers will support clients stepping down to lower levels of care with applying for independent living opportunities (mainstream vouchers or MHSA units); client will be stepped down from FSP and connected to ongoing outpatient treatment. • There will be additional support to FSP providers and clients via the MHSA Housing Initiative Taskforce prioritization of "outreach and field-based services" to support ongoing and long-term housing retention via an occupational therapist and peer team. • FSP clients who are at risk of homeless are identified by the FSP provider and are supported to apply for housing opportunities including linkages to the Human Agency Core Service Agencies once they are closer to becoming homeless or are homeless to see if they qualify for any other housing opportunities (i.e. Emergency Housing Vouchers). o For non-FSP clients, there are programs that help link eligible clients to FSP, including Adult Resource Management, Pathways and Service Connect teams for individuals transitioning out of incarceration. • Explore developing a housing continuum that moves from a Housing First model through Supported Housing training resulting in prioritization of voucher eligibility, through No Place Like Home, HSA Continuum of Care work, new MHSA supported housing (potentially more flexible eligibility requirements), etc.

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BEHAVIORAL HEALTH & RECOVERY SERVICES

Recommendation	Workgroup Feedback	How will this be addressed
Incorporate Step Down Services & Guidelines for FSP Programs	General Feedback: - Having a tiered system or step-down services within the FSP program so that client can stay with same provider - Step-down conversations should be wellness-focused and include client defined goals at intake and ongoing (e.g. wellness and recovery-oriented model of providing services) - There needs to be transparency re: goals, goal achievement, timelines in step-down and timely evaluation (life changes too fast, opportunities missed for readiness for next steps, or no recognition that relapse or increased symptoms) - There could be a more formal use of intake and treatment planning assessments (i.e. KET, CANS, ANSA) and discharge planning - Coordination of the entire system for step-down process - hospitals, school system, transitional supports for TAY, etc. need to work together and be fluid, be communicating - Should include benefits (SSI) counseling	• FSP step down options within the FSP programs will be included in FSP RFP's and subsequent contracts; this will require a review of indicators and guidelines for step down. • Step-down guidelines will be developed and include feedback (e.g. wellness, recovery-oriented, timely evaluation, etc.) provided via key interviews, focus groups and the FSP workgroup. • Third Sector consultants will continue to support both step-down requirements and cost-modeling to support this tier of work.
Enhance Ongoing Data Collection and Evaluation	General Feedback - Measuring whole person and whole organization (i.e. FSP providers) wellness is important to know if FSP is working and sustainable - The client and provider interviews were a small sample size; how can we continue conversations? - What if outcomes are not being met, what is the plan for accountability? Need timely evaluation of whether services meet the need	• Annual client/provider interviews will be added as a deliverable of the FSP Annual Report developed by an external evaluation consultant. o This annual evaluation will also integrate continuous improvement findings to ensure timely service adjustments and course corrections are implemented • Third Sector's contract will be extended to support the development of a local data collection plan, which will include program-level, individual-level outcomes, and continuous improvement indicators. This could include exploring how to measure provider wellness. • As part of the Statewide collaborative, San Mateo will continue to work with Third Sector on FSP Program continuous improvement and advocacy to DHCS for data collection improvements

Mental Health Services Act (MHSA) Steering Committee Meeting

Thursday, December 2, 2021 / 3:00 – 4:30 PM
Zoom Meeting: https://us02web.zoom.us/j/83216209789
Dial in: +1 669 900 6833 / Meeting ID: 832 1620 9789

MINUTES

1. **Welcome**   5 min
   Jean Perry, MHSARC Commissioner and Leticia Bido, MHSARC Commissioner

2. **Logistics & Agenda Review –** *Doris Estremera, MHSA Manager*   5 min
   - Previous meeting minutes available on the MHSA website,
     www.smchealth.org/MHSA
   - Introductions public members (name, pronouns, affiliation) were shared via chat
   - Introduced Steering Committee members: Jairo Wilches, Mary Bier, Juliana
     Fuerbringer, Kava Tulua, Melissa Platte, Yoko Ng
   - Introduced new MHSARC Commissioners: Frieda Edgette, Chelsea Bonini
   - Stipends available to clients and family members participating; information
     collected via chat
   - Notice that meeting was being recorded
   - For General Public Comments (non-agenda items) requested sign up via chat
   - Participation guidelines – enter questions in chat, will address those first, can
     also use raise hand button during question/answer and unmute when called on,
     share airtime, practice both/and thinking, be brief and meaningful
   - Quick Poll – participants reported demographics, 90% response rate:

What is your age range?	
16-25	5%
26-59	60%
60+	35%

What is your gender identity?	
Female/Woman	75%
Male/Man	20%
Gender Non-Conforming	5%

Race/Ethnicity
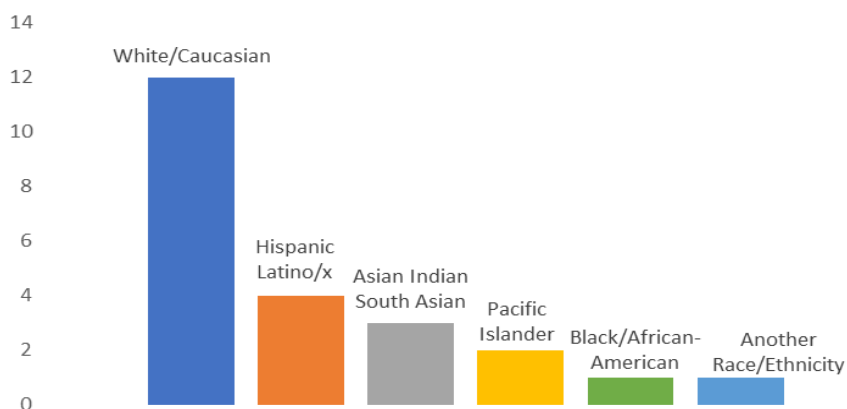
What part of the county do you live in OR work in?	
Central County	25%
County-wide	30%
East Palo Alto/Belle Haven	5%
North County	20%
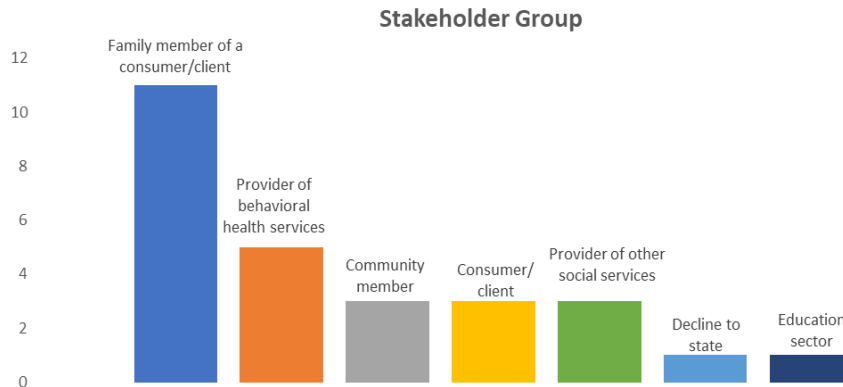
Stakeholder Group

- MHSA Overview
  - 1% tax imposed on personal income over $1M to transform public mental health systems; this translates to $34.3M annual avg in the last five years through fiscal year 2020-21
  - 76% of revenue allocated to direct services and treatment for individuals living with serious mental illness; 51% of this must go to Full Service Partnerships (FSPs)
  - 19% goes to PEI; 5% to INN
  - Two components WET and CFTN do not have automatic allocations but, counties can allocate up to 20% per year to these components. In SMC, we transfer annually to WET for workforce development program and to CFTN for client devices, telehealth and electronic healthcare record system

3. Announcements   10 min
   - MHSA membership **–** *Doris Estremera*
     - Steering Committee members will receive a follow-up demographic survey; we will be recruiting new members
     - Steering committee applications and member roles/responsibilities are posted on the MHSA website, www.smchealth.org/MHSA, under "Steering Committee" tab
   - Infrastructure funding – *Jean Perry*
     - $2.2 billion dollars available in the state of California for mental health infrastructure; applications rolled out recently.
     - SMC submitted an application for the planning grants
     - Please provide BHRS with ideas – for example: upgrade the SSF clinic into a full behavioral health location, add 5th MHRC at Cordilleras, etc.

4. **General Public Comment** – *Leticia Bido*   10 min
   - **Instructions**
     - o For non-agenda items; comments limited to 2 minutes
     - o Please do not respond to public comments to avoid back and forth, we will respond if we are able to or follow-up after the meeting
     - o Requested names of individuals who are interested in providing general public via the chat.
     - o Additional public comments can also be submitted via email to mhsa@smcgov.org.

   - **Comments**
     - o Jairo: application process for second Advocacy Academy is now open- a 6-week course clients/family members to become advocates in their community, their lives, BHRS and MHSA. Copeland center conducts the academy; the first academy earlier this year and will start the second round in February 2022. Last week graduated a cohort of the "Lived Experience Academy".
       ### From Chat:
         - ▪ Jairo: posted Advocacy Academy flyer
         - ▪ Lanajean: Both family members and peers are eligible for Advocacy Academy. correct?
         - ▪ Jairo: yes, clients and family members/caretakers can join the Advocacy Academy
     - o Kathy: I am a family member and with solutions for affordable housing. We need accountability for Full Service Partnerships and other BHRS settings; "it's not what you expect, it is what you inspect." People have to be treated well, it's been my son's experience where appointments are cancelled and not communicated.
     - o Kathy: San Francisco started a program, Collaborative Caregiving Support Teams (it was on Saturdays' Chronicle newspaper) – program to help formerly homeless and individuals with serious mental illness can benefit; provides help with daily living (cleaning, shopping) run by dept of disability, dept of aging and dept of homeless and supportive housing. $600/client/year and keeps individuals from being evicted from their housing.
     - o Joan: here with Solutions for Supportive Housing in support for this effort

5. **Update - Housing Initiative Taskforce Recommendations**   30 min
   - Doris provided context – in the Spring of this year, 30+ individuals came together as part of a Housing Taskforce to prioritize and make recommendation related to funding for housing resources and supports; a full spectrum of housing services for individuals living with mental health challenges was developed. All materials are available on the MHSA website, https://www.smchealth.org/general-information/mhsa-housing. We will be

providing the progress we have made since the following 11 Housing Taskforce Recommendations were released:

1) Supportive Housing Units – *Judy Davila, Housing Consultant*
   o Judy shared slides (attached below)
   o $5M of MHSA funds were transferred to Department of Housing for their affordable housing fund, a funding availability notice was released, staff reviewed applications received and selected 3 projects
   o Projects were examined to fit following criteria:
     ▪ interest and experience of developer to make housing for special needs populations and experience developing permanent supportive housing
     ▪ project feasibility- permits, financing, env impact, community outreach, readiness to begin construction
     ▪ location – did it have public transportation, businesses and services nearby
     ▪ building design - safety, accessibility, community rooms, confidential office space, would it encourage interactions,
     ▪ are population of building a good mix
     ▪ amenities such as daycare, laundry, garages, computer labs, accessible units, etc.
   o Three projects were selected and funds committed:
     ▪ Week St. Apartments: EPA, MidePen & EPA CanDo; 135 affordable units, 8 MHSA units, 2024 completion
     ▪ North Fair Oaks Apartments: NFO Redwood City; Affirmed Housing; 84 affordable units, 11 MHSA units, 2025 completion
     ▪ Fire House Square Apartments: South San Francisco; Eden Housing; 82 affordable senior units, 6 MHSA units; 2024 completion
   o Two additional projects that do not have MHSA development funds but will have MHSA units:
     ▪ Kiku Apartments: Downtown San Mateo; Mid Pen; 224 affordable housing; 9 MHSA units, 2024 completion
     ▪ NPLH - Light Tree Apartments: East Palo Alto; 198 affordable units; 9 MHSA units
   o Previously funded MHSA units: in 2007 State created the MHSA Housing Program, San Mateo received $6.7M allocated to 6 housing projects for a total of 62 units
     ▪ 2012 - 636 El Camino in South San Francisco; 20 MHSA units
     ▪ 2013 - Delaware Pacific in San Mateo; 10 MHSA units
     ▪ 2012 - Cedar Street in Redwood City; 14 MHSA units
     ▪ 2019 - Waverly Place in Redwood City; 15 MHSA units
     ▪ 2020 - Fair Oaks Commons in Redwood City; 6 MHSA units
     ▪ 2020 Arroyo Green senior living; 6 MHSA units
     ▪ 43 new units in development = 150 dedicated MHSA housing units! 55 years with onsite services, for 20 years at a minimum

- There will be one more round of funding going into development next year!

2) Housing Locator and Field-based Services – *Doris Estremera*
   o Recommendations 2, 6 and 7 are related to improve how we organize and manage available housing, how we support clients in finding housing, maintain their housing, receive ongoing living skills development, and peer navigators supports.
   o This is a new project and will require developing a new scope of work and putting it out for a bidding process. A Request for Proposal process will be released for agencies to apply to provide the services.
   o The project will include Housing Locator services including a webpage with up-to-date information on available housing resources, peer supports, outreach and field-based services involving an Occupational Therapist and a Peer Support Specialist.
   o Will launch the RFP hopefully in the Spring of 2022. Judy Davila will help us scope out the project based on input we received from the Taskforce and then we will open it up for input from community stakeholders.
3) Supportive services for new housing units developed – Doris reported that these will be made available in the future when the new supportive housing units open for service
4) Homeless Outreach Teams – *Ally Hoppis, Supervising Mental Health Clinician for BHRS Crisis and Outreach Team*
   o new and improved team coming, HEAL – Homeless Engagement, Assessment and Linkages; it was a very successful program that we are bringing back
   o are in the hiring phase three new clinicians to go out into the community and meet clients where they are in their various stages of homeless either at-risk, recently or chronically homeless
   o will get referrals, go into shelters, provide workshops, assessments, treatment plans, case management and linkages
5) Transitional housing support sand training – Doris reported that the target date is TBD and likely will be started after getting through recommendations 2, 6, and 7
6) Outreach and field-based housing services –addressed above with item #2
7) Housing webpage – addressed above with item #2
8) Flexible funds for housing related expenses (moving costs, deposits, first month's rent, etc.) – Doris reported that the original revenue source identified for this item turned out to be very inconsistent; will propose this for the upcoming MHSA Annual Update ongoing budget starting FY 22-23
9) Increased FSP housing funds – current housing rate was increased but, will continue work with FSP consultants at Third Sector to ensure appropriate cost modeling for housing
10) Board & Care (B&C) Support – *Talisha* Racy

o MHSA funding has been supporting virtual groups during the pandemic and included tablets; the groups will continue
o Working on creating more incentives for B&C operators to show B&C appreciation including funding for enhancing living environments that are trauma-informed, culturally responsive and inclusive spaces.
o Giving incentives for B&C that are able to maintain 95% occupancy.
o Trainings on creating trauma informed spaces.
o Over the years B&C's are closing. 2-3 have closed in the past two years → recruitment efforts to open new B&C's and replace some lost beds
o Appreciation efforts to honor B&C operators
o Will return to share stories/pictures of spaces that have been transformed

11) Increase FSP slots for children/youth (C/Y) and transition-age youth (TAY) – Doris reported that funding for 10 C/Y and 5 TAY slots were added Edgewood's contract

- Public Input
  From Chat:
  o Jean: How do MHSA supportive services relate to FSP services?
    ▪ These are distinct but related services. When the Housing Program was developed the FSP services were used as the model to develop supportive services. Not all MHSA housing unit tenants are FSP clients, they may be ineligible for FSP but receiving intensive case management and some have a choice to move into FSP and yet, are guaranteed full spectrum and on-site services if receiving Supportive Services only. The MHSA resident service coordinator works with the tenants and with FSP teams and assigned case managers
  o Jean: What were the topics of client board and care groups?
    ▪ Talisha:it included a combination of Seeking Safety, Illness Management and Recovery and Co-occurring support groups. These are ongoing groups.
  o Linder: Board and Care. How often are properties inspected? Do you require that wi-fi must be provided to clients in the house?
    ▪ Talisha: we don't require Wi-Fi, some do have it. In terms of inspecting, we are not the licensing body but, BHRS has a B&C liaison staff that regularly visits the B&C and can bring up issues. The liaison may go once a week or a couple of times a week depending on needs.
  o Jean: What are the changes in B&C that are targeted? Did residents have input/recommendations?
    ▪ Talisha: we are in the beginning stages; nothing has been decided. BHRS will seek B&C operator input and request that they seek client input as well. We want to be able to help B&C with maintenance costs as an incentive to remain open.

- o Karen: Good Afternoon - for life skills development. My name is Karen Shea and with Solutions for Supportive Homes - our former foster son after he aged out had a terrible time - he has sickle cell disease and FASD. He really needs section 8 and supportive housing. He was homeless and sick with sickle cell pain all the time and now we are helping again -- but he needs long term housing and truly supportive services. He can't be homeless or he will die from sickle cell disease.
  - Karen: San Mateo County let him become homeless; he got super sick and I had to come back from Los Angeles to pick him up and help him, I am over 60 years old. He needs a place to live that is safe, he is understood and gets daily living supports. FSP service has to be comprehensive, not just a case manager that checks in once a month. Why would San Mateo County let him roll off of their radar to on the street, he was always in the E.R. We tried to bring him to the mental health hospital and there was no bed. How are we one of the most affluent counties and have an African-American kid that was born here, why can't he have section 8 and a place to live. I will never be a foster parent again and will not recommend it. He is on SSI and doesn't have section 8. If he is homeless again, he will be dead. He's 27 years old and I need help.
- o Franz: B&C: New/novice-are B&C's in private residential facilities or multi-unit facilities?
  - Talisha (by email, post meeting): The BHRS contracted board and care are primarily private homes licensed as an Adult Residential Facility (ARF) or Residential Facility for the Elderly(RCFE). We also have some beds in larger facilities.

Other Comments:
- o Lanajean: Wi-Fi is so important nowadays with telehealth and online services and seems more urgent than beautifying spaces.
- o Lanajean: who is the licensing body in-charge of B&C inspections and what is required to be compliant?
  - Talisha: this falls under Community Care Licensing; they go out at least once per year. If out of compliance, then there will be a Plan of Correction. Talisha shared this website: https://www.cdss.ca.gov/inforesources/community-care-licensing.

6. **Full Service Partnerships (FSPs) Workgroup Results** – *Jean Perry*   20 min
   - A workgroup was selected from an application process – we made an effort to include diverse stakeholders (culturally, experience, geographic location)
   - Third Sector consultants has been working with San Mateo County for a year to understand FSPs and improving quality of services and evaluation outcomes
   - The original recommendations from Third Sector were minimal, not too many clients and providers had participated in interviews.
   - The FSP workgroup added to the input by providing recommendations related to minimum FSP service expectation, identifying additional services needed, supporting staff retention and appropriate contractor rates, need to provide trauma informed, substance use and peer and family supports, ensuring housing and retention services (support with daily living skills), incorporating step-down services and guidelines. We shared stories of how FSP graduation is occurring. And, we provide input on enhancing ongoing data collection and evaluation including accountability – monitoring of deliverables.
   - The full document with details on the recommendation is available on the MHSA website, www.smchealth.org/MHSA, under the "Announcements" tab. It includes the input
   - The recommendations will be incorporated into the RFP … we discovered that therapy was not provided for everyone.

      Public Input
      - o Jairo: are wages stipulated in the contracts with FSPs.
         - ▪ Doris: No wages are not stipulated in contracts but, cost modeling for the service do incorporate wages. We are working with the consultant Third Sector to look at the minimum positions that are expected, what that would cost and that will determine the RFP award amount
         - ▪ Jean: Third Sector has been retained to continue to work with us during the RFP development phase and includes the budget development.
      - o Suzanne: the FSP Workgroup Recommendations are excellent.
         - ▪ Doris: it was a great workgroup with lots of experience and input to share.

7. **Next MHSA Workgroup: MHSA Innovation (INN) Planning** – *Doris Estremera*   10 min
   - Doris – we are required to use 5% of MHSA revenue on innovative projects. For San Mateo County this translates to about $2M per year for new innovative projects with projects running for 3-5 years max
   - INN projects have to be approved by the State, we anticipate a year-long process to plan for approval then an additional 6-8 months to go to bidding for projects that require a contracted provider
   - The last INN planning cycle started in 2019 and one project just launched this past fall – the Social Enterprise Café for Filipino/a/x Youth. Two additional project RFPs are releasing this month.
   - INN has to introduce a new practice or approach that has not been done anywhere else, including out-of-state.

- INN projects can include a change to an existing practice… for example, applying something to a specific target population or changing something about the model. The Pride Center was innovative because a comprehensive, one-stop shop for mental health and social service for the LGBTQ community did not exist anywhere else. Pride Centers do exist in other states and counties but, not providing comprehensive mental health services.
- INN projects can apply a promising practice that has been successful in other settings. For example, the Social Enterprise Café project is applying a leadership and skills development for youth in running a café… this has been proven effective in public health settings. We are applying this model to behavioral health spaces and addressing a behavioral health need for Filipino/a/x youth (linkages, cultural identify formation and prevention)
- If a project has been demonstrated effective in the literature or google searches, and other research… then it is not considered innovative.
- The new INN workgroup will develop an inclusive and supportive process for individuals to submit INN ideas. A consultant will be brought on board to support this process. The workgroup will be involved in selecting the ideas that move forward to full scope proposal.
    o 10-12 participants will be selected via a Participant Survey that will be released in January
    o We will kick-off the work at the February MHSA Steering Committee meeting then the workgroup will meet monthly between March-May
- The INN Planning timeline was shared
- Public Input
    o Jairo: for those that want to participate in the INN Workgroup, do we need to complete a survey to get selected?
        ▪ Doris: yes, the Participation Survey will release in January.

8. Adjourn

* Public Participation: All members of the public can offer comment at this public meeting; there will be set opportunities in the agenda to provide input. You can also submit questions and comments in the chat. If you would like to speak, please click on the icon labeled "Participants" at the bottom center of the Zoom screen then click on "Raise Hand." The host(s) will call on you and you will unmute yourself. Please limit your questions and comments to 1-2 minutes. The meeting will be recorded. Questions and public comments can also be submitted via email to mhsa@smcgov.org.

*REMINDER – Please Complete the Steering Committee Feedback Survey

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

ATTENDANCE

There were up to 25 participants logged in to the Zoom app. Below is a list of attendee names as recorded from Zoom; call-in numbers are typically unidentifiable.

MHSA Steering Committee Co-Chairpersons
1. Jean Perry (she/her), MHSARC Commissioner
2. Leticia Bido (she/her), MHSARC Commissioner

MHSA Steering Committee Members
3. Yoko Ng (she/her), MHSARC Commissioner
4. Jairo Wilches, BHRS Office of Consumer and Family Affairs - OCFA
5. Juliana Fuerbringer, Family Member, California Clubhouse Board President
6. Mary Bier (she/her), North County Outreach Collaborative
7. Melissa Platte (she/her), Executive Director, Mental Health Association
8. Kava Tulua (sher/her), One East Palo Alto
9. Maria Lorente-Foresti (she/her), Director BHRS Office of Diversity and Equity - ODE

BHRS Staff Supports
- Doris Estremera (she/her) MHSA Manager, BHRS ODE
- Sylvia Tang (she/her), BHRS ODE
- Ankitha Neelavar (sher/her), Intern, BHRS ODE

Presenter(s)
- Judy Davila, BHRS consultant
- Ally Hoppis (she/her), BHRS Crisis and Outreach
- Talisha Racy, BHRS Clinical Services Manager

Participants
1. Frieda K. Edgette (she/her), MHSARC Commissioner
2. Chelsea Bonini, MHSARC
3. Suzanne Moore, Family Member, Solutions for Supportive Housing, Healthcare for the Homeless Board Member
4. Eddie Flores (he/him), Director Youth Behavioral Health Programs, Peninsula Health Care District
5. Lanajean Vecchione (she/her), Lived Experience Academy
6. Kathy Gilbert (she/her), Solutions for Supportive Housing
7. Claudia Saggese (she/her), Director Office of Consumer and Family Affairs
8. Sydney Hoff (she/her), Felton Institute
9. Franzmarie Lippincott (she/her), Chinese Health Initiative
10. Linder Allen
11. Pat Willard
12. Kms - Karen
13. Minet Azucena
14. Carol Gosho
15. Unidentifiable (moto g power)
16. Unidentifiable (phone number)

Be the one to help

Mental Health Service Act (MHSA)
MHSA Steering Committee

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

The MHSA Steering Committee meets the first Thursday at 3pm in February, May, September and December to provide input, make recommendations and stay up-to-date on new MHSA developments and ongoing programming.

Meeting objectives include:

- Present the MHSA Annual Update – learn about implementation highlights, program outcomes and the latest fiscal updates

- Launch a new cycle of Innovation (INN) Projects and get involved in the new MHSA INN Workgroup

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

* To reserve language services, please contact us at mhsa@smcgov.org at least 2 weeks prior to the meeting.

DATE & TIME

Thursday, February 3, 2022
3:00 pm – 4:30 pm

Zoom Meeting:
https://us02web.zoom.us/j/83216209789
Dial in: +1 669 900 6833
Meeting ID: 832 1620 9789
iPhone one-tap: +16699006833,,83216209789#

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

www.smchealth.org/MHSA

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

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

Mental Health Services Act (MHSA) Steering Committee Meeting

Thursday, February 3, 2022 / 3:00 – 4:30 PM
Zoom Meeting: https://us02web.zoom.us/j/83216209789
Dial in: +1 669 900 6833 / Meeting ID: 832 1620 9789

AGENDA

1. **Welcome**   5 min
    Jean Perry, MHSARC Commissioner and Leticia Bido, MHSARC Commissioner

2. **Logistics & Agenda Review** – *Leticia Bido*   5 min
    *   Previous meeting minutes available on the MHSA website,
        www.smchealth.org/MHSA

3. **Announcements** – *Jean Perry*   5 min
    *   INN Workgroup

4. **General Public Comment** – *Leticia Bido*   10 min
    *   For non-agenda items
    *   Additional public comments can also be submitted via email to
        mhsa@smcgov.org.

5. **MHSA Annual Update** – *Doris Estremera, MHSA Manager*
    *   Highlights and Fiscal Projections – *Doris Estremera*   25 min

        o **Cariño Project** - *Dr. Belinda Hernandez Arriaga, EdD, LCSW*   10 min
           Executive Director of ALAS (Ayudando Latinos A Soñar)
        o **BHRS Pathways Program** - *Tennille Tucker, LCSW Supervising*   10 min
           Mental Health Clinician and Angel Nguyen, MFT Mental Health   20 min
           Program Specialist

    *   Public Input

6. **Adjourn**

* Public Participation: All members of the public can offer comment at this public meeting; there will be set opportunities in the agenda to provide input. You can also submit questions and comments in the chat. If you would like to speak, please click on the icon labeled "Participants" at the bottom center of the Zoom screen then click on "Raise Hand." The host(s) will call on you and you will unmute yourself. Please limit your questions and comments to 1-2 minutes. The meeting will be recorded. Questions and public comments can also be submitted via email to mhsa@smcgov.org.

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*REMINDER – Please Complete the Steering Committee Feedback Survey

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

Mental Health Services Act (MHSA)
Steering Committee Meeting
February 3, 2022

Before we begin…

- Agenda, handouts, slides: www.smchealth.org/MHSA, under "Announcements" tab
  - o Past meeting materials/minutes: under "Steering Committee" tab
- Introductions: your name, pronouns and affiliation in the chat
  - Steering Committee members
- Stipends for clients and family members participating
  - You can let us know in the chat (private message) - please provide your email
- Meeting is being recorded
- Quick demographics poll

Participation Guidelines

- You can enter questions in the chat box as we go
  - For each agenda topic there will be time for questions/comments – you can also use the "Raise Hand" button during this time.
- If you have a general public comment (non-agenda items), let us know now in the chat.
- Share your unique perspective and experience
- Share the airtime; allow every voice to be heard (step up/step back)
- Practice both/and thinking; consider all ideas along with your personal advocacy
- Be brief and meaningful when voicing your opinion

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

Agenda

1. MHSA Announcements – INN Workgroup

2. General Public Comments

3. MHSA Annual Update
   - Implementation Highlights, Outcomes, Fiscal Projections
   - Program presentations

4. Public Input

Announcements & General Public Comment

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

MHSA Annual Update

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

MHSA Components

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

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

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

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

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

1% tax on personal income over $1 million
San Mateo County: $34.3M annual 5-year average through FY 20-21

Annual Update Timeline

- MHSA Annual Update document will be posted Feb 25th
- **30-Day Public Comment** @MHSARC Meetings:
  - March 2nd: Open 30-day comment period + public hearing
  - April 6th: Close public comment and vote to recommend the approval of the MHSA Annual Update
- Public Comments may be provided verbally at the meeting or in writing to: mhsa@smcgov.org

MHSA Revenue & Expenses

Fiscal Strategies

- In FY 21-22:
  - o Implemented a <u>One-time Spend Plan</u> for $11.7M
  - o Increased the <u>Ongoing Budget to $3M Over-Revenue</u>
- For FY 22-23:
  - o Proposal to increase FSP funding
    - ▪ Based on FSP Workgroup Recommendations and Third Sector consultants cost modeling for upcoming RFP
    - ▪ Increase <u>Ongoing Over-Revenue</u> strategy to ~$5M

$11.7M One-Time – Status Update

Priority	Item	FY 21/22	FY 21/22 Status	FY 22/23
Housing Initiative Taskforce	BHRS Housing Webpage	$100,000	Delayed	$0
	Development of Supportive Housing Units	$5,000,000	Completed	$5,000,000
Post-COVID Supports (Prevention and Early Intervention)	Community mental health and substance use education	$50,000	Delayed	$50,000
	Community wellness and recovery supports	$50,000	Delayed	$50,000
	Field and group supports	$100,000	Delayed	$100,000
	Older adult supports	$50,000	In Progress	$50,000
	Health Equity Initiative capacity development	$30,000	Delayed	$30,000
	School mental health supports	$46,000	Completed	$46,000
	Racial Equity and Multicultural Organizational Development	$125,000	In Progress	$125,000
Mental Health Surge Needs	Workforce Development	$200,000	In Progress	$200,000
	Workforce Wellness	$100,000	In Progress	$100,000
	SMI Private Provider Network (SSPN) incentives	$125,000	In Progress	
	Grand Total			**$11,727,000**

See Meeting Handout for item descriptions

Questions?

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

Implementation Highlights

Community Services and Supports
(Clients Served)

Full Service Partnership*

18/19: 520
19/20: 608
20/21: 660

Outreach & Engagement

18/19: 475
19/20: 412
20/21: 1288**

System Development

18/19: 2,739
19/20: 2,053
20/21: 2,031

*There are 422 total available FSP slots across all age groups
** The Cariño Project in the coastside region launched July 2020

Implementation Highlight: FSP Workgroup

- Full Service Partnership Workgroup
  - Provided recommendations for minimum service requirements, service improvements
  - Request for Proposal to release soon

Bradley was discharged from his last psychiatric hospitalization in May 2021. Upon his discharge, Bradley was faced with many challenges such as living in a group setting and having to start from scratch with his belongings and lifestyle. Bradley has since signed the lease for his own apartment and continues to engage with FSP multiple times a week and has become medication compliant along with discovering how to live independently at 72 years old. He has engaged with his peer mentor and enjoys outing in the community during his meetings. Bradley continues to draw "doodles" to show his team what his life is like through his eyes. Bradley will tell you "this is all because of Telecare" and constantly reminds his team of his appreciation to turn "a creep into a prince".

Prevention and Early Intervention
(Clients Served)

	Ages 0-25	Early Intervention	Prevention	Recognition of Early Signs of MI	Stigma & Discrimination Prevention	Access & Linkage to Treatment
FY 18-19	501	925	4,409	179	152	6,764
FY 19-20	483	878	4,598	69	47	5,858
FY 20-21	1,638*	1,110	2,533	184	160	7,499

* FY 20-21 (Ages 0-25) MBSAT program launched with three agencies, HAP-Y moved into PEI component

Implementation Highlight: PEI Outcomes

- MHSA Prevention & Early Intervention Outcomes
  - State Required: Access, Stigma Reduction, Protective Factors (Knowledge, Skills, and/or Abilities), General Mental Health
- Office of Diversity and Equity (Theory of Change) Outcomes
  - Local Stakeholder Process: Access, Stigma Reduction, Self-Empowerment, Community Advocacy, Cultural Humility & Responsiveness
- Additional Outcomes
  - Programs: Cultural Identity Formation, Connection & Support

Kick-Off & Ongoing Meetings → Alignment of Outcomes → Identify Program Indicators & Tools → Develop Crosswalks & Templates

Innovation Highlights

- The Pride Center
  - Final 5-Year Report now available
- Help@Hand
  - Wysa app kick-off + marketing and testing w/BHRS clients
- New Project Kick-off
  - Social Enterprise and Wellness Cafe for Filipino/a/x youth
- New RFPs
  - PIONEERS Program
  - Prevention services in low-income housing

SAN MATEO COUNTY PRIDE CENTER

help @ hand™
CONNECTING PEOPLE WITH CARE

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Questions?

The Cariño Project

- *Dr. Belinda Hernandez Arriaga, EdD, LCSW*
    Executive Director of ALAS (Ayudando Latinos A Soñar)

BHRS Pathways Program

- *Tennille Tucker, LCSW Supervising Mental Health Clinician*
- *Angel Nguyen, MFT Mental Health Program Specialist*

SAN MATEO COUNTY HEALTH
**BEHAVIORAL HEALTH
& RECOVERY SERVICES**

Questions & Public Input

SAN MATEO COUNTY HEALTH
**BEHAVIORAL HEALTH
& RECOVERY SERVICES**

Get Involved!

- **Subscribe to receive opportunities to get involved in MHSA planning:**
www.smchealth.org/MHSA

- **BHRS-wide opportunities:**
https://www.smchealth.org/get-involved

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Thank you!

Jean Perry, MHSARC Commissioner
Leticia Bido, MHSARC Commissioner
Doris Estremera, MHSA Manager
Email: mhsa@smchealth.org
Website: www.smchealth.org/MHSA

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

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Cariño Project

Wrap-around Community Support

Social services
Case Management
Cariño During COVID
Safety-net Support
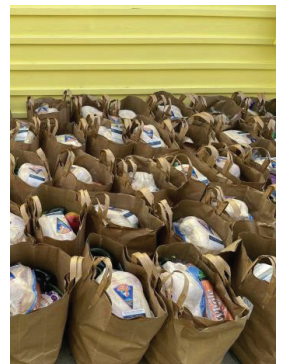
Mental Health Services

Dr. Rafael Padilla, Clinical Supervisor, Cariño Project

Community Outreach

Cultura & the Arts
Youth Outreach
Mother's Group and Activities
(Hiking, Gardening, Baby & Me)
Culturally Oriented Paint Nights
COVID-19 Information
Emergency Preparedness Workshops
PPE Distribution

Creating Comunidad

- 1221 unduplicated Clients across all MCWP Programs, from 700 Unique families
- 147 Unique clients at Paint Nights alone
- 300 Clients engaged with multiple programs
- Offered 3 different groups: mother's group, baby and me, youth group
- Provide ongoing financial support to 130 individual clients for their basic needs as part of our case management program

Cariño Consumers

Avg Household size **4**

Most clients are **Latino** (87%), or **Asian** (4%)

66% **Female**, 28% **Male**

90% **Spanish speakers**

Clients range from **Half Moon Bay**
El Granada | La Honda | Montara | Moss Beach,
Pacifica | Pescadero | San Gregorio

We provide ongoing case management support to newcomer families recently arrived

from **Central and South America**

— — —

Thank You
San Mateo County
& BHRS
For Providing Care To
The Community

Estamos agradecido con Liz Camarena - West por el desarrollo del nombre del Proyecto Cariño.

¡Gracias Liz!

SAN MATEO COUNTY PATHWAYS MENTAL HEALTH COURT PROGRAM

HISTORY AND BACKGROUND

Formed in 2006 as a joint collaboration of San Mateo County Courts, Probation Department, District Attorney Office, Sheriff's Office, Correctional Mental Health, NAMI and Behavioral Health and Recovery Services

Goals

- reduce recidivism and incarceration of the seriously mentally ill
- stabilize housing
- reduce acute care utilization
- engage and maintain participation in personal recovery

ELIGIBILITY CRITERIA

- San Mateo County Residency
- age 18 or older
- have a diagnosis of a serious mental illness (formerly Axis I) with a functional impairment
- statutory eligibility for probation
- voluntarily agree to participate in Pathways

REFERRAL PROCESS

- Anyone can refer (attorneys, family, friends, providers, self-referral)
- Complete and submit referral form
- The form is routed to the client's attorney, who will bring the case to the Pathways court calendar
- Once assigned in court, Pathways BHRS staff will complete a clinical assessment and present a recommendation to the court at a future court date

PATHWAYS STAFF

- 1 Family Partner
- 1 Senior Community Worker
- 1 Mental Health Counselor
- 1 Case Management/Assessment Specialist (AOD)
- 2 Clinicians
- 1 Mental Health Program Specialist

TREATMENT RESOURCES AND OPTIONS

- Evaluations by Pathways clinicians
- Intensive case management by Pathways BHRS Staff, including field-based support
- Intensive supervision by Probation staff
- Individual and group therapy and skills building
- Ongoing psychiatric consultation (with regional BHRS clinic or private provider)
- Residential AOD services
- Intensive AOD Outpatient Services
- Supportive temporary housing at shelter slots (Maple Street) or SRO (Industrial Hotel)

PROGRAM SUMMARY

- Program length is usually 1-2 years (the length of the probation)
- Pathways clients must be treatment compliant
- Pathways clients remain in Pathways after graduation as Pathways Alumni. They can then continue in Pathways activities and maintain their sense of community
- Probation drug screening when court ordered
- Incentives (reduction of fines; criminal charges may be dismissed or reduced; financial assistance in reaching goals)
- Sanctions (jail time; reinstatement of criminal proceedings)
- Pathways picnics and group outings
- Pathways groups: Clubhouse, women/men's process groups, cognitive behavioral skills
- Pathways is staffed 6 days a week
- Graduation ceremony

PATHWAYS DATA

- As of June 2021, 142 clients have graduated and become Pathways Alumni

- Annual Report 2020-2021 Pathways served 65 clients
  - 11 clients obtained employment
  - 8 clients newly obtain stable housing (1 obtained permanent housing vouchers, 5 are in sober living environments homes and 2 are in social rehabilitation or board and care settings
  - 2 clients enrolled in school
  - 1 clients were able to maintain children in their homes

ADDITIONAL PARTNERSHIPS

- Veterans Treatment Court & Military diversion (27 enrolled and 133 graduates)
- 1370 Misdemeanor Court
- Mental Health Diversion (Intensive Mental Health Diversion)

SUCCESS STORY

NEW $11.7* One-Time Plan
For Housing Initiative + Post-COVID Supports and MH Surge
up to $1,080,000 must be spent in prevention and early intervention efforts

Priority	Item	FY 21/22	FY 22/23	Total	Item Description
Housing Initiative Taskforce	BHRS Housing Webpage	$100,000	$0		Development of an online BHRS Housing webpage with comprehensive one-stop housing information (including data dashboard for unmet need) for clients and staff use. Will be supported w/ongoing management, housing locator services and peer supports contract.
	Development of Supportive Housing Units	$5,000,000	$5,000,000		Establishment of an ongoing Housing Fund with Department of Housing (DoH) for the development of supportive housing units for BHRS clients. Transfer of funds to DoH to include in their application process for affordable housing developers.
	Total Housing	**$5,100,000**	**$5,000,000**	**$10,100,000**	
Post-COVID Supports (Prevention and Early Intervention)	Community mental health and substance use education	$50,000	$50,000		Behavioral health 101 campaign for communities who are in need of linkages to behavioral health services - in threshold languages and focused on special populations (i.e. TAY, cultural groups, essential workers). For substance use - a focus on opioid overdose prevention strategies.
	Community wellness and recovery supports	$50,000	$50,000		Partner with libraries and other community spaces to provide PTSD training, WRAP, healthy eating, self-care and other wellness topics with linkages to behavioral health services.
	Field and group supports	$100,000	$100,000		Increase field and group supports for grief and hoarding (eviction prevention), eating disorders, cultural/spiritual coaching.
	Older adult supports	$50,000	$50,000		Partner with Aging & Adult Services and other Older Adult service providers in the community to support older adult identified COVID-related needs (awareness campaign, support groups, peer lead support, resource sharing, digital literacy support, etc.)
	Health Equity Initiative capacity development	$30,000	$30,000		Strategic planning facilitation/consultation focused on post-COVID response, strengthening collaboration and improving HEI outcome reporting.
	School mental health supports	$46,000	$46,000		Suicide Prevention (Kognito) training for school districts not covered by a Healthcare District and Early Alert text-based system that parents and school staff can access and be connected to resources as needed.
	Racial Equity and Multicultural Organizational Development	$125,000	$125,000		Training and consultant to support advancement of racial equity work including implicit bias training, developing culture of trust, inclusive communication and CBO technical assistance. ($30K for consultant + $25K for translations + $20-30K trainer fees)
	Total Prevention	**$451,000**	**$451,000**	**$902,000**	Total Available for Prevention Efforts: $1,080,000
Mental Health Surge Needs	Workforce Development	$200,000	$200,000		Workforce training for BHRS and contractors in eating disorders and other treatments (PTSD, EMDR, trauma-focused CBT, MBSAT/Seeking Safety to support co-occurring SMI/SUD, 3P and other EBPs for justice involved) that are expected to surge as we transition out of shelter-in-place.
	Workforce Wellness	$100,000	$100,000		Workforce post-COVID infrastructure consultation and re-entry supports; self-care, provider wellness month continuation, work-life integration, emotional wellness.
	SMI Private Provider Network (SSPN) incentives	$125,000			The SPPN provides therapy to clients at regional clinics. Incentives can engage providers to SSPN quickly (current waitlist of 38 clients is projected to increase to ~80 clients). This would provide $5,000 sign-on incentive for a one year contract for 10 slots, for 25 providers.
	Total MH Surge	**$425,000**	**$300,000**	**$725,000**	Total Available for MH Surge Needs: $820,000
			Grand Total	**$11,727,000**	

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Services Act (MHSA) Steering Committee Meeting
Thursday, February 3, 2022 / 3:00 – 4:30 PM
Zoom Meeting: https://us02web.zoom.us/j/83216209789
Dial in: +1 669 900 6833 / Meeting ID: 832 1620 9789

MINUTES

1. **Welcome**   5
    Jean Perry, MHSARC Commissioner and Leticia Bido, MHSARC Commissioner   min

2. Logistics & Agenda Review – Leticia Bido   5
    - Previous meeting minutes available on the MHSA website,   min
      www.smchealth.org/MHSA
    - Introductions public members (name, pronouns, affiliation) were shared via chat
    - Steering Committee members: Chris Rasmussan, Clarise Blanchard, Adriana Furuzawa, Juliana Fuerbringer, Kava Tulua, Mary Bier
      o New members: Eddie Flores, Peninsula HCD and Paul Nichols, MHSARC
    - Stipends available to clients and family members participating; information collected via chat
    - Notice that meeting was being recorded
    - For General Public Comments (non-agenda items) sign up via chat
    - Participation guidelines – enter questions in chat, will address those first, can also use raise hand button during question/answer and unmute when called on, share airtime, practice both/and thinking, be brief and meaningful

    - Quick Poll – participants reported demographics, 90% response rate:

What is your age range?	
26-59	65%
60+	35%

What is your gender identity?	
Female/Woman	78%
Male/Man	22%

Race/Ethnicity
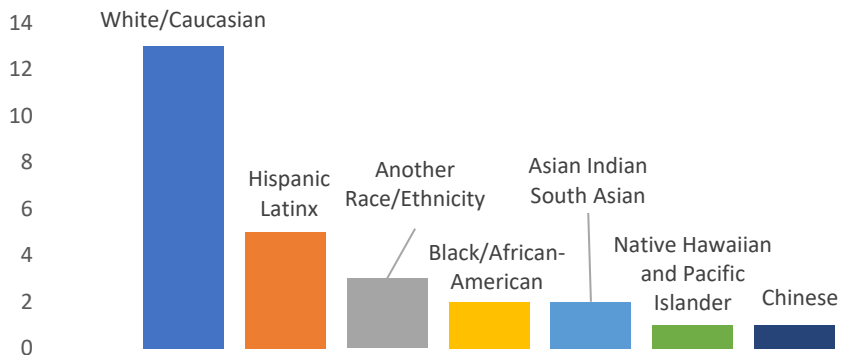
What part of the county do you live in OR work in?	
Central County	43%
County-wide	22%
East Palo Alto/Belle Haven	4%
North County	17%
South County	13%

Stakeholder Group
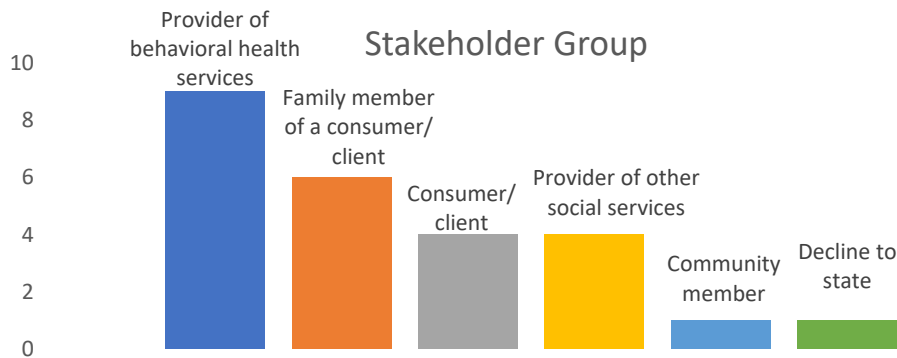
3. **Announcements** – *Jean Perry*   5
   - INN Workgroup   min
     o New proposals are submitted for approval to oversight committee every three years
     o Consultant has been hired to facilitate the workgroup and will be available throughout the process for technical assistance
     o There is an application to participate in the innovation wrkgrp. Will select ~12 members based on demographic diversity
     o You must be able to attend all three (3) meetings on Thursdays, February 17th, March 17th and April 21st, from 3-4:30PM.
     o Interest survey is on the MHSA website and will be shared in chat
     o **You do not have to be part of the workgroup to submit an idea**
     o Workgroup is to help us develop an inclusive and supportive process for submitting, selecting and funding innovative ideas!
   - 5% of MHSA funding must be allocated to new best practices in behavioral health services. See below for more details.
   - **Director's Update - Pride Center (Innovation) article**
     https://www.smchealth.org/sites/main/files/file-attachments/directors_update_feb_2022.pdf?1643233640 –

4. **General Public Comment** – *Leticia Bido*   10
   - For non-agenda items   min
   - Additional public comments can also be submitted via email to mhsa@smcgov.org.

- o Comment from Jean Perry:
  FSP workgroup demands for clients to have access to therapy! Checks and balances are needed for RFPs and contractors that get selected as providers of FSP. Deficit needs to be addressed.
- o Question from Carol Gosho: Do you have an annual report of MHSA projects from beginning to end? How much was spent and what was the outcome? Response from Doris: yes, we will be highlighting it today and posting by Feb 25th on the MHSA website

5. **MHSA Annual Update –** *Doris Estremera, MHSA Manager*
   - Highlights and Fiscal Projections – *Doris Estremera*   25
   - MHSA Overview   min
     - o 1% tax imposed on personal income over $1M to transform public mental health systems; this translates to $34.3M annual avg in the last five years through fiscal year 2020-21   10
     - o 76% of revenue allocated to direct services and treatment for individuals   min living with serious mental illness; 51% of this must go to Full Service Partnerships (FSPs)   10
     - o 19% goes to PEI; 5% to INN   min
   - MHSA Annual Update timeline   20
     - o Annual Update document will be posted by Feb 25th   min
     - o March 2, open 30 day comment period + public hearing
     - o April 6, close public comment and vote to recommend the approval of the MHSA Annual Update
   - MHSA Revenue & Expenses
     - o FY 20-21 revenue came in at $5M over the projection from last year. The projected decreases in future years are not due to a recession, COVID delay in taxes gave a bigger revenue in FY 20-21 plus there were adjustments made from previous years' higher than anticipated economic growth.
     - o Overall the trend is upward growth, millionaires made more millions during the pandemic.
     - o Waiting on State to release latest projections for FY 22-23 and 23-24
   - Last Annual Update, FY 21-22:
     - o Implemented a one-time spend plan for $11.7M. Today will provide a status update: some things are delayed, some are completed
     - o Increased the ongoing budget to $3M over revenue. This helps dig into the overages, if the economy happens to drop in future years…
     - o A reserve is still in effect so that we do not have to cut services in an economic downturn
   - FY 22-23
     - o proposal to increase FSP funding, as per the FSP Workgroup and consultant recommendations
     - o Increase ongoing budget to ~$5M over-revenue
   - Public Input/Questions

- o William: Status Update on 11.7M, does the $5M for housing proposal marked as completed mean that the housing units have been developed?
- o Response from Doris: No, it means the funding was transferred to Dept of Housing to support the Notification of Award. Developers have been selected and the developments are moving forward.
- o Jean: Strategy to increase therapist workforce. SSPN Incentives. These could really help out, considering how expensive it is to live here
- o Response from Doris: will look into where things are at with this strategy
- o Jean: what about the people who are already here working? Are the new hires going to be better positioned than the people who are already working?
- o Response from Doris: there are workforce strategies to support those that are already working, ex. student loan forgiveness. This received a one-time allocation recently from the state and we have launched the application process here in San Mateo County

- **Cariño Project** - *Dr. Belinda Hernandez Arriaga, EdD, LCSW*
  Executive Director of ALAS (Ayudando Latinos A Soñar)
  - o Dr. Belinda is founder, exe director, licensed clinician, educator, prof at USF. ALAS started in 2011 after hearing community isolation and need for youth to have space for their culture.
  - o Grassroots beginnings w/ MHSA funding
  - o wraparound community support, cultural arts model, offers social services, food insecurity, Case management, medical resources, COVID responses. Safety-net support. Started a Crisis food pantry during COVID
  - o Mental Health Services, Clinical Suprevisor Dr. Rafael Padilla. Provide free culturally centered mental health services
  - o Community Outreach – Cultura and the Arts, Youth Outreach, Paint nights, Mother's groups
  - o Last year, served 1221 unduplicated clients, 700 unique families!
  - o Consumers: 87% Latine, 4% Asian, 66% Female, 90% Spanish Speakers
  - o Serve individuals from Half Moon Bay, EL Granada, La Honda, Montara, Moss Beach, Pacifica, Pescadero, San Gregorio. Case management and support to newcomer fams from Central and South America
- **BHRS Pathways Program** - *Tennille Tucker, LCSW Supervising Mental Health Clinician and Angel Nguyen, MFT Mental Health Program Specialist*
  - o Tennille Tucker: Clinical Supervisor w BHRS Pathways. Presenting on Pathways Mental Health Court Program
  - o Formed in 2006, collaboration of SMC Courts, Probation Department, DA, Sheriff, Correctional Mental Health, NAMI, and BHRS.
  - o Developed many of these programs... a totally brand new process that continues to expand
  - o Goal: Reduce recidivism and incarceration, Stabilize housing, Reduce acute care utilization, Engage and maintain participation in personal recovery

- o Referrals can be done by anyone, decided in Pathways Court
- o Evaluations by Pathways clinicians, field-based support, probation officers provide intensive supervision, therapy, AOD services, temporary housing
- o Program is 2-3 years w/treatment and court compliance, incentives to stay on this pathway, but with sanctions
- o As of June 2021, 142 Clients have graduated
- o Veterans Treatment Court and Military diversion, Misdemeanor Court, Mental Health Diversion

- • Public Input/Questions
  - o Jean: What does it mean to be 'restored'?
  - o Response from Angel: it means that the person is returned to 'competency' in the eyes of the court. If the person cannot converse with their counsel, the restoration is a stabilization for the defendant to understand they are entering the legal process. If they are not restored, they cannot move forward with the legal proceedings.
  - o Chris: How many clients are homeless?
  - o Response from Angel, around 50%

6. Adjourn

* Public Participation: All members of the public can offer comment at this public meeting; there will be set opportunities in the agenda to provide input. You can also submit questions and comments in the chat. If you would like to speak, please click on the icon labeled "Participants" at the bottom center of the Zoom screen then click on "Raise Hand." The host(s) will call on you and you will unmute yourself. Please limit your questions and comments to 1-2 minutes. The meeting will be recorded. Questions and public comments can also be submitted via email to mhsa@smcgov.org.

*REMINDER – Please Complete the Steering Committee Feedback Survey

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

ATTENDANCE

There were up to 40 participants logged in to the Zoom app. Below is a list of attendee names as recorded from Zoom; call-in numbers are typically unidentifiable.

MHSA Steering Committee Co-Chairpersons

1. Jean Perry (she/her), MHSARC Commissioner
2. Leticia Bido (she/her), MHSARC Commissioner

MHSA Steering Committee Members

3. Adriana Furuzawa (she/ella/ela), Felton Institute (re)MIND/BEAM
4. Chris Rasmussan, MHSARC Vice-Chair
5. Clarise Blanchard, (she, Her), StarVista Department Director
6. Eddie Flores (he/him), Director Youth Behavioral Health Programs, Peninsula Health Care District
7. Juliana Fuerbringer, Family Member, California Clubhouse Board President
8. Mary Bier (she/her), North County Outreach Collaborative
9. Paul Nichols, MHSARC
10. Kava Tulua (sher/her), One East Palo Alto

BHRS Staff Supports

11. Doris Estremera (she/her) MHSA Manager, BHRS ODE
12. Sylvia Tang (she/her), BHRS ODE

Presenter(s)

13. Dr. Belinda Hernandez Arriaga, EdD, LCSW Executive Director of ALAS (Ayudando Latinos A Soñar)
14. Tennille Tucker, LCSW Supervising Mental Health Clinician, BHRS Pathways
15. Angel Nguyen, MFT Mental Health Program Specialist, BHRS Pathways

Participants

16. Adele Dunnigan
17. Amanda Pyle (she/her), Director of Community Services for GGRC
18. Aris Payan, Youth Engagement Specialist at SafeSpace
19. Carol Gosho, Pres. NAMI San Mateo County and family member
20. Carolyn Shepard, S4SH
21. Charo Martinez (ella)
22. Chelsea Bonini
23. Frieda K. Edgette (she/her), MHSARC Commissioner & Youth Committee Chair
24. John Butler
25. Lanajean Vecchione she/her, Lived Experience Academy and Advocacy Academy and Health Equity Initiatives
26. LaShelle Burch, LCSW she/her with Suicide Prevention Team at VA
27. Lynda Kaufmann, Director of Admissions and Contacts for Psynergy Programs
28. Mai Le (she/her), SMC Health, Health Policy and Planning
29. Marina Kravtsova
30. Mary Cheryl Gloner, she/her - Project Safety Net
31. Melinda Henning
32. Michael Solorio, Friends for Youth
33. Noreena Vannarat - SMC VRS
34. Randy Torrijos
35. Sydney Hoff (she/her), Program Manager of Felton Institute's (re)MIND and BEAM
36. William Elting, he/him/his, Community Member
37. Yolanda Ramirez
38. Ziomara Ochoa
39. Unidentifiable (phone number)
40. Unidentifiable (phone number)

APPENDIX 2. MHSA ANNUAL UPDATE MATERIALS

Mental Health Services Act (MHSA)
Mental Health and Substance Abuse Recovery Commission

March 2, 2022

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

MHSA Components

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

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

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

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

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

1% tax on personal income over $1 million
San Mateo County: $34.3M annual 5-year average through FY 20-21

MHSA Annual Update

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Public Comments

- Annual Update and Executive Summary available on the MHSA website
- 30-Day Public Comment Period at MHSARC Meetings:
    - March 2nd: Open 30-day comment period + public hearing
    - April 6th: Close public comment and vote to recommend the approval of the MHSA Annual Update
- Submitting Public Comments
    - May be provided verbally at the meeting or in writing to: mhsa@smcgov.org
    - Will be forwarded to commissioners as they are received, and responses developed to share and review as public record during the closing of the public comment period

MHSA Revenue & Expenses

Fiscal Strategies

- In FY 21-22:
  - o Implemented a <u>One-time Spend Plan</u> for $11.7M
  - o Increased the <u>Ongoing Budget to $3M Over-Revenue</u>
- For FY 22-23:
  - o Proposal to increase FSP funding
    - ▪ Based on FSP Workgroup Recommendations and Third Sector consultants cost modeling for upcoming RFP
    - ▪ Increase <u>Ongoing Over-Revenue</u> strategy to ~$5M

$11.7M One-Time – Status Update

Priority	Item	FY 21/22	FY 21/22 Status	FY 22/23
Housing Initiative Taskforce	BHRS Housing Webpage	$100,000	Delayed	$0
	Development of Supportive Housing Units	$5,000,000	Completed	$5,000,000
Post-COVID Supports (Prevention and Early Intervention)	Community mental health and substance use education	$50,000	Delayed	$50,000
	Community wellness and recovery supports	$50,000	Delayed	$50,000
	Field and group supports	$100,000	Delayed	$100,000
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Mental Health Surge Needs	Workforce Development	$200,000	In Progress	$200,000
	Workforce Wellness	$100,000	In Progress	$100,000
	SMI Private Provider Network (SSPN) incentives	$125,000	In Progress	
	Grand Total			**$11,727,000**

See Meeting Handout for item descriptions

Implementation Highlights

Implementation Highlight: FSP Workgroup

- Full Service Partnership Workgroup
  - Provided recommendations for minimum service requirements, service improvements
  - Request for Proposal to release soon

> Bradley was discharged from his last psychiatric hospitalization in May 2021. Upon his discharge, Bradley was faced with many challenges such as living in a group setting and having to start from scratch with his belongings and lifestyle. Bradley has since signed the lease for his own apartment and continues to engage with FSP multiple times a week and has become medication compliant along with discovering how to live independently at 72 years old. He has engaged with his peer mentor and enjoys outing in the community during his meetings. Bradley continues to draw "doodles" to show his team what his life is like through his eyes. Bradley will tell you "this is all because of Telecare" and constantly reminds his team of his appreciation to turn "a creep into a prince".

WE ARE JUST FRIENDS

Implementation Highlight: PEI Outcomes

- MHSA Prevention & Early Intervention Outcomes
  - State Required: Access, Stigma Reduction, Protective Factors (Knowledge, Skills, and/or Abilities), General Mental Health

- Office of Diversity and Equity (Theory of Change) Outcomes
  - Local Stakeholder Process: Access, Stigma Reduction, Self-Empowerment, Community Advocacy, Cultural Humility & Responsiveness

- Additional Outcomes
  - Programs: Cultural Identity Formation, Connection & Support

| Kick-Off & Ongoing Meetings | Alignment of Outcomes | Identify Program Indicators & Tools | Develop Crosswalks & Templates |

INN Planning Timeline

INN Workgroup

| Design INN Engagement Process Feb-Apr 2022 | → | Submission and Selection of INN Ideas May 2022 | → | State Feedback on INN Ideas Jun 2022 | → | DRAFT INN Proposals July- Aug 2022 | → | MHSA Steering Committee - Stakeholder Input Sep 2022 |

| 30-day Public Comment & Public Hearing Oct- Nov 2022 | → | Board of Supervisors and State approval Dec 2022-Jan 2023 | → | Procurement of Service Providers Jan – Jun 2023 | → | Projects Commence July 2023 |

MHSARC Discussion
& Public Comment

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

Thank you!

Jean Perry, MHSARC Commissioner

Leticia Bido, MHSARC Commissioner

Doris Estremera, MHSA Manager

Email: mhsa@smchealth.org

Website: www.smchealth.org/MHSA

MHSA Public Comment Submission

MHSA Annual Update Fiscal Year 2022-23

Page 1: Stakeholder Info & Comment

Q1 Contact Information (optional)

First Name: Cathy   Last Name: Baird

Agency/Organization: Showing Up for Racial Justice (SURJ) San Mateo

Q2 Which stakeholder group do you identify with?

Showing Up for Racial Justice (SURJ) San Mateo

Q3 Provide your comment here.

With funding from San Mateo County's Behavioral Health Services, four incorporated cities (Daly City, South San Francisco, City of San Mateo, and Redwood City) started a 2-year long pilot program in December 2021 with mental health clinicians embedded with those cities' police department. The program is called the "Community Wellness & Crisis Response Team." This program, in effect, criminalizes mental health crises for people who are neither armed nor dangerous. My expectation is that NAMI California would seek to have this program terminated immediately, to be replaced by non-law enforcement programs such as CAHOOT and San Francisco's Street Crisis Response Team program.

Response

Thank you for your public comment in response to the Mental Health Services Act (MHSA) Annual Update.   We empathize with your concern regarding the Community Wellness & Response Team pilot. BHRS has been involved in training the mental health clinicians, partnering with law enforcement to enhance understanding of mental illness, and monitoring response outcomes to ensure an appropriate response to all mental health crisis calls.

While the Community Wellness & Response Team pilot is not funded by MHSA, the Youth Stabilization, Opportunity, and Support (**Youth S.O.S.**) Team in partnership with BHRS, is a new MHSA funded program that also launched this year. The Youth S.O.S. team is designed to respond to children and youth ages 0-25 across the county that are experiencing a mental health crisis. The Youth S.O.S. Team is comprised of mental health clinicians, a youth peer partner, and family partners to comprehensively address any assessment, psychoeducation, therapeutic, or case management needs. This model will also be an opportunity for us to learn. Both the Community Wellness & Response Team and the Youth S.O.S. Team will be staffed by StarVista clinicians, who as an agency has a longstanding presence in the San Mateo County community response to mental health crises.

Q1 Contact Information (optional)

First Name: Pat   Last Name: Willard

Q2 Which stakeholder group do you identify with?

Community Member with no affiliation (no agency or group)

Q3 Provide your comment here.

Dear San Mateo County MHSA,

On December 2, 2021 San Mateo County issued a press release announcing the launch of a County funded pilot program called "Community Wellness and Crisis Response Team" that includes the following description of its operation model:

"Once officers declare the scene safe, clinicians will assess the individual and determine the best methods of immediate care." In other words, when someone calls 911 about a mental health crisis situation and says that the individual in crisis has no weapon, is not violent, isn't threatening anyone, and has no criminal record, police officers will still respond. It doesn't matter whether it's an adult or a 6-year-old child. The bottom line is the mental health issues are treated like a crime.

I call upon you to bring an end to the police with embedded clinician Community Wellness and Crisis Response Pilot Project. In its place, please call for and fund the implementation of a program in Redwood City, Daly City, South San Francisco and City of San Mateo that is akin in every way to the San Francisco Street Crisis Response Team. The Street Crisis Response Team does not embed clinicians with law enforcement, but instead works in collaboration with the fire department.

Thank you.

 Response

Thank you for your public comment in response to the Mental Health Services Act (MHSA) Annual Update. We empathize with your concern regarding the Community Wellness & Response Team pilot. BHRS has been involved in training the mental health clinicians, partnering with law enforcement to enhance understanding of mental illness, and monitoring response outcomes to ensure an appropriate response to all mental health crisis calls.

While the Community Wellness & Response Team pilot is not funded by MHSA, the Youth Stabilization, Opportunity, and Support (**Youth S.O.S.**) Team in partnership with BHRS, is a new MHSA funded program that also launched this year. The Youth S.O.S. team is designed to respond to children and youth ages 0-25 across the county that are experiencing a mental health crisis. The Youth S.O.S. Team is comprised of mental health clinicians, a youth peer partner, and family partners to comprehensively address any assessment, psychoeducation, therapeutic, or case management needs. This model will also be an opportunity for us to learn. Both the Community Wellness & Response Team and the Youth S.O.S. Team will be staffed by StarVista clinicians, who as an agency has a longstanding presence in the San Mateo County community response to mental health crises.

Q1 Contact Information (optional)

Respondent skipped this question

Q2 Which stakeholder group do you identify with?

Community Member with no affiliation (no agency or group)

Q3 Provide your comment here.

Stop criminalizing mental health conditions. The Sheriff and police should adopt a different model for emergency calls with a mental health or substance abuse or crisis component. Triage 911 at the front end, with a mental health provider in the dispatch center. If no weapon or threat is involves, do not send an armed cop. Send a crisis counselor/EMT as they have been doing successfully for more than 30 years with CAHOOTS in Eugene, OR

Response

Thank you for your public comment in response to the Mental Health Services Act (MHSA) Annual Update. BHRS is committed to appropriate and safe mental health crisis response for clients. BHRS has been involved in training the mental health clinicians, partnering with law enforcement to enhance understanding of mental illness, and monitoring response outcomes to ensure an appropriate response to all mental health crisis calls.

While this pilot is not funded by MHSA, the Youth Stabilization, Opportunity, and Support (**Youth S.O.S.**) Team in partnership with BHRS, is a new MHSA funded program that also launched this year. The Youth S.O.S. team is designed to respond to children and youth ages 0-25 across the county that are experiencing a mental health crisis. The Youth S.O.S. Team is comprised of mental health clinicians, a youth peer partner, and family partners to comprehensively address any assessment, psychoeducation, therapeutic, or case management needs. This model will also be an opportunity for us to learn. Both the Community Wellness & Response Team and the Youth S.O.S. Team will be staffed by StarVista clinicians, who as an agency has a longstanding presence in the San Mateo County community response to mental health crises.

Q1 Contact Information (optional)

First Name: Emily   Last Name: Morris

Q2 Which stakeholder group do you identify with?

 Community Member with no affiliation (no agency or group)

Q3 Provide your comment here.

I believe it's critical to remove police officers and policing from all mental and behavioral health services in San Mateo County. The presence of police escalate situations, which is utterly unhelpful when someone is having a mental health crisis. Police pose a real danger to communities in San Mateo, particularly communities of color. I'm asking you to remove police officers from responding to mental health crises.

 Response

Thank you for your public comment in response to the Mental Health Services Act (MHSA) Annual Update. BHRS is committed to appropriate and safe mental health crisis response for clients. BHRS has been involved in the mental health clinicians and law enforcements pilots, monitoring the outcomes and training of law enforcement.

While this pilot is not funded by MHSA, the Youth Stabilization, Opportunity, and Support (**Youth S.O.S.**) Team in partnership with BHRS, is a new MHSA funded program that also launched this year. The Youth S.O.S. team is designed to respond to children and youth ages 0-25 across the county that are experiencing a mental health crisis. The Youth S.O.S. Team is comprised of mental health clinicians, a youth peer partner, and family partners to comprehensively address any assessment, psychoeducation, therapeutic, or case management needs. This model will also be an opportunity for us to learn. Both the Community Wellness & Response Team and the Youth S.O.S. Team will be staffed by StarVista clinicians, who as an agency has a longstanding presence in the San Mateo County community response to mental health crises.

Q1 Contact Information (optional)

First Name: Suzanne   Last Name: Moore

Agency/Organization: Solutions 4 Supportive Homes, NAMI

Q2 Which stakeholder group do you identify with?

 Families of clients/consumers

Q3 Provide your comment here.

Thank you for the work, especially on the recent work of the housing task force. I have 3 areas of thoughts:

1. Importance to identify those at hi risk for homelessness and create plans to prevent. Clients living w/ aging care givers are at risk. I understand they have not been counted - their numbers are unknown. ACTION: assist families to plan for this transition.

2. Supportive housing needed for evaluation of level of function and skill building. We know chronic mental health issues are not static and are prone to episodes of decompensation. We know that skill-building can better assure success in transition. ACTION: create a pathway for skill-building supportive housing.

3. Permanent supportive housing for those who cannot live independently: ACTION - work in collaboration with public/private sectors to create this much-needed housing.

Thank you!

Response

Thank you for your public comment in response to the Mental Health Services Act (MHSA) Annual Update. Your comments and recommendations are very much aligned with the MHSA Housing Taskforce recommendations, which have allocated funding and are being implemented and moving forward.

1. Eligibility, specifically the definition for "at-risk of homelessness" for MHSA funded units and the associated supportive services is determined based on federal and state legislation. Where we may have some flexibility is with the newly proposed Supportive Housing units being developed in collaboration with the Department of Housing. We appreciate your comment to include clients living w/ aging care givers. As we work on the eligibility requirements along with stakeholder input, we will have to consider State funding and BHRS service provision requirements along with current gaps between need and housing support resources to ensure that individuals with the greatest need and the most barriers are prioritized.

2. Funding was allocated for outreach and field-based services to support ongoing and long-term housing retention, which includes independent living skills assessment and development. The outreach team would be comprised of an Occupational Therapist and Peer Counselor with co-occurring experience. This service procurement is targeted for next fiscal year 2022-2023.

3. Funding was allocated to address permanent supportive housing solutions, specifically to develop Supportive Housing units within affordable housing developments. These units are coupled with intensive coordinated services to help individuals living with mental health challenges retain their housing, support their recovery and resiliency, and maximize their ability to live and work in the community.

To: Doris Estremera, Director, SMC MHSA
      Members of the MHSARC Commission

The parents of **Solutions for Supportive Homes** (www.s4sh.org) wish to thank the Housing Task Force and the FSP Task Force work groups - representing families, clients, and providers - for their recommendations for improvements in these two areas.

And we are pleased that 34 MHSA units have already been allocated to affordable housing developers for projected completion by 2024-2025.

We agree we must meet the tremendous need for supportive homes for those who are currently unhoused. At the same time, we must call attention to a less visible but no less vulnerable population of adults living with mental health challenges: those who are being cared for by aging parents and are at *imminent risk* of homelessness when their family caregivers die. Our 2019 NAMI survey revealed 54 families who said they do not have sufficient resources to ensure the loved one they've been supporting can successfully survive in the community when they are gone. We believe there are many more. But unfortunately, while our county is careful to count the unhoused biennially to inform intelligent planning, there is no definition or count of those at imminent risk.

Steps to prevent these "invisibles" from adding to our county's homelessness burden would be:
1. Include those who are at *imminent risk of homelessness* in official counts and projections of supportive housing needs.
2. Allow those at *imminent risk of homelessness* to be eligible to apply for MHSA housing units.
3. Include families in needs assessments, goals, and service implementation for their children.
4. Assist aging parents in transitioning their adult children into supportive homes while they are still able.

The FSP Task Force and the Housing Task Force discussed the fact that **families are in need of services along with their adult children.** Families are on the front lines of care and have the day-to-day insight into needs that the clients may not recognize themselves due to their illness. Parent participation with service providers in assessing needs, setting goals, and implementing service plans is vital to the success of their children's treatment. And as aging mothers and fathers find themselves with diminished capacity, they need help, as their loved ones will have to build more independent living skills and look to someone outside of their family for their support. **Even within the constraints of HIPAA, we believe that we need to - and that we can - value and acknowledge the support that families are providing.**

As one observer reflected recently, "often the main difference between that homeless guy on the street and my friend's son is … a mother. And when that mother dies, what you get is … another homeless guy on the street."

We thank you for your continued diligence and partnership in our ongoing work to build the comprehensive system of mental health and mental illness care we all envision.
Sincerely,

Carolyn Shepard
President
Solutions for Supportive Homes

List of Parents and Families who wanted their voices heard:

Joan Dower	Diane Warner
Emily Chandler	Kathy Gilbert
Suzanne Moore	Melinda Henning
Jem Azucena	Joe Lanam
Nancy Gittleman	Leanna Harper
Karina Marwan	Mary Beau
Neil Hersh, PhD	Helene Zimmerman
Karen Shea	Rachel Day
Steve Beck	Ammi Rostin
Dorothy Christian	Scott Anderson
Linder Allen	

Response

Thank you for your public comment in response to the Mental Health Services Act (MHSA) Annual Update. Your comments and recommendations are very much aligned with the MHSA Housing Taskforce recommendations, the MHSA Full Service Partnership Workgroup and stakeholder sentiments overall.

1. Include those who are at *imminent risk of homelessness* in official counts and projections of supportive housing needs.
2. Allow those at *imminent risk of homelessness* to be eligible to apply for MHSA housing units.
3. Include families in needs assessments, goals, and service implementation for their children.
4. Assist aging parents in transitioning their adult children into supportive homes while they are still able.

We appreciate your comments to include families in services for their children and to include adults living with mental health challenges who are being cared for by aging parents and at *imminent risk of homelessness* in our projection of needs, eligibility to apply for MHSA housing units and supports to the aging parents. As we work on the MHSA housing eligibility and service requirements along with stakeholder input, we will have to consider State funding and BHRS service provision requirements along with current gaps between need and housing support resources to ensure that individuals with the greatest need and the most barriers are prioritized.

Additional Comments and Responses:

- Commissioner Michael Lim: Regarding the homeless counts and being able to include individuals who are housing insecure … how will we go about doing something like this. It's not BHRS area to do the count of homeless, how do we pass on this request to the Board of Supervisor or the appropriate department that does the count so that we do include these individuals.

- BHRS Director Scott Gilman: the problem is with the definition of this count – are they at risk of homelessness because the caregivers can no longer handle them, because the caregiver has cardiac condition, because the caregiver is aging, how would we define this? There is also no current database that we can easily look at but, this is an extremely important point because this population is growing and there is a need and we have to figure this out. Additionally, the population you are describing are folks that may or may not be in services if the families are taking care of them.

  We don't have an answer but, we are hoping to do some stakeholder focus groups in the future, and we are definitely bringing this issue to the consultants that are supporting behavioral health facilities development as part of the Behavioral Health Continuum Improvement Program and the Community Care Expansion funds.

- Commissioner Michael Lim: It would call for a collaboration with the consultant and the Solutions for Supportive Homes group and see what we come up with, because this is a conundrum.

- Commissioner Candice Hawley: Can't providers help with this information. If I am a provider, I would know if my client has supports and how fragile that support might be. I can report that I have X number of cases that are being cared for by an elderly family members. Then we don't have to wait for these individuals to be in distress because their parents have died.

- BHRS Director Scott Gilman: I think this is a good idea and we would have to put some thoughts into how we can make this happen, look at how others have delt with this, put together some focus groups. Yes, we definitely have to address this.

- Member of the Public, Martin Fox: the people who collect this kind of data are people that get referrals from me. I tell parents of adult children with serious mental illness to set up an estate plan that deals with all of these issues and one of these issues is how to take care of their children. The County Bar Association has a population of lawyers who deal with these issues all of the time because they have to make decisions upon the assets that the parents do have available and help those that don't. The County Bar Association, estate planning section can get us numbers. We can also contact the public law library that does a lot of work in this area as well.

APPENDIX 3. FSP FOCUS GROUP SUMMARIES

Multi-County FSP Innovation Project

San Mateo County Client
Interview Synthesis

Spring 2021

Client engagement methods

- In March - April 2021, as part of the Multi-County FSP Innovation Project, Third Sector interviewed 8 individuals receiving services across San Mateo County's different FSP programs.

- Third Sector conducted these one-on-one interviews by phone, and compensated clients for their time with $40 Visa gift cards per interview.

- The purpose of the FSP client interviews was to gain deeper insight into potential changes to service design and graduation processes, supporting improvements to current FSP services.

Time in Program (n=8)

Chose not to share
5+ years
3-5 years
2-3 years
1-2 years
6-12 months

Clients

0   1   2   3

FSP Age Group (n=8)

Adult 75%
TAY 13%
Older Adult 12%

Participant Race (n=8)

Black/African American 25%
LatinX/ Hispanic 13%
Asian Amerian/ Pacific Islander 12%
White/ Caucasian 12%
Two or more races 13%
Chose not to share 25%

Participant Gender (n=8)

Female 12%
Male 63%
Chose not to share 25%

Service Guideline Insights

Overall experience

Overall, clients had positive experiences with FSP services

- Six out of eight clients expressed largely positive experiences with their providers in San Mateo County. Most clients gave reasons such as case management support, connection to outside resources, and availability of staff.
- One of the eight clients expressed dissatisfaction and frustration with their family member's provider, citing reasons of inconsistency in appointments and other aspects of service delivery.

"It's been very good for me, Telecare has been good to me. I've been with them for 13 years. They have helped me with medication, provided housing, and also helped me get a job."

"Most of my interactions have been really positive. I feel like they really genuinely care."

"Caminar has been really hit or miss. If we get calls for support, great. If not, I don't know who to ask. I don't know who is taking care of my [family member's] case. It's been on and off. There hasn't really been a routine schedule where he [family member] has appointments with different staff."

"I've been stable, not hospitalized for over a year. I feel like Caminar has allowed me to be myself, say how I feel, rather than tell me about how I should feel."

THIRD SECTOR

Needed services

Therapy / psychiatry services are not provided in-house and are inconsistently available

- Providers refer clients out for therapy, but there is not always someone available at no- or low-cost, or there is a lot of turnover in who a client ends up seeing.
- Two clients noted that their psychiatry services were provided by individuals still going through school to get their accreditation, who then move-on once they complete their degrees.

"It would be helpful if they provided a therapist. One that doesn't cost me any money because I don't have much money. They give me the pills but won't give me the therapy."

"I keep begging for a DBT program. There is a big demand for it, and very few are offered. Also group therapy, that's another thing not offered. It's impossible for anyone to get that therapy, because they're all booked, and the people who are trained in this are too few. The waitlist is too long."

"A ride to the DMV wouldn't hurt. And if they could cover my behind the wheel classes that would be helpful."

Clients have inconsistent access to transportation services

- Despite being offered bus tokens [*see flex funding section*], one client mentioned that it would be helpful to have more rides directly to certain places from their care provider. However, other clients mentioned that they had received ride to clinics and other places, and expressed gratitude for how helpful they were.

Team-based collaboration

Clients interact with many different staff

- Six out of eight clients indicated seeing multiple different case workers, psychiatrists, and/or nurses throughout their FSP involvement, mostly due to staff turnover.

"I see a doctor. I saw another doctor, but unfortunately they left. I also work with two different case workers. I worked with another one but she left there. I also got to work with two other case workers and the nurse. But she was being switched around. It made me sad when she told me she was leaving."

"My [family member] had difficulty trusting them, and depending on them to help him get better. He just got more suspicious and it's difficult for him to build rapport with the case managers, and clinicians. Nothing was consistent. It was really hard to keep track of who is who"

"It's good because I can talk to one of them, if I need a different opinion about something, I can talk to another one. They're all working in the same field, giving help you know."

There is collaboration between staff and teams

- Multiple clients were aware that the members of of their teams had meetings about them and always knew what was going on with their case.
- Clients expressed that even when they have to meet or talk with someone who is not usually on their care team, they are still knowledgeable and able to give them the support they need.

THIRD SECTOR

Staff capacity and challenges

Clients perceive staff to be busy and overworked, and feel the stress of staff turnover

- Two out of eight clients noticed that staff seemed extremely busy and overworked. Another noted that numerous people on his care team had left, and that some departures were difficult.

"I had a social worker in there and she was super overworked. She had everyone in the hospital. I think she had one other partner."

"I think they're understaffed. They need more support. It's unfortunate but they do... there are a lot of people using their services. I think it's because it's a county program they don't get the support they need."

Clients reported problems filing complaints

- One client described a situation where she wished to file a formal complaint. Despite the county having a designated phone line for clients to call and file a grievance, this client was told that wasn't possible.

"I did want to file a formal complaint, but my case manager told me that I wasn't able to do that. One time I did get a call from a particular staff member, and...it sounded like he was recording the call...I did receive an apology call after that. But there was no way for me to file a formal complaint about something that I was really upset about..so what can I do? We're just being victims and not be allowed to talk to anyone about it. So that was difficult. I think that was the lowest experience with [my provider]."

THIRD SECTOR

Service location, hours, and frequency

FSP staff are able to meet clients where it's convenient for them

- While most meetings are currently still happening virtually (mostly by phone), staff are still dropping things off for clients as needed or having them come into the office or clinic for medication.
- Clients appreciate that prior to Covid staff would meet where it was most convenient for them, often at a client's home, work, or restaurant near them.

> "I preferred to meet with them at the hotel. Because I didn't have to leave. I could come out of my room, talk to them in the lobby, or they could come up to my room."
>
> "Before not [meeting] regularly, but from time to time. Only regular after Covid when the case manager started scheduling a one time per month video conference. But before Covid, we don't have a regular session. To my knowledge we didn't have a routine one time per month session until Covid."

Consistent, regularly scheduled meeting times are preferred and boost engagement

- Frequency of services differed a lot amongst clients (from once per week to once every other month).
- The clients who have more frequent touch-points were the ones with recurring meetings scheduled with their caseworkers, therapists, and/or psychiatrists. The clients who said they set up appointments with their caseworker as they go tend to engage with FSP staff less frequently.
- Services are only offered on weekdays, which works well enough, but most clients indicated that some weekend availability would be helpful.

THIRD SECTOR

Peer support and cultural relevance

Peer support is very important to clients, but sometimes hard to find true "peers"

- Not all providers offer peer support services in-house, but all clients mentioned that were at least referred to peer support resources (i.e. through their housing, NAMI, AA/NA, ILP, California Clubhouse)

"*My case manager introduced me to my support brothers. They took me in, they've always been there for me, supported me… I'm Black, they're Black. One of them just got married, I went to his wedding. They're good people.*"

"*She taught me about breathing techniques. She wasn't telling me about her personal life, but it related with what we were discussing, and it was something that resonated with me...She could give me good advice on how to help it. Because she had to do it herself... Instead of giving me lessons that she's learned in a class setting, she would give me what worked for her.*"

"*I think it's very helpful [that one of my care team members is Black]...Birds of a feather flock together... But I don't feel that race is the reason that me and my case manager click. I appreciate his [case manager's] guidance and that's why we click. It doesn't matter if he's Black or White.*" (Black)

Racial dynamics

- Clients had mixed views on whether race impacted their FSP experience
- One client who identified as Black suggested that it would be helpful if their provider connected them with people from the National Association for the Advancement of Colored People (NAACP).

THIRD SECTOR

Translation and language barriers

Clients have been challenged by language barriers and translation competency

- Two out of eight clients shared that their service was hindered by negative experiences with translators, either themselves or for family members enrolled in FSP services.
- One client, a native Spanish speaker, shared that when the translator was speaking, the responses from the care team did not correspond to the questions that the consumer had asked. However, when he spoke to a staff member who was a native Spanish speaker, they had no issue communicating.
- One client shared that translators weren't effective because they were always changing and it was difficult for her family member to build trust or be honest when there was no consistency. She also shared that to her knowledge, no provider staff spoke Korean, her family member's native language. Cultural stigma around receiving mental health services also made it difficult to address these challenges.

> *"Well, sometimes I lose hope because there is no communication...if I ask them [translators] a question, I'm not sure what they say to the others [doctors]. I'm not sure what they are translating. Sometimes they answer me with something that does not match what I asked."*

> *"Part of the problem is that neither of [them] speak English, they speak Korean. Caminar would try and get translators, but most of the time, translating doesn't really work. Because [he] isn't willing to open up unless the doctor or case manager was the person who spoke the language...His responses were always really the surface level...partly because the translators changed all the time. Each time there had to be an introduction, and I think he felt ashamed of needing to rely on them. That was really stressful."*

Flex funding and housing

Clients have benefited from flex funding for a variety of different needs

- Two out of eight clients received bus tokens to support their transportation needs.
- Two out of eight clients received other supports, such as gift cards and outings to restaurants.
- Two out of eight clients had never been offered any sort of supplemental funding.
- One client shared that their housing was covered by their provider. Another client mentioned that he had been offered housing, but he declined it since it was in an area where he didn't know anyone.

> "I think they offered it to me. I was at the office for a sit down meeting and they asked if I wanted bus tokens because I'd been riding the bus and I said yes, and they gave me a handful."
>
> "They got me a burger one time, and a BART card. I got a giftcard for some stuff at Safeway. They try to help me with my passport and the embassy."
>
> "I'm in THP, it's funded by MHSA and Caminar. Caminar is supporting me to live here. Now I've got my own room just with that."

THIRD SECTOR

Graduation Criteria Insights

Graduation readiness: goals and indicators for recovery

Independence is a core goal of San Mateo FSP clients

- Clients defined success in a variety of ways, but everyone all clients interviewed mentioned some form of independence.
- Many clients also mentioned multiple, staged goals: while their initial goals were focused on stabilization and socialization, as they recover, their goals progress to focus on housing, employment, income, and family reconnection.

"[Success looks like] doing something positive, and proactive for my recovery. Taking things one day at a time."

"My next major goal is really becoming even more independent."

Note: some clients indicated multiple goals

Supports clients still need

Clients emphasized wanting to feel equipped with "tools"

- A number of clients wanted to ensure that they had the tools that they needed to succeed without FSP. Examples included family communication strategies, therapy, personal responsibility, and anxiety management strategies.

"Sometimes people in my family don't understand mental illness...it's easier to, say, call my case manager; he'll tell you how it is. And it's easier for him to explain to them that I'm fine and they don't have to worry. Transitioning to not having case managers like this could make it difficult to handle these conversations and family."

"I fall back sometimes, I get anxiety, but the tools that she's given me, I feel like I'm better equipped to handle it as things get bad. I meet new goals that I've set for myself. So the goals change."

Clients also wanted to accomplish concrete goals

- Other clients mentioned that they could not imagine graduating from FSP without accomplishing very specific goals related to employment (e.g., a military job), financial stability, sobriety and health and wellbeing (e.g., primary care / vaccinations).

THIRD SECTOR

Conversations about transition

Only some clients discuss transition with their case managers

- Three of the five individuals interviewed on this topic had discussed graduation and stepdown with their case managers, while the other two had not had any conversations about the topic.

- Clients who do not discuss stepdown with their case managers still think about the topic. For those clients, it would be reassuring to know that they won't be asked to transition until they have met their goals or have specific resources (e.g., housing, car, financial stability, etc.)

"

"I see it happening organically as I get close to accomplishing these goals and get the job that gets me off of disability and such. They'll know I'm moving that direction based on what we talk about and stuff and progress I've made and we'll just know."

"Ahead of time, it wasn't a big surprise. She told me, 'As you get better we're going to go to every other week, and then…' So I knew that's how it was going to go to be, so I was ready for that… I agreed 'Yeah, I'm ready for that step.' It wasn't a surprise, they eased me in the entire way, she held my hand the entire way."

"

THIRD SECTOR

Ideal stepdown transition

Clear and multi-stage communication is important to clients

- Many clients emphasized the helpfulness of taking things in "steps", whether that is progress towards goals, or a rampdown in support from the FSP program.
- Similarly, clients requested that transitions be planned and carefully communicated so as to avoid surprises or abrupt endings to services.

"Talking about it and having that communication where we're on the same page. I don't want to deal with the stress of all that when they pop out and say we're done with your services as of today."

"[The "support brothers"] took me in, they've always been there for me, supported me, especially if it's positive. They support me in whatever I do. They're nice guys. I'm Black, they're Black."

"It would be cool if there was a BBQ and people showed up. They had an ice cream truck last time; that would be cool."

Clients also valued celebration and peer supports in transitioning from FSP

- Many FSP clients stated that graduating from the program would feel like a cause for celebration and requested an acknowledgement of that.
- Peer and therapeutic supports were also requested as part of the stepdown process, including involvement from the case managers, psychiatrists, and nurses.

THIRD SECTOR

About the Multi-County FSP Innovation Project

When the Multi-County FSP Innovation Project is complete, counties will have an improved ability to collect and use data that illuminates **who FSP is serving, what services they receive, and what outcomes are achieved**. Findings from each county will contribute to **statewide recommendations to create more consistent FSPs** that deliver on FSP's "whatever it takes" promise.

Participating Counties

Fresno

Sacramento

San Bernardino

San Mateo

Siskiyou

Ventura

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Third Sector Capital Partners, Inc.
info@thirdsectorcap.org | www.thirdsectorcap.org

San Mateo County BHRS FSP Innovation Project
Implementation Phase

Child/Youth/TAY FSP Provider Engagement Synthesis

Method
- Third Sector conducted a two-hour hour virtual focus group with individual providers. In total, perspectives from six (6) staff members across San Mateo County's two (2) **Child/Youth/TAY FSP programs were represented**.
- In the first half of the session, staff were asked forward-looking questions to inform new **service guidelines**, including questions related to staffing specialization, caseload size, frequency of services, service hours, education/employment support, and flex funding. In the second half of the session, staff were asked questions to inform new **eligibility and graduation guidelines**, including questions related to recovery-oriented services, assessing readiness, preparing for transition, and post-graduation support. For each of these topics, providers shared information about their program priorities and offered suggestions for BHRS to support their work. Their feedback is synthesized below.

Takeaways & Key Recommendations
Based on provider feedback, BHRS may be able to support providers in the following ways:

Eligibility criteria:
- *YTAC referral system is missing eligible youth* from drop-in centers, those not currently connected to a mental health provider, and potential self-referrals. Providers recommended there be a better linkage between drop-in centers and the County referral system.
- *Enrollment/intake process* is overwhelming and sometimes retraumatizing due to amount of paperwork, level of detail, and repetition
- *Providers are unable to adequately service youth with psychosis*, and would like resources for/access to more suitable treatment options
- *Mental health and FSP knowledge is limited* among families of eligible youth; families would therefore benefit from in-home services and family education when first establishing care

Service guidelines:
- *Family and peer advocates are invaluable* and need more pathways to promotion to reduce attrition
- *Billing should allow earlier addition of specialist* to the treatment team, as well as in-house substance abuse counselors to be added as available specialists for TAY clients
- *Caseload size and frequency of services* should adjust based on client level of need, not a fixed number
- *Swing shift hours may be more suitable* for the TAY population
- *County employment partnerships* would help providers support TAY in achieving their employment goals
- *More flex funding guidance and support* would help providers strategically utilize all available flex funds

Graduation guidelines:
- *Staff look at several indicators of graduation readiness,* such as meeting treatment goals, family support, etc., and it differs by client, so providers do not wish to use a single standardized readiness assessment tool
- *Staff would like to be able to check on their graduated clients*, which County policy could encourage with appropriate privacy, consent, and billing policies
- *County facilitated communication/partnerships with out of county programs and providers*, would help providers transition care when clients move out of county

Detail

Eligibility Criteria Detail
(+) Assets
+ TAY FSP is great option for youth aging out of foster care   + Drop-in centers are open to the community and are a great way to provide knowledge about mental health in a nontraditional setting
(Δ) Opportunities
Δ Referrals, outreach, and engagement all down because of COVID Δ AB1299 fixed policy issues for out of county foster care placements, but now Fred Finch is not utilized and hard for those staff to find eligible youth   ○ *"I assume there must be youth who are living out of county who are in foster care. But maybe because it's a small program, it's hard for referral partners to keep it top of mind. We used to have lots of staff meetings with child welfare workers, but when they left, knowledge about the program was gone too."* -FSP Program Director   Δ Child/Youth/TAY with psychosis technically eligible but treatment current providers can provide is very limited   ○ *"There are options for early intervention and youth psychosis, but nothing available for TAY population"* -TAY, Case Manager   Δ Enrollment process is overwhelming and sometimes triggering, especially for clients from historically marginalized populations   ○ *"If they make it through that then the process of engagement goes well, but would be good to have a way to smooth the process out and make it less triggering for clients who have had to go through similar processes which have been traumatizing"* -TAY, Enrichment Services Specialist   Δ Lack of community education and awareness of mental health in general and FSP services among eligible populations, but resources and capacity currently limit the ability to provide in-home services and family education when first establishing care   ○ *"I have youth that would qualify for FSP, but they have never heard of "mental health"...don't understand what the services mean...don't want their child to talk about their trauma"* -TAY, Therapist   Δ Many eligible youth are not being referred because they are not currently connected to a provider and therefore don't have access to the YTAC referral process / committee; no one knows the referral phone number or option for self-referral Δ Currently, staff and peer partners at drop-in centers do not have enough access/agency to make referrals for youth as needed; there is not enough direct linkage between the drop-in centers and County referral system

Service Guidelines Detail
Specialization
(+) Assets
+ Nurse practitioner, because they are able to follow youth, i.e. at-home, in-school, etc.   + Peer and family advocates are critical for their lived experience and could use even more of them
(Δ) Opportunities

Δ High turnover among peer and family advocates//support specialists due to:
    ○ No career ladder/opportunity for advancement/pathway to promotion
    ○ Large amounts of required paperwork
    ○ High caseloads
Δ Specialists are not always able to join the treatment team early enough in the treatment plan process due to billing restrictions
Δ Most TAY clients would benefit from substance abuse counseling, but currently have to refer out for that specialist
    ○ *"Sometimes there are resources to direct them to, but it would be better for it to be in house for direct collaboration and support of the youth. Co-occurring MH and SUD can get really tricky so in house positions on both sides would be great" -TAY FSP, Behavioral Support Specialist*

Caseload Size
(Δ) Opportunities
Δ Should be based on client level of need and level of connectedness (to FSP program and other providers/services), not a fixed number

Frequency of Services
(+) Assets

+ Similar to caseload size, number and type of touchpoints per week should be client specific
    o *"It's a TAY dance on level of engagement; clients are set in what they see they need and then other times they are open to learning about themselves and open to being more engaged" - TAY FSP, Behavioral Support Specialist*
+ Ability to keep cases open during period of no engagement
    ○ *"Ability of program to go into community and look for people [i.e. in jail and/or in-patient] and ability to stick with people even during long periods of "going dark" is really important" - TAY FAP, Enrichment Services Specialist*

Service Hours
(+) Assets
+ All programs are able to provide 24/7 services by utilizing on-call crisis teams outside of normal business hours
(Δ) Opportunities
Δ Should have flexibility to provide more TAY services on swing shift basis to accommodate TAY population natural tendencies, i.e. starting office hours later in the day and staying open late

Education/Employment
(+) Assets
+ Specialists are valuable in helping clients achieve education and employment goals, i.e. Guidance and Career Specialist, Youth and Parent Partners
(Δ) Opportunities
Δ More County employment partnerships

Flex Funding
(+) Assets
+ Being able to spend it on food and other engagement incentives helps built rapport early on
(Δ) Opportunities
Δ Not exactly sure what to do with the money or how much they have available   Δ Provide suggestions on how providers should spend the money and more oversight on availability of funds so providers feel encouraged and supported to spend it down

Graduation Guidelines Detail
(+) Assets
+ Providers are talking to clients about graduation from day 1   + Graduation works best when it is a slow and collaborative process between treatment team and client, not rushed by the County   + Transition-facilitated CFT team meeting works great   + Not having to use one standardized readiness assessment tool   o *"A really interdisciplinary effort goes into assessing readiness - the whole team. It's more nuanced and sensitive than a simple readiness assessment. You see things brought up like a client's natural supports, more subtle aspects of their family life - and those are really important to clients and that can have a deep impact." TAY FSP, Enrichment Services Specialist*
(Δ) Opportunities
Δ Hard to communicate and work towards graduation in a remote setting during COVID   Δ Not able to graduate out of county foster youth because there were no other services to refer them to   Δ Aging out or services being discontinued because child welfare case closes often feels abrupt and without much County follow-up   Δ There is not much interaction happening post-graduation, but providers feel as if this would be helpful to the clients (i.e. 30 day phone call, etc.)   Δ It would be helpful if the County facilitated communication/partnerships with out of county programs and providers, because a lot of transitions are because clients move out of county and it can be challenging to coordinate their ongoing care

San Mateo County BHRS FSP Innovation Project
Implementation Phase - April 2021

Adult FSP Provider Engagement Synthesis

Method
- Third Sector conducted a two-hour hour virtual focus group with **8 staff** across BHRS's **3 Adult FSP programs**.
- Staff were asked questions to inform potential changes to **eligibility criteria**, **service guidelines** (including questions related to staffing specialization, caseload size, frequency of services, service hours, housing/jail coordination, and flex funding), **and graduation guidelines** (including questions related to recovery-oriented services, assessing readiness, preparing for transition, and post-graduation support). For each topic, providers shared information about their program priorities and offered suggestions for BHRS to support their work.

Takeaways & Key Recommendations
Based on provider feedback, BHRS may be able to support providers in the following ways:

Eligibility criteria:
- *The BHRS/Core Service Agency referral system* is not set-up for eligible adults to self-refer or reconnect directly to services after a period of disengagement. Providers recommended there be a better authorization process for individuals identified as eligible outside of the County process.
- *Because authorization decisions happen at the County level* individuals who providers see as eligible are sometimes denied FSP services without citing a reason. This leads to confusion around eligibility criteria.
- *Providers are unable to adequately service older/elderly with physical health issues* and would like resources for/access to more suitable healthcare options
- *Eligible individuals and the community at-large* have limited knowledge about mental health services in general, the FSP program, and/or how to access FSP services

Service guidelines:
- *Providers are not currently contracted to provide therapy*, which makes it almost impossible to provide the treatment that each client needs. There are not enough therapists in the county to refer out to so clients are currently going without therapy services.
- *Peer advocates are invaluable* and could use more of them
- *In-house substance abuse counselors* would be a helpful specialist to add to treatment teams
- *There is a discrepancy between providers* as to what the expectation is for number of contacts per week from 1x/week up to 3-7X/week
- *After hours and crisis care is not always being provided by in-house*, FSP-specific treatment team members
- *Housing subsidies/vouchers being tied to FSP involvement* are forcing clients to stay in FSP even after they are ready to step-down
- *Better coordination with other providers* would give clients more seamless continuity of care when moving between jail, hospitalizations, residential treatment, and FSP
- *More flex funding guidance and support* would help providers strategically utilize all available flex funds

Graduation guidelines:
- *Staff look at several indicators of graduation readiness,* such as meeting treatment goals, housing stability, etc. Try to start conversation as early as possible but it differs by client.
- *County-facilitated communication/partnerships with out-of-county programs and providers* would help providers transition care when clients move out of county

Detail

Eligibility Criteria Detail
(+) Assets
+   Are able to see clients of any age 18+ and criteria on paper seems to be working
(Δ) Opportunities

Δ   Criteria is sometimes at odds with what they are contracted to provide
      ○   *"Have to find higher-functioning person to be able to fully take advantage of the program -- but that is not the only group that should be able to take advantage of the program" -FSP Director*
Δ   Older adult/elderly community is more challenging because they have mental and physical health needs that are hard to address under current service model
Δ   Some clients who are eligible still get lost in the intake process or do not get approved for services for some reason
Δ   Clients having to go through BHRS referral process, Core Service Agencies, or service connect is an access barrier for initial service authorization and for clients trying to reconnect to services
      ○   *"We'll have former clients who are disenrolled because they are in jail or a locked facility for a long time. Sometimes they'll ask if we can just take them back on, but they have to go through a whole reauthorization process and we can't just re-enroll them" -FSP Case Manager*
Δ   Everyday individuals do not know what the County has to offer or that the services exist; need more education to general population / community at-large so people know FSP is even a thing

Service Guidelines Detail
Specialization
(+) Assets
+   Peer advocates prior to COVID were essential, but their job scopes have been limited due to COVID quarantine policies +   Jobs Plus Program for employment and education +   Housing Resource Manager
(Δ) Opportunities

Δ   For new clients it would be good if they were introduced to case management earlier in their journey so they are receiving support while getting matched to the right level of service
Δ   Providers are not currently contracted to provide therapy, only for case management, which makes it almost impossible to provide the treatment that each client needs.
      ○   Sometimes due to high staff turnover and clinicians getting promoted into manager positions
      ○   Some providers use interns who need academic/licensing hours in order to provide clients with therapy
      ○   Shortage of therapists at a County level, so hard to refer clients out for therapy services
      ○   FSP licensed Clinical Case Managers are able to provide some therapy in-house, but it is hard to hire for and fill those positions
      ○   *"At county level, shortage of therapists and they are not accepting people with suicide attempt or previous psychiatric hospitilizatons. So clients are not being accepted to therapy programs, and there's a limit of therapy programs and a waitlist to begin with. The private provider network isn't accepting clients with SMI and/or suicide attempt in the last year. They say that they cannot provide services to meet those needs." -FSP Case Manager*

Δ   Peer advocates job scopes have been limited during COVID as they are now allowed to come into the office
Δ   More peer advocates
   ○   *"More peer groups would be beneficial and client advisory board that meets more regularly or one that is county-wide and not just organization specific" - FSP Case Manager*
Δ   Reliance on Case Manager to know what specialists and resources are out there and they need more education on the specific services available to them and their clients
Δ   Do not have substance use counselors but would be very beneficial
Δ   Have access to prescribers but if the client isn't enrolled in Medi-Cal it's hard to fill meds
   ○   *"Sometimes we loan clients the funds but that can be expensive/ not possible." -FSP Case manager*

Caseload Size

(Δ) Opportunities

Δ   Maximum caseload size differs by provider, somewhere between 10 to 15. Providers feel 10 is more manageable than 15, which feels very heavy to those with that caseload.
   ○   *"10 is max with still being able to help each client; 8-10 is good load but really depends on the client because 1 client can feel like 3; not just based on numbers" - FSP Case Manager*
   ○   *"12 feels good enough but comes down to frequency of services and that depends on crises; 12 gives that wiggle room to flex if needed" -FSP Case Manager*

Frequency of Services

(+) Assets

+   Having flexibility in what is contracted/expected is key so that care can be adapted and individualized to each client needs

(Δ) Opportunities

Δ   There is a discrepancy between providers as to what the expectation is for number of contacts per week; answers included 1x, 3x, and 3-7x/week
   ○   *"Was told 3 touches per week (either in-person or by phone)" -FSP Case Manager at organization A*
   ○   *"1x/week, can go up to 4X/week if the client is in crisis but it's based on the needs of the client at the time." -FSP Case Manager at organization B*
   ○   *"Contracted to do 3-7 touches per week per client (could be a combo of anyone from the care team) but it seems overwhelming for some clients and challenging for team members. Some clients do not want this level of engagement so mandate is a challenge." -FSP Director at Organization C*
Δ   It is challenging, due to staff capacity and sometimes client engagement, to get more than one contact per week
   ○   *"Challenge is mostly on staff capacity; sometimes it's getting in touch with clients and them picking up the phone but mostly it's my time." - FSP Case Manager*

Service Hours

(+) Assets

+ Providers all providing treatment during normal business hours with clients being able to access care outside of those hours through call-in center, mobile support, or in-house crisis response team

(Δ) Opportunities

Δ Not all 24/7 care right now is being provided by in-house, FSP-specific treatment team members
Δ Might be worth looking at exempt / non-exempt status of FSP staff as one way to expand the flexibility in what hours staff are able to provide care to clients
   ○ *"Would be more advantageous to clients, but clinicians may not like losing overtime"* -FSP Case Manager

Housing & Jail Coordination

(+) Assets

+ Housing is most important thing because not having stable housing leads to other issues and problems

(Δ) Opportunities

Δ Clients have exhausted all housing options by the time they start FSP and the County is not client friendly when it comes to housing
   ○ *"Sometimes they are not even set up on the right benefits to be able to access housing services; especially for AB109 clients coming out of jail."* -FSP Case Manager
Δ Housing is most important goal for most clients, but over 50% of clients are unhappy with their housing situation
Δ Case Managers need more County-wide education and resources about available housing options
Δ Clients are often "stuck" in FSP even though they are ready to be stepped-down because their housing subsidy/voucher is tied to their FSP involvement
   ○ *"If he leaves FSP he loses housing subsidy, but being in FSP and having to meet 2x/week is holding him back. And he is taking someones spot who could really use the FSP level of care."* - FSP Case Manager
Δ Challenging to get housing for people with criminal legal histories, but often clients only want to engage with a provider if it comes with housing benefits
   ○ *"Clients only want to engage if the provider has housing. They won't work with you if you don't have housing to offer them."* -FSP Case Manager
   ○ *"The first thing clients ask is can you get me housing? Coming out of the hospitals, rehab, etc. Had a few successful stories of getting a housing voucher for mental health specifically. Even for the vouchers, it's a challenge to find housing where the landlord will rent the unit to someone who has a voucher and SMI."* -FSP Case Manager
Δ Case Managers need more support going through the housing application process, especially for individuals coming out of jail, as it's a lot of paperwork and bureaucratic barriers
Δ Clients are coming out of jail without benefits and without having had any mental health treatment while incarcerated; some clients and FSP Case Managers are being told that they have to be out of jail for three months and in good standing with the program to even apply for benefits
   ○ *"Coming from jal with no benefits is a big issue. Was able to use AB109 to gain housing with some members but that funding is only temporary and there is a max on the number of AB109 clients and max AB109 dollars our program can accept. Even in those cases, it is still a month long process to apply and get someone into housing. There is also apparently a MediCal change that has resulted in clients being released from jail with no medication. They used to get 2 weeks worth of medication upon release. This is a big issue."* -FSP Case Manager
Δ There is a disconnect when clients are moving between programs, i.e. coming out of hospitals or in/out of residential.
   ○ *"It gets complicated on who is allowed to write what medication for who. We need more coordination so there is a more seamless provision of medication for clients."* -FSP Case Manager

Flex Funding

(Δ) Opportunities

- Δ Has been a useful resource in the past, , i.e. to support purchasing client medication, but was cut because of budget cuts
- Δ Guidance on allowable uses of Flex Funding keeps changing, so it is just not currently getting used
  - ○ *"Think we have Flex Funds and tried to get some funding approved, but then were told not to spend money in that way because it would hinder clients "learning"" -FSP Case Manager*
- Δ Most Case Managers are not familiar with or aware of Flex Funds

Graduation Guidelines Detail

(+) Assets

- + Most providers are talking about graduation at the very beginning and again when a client has met all their goals that were specified in the referral
  - o *"Model is to talk about graduation in the very beginning but the reality is that not everyone can tolerate that kind of conversation. Some folks disappear when we talk about graduation which prolongs the graduation." -FSP Case Manager*
- + There is a process and annual packet of paperwork to talk with clients about their status and goals towards graduation. Often internal care team conversations happen internally to determine if it's beneficial before introducing to the client at all
  - o *"Goals are identified by the treatment team: psychiatrist, nurse, sometimes social worker. When I feel the client has met the goals, I check with the treatment team for input, where I think the client should be. I always double check with the treatment team. They take my input into account." -FSP Case Manager*
- + There is currently flexibility for providers to determine when graduation is appropriate and not
  - o *"There's fluidity in our program. We have flexibility with timing around step-down, it's not formulaic. We're able to accommodate changes in needs and readiness to graduate." -FSP Case Manager*
- + Really good experience when it is slow and client-driven

(Δ) Opportunities

- Δ Referral source has been communicating a 3-12 month program length to clients and Case Manager
  - ○ *"The person who does the referral tells the client that the services are 3-6M or up to a year, depending on client needs. Didn't used to be like that, but now implemented that." - FSP Case Manager*
- Δ Need a more coordinated process for clients who are not ready to graduate or step-down but are moving to a new county so they do not have a lapse in treatment
  - ○ *"It becomes more expensive to live in SMC. For clients who aren't ready to step down from FSP, but are moving to a new county, they have to go through the whole approval process again in a new county. Would be great to have people qualify in one county if they qualify in another county, moving seamlessly." -FSP Case Manager*
- Δ One of the biggest concerns with step-down and why it's sometimes intentionally slower for clients is because of medication and wanting to make sure there is no lapse in care
  - ○ *"Always try to keep them on and implement a warm handoff. Waiting longer usually has to do with meds - not always, but is a big focus. Want to make sure they can start a new service with meds. Clients may not want to change psychiatrist, but they have to if they step-down, so that causes resistance." - FSP Case Manager*
- Δ Case Managers are often focused on more high-need clients and helping clients think about or start the step-down and/or graduation process takes a back seat
  - ○ *"I honestly focus more on the high need clients, when chatting with my supervisor, etc. The process of stepping down starts with me, but it's hard if I have other priorities. Challenge to handle the workload and make sure it's prioritized." - FSP Case Manager*

MHSA FSP Workgroup – Stakeholder Feedback

Recommendation	Workgroup Feedback	How will this be addressed
Set Minimum FSP Service Requirements	General Feedback: - Therapy services need to be offered by providers - Nutrition, physical activity, evidence-based tx (e.g. EMDR) peer support are low-cost services that can have a big impact C/Y/TAY Breakout: - Young adult peer supports is essential - Need family support groups in multiple languages - Important to build independence of client and natural supports Adult Breakout: - Quality FSP services should include food and life skills training	• At minimum, the following <u>FSP requirements</u> (per MHSA legislation) will be included in FSP Request for Proposal (RFP) process and subsequent contracts: 1. Mental health treatment plans (ISSP) 2. Therapy and psychiatric services 3. Co-occurring assessment and referrals 4. Alternative and culturally specific treatment 5. Wrap-around services to children 6. Peer/family supportive services 7. Supports to assist the clients/family to obtain and maintain employment, housing, and/or education and life skills development 8. Case management – Personal Service Coordinator; available 24/7 9. Crisis intervention/stabilization services 10. Non-mental health services (food, clothing, housing supports, supports with cost of health care and co-occurring treatment, respite care) 11. Language capacity/services

Identify Additional FSP Client/Family Resources Needed	General Feedback:
	- Early Psychosis resources are provided by Felton Institute, how can we ensure that providers know?
	- Broaden definition of family to communities of support, providing them with education and supports.
	
	C/Y/TAY Breakout:
	• Community education about SMI and reducing stigma
	• Education for parents on how to advocate for their kids, how to help and connect to resources
		• The following services are contracted out, include separate funding, and provide additional supports for FSP clients, families/communities of support and providers:
		  o Supported education/employment
		  o Early psychosis
		  o Housing units for SMI/SED, peer supports and maintenance
		  o Life skills development
		  o Wellness Centers, Drop-in Centers
		  o Education and outreach for clients, families, and community
		• Interagency collaboration will be an expectation of all contracted providers, to ensure awareness and access to additional supports available to FSP clients; via consults, education and outreach, and other standing committees (e.g. Youth Transition Assessment Committee)

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Recommendation	Workgroup Feedback	How will this be addressed
Support Staff Retention & Appropriate Contractor Rates	General Feedback and Breakouts: - Staffing and contractor rates need to be updated to support all activities - Pay rates and benefits of staff impact whether people feel valued - Need ongoing sustainable plan to renew rates to retain staff - Need recruitment/retention of staff of color and bilingual; including monetary hiring incentives - Improve compensation and benefits for peer supports to increase Peer Staff retention - Need supports for peer staff	• Third Sector's contract will be extended for another 6 months to support appropriate cost modeling for FSPs that considers all existing and any new service expectations including retention needs of clinical and peer staff • BHRS' goal is to conduct RFP processes every three years if possible, for FSP services. Three-year FSP contract terms allow for level-setting FSP rates via the RFP process and aligning FSP cost increases with MHSA budgeting. • Upcoming BHRS workforce strategies will include Student Loan Repayment, Undergraduate Scholarship, Graduate Stipends and Pipeline programs, available to both BHRS staff and contracted providers' staff
Develop Trauma-Informed FSP Providers	General Feedback: - Trauma informed capacity across services provided, data collected and staff supports C/Y/TAY Breakout: - More robust assessment of intergenerational trauma, ACEs, etc. in order to match services to family needs from the start	• BHRS Trauma-Informed Systems training will be expanded beyond BHRS to include (and required of) contracted providers

Prioritize Substance Use Integration	General Feedback:
	- Substance se capacity needs to be strengthened and include education on harm reduction
		• The following will be expectations of FSP providers, per California Institute for Behavioral Health Solutions (CIBHS) recommendations:
		  o Service philosophy - trauma-informed, SU/MH integrated care
		  o Trainings and EBPs - baseline knowledge of co-occurring for all staff, Motivational Interviewing, CBT/DBT, strength-based case management, peer supports, harm reduction, etc.
		  o Assessment tools - to support understanding of SUD and impact on MH (coping vs. causal) and appropriate treatment and referrals (e.g. methadone, harm-reduction, residential tx, etc.)

Recommendation	Workgroup Feedback	How will this be addressed
Strengthen Peer & Family Supports	General Feedback - Peers are an essential service and evidence-based but, there are not enough peer specialists available. - Peer supports for family members of both youth and adults - Provide a wider menu of supports for clients and families/community of support (e.g. motivational interviewing, DBT group, etc.).	• FSP providers will be expected to include an increased role of peers (both for clients and family members of youth and adults) to support care coordination and linkages to additional supports and services. • The MHSA Housing Initiative Taskforce prioritized "peer-led housing locator services" and "outreach and field-based services," to support ongoing and long-term housing retention. The planning for this RFP will begin in 2022 and include input sessions with stakeholders. • Training for peers will be expanded via SB 803 Peer Programs, requires continuing education for certified peers. Separate funding has been identified and can include clients, families/communities of support.
Ensure Housing Access & Retention Services	Adult Breakout: • Housing is a bedrock to recovery, as much as therapy or other clinical svc. • SMC should ensure housing is not impacted by graduation • When in housing; need supports (hoarding, meals, managing budget, weekly cleaning routines, etc.) General Feedback: • Need to identify those at risk for homelessness during transition from foster care, incarceration, armed services, in-patient, family caregivers, or other personal circumstances, etc. • It is difficult to adopt a "housing first" model due to cost of living • Individuals at times are not eligible for vouchers (e.g., due to criminal history); U.S. Dept HUD requirement • FSP housing supports are often the only places available to for clients with complex housing histories.	• Housing transition supports and/or linkages (e.g. to new Housing Locator services) will be an expectation of FSP providers. FSP providers will support clients stepping down to lower levels of care with applying for independent living opportunities (mainstream vouchers or MHSA units); client will be stepped down from FSP and connected to ongoing outpatient treatment. • There will be additional support to FSP providers and clients via the MHSA Housing Initiative Taskforce prioritization of "outreach and field-based services" to support ongoing and long-term housing retention via an occupational therapist and peer team. • FSP clients who are at risk of homeless are identified by the FSP provider and are supported to apply for housing opportunities including linkages to the Human Agency Core Service Agencies once they are closer to becoming homeless or are homeless to see if they qualify for any other housing opportunities (i.e. Emergency Housing Vouchers). o For non-FSP clients, there are programs that help link eligible clients to FSP, including Adult Resource Management, Pathways and Service Connect teams for individuals transitioning out of incarceration. • Explore developing a housing continuum that moves from a Housing First model through Supported Housing training resulting in prioritization of voucher eligibility, through No Place Like Home, HSA Continuum of Care work, new MHSA supported housing (potentially more flexible eligibility requirements), etc.

Recommendation	Workgroup Feedback	How will this be addressed
Incorporate Step Down Services & Guidelines for FSP Programs	General Feedback: - Having a tiered system or step-down services within the FSP program so that client can stay with same provider - Step-down conversations should be wellness-focused and include client defined goals at intake and ongoing (e.g. wellness and recovery-oriented model of providing services) - There needs to be transparency re: goals, goal achievement, timelines in step-down and timely evaluation (life changes too fast, opportunities missed for readiness for next steps, or no recognition that relapse or increased symptoms) - There could be a more formal use of intake and treatment planning assessments (i.e. KET, CANS, ANSA) and discharge planning - Coordination of the entire system for step-down process - hospitals, school system, transitional supports for TAY, etc. need to work together and be fluid, be communicating - Should include benefits (SSI) counseling	• FSP step down options within the FSP programs will be included in FSP RFP's and subsequent contracts; this will require a review of indicators and guidelines for step down. • Step-down guidelines will be developed and include feedback (e.g. wellness, recovery-oriented, timely evaluation, etc.) provided via key interviews, focus groups and the FSP workgroup. • Third Sector consultants will continue to support both step-down requirements and cost-modeling to support this tier of work.
Enhance Ongoing Data Collection and Evaluation	General Feedback - Measuring whole person and whole organization (i.e. FSP providers) wellness is important to know if FSP is working and sustainable - The client and provider interviews were a small sample size; how can we continue conversations? - What if outcomes are not being met, what is the plan for accountability? Need timely evaluation of whether services meet the need	• Annual client/provider interviews will be added as a deliverable of the FSP Annual Report developed by an external evaluation consultant. o This annual evaluation will also integrate continuous improvement findings to ensure timely service adjustments and course corrections are implemented • Third Sector's contract will be extended to support the development of a local data collection plan, which will include program-level, individual-level outcomes, and continuous improvement indicators. This could include exploring how to measure provider wellness. • As part of the Statewide collaborative, San Mateo will continue to work with Third Sector on FSP Program continuous improvement and advocacy to DHCS for data collection improvements

Be the one to help

Mental Health Service Act (MHSA)

Provide input on MHSA Full Service Partnership (FSP) priorities and services!

MHSA prioritizes Full Service Partnership (FSP) services for individuals living with serious mental illness. Join us for a time-limited workgroup to explore FSP priority outcomes and service improvements!

Objectives include:

- Learn about the FSP service model and current evaluation efforts
- Prioritize local FSP outcomes
- Provide input on FSP services for ongoing quality improvement

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

Please contact mhsa@smcgov.org or 650-573-2889, at least 2 weeks in advance, to reserve language services.

DATES & TIME

September 2, 2021 (open to the public)
October 7, 2021 (workgroup only)
November 4, 2021 (workgroup only)

3:00 P.M. - 4:30 P.M.

To join this workgroup, we ask that you:

- Can commit to attending all three (3) meetings.

- Complete this short interest survey https://www.surveymonkey.com/r/MHSAWorkgroup, which includes participant selection guidelines.

- The workgroup will be limited to 10-12 individuals.

www.smchealth.org/MHSA

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

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

Sea la persona que ayude

 Ley de servicios de salud mental (MHSA)

¡Provea sugerencias sobre las prioridades y los servicios del programa de Colaboración de Servicio Integral (FSP) de la MHSA!

La MHSA da prioridad a los servicios del programa de Colaboración de Servicio Integral (Full Service Partnership, FSP) para personas con enfermedades mentales graves. ¡Participe en un grupo durante un tiempo limitado para explorar los resultados y el mejoramiento de los servicios de FSP!

Los objetivos incluyen:

- Aprender sobre el modelo de servicios de FSP y los esfuerzos para evaluar el programa.
- Priorizar los resultados locales de FSP.
- Proveer comentarios sobre los servicios de FSP para mejorar la calidad continua del programa.

✓ Hay estipendios disponibles para clientes o los miembros de su familia.
✓ Se proporcionará interpretación de idiomas conforme sea necesario.*

Comuníquese al 650-573-2889 o en mhsa@smcgov.org, al menos con 2 semanas de anticipación para reservar servicios de ayuda con el idioma.

FECHAS Y HORARIO

2 de sep, 2021 (abierto al público)
7 de oct, 2021 (grupo FSP únicamente)
3 de nov, 2021 (grupo FSP únicamente)

de 3:00 p. m. a 4:30 p. m.

Para formar parte del grupo FSP, le pedimos que usted:

- Se comprometa a asistir a las tres (3) juntas en septiembre, octubre y noviembre.

- Responda a la siguiente encuesta de interés https://www.surveymonkey.com/r/MHSA Workgroup, incluye información acerca de la selección de los participantes.

- El grupo será de 10 a 12 personas.

www.smchealth.org/MHSA

 SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

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

助人為樂

《心理健康服務法》(MHSA)

心理健康服務法 (Mental Health Service Act, MHSA)
的全面合作服務 (Full Service Partnership, FSP) 優先服務
對象及服務內容提出意見！

心理健康服務法（MHSA）中的全面合作服務（FSP）是優先照顧患嚴重精神疾病的個人的服務。加入我們，成立一個臨時工作小組，探討FSP首要之務的成果以及服務改進！

目的包括：

- 瞭解FSP服務模式與現行的評估辦法
- 將當地的FSP成果列為首要目標
- 提出FSP哪些服務有待改進的相關意見，使服務品質不斷進步

✓ 客戶/家庭成員可獲得固定津貼
✓ 如有需要可提供語言翻譯服務*

*若要使用語言服務，請透過*mhsa@smcgov.org*或*650-573-2889*與我們聯絡，至少需提前2週預約。

日期與時間

2021年9月2日 (開放給大眾)
2021年10月7日(僅開放給工作小組)
2021年11月3日(僅開放給工作小組)

下午3:00 - 4:30

加入此工作小組的要求如下：

- 可參加全部三 (3) 次會議。

- 填妥下列這份簡短的意願調查問卷
  https://www.surveymonkey.com/r/MHSAWorkgroup，此問卷內含參加者遴選準則。

- 此工作小組有10-12人的名額限制。

www.smchealth.org/MHSA

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

THIRD SECTOR

Multi-County Full Service Partnership (FSP) Innovation Project

Implementation Report | September 2021

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Executive Summary: Multi-County FSP Innovation Project

Implementing a more uniform data-driven approach to Full Service Partnerships using using one-time CSS unspent funds

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Origins of the Multi-County FSP Innovation Project

The Opportunity for Improvement

California has made significant strides since the creation of the Mental Health Services Act (MHSA). However, client outcomes data and concerns raised by county mental health directors suggests that counties still struggle to achieve the originally intended outcomes of the Full Service Partnership (FSP) program and understand their own impact.

An Initial County Pilot

From 2018 – 2020, the Los Angeles County Department of Mental Health partnered with Third Sector to transform the program into an outcomes-oriented and data-informed FSP that reflects the spirit of "doing whatever it takes."

The Multi-County Collaboration

Six counties -- Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura -- launched the Multi-County FSP Innovation Project to leverage their collective resources and experiences to transform how FSP data is used to continuously innovate and improve FSP services across California. While most counties are using their Innovation Plan funding to support the project, San Mateo County is using one-time CSS unspent funds.

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The Multi-County FSP Innovation Project focuses on five shared goals

Project Goals
Upon completion of the Multi-County FSP Innovation Project, counties will have increased capacity for collecting and using data for FSP services. These improvements will support participating counties' clients in their recovery and improve the statewide system.

1 Develop a shared understanding and more consistent interpretation of FSP's core components across counties, creating a common FSP framework

2 Increase the clarity and consistency of enrollment criteria, referral, and graduation processes through developing and disseminating clear tools and guidelines across stakeholders

3 Improve how counties define, track, and apply priority outcomes across FSP programs

4 Develop a clear strategy for tracking outcomes and performance measures through various state-level and county-specific reporting tools

5 Develop new and/or strengthen existing processes for continuous improvement that leverage data to foster learning, accountability, and meaningful performance feedback

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We are leveraging a multi-stakeholder partnership to accomplish project goals over the course of 4.5 years

2019 — **Phase I Plan:** Counties worked with Third Sector and the MHSOAC to build a new partnership that would encourage peer learning, further improvement to FSPs, and accelerate county collaboration

2020 — **Phase II Landscape:** An 8-month "listening and "learning" (Landscape Assessment) phase allowed us to gather context and feedback from County staff, providers, and consumers

2021 — **Phase III Implement:** 12 months of implementation activities that were informed by a prioritization process that ensures we are meeting government and stakeholder needs

Phase IV Sustain: A 2-month dedicated sustainability period will support counties in cementing collaborative continuous improvement processes

2022

2023 — **Phase V Evaluate:** During the 2.5-year evaluation period, RAND will assess the contributions of this project to statewide learning and improved FSP outcomes

2024

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California's Full Service Partnership (FSP) delivers a "whatever it takes" approach to comprehensive, community-based mental health services

Population

FSP serves over 60,000 individuals and families across California experiencing severe emotional disturbances or serious mental illness.

$ Funding

The County directs the majority of its CSS to fund FSP

Services

FSP providers deliver a diverse range of evidence-based services modeled after ACT and AB2034 (pilot of recovery-oriented approach targeting homeless SMI) including therapy, psychiatric services, peer supportive services, housing services, and a wide range of case management services geared towards developing life skills and coping mechanisms.

Outcomes

As stipulated in the Mental Health Services Act (MHSA) Regulations, FSPs provide **consumer-centric services to achieve goals** identified in individuals' Individual Services and Supports Plans (ISSP).

*California counties are provided **substantial flexibility** in FSP operations, data collection, and approaches. While this local control has supported innovative, community-responsive services, **counties have different operational definitions and inconsistent data processes**, making it **challenging to understand and tell a statewide impact story**.*

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Project counties and the MHSOAC contributed $8.3M of state and local funding to support the multi-year collaboration

Project Roles & Responsibilities

Counties: The participating counties are Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura. Lake and Stanislaus will be joining the project as a Wave 2 in August 2021.

THIRD SECTOR   **Third Sector:** Third Sector is providing project management, outcomes-focused technical assistance, and implementation support.

RAND CORPORATION   **RAND:** RAND is providing data and outcomes technical assistance, data cleaning and quality improvement support, and conducting the overall project evaluation.

CalMHSA   **CalMHSA:** CalMHSA is serving as the project's fiscal intermediary, including contract and fiscal management as well as administrative oversight.

MHSOAC   **MHSOAC:** The CA Mental Health Services Oversight and Accountability Commission (MHSOAC) supported the Innovation planning process as well as the development of statewide project resources and Learning Community events.

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Project Partner: Third Sector

A non-profit advisory firm transforming public systems to advance improved and equitable outcomes

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Third Sector is a non-profit that brings government closer to communities by aligning policy, dollars, data, & services for improved & equitable outcomes

Anatomy of an Outcomes Orientation

*Evaluate the effect of services on outcomes to inform policy decisions, **improving the efficiency and effectiveness** of spending over time*

*Implement policies that link funding to outcomes, providing **increased flexibility and transparency** in spending of taxpayer dollars*

POLICY

DATA

BETTER OUTCOMES

DOLLARS

*Share data to support service delivery focused on outcomes, allowing providers to **align services with the needs of their community***

SERVICES

*Utilize contracts to leverage flexible funding by creating incentives for **coordination, innovation,** and **continuous improvement** in services*

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Third Sector helps government and communities use data and lived experience to strengthen human services and improve lives

Third Sector Engagements

19

Launched Outcomes-focused Contracting Projects

75+

Consulting Engagements

Since 2011, Third Sector has worked with 40+ communities to deploy more than $1.2 billion in government resources toward improved outcomes

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San Mateo County Initiatives & Learnings

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San Mateo County Implementation Activities

San Mateo County Department of Behavioral Health and Recovery Services collaborated with providers to select the following activities to work on during the Multi-County FSP Innovation Project.

ELIGIBILITY CRITERIA

Revise county-specific FSP eligibility criteria to ensure that counties **prioritize FSP services to the highest-need clients**.

SERVICE REQUIREMENTS

Develop **minimum service requirements of FSP to adopt as official guidance**. E.g.: % of field-based services, telehealth options, housing and employment services offered, peer supports available, etc.

STEP DOWN GUIDELINES

Develop **standardized graduation guidelines** to support staff in making individual stepdown and graduation decisions while considering ISSPs and system-wide outcomes. Guidelines include improved definitions of "stability" and discussion prompts.

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San Mateo County Activities and Next Steps

Activities Under Development	What's Next?
Co-creating Child/Youth/TAY FSP Service Exhibit with San Mateo BHRS staff that will become the basis for the new Request for Proposal to procure for Child/Youth/TAY services in the county	**Finalize** Child/Youth/TAY and Adult Service Exhibits and Requests for Proposal
Sharing best practices from Los Angeles County Department of Mental Health to inform the **revised Adult FSP Service Exhibit** that will become the basis for the Request for Proposal to procure for Adult services	Continue **gathering local input** to prioritize local FSP outcomes and provide input on FSP services for ongoing quality improvement
Using **provider and client interview and focus group feedback to inform Service Exhibits** and RFPs	Developed **standardized graduation/ step-down process** that can now be used across all FSP providers in the county
Developing **standardized graduation readiness guidelines** to be used in conjunction with new graduation / step-down process	

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San Mateo County Stakeholder Engagement Overview

Stakeholder Engagement Overview	Engagement Insights
Third Sector interviewed clients and FSP staff at two points: ● **Round 1 (August - September 2020):** to understand FSP programs' strengths & challenges, helping guide the county's selection of implementation activities ● **Round 2 (March - April 2021):** to gain more detailed insights that informed the new service exhibits **Client Engagement Summary:** Third Sector interviewed clients (selected by each FSP program) 1-on-1, over the phone. Clients received a $35+ gift card for participating. Third Sector interviewed 13 clients during the landscape phase and 14 during implementation. **Provider Engagement Summary:** Third Sector interviewed front-line FSP staff in focus groups, speaking to 8 staff during the landscape phase, and 12 during implementation.	**Therapy/psychiatry are not provided in-house and are inconsistently available** Providers refer clients out for therapy, but there is not always someone available at no- or low-cost, or there is a lot of turnover in who a client ends up seeing. **Peer and family advocates are essential for both providers and clients** Peer support is very important to clients, but it's sometimes hard to find true "peers" and/or staff attrition is high due to lack of pathways for career advancement **Graduation/step-down should be discussed earlier and more often** Providers could use more standardization and guidance around graduation readiness and process, while clients wish to be more involved in conversations and decisions about their transition

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Questions & Additional Input

*Any additional feedback on **needed improvements** to mental health services in San Mateo County?*

*Any additional **coordination or support** San Mateo BHRS could be providing mental health service providers or clients?*

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Cohort (Multi-County) Updates

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Cohort Implementation Activities

Over the last 10 months, The six participating counties collaborated to achieve the goals below.

DEFINE FSP POPULATIONS

Standardize definitions of FSP populations (e.g., homeless, justice-involved, high utilizer of psychiatric facilities, etc.)

IDENTIFY OUTCOME & PROCESS METRICS

Identify priority outcomes and process measures, and associated metrics, to track what services FSP clients receive and the success of those services

DEVELOP DCR RECOMMENDATIONS

Develop recommendations for revising Data Collection & Reporting (DCR) forms, metrics, and/or data reports to increase the utility of state data

Overarching Impact: **The cohort solutions will enable counties to better understand who FSP serves and how effective FSPs are at achieving outcomes for those focal populations**

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Cohort Accomplishments and Plans

Accomplishments to Date	What's Next?
Developed operational definitions for the following **FSP sub-populations** and associated "at risk" categories: homeless, justice involved, and high utilizers of psychiatric facilities	Determine a strategy for disaggregating the adult FSP outcome metrics by the key FSP sub-populations and other key demographic categories (race, geography, etc.)
Identified priority adult FSP **outcomes** (see below) and **process measures** (frequency and location of services).	Determine which services counties should track as priority process measures
Developed **outcomes metrics** to track the following outcomes: increased stable housing, reduced justice involvement, reduced psychiatric facility utilization/crisis services, and increased social connectedness	Finalize DCR System Enhancement Recommendations Memorandum
Solicited feedback on the areas for improvement related to the Data Collection and Reporting System **(DCR)** and developed recommendations to improve the user experience and inform future system enhancements	Support RAND & counties to design continuous improvement structures

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Cohort Next Steps

DATA QUALITY IMPROVEMENT

RAND will support counties in improving data quality via monthly check-in meetings, ultimately supporting more real-time programmatic improvement the statewide continuous improvement process.

LEARNING COMMUNITY

All involved counties will finalize shared outcomes and population definitions to use in a statewide FSP Learning Community that will allow county behavioral health agencies to promote statewide improvements and advance collective learning.

EVALUATION

RAND conducts quantitative and qualitative analysis using data from each county and stakeholder interviews. Monthly meetings between RAND, counties, Third Sector and CalMHSA continue through 2024 to share evaluation updates and troubleshoot data challenges.

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Updates from Other Participating Counties

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Fresno County Implementation Activities

Fresno County Department of Behavioral health collaborated with providers to select the following activities to work on during the Multi-County FSP Innovation Project.

REAUTHORIZATION PROCESS

Develop a process in which FSP providers communicate to DBH at regular intervals where FSP clients are in their treatment plans in order to assess reauthorization needs

CHILD REFERRAL & ENROLLMENT

Develop a standardized youth FSP referral and enrollment process with enhanced communication between DBH and contracted providers

DATA COLLECTION & REPORTING

Streamline existing and/or develop new data reports or methods so that DBH and providers can more effectively collect, access, and use FSP data to inform care decisions

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Fresno County Stakeholder Engagement Overview

Stakeholder Engagement Overview	Engagement Insights

Purpose of Engagement:
Third Sector interviewed clients and staff at two points:
- **Landscape Phase** (July - Aug 2020): to understand FSP strengths and gaps, which guided project focus areas
- **Implementation Phase** (Feb - May 2021): to understand caregiver experiences with referrals and get targeted feedback on BHS services to inform new Service Exhibits

Client Engagement Summary:
Third Sector conducted one-on-one phone interviews with **32 clients or caregivers of clients**: 16 interviews during the landscape phase and 16 during implementation. Individuals received $35+ gift cards for participating.

Provider Engagement Summary:
Since July 2020, FSP providers in Fresno County participated in a **digital survey with over 70 responses** as well as **10 focus groups and workgroup meetings** to share their perspectives and help shape the priorities of the Multi-County FSP project, including the redesign of FSP referral and reauthorization procedures and improvements to the county's data sharing practices.

Data Access and Usage
FSP providers have mixed experiences with accessing and using DBH data to make program improvements. DBH staff believe the county's new data dashboard platform will improve both accessibility and usability.

FSP Program Waitlists
Several caregivers of FSP participants pointed to waitlists as a pain point of the referral process. This insight is guiding DBH's commitment to ensure that changes to the county's referral and reauthorization processes improve the waitlist experience.

Data Disaggregation
Providers and DBH staff both want to focus their efforts on high-need areas and high-risk populations and would find it valuable to have client data disaggregated by variables like race, diagnosis, age, etc. to inform FSP improvement efforts.

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Fresno County Accomplishments and Plans

Accomplishments to Date	What's Next?

Accomplishments to Date:
- Developed **new proposed procedures for reauthorizing clients** to receive FSP services and for collecting data on the primary reasons clients participate in FSP
- Developed recommendations to **streamline the Child FSP referral process**
- **Identified high-priority metrics** from both providers and DBH to include in Fresno's new data dashboard platform (Domo)

What's Next?
- **Determine appropriate staffing structures** to support potential changes to Fresno's FSP reauthorization and referral processes
- **Pilot changes to DBH's continuous improvement process** (e.g., new meetings and dashboard utilization practices)
- **Gather and incorporate final input from FSP providers** on continuous improvement process and data dashboard changes

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Sacramento County Implementation Activities

Sacramento County Behavioral Health Services (BHS) collaborated with providers to select the following activities to work on during the Multi-County FSP Innovation Project.

CLIENT STEP DOWN PROCESS

Develop a standardized FSP client stepdown readiness review process, supported by tools that help the County more regularly assess whether a client is ready to step-down while centering client needs and desires.

STEP DOWN GUIDELINES

Develop standardized graduation guidelines to support staff in making individual stepdown and graduation decisions while considering ISSPs and system-wide outcomes. Guidelines include improved definitions of "stability" and discussion prompts.

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Sacramento County Stakeholder Engagement Overview

Stakeholder Engagement Overview	Engagement Insights
Third Sector interviewed clients and FSP staff at two points: • **Round 1:** to understand FSP programs' strengths & challenges, helping guide the county's selection of project focus areas • **Round 2:** to better understand the existing step-down & graduation process, as the county considered changes **Client Engagement Summary:** Third Sector interviewed clients (selected by each FSP program) 1-on-1, over the phone. Clients received a $35+ giftcard for participating. Third Sector interviewed 15 clients during the landscape phase and 17 during implementation. **Provider Engagement Summary:** Third Sector interviewed front-line FSP staff in focus groups, speaking to 8 staff during the landscape phase, and 13 during implementation. **Additionally, 12 director-level FSP staff helped co-create the graduation guidelines** during six, 90-min workgroups. 19 staff, from all levels and programs, gave feedback on the completed guidelines and plans for implementing them.	**Discussions about Graduation** Clients and staff reported that graduation and the temporary nature of FSP services aren't discussed consistently with new clients, and so for some clients later conversations about graduation are a surprise. **Warm Hand-Offs During Step down** Clients and staff value warm hand-offs between FSP and step down programs. Clients want gradual step downs with support from staff they know, while provider staff want the staffing and billing flexibility to offer more of that support. **Client-Staff Relationships** Clients reported making the most progress after they felt connected to staff; many are hesitant to leave FSP, afraid they won't be able to find similar connections with step-down staff. However, some clients struggle in FSP in part because they don't feel staff understand their backgrounds.

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Sacramento County Accomplishments and Plans

Accomplishments to Date	What's Next?
Co-created draft FSP graduation guidelines with provider staff that provider staff & the BHS management team are excited about	Create **graduation guideline reference sheets** for providers, that include discussion prompts they suggested
Developed a training deck to **illustrate the ideal step down process**.	Develop and conduct a **training session for high-intensity provider staff** on the new graduation guidelines
Created a 1-2 year workplan for 3 activities that will **improve the stepdown process** by better incorporating client voice & ensuring more regular review of all client cases	Support BHS on **incorporating the graduation guidelines into policies** and materials

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San Bernardino County Implementation Activities

San Bernardino County Department of Behavioral Health collaborated with providers to select the following activities to work on during the Multi-County FSP Innovation Project.

REFERRAL FORMS & PROTOCOLS

Create a consistent referral process and form across adult FSP programs and develop protocols for FSP referrals between entities that ensure for warm hand-offs

STEP DOWN GUIDELINES

Develop protocols on how to approach step down in a way that is responsive to clients' individual recovery journeys while ensuring that FSPs focus on building the client skills necessary to successfully step down

DATA COLLECTION & REPORTING

Update existing and/or develop new data reports that allow providers and departmental staff to more effectively access and utilize client data to understand outcomes and inform care decisions

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San Bernardino County Stakeholder Engagement Overview

Stakeholder Engagement Overview	Engagement Insights
Client Engagement: Third Sector worked in partnership with Clubhouse & Research & Evaluation staff to interview **24 individuals** receiving services across **4 adult FSP programs**. Third Sector compensated clients for their time with $35+ Visa gift cards. The purpose of these interviews was to seek targeted feedback about what clients' goals are in FSP, what services are most helpful for achieving those goals, and how FSP could better prepare clients to step down. **Provider Engagement:** San Bernardino County embraced a collaborative approach to building solutions in partnership with the provider community. Provider staff and departmental staff jointly participated in Working Groups to build standard referral forms, create step down protocols, and strategize on new data reports. This approach should ensure that the solutions built will effectively meet the needs of both San Bernardino County DBH and the provider community. Third Sector also conducted a focus group with peer staff to obtain their insights on how the step down process could be improved.	**Step down should be discussed early and routinely in a client's FSP journey** Some clients stated that they first discussed step down with their providers a few months before leaving, leading to increased anxiety and unpreparedness for stepping down. Clients who gradually began discussing step down soon after enrollment had the most positive outlook on stepping down. **Additional supports from care teams during step down transitions are very important** Peer staff emphasized the need for care teams to help individuals settle into a new environment and routine before stopping services. This is especially crucial for individuals who need to transition housing during the step down process. **Providers would benefit from more routine data sharing** Providers would benefit from regular outcomes reports to better understand how effective their services are and assess where improvements could be made.

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San Bernardino County Accomplishments and Plans

Accomplishments to Date	What's Next?
Created a standard electronic referral form across all adult FSP specialty programs, streamlining the disparate paper referral forms in circulation	Continue determining the feasibility of **embedding the electronic referral form into AVATAR**
Drafted referral protocols outlining the overall referral process and roles and responsibilities at each step of the process	**Determine an access strategy for external referring sources** that would not have access to the electronic referral form within AVATAR
Drafted step down protocols for each adult FSP specialty program to help care teams balance client needs with a focus on enabling increased independence	**Revise the step down protocols** based on department and provider feedback
Identified outcomes and services data that providers would like to receive on a regular basis	Consult with IT and the Research & Evaluation teams to **determine the feasibility of developing new data reports** that capture relevant outcomes and services data

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Siskiyou County Implementation Activities

Siskiyou County Behavioral Health Services (BHS) collaborated with their provider staff to select the following activities to work on during the Multi-County FSP Innovation Project.

SERVICE GUIDELINES

Develop an FSP Service Exhibit
that includes staffing, caseloads, FSP levels of care, and housing and SUD support guidelines to adopt as official guidance

STEP DOWN GUIDELINES

Define indicators of recovery
(including how those indicators are tracked in data) to lay the foundation for developing FSP graduation criteria

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Siskiyou County Stakeholder Engagement Overview

Stakeholder Engagement Overview	Engagement Insights
Purpose of Engagement: Third Sector interviewed clients and staff at two points: ● **Landscape Phase** (July - Aug 2020): to understand FSP strengths and gaps, which guided project focus areas ● **Implementation Phase** (Mar - Apr 2021): to understand perspectives on recovery and get targeted feedback on BHS services to inform new Service Exhibits **Client Engagement Summary:** Third Sector conducted one-on-one phone interviews with **23 clients**. Third Sector conducted 9 interviews during the landscape phase and 14 during implementation. Clients received $35+ gift cards for participating. **Provider Engagement Summary:** Third Sector conducted 4 focus groups with **30+ staff** over the course of the project. Third Sector will complete a second round of engagement to gather feedback on definitions for and indicators of recovery in September – October 2021.	**Capacity Constraints & Inconsistent Experiences** Clients described inconsistencies in the level of support that they receive and perceived staff as generally overworked. Staff noted that having a new, weighted caseload system. as outlined in the Service Exhibits, will help with these challenges. **Challenges Transitioning to New Care Teams** Staff capacity constraints exacerbated the challenges some clients experience when transitioning to new care team members. Staff see the guidelines outlined in the Service Exhibits as a helpful structure to ensure all clients experience smooth transitions. **Client-Centric, Culturally Responsive Care** Staff believe that BHS' plan to implement Strengths Model Case Management will help make care more culturally responsive and client-centered.

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Siskiyou County Accomplishments and Plans

Accomplishments to Date	What's Next?
Created **Adult and Child FSP Service Exhibits** for BHS to use as official FSP care guidance	**Incorporate new definition and indicators** of recovery into FSP Service Exhibits
Developed a **new tiered system of FSP care** to better serve BHS' highest need clients	**Implement new team meetings** designed to coordinate care for clients in different tiers
Created a **new EHR form** to track changes to clients' FSP tiers while they are in services	**Finalize the process** for assigning and changing client FSP tier designations
Drafted an **initial definition of "recovery"** to guide BHS in transitioning clients out of FSP	**Refine definition of recovery and identify indicators** of recovery for all age groups

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Ventura County Implementation Activities

Ventura County Behavioral Health collaborated with providers to select the following activities to work on during the Multi-County FSP Innovation Project.

ELIGIBILITY GUIDELINES

Revise county-specific FSP eligibility criteria to ensure that counties prioritize FSP services to the highest-need clients.

SERVICE GUIDELINES

Develop minimum service requirements of FSP to adopt as official guidance. E.g.: % of field-based services, housing and employment services offered, peer supports available, etc.

STEP DOWN GUIDELINES

Develop standardized graduation guidelines to support staff in making individual stepdown and graduation decisions while considering ISSPs and system-wide outcomes.

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Ventura County Stakeholder Engagement Overview

Stakeholder Engagement Overview	Engagement Insights
Purpose of Engagement: Third Sector interviewed clients and FSP staff at two points: ● **Landscape Phase** (July - Aug 2020): to understand FSP strengths and gaps, which guided project focus areas ● **Implementation Phase** (Feb - Mar 2021): to inform new guidelines for FSP eligibility, services, and graduation	**Programs could benefit from increased consistency** Specialty FSP programs are better equipped to offer a high level of care, with smaller caseloads and more field-based service capability than clinic-based FSP programs.
Client Engagement Summary: Third Sector conducted one-on-one phone interviews with **32 clients.** Third Sector conducted 19 interviews during the landscape phase and 22 during implementation. Clients received $35+ giftcards for participating.	**Clients would like to access additional services** FSP clients expressed a desire for additional support with employment, housing, transportation, and money management. Providers agreed that they would like more resources to implement these services.
Provider Engagement Summary: Third Sector engaged **35 staff** over the project life cycle. Through focus groups and interviews, Third Sector met with 14 direct-care staff during the landscape phase and 11 during implementation. Additionally, 10 director-level FSP staff co-created eligibility and graduation guidelines in a series of six workgroups.	**Clients and staff develop trusting relationships** While providers are successful at building trusting relationships with their clients, these deep relationships may impede graduation. Many individuals live with trauma and a history of crisis, which makes transitions difficult.

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Ventura County Accomplishments and Plans

Accomplishments to Date	What's Next?
Developed new, clarified guidelines for **FSP services**, including FSP level of care and flex funding access	**Operationalize new service guidelines**, which will involve additional staff hiring and training
Created new guidelines for **FSP eligibility,** building on MHSA-defined criteria with enhanced definitions for focal populations like "homeless" and "high utilizer"	**Integrate with existing data collection**—by modifying referral forms, VCBH can ensure data is available at the time of eligibility decisions, so that focal populations are prioritized for admission to FSP
Created new guidelines for **FSP graduation,** so that programs have a shared standard for "graduation readiness"	**Collect staff feedback** about the guidelines before incorporating them into policy and practice

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info@thirdsectorcap.org | www.thirdsectorcap.org

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What additional feedback, insights, and proposed solutions do you have for BHRS?

1 Select which breakout discussion you would like to join:

Child/Youth/TAY FSP   OR   **Adult FSP**

2 Review the client and provider insights applicable to your breakout room

3 Discuss additional feedback and add it to the stickies on slide 15 or 16:

- *What feedback and insights for FSP service improvement were not captured? What are other gaps in FSP services?*
- *What else should BHRS be thinking about?*
- *How else could the insights be addressed by BHRS and/or FSP providers?*

Child/Youth/TAY FSP breakout room: additional feedback / insights (1/2)

Eligibility Criteria

consideration for intergenerational trauma; screen for ACEs, get a baseline for where the family is at. understand who needs which services at the start and for whom - the whole family needs

Care Coordination

more education with police, other institutions to understand SMI. Educate schools more generally

capacity to flex on hours and meet family needs (before work, etc) & multiple family members (other siblings, etc)

coordination with the providers who are meeting the other needs of the consumer; interconnection with other programs (including early psychosis programs); addressing needs of *whole* person

continued flexibility! That has been great.

Cultural Relevance

especially challenging to retain staff who meet these skills; pipeline challenges here. Need to validate peer supports & ensure compensation & benefits for retention

building natural supports so that then can move on from FSP. Whole person readiness for graduation

building independence of consumer to help themselves (get their own refills, follow up appointments

make sure housing isnt impacted with graduation

Transfer / Graduation

Child/Youth/TAY FSP breakout room: additional feedback / insights (2/2)

Direct service requirements

desire for ongoing dialogue -- BHRS as a conduit, but where is the larger community wrap? break down silos, not BHRS as an intermediary.

peer supports - essential to youth to hear it from someone their age. not be siloed in how that happens

family support group, multiple languages - enhancing natural supports

peer supports - essential to youth to hear it from someone their age. not be siloed in how that happens

therapy

need to beef up capacity for substance use issues

lower caseloads, bigger teams so there is less burnout. absorb the trauma of this work

how to balance family services and the services they do / don't want to the contract/billing challenges?

[Other]

DBT jeopardy! fun ways to learn about DBT for the family; educational opportunities for the family community education around SMI through FSP contract; reducing stigma

pay rates & benefits. impacts whether people feel valued

education on harm reduction

3 year limited term contracts are challenge

community education around SMI through FSP contract; reducing stigma;

education for parents on how to advocate for their kids of all ages

knowing the signs; how to help someone in crisis, bullying. text hotline, resources for their age group

need bandwidth for training, apprenticeship, as a pipeline

recruitment & retention of staff (esp. staff of color, bilingual) -- had to retrain. salary is an issue

things that support people who receive care also support caregivers. employee & client support. work through trauma on both / all sides. "not just a paycheck but an environment. "

Adult FSP breakout room: additional feedback / insights

Eligibility Criteria

- **Don't wait until individuals are homeless or in crisis to connect them to FSP** -- we know mental health varies day to day.
- Limited # of FSP slots by county -- how is this determined?
- If a client is ineligible for FSP, **refer them to other services** where they CAN go.
- Defining "success" for clients is also mediated by culture. Clients probably prefer to receive services from staff who share their culture.
- "Skill-building" can also include rituals and healing practices
- [x]

Cultural Competency

Care Coordination

- Individuals who are at risk of homelessness are **most vulnerable when in transition** (e.g. from foster care, incarceration)
- SMC doesn't have a "housing first" model, and that's a huge loss.
- Case managers can only do so much to prepare clients for housing.
- Individuals who are not eligible for housing vouchers experience added hardship.
- Need better ongoing communication between staff teams and clients
- SUD services cannot be separate
- **Care coordinator** role could do this. Ideally a case manager could play this role, but they don't have capacity.
- To prevent decompensation, some programs are operating multiple levels of care within the same team

Transfer / Graduation

- Stepdown is difficult: how are we measuring success? "Success" can vary a lot and is nonlinear.

Direct service requirements

- **peer therapy +2**
- therapy
- early psychosis
- Can FSP clients have **consultations with their doctors by email**?
- Quality of FSP services also includes food and life skills training
- Clear theme of **scarcity of housing and staff** -- this impacts everything else. Housing is a **bedrock to recovery**, as much of a human need as therapy or other clinical services.
- Contractor rates need to be updated (operating on recession-era rates) -- need a plan in place, so they have more stability
- For next discussion: data (priority outcomes) should capture the individual's understanding / assessment. Could consider getting anonymous client feedback.

Other Issues

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Mental Health Services Act (MHSA)

FSP Workgroup Meeting #2 – 10/7/21

<u>**Summary**</u>

- **What is Full Service Partnership (FSP):**
  - It is a "whatever it takes" consumer-centric approach to supporting clients in achieving their goals as identified in their Individual Services and Supports Plan (ISSP).
  - Services include therapy, psychiatric services, peer supportive services, case management and life skills development.
  - MHSA mandates the majority of Community Services and Supports (CSS) component funds to FSP programs.

- **What is the Multi-County FSP Project:**
  - Statewide collaboration with 6 Counties to share learnings and best practices and provide FSP improvements that are data driven.

- **Stakeholder Engagement to-date:**
  - 13 clients during planning and 14 during implementation
  - 8 provider staff during planning and 14 during implementation
  - Input is informing the new Request for Proposal service exhibit and policies and procedures.

<u>**Larger Group Input**</u>

- **Stakeholder Engagement:** Astounded as small number of individuals sampled. Some family members were interviewed but for the most part all three were living in silos without natural supports. Selected 8 individuals who have ever received services and provided their feedback. Some refused to respond, which is not useful. Can we look beyond the sample? I am connected to families that received FSP services in the past. Many of the issues that existed then still are showing up in this sample. How can we get the real data to move real change?
  - We reached out to a lot more than who we ended up interviewing. There were challenges getting in touch with folks.
  - The work was not meant to be a robust evaluation but about incorporating the voice of consumers and their families in the conversation.
  - While a small sample size, it is a good start and continuous improvement will be part of this process. How can we continue to conversations?
  - Third sectors efforts are a slice of the feedback that is gathered MHSA-wide. This FSP Workgroup is intended to do just this – supplement the input we have received to-date.

- **Early Psychosis Resources:** One of the comments from the FSP providers was that they did not have resources to treat individuals with psychosis. We have early psychosis programs and should have these resources available to the youth and TAY population. Why is this even an issue highlighted? Some staff don't know that Felton Institute exists because it is listed as a deficit.
  - Felton Institute offer (re)MIND and BEAM programs for young adults. Clients from TAY FSP work in collaboration with Felton Institute. For young adults we have the Youth-to-Adult Transition Committee, which includes BHRS, Felton Institute, Edgewood and other partners. There is collaboration amongst the programs. Even though it's a stand-alone service for early psychosis, there is collaboration.

- **Therapy Services:** There was a statement about there not being enough funding in the contract to cover provision of therapy, is that the problem?
    - It's both a funding and contracting issue… it needs to be in the scope and there needs to be funding for it. It is also an issue about staff turnover and having the appropriate funding to retain staff.
    - Individual therapy is something that is consistently provided to youth clients in the FSP programs.
    - Edgewood has embedded clinicians, psychiatrist and nurse practitioners in-house. Is some of this feedback about access related to contracting amounts to be able to retain clinicians and/or hire psychiatrists.
    - By having these resources, I can function well and contribute to my community… the more resources, the more feedback we get from clients that can provide it.
    - My son has been in and out of FSP programs and he has never had a therapist available to him. The bulk of people in FSP do not have therapy available to them and it puts a burden on medication alone, given by a doctor who sees a client for 10 minutes once a month. The notion of FSP has a long way to go to live up to the meaning of the term. We have to find a way to create opportunities to evidence-based services. Why can't we find the way to adequately fund this program?

- **Peer Support Services:** This is absolutely essential service, it is evidence-based, and it does not have a huge price tag but there are not enough peer specialists available to families. The turnover is high because they are paid so little and have little job security, of course they will move on. We need to fund our contractors appropriately or we will not have continuity and expertise of years in serving. This is not an equity approach to both those providing the care and receiving the care.

- **Nutrition Services:** There are effective, low-cost services that are proven to positively impact depression and other mental health outcomes including nutrition, physical activity, EMDR. It is a small investment that can have a big impact

Multi-County Full Service Partnership (FSP) Innovation Project

Outcomes Feedback | November 2021

Agenda

Recap: What is FSP and the Multi-County Innovation Project

Program level outcomes (cross-county)

Individual level outcomes (step-down readiness indicators)

What's next

California's Full Service Partnership (FSP) delivers a "whatever it takes" approach to comprehensive, community-based mental health services

Population

FSP serves over 60,000 individuals and families across California experiencing severe emotional disturbances or serious mental illness.

Funding

The County directs the majority of its CSS to fund FSP

Services

FSP providers deliver a diverse range of evidence-based services modeled after ACT and AB2034 (pilot of recovery-oriented approach targeting homeless SMI) including therapy, psychiatric services, peer supportive services, housing services, and a wide range of case management services geared towards developing life skills and coping mechanisms.

Outcomes

As stipulated in the Mental Health Services Act (MHSA) Regulations, FSPs provide consumer-centric services to achieve goals identified in individuals' Individual Services and Supports Plans (ISSP).

*California counties are provided **substantial flexibility** in FSP operations, data collection, and approaches. While this local control has supported innovative, community-responsive services, **counties have different operational definitions and inconsistent data processes**, making it **challenging to understand and tell a statewide impact story**.*

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Project counties and the MHSOAC contributed $8.3M of state and local funding to support the multi-year collaboration

Project Roles & Responsibilities

Counties: The participating counties are Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura. Lake and Stanislaus will be joining the project as a Wave 2 in August 2021.

Third Sector: Third Sector is providing project management, outcomes-focused technical assistance, and implementation support.

RAND: RAND is providing data and outcomes technical assistance, data cleaning and quality improvement support, and conducting the overall project evaluation.

CalMHSA: CalMHSA is serving as the project's fiscal intermediary, including contract and fiscal management as well as administrative oversight.

MHSOAC: The CA Mental Health Services Oversight and Accountability Commission (MHSOAC) supported the Innovation planning process as well as the development of statewide project resources and Learning Community events.

Today we will discuss and get feedback on how FSP success is tracked, on both a program level and individual client/family level

FSP Programs

Individual FSP Clients

FSP Program-Level Outcomes

- Ways to measure the level of success and impact of FSP programs, and the communities they serve, on a whole
- Grounded in measures and data that is currently collected / tracked across FSP programs in all counties

FSP Individual-Level Outcomes

- Ways to measure when each individual client (and family) has achieved success in their FSP program and are ready to step-down to a different level of care

Agenda

Recap: What is FSP and the Multi-County Innovation Project

Program level outcomes (cross-county)

Individual level outcomes (step-down readiness indicators)

What's next

The six counties on this project met for a "cohort" workgroup to define outcomes that can be used to compare FSP impact

Goal: *Improve counties' ability to compare outcomes achievement by developing a shared vision and definitions for specific FSP outcomes, and use these new measurements compare program-level outcomes, learn from each other as counties, and share best practices*

Progress

- Prioritized adult FSP outcomes to understand program-level impact of FSP
- Developed metrics that use existing datasets to track these outcomes and services

Utilization Plan & Next Steps

- **RAND Evaluation:** Counties will pull and share outcomes and services data with RAND twice during 2022 (once by end of January and once by end of July) in order for RAND to conduct an evaluation

- **County Continuous Improvement:** Counties will utilize the same data to develop routine data reports that can be used for continuous internal and cross-county learning

- **Develop Child FSP Program-Level Outcomes:** Additional counties have joined this statewide collaboration and will work to define Child FSP program-level outcomes in 2022-23

Counties selected program-level outcomes that could be measured using existing shared datasets

Counties only share two types of data sets:
1. the state-required Data Collection and Reporting (DCR) system, and
2. Electronic Health Records (EHRs).

Counties have chosen to adopt other additional systems voluntarily. San Mateo, for example, has also adopted CANS, the LOCUS, and the PSC-35.

Tool	Counties	Purposes	
DCR Forms (PAF, KET, 3M)	All six	State Reporting	Outcomes Reports
CANS (Child)	All six	Outcomes Reports	Treatment Planning
LOCUS	Sacramento San Mateo	Outcomes Reports	Treatment Planning
PSC-35 (Child)	San Mateo Ventura	Treatment Planning	Caregiver Assessment

The goal when selecting the shared program-level outcomes on the next slide was to use existing datasets to avoid adding more reporting burden for providers.

Given these constraints, the following Adult program-level outcomes were agreed upon by the Cohort Working Group

Increased stable housing [Source: DCR]	**A)** The number of days that each FSP participant experienced (i) stable housing, (ii) temporary housing, and (iii) unstable arrangements during the previous 12-month period. **B)** The number of times that each FSP participant experienced unstable housing/homelessness during the previous 12-month period.
Reduced justice involvement [Source: DCR]	**A)** Whether each FSP client was incarcerated (yes/no) over the previous 12 months **B)** The number arrests that each FSP client experienced during the previous 12 months
Reduced utilization of psychiatric facilities [Source: DCR and/or EHR Systems]	*Measure #1: Reduced Psychiatric Admissions* **A)** The number of days hospitalized that each FSP participant experienced during the previous 12-month period—in both psychiatric hospitals and general hospitals receiving psychiatric care. **B)** The number of psychiatric admissions that each FSP participant experienced during the previous 12-month period—in both psychiatric hospitals and general hospitals receiving psychiatric care. *Measure #2: Reduced CSU Admissions* The number of Crisis Stabilization Unit admissions that each FSP participant experienced during the previous 12-month period.
Increased social connectedness [Source: 3M in DCR]	Counties to add the following 1-item measure to their 3M: "How often do you get the social and emotional support that you need?" Response options: always, usually, sometimes, rarely, never.
Frequency and location of services [Source: EHR]	Number of each service each client received: Individual Therapy, Group Therapy, Rehab Services, Medication Management, Case Management, Housing Services (for counties able to track)

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San Mateo has flexibility in how these program-level outcomes are used locally. We'd like your feedback:

Are there additional program-level measures of success that BHRS/providers should examine to understand program trends and outcomes?

How might you adopt the existing adult-focused measures for a child/youth conversation?[1]

[x]   [x]

[x]   [x]

[x]   [x]

[x]   [x]

(1) The Cohort Working Group focused on program level outcome measures for Adult FSP programs and clients. The next year it will revisit the list with a focus on Child/Youth/TAY FSP programs and clients.

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Agenda

Recap: What is FSP and the Multi-County Innovation Project

Program level outcomes (cross-county)

Individual level outcomes (step-down readiness indicators)
- *Child/Youth/TAY breakout room*
- *Adult FSP breakout room*

What's next

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San Mateo BHRS is choosing individual level outcomes to measure when clients have achieved both "stability" and "recovery"

Definitions adopted from CIBHS

Stability is...

- The **absence of negative outcomes** (i.e. don't require inpatient hospitalization, no longer homeless)

- An important milestone, but **not necessarily a sufficient outcome to discharge a person** from services

Recovery is...

- **Proactive movement toward the life a person wants to lead**, which includes the ability to formulate and take action steps toward improving areas that are important in their life

- A highly individualized term that denotes **both the end results that the person is seeking and the journey** the person is taking to move toward their desired future

- Recovering a **sense of self, identity, and power in life**

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Which individual level outcomes should be used to determine readiness to step-down from FSP for Adults

Adult

- has benefits in place
- has structure in their daily life
- school attendance and performance
- has insight into their mental illness
- compliant with medication
- no complex needs
- keeps appointments without help
- gainfully employed
- engaged in treatment
- engaged with justice systems processes
- additional indicators

- no longer needs intensive services
- stably housed
- meets treatment goals
- no psychiatric inpatient stays
- client's buy-in
- no incarcerations w/in past 6 months
- has adequate resources
- has social support
- reduced self-harm
- independent
- stable behaviors & symptoms
- Setting self-identified goals

Discussion: How do we ensure that clients feel included and comfortable with conversations about step down?

Notes:

Initial BHRS brainstorm of which individual level outcomes to use to determine readiness to step-down from FSP for C/Y/TAY

C/Y/TAY

Child/Youth

School attendance and performance

family functioning | socio- emotional progress | family support in place

family engaged with child welfare process

stably housed | client's buy-in

reduced self-harm | stable behavior and symptoms

meets treatment goals | engaged in treatment

engaged with justice systems processes

has social support / network | employed or engaged in education/ training

independent | has adequate resources

TAY

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What changes/additions would you make to the individual level outcomes that should use to determine when FSP services are no longer needed for Child/Youth FSP clients?

Child/Youth

School attendance and performance

family functioning

socio- emotional progress

family support in place

family engaged with child welfare process

[new]

[new]

[new]

[new]

[new]

Notes:

What changes/additions would you make to the individual level outcomes that should use to determine when FSP services are no longer needed for Child/Youth FSP clients?

TAY

independent

has adequate resources

has social support / network

employed or engaged in education/ training

[new]

[new]

[new]

[new]

[new]

Notes:

What changes/additions would you make to the individual level outcomes that should use to determine when FSP services are no longer needed for Child/Youth FSP clients?

Child/Youth & TAY

stably housed

client's buy-in

reduced self-harm

stable behavior and symptoms

meets treatment goals

engaged in treatment

engaged with justice systems processes

[new]

[new]

[new]

[new]

[new]

Notes:

Discussion: How do we ensure that clients and families feel included and comfortable with conversations about step down?

Notes:

Agenda

Recap: What is FSP and the Multi-County Innovation Project

Program level outcomes (cross-county)

Individual level outcomes (step-down readiness indicators)

What's next
- *December (date TBD):* **Optional MHSA workgroup meeting**
  Topic: **30 min. meeting to review how feedback is being addressed**

Appendix

Third Sector is a non-profit that brings government closer to communities by aligning policy, dollars, data, & services for improved & equitable outcomes

Anatomy of an Outcomes Orientation

*Evaluate the effect of services on outcomes to inform policy decisions, **improving the efficiency and effectiveness** of spending over time*

*Implement policies that link funding to outcomes, providing **increased flexibility and transparency** in spending of taxpayer dollars*

POLICY

DATA

BETTER OUTCOMES

DOLLARS

SERVICES

*Share data to support service delivery focused on outcomes, allowing providers to **align services with the needs of their community***

*Utilize contracts to leverage flexible funding by creating incentives for **coordination**, **innovation**, and **continuous improvement** in services*

Third Sector helps government and communities use data and lived experience to strengthen human services and improve lives

Third Sector Engagements

19 Launched Outcomes-focused Contracting Projects

75+ Consulting Engagements

Since 2011, Third Sector has worked with 40+ communities to deploy more than $1.2 billion in government resources toward improved outcomes

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San Mateo has flexibility in how these program-level outcomes are used locally. We'd like your feedback:

Are there additional program-level measures of success that BHRS/providers should examine to understand program trends and outcomes?

How might you adopt the existing adult-focused measures for a child/youth conversation?[1]

Vocational development and vocational outcomes; evidence-based workforce training / services

Better definition of what "social supports/social connectedness" means

Whole-person care and impacts of that - length of life, quality of life, cost on healthcare

Greater focus on education support and education outcomes

Cohesiveness of FSP system and and juvenile justice system

A measure for whole health/wellness for clients; whole-person care of clients

Wellness / functioning of organization providing services (i.e. retention, staff satisfaction, etc.)

Client's own understanding about how they are doing / how they are progressing

Cohesiveness of FSP system and educational system; capacity of FSP providers to engage with school system

Accountability for providing 24/7 support and support for loss of social connectedness

What is the system of checks, balances and accountability if measures are not being met?

Gauging if MH stigma is being reduced in the community

Connection to other elements of C/Y/TAY care team

(1) The Cohort Working Group focused on program level outcome measures for Adult FSP programs and clients. The next year it will revisit the list with a focus on Child/Youth/TAY FSP programs and clients.

Which individual level outcomes should be used to determine readiness to step-down from FSP for Adults

Adult

no incarcerations w/in past 6 months

has benefits in place

reduced self-harm

school attendance and performance

stable behaviors & symptoms

compliant with medication

no complex needs

keeps appointments without help

gainfully employed

engaged in treatment

no longer needs intensive services

engaged with justice systems processes

no psychiatric inpatient stays

independent

has structure in their daily life - something they are engaged in (art class, library, clubhouse). activities

Meets treatment goals: all the systems that are supporting the client feel that the client is ready. includes the client, case manager, social support system, psych team

client's buy-in -- need this. can people do their own self assessment and decide that they are ready (or not)

has social support through peers and supporting others, whether thru clubhouse, etc. hearing from other peers

Insight into their mental illness / independence: self motivation; readiness to change; willingness to use information

has adequate resources (what does adequate mean)? but do they have benefits, social supports, primary care, etc. should be in place

Has self-identified goals/purpose: spending thor time on things that are meaningful to them

a definition and a sense of self that's not just i am mentally ill. purpose gives a sense of identity

safety net - period of time where someone can be stepped back up, so that if someone needs services they can step back up

built trusting relationship with therapist

obtaining collateral info from the family about what's going on

Stable housing: type of housing, programs supporting with applications, vouchers, subsidies. is someone engaging in that process

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Discussion: How do we ensure that clients feel included and comfortable with conversations about step down?

- Whatever the method is, do it routinely and consistently.
  - Ongoing convo about how the client is doing, engaging in treatment and how they think the services is going.
  - How we adjust to that along the way, i.e. feedback-informed treatment
  - How does the client feel like the provider is supporting them?
- Starts the moment that they enter the program → What goals would you like to achieve? How are you doing with your goals? Talk about the readiness for next steps right from the beginning. It's an open conversation from the start.
- Self-assessment tool for the client to understand their own progress
- Have conversations with clients
- Coordinate and build out services to be consistent; review contracts to ensure that we are getting what we are asking for, including regular conversations with clients
- Some people may ask to get out of the program even if they are not ready. Can the specialists look into the case and give them support; build a relationship to convince the person to keep trying towards their goals

Other Notes:
- Tiered system where client can stay with same provider is better than transitioning agencies
- No tool exists to measure all of these things -- this is a starting point statewide
- What are we stepping down to?
  - Moving from multiple touchpoints a week to ~one per week
  - Concern around conservatorship for example → independence; this is a slightly different situation but could imagine this could occur
- FSP can't be successful unless the rest of the system can coordinate to make things happen. E.g., if someone needs hospitalization for stabilization, hospital needs to be willing to coordinate to keep someone there for 2 weeks if that's what's needed, not just 3 days.
  - Client centered, client outcomes focused, not just cost savings, etc.
  - Entire system needs to work together and be fluid, be communicating
- Goes beyond just client buy-in and WRAP plan → how does someone take what they've learned, embrace it, make it their own, and carry it forward
- If there is a contractual shortcoming, look at the root cause as to why. if agency is struggling to get nursing staff on board, looking at it as a system issue; "why"

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Initial BHRS brainstorm of which individual level outcomes to use to determine readiness to step-down from FSP for C/Y/TAY

C/Y/TAY

Child/Youth

School attendance and performance

family functioning

socio- emotional progress

family support in place

family engaged with child welfare process

stably housed

client's buy-in

reduced self-harm

stable behavior and symptoms

meets treatment goals

engaged in treatment

engaged with justice systems processes

has social support / network

employed or engaged in education/ training

independent

has adequate resources

TAY

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What changes/additions would you make to the individual level outcomes that should use to determine when FSP services are no longer needed for Child/Youth FSP clients?

Child/Youth

School attendance and performance

health of family

family functioning

socio- emotional progress

family support in place

family engaged with and knowing how to navigate child welfare, juvenile justice, and/or county mental health process

ability to manage crises, have a safety plan

developing own natural support system (child and/or family)

Notes:
- School attendance and performance
  - What about children who are not going to school?
  - Measure should not be yes/no, but be able to measure actual engagement, involvement, and performance (i.e. staying the the classroom, learning is happening)
  - How to take into consideration a school systems or classrooms readiness for children with FSP needs? -- FSP and educational systems are not structured to work well together
- Whole family if affected when child is ill so measure of how family is learning how to support their child
  - Parent and other siblings need to be considered

What changes/additions would you make to the individual level outcomes that should use to determine when FSP services are no longer needed for Child/Youth FSP clients?

TAY

independent

has adequate resources

has social support / network

employed or engaged in education/ training

manage own mental health and psychiatric needs

hopefulness (for future)

natural supports (esp. around housing
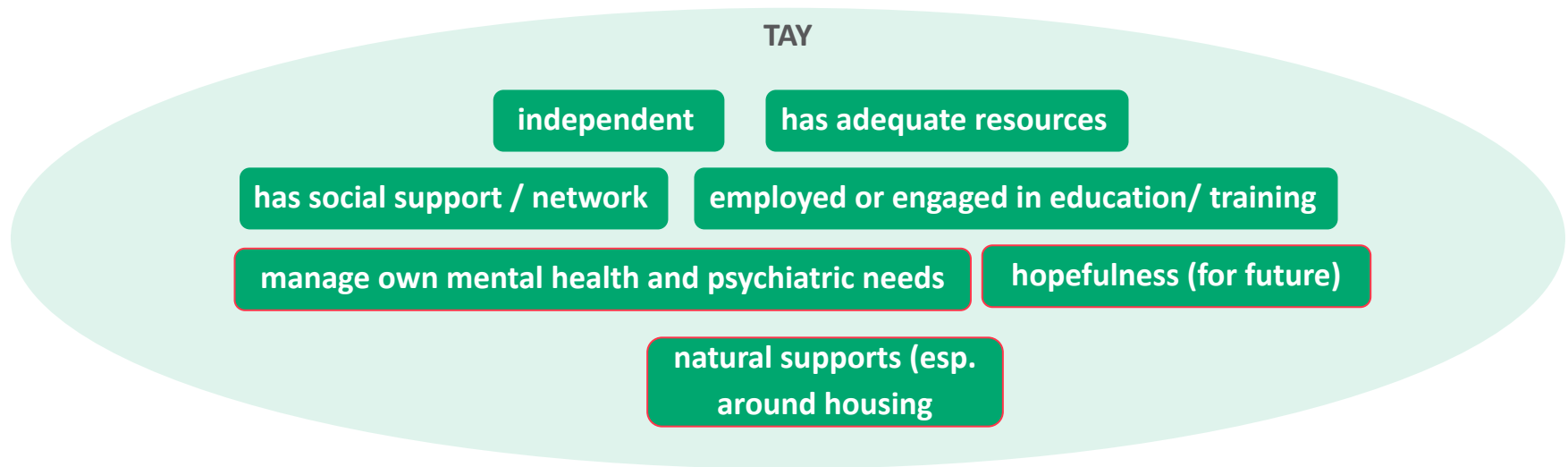
Notes:
- TAY might need more time to achieve stability, i.e. moving from foster care to own housing
- Intergenerational trauma and its connection to lack of hopefulness
- When TAY are discharged from hospital and home is not an option, struggle to find housing placement (i.e transitional housing)

What changes/additions would you make to the individual level outcomes that should use to determine when FSP services are no longer needed for Child/Youth FSP clients?

Child/Youth & TAY

stably housed

client's buy-in

reduced self-harm

meaningfully engaged in treatment

stable behavior and symptoms

meets treatment goals

engaged with justice systems processes

Sufficient time since last crisis

ability to manage crises, have a safety plan

Families able to recognize and manage crises

Peer support in place, i.e. family and child support networks from other C/Y/TAY families
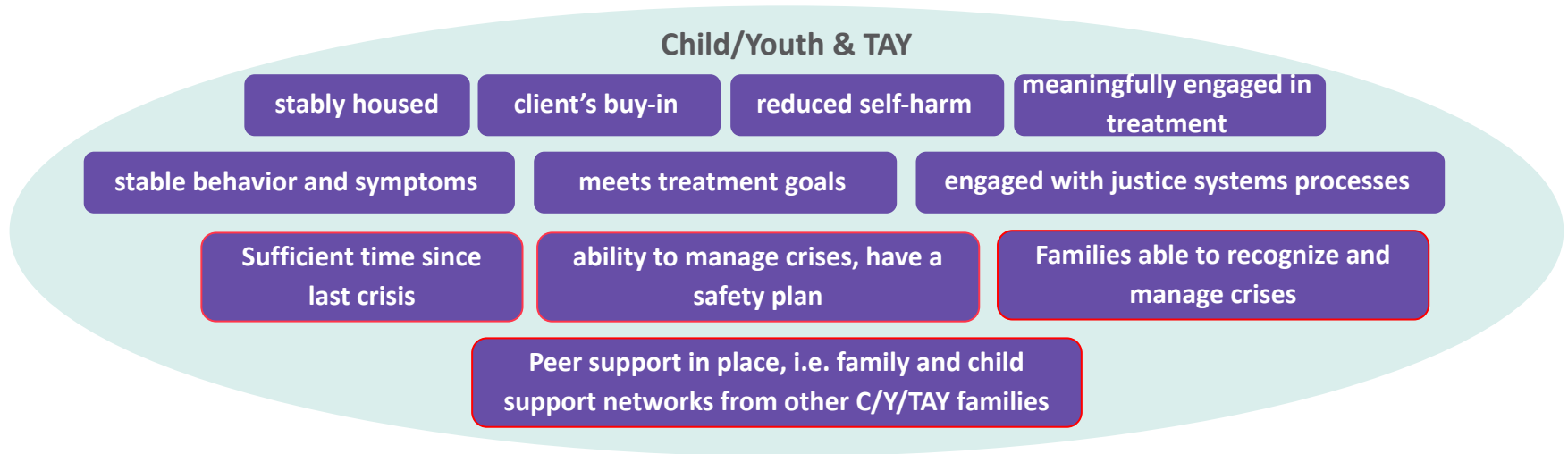
Notes:
- Minimum level of maturity / ability to problem solve under stress and if they are to ever be in crisis again
- Mental health / first aid training should be required → the outcome of which would be families that are able to navigate their child's crisis and know what to do (i.e. recognize and be able to manage at home)
  - More community education and training around mental health challenges that FSP individuals face
- Ability to provide step-down services within their FSP program, i.e. pull out pieces one team member at a time and step people down before they graduate all within the same program / agency
  - Challenging to do right now because contracted to provide a certain number of services / hours per month
- Key Event Tracker (KET) - the concept behind this form is really good
- Is there way to more formally connect CANS and ANSA to treatment goals and determining when it's time to start stepping down?
- Involving families in step-down process piece by piece +1
- Peer support for families of C/Y/TAY FSP clients to provide normalcy for kids and parents; getting to know people in similar life situations; self-built support networks from within FSP
  - So that there is a pool of people with shared experience after step-down / graduation

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Discussion: How do we ensure that clients and families feel included and comfortable with conversations about step down?

Notes:
- Describing and promoting wellness model, as opposed to medical model +1
  - Quality of life indicators
- Giving a sense of what wellness looks like so they have an idea of what the goal is
- Be clear about what is happening during the step-down process and what does it look/feel like -- need to mitigate some of the fear and retriggering that sometimes happens around this
  - WHat will still be available
  - Making more things available
  - Being flexible about that process
- benefits counseling
- Having every component in place (housing, medical, etc.) so someone can transition off
- Need to be capturing trauma at intake to support if a client may need longer time to heal

APPENDIX 5. MHSA FUNDING SUMMARY

MHSA FY 22-23
Programs Budget

Service Category	Community Services and Supports (CSS)		
	Program	BHRS Staff/Agency	FY 22-23 Amount
Full Service Partnership (FSP)	**Children and Youth (C/Y)**		
	Integrated SAYFE	Edgewood + MediCal match	$2,161,874
	Comprehensive C/Y "Turning Point"	Edgewood + MediCal match	$2,943,639
	Out-of-County Foster Care	Fred Finch	$235,995
	Transition Age Youth (TAY)		
	Enhanced Education (TAY)	Caminar	$204,284
	Comprehensive TAY "Turning Point"	Edgewood + MediCal match	$3,157,836
	Adult & Older Adult		
	Adult and Older Adult FSP	Telecare + MediCal match	$2,948,929
	Adult and Older Adult FSP	Caminar + MediCal match	$812,424
	Assisted Outpatient Tx (AOT) FSP	Caminar + MediCal match; BHRS	$1,713,132
	Embedded South County FSP	Mateo Lodge	$131,188
	Housing Supports		
	TAY Supported Housing	Mental Health Association	$421,607
	Telecare Adult and Older Adult FSP Housing	Telecare	$1,814,682
	Caminar FSP/AOT Housing Support Program	Caminar	$564,696
	Board and Care	Various	$2,200,000
	Adult/Older Adult Supported Housing Services	Mental Health Association	$298,992
		TOTAL FSP	**$19,609,278**
General System Development (GSD)	**Co-Occurring Integration**		
	Co-Occurring Service Integration	Various	$407,823
	Co-Occurring Residential	Advent Group Ministries	$50,000
	Recovery Support Services	VoR, StarVista (Girls Program)	$164,591
	Co-Occurring Providers	Lea Goldstein, Brian Greenberg	$31,106
	Co-Occurring Staff	BHRS Staff	$282,156
	Coastside Multicultural Wellness (80%CSS)	El Centro	$44,000
	Older Adult System of Care		
	OASIS	BHRS Staff	$1,044,408
	Senior Peer Counseling (50% CSS)	Peninsula Family Services	$176,847
	Criminal Justice Integration		
	Pathways, Court Mental Health	BHRS Staff; MHA	$190,971
	Criminal Justice Restoration and Diversion	BHRS Staff	$250,000
	Pathways, Housing Services	Life Moves	$119,600
	Juvenile Girls Program	StarVista	$64,439
	Other System Development		
	Child Welfare Partners Program; Pre-to-Three	BHRS Staff	$594,646
	Puente Clinic	BHRS Staff	$371,805
	Trauma-Informed Interventions (NMT)	Various; MHA	$211,000
	EBP Clinicians	BHRS Staff	$1,533,166
	School-based MH	BHRS Staff	$500,000
	Crisis Coordination	BHRS Staff	$76,167
	Peer and Family Partner Support		
	Peer Workers and Family Partners	BHRS Staff	$1,763,627
	OCFA Stipends	MHA; BHRS	$35,000
	Multicultural Wellness Center	One EPA	$208,272
	Peer Support	Heart and Soul	$530,071
	The California Clubhouse	California Clubhouse	$344,250
	Primary Care Integration		
	Primary Care Interface (20% CSS)	BHRS Staff	$256,887
	Total Wellness	BHRS Staff	$750,000
	Infrastructure Strategies		
	IT and Support Staff	BHRS Staff	$1,033,310

	Communications support	Various	$75,000
	Contractor's Association	Caminar	$111,858
	CSS Evaluations	AIR, PWA, AHDS	$152,409
	CSS Planning	RDA, J. Davila	$84,260
	CSS Admin	BHRS Staff	$954,942
		TOTAL GSD	$12,412,611
Outreach and Engagement (O&E)	Family Assertive Support Team (FAST)	Mateo Lodge	$325,732
	Coastside Multicultural Wellness (80%CSS)	ALAS	$316,000
	Adult Resource Management (ARM)	new priority for MHSA	$1,720,650
	Housing Locator, Outreach and Maintenance	TBD	$1,075,000
	HEAL Program - Homeless Outreach	TBD	$325,000
	SMC Pride Center (35% CSS)	StarVista	$245,000
	Ravenswood Family Health Center (40% CSS)	Ravenswood	$18,082
		TOTAL O&E	$4,025,464
		GRAND TOTAL CSS	$36,047,352
		Percent FSP (51% required)	54%
		Percent CSS of Total Budget	76%

Workforce Education and Training (WET)		
WET (annual transfer from CSS)	Training Contracts, BHRS Staff	500,000

Capital Facilities and Technology Needs (CFTN)		
CFTN (annual transfer from CSS)	Various	330,000

Prevention and Early Intervention (PEI)			
Service Category	Program	BHRS Staff/Agency	Amount
Prevention & Early Intervention Ages 0-25	Early Childhood Community Team (ECCT)	StarVista	$455,742
	Community Interventions for School Age & TAY		
	Project SUCCESS	Puente de la Costa Sur	$314,944
	Trauma-Informed Co-Occurring	Latino Commission; Puente; StarVista; YMCA	$380,000
	Trauma-Informed Systems	First5 SMC; Consultant	$150,000
	Youth Crisis Response and Prevention	StarVista	$942,039
	Early Psychosis	Felton Institute	$615,389
	Health Ambassador Program - Youth	StarVista	$257,500
	Access & Linkage to Treatment (50%)	Various	$1,175,026
	Prevention, Stigma Discrimination (50%)	BHRS Staff	$811,904
		TOTAL Ages 0-25	$5,102,544
Prevention	Community Outreach, Engagement and Capacity		
	Office of Diversity and Equity	BHRS Staff	140,565
	Health Equity Initiatives	Co-chairs; BHRS Staff	$161,274
	Health Ambassador Program	BHRS Staff	$152,476
Recognition of Early Signs of MI	Adult Mental Health First Aid	OneEPA, PCRC, StarVista, HOPE	$71,869
Stigma Discriminaiton and Suicide Prevention	Digital Storytelling and Photovoice	BHRS Staff	$62,948
	Mental Health Awareness; Be the ONE	BHRS Staff; CalMHSA	$147,321
	SMC Suicide Prevention Committee	BHRS Staff; CalMHSA	$147,321
Early Intervention	SMART	American Med Response West	$149,350

MHSA FY 22-23
Programs Budget

	Primary Care Interface (80% PEI)	BHRS Staff	$411,019
	Early Psychosis	Felton Institute	$263,738
Access & Linkage to Treatment	Ravenswood Family Health Center (60% PEI)	Ravenswood	$27,122
	North County Outreach	HealthRight 360	$116,975
	East Palo Alto Outreach	One EPA	$110,046
	Coastside Community Engagement (20%PEI)	ALAS; YLI	$44,977
	SMC Pride Center (65% PEI)	StarVista	$318,500
	Senior Peer Counseling (50% PEI)+ OA Outreach	Peninsula Family Service	$326,847
	PEI Admin	BHRS Staff + S&S	$860,917
	PEI Planning + Eval	RDA, AHDS	$272,760
		TOTAL	$3,786,024
		GRAND TOTAL PEI	$8,888,568
		Percent Ages 0-25 (51% required)	57%
		Percent PEI of Total Budget	**19%**

INNOVATIONS			
	Social Enterprise	Daly City Partnership	$590,251
	PIONEERS	TBD	$280,000
	Co-location of PEI in Low-income Housing	TBD	$280,000
	INN Evaluation	RDA	$87,000
		TOTAL INN	$1,237,251

Obligated Funds			
		FY 21-22	FY 22-23
	Total Reserve (Prudent + Operational)	$24,690,444	$24,690,444
	INN (5% of revenue)	$2,469,044	$2,317,234
	INN Ongoing	$6,590,881	$6,562,424
	Updated One-Time Spend Plan	$6,947,915	$1,539,000
	New One-Time Spend Plan	$11,727,000	$5,751,000
	Unencumbered Housing Funds	$97,088	$57,088
	WET Ongoing	$500,000	$500,000
	TOTAL	$53,022,372	$41,417,190

GRAND TOTAL Budget (CSS+WET+PEI+CFTN)	$45,765,920
(OneTime+INN)	$54,350,259

FY 2022/23 Mental Health Services Act Annual Update
Funding Summary

County: San Mateo   Date: 3/1/22

	MHSA Funding					
	A	**B**	**C**	**D**	**E**	**F**
	Community Services and Supports	**Prevention and Early Intervention**	**Innovation**	**Workforce Education and Training**	**Capital Facilities and Technological Needs**	**Prudent Reserve**
A. Estimated FY 2022/23 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	28,352,592	8,312,558	8,039,335	1,427,005	3,499,883	0
2. Estimated New FY 2022/23 Funding	37,984,264	9,496,066	2,498,965	0	0	0
3. Transfer in FY 2022/23[a/]	0	0	0			0
4. Access Local Prudent Reserve in FY 2022/23	0	0	0	0	0	0
5. Estimated Available Funding for FY 2022/23	66,336,856	17,808,624	10,538,300	1,427,005	3,499,883	0
B. Estimated FY 2022/23 MHSA Expenditures	39,844,460	9,969,567	1,731,512	1,014,000	2,261,000	0
G. Estimated FY 2022/23 Unspent Fund Balance	26,492,396	7,839,057	8,806,788	413,005	1,238,883	0

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2022	8,879,780
2. Contributions to the Local Prudent Reserve in FY 2022/23	0
3. Distributions from the Local Prudent Reserve in FY 2022/23	0
4. Estimated Local Prudent Reserve Balance on June 30, 2023	8,879,780

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 2022-23 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: San Mateo

	Fiscal Year 2022-23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Children and Youth	5,341,508	4,763,508	578,000	0	0	0
2. Transition Age Youth	3,362,120	2,937,120	425,000	0	0	0
3. Adults and Older Adults	5,605,673	4,908,673	697,000	0	0	0
4. Housing Initiative	5,299,977	5,192,045	0	0	0	0
5. Housing Initiative (One-Time Spend Plan)	100,000	100,000	0	0	0	0
	-		0	0	0	0
	-		0	0	0	0
	-		0	0	0	0
	-		0	0	0	0
	-		0	0	0	0
Non-FSP Programs			0	0	0	0
1. Older Adult System of Care	1,441,081	1,221,255	219,826	0	0	0
2. Criminal Justice Integration	700,011	625,010	75,001	0	0	0
3. Co-Occurring Services	1,097,237	979,676	117,561	0	0	0
4. Other System Development	4,075,612	3,286,784	788,828	0	0	0
5. Peer and Family Supports	3,428,652	2,881,220	547,432	0	0	0
6. Primary Care Integration	1,006,887	1,006,887		0	0	0
7. Infrastructure Strategies	1,220,168	1,220,168		0	0	0
8. Outreach and Engagement	4,025,464	4,025,464		0	0	0
9. Supported Employment (One-Time Spend Plan)	400,000	400,000		0	0	0
10. DoH Supportive Housing Units (One-Time Spend Plan)	5,000,000	5,000,000				
11.	0					
12.	0					
	0					
	0					
	0			0	0	0
CSS Administration	954,942	954,942	0	0	0	0
CSS Planning	84,260	84,260	0	0	0	0
CSS Evaluation	152,409	152,409	0	0	0	0
CSS MHSA Housing Program Assigned Funds	105,039	105,039	0	0	0	0
Total CSS Program Estimated Expenditures	43,143,592	39,844,460	3,448,648	0	0	0
FSP Programs as Percent of Total Ongoing	59.3%					

FY 2022/23 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: San Mateo   Date: 3/1/22

	Fiscal Year 2022/23					
	A	**B**	**C**	**D**	**E**	**F**
	Estimated Total Mental Health Expenditures	**Estimated PEI Funding**	**Estimated Medi-Cal FFP**	**Estimated 1991 Realignment**	**Estimated Behavioral Health Subaccount**	**Estimated Other Funding**
PEI Programs - Prevention						
1. Early Childhood Community Team	455,742	455,742	0	0	0	0
2. Community Interventions for School Age and TAY	694,944	694,944	0	0	0	0
3. Community Outreach, Engagement and Capacity Building	1,166,128	1,166,128	0	0	0	0
4. Trauma-Informed Systems	150,000	150,000	0	0	0	0
5. Trauma-Informed Systems (One-Time)	100,000	100,000	0	0	0	0
6. Community MH 101 Education (One-Time)	180,000	180,000	0	0	0	0
7. Post-Covid Supports (One-Time)	451,000	451,000	0	0	0	0
8. Help@Hand Sustainability (One-Time)	300,000	300,000	0	0	0	0
	-		0	0	0	0
PEI Programs - Early Intervention						
1. Early Onset of Psychotic Disorders	879,127	879,127	0	0	0	0
2. Early Crisis Interventions	1,091,389	1,091,389	0	0	0	0
3. Primary Care/Behavioral Health Integration	1,027,546	1,027,546	0	0	0	0
4. Crisis Coordination (One-Time)	50,000	50,000	0	0	0	0
	0		0	0	0	0
PEI Programs - Outreach for Increasing Recognition of Early Signs of MI						
1. Mental Health First Aid	71,869	71,869				
2.	0					
PEI Programs - Access and Linkage to Treatment						
1. Outreach Collaboratives	604,042	604,042				
2. Cultural Centers	544,954	544,954				
3. Older Adult Outreach	326,847	326,847				
4. Primary Care-Based Efforts	27,122	27,122				
	0					
PEI Programs - Stigma and Discrimination Reduction	0					
1. Digital Storytelling & Photovoice	125,896	125,896				
2. Mental Health Awareness	206,587	206,587				
PEI Programs - Suicide Prevention	0					
1. Sucide Prevention Inititive	206,587	206,587				
PEI Evaluation						
1.	272,760	272,760				
	0		0	0	0	0
PEI Administration	860,917	860,917	0	0	0	0
PEI Assigned Funds - CalMHSA	176,110	176,110				
Total PEI Program Estimated Expenditures	9,969,567	9,969,567	0	0	0	0

FY 2022/23 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: San Mateo   Date: 3/1/21

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Social Enterprise	767,000	767,000				
2. PIONEERS	330,000	330,000				
3. PEI in Low-Income Housing	330,000	330,000				
4. AB114 - Help@Hand (Tech Suite)	187,657	187,657				
5. Evaluation	116,855	116,855				
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	0					
Total INN Program Estimated Expenditures	1,731,512	1,731,512	0	0	0	0

FY 2022/23 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: San Mateo   Date: 3/1/22

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and Technical Assistance	100,000	100,000				
2. Training for/by Consumers	60,000	60,000				
3. Behavioral Health Career Pathways	80,000	80,000				
4.	-					
WET (One-Time Spend Plan)	-					
1. Online Training Capacity	60,000	60,000				
2. Workforce Capacity (EMDR, DBT, Self Care	280,000	280,000				
3. Peer Certification and Training	50,000	50,000				
4. CSIP Stipend Increase (One-Time)	24,000	24,000				
5. Workforce Wellness (One-Time)	100,000	100,000				
6.	-					
	-					
	-					
	-					
	-					
	-					
	-					
	-					
	-					
WET Administration	260,000	260,000				
Total WET Program Estimated Expenditures	1,014,000	1,014,000	0	0	0	0

FY 2022/23 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: San Mateo   Date: 3/1/22

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects (One-Time)						
1. EPA Clinic	700,000	700,000				
2. Cordilleras	250,000	250,000				
3. SSF Clinic	500,000	500,000				
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
1. Client Devices	330,000	330,000				
2.	0					
CFTN Programs - Technological Needs Projects (One-Time)						
1. Network Adequacy Compliance	100,000	100,000				
2. IT Infrastructure	301,000	301,000				
3. Telepsychitry/health	80,000	80,000				
	0					
	0					
	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	2,261,000	2,261,000	0	0	0	0

APPENDIX 6. FSP EVALUATION REPORT

Full Service Partnership (FSP) Outcomes

Findings from 2020-2021 Fiscal Year

Manxi Yang, MPP

San Mateo County Behavioral Health and Recovery Services

April 2022

AIR®

Advancing Evidence.
Improving Lives.

Full Service Partnership (FSP) Outcomes

Findings from 2020-2021 Fiscal Year

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San Mateo County Behavioral Health and Recovery Services

April 2022

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Exhibits

Executive Summary

Full Service Partnerships (FSPs) are a set of enhanced, integrated services administered through San Mateo County contracted providers to assist individuals with mental and behavioral health challenges. The American Institutes for Research (AIR) is working with San Mateo County ("the County") to understand how enrollment in FSP promotes resilience and improves health outcomes of individuals served. Two data sources are used for this report: (1) self-reported survey data are collected by providers from FSP clients, (hereafter, "partners'") and (2) electronic health records (EHR) obtained through the County's Avatar system. In the County there are currently four comprehensive FSP providers: Edgewood Center and Fred Finch Youth Center (hereafter, Edgewood/Fred Finch)[1] serving children, youth, and transition age youth; and Caminar and Telecare serving adults and older adults. *This year's report includes data from all FSP providers but only included Telecare data from December 2018 to June 2021. Telecare changed its EHR system for the FSP program data and is having technical difficulties providing the data prior to the change of the EHR system. Due to this change, we report data from Telecare separately.*

Exhibit 1 presents outcomes for child (16 years and below), transitional age youth (TAY) (16-25 years), adult (25 to 59 years), and older adult (60 years and older) clients (hereafter referred to as "partners") of the Full Service Partnership (FSP) program in the County. In some cases, the EHR data will have a larger sample size than the survey data, as partners did not always complete the program surveys. Survey data presented in Exhibit 1 is obtained only from Edgewood/Fred Finch and Caminar. Due to changes in the reporting systems for Telecare, their data is provided in Exhibit 3.

For all outcomes, we compared the year just prior to enrollment in a FSP and the first year enrolled in FSP. Red (and bold) font in Exhibit 1 indicates percent change that was not favorable (e.g., worse academic grades for children and TAY partners; 4 out of 32 outcomes). Percent improvement is the change in the number of partners with the outcome of interest (e.g., homelessness, incarceration, employment) in the year after joining FSP relative to the year prior to participating in FSP. For example, the number of adult partners experiencing homelessness changed from 46 before FSP enrollment to 34 in the first year following FSP enrollment, a 26% improvement. We first provide self-reported and EHR outcomes for adults and older adults followed by child and TAY partners.

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[1] The self-reported data from Edgewood Center and Fred Finch Youth Center is combined into one dataset, therefore, we refer to both centers as Edgewood/Fred Finch in this report to be consistent with the data.

Self-reported outcomes for adults and older adults: For adults and older adults, the majority of self-reported outcomes improved from the year prior to enrollment to the first year enrolled in a FSP.

- 10 out of 16 outcomes improved for both adult and older adult partners, including fewer partners experiencing homelessness, arrests, mental health emergencies, physical health emergencies, and active substance use disorders.

- Three outcomes only improved for adult partners, including fewer detentions or incarcerations, more employment, and more partners reporting substance use disorder treatment, which may indicate that the integrated care and case management services offered through FSP connected adult partners with needed care. There was no change on detention or incarceration for older adults, however, when looking at arrests, fewer older adult partners reported being arrested from the year prior to the first year during FSP enrollment. Also, older adults did not report changes on employment, which may be because they mostly are not in workforce. One outcome worsened for older adult partners: fewer partners reported receiving substance use disorder treatment.

Healthcare utilization (EHR data) for adults and older adults: For adult and older adult partners, we detected statistically significant changes in outcomes from the year before FSP compared to the first year in FSP for all healthcare utilization outcomes. Compared to the year before joining a FSP, there was a:

- Decrease in the percent of partners with any hospitalization

- Decrease in mean hospital days per partner

- Decrease in percent of partners using any psychiatric emergency services (PES), and

- Decrease in mean PES event per partner

Self-reported outcomes for child and TAY partners: Similar trends are seen for child and TAY partners where most of the self-reported outcomes improved from the year prior to enrollment to the first year enrolled in a FSP.

- 10 out of 16 outcomes improved for both child and TAY partners, including reduced homelessness, arrests, mental and physical health emergencies, and school suspensions.

- Two outcomes only improved for TAY partners, including fewer detentions or incarcerations and increased school attendance. Detention or incarceration did not change for child partners. However, for child partners, when looking at arrests, there were significant decreases between the year prior to FSP and the first year after FSP enrollment (62 in the year just prior compared to 10 in the first year with FSP).

- Three outcomes worsened for child or TAY partners. Child and TAY partners reported decreased academic grades during the first year after enrolling in a FSP program. Child partners also reported decreased attendance after enrollment.

Healthcare utilization (EHR data) for child and TAY partners: For child and TAY partners, we detected statistically significant changes in outcomes from the year before FSP compared to the first year in FSP for all healthcare utilization outcomes. Compared to the year before joining a FSP, there was a:

- Decrease in the percent of partners with any hospitalization

- Decrease in mean hospital days per partner

- Decrease in percent of partners using any psychiatric emergency services (PES), and

- Decrease in mean PES event per partner

Exhibit 1. Percent Change in Outcomes by Age Group, Year before FSP Compared with First Year with FSP

FSP Outcomes *Self-reported Outcomes*	Adult (25 to 59 years) N = 113			Older adult (60 years & older) N = 19		
	Yr before	*Yr after*	*change*	*Yr before*	*Yr after*	*change*
Homelessness	46 (41%)	34 (30%)	-26%	3 (16%)	1 (5%)	-67%
Detention or Incarceration	35 (31%)	22 (19%)	-37%	2 (11%)	2 (11%)	0%
Employment	0 (0%)	3 (3%)	N/A	0 (0%)	0 (0%)	N/A
Arrests	24 (21%)	4 (4%)	-83%	2 (11%)	0 (0%)	-100%
Mental Health Emerg.	84 (74%)	29 (26%)	-65%	10 (53%)	2 (11%)	-80%
Physical Health Emerg.	49 (43%)	17 (15%)	-65%	6 (32%)	3 (16%)	-50%
Active S.U. Disorder	60 (53%)	55 (49%)	-8%	4 (21%)	3 (16%)	-25%
S.U. Treatment	27 (24%)	33 (29%)	22%	3 (16%)	2 (11%)	-67%
Healthcare Utilization (EHR data)	Adult (25 to 59 years) N = 342			Older adult (60 years & older) N = 62		
	Yr before	Yr after	change	Yr before	Yr after	change
Hospitalization	122 (36%)	56 (16%)	-54%	18 (29%)	12 (19%)	-33%
Hospital Days per partner	12.1	4.2	-66%	10.5	5.5	-48%
PES	184 (54%)	133(39%)	-28%	25 (40%)	15 (24%)	-40%

PES Event per partner	1.7	1.0	-38%	1.1	0.6	-49%

FSP Outcomes Self-reported Outcomes	Child (16 years and younger) N = 201			TAY (17 to 25 years) N = 250		
	Yr before	Yr after	change	Yr before	Yr after	change
Homelessness	9 (4%)	6 (4%)	-33%	33 (13%)	32 (13%)	-3%
Detention or Incarceration	29 (14%)	29 (14%)	0%	38 (15%)	32 (13%)	-16%
Arrests	62 (31%)	10 (5%)	-84%	119 (48%)	20 (8%)	-83%
Mental Health Emerg.	69 (34%)	8 (4%)	-88%	114 (46%)	25 (10%)	-78%
Physical Health Emerg.	14 (7%)	1 (0%)	-93%	55 (22%)	5 (2%)	-91%
Suspension	44 (22%)	20 (10%)	-55%	24 (10%)	5 (2%)	-79%
Grade	3.39	3.06	-10%	3.21	3.15	-2%
Attendance	2.20	1.95	-11%	2.40	2.48	3%
Healthcare Utilization (EHR data)	Child (16 years and younger) N =211			TAY (17 to 25 years) N = 201		
	Yr before	*Yr after*	*change*	*Yr before*	*Yr after*	*change*
Hospitalization (N)	10 (5%)	3 (1%)	-70%	26 (13%)	16 (8%)	-38%
Hospital Days per partner	1.3	0.1	-91%	5.1	2.2	-57%
PES (N)	51 (24%)	22 (10%)	-57%	87 (43%)	54 (27%)	-38%
PES Event per partner	0.5	0.2	-56%	1.1	0.7	-31%

Note. Exhibit 1 above indicates the change in the number of partners with outcome of interest, comparing the year just prior to FSP with the first year on FSP. Counts are presented in Exhibit 1 to indicate the number of partners with outcome of interest and percentages are presented in the parenthesis. For example, in Yr before, there were 46 adults that experienced homelessness, which is 41% of all 113 adults, then in the Yr after, there were 34 adults, which is 30% of all adults that experienced homelessness. Percent change in ratings indicates the change in the average rating for the first year on the program as compared to the year just prior to FSP. For self-reported outcomes, there are only 19 older adult partners, therefore, caution is needed when interpreting the results with small sample size. The percent difference with employment is reported as N/A because the percent of partners with employment was 0% in the Yr before (from 0% to 0% or 0% to 3%)). Thus, the denominator is 0. Red (and bold) font indicates outcomes that worsened, such as lower school attendance for child partners or lower grades for child and TAY partners.

When looking at healthcare utilization outcomes across years for all cohorts, the reductions are consistently observed over the years since the inception of the FSP program. There are 816 partners who joined the FSP program since 2006 and have health utilization data in the EHR. Among these partners, we looked at their change in outcomes between the first year of FSP

and the year prior to FSP. As shown in Exhibit 2, we calculated the overall improvement as the mean change across all 816 partners for people who joined FSP from 2006 to 2020. Then we present the range of improvement, which is the lowest to the highest improvement across years.

Exhibit 2. Overall and Range of Improvement across Years on Health Utilization Outcomes

Health Utilization Outcomes*	Overall Improvement	Range (Partnerships Beginning 2006 – 2020)
Healthcare Use (EHR data, N= 816)		
Partners with Hospitalizations	51%	17% – 75%
Mean Hospital Days	63%	(7%) – 87%
Partners with PES	35%	12% – 60%
Mean PES Events	39%	9% – 68%

* These outcomes are presented overall for all clients as well as by year of partnership; the range presented is from the lowest to highest percent changes among the calendar years (2006-2021).

Telecare changed its electronic healthcare record (EHR) system on December 1, 2018, and was only able to provide the data after the conversion date due to data reliability issues. Due to the incompleteness of the Telecare data, we conducted a separate analysis for Telecare. There are 40 partners in the Telecare survey data who have completed at least a year of the FSP as of June 30, 2021. Our analysis combined all age groups for this separate analysis because of the small sample size. Exhibit 3 shows improvements for Telecare partners on homelessness, incarceration, arrests, physical health emergencies, and active substance use disorder. The Telecare partners did not have improvements on employment, more frequently reported having mental health emergencies, and fewer reported having substance use disorder treatments.

Exhibit 3. Percent Change in Outcomes among Telecare partners, Year before FSP Compared with First Year with FSP

FSP Outcomes *Self-reported Outcomes*	Everyone N = 40		
	Yr before	*Yr after*	*change*
Homelessness	9 (23%)	6 (15%)	-33%
Detention or Incarceration	1 (3%)	0 (0%)	-100%

Employment	0 (0%)	0 (0%)	N/A
Arrests	6 (15%)	0 (0%)	-100%
Mental Health Emerg.	11 (28%)	14 (35%)	27%
Physical Health Emerg.	6 (15%)	1 (3%)	-83%
Active S.U. Disorder	23 (58%)	10 (25%)	-57%
S.U. Treatment	3 (8%)	0 (0%)	100%

Note. Exhibit 3 indicates the change in the percent of partners with any events, comparing the year just prior to FSP with the first year on FSP. For Telecare's self-reported outcomes, there are 40 partners, therefore, caution is needed when interpreting the results with small sample size. The percent difference with employment is reported as N/A because the percent of partners with employment did not change (from 0% to 0%). Thus, the denominator is 0. Red (and bold) font indicates outcomes that worsened, e.g., more frequently reported mental health emergencies.

Background and Introduction

The Mental Health Services Act (MHSA) was enacted in 2005 and provides a dedicated source of funding to improve the quality of life for individuals living with mental illness. In San Mateo County (the County), a large component of this work is accomplished through Full Service Partnerships (FSP). FSP programs provide individualized integrated mental health services, flexible funding, intensive case management, and 24-hour access to care ("whatever it takes" model) to help support recovery and wellness for persons with serious mental illness (SMI) and their families. In the County there are currently four comprehensive FSP providers: Edgewood Center and Fred Finch Youth Center (hereafter, Edgewood/Fred Finch)[2] serving children, youth, and transition age youth; and Caminar and Telecare serving adults and older adults.

The County has partnered with the American Institutes for Research (AIR) to understand how enrollment in the FSP is promoting resiliency and improving health outcomes of the County's clients living with mental illness. Two data sources are used for this report: (1) self-reported survey data are collected by providers from FSP clients, (hereafter, "partners'") and (2) electronic health records (EHR) obtained through the County's Avatar system.

This year's report includes data from all FSP providers but only included Telecare data from December 2018 to June 2021. Telecare changed its EHR system for the FSP program data and is having technical difficulties providing the data prior to the change of the EHR system.

Initial survey data are collected by providers via an intake assessment, called the Partnership Assessment Form (PAF), which includes information on well-being across a variety of measures (e.g., living in a residential setting) at the start of FSP and over the twelve month "lookback" window of the year prior to FSP enrollment. While participating in the FSP, survey data on partners is gathered in two ways. Life changing events are tracked by Key Event Tracking (KET) forms, which are triggered by any key event (e.g., a change in residential setting). Partners are also assessed regularly with Three Month (3M) forms. Changes in partner outcomes are gathered by comparing data on PAF forms to data compiled from KET and 3M forms.

EHR data collected through the County Avatar system contain longitudinal partner-level information on demographics, FSP program participation, hospital stays, and psychiatric emergency services (PES) utilization before and after the enrollment date within the County health system. The Avatar system is limited to individuals who obtain care in the County health system. Hospitalizations outside of the County, or in private hospitals, are not captured.

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[2] The self-reported data from Edgewood Center and Fred Finch Youth Center is combined into one dataset, therefore, we refer to both centers as Edgewood/Fred Finch in this report to be consistent with the data.

This report presents changes in partners' self-reported and hospitalization outcomes in two consecutive years: (1) the baseline year, i.e., the 12 months prior to enrollment in the FSP program, and (2) the first full 12 months of the partner's FSP participation. Children (aged 16 and younger), transition aged youth (TAY; aged 17 to 25), adults (aged 25 to 59), and older adults (aged 60 and older) were included in the analysis if they had completed at least one full year with the FSP program by June 30, 2021 (the data acquisition date). Trends in EHR data are subsequently presented as an average across all years of the program as well as annually, by year of FSP program enrollment. Note that the difference in the number of partners between the self-reported and EHR data is due to the difference in age group definition (see Appendix C) and not every partner has a health care record in the County's EHR system.

Appendices provide details on our methodology as well as detailed findings for specific outcomes. Appendix A presents additional detail on residential outcomes. Appendix B provides outcomes for individual FSP providers. Appendix C provides methodology for both the self-reported outcomes and the EHR-based hospitalization outcomes.

Self-reported outcomes

Overview

The following section presents outcomes for: 201 child (aged 16 and younger) FSP partners; 250 TAY (aged 17 - 25) FSP partners; 113 adult (aged 26-59) FSP partners; and, 19 older adult (aged 60 and older) FSP partners who joined and completed at least a year in FSP since 2006. The results compare the first year enrolled in an FSP with the year just prior to FSP enrollment for partners completing at least one year in an FSP program.

Outcomes Assessed. Several outcomes are broken down by age category, as described below. Note that employment, homelessness, arrests and incarceration outcomes are not presented for adults aged 60 or older, as there are insufficient observations in this age group for meaningful interpretation (i.e., there are fewer than 5 older adult partners total with any of these events).

1. **Partners with any reported homelessness incident:** measured by residential setting indicating homelessness or emergency shelter (PAF and KET).

2. **Partners with any reported detention or incarceration incident:** measured by residential setting indicating Jail or Prison (PAF and KET).

3. **Partners with any reported employment**: measured by employment in past 12 months and date employment change (PAF and KET).[3]

4. **Partners with any reported arrests:** measured by arrests in past 12 months and date arrested (PAF and KET).

5. **Partners with any self-reported mental health emergencies:** measured by emergencies in past 12 months and date of mental health emergency (PAF and KET).

6. **Partners with any self-reported physical health emergencies:** measured by emergencies in past 12 months and date of acute medical emergency (PAF and KET).

7. **Partners with any self-reported active substance use disorder**: measured by self-report in past 12 months and captured again in regular updates (PAF and 3M).

8. **Partners in substance use disorder treatment**: measured by self-report in past 12 months and captured again in regular updates (PAF and 3M).[4]

In addition, we also examine three outcomes specific to child and TAY partners:

1. **Partners with any reported suspensions**: measured by suspensions in past 12 months (PAF) and date suspended (KET).

2. **Average school attendance self-rating**: an ordinal ranking (1-5) indicating overall attendance; measured for past 12 months (PAF), at start of FSP (PAF), and over time on FSP (3M).

3. **Average school grade self-rating**: an ordinal ranking (1-5) indicating overall grades; measured for past 12 months (PAF), at start of FSP (PAF), and over time on FSP (3M).

Mental and physical health emergencies by living situation. Mental and physical health emergencies are considered in conjunction with residential status for all age groups combined. Specifically, we explore the likelihood of an emergency in relation to whether the partner's living situation in their first year of FSP participation is "advantageous" (i.e., living with family or foster family, living along and paying rent, or living in group care or assisted living) or "higher risk" (i.e., homeless, incarcerated, or in a hospitalized setting.

Telecare changed its electronic healthcare record (EHR) system on December 1, 2018 and was only able to provide the data after the conversion date due to data reliability issues. Due to the incompleteness of the Telecare data, we conducted a separate analysis for Telecare. Below we present the findings from the analysis of Caminar and Edgewood/Fred Finch combined data

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[3] Employment outcome is not applicable to child and TAY partners.
[4] If more partners reported receiving substance use disorder treatment in the year following their FSP enrollment, it may indicate that the integrated care and case management services offered through FSP connected partners with needed care.

since FSP inception—the main analysis, and the findings from the analysis using Telecare data from December 2018.

Caminar and Edgewood/Fred Finch

Self-Reported Outcomes by Age Group

Adults. Exhibit 4 compares outcomes for adult partners in the year prior to FSP enrollment with the first year in a FSP. Homelessness, incarceration, arrests, self-reported mental and physical health emergencies, and substance use problems decreased. In addition, employment and reported treatment of substance use disorder increased. These findings demonstrate improvements for adult partners in the first year of FSP enrollment for all outcomes.

Exhibit 4. Outcomes for Adult Partners Completing One Year with FSP (n = 113)
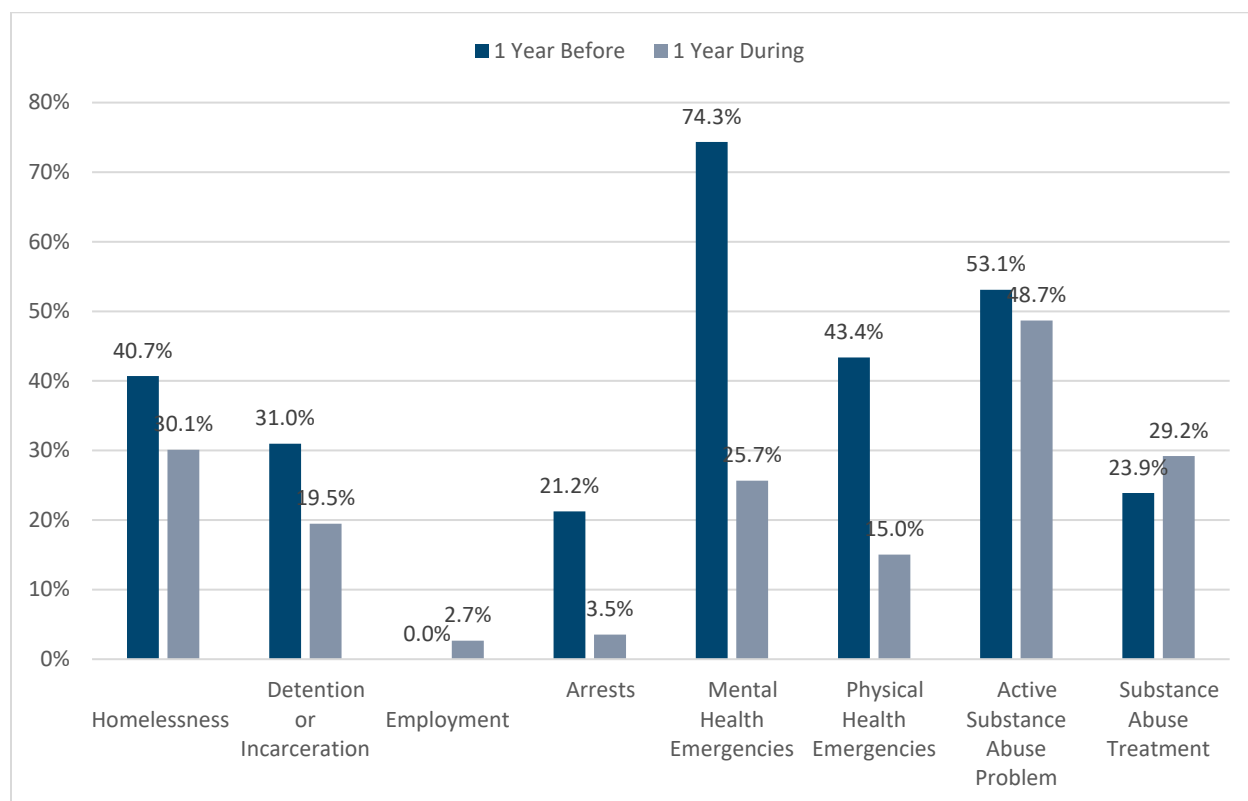
Older Adults. Exhibit 5 compares outcomes in the year prior to FSP enrollment with outcomes reported in the first year of FSP enrollment for older adult partners. Similar to adult partners, self-reported mental and physical health emergencies, and substance use disorder all decreased. Each of these demonstrated improvement for older adult partners in the first year of FSP enrollment. Slightly fewer older adults (from 3 in the year prior to 2 in the first year of

FSP) reported treatment for substance use disorder during the first year of FSP enrollment compared to one year before. Given the small sample size, these results are inconclusive.

Exhibit 5: Outcomes for Older Adult Partners Completing One Year with FSP (n = 19)
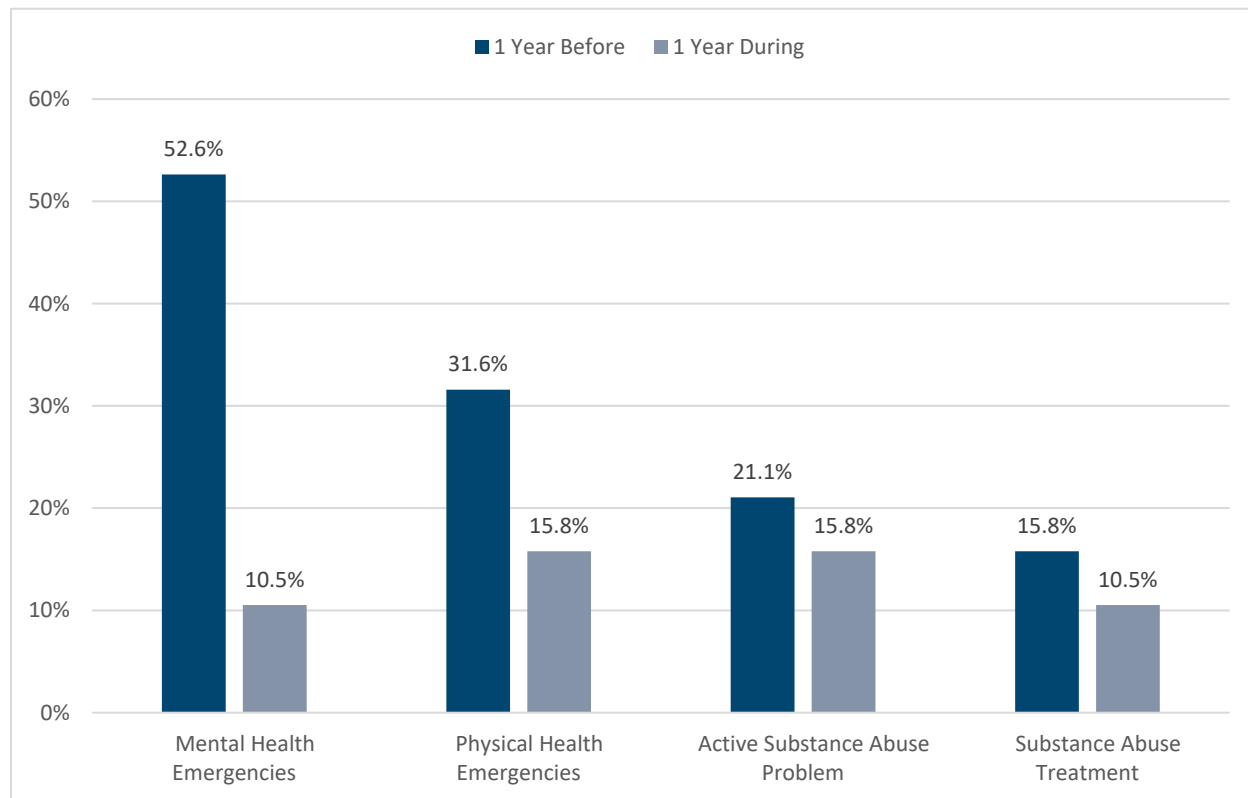
Note: Employment, homelessness, arrests and incarceration outcomes are not presented for older adults, as there are insufficient observations in this age group for meaningful interpretation.

Children. Exhibit 6 below shows the comparison of outcomes in the year prior to FSP enrollment with the first year enrolled in an FSP program for child partners. There was a decrease in homelessness, arrests, suspensions, and mental or physical health emergencies after enrollment in a FSP program. However, detention or incarceration remained the same for children, (29 incidents in the first year with FSP and 29 in the year prior to FSP enrollment). The incidence of arrests reduced by a large magnitude after enrollment in FSP (10 in the first year with FSP compared to 62 in the year just prior).

Exhibit 6: Outcomes for Child Partners Completing One Year with FSP (n = 201)
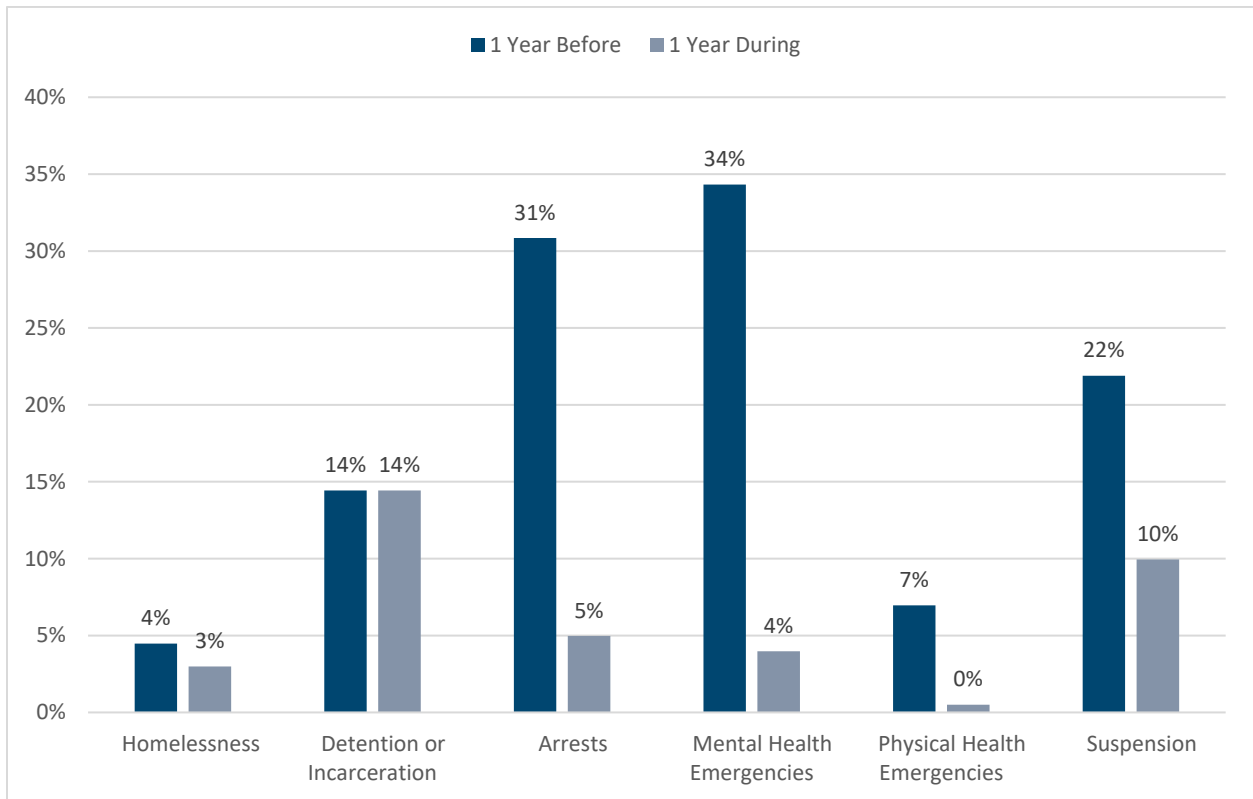
Exhibit 7 presents outcomes on school attendance and grades. School attendance and grades for child partners declined modestly. These ratings are on a 1-5 scale, coded such that a higher score is better.

Exhibit 7: School Outcomes for Child Partners Completing One Year with FSP (n = 201)
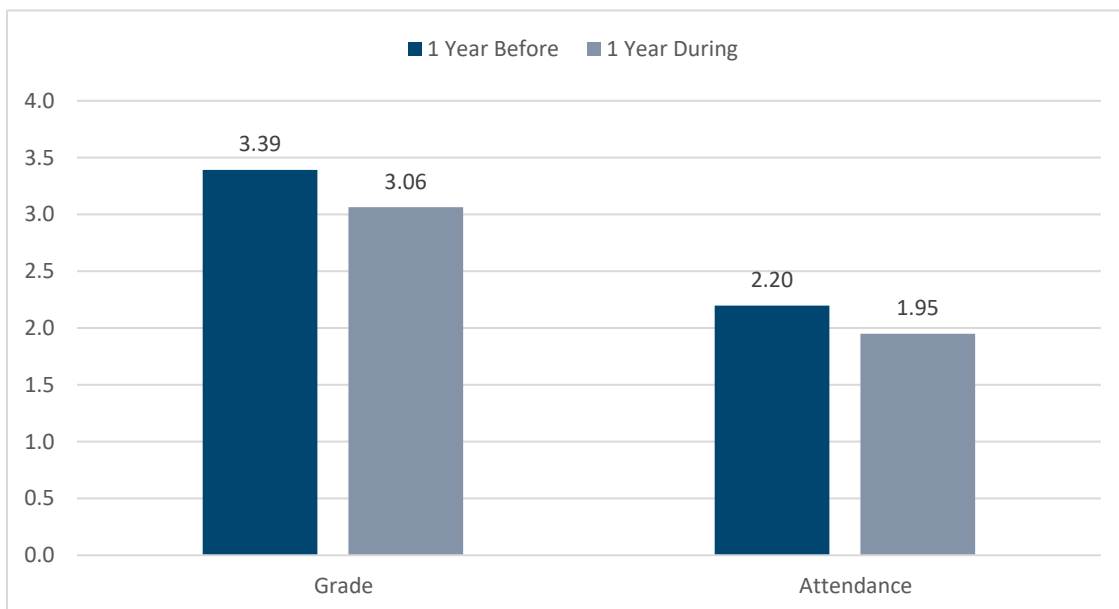
TAY. Exhibit 8 shows the comparison of outcomes in the year prior to FSP to the first year in the program for TAY partners.[5] All self-reported outcomes decreased (an improved status), though the differences for homelessness and incarceration is small. Homelessness decreased from 33 (13.2%) in the year prior to enrollment to 32 (12.8%) in the year following enrollment. Incarceration decreased from 38 (15.2%) in the year prior to enrollment to 32 (12.8%) in the year following enrollment.

Exhibit 8: Outcomes for TAY Partners Completing One Year with FSP (n = 250)
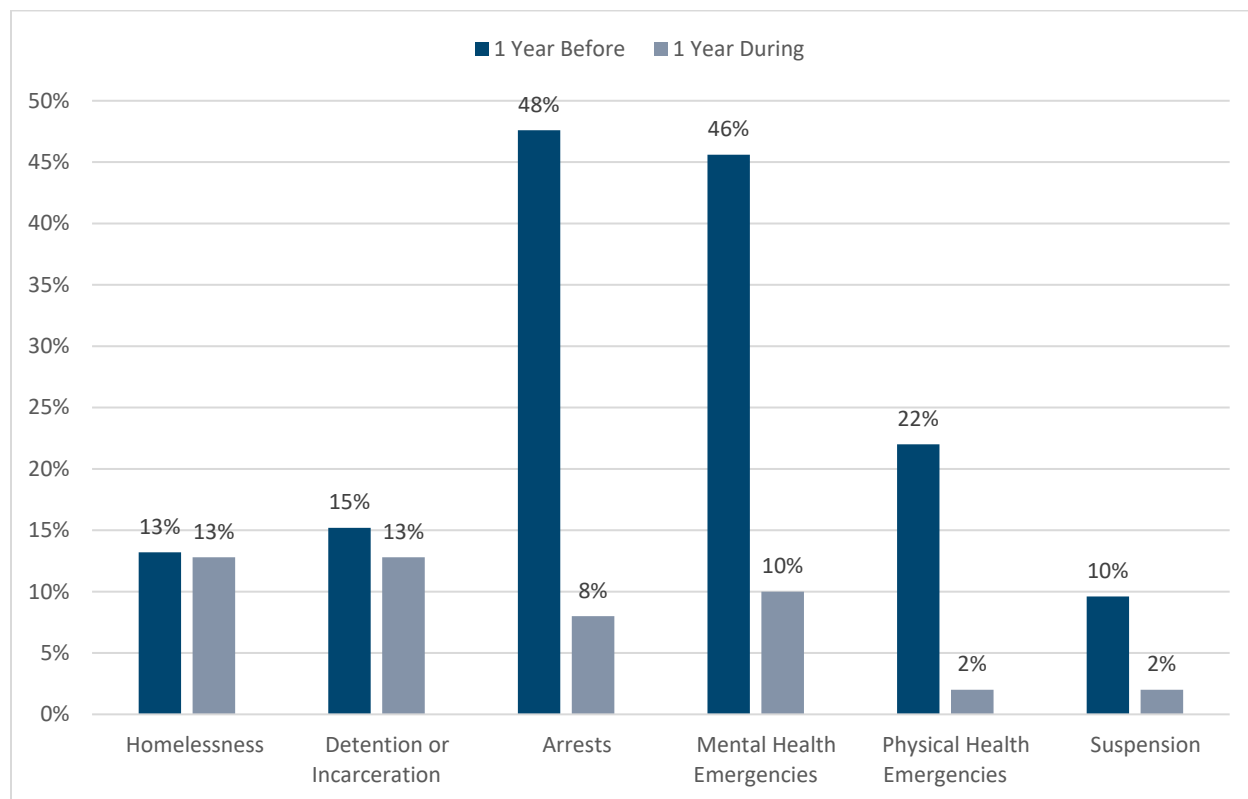
Exhibit 9 shows outcomes on school attendance and grades for TAY partners. These ratings are on a 1-5 scale; a higher score is better. There was a small decrease in grade and a slight increase in attendance after enrollment in a FSP.

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[5] The 43 older TAY partners in Caminar are excluded from these outcomes because these providers do not reliably gather TAY specific outcomes. Note that employment as an outcome is not presented for TAY because many of these individuals are in school.

Exhibit 9: School Outcomes for TAY Partners Completing One Year with FSP (n = 250)
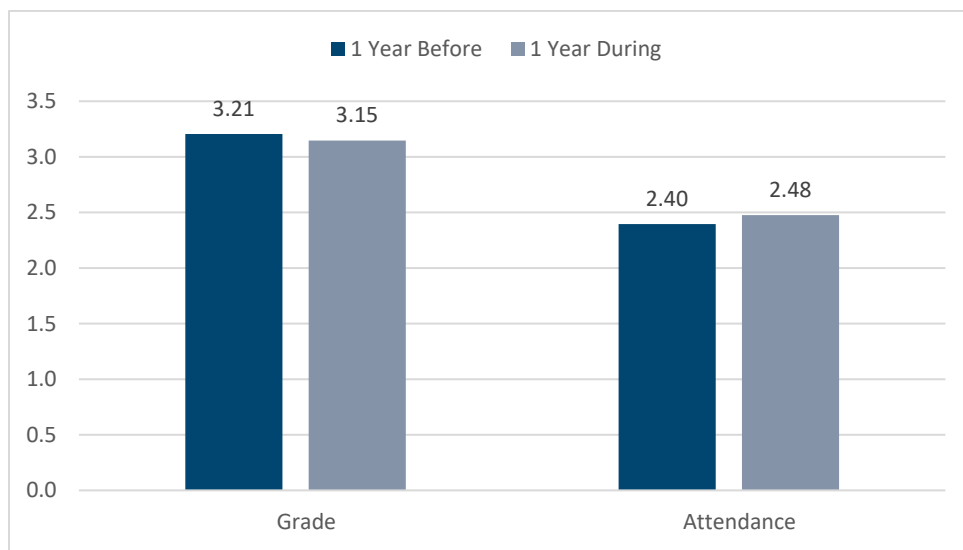
Mental and physical health emergencies by living situation

Exhibit 10 shows the mental and physical health emergencies in adult and older adult partners living in advantageous vs. higher risk living situations in the first year of participating in a FSP. Advantageous settings are defined as living with family or foster family, living alone and paying rent, or living in group care or assisted living. High risk settings are defined as homelessness, incarceration, or in a hospitalized setting. As shown in the exhibit, both mental and physical health emergencies were more common among individuals who experienced a high-risk residential setting in their first year of FSP participation.

Exhibit 10: Emergency Outcomes as a Function of Residential Setting
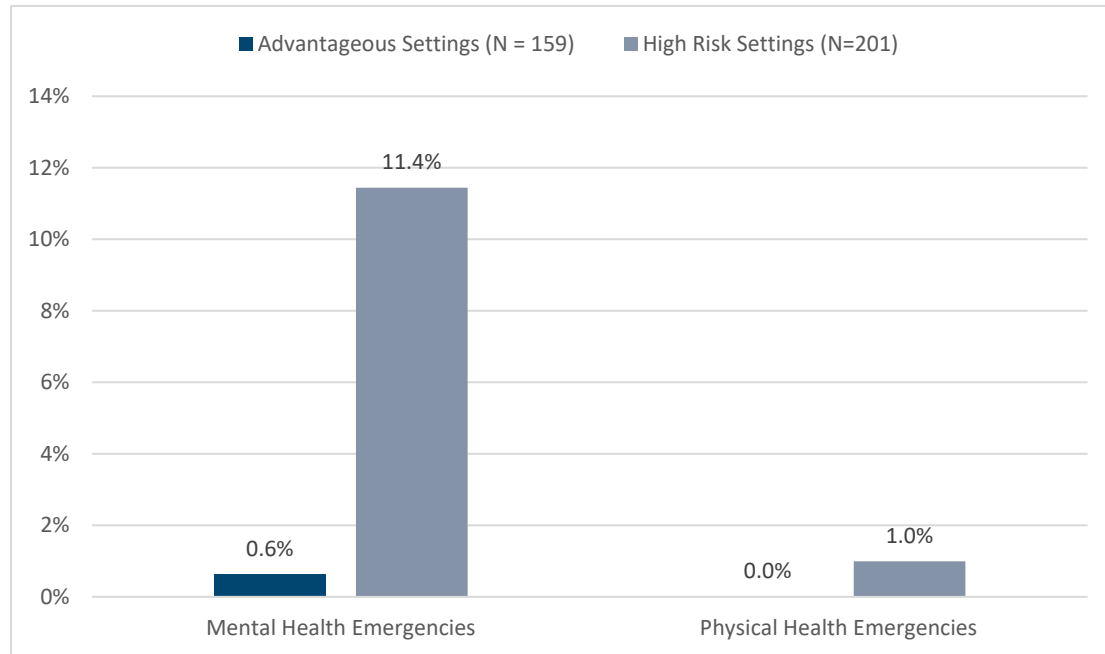
Telecare

Self-Reported Outcomes—All age groups

Telecare data only includes 40 partners who have completed at least one year of FSP as of June 30, 2021. Due to the small sample size, we have combined findings for all age groups. Exhibit 11 shows the comparison of outcomes for all Telecare partners in the year prior to FSP enrollment with the first year in an FSP. Homelessness, detention or incarceration, arrests, self-reported physical health emergencies, and substance use disorders all decreased after enrollment in FSP. Each of these outcomes demonstrates improvements for partners in the first year of FSP enrollment. Mental health emergencies were higher in Telecare partners a year after enrollment in a FSP program. In addition, fewer Telecare partners reported receiving treatment for substance use disorders one year during the FSP program compared with one year before enrollment.

Exhibit 11: Outcomes for Telecare Partners Completing One Year with FSP (n = 40)
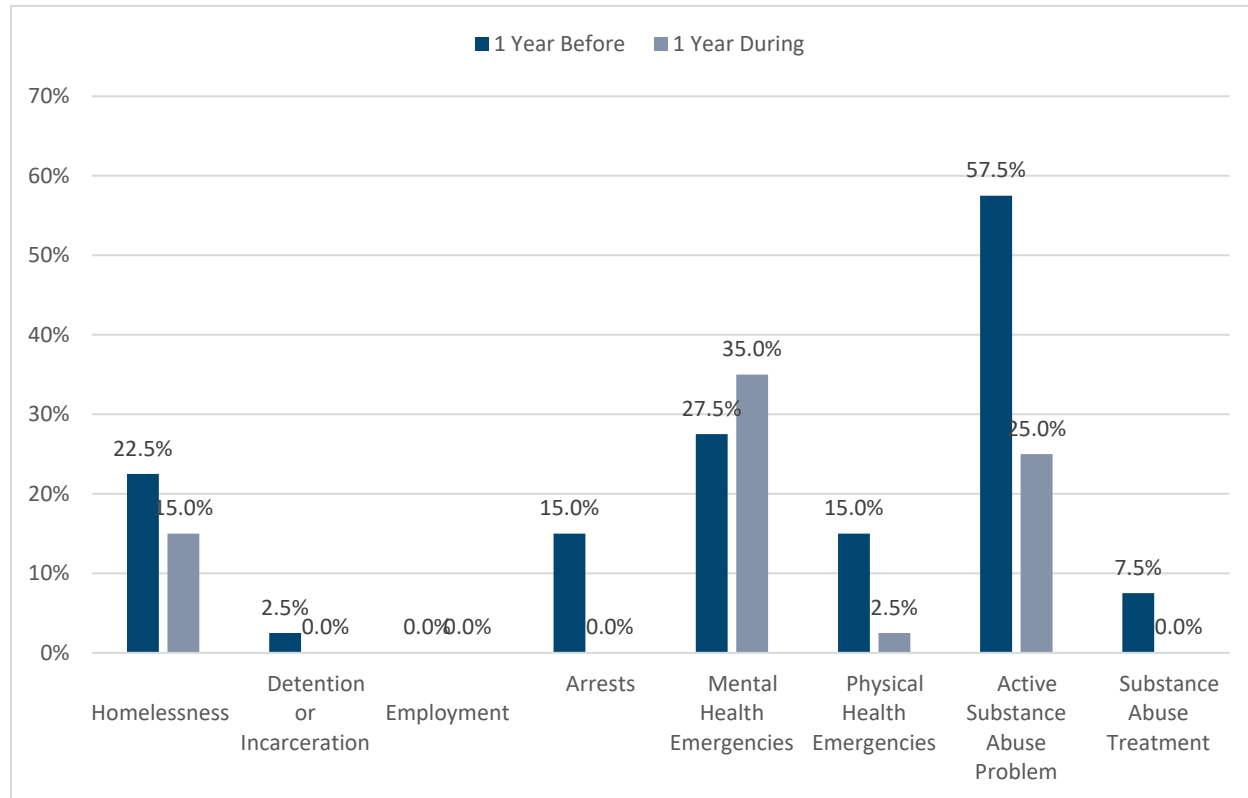
Mental and physical health emergencies by living situation

Exhibit 12 shows the mental and physical health emergencies in adult and older adult partners living in advantageous vs. higher risk living situations in the first year of a FSP. Mental and physical health emergencies only happened with individuals who lived in high-risk residential setting in their first year of FSP participation; there were no mental or physical health emergencies for adult and older adult partners living in advantageous situations.

Exhibit 12: Emergency Outcomes as a Function of Residential Setting among Telecare Partners

Legend: ■ Advantageous Settings (N=3) ■ High Risk Settings (N=24)

Chart values:
- Mental Health Emergencies: 62.5%
- Physical Health Emergencies: 29.2%

Y-axis: 0.0%, 10.0%, 20.0%, 30.0%, 40.0%, 50.0%, 60.0%, 70.0%
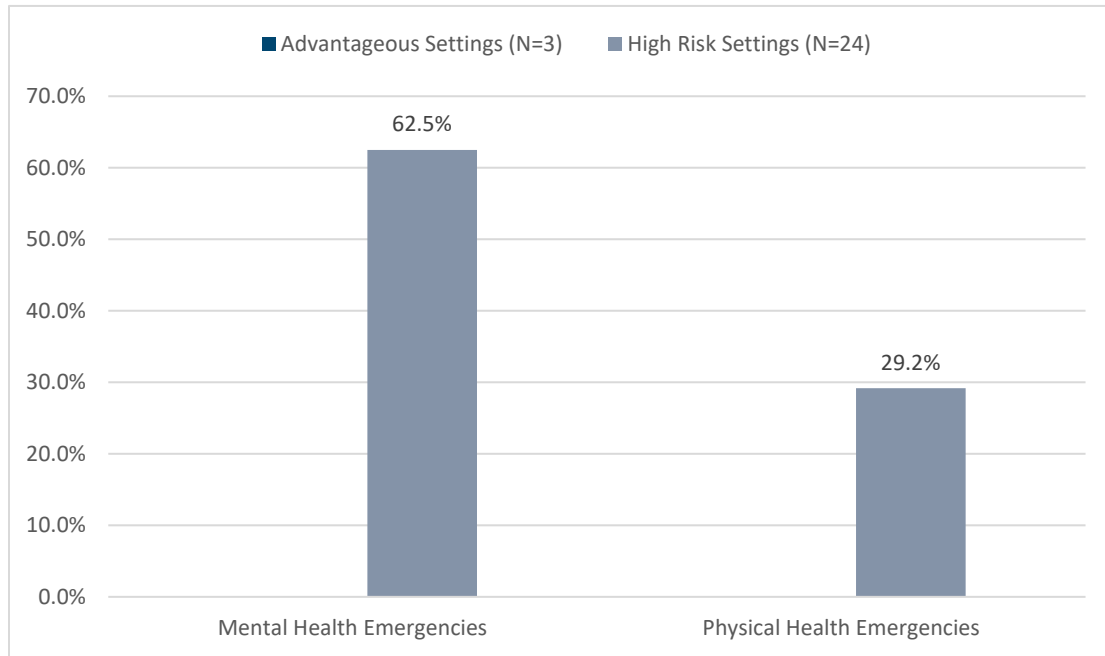
Health Care Utilization Overall and Over Time

Overview

This section describes (1) overall healthcare utilization across all partners from the beginning of the FSP program, (2) healthcare utilization by age group from the beginning of the FSP program, and (3) healthcare utilization for partners by year (2006-2021).

Four hospitalization outcomes are presented for the 211 child, 201 TAY, 342 adult, and 62 older adult FSP partners using the Avatar system (EHR):

1. **Partners with any hospitalizations:** measured by any hospital admission in the past 12 months;

2. **Partners with any PES:** measured by any PES event in the past 12 months;

3. **Average length of hospitalization (in days):** the number of days associated with a hospital stay in the past 12 months; and,

4. **Average number of PES event:** the number of PES events in the past 12 months.

Overall Healthcare Utilization Outcomes Across all Partners

We detected statistically significant changes in outcomes from the year before FSP compared to the first year in FSP for all hospitalization outcomes (Exhibit 13). Percent of partners with any hospitalization decreased from 22% before FSP to 11% during FSP. Days in the hospital decreased from 7.46 days before FSP to 2.74 days during FSP. Percent of partners with any psychiatric emergency services (PES) decreased from 43% before FSP to 27% during FSP. The average number of PES events decreased from 1.18 events before FSP to 0.72 events during FSP.

Exhibit 13: FSP Partners Have Significantly Improved Hospitalization Outcomes (n=816)

	Percentage/Mean	95% Confidence Interval
Percent of Partners with Any Hospitalization*		
1 Year Before	22%	(19% - 24%)
Year 1 During	11%	(9% - 13%)
Mean Number of Hospital Days *		
1 Year Before	7.46	(5.95 - 8.96)
Year 1 During	2.74	(1.86 - 3.62)
Percent of Partners with any PES Event*		
1 Year Before	43%	(39% - 46%)
Year 1 During	27%	(24% - 31%)
Mean PES Events, per Partner*		
1 Year Before	1.18	(1.02 - 1.34)
Year 1 During	0.72	(0.59 - 0.84)

Note. *Significance testing was conducted using Chi-square tests for percentages and t-tests for means; results are statistically significant at the 5% level.

Health Care Utilization for FSP Partners by Age Group

Hospitalization outcomes are presented in Exhibits 14-17, respectively by age group. For all four age groups, the percent of FSP partners with any hospitalization or PES event decreased after joining FSP. The mean number of hospital days experienced by FSP partners and average number of PES events also decreased after FSP enrollment for all age groups.

Exhibit 14: Hospitalization and PES Outcomes for Adult Partners Completing One Year with FSP (n = 342)
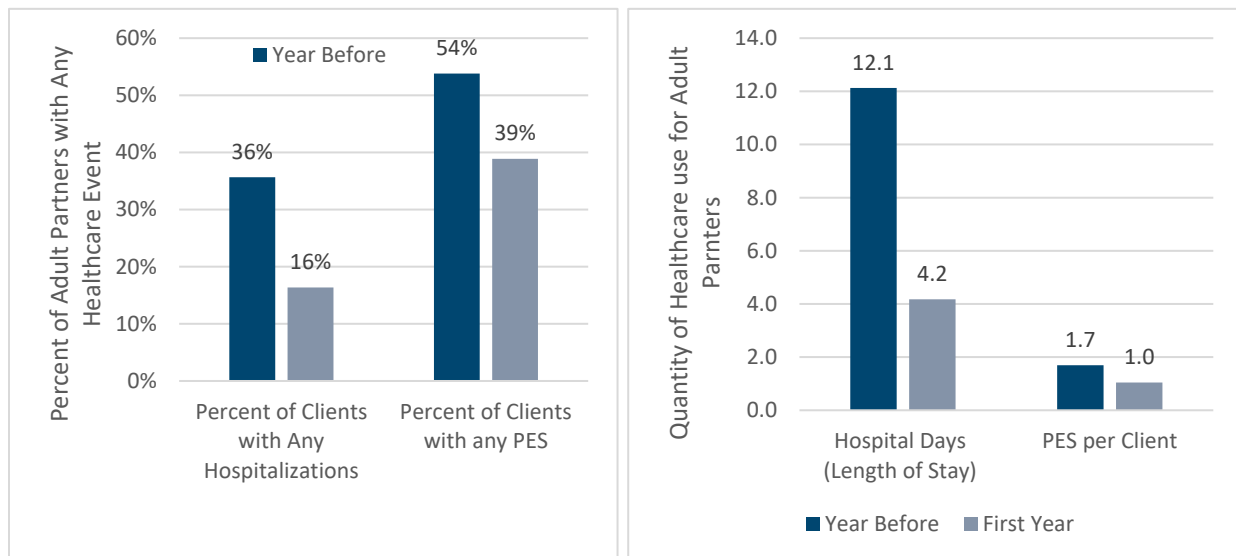
Exhibit 15: Hospitalization and PES Outcomes for Older Adult Partners Completing One Year with FSP (n = 62)
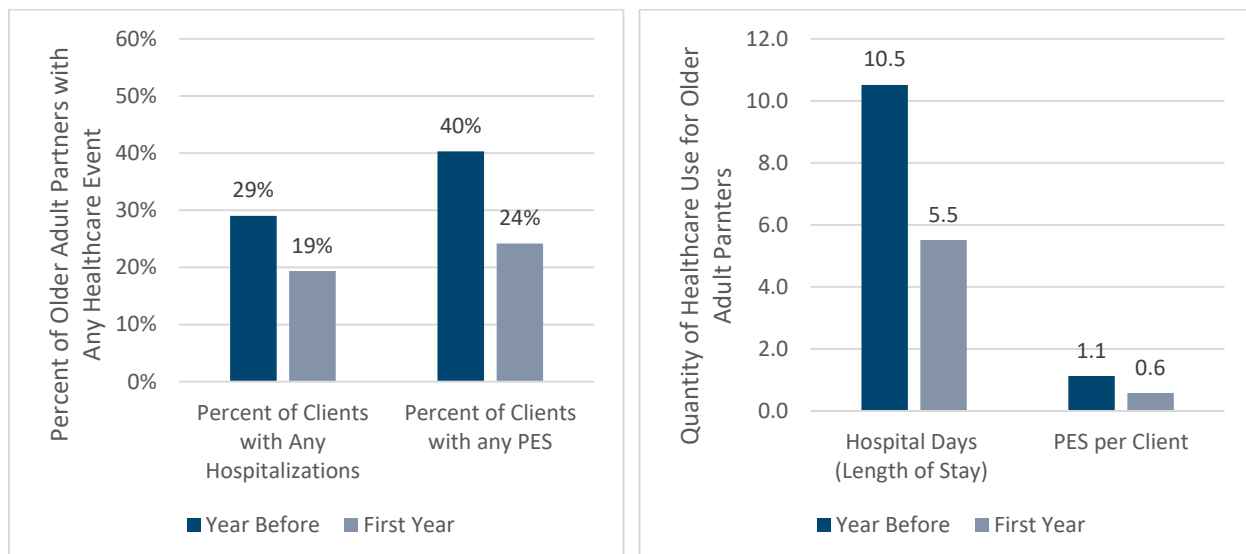
Exhibit 16: Hospitalization and PES Outcomes for Child Partners Completing One Year with FSP (n = 211)
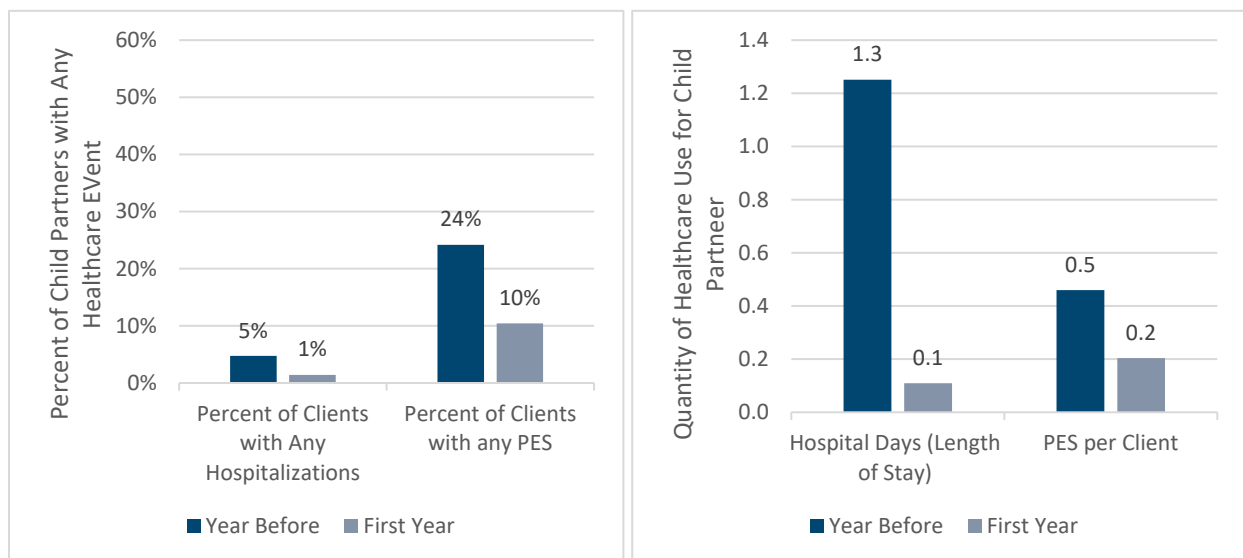
Exhibit 17: Hospitalization and PES Outcomes for TAY Partners Completing One Year with FSP (n = 201)
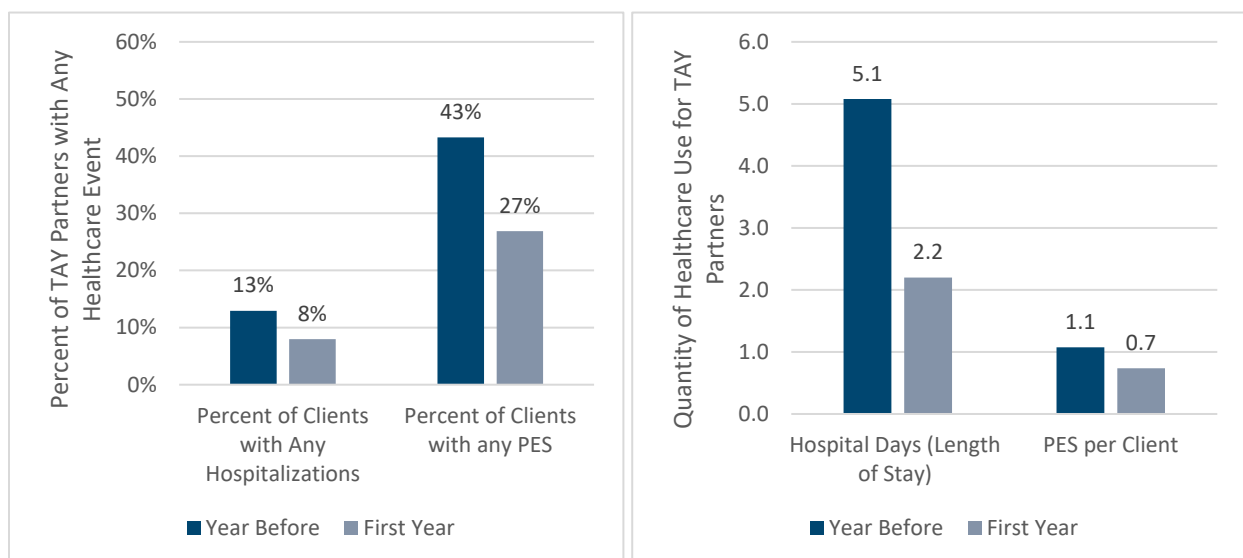
Health Care Utilization for FSP Partners over Time

Exhibits 18-21 show the four healthcare utilization outcomes, including the percent of partners with any hospitalization, mean hospital days per partner, percent of partners using any psychiatric emergency services (PES), and mean PES event per partner, stratified by enrollment year. As can be seen in Exhibit 18, the percent of partners with any hospitalization decreased after joining an FSP program for all enrollment year cohorts.

Exhibit 18: Percent of Partners with Any Hospitalization by FSP enrollment year.
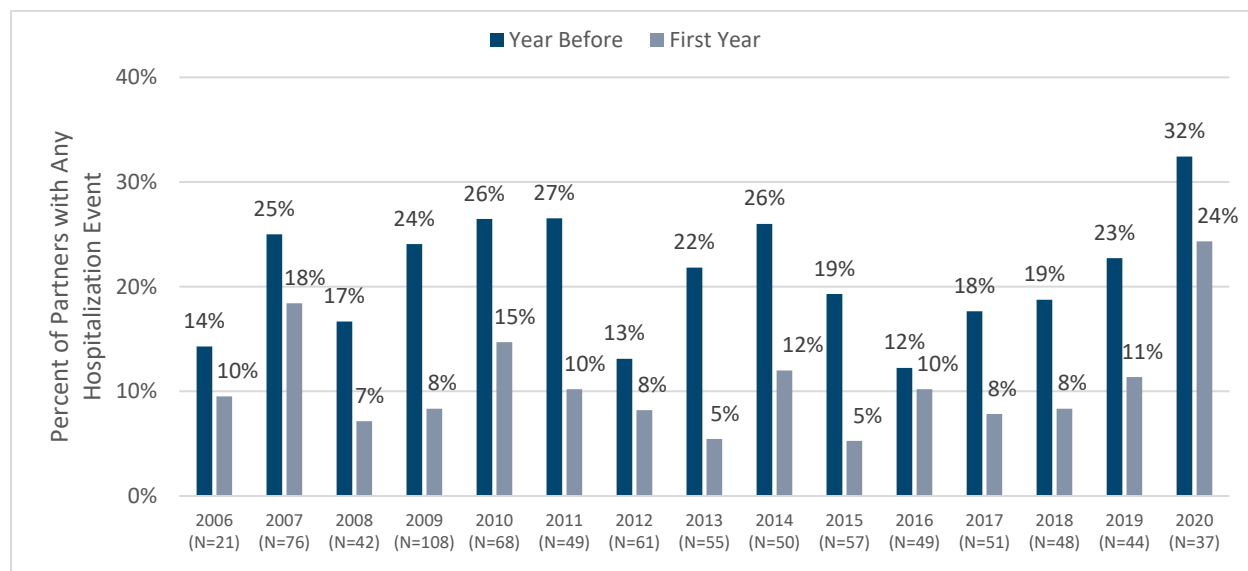
Exhibit 19 displays the mean hospital days per partner by enrollment year. With the exception of 2006 and 2007 cohorts, most partners experienced decrease in the mean number of hospital days regardless of when they enrolled in the program.

Exhibit 19: Mean Number of Hospital Days by FSP Enrollment Year
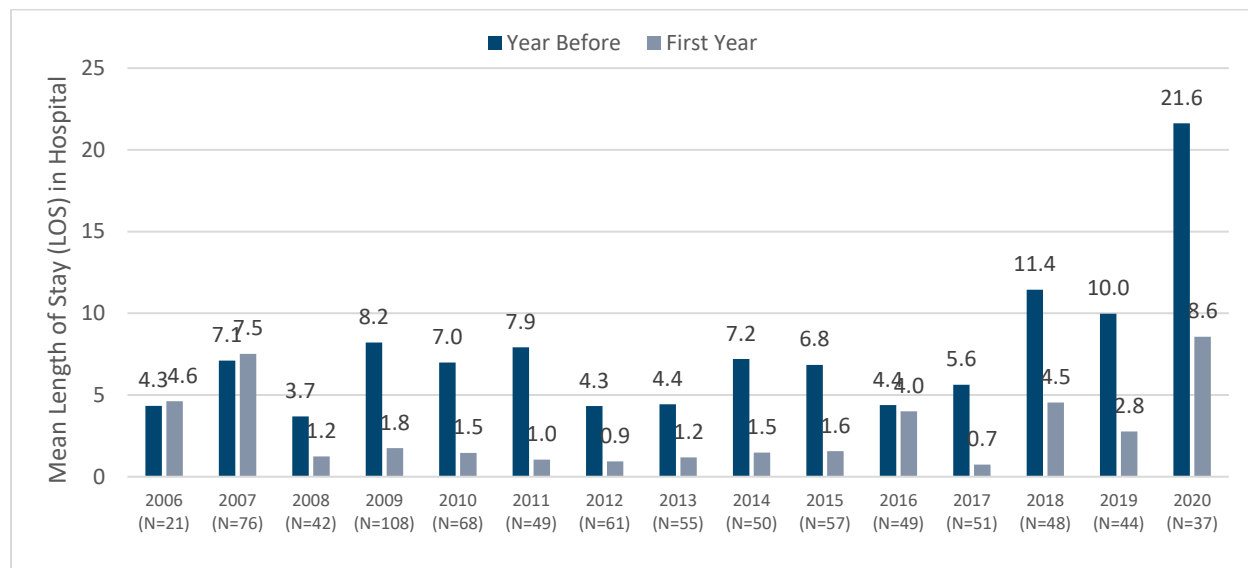
Exhibit 20 displays the percent of partners with any PES event by the year they began FSP. All cohorts experienced a decline in the likelihood of a PES event.

Exhibit 20: Percent of Partners with any PES Event by FSP Enrollment Year
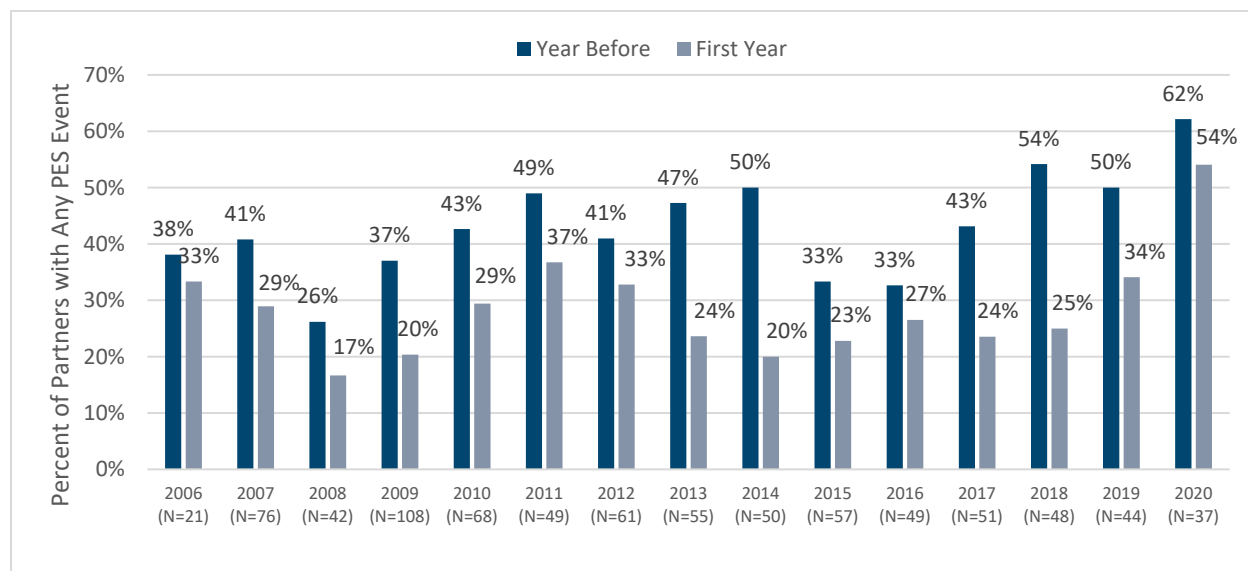
Exhibit 21 displays the mean PES events per partner by FSP enrollment year. All cohorts experienced a reduction in PES events.

Exhibit 21: Mean PES Events by FSP Enrollment Year
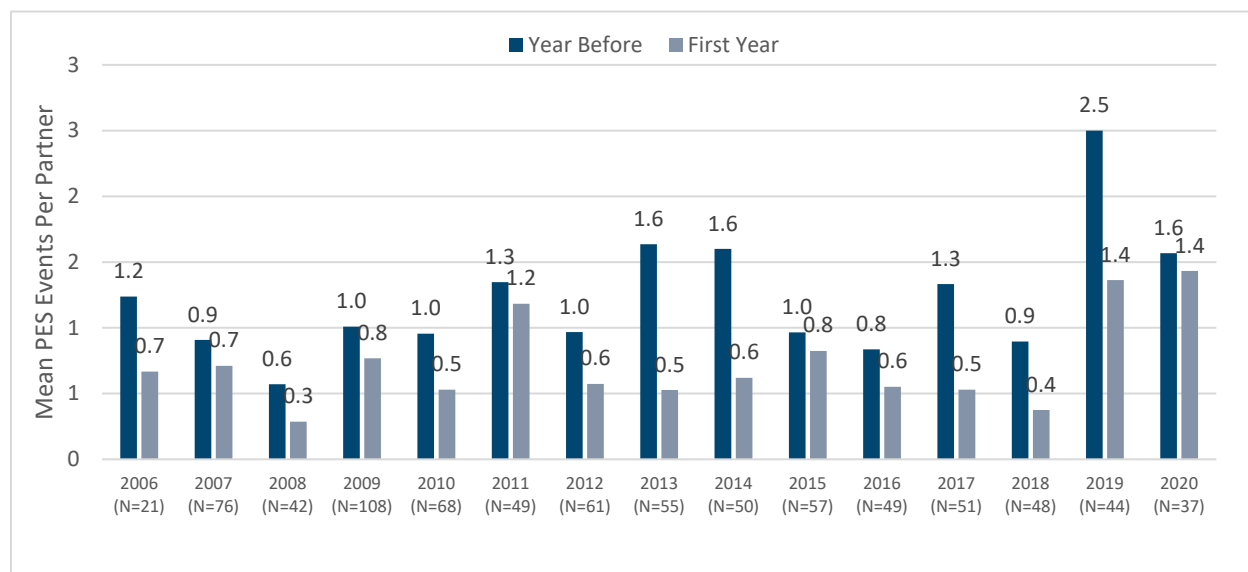
Appendix A: Additional Detail on Residential Outcomes

For residential setting outcomes, by FSP provider, we present all the categories of living situations and compare the percentages of any partners spending any time in various residential settings the year prior to FSP and in the first year of FSP participation. In the County there are currently four comprehensive FSP providers: Edgewood Center and Fred Finch Youth Center (hereafter, Edgewood/Fred Finch)[6] serving children, youth, and transition age youth; and Caminar and Telecare serving adults and older adults. A list of all residential settings and how they are categorized, is presented in Appendix C with the methodological approach.

As can be seen in Exhibit A1, A2, and A3, the percent of clients reporting any time in an inpatient clinic, homeless, incarcerated, or living with parents decreased. In contrast, for the percent of clients who reported any time living alone or with others, paying rent increased or remained the same. Inconsistency across providers is observed for clients reporting any time in assisted living, group home or community care environment, where the percent of Caminar and Edgewood/Fred Finch partners decreased and the percent of Telecare partners slightly increased.

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[6] The self-reported data from Edgewood Center and Fred Finch Youth Center is combined into one dataset, therefore, we refer to both centers as Edgewood/Fred Finch in this report to be consistent with the data.

Exhibit A1: Percentage of Caminar Partners Completing 1 year in the FSP Program Who Lived in A Residential Settings for Any Time During the Study Period (n = 175)
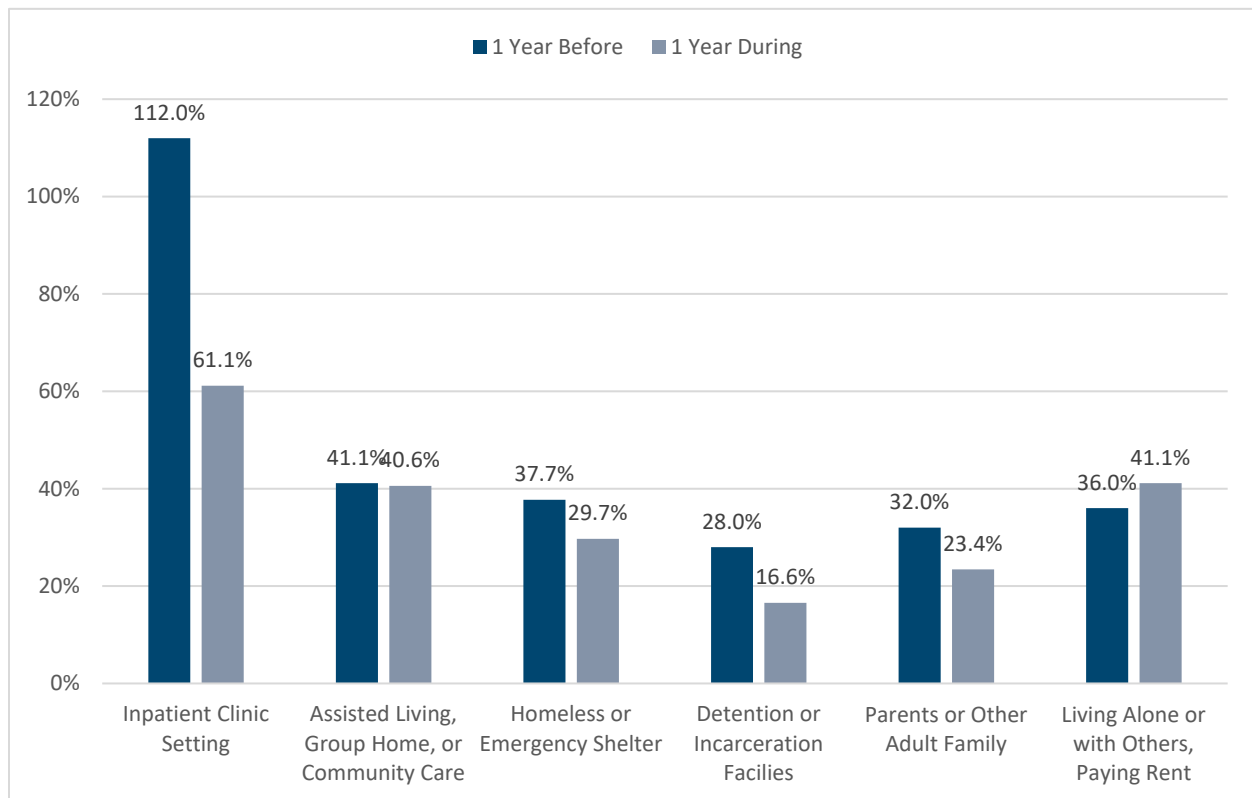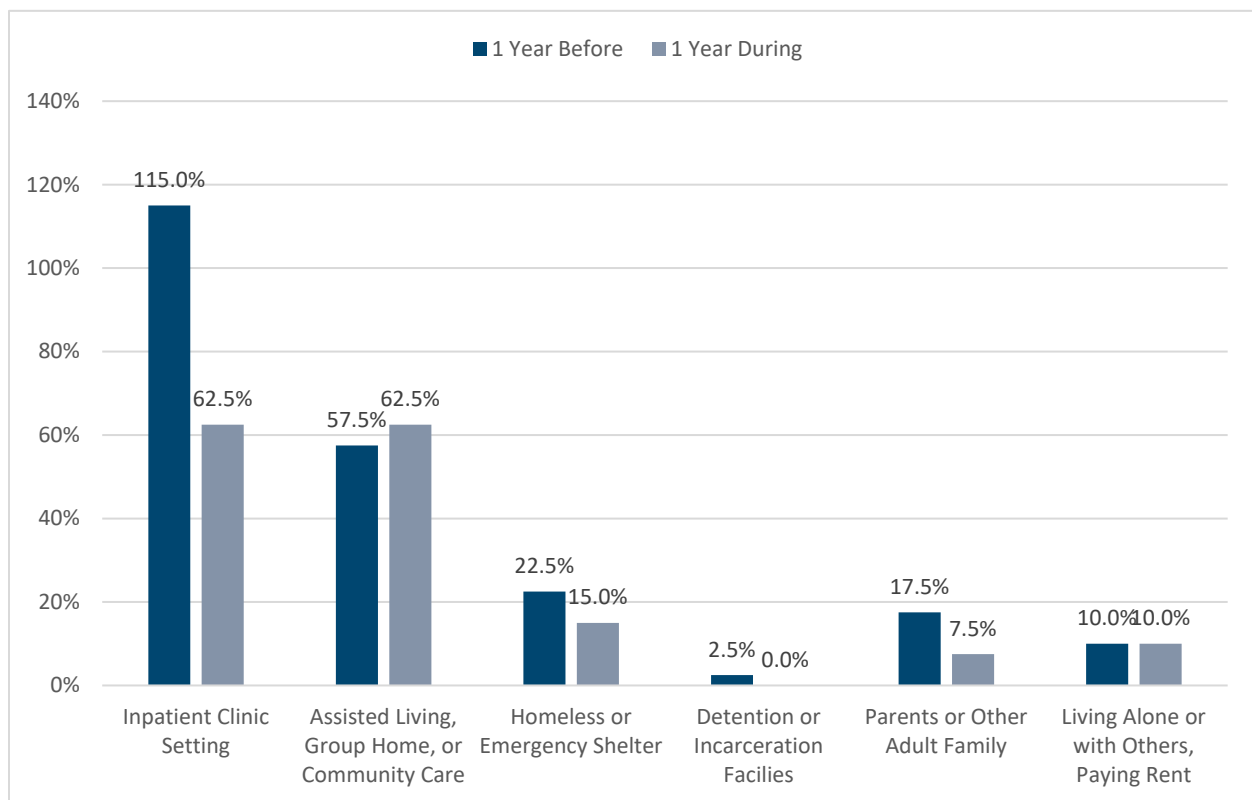

Note. Residential settings are not mutually exclusive, so percents may exceed 100.

Exhibit A2: Percentage of Edgewood/Fred Finch Partners Completing 1 year in the FSP Program Who Lived in A Residential Settings for Any Time During the Study Period (n = 451)
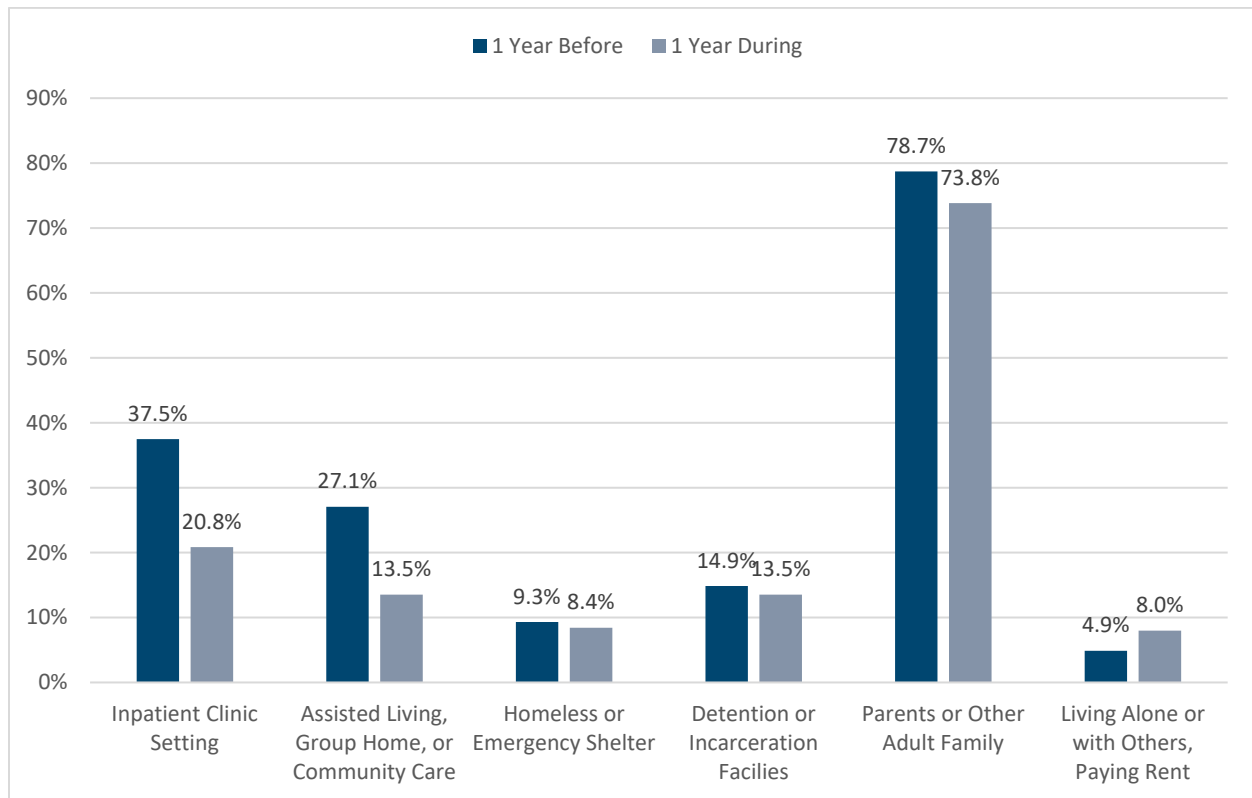
Note. Residential settings are not mutually exclusive, so percents may exceed 100.

Exhibit A3: Percentage of Telecare Partners Completing 1 year in the FSP Program Who Lived in A Residential Settings for Any Time During the Study Period (n = 40)

Note. Residential settings are not mutually exclusive, so percents may exceed 100.

Appendix B: Additional Detail on Outcomes by FSP Providers

This section provides more detail on the results presented in the main report. No outcomes are presented for any group of partners with 10 or fewer individuals.

Exhibit B1-B3 presents the percent of partners with any events the year just prior to FSP enrollment and the first year in an FSP, as well as the percent improvement for each FSP provider. Percent improvement is the change in percent of partners who experienced the named event in the first year of FSP participation relative to the percent of partners experiencing the event in the year prior to participating in FSP.

As can be seen in Exhibit B1, there are improvements comparing the year prior to FSP to the first year during FSP for Caminar on all the available self-reported outcomes.

Exhibit B1. Percent of Caminar Partners with Outcome Events by Year and Percent Change in Prevalence of Outcome Events (Year before FSP vs. the first year of FSP participation) (n=175)

Survey Outcomes, Caminar	1 Year Before	Year 1 During	Change (%)
Homelessness	37.7%	29.7%	-21.2%
Detention or Incarceration	28.0%	16.6%	-40.8%
Arrests	22.9%	3.4%	-85.0%
Mental Health Emergencies	72.0%	28.0%	-61.1%
Physical Health Emergencies	38.3%	12.0%	-68.7%
Employment	0.0%	1.7%	N/A
Active Substance Use Disorder	49.7%	44.6%	-10.3%
Substance Use Disorder Treatment	21.1%	24.6%	16.2%

As can be seen in Exhibit B2, there are improvements comparing the year prior to FSP to the first year during FSP for Telecare on most available self-reported outcomes, except for mental health emergencies, employment, and substance use disorder treatment. The percent difference with employment is reported as N/A because the percent of partners with employment did not change (from 0% to 0%). Thus, the denominator is 0.

Exhibit B2. Percent of Telecare Partners with Outcome Events by Year and Percent Change in Prevalence of Outcome Events (Year before FSP vs. the first year of FSP participation) (n=40)

Survey Outcomes, Telecare	1 Year Before	Year 1 During	Change (%)
Homelessness	22.5%	15.0%	-33.3%
Detention or Incarceration	2.5%	0.0%	-100.0%
Arrests	15.0%	0.0%	-100.0%
Mental Health Emergencies	27.5%	35.0%	27.3%
Physical Health Emergencies	15.0%	2.5%	83.3%
Employment	0.0%	0.0%	N/A
Active Substance Use Disorder	57.5%	25.0%	-56.5%
Substance Use Disorder Treatment	7.5%	0.0%	-100.0%

Note. Red (bold) font indicates outcomes that worsened, such as more frequently reported mental health emergencies.

Exhibit B3 shows improvement for Edgewood/Fred Finch partners in all outcomes except for self-rated academic grade and school attendance.

Exhibit B3. Percent of Edgewood/Fred Finch Partners with Outcome Events by Year and Percent Change in Prevalence of Outcome Events (Year before FSP vs. the first year of FSP participation) (n=451)

Survey Outcomes, Edgewood	1 Year Before	Year 1 During	Change (%)
Homelessness	9.3%	8.4%	-9.5%
Detention or Incarceration	14.9%	13.5%	-9.0%
Arrests	40.1%	6.7%	-83.4%
Mental Health Emergencies	40.6%	7.3%	-82.0%
Physical Health Emergencies	15.3%	1.3%	-91.3%
Suspension	15.1%	5.5%	-63.2%
Academic Grade	3.33	3.09	-7.2%
School Attendance	2.26	2.13	-5.9%

Note. Red (bold) font indicates outcomes that worsened, such as the decline in grade ratings.

Appendix C: Methods

Methodology for FSP Survey Data Analysis

The FSP survey data are collected by providers via discussions with partners and should thus be viewed as self-report. Among the providers included in these analyses (Edgewood/Fred Finch, Caminar, and Telecare), 666 partners completed a full year with FSP since program inception.

In general, three datasets are obtained for this report: one from Caminar, one from Telecare and one from Edgewood/Fred Finch. All providers provide their datasets in a Microsoft Excel format. In 2018, Telecare changed their data system for the FSP survey in which the data structure and variable names were different from before. Due to data reliability issues, Telecare only provided the data after their data system change—i.e., data from December 2018 onward. Therefore, the main analysis of this report includes all Caminar and Edgewood/Fred Finch partners, and a separate analysis is included for Telecare data since December 2018.

Edgewood/Fred Finch serve child partners and transitional age youth (TAY) partners. Caminar and Telecare serve primarily adult and older adult partners, and a small number of older TAY clients. Exhibit C1 below describes the age group of partners completing at least one full year of FSP from 2006 to 2021 by provider. For Telecare, this data includes December 2018 through June 2021.

Exhibit C1: Summary of Partners One Full Year of FSP

Age Group	Edgewood/ Fred Finch	Caminar	Telecare	Total*
Child (aged 16 and younger)	201	--	--	201
TAY (aged 17 – 25)	250	43	2	295
Adult (aged 26 -59)	--	113	25	138
Older Adult (aged 60+)	--	19	13	32
Total	451	175	40	666

Note. *Telecare partners in the analysis include only those who joined the FSP after December 1, 2018 due to data availability. Telecare partners were not reported in the survey outcomes by age group, a separate analysis was conducted for Telecare partners all age groups combined due to small sample size.

A master assessment file with FSP start and end dates and length of FSP tenure was created at the client level. Note that for clients who stopped and then reestablished their FSPs, we only kept the record corresponding with their most recent participation in an FSP (using Global ID), as indicated in the State's documentation.

Partner type (child, TAY, adult, and older adult) is determined by the Partnership Assessment Form (PAF) data.

- For Caminar and Edgewood/Fred Finch, this was done by selecting records with specific Age Group codes, i.e.:
    - Caminar: selected records with Age Group codes of "7" (TAY partner, aged 17 to 25), "4" (adult partner, aged 25 to 59), and "10" (older adult partner, aged 60 and older).
    - Edgewood/Fred Finch: selected records with Age Group codes of "1" (child partner, aged 16 and younger) and "4" (TAY partner, aged 17 to 25).
    - In both cases, this was confirmed using the data file's continuous *Age* variable.
- For Telecare data, partners were given an age appropriate PAF. Records with specific *Form Type* codes were retained in the analysis (i.e., Form Types "TAY_PAF". "Adult_PAF" and "OA_PAF").

Partnership date and *end date* were determined as follows: Partnership date was determined using enrollment start date. End date was determined by the reported date of the partnership status change in the Key Event Tracking (KET) form to "discontinued." For clients still enrolled at the time of data acquisition, we assigned an end date of June 30, 2021.

All data management and analysis was conducted in Stata. All code is available upon request. Additional details on the methodology for each outcome are presented below.

Residential Setting

1. Residential settings were grouped into categories as described in the table below (Exhibit C2).

2. The baseline data were populated using the variable *PastTwelveDays* (Caminar and Edgewood/Fred Finch) or *res_past12m_days_int* (Telecare) collected by the PAF. Individuals without any reported locations were assigned to the "Don't Know" category.

3. The partner's first residential status once they joined FSP is determined by the *Current* (Caminar and Edgewood/Fred Finch) or *res_curr_dsr* (Telecare), collected by the PAF. Individuals without any reported current residence were assigned to the "Don't Know" category. Some individuals had more than one first residence location. In this case, if there was one residence with a later date (as indicated by the variable, *DateResidentialChange* (Caminar and Edgewood/Fred Finch) or *main_resident_date* (Telecare)), this residence was considered to be the first residential setting. If the residences were marked with the same date, both were considered as part of the partner's first year in an FSP.

4. Additional residential settings for the first year were found using the KET data, inclusive of all residence types listed with a corresponding date of residential change (*DateResidentialChange* (Caminar and Edgewood/Fred Finch) or *main_resident_date* (Telecare)) occurring within one year of the FSP partnership start date. If no residential data were captured subsequent to the PAF by a KET, it was assumed that the individual remained in their original residential setting.

Exhibit C2: Residential Setting Categories and Corresponding Classification Values used to Derive Them

Category	Telecare, Caminar, Edgewood/Fred FinchSetting Value[7]
With family or parents	
With parents	1
With other family	2
Alone	
Apartment alone or with spouse	3
Single occupancy (must hold lease)	19
Foster home	
Foster home with relative	4
Foster home with non-relative	5
Homeless or Emergency Shelter	
Emergency shelter	6
Homeless	7
Assisted living, group home, or community care	
Individual placement	20
Assisted living facility	28
Congregate placement	21
Community care	22
Group home (Level 0-11)	11
Group home (Level 12-14)	12
Community treatment	13
Residential treatment	14
Inpatient Facility	
Acute medical	8
Psychiatric hospital (other than state)	9
Psychiatric hospital (state)	10
Nursing facility, physical	23
Nursing facility, psychiatric	24
Long-term care	25
Incarcerated	
Juvenile Hall	15
Division of Juvenile Justice	16
Jail	27
Prison	26
Other / Don't Know	
Don't know	18
Other	17

Employment

Employment outcomes were generated for adults only. Therefore, Edgewood/Fred Finch data were excluded.

1. The baseline data were populated using the PAF data. An individual was considered as having had any employment if there was a non-zero, non-blank value for one of the following variables (note that variable names differ slightly by dataset):

   a. Any competitive employment in past twelve months (any competitive employment; any competitive employment for any average number of hours per week; any average wage for competitive employment)

   b. Any other employment in past twelve months (any other employment; any other employment for any average number of hours per week; any average wage for any other employment)

2. Ongoing employment was populated using any dates of employment change (variable names vary slightly by file) noted in the KET file within the first year of membership in FSP (as determined by the partnership start date). An employment change was coded if the new employment status code corresponding to the employment change date indicated competitive employment or other employment. If the KET contained no information on employment, the original employment was presumed to sustain throughout FSP membership.

Arrests

1. The baseline arrest data were populated using the variable *ArrestsPast12* (Caminar and Edgewood/Fred Finch) or *lgl_arrest_p12_times* (Telecare) collected by the PAF. If the variable was blank, the partner was assumed to have zero arrests in the year prior to FSP.

2. Ongoing arrests were populated using any dates of arrest (variable names vary slightly by file) noted in the KET file within the first year of membership in FSP (as determined by the partnership date). If the KET contained no information on arrests, the partner was assumed to have had no arrests in the first year in an FSP.

Mental and Physical Health Emergencies

1. The baseline utilization of emergency services was populated using the PAF's variables for mental health emergencies (*MenRelated* (Caminar and Edgewood/Fred Finch) or *emr_mental_p12* (Telecare)) and physical health emergencies (*PhysRelated* (Caminar

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[7] Setting names determined by the following guide:
https://mhdatapublic.blob.core.windows.net/fsp/DCR%20Data%20Dictionary_2011-09-15.pdf

and Edgewood/Fred Finch) or *emr_physical_p12* (Telecare)*)*, respectively. If either of these fields were blank, the partner was assumed to have had zero emergencies of that type in the year prior to FSP.

2. Ongoing emergencies were populated using the variable indicating the date of emergency (variable names vary slightly by file) in the KET file, as long as the date is within the first year with FSP as determined by the partnership date. The type of emergency was indicated by *EmergencyType* (Caminar and Edgewood/Fred Finch) or *main_emergency_int_dsr* (Telecare) ("1"=physical; "2"=mental). We assumed that no information on emergencies in the KET indicated that no emergencies had occurred in the first year on FSP.

Substance Use Disorder

1. Baseline data on substance use disorder were populated using variables in the PAF for active substance use disorder (*ActiveProblem* (Caminar and Edgewood/Fred Finch) or *sub_co_mh_sa_probl_past* (Telecare)*)* and participation in substance use disorder treatment and recovery services (*AbuseServices* (Caminar and Edgewood/Fred Finch) or *sub_sa_services_now* (Telecare)*)*. If these fields were blank, the partner was assumed to have had no substance use disorder nor received substance use disorder treatment and recovery services in the year prior to FSP.

2. Ongoing substance use disorder data were populated using the 3M data variables of the same name. Any record of an active substance use disorder or participation a substance use disorder treatment during the first year of FSP was recorded. If there were no observations in the variables of interest, clients were assumed to have no ongoing substance use disorder or participation in substance use disorder treatment.

Methodology for Avatar Data Analysis

Hospitalization outcomes were derived from electronic health records (EHR) data obtained through the Avatar system. Using EHR data avoids some of the reliability shortcomings of self-reported information but presents several challenges as well. The Avatar system is limited to individuals who obtain care in the County hospital system. Hospitalizations outside of the County, or in private hospitals, are not captured. The hospitalization outcomes include 816 partners who were both (1) included in the Avatar system and (2) completed one full year or more in a FSP program by the June 2021 data acquisition date. Thus, individuals included in the EHR analysis had to have started with the FSP between July 2006 (the program's inception) and June 2020.

All data management and analysis were conducted in Stata. Code is available upon request.

To count instances of psychiatric hospitalizations and PES admissions, we relied on the Avatar *view_episode_summary_admit* table. Exhibit C3 shows the corresponding program codes. Additionally, FSP episodes were identified through the Avatar *episode_history* table.

Exhibit C3: Program codes among clients ever in the FSP

Program code	Program value
Psychiatric Hospitalizations	
410200	ZZ410200 PENINSULA HOSPITAL INPT-MSO I/A
410205	410205 PENINSULA HOSPITAL INPATIENT
410700	410700 SMMC INPATIENT
921005	921005 NONCONTRACT INPATIENT
926605	926605 JOHN MUIR MED. CTR INPT MAN CARE
Psychiatric Emergency Services	
410702	Z410702 SMMC PES -termed 10/31/14
410703	410703 PRE CONV SMMC PES~INACTIVE
41CZ00	41CZ00 SAN MATEO MEDICAL CENTER - PES

Notes. Data represent all utilization from FSP clients for these codes, as pulled from Avatar on February 18, 2022.

Partner type (child, TAY, adult, and older adult) was determined by the partner's age on the start date of the FSP program, as derived from the *c_date_of_birth* variable from the *view_episode_summary_admit* table and the *FSP_admit_dt* variable from the *episode_history* table.

As we have discussed in the previous year's report, the distribution of partners by age group is different between the Avatar data and the FSP Survey data. This is likely due to the different

ways age group was determined. For the survey data, AIR determined age group by whether the partner was evaluated using the child, TAY, adult, or older adult FSP survey forms. For the Avatar data, AIR assigned individuals to an age group based upon the date they joined FSP and their reported date of birth.

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APPENDIX 7. CONTRACTOR'S ASSOCIATION GRANT FUNDING REPORT

Caminar

CONTRACTOR	Comments
AUM	Goal#1: Participants will have a basic understanding of epigenetics and racism. At least 75% of participants (BHRS Contractors) will be able to identify 2 ways that racism has biological implications that are transferred multigenerationally through chemicals, cells, hormones and fibers in the body that manifest adverse mental and physical health outcomes. Goal Achieved Goal#2: Through guided meditation, movement, art and role playing, participants will have a visceral experience of the effects of racism both as white privilege and as the experience of oppression on the part of people of color. 75 % of participants (BHRS Contractors) will come away being able to describe 2 ways that of institutional racism is experienced. Goal Achieved Goal #3: Participants will learn at least one new tool that can be used specifically with people of color in their caseloads. 75% of participants (BHRS Contractors) will be able to use at least one emotional intelligence tool specifically designed to address issues of racism.
California Clubhouse	We updated printed and electronic marketing and information materials and data system that better reflect cultural competency; We updated our agency Cultural Competency Plan which includes an evaluation of our current norms, values, and practices in our organization that advantage some people at the exclusion and oppression of others; We created an organizational Annual Staff Training Plan with curriculum that addresses racial equity, equality, social justice, cultural competency, humility, inclusiveness, and traum; 100% of agency staff (7) received training in cultural awareness; Increased participation in San Mateo County Health Initiatives and on the Peer Task Force Steering Committee
Children's Health Council	96% of staff participated in Training
Edgewood	This year, Edgewood was able to continue its work towards becoming a trauma informed system. Activities included: - Four members of the Executive Leadership team participating in a white accountability training series and Racial Equity for Leaders of Color training series facilitated by the SF DPH. - Sixteen attendees at the Black Health Matters training facilitated by our partners at Arts Unity Movement - Contracting with the California Institute for Behavioral Health Solutions to faciltiate a series of telehealth engagement trainings. Topics included: It Starts With YOU: Provider Self-Care, Understanding Mindfulness While Working with System Involved Youth and Familes, and Utilizing Daily Spiritual Practices in Telehealth- all of which have been added to our e-learning library for future use. - Senior Leadership team hosted seven open forum dialogues about race and its impact on our work, which were mostly in response to the recent unfortunate, violent acts of racism in the community. - 15 service providers and supervisors attend a family therapy training that focused on self-awareness, bias and culturally aware practices in family treatment. Outcomes included: - At the time of this report, 73% are in compliance with their training requirements, including the 8 hours of cultural competency. - 64% of our providers participated in at lesat one improving engagement in telehealth services.
El Centro	(10) staff received (2) two-day Motivational Interviewing (MI) trainings by a certified facilitator. Staff learned specific Motivational Interviewing techniques and gained specific skills to enhance clients' motivations to change problematic behaviors. Additionally, (10) staff received training in Cultural and Linguistic standards and improved their skills and understanding of the health care experiences of patients with diverse backgrounds.
Felton Institute	Outcome #1: In December 2020, eleven staff members of Felton Institute (re)MIND®/BEAM San Mateo attended and participated in six virtual CBTp training sessions for frontline providers. In addition, eleven staff members participated in 1h/weekly team CBTp consultations with the trainers for the remainder of the fiscal year. Outcome #2: As of May 2021, seven Felton Institute (re)MIND®/BEAM San Mateo staff members attended and participated in one co-occurring disorders training and at least one cultural responsiveness training.
Fred Finch	The Impact of Poverty Nicole Klasey, Psy.D., & Nola Brantley (12/18/20) Working with Arab & Middle Eastern Populations: Clinical & Cultural Considerations Mary N. Iskarous, Psy.D. (4/17/21) Attachment, Regulation & Competency (ARC) Complex Trauma Treatment Matthew Madaus, LCSW 5/26/21 Supporting the multifaceted issues of grief in children. Shoshana Phoenixx 6/18/21 Suicide and Youth: Understanding, Safety Planning, and Decreasing Future Suicidal Ideation with System involved Youth. Pamela Parkinson, Ph.D., LCSW 6/30/21 All trainings attended by all staff (10) except for Consultations with Tequelia Washington (2 staff, all staff attended Affinity groups) and Working with Arab Populations (1 staff).
Free At Last	A minimum of seventy-five percent (75%) of Funding Recipients' staff who provide direct services will participate in training that develops new skills in the areas of trauma, co-occurring disorders and/or cultural awareness. When responding also include how many staff working with BHRS in San Mateo County this represents for your agency. We had 90% or 20 of 22 Free At Last staff who participated in the training increased their knowledge and or skills to assist them with their work. We had 90% or 20 of 22 of Free At Last staff who participated in the training saw the value in the training. 100%, 22 of 22 staff have access to evidence based materials. Materials have been distributed to all the programs for staff to have direct access to them.
Heart and Soul	We were able to provide workshops and presentations for staff and participants about various aspects of racial awareness and social justice. Participants learned about social structure and how to be an anti-racist in light of current events. We were also able to help fund some Seeing Through Stigma panels on the same topics.
Latino Commission	Developed, produced, broadcast and stored video and audio professional trainings for staff. We increased and improved capacity to access staff trainings, using digital communications, podcasts, Webinars, Microsoft Teams Meetings and Teams Live Events. Contracted professional licensed presenters, a MD, PsyD, LCSW and RN. 100% of certified counselors (10/10) direct services staff completed 100% of trainings, with 75% of all staff (26/34) completing all 19 virtual trainings. * Medical Virtual Training Sessions, presented by: Dr. Christian O'Neill, M.D. Medical Updates, Covid 19 9/7/2020 Medical Training, Medication Management 5/7/2021 * COMMON HEALTH-RELATED ISSUES FOR THE CLINICIAN, Luke Camarillo, RN Strategies for Wellness 3/18/2021 The Chain of Infection 4/22/2021 Upper Respiratory Disease 5/20/2021 Systematic Approaches 6/17/2021 * Enderezando Las Raices and Cognitive Behavior Therapy, Debra Camarillo, MA, CATC I History Working Towards Health Equity 8/27/2020 Maize-based Philosophy, In Lak Etch 9/3/2020 Reflection 9/10/2020 La Cultura Cura 'Culture Heals' 10/1/2020 * CULTURAL COMPLIANCE FOR THE CLINICIAN, Luís Cíprez, LCSW Cultural Competence 3/17/2021 Cultural Humility 4/21/2021 Addressing the Cultural Needs of Clients 5/19/2021 Explicit and Implicit Bias 6/23/2021 * Mental Health Virtual Training Sessions, presented by: Dr. Karla Solis, PsyD Transference 2/9/2021 Defense Mechanisms 3/9/2021 Impulsivity 4/13/2021 Cognitive Distortions 5/11/2021 Mood and Personality Disorders 6/8/2021

CONTRACTOR	Comments
Mental Health Association	MHA purchased 27 different books focused on education about racism. Multiple copies of several books were ordered, distributed and were the basis for monthly cultural humility staff meetings over the past twelve months. Staff were also provided with a list of books and materials that MHA purchased on their behalf for their personal use. MHA hosts an ongoing monthly cultural humility meetings for staff. Staff are asked to rotate facilitation of this activity, pairing up to present on different topics and experiences. They have also invited individuals from outside of MHA to facilitate conversations about racism as well as implicit bias. We have identified online materials as an additional means of providing part-time and overnight staff with opportunities to engage in this work through paid participation during times they do not normally work. Funds were also used to pay part-time staff to work during hours they would not normally to complete sexual harassment training and other related trainings.
Mental Health Association	Curriculum and materials related to cultural competency will be uploaded to Association website's members only portal and available for access by members' staff 24 hours a day. Member agencies have a chance to include materials that have been most helpful to them, thereby increasing the sharing of resources. 100% of BHRS Contractor Association members' staff will have access to training and materials specifically designed and related to improving cultural competency, particularly through the sharing of resources and information among member agencies. This will have a positive impact on at least 1,000 employees of member agencies.
Peninsula Family Service	Engaged Old School and Ashton Applewhite to conduct 2 90 minute virtual rainings on Ageism for staff and volunteer peer counselors. The first training, held on 3/2/21 was entitled" Let's Dismantle Ageism." Approximately 12 staff and 15 volunteers attended. The second training was held on 3/16/21 an entitled" Confronting Ageism and Ableism in the Pandemic's wake. 13 staff and 19 volunteers attended. Most staff and volunteers are older adults. They found both trainings helpful in their personal and professional lives.
Puente	Puente is grateful for the support of the Mental Health Association of San Mateo County. Puente served 2,670 unduplicated participants from May 2020 to April 2021, which is a 50% increase from the previous year. During fiscal year 20/21, Puente's Behavioral Health and Recovery Services (BHRS) team provided 162 unduplicated individuals with one-on-one counseling sessions and 223 individuals with group sessions. These services were provided at no cost to the participants in the rural towns of Pescadero, La Honda, Loma Mar, and San Gregorio in San Mateo County. The ability to improve capacity to address trauma and to incorporate evidence-based practices into day-to-day resources involves a multi-pronged public health approach inclusive of education and awareness, prevention and early identification, and effective treatment. Puente was uniquely able to take this multi-pronged approach in serving the Rural South Coast community.
Service League	All classes were attended via oom. All training series provided all participants with an increased knowledge of a variety of evience based cultural competency topics. Trainings will assist all staff to better undersdtand the challenges that our clients face in their lives.
Sitike	Sitike utilized the grant monies to invest in an organizational change model dedicated to assisting our organization in nurturing and sustaing trauma-informed practices. In addition, we partnered with other local non-profits to improve our capacity to provide integrated models for addressing trauma and co-occurring didsorders, improve cultural humility, and improve capacity to incorporate evidenced based practcies into day-to-day resources. Through these initiatives, we've begun cultivating a healing environment by increasing organizational resilience and improving workforce skill and experience.
Star Vista	StarVista is committed to utilizing highly researched evidence-based practices in providing treatment services to clients specifically focused on trauma informed services for co-occurring disorders. A number of StarVista programs utilize the Seeking Safety model of Lisa Najavits, PhD, and have requested additional training to build clinical skills. The Title "Seeking Safety" is also the objective of the model. Seeking Safety is an evidence-based practice designed for working with people who have co-morbid issues with regard to trauma (PTSD), substance use disorders (SUD). The goal of Seeking Safety is to promote recovery by assisting the individual in developing strategies to keep them safe from the effects of trauma and the painful impact of substance use. StarVista will be providing a 2 hour trainings on 3 separate occasions over several months, on different days and times to engage as many StarVista clinicians as possible. The trainings will be provided by Clarise Blanchard, PhD. Department Director and Charlotte Ormond, PsyD., private practice therapist. Training Objectives: Participants are able to: 1. Discuss current understanding of evidence-based treatment of trauma and substance abuse 2. Demonstrate empathy and understanding of trauma and substance abuse 3. Describe Seeking Safety, an evidence-based model for trauma and/or substance abuse 4. Identify assessment and treatment resources 5. Identify how to apply Seeking Safety for specific populations, such as homeless, adolescents, criminal justice clients
Voices of Recovery	Voices of Recovery San Mateo County committed to training staff outside working hours in a Leadership Development Training. This training had to be rescheduled due to COVID 19 the rescheduled date is : Training and additional staff hours - $6075.95, Voices staff are part-time, and training will have to take place outside of working hours. - Leadership Develop - Cultural Competency - Facilitators Best Practices - Trauma informed - Relapse Prevention - Etc.

Report created by: Caroline Raymundo

APPENDIX 8. PEI THREE-YEAR EVALUATION REPORT

San Mateo County Behavioral Health and Recovery Services (SMC BHRS) Provider Outreach Annual Report

FY 2020-2021

Koray Caglayan, PhD
Lee Nethercott, BA

December 2021

AIR®

Advancing Evidence.
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San Mateo County Behavioral Health and Recovery Services (SMC BHRS) Provider Outreach Annual Report

FY 2020-2021

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Lee Nethercott, BA

DECEMBER 2021

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Exhibits

Executive Summary

In 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA), to provide funding to Counties for mental health services by imposing a 1 percent tax on personal income in excess of $1 million. The Community Services and Supports (CSS) component of MHSA was created to provide direct services to individuals with severe mental illness and included Outreach and Engagement activities.

San Mateo County Behavioral Health and Recovery Services (SMC BHRS) funds the North County Outreach Collaborative (NCOC) and the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) to provide outreach and engagement activities throughout San Mateo County. Each collaborative has providers who provide direct services to the populations they serve.

This report summarizes self-reported data from attendees across individual and group outreach events that occurred in fiscal year (FY) 2020-2021 (July 1, 2020, through June 30, 2021). We also present historical data since FY 2014-2015 to show how outreach has changed over time. The appendices provide information at the provider level.

Total Attendance

For FY 2020-2021, SMC BHRS providers reported a total of 7,499 attendees at all outreach events. This number was lower than for FY 2019-2020, when there were 13,023 attendees, but is comparable to the numbers observed in prior years. The decrease from the previous year is driven by a reduction in both the group and individual outreach events in FY 2020-2021. For example, in FY 2019-2020, SMC BHRS providers reached 12,210 attendees across 252 group outreach events, while in FY 2020-2021 providers reached 6,984 attendees across 115 group outreach events.

Demographic Characteristics of Outreach Attendees

NCOC

There was a total of 7,254 attendees at NCOC's outreach events. NCOC's most common age group among outreach attendees was adults (33%). Almost half of the attendees were female (49%). The three largest racial/ethnic groups were White (27%), Mexican (14%), and Asian (7%). Twenty-four percent of attendees declined to state their race and ethnicity. Of those reporting special population status (i.e., homeless, at risk of homelessness, vision impaired, hearing impaired, veterans), 36 percent of attendees reported being at risk of homelessness, and 21 percent of attendees reported having a physical/mobility disability.

EPAPMHO

There was a total of 254 attendees at outreach events. EPAPMHO outreach attendees were largely adults (57%). Most attendees were female (67%). The greatest proportion of attendees by ethnicity were Mexican (41%), followed by Hawaiian (16%). The percentage of Mexican attendees almost doubled from 22.8 percent to 41.1 percent over the last two years. Of those reporting special population status, 28 percent were at risk of being homeless and 25 percent were homeless.

Outreach Event Characteristics

NCOC

NCOC individual outreach events ranged from 15 minutes to 2 hours, averaging 40 minutes. Outreach events took place virtually and over the phone. Most individual outreach events were conducted in English (95%).

NCOC group outreach events ranged from 5 minutes to 8 hours, averaging 83 minutes. Of the 112 group outreach events, most were conducted in non-traditional locations and virtually. All outreach events were conducted in English.

NCOC individual outreach events resulted in mental health referrals (78%) and substance use referrals (9%). Providers made 866 referrals for 226 NCOC individual outreach attendees. Of the different referral types, the top four types of referrals made for attendees were in food (19%), medical care (19%), "other" category (17%), and financial services (14%). "Other" category referrals that were reported include obtaining referrals for communication, check-ins, and COVID testing.

EPAPMHO

EPAPMHO individual outreach events lasted from 10 to 60 minutes and averaged 21 minutes. Outreach events took place mostly in offices and over the phone. Over half were held in Spanish (53%).

There were three EPAPMHO group outreach events that lasted 90 minutes. All three events occurred in offices. Two events were conducted in English while one event was conducted in Tongan.

EPAPMHO individual outreach events resulted in mental health referrals (37%) and substance use referrals (20%). Providers made 367 referrals for 194 attendees. Of the different referral types, the top three types of referrals were for housing (20%), food (17%), and "other" category (14%). "Other" referrals that were reported were mostly referrals for the Housing Energy Assistance Program (HEAP).

Recommendations

We have the following recommendations based on FY 2020-2021 data. These recommendations fall under two umbrellas: those aimed at enhancing outreach and those to improve data collection.

Enhance Outreach

Continue to conduct outreach in languages other than English. This past reporting year, outreach events were conducted in languages that represented the residents served by the participating providers. For example, the EPAPMHO collaborative conducted outreach in Spanish, as the Mexican population was the largest racial/ethnic population attending these events. Similarly, EPAPMHO group sessions were offered in Tongan, as participants indicated it as their preferred language. Conducting outreach in languages other than English can ensure that the SMC BHRS outreach program is serving the needs of the county's non-English speaking population.

Continue to offer non-office locations for group and individual outreach events. The data for this year show that many outreach events were conducted in communities, in non-traditional locations such as virtual meetings, and through telehealth services. Although this may have been in response to the pandemic, the county should consider continuing to provide alternative locations or venues, including a virtual option. This will help with the outreach efforts and also give county residents multiple options to avail themselves of the services offered through the program.

Improve Data Collection

Make "other"/unspecified categories clearer. Outreach staff have made an effort to provide better data collection and minimize missing data. For example, participants who selected the "other community location" were able to indicate the other locations in an open text field provided by the survey. The data show that, in many cases, attendees reported Zoom calls or similar virtual platforms for other locations. However, in some cases, it is difficult to assess the nature of the responses that fall under the "other" category. For example, for referrals, the "other" category (17%) included common responses such as "communication" or "check-ins" without any further detail. A next step could be providing more information related to these responses to better understand the nature of the referral.

It will also be beneficial to offer more categories for respondents to use when describing the "location" of individual outreach events, as up to 13 percent of respondents served by the EPAPMHO collaborative selected "unspecified" field locations.

Introduction

In 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA), to provide funding to Counties for mental health services by imposing a 1 percent tax on personal income in excess of $1 million. Activities funded by MHSA are grouped into various components. The Community Services and Supports (CSS) component was created to provide direct services to individuals with severe mental illness. CSS is allotted 80 percent of MHSA funding for services focused on recovery and resilience while providing clients and families with an integrated service experience. CSS has three service categories: (1) Full-Service Partnerships, (2) General System Development Funds, and (3) Outreach and Engagement.

The San Mateo County Behavioral Health and Recovery Service (SMC BHRS) MHSA Outreach and Engagement strategy aims to increase access and improve linkages to behavioral health services for underserved communities. Strategies include community outreach collaboratives, pre-crisis response, and primary care-based efforts. SMC BHRS has seen a consistent increase in representation of underserved communities in its system since the strategies were deployed.

Community outreach collaboratives funded by MHSA include the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) and the North County Outreach Collaborative (NCOC). EPAPMHO caters to transition-age youth and underserved adults; Latino, African-American, and Pacific Islander communities; and people who are Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) in East Palo Alto. NCOC caters to rural and/or ethnic communities (Chinese, Filipino, Latino, Pacific Islander) and LGBTQ communities in the North County region, including Pacifica. These collaboratives provide advocacy, systems change, resident engagement, expansion of local resources, and education and outreach to decrease stigma related to mental illness and substance use. They work to increase awareness of, and access and linkages to, culturally and linguistically competent services for behavioral health, Medi-Cal and other public health services, and social services. They participate in a referral process to ensure that those in need receive appropriate services such as food, housing, and medical care. Finally, they promote and facilitate resident input into the development of MHSA-funded services and other BHRS program initiatives.

The American Institutes for Research (AIR) has supported SMC BHRS in providing findings from the county's outreach activities since FY 2014-2015. This annual report reports on outreach activities conducted by providers in fiscal year (FY) 2020-2021 (July 1, 2020, through June 30, 2021). Providers collected outreach data using an electronic form (SurveyMonkey®) that gathers information self-reported by the attendees. AIR created this form based on interviews with San Mateo County staff and focus groups with providers. After data are entered, AIR cleans the data and calculates aggregated counts and percentages to describe outreach activities.

This report focuses on EPAPMHO's and NCOC's outreach events that occurred during FY 2020-2021. We also present historical data from FY 2014-2015, FY 2015-2016, FY 2016-2017, FY 2017-2018, FY 2019-2020, and FY 2020-2021 to show how outreach has changed over time. Counts of attendees do not necessarily represent unique individuals because a person may have been part of more than one outreach event, taken part in both individual and group outreach events, and/or interacted with different providers. Summaries are also available to help SMC BHRS and its providers better understand each individual provider's outreach efforts. Please refer to Appendixes A through H.

Overall Outreach

During FY 2020-2021, SMC BHRS outreach providers reported a total of 7,499 attendees at outreach events—515 attendees reached through individual outreach events and 6,984 attendees reached across 115 group outreach events. An individual outreach event occurs with a single attendee. Group outreach events include multiple attendees. The count of attendees is not necessarily unique because a person may have been a part of multiple individual or group outreach events.

Exhibit 1 shows outreach attendees, by collaborative, provider, and event type (i.e., individual or group), for FY 2020-2021.

Exhibit 1. Outreach Attendees, by Collaborative, Provider, and Event Type, FY 2020-2021

Provider Organization	Number of Individual Outreach Attendees	Number of Attendees at Group Outreach Events	Total Attendees Reported Across All Events
North County Outreach Collaborative (NCOC)			
Asian-American Recovery Services	95	148	243
Daly City Peninsula Partnership Collaborative	197	976	1,173
Daly City Youth Health Center	0	1,636	1,636
Pacifica Collaborative	4	3,921	3,925
Star Vista	14	263	277
Total (NCOC)	310	6,944	7,254
East Palo Alto Partnership for Mental Health Outreach (EPAPMHO)			
Anamatangi Polynesian voices	35	40	75
El Concilio	101	0	101
Free at Last	69	0	69
Total (EPAPMHO)	205	40	245
Total (NCOC and EPAPMHO)	515	6,984	7,499

Note: Multicultural Counseling and Education Services of the Bay Area (MCES) changed its name to Anamatangi Polynesian voices.

It is expected that the NCOC would serve a much larger proportion of the outreach collaborative effort, as it serves the entire northern region of San Mateo County (estimated population 140,149), including the cities of Colma, Daly City, and Pacifica, which is five times the population of the city of East Palo Alto, served by EPAPMHO. The north region also spans a much wider geographical area, making group events (vs. individual outreach) such as community wide fairs more feasible. In contrast, East Palo Alto spans 2.5 square miles, making an individual approach to outreach more achievable.

The total number of NCOC outreach attendees showed an increase over time from 2014-2020, with FY 2018-2019 being the exception, then dropped a little in FY 2020-2021. In 2019-2020, the total number of NCOC attendees increased significantly due to the COVID-19 pandemic. The COVID-19 regional stay-at-home order was issued March 16, and services provided from March to June 2020 showed an increase in outreach, as many more residents were likely seeking mental health services in response to the pandemic. Events sponsored by the Daly City Peninsula Partnership Collaborative and the Daly City Youth Health Center also addressed food security during the pandemic (FY 2019-2020) by distributing food during the events. A higher attendance at these events may contribute towards an overall increase seen in FY 2019-2020. **Exhibit 2** shows the trends in the total outreach attendees over the years for both collaboratives.

Exhibit 2. Total Outreach Attendees, by Collaborative, FY 2014-2021
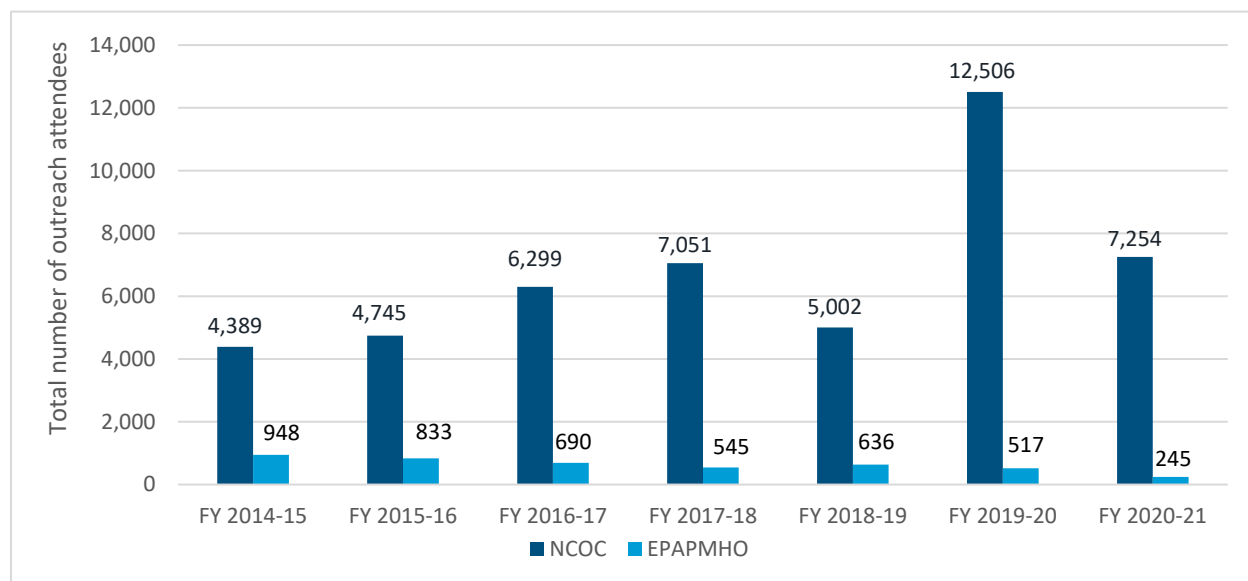
Note: The attendee numbers from previous fiscal years are slightly higher than those reported in the previous reports because some outreach data were reported after that fiscal year.

Exhibits 3a and 3b present the top five race/ethnicity groups served by individual or group outreach in each year for FY 2014-2015, FY 2015-2016, FY 2016-2017, FY 2017-2018, FY 2018-2019, FY 2019-2020, and FY 2020-2021 within each collaborative. A table with the entire breakdown of race/ethnicity groups from FY 2014 to FY 2021 is presented in Appendix I.

Exhibit 3a. Percentage of Race/Ethnicity Groups Served by NCOC, FY 2014-2015 to FY 2020-2021
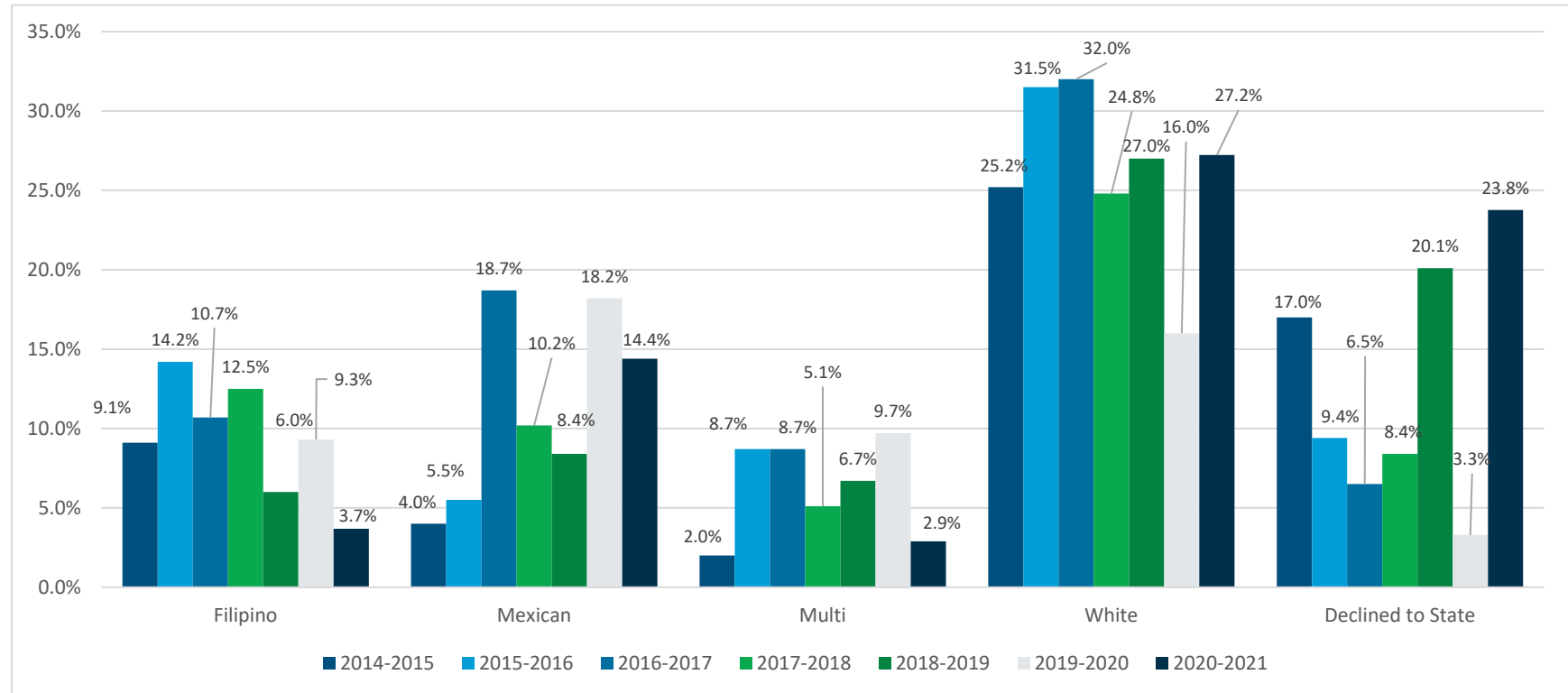
Exhibit 3b. Percentage of Race/Ethnicity Groups Served by EPAPMHO, FY 2014-2015 to FY 2020-2021

Legend: 2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021

Race/Ethnicity	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
Black	9.1%	24.5%	23.8%	36.5%	23.2%	17.9%	11.8%
Mexican	2.6%	23.4%	13.0%	9.7%	23.8%	22.8%	41.1%
Multi	2.4%	7.9%	10.7%	16.8%	13.1%	7.5%	3.7%
Tongan	10.4%	14.5%	17.5%	16.1%	14.8%	5.8%	6.1%
White	26.9%	9.8%	7.8%	8.6%	8.4%	3.5%	4.9%
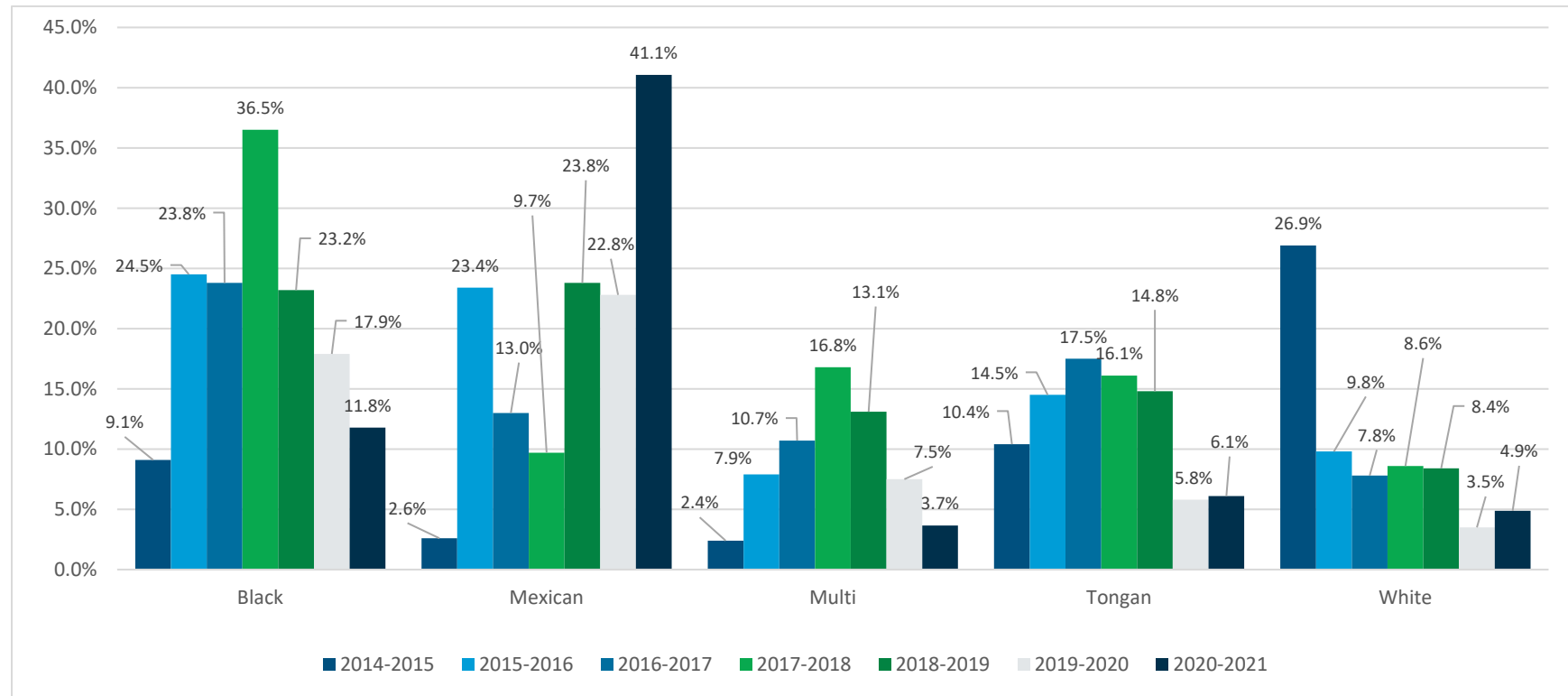
The NCOC has seen a fluctuation in outreach numbers overall, and there are a few key differences in the racial/ethnic demographics of the outreach attendees. For example, Filipino, Mexican, and multi-racial attendees at these events decreased from FY 2019-2020 to FY 2020-2021, while White attendees and those who declined to state their race/ethnicity increased during this time period.

The EPAPMHO has also seen a decrease in outreach numbers overall, and there are a few key differences in the racial/ethnic demographics of the outreach attendees. From FY 2019-2020 to FY 2020-2021, there has been an observed decrease in attendance by Black and multi-racial attendees at these events. However, there is a significant increase in attendees who are Mexican, and slight increases in the percentages of attendees who are Tongan and White.

Exhibits 4a and 4b present the percentages of the mental health and substance use referrals made as a result of attending the outreach events, by collaborative, for FY 2014-2015 through FY 2020-2021.

Compared to FY 2019-2021, mental health referrals increased by 16 percent in FY 2020-2021. Substance use referrals decreased significantly—by 44 percent—during this time frame.

Exhibit 4a. Percentage of Mental Health/Substance Use Referrals by NCOC, FY 2014-2015 to FY 2020-2021
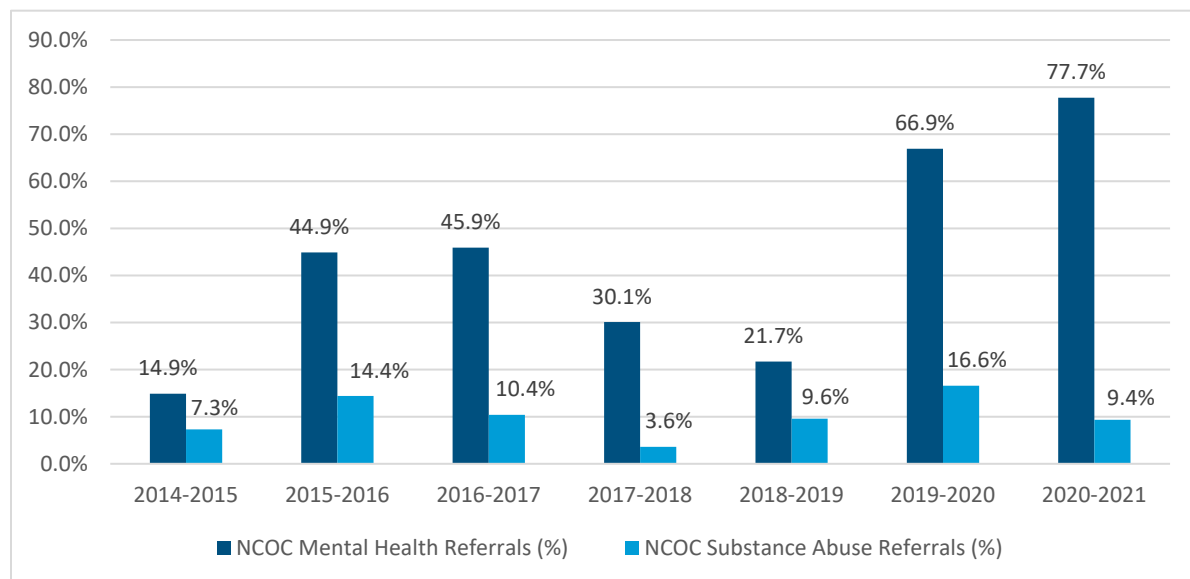
Exhibit 4b. Percentage of Mental Health/Substance Use Referrals by EPAPMHO, FY 2014-2015 to FY 2020-2021

Legend: ■ EPAPMHO Mental Health Referrals (%)   ■ EPAPMHO Substance Abuse Referrals (%)

Data labels by fiscal year:
- 2014-2015: 17.8%, 44.9%
- 2015-2016: 26.2%, 30.0%
- 2016-2017: 13.6%, 24.5%
- 2017-2018: 30.2%, 37.8%
- 2018-2019: 24.0%, 31.8%
- 2019-2020: 27.7%, 36.9%
- 2020-2021: 37.1%, 19.5%
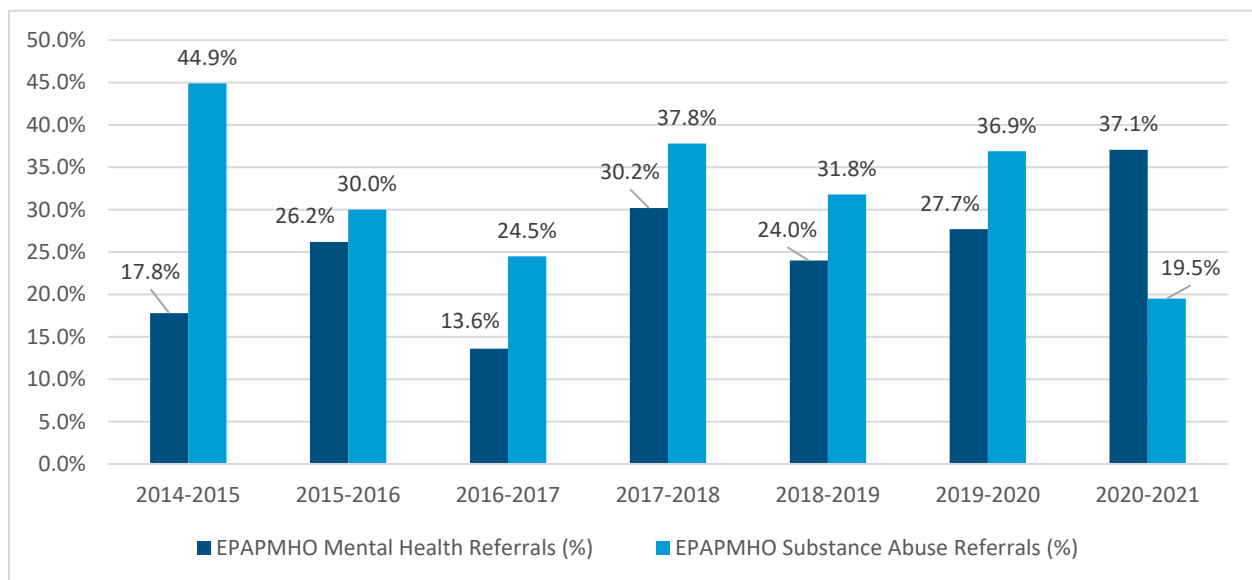
Exhibits 5a and 5b present referrals to social services, from FY 2014-2015 through FY 2020-2021, for each collaborative. The percentages represent percent of total attendee referrals to social services.

- NCOC had 866 referrals in FY 2020-2021 to social services, compared to 1,101 referrals in FY 2019-2020, 330 referrals in FY 2018-2019, 592 referrals in FY 2017-2018, 496 referrals in FY 2016-2017, 485 referrals in FY 2015-2016, and 379 referrals in FY 2014-2015. In FY 2020-2021, EPAPMHO had 367 referrals to social services, compared to 563 referrals in FY 2019-2020, 921 referrals in FY 2018-2019, 727 referrals in FY 2017-2018, 652 referrals in FY 2016-2017, 1,433 referrals in FY 2015-2016, and 438 referrals in FY 2014-2015.

- In FY 2020-2021, NCOC had decreases in housing, medical care, and transportation compared to the prior year. In particular, the referrals for housing were the lowest since FY 2014-2020. On the other hand, the percentage of referrals to financial, food, and form assistance increased in FY 2020-2021 compared to the previous year, indicating the residents continued to face challenges pertaining to food security, employment, and assistance to complete forms to avail themselves of benefits.

- In FY 2020-2021, EPAPMHO had decreases in the percentage of food referrals. The percentage of financial, form assistance, housing, medical care, and transportation referrals increased.

Exhibit 5a. Referrals to Social Services Made by NCOC, FY 2014-2015 to FY 2020-2021

Legend:
- EPAPMHO FY2014-2015
- EPAPMHO FY2015-2016
- EPAPMHO FY2016-2017
- EPAPMHO FY2017-2018
- EPAPMHO FY2018-2019
- EPAPMHO FY2019-2020
- EPAPMHO FY2020-2021

Category	FY2014-2015	FY2015-2016	FY2016-2017	FY2017-2018	FY2018-2019	FY2019-2020	FY2020-2021
Financial	0.9%	6.2%	4.6%	3.9%	2.0%	3.4%	5.7%
Food	8.2%	16.3%	11.8%	8.8%	6.7%	11.2%	16.6%
Form assistance	0.7%	7.0%	7.2%	8.1%	6.4%	3.4%	13.9%
Housing	27.4%	22.6%	33.0%	32.6%	29.0%	32.1%	19.9%
Medical care	49.1%	25.9%	26.8%	33.4%	33.8%	33.7%	10.6%
Transportation	0.2%	3.0%	6.0%	3.9%	2.8%	0.7%	0.0%

Exhibit 5b. Referrals to Social Services Made by EPAPMHO, FY 2014-2015 to FY 2020-2021
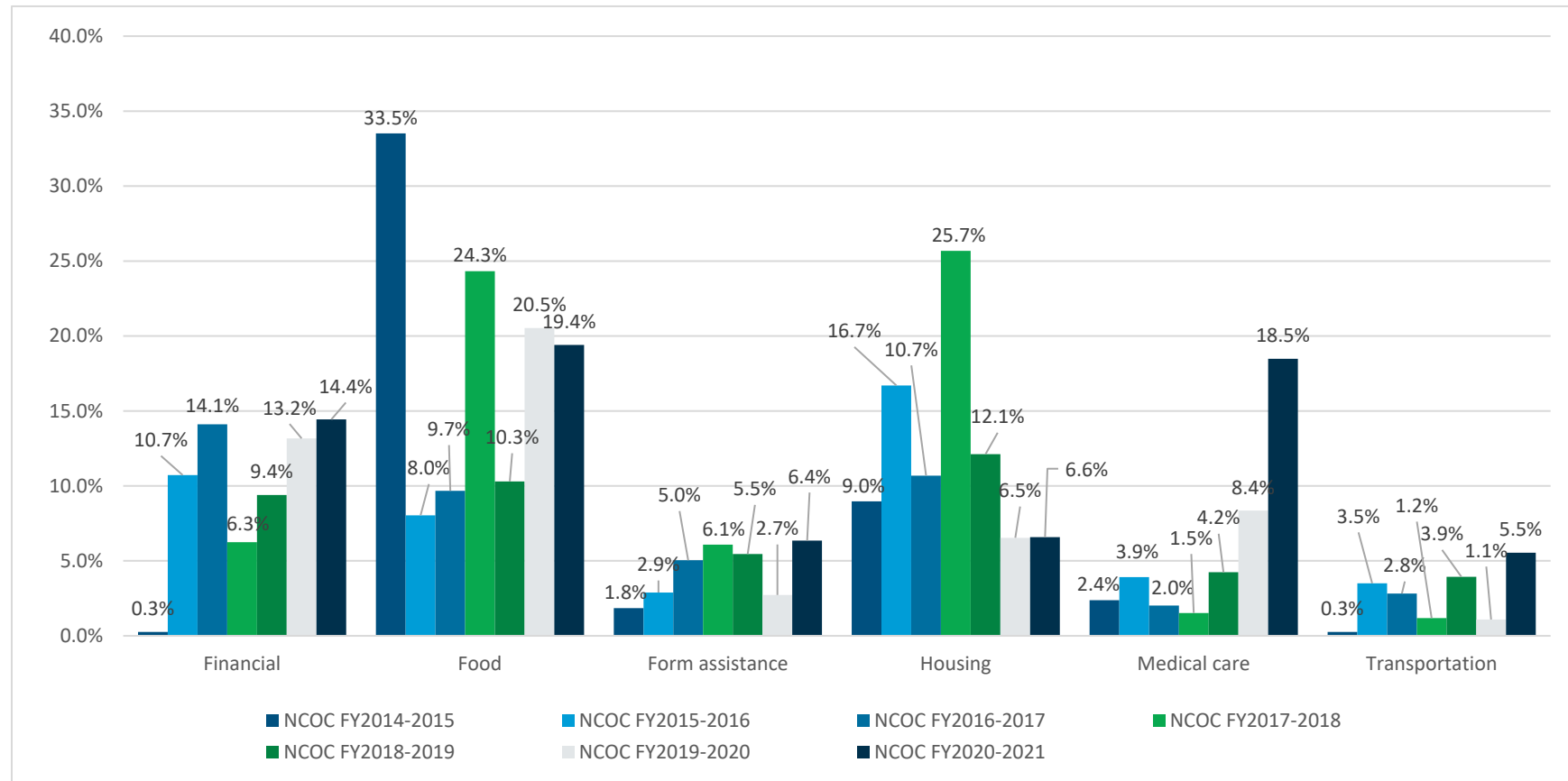
NCOC

This section provides details about 7,254 attendees at NCOC group and individual outreach events across the five provider organizations in FY 2020-2021.

Demographics

Age: Attendees across NCOC outreach events were adults (26-59 years, 33%), children (0-15 years, 25%), transition-age youth (16-25 years, 19%), and older adults (60 years or older, 13%) in FY 2020-2021. Nine percent of attendees declined to state their age. See **Exhibit 6** for the number and percentage of total outreach attendees representing each reported age group.

Exhibit 6. Age of Total Outreach Attendees Served by NCOC, FY 2020-2021
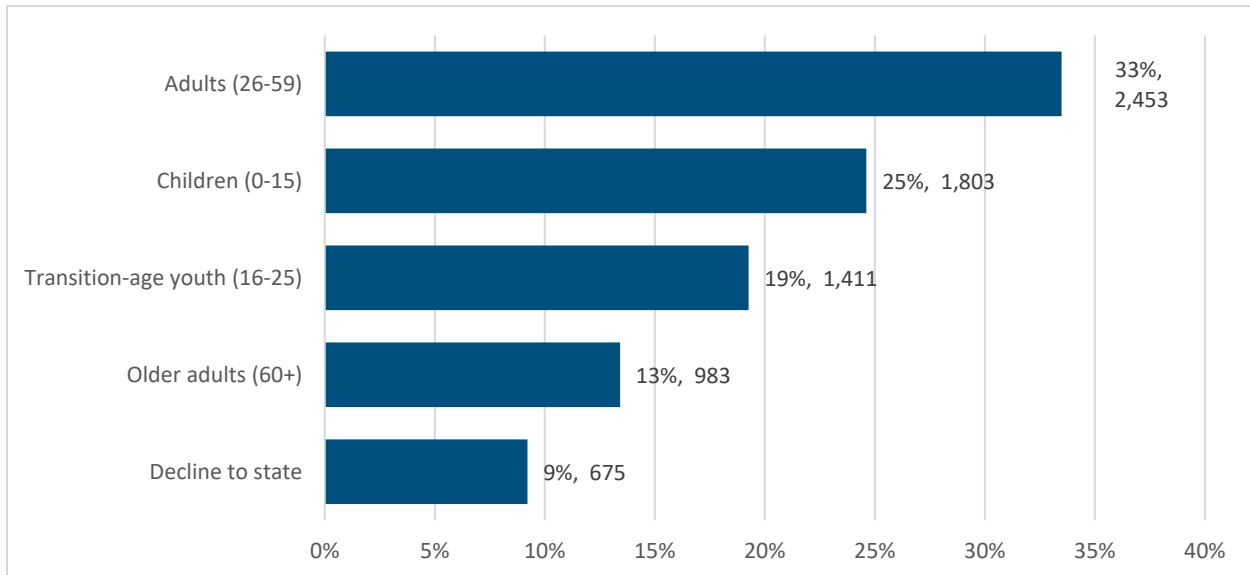
Note: Percentages may not sum to 100 percent because of rounding. The denominator for age percent is the sum of all age data reported. Total count for age reported may exceed the total number of attendees, because some providers may have reported individuals in two or more age groups, leading to extra counts in some cases for the group outreach attendees. The denominator for age percent is the sum of all age data reported.

Sex at birth: In FY 2020-2021, attendees across NCOC events indicated their sex at birth as females (49%), males (30%), or declined to state their sex at birth. (See **Exhibit 7** for the number and percentage of outreach attendees reporting each sex type.)

Exhibit 7. Sex at Birth of Outreach Attendees Served By NCOC, FY 2020-2021
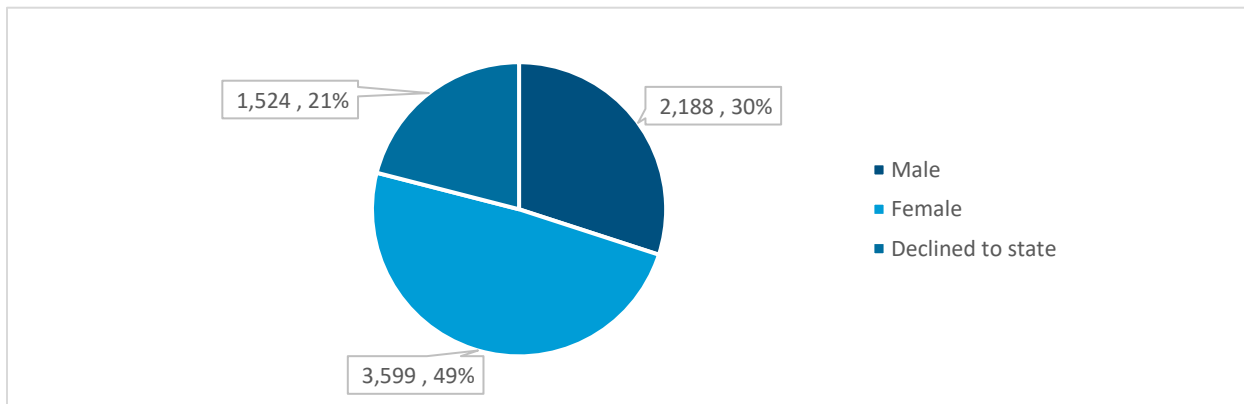
Note: Percentages may not sum to 100 percent because of rounding. Total count for sex reported may exceed the total number of attendees, because some providers may have reported individuals in two or more sex groups, leading to extra counts in some cases for the group outreach attendees. The denominator for sex percent is the sum of all sex data reported.

Gender: Attendees in FY 2020-2021 identified themselves as female (41%), male (24%), or other gender (1%). Thirty-four percent declined to state their gender. See **Exhibit 8** for the number and percentage of attendees reporting each gender type.

Exhibit 8. Gender of Outreach Attendees Served By NCOC, FY 2020-2021
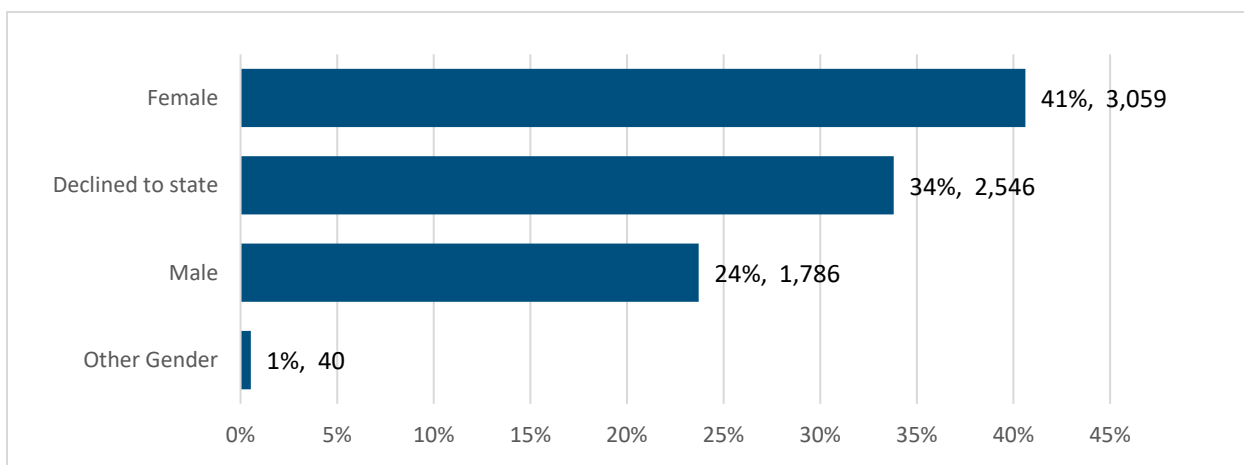
Note: Percentages may not sum to 100 percent because of rounding. Total count for gender may exceed the total number of attendees, because some providers may have reported individuals in two or more gender groups, leading to extra counts in some cases. The denominator for gender percent is the sum of all gender data reported.

Race and ethnicity: In FY 2020-2021, the five largest racial/ethnic groups represented by all NCOC attendees were White (27%), Mexican (14%), and Asian (7%). Five percent of the attendees were other race and ethnicity, and 24 percent declined to state their race. See **Exhibit 9** for the number and percentage of attendees representing each reported racial/ethnic group.

Exhibit 9. Race and Ethnicity of Outreach Attendees Served By NCOC, FY 2020-2021
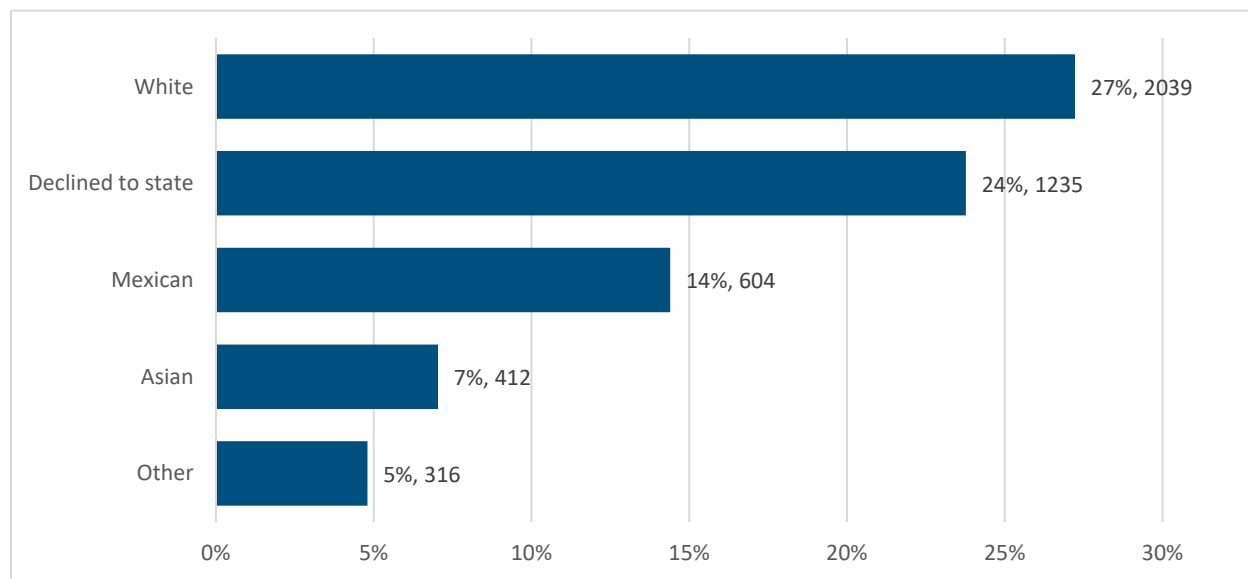
Note: The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported. Total count for race/ethnicity may exceed the total number of attendees, because some providers may have reported individuals in two or more race/ethnicity groups, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Special populations: Of the attendees indicating they were part of special populations, 36 percent were at risk of homelessness, 21 percent had a physical/mobility disability, 11 percent had chronic health conditions, 8 percent were visually impaired, 8 percent were homeless, 6 percent had other disabilities, 5 percent were veterans, 2 percent were hearing impaired, and 2 percent had a developmental disability. Refer to **Exhibit 10** for the number and percentage of attendees representing each special population in FY 2020-2021.

Exhibit 10. Special Populations Served By NCOC, FY 2020-2021
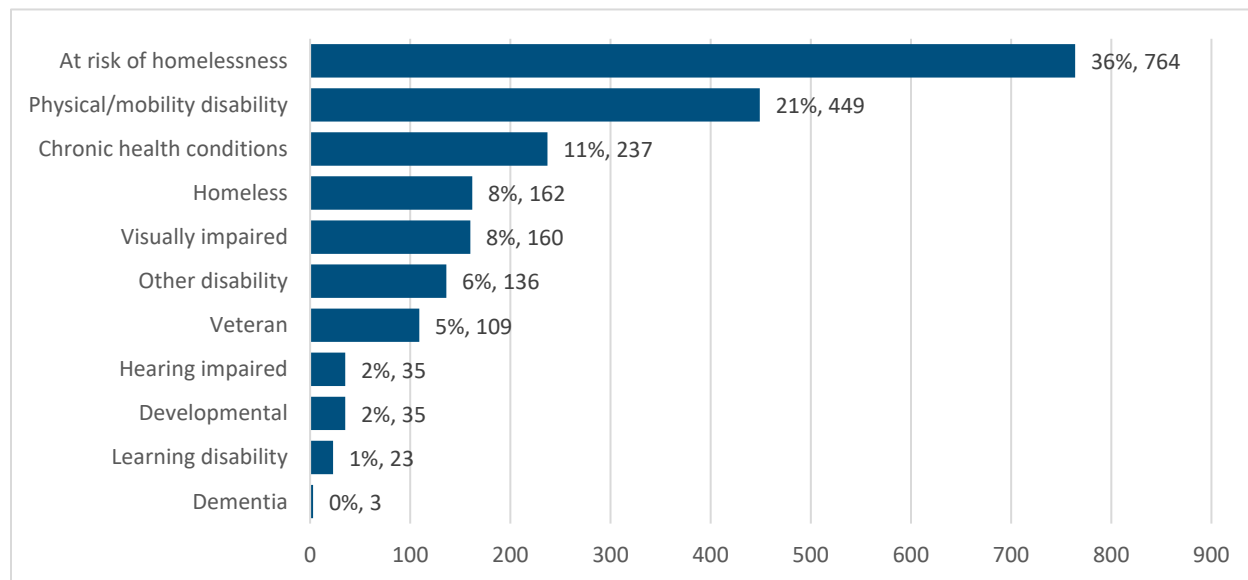
Note: Attendees could be included in more than one special population. Percentages may not sum to 100 percent because of rounding. The denominator for special population group is the sum of all special population data reported.

Additional Outreach Characteristics (Individual Outreach Events Only)

Previous contact: More than half of individual outreach events (61%) were conducted with attendees who previously had attended an outreach event.

Mental health/substance use referrals: NCOC individual outreach events resulted in mental health referrals (78%) and substance use referrals (9%) in FY 2020-2021.

Referrals to social services: Providers made 866 referrals to 310 NCOC individual outreach attendees. Of the different referral types, the top four types of referrals made for attendees were food (19%), medical care (18%), "other" category (17%), and financial services (14%). Participants also obtained referrals for legal, housing, form assistance, transportation, and health insurance services. About one percent were referred to emergency protective services. In **Exhibit 11**, we summarize the number and percentage of attendees receiving a given type of referral in FY 2020-2021.

Exhibit 11. Referrals to Social Services, FY 2020-2021
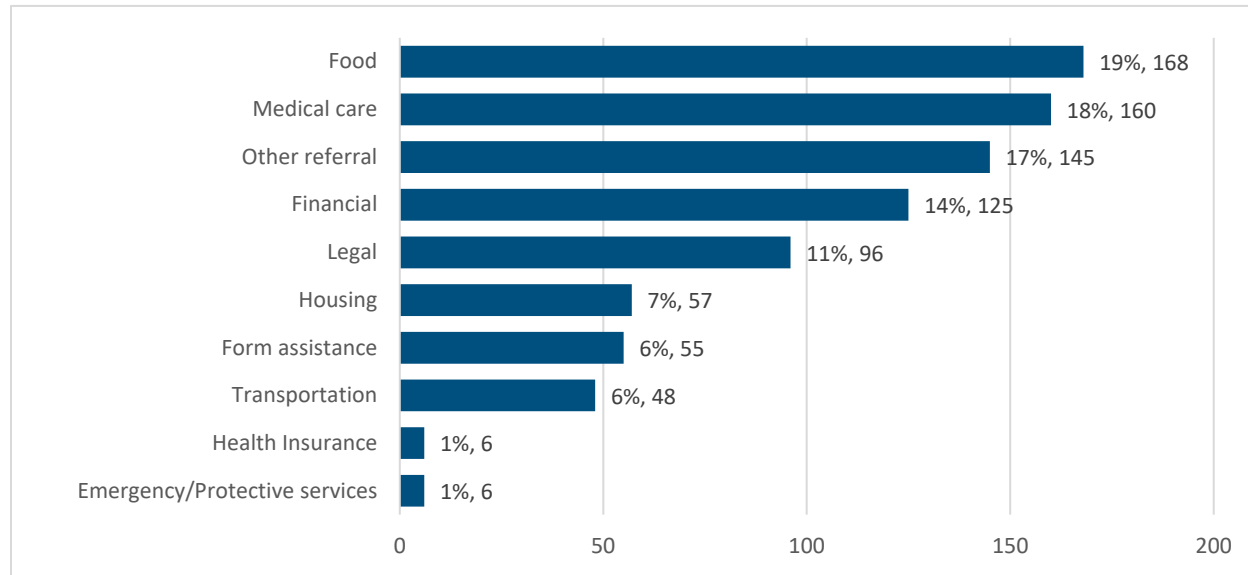
Horizontal bar chart showing referrals to social services:
- Food: 19%, 168
- Medical care: 18%, 160
- Other referral: 17%, 145
- Financial: 14%, 125
- Legal: 11%, 96
- Housing: 7%, 57
- Form assistance: 6%, 55
- Transportation: 6%, 48
- Health Insurance: 1%, 6
- Emergency/Protective services: 1%, 6

Note: Percentages may not sum to 100 percent because of rounding. Attendees could choose more than one category. The denominator for referral group is the sum of all referral data reported.

Event Characteristics

Location: NCOC individual outreach events occurred primarily in other community locations (64%), over the phone (28%) or "other locations" (8%) in FY 2020-2021. Group outreach events occurred primarily in non-traditional locations (41%), other community locations (26%), "other locations" (17%), and telehealth (16%). Other community locations included places such as Boys & Girls Club, community centers, Daly City Youth Health Center, health fairs, fair grounds, malls, and public parks. The "other locations" category includes all the locations that were reported that make up less than 10 percent of the total locations reported. **Exhibits 12 and 13** present individual and group outreach event locations in FY 2020-2021.

Exhibit 12. Locations of NCOC Individual Outreach Events, FY 2020-2021
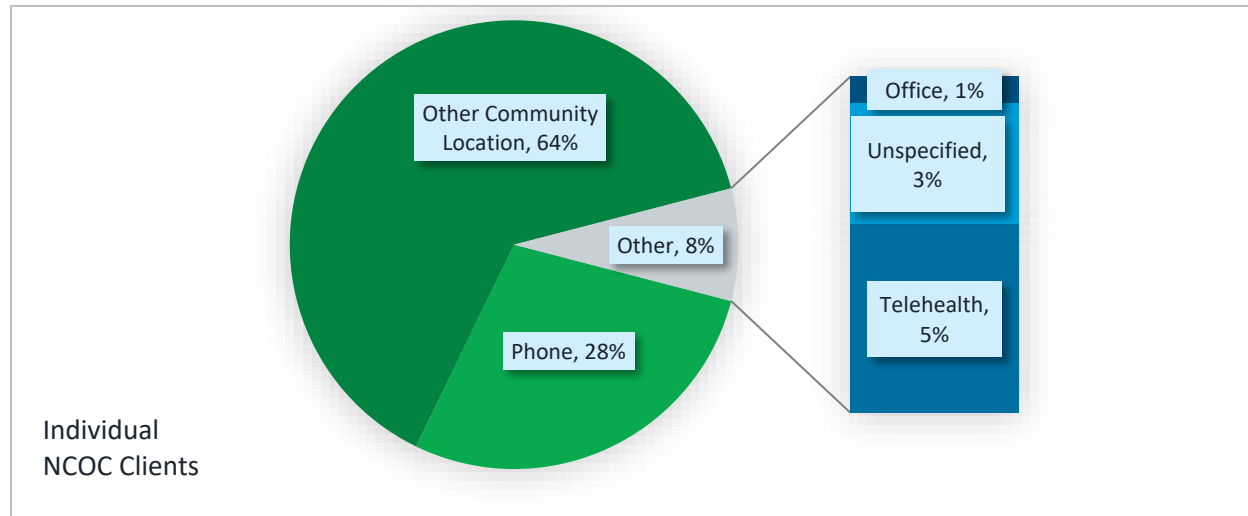
Note: The breakdown for the "Other" category is slightly higher than 8 percent due to rounding.

Exhibit 13. Locations of NCOC Group Outreach Events, FY 2020-2021
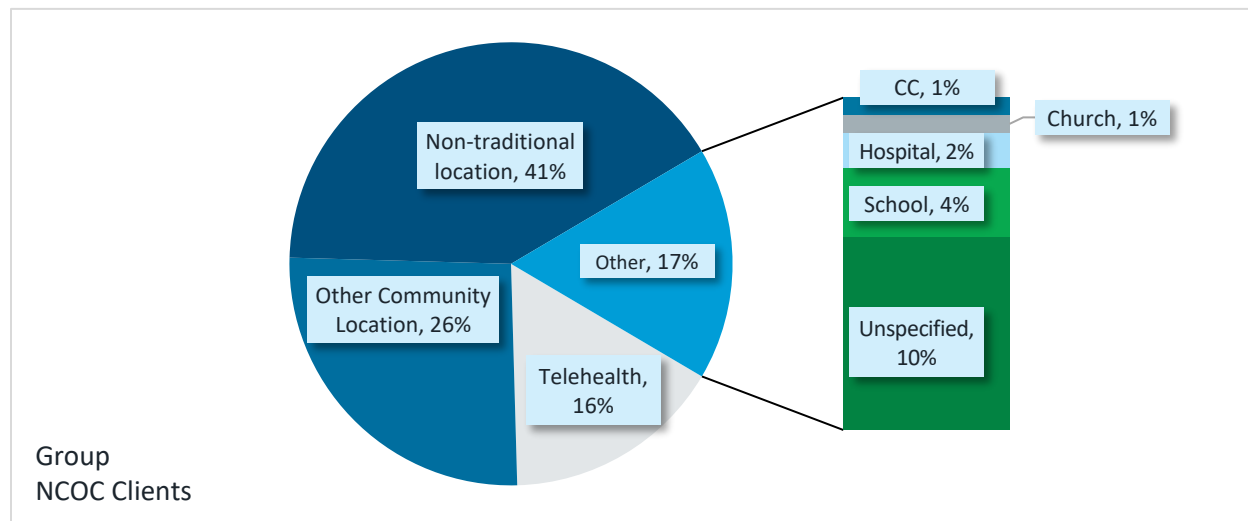
Note: CC = Age-Specific Community Center, Church = Faith-Based Church/Temple, Unspecified = Field (unspecified). Percentages may not sum to 100 percent because of rounding. Attendees could choose more than one category. The denominator for location percent is the sum of all location data reported.

Length of contact: For FY 2020-2021, the individual outreach events ranged from 5 to 120 minutes and lasted 40 minutes on average. The average length of NCOC group outreach events ranged from 1 to 240 minutes and lasted 83 minutes on average.

Language used: NCOC individual outreach events were conducted in English (95%), Mandarin (2%), and Cantonese (2%) in FY 2020-2021. NCOC group outreach events were conducted in English (100%) in FY 2020-2021.

Preferred language: NCOC individual outreach attendees preferred English (88%), Mandarin (5%), Cantonese (3%), Tongan (3%), and Samoan (1%). NCOC group outreach attendees preferred English (83%), Spanish (11%), Tagalog (1%), Tongan (1%), Cantonese (1%) and other languages (3%). **Exhibits 14 and 15** present breakdowns of preferred languages at individual and group outreach events in FY 2020-2021.

Exhibit 14. Preferred Languages of NCOC Individual Outreach Attendees, FY 2020-2021
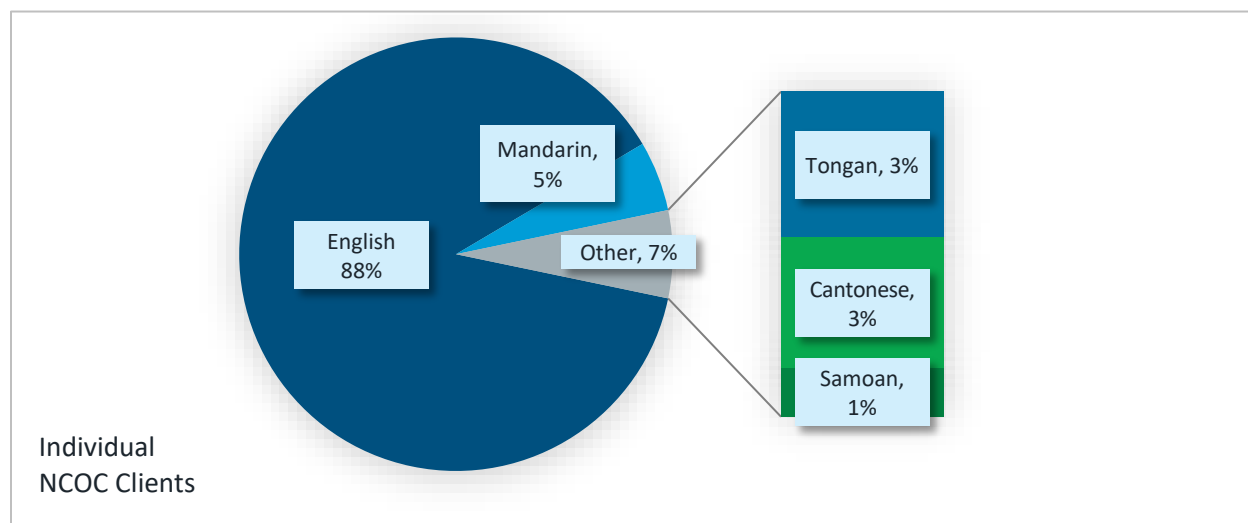
Exhibit 15. Preferred Languages of NCOC Group Outreach Attendees, FY 2020-2021
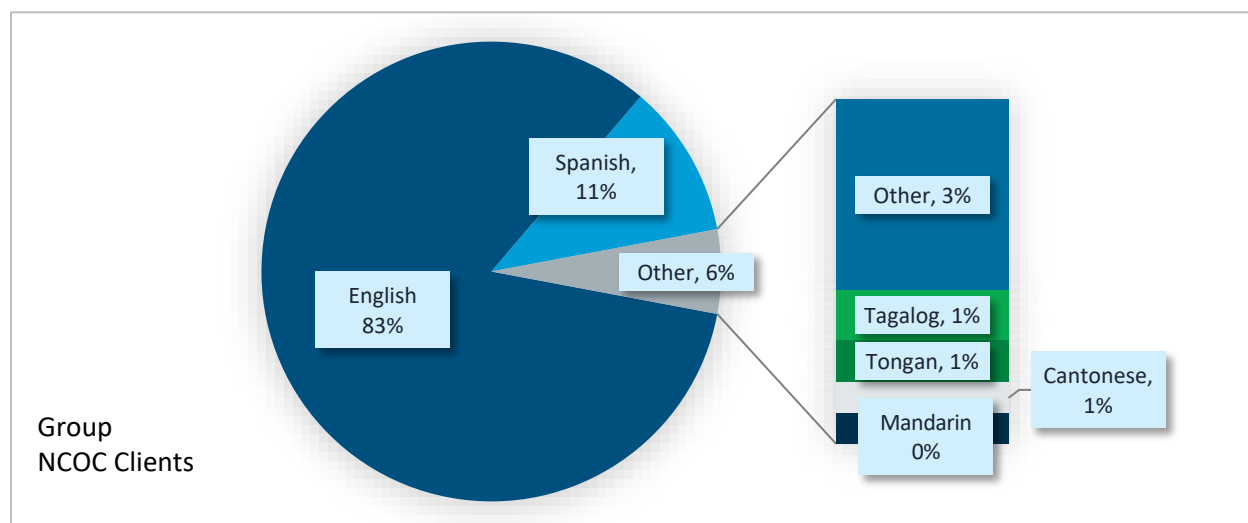
Note: Percentages may not sum to 100 percent because of rounding. The denominator for preferred language percent is the sum of all preferred language data reported.

EPAPMHO

This section provides details about 245 attendees at EPAPMHO group and individual outreach events across three provider organizations in FY 2020-2021.

Demographics

Age: EPAPMHO individual and group outreach attendees were adults (26-59 years, 57%), transition-age youth (16-25 years, 20%), children (0-15 years, 12%), and older adults (60+ years or older, 10%) in FY 2020-2021. See **Exhibit 16** for the number and percentage of outreach attendees representing each reported age group.

Exhibit 16. Age of Outreach Attendees Served By EPAPMHO, FY 2020-2021
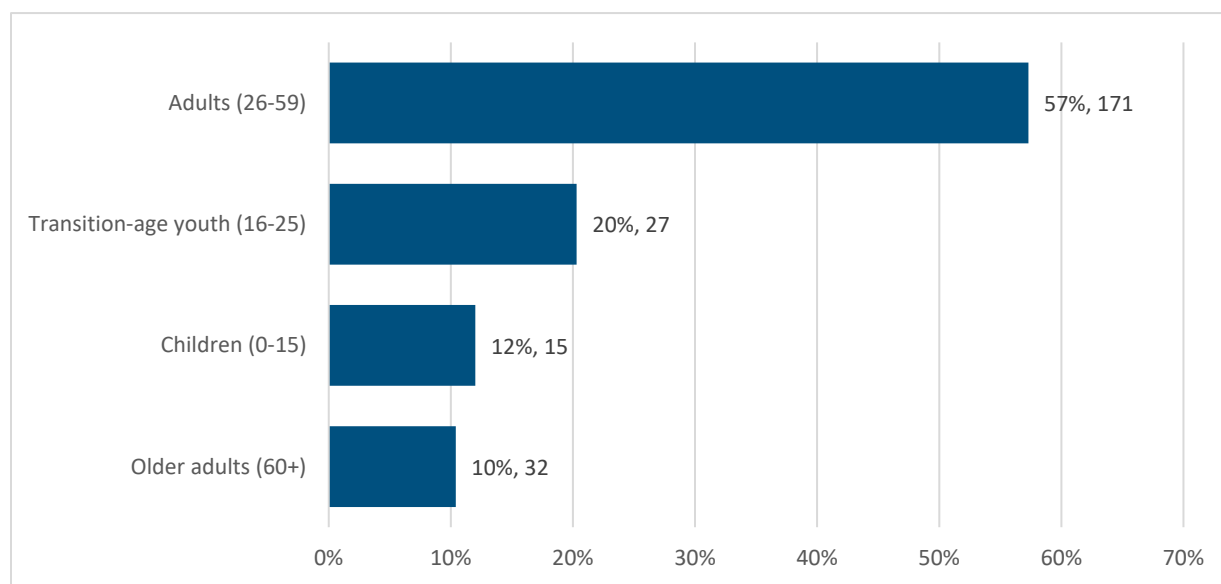
Note: Percentages may not sum to 100 percent because of rounding. The denominator for age percent is the sum of all age data reported.

Sex at birth: Attendees across EPAPMHO outreach events indicated their sex at birth as male (31%), female (67%), or declined to state (2%). See **Exhibit 17** for the number and percentage of outreach attendees representing each reported sex.

Exhibit 17. Sex at Birth of Outreach Attendees Served By EPAPMHO, FY 2020-2021
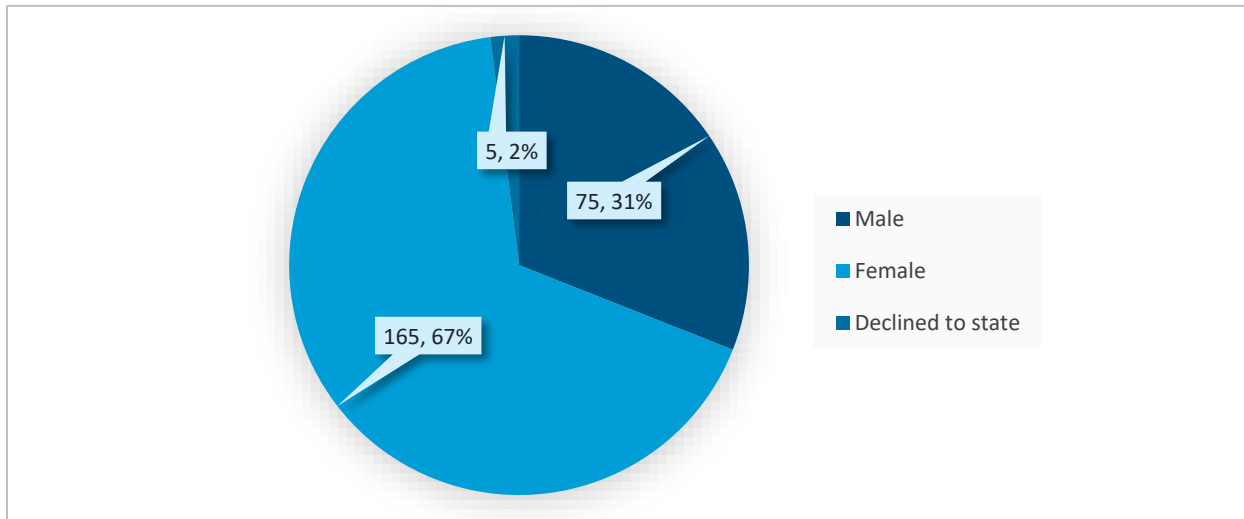
Note: Percentages may not sum to 100 percent because of rounding. The denominator for sex percent is the sum of all sex data reported.

Gender: Attendees across EPAPMHO individual and group outreach events identified themselves primarily as female (67%), male (31%), or declined to state (2%). See **Exhibit 18** for the number and percentage of individual and group outreach attendees representing each reported gender.

Exhibit 18. Gender of Outreach Attendees Served By EPAPMHO, FY 2020-2021
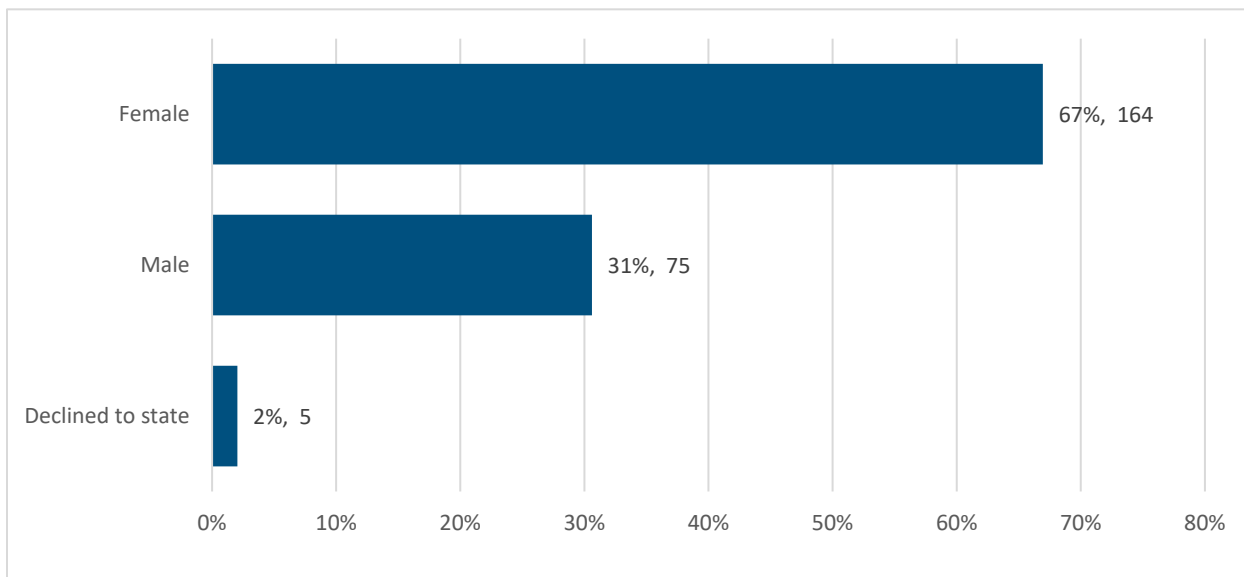
Note: Percentages may not sum to 100 percent because of rounding. Total count for gender may exceed the total number of attendees, because some providers may have reported individuals in two or more gender groups, leading to extra counts in some cases. The denominator for gender percent is the sum of all gender data reported.

Race and ethnicity: In FY 2020-2021, the four largest racial/ethnic groups represented by all EPAPMHO attendees were Mexican (41%), Hawaiian (16%), African American (12%), and Samoan (8%). See **Exhibit 19** for the number and percentage of attendees representing each reported racial/ethnic group.

Exhibit 19. Race and Ethnicity of Outreach Attendees Served By EPAPMHO, FY 2020-2021
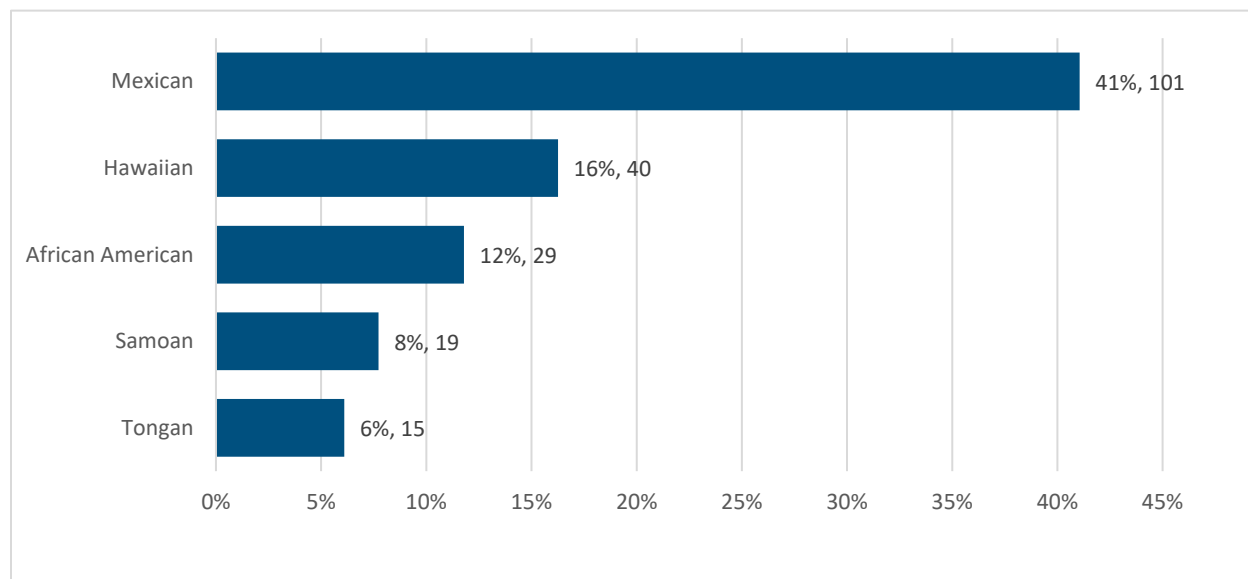
Note: Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported.

Special populations: Of the special populations, 28 percent were at risk of homelessness, 25 percent were homeless, 24 percent had chronic health conditions, 9 percent were hearing impaired, 6 percent had a physical/mobility disability, 2 percent were visually impaired, 2 percent were veterans, 2 percent had a developmental disability, and 1 percent had other disabilities. Refer to **Exhibit 20** for the number and percentage of attendees representing each special population in FY 2020-2021.

Exhibit 20. Special Populations Served by EPAPMHO, FY 2020-2021
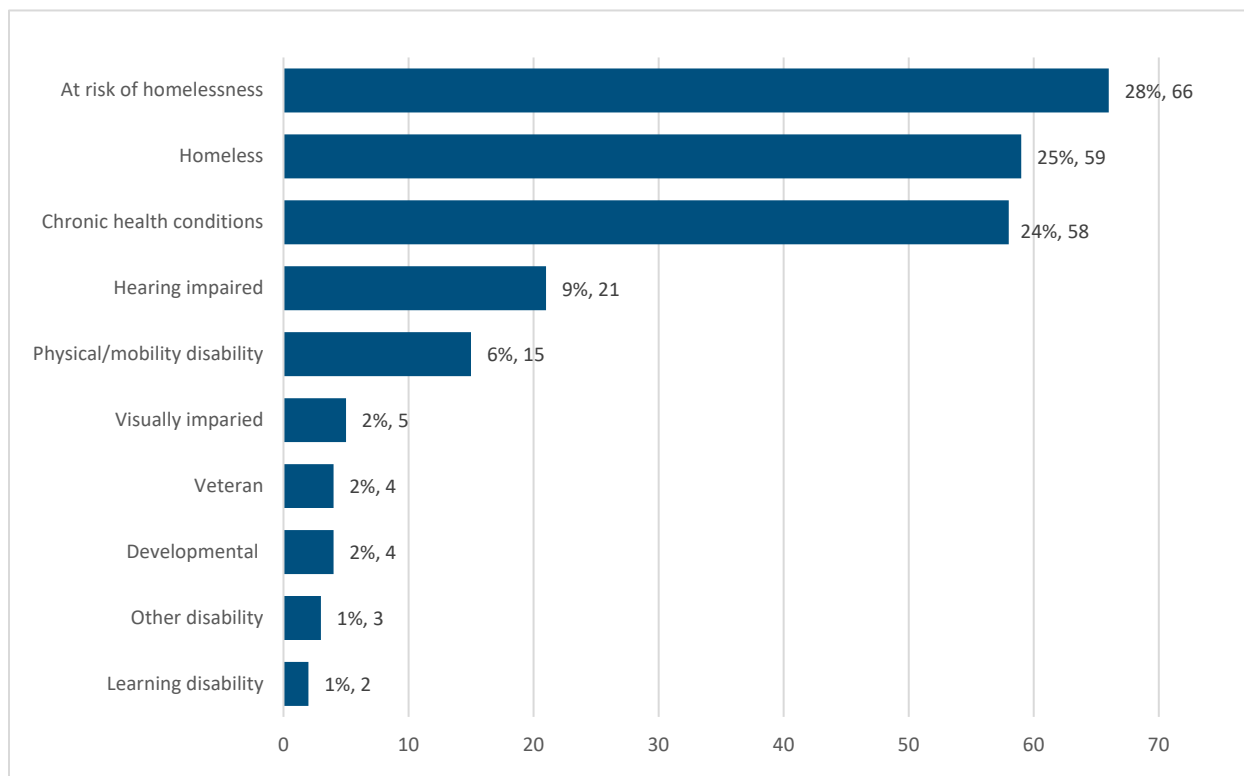
Note: Attendees could be included in more than one special population. The denominator for special population group is the sum of all special population data reported.

Additional Outreach Characteristics (Individual Outreach Events Only)

Previous contact: Sixteen percent of individual outreach events were conducted with attendees who had a previous outreach contact with EPAPMHO.

Mental health/substance use referrals: EPAPMHO individual outreach events resulted in mental health referrals (37%) and substance use referrals (20%) in FY 2020-2021.

Referrals to social services: Providers made 367 referrals to 205 EPAPMHO individual outreach attendees. Of the different referral types, the top five types of referrals made for attendees were for housing (20%), food (17%), other referrals (14%), form assistance (14%), and legal (13%). "Other" referrals that were reported were mostly referrals for the Housing Energy Assistance Program (HEAP). **Exhibit 21** summarizes the number and percentage of attendees receiving a given type of referral.

Exhibit 21. Referrals to Social Services, FY 2020-2021
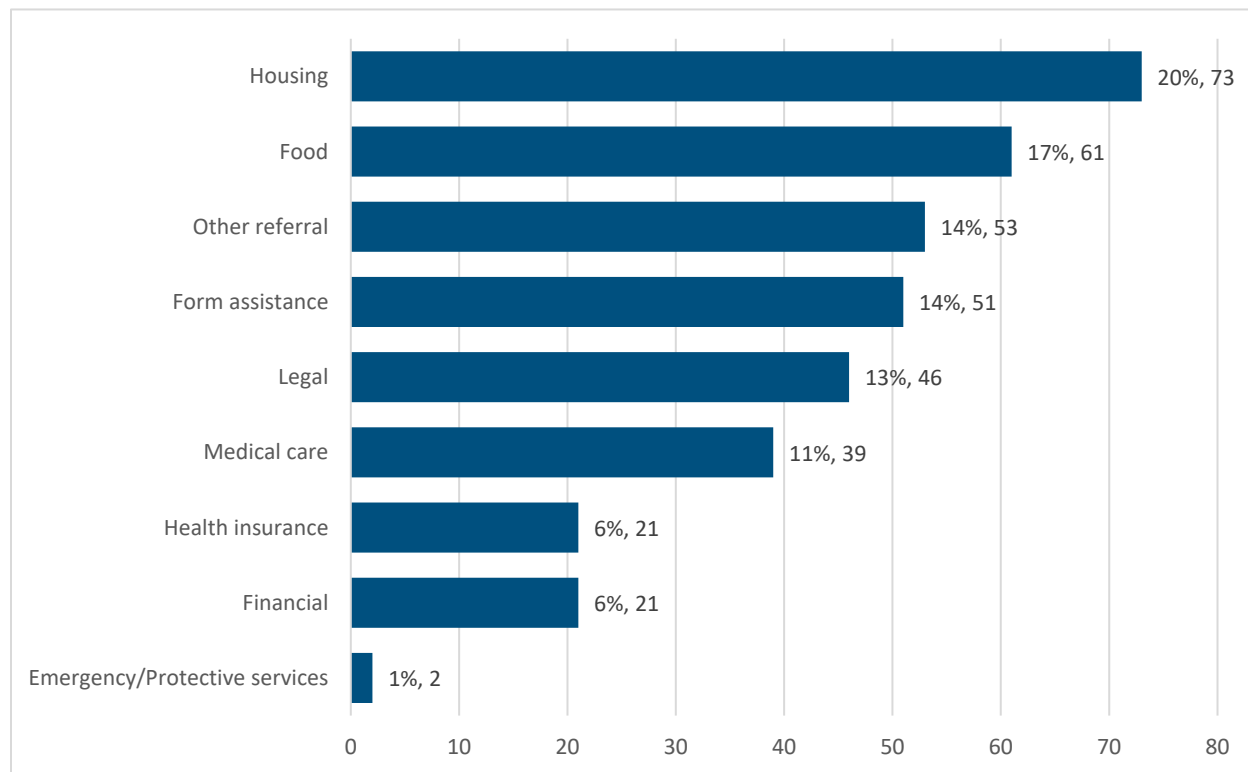
Note: Percentages may not sum to 100 percent because of rounding. Attendees could choose more than one category. The denominator for referral group is the sum of all referral data reported.

Event Characteristics

Location: EPAPMHO individual outreach events occurred in offices (61%), over the phone (21%), in unspecified field locations (13%), or at home (3%). **Exhibit 22** presents individual outreach event locations. All EPAPMHO group outreach events occurred in offices.

Exhibit 22. Location of EPAPMHO Individual Outreach Events, FY 2020-2021
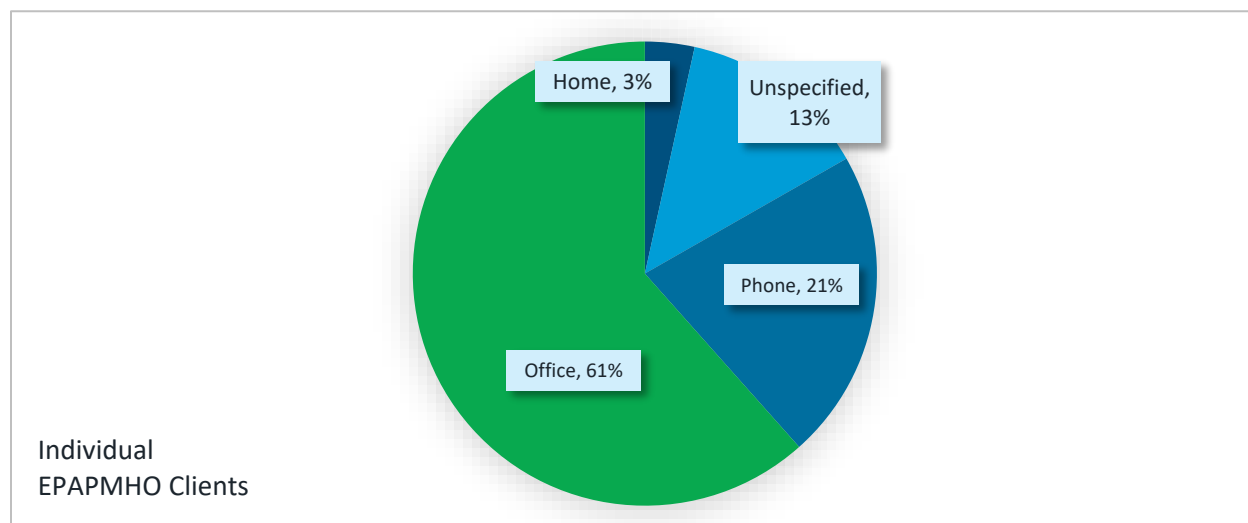
Length of contact: In FY 2020-2021, the individual outreach events lasted from 10 to 60 minutes and were, on average, 21 minutes. The group outreach events lasted from 15 to 90 minutes and were, on average, 90 minutes.

Language used: EPAPMHO individual outreach events were conducted in Spanish (53%), English (31%), Samoan (9%), and Tongan (8%). Out of three group outreach events, two were conducted in English and one was conducted in Tongan.

Preferred language: EPAPMHO individual outreach attendees preferred Spanish (53%), English (31%), Samoan (9%), and Tongan (7%). Attendees at the EPAPMHO group outreach preferred English (72.5%) and Tongan (27.5%). **Exhibits 23 and 24** present breakdown of preferred languages at individual outreach events in FY 2020-2021.

Exhibit 23. Preferred Languages of EPAPMHO Individual Outreach Attendees, FY 2020-2021

Individual
EPAPMHO clients

Tongan, 7%

Samoan, 9%

English, 31%

Spanish, 53%
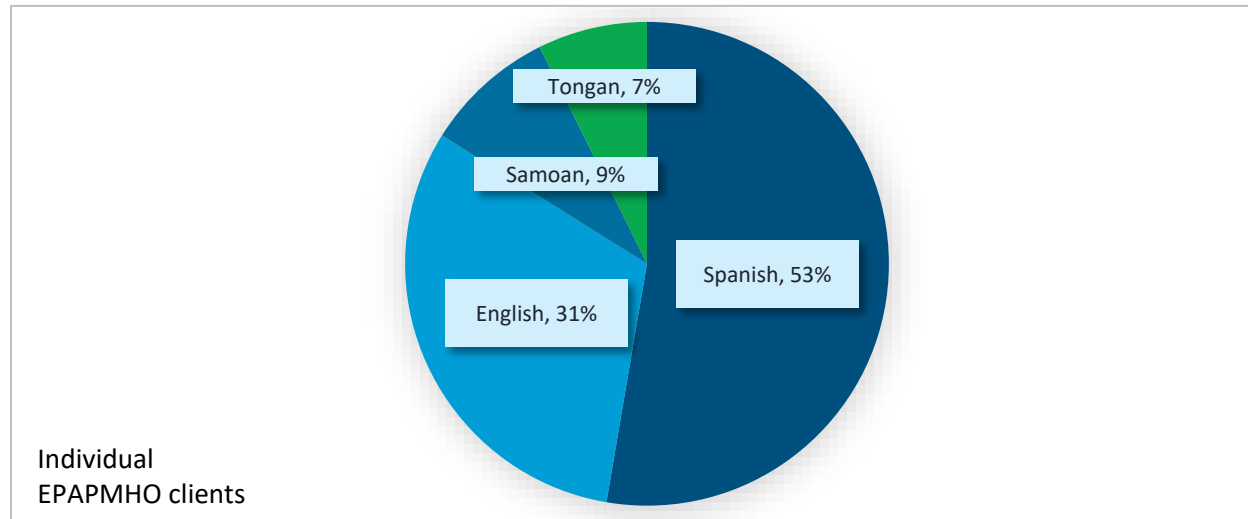
Exhibit 24. Preferred Languages of EPAPMHO Group Outreach Attendees, FY 2020-2021
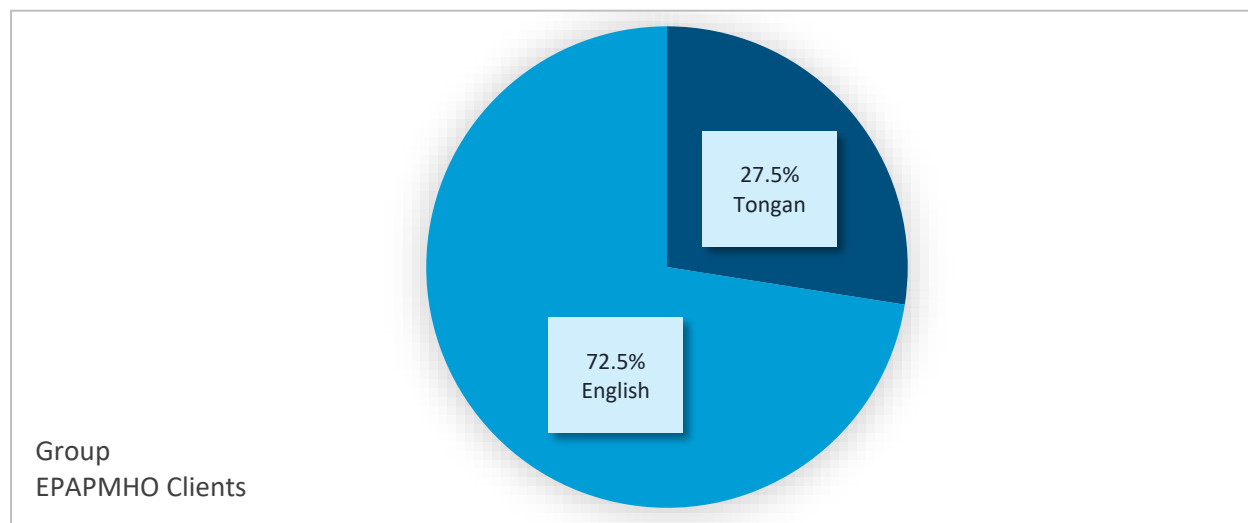
Group
EPAPMHO Clients

27.5%
Tongan

72.5%
English

Recommendations

We have the following recommendations based on FY 2020-2021 data. These recommendations fall under two umbrellas: those aimed at enhancing outreach and those to improve data collection.

Enhance Outreach

Continue to conduct outreach in languages other than English. This past reporting year, outreach events were conducted in languages that represented the residents served by the participating providers. For example, the EPAPMHO collaborative conducted outreach in Spanish, as the Mexican population was the largest racial/ethnic population attending these

events. Similarly, EPAPMHO group sessions were offered in Tongan because participants indicated it as their preferred language. Conducting outreach in languages other than English can ensure that the SMC BHRS outreach program is serving the needs of the county's non-English speaking population.

Continue to offer non-office locations for group and individual outreach events. The data for this year show that many outreach events were conducted in communities, in non-traditional locations such as virtual meetings, and through telehealth services. Although this may have been in response to the pandemic, the county should consider continuing to provide alternative locations or venues, including a virtual option. This will help with the outreach efforts and also give county residents multiple options to avail themselves of the services offered through the program.

Improve Data Collection

Make "other"/unspecified categories clearer. Outreach staff have made an effort to provide better data collection and minimize missing data. For example, participants who selected the "other community location" were able to indicate the other locations in an open text field provided by the survey. The data show that, in many cases, attendees reported Zoom calls or similar virtual platforms for other locations. However, in some cases, it is difficult to assess the nature of the responses that fall under the "other" category. For example, for referrals, the "other" category (17%) included common responses such as "communication" or "check-ins" without any further detail. A next step could be providing more information related to these responses to better understand the nature of the referral.

It will also be beneficial to offer more categories for respondents to use when describing the "location" of individual outreach events, as up to 13 percent of respondents served by the EPAPMHO collaborative selected "unspecified" field locations.

Appendix A. FY 2020-2021 Outreach, Anamatangi Polynesian Voices

For FY 2020-2021, Anamatangi Polynesian Voices reported a total of 38 outreach events, 35 individual events, and 3 group events. There were 75 attendees. The individual outreach events lasted from 20 to 36 minutes and were 30 minutes on average. The group outreach events were 90 minutes on average.

Outreach events:

- Most frequently took place in an office (**47.4%**, n=18). Other locations of events and their respective percentages are shown in **Exhibit A1.**

Exhibit A1. Locations of Outreach Events, FY 2020-2021
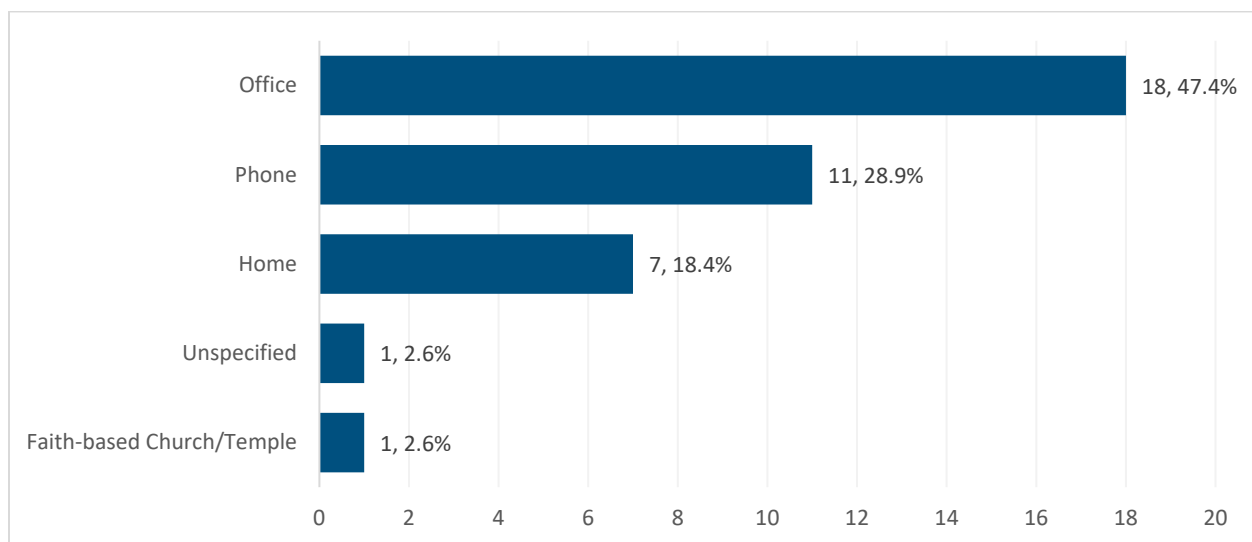
- Were conducted in Samoan (44.7%; n=17), Tongan (44.7%; n=17) and English (10.5%; n=4)

- Resulted in 29 mental health referrals and 0 substance use referrals.

- Resulted in 59 social services referrals. (See Exhibit A2.) An individual outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Referrals were made primarily to Legal (33.9%; n=20), Food (22.0%, n=13), Housing (20.3%, n=12), and Health Insurance (15.3%, n=9).

Exhibit A2. Social Services Referrals, FY 2020-2021
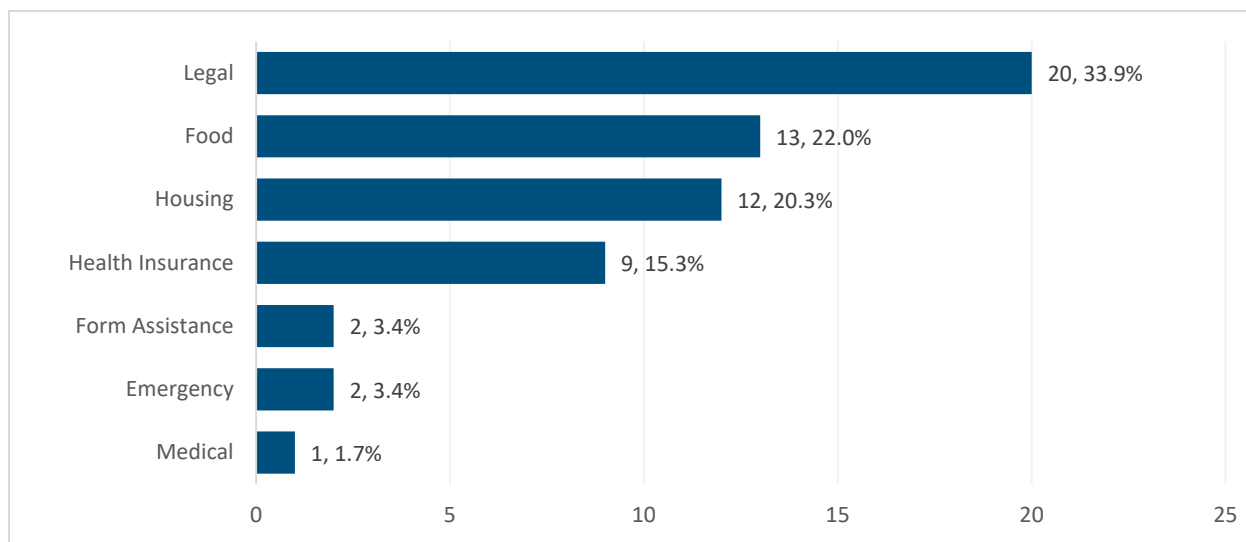
Outreach event attendees:

- Most often were female (58.7%, n=44). Thirty-five percent were male (34.7%, n=26). Five individuals declined to state their sex at birth.

- Identified their gender as female (58.7%, n=44. Thirty-five percent identified as male (34.7%, n=26). Five individuals declined to state their gender.

- Identified as Heterosexuals (89.3%, n=67), or Gay/Lesbian (4%, n=3). Seven percent of the attendees declined to state their sexual orientation (6.7%, n=5).

- Comprised of adults (26-59 years, 41.3%; n=31), transition-age youth (16-25 years, 21.3%; n=16), and children (15 years and younger, 20.0%; n=15).

- Were primarily Hawaiian (53.3%, n=40), and Samoan (24.0%, n=18). (See Exhibit A3.)

Exhibit A3. Attendees by Top Race/Ethnicity Category, FY 2020-2021
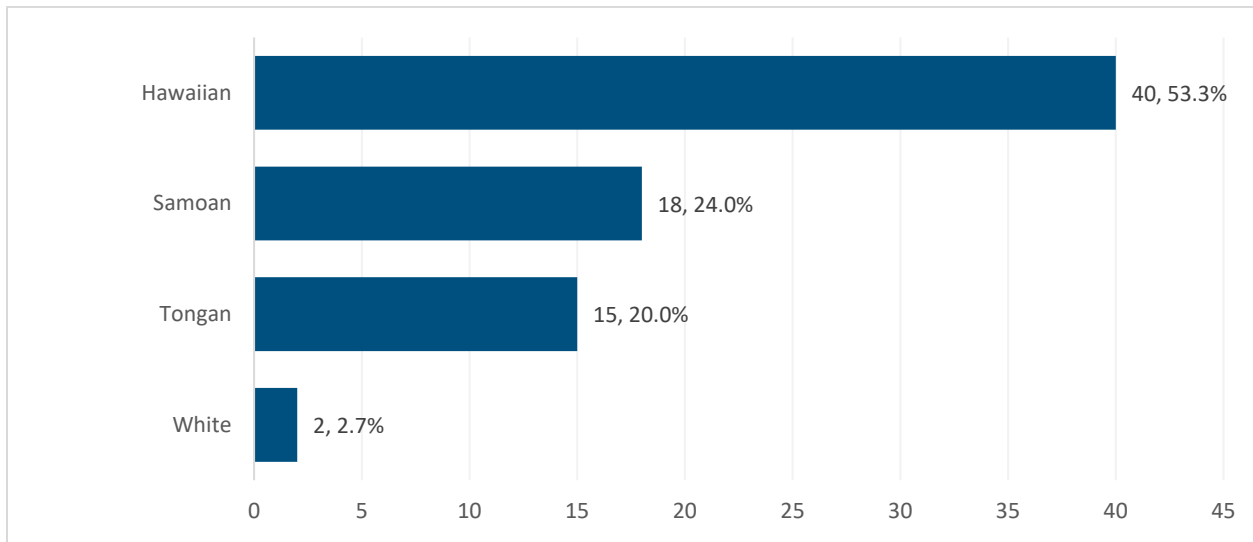
In FY 2020-2021, Anamatangi Polynesian Voices attendees reported being in special populations groups. Out of the service recipients in the special population groups, **23.3 percent** were at risk of homelessness, **20.5 percent** had a mobility disability, and **19.2 percent** were visually impaired. (See **Exhibit A4**.) They also reported having chronic health conditions, being homeless, having a developmental disability, and having another disability.

Exhibit A4. Service Recipients by Special Populations, FY 2020-2021
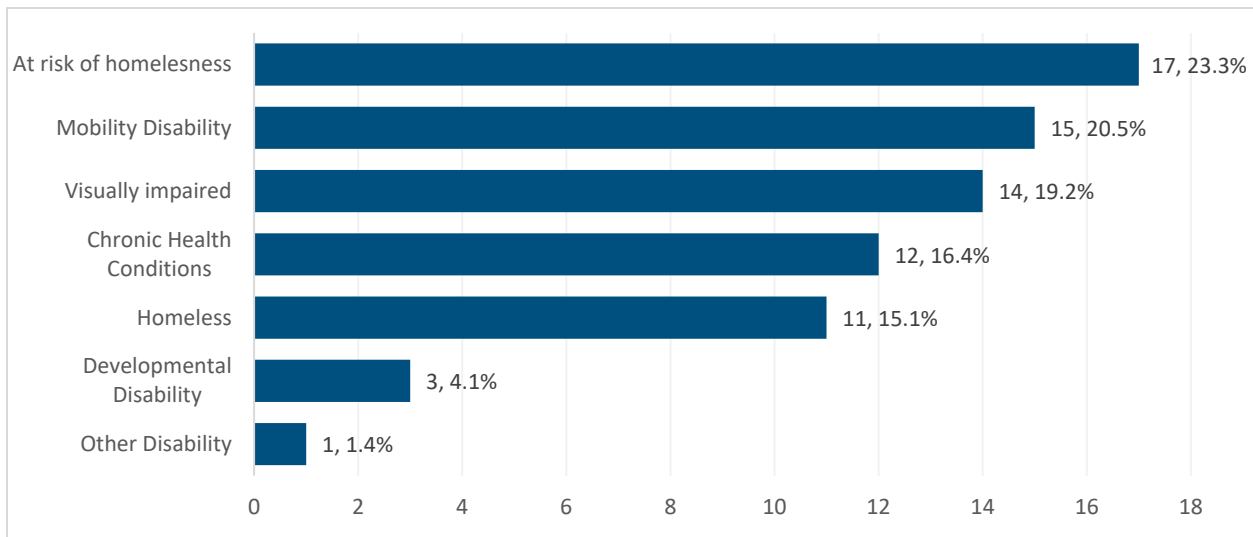
Appendix B. FY 2020-2021 Outreach, Asian American Recovery Services (AARS)

For FY 2020-2021, Asian American Recovery Services (AARS) reported a total of 99 outreach events, 95 individual events and 4 group events. There were 243 attendees. Individual outreach events lasted from 15 to 120 minutes and lasted 29 minutes on average. The group outreach events lasted from 30 to 120 minutes and lasted on average 56 minutes.

Outreach events:

- Most frequently took place over the phone (**85.9%**, n=85). Other locations of events and their respective percentages are shown in **Exhibit B1**.

Exhibit B1. Locations of Outreach events, Fiscal year 2020-2021
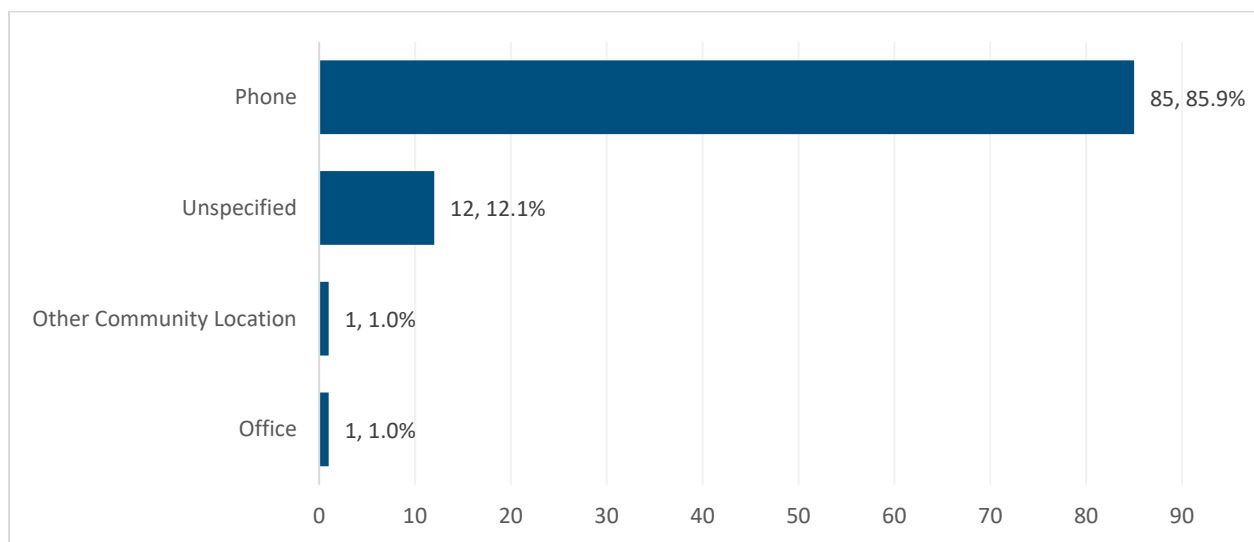
- Were conducted in English (100%, n=99).

- Resulted in 50 mental health referrals and 15 substance use referrals at the individual outreach events.

- Resulted in 361 social services referrals (**Exhibit B2**). An individual outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Referrals were primarily made to other services including Covid-19 testing (25.5%, n=92), Medical Care (20.2%, n=73), Food (20.2%, n=73), Financial (18.8%, n=68) services, and Legal Referrals (**10.2%**, n=37).

Exhibit B2. Social Services Referrals, FY 2020-2021

Bar chart showing Social Services Referrals:
- Other Services: 92, 25.5%
- Medical: 73, 20.2%
- Food: 73, 20.2%
- Financial: 68, 18.8%
- Legal: 37, 10.2%
- Housing: 8, 2.2%
- Health Insurance: 5, 1.4%
- Form Assistance: 5, 1.4%

Outreach event attendees:

- Most often were female (**70.0%**, n=170). Thirty percent were male (**29.6%**, n=72). Less than one percent declined to report their sex at birth.

- Identified their gender as female (**65.1%**, n=140), male (**33.5%**, n=72), female to male transgender (**1.2%**, n=3), and indigenous (**0.8%**, n=2).

- Identified as Heterosexuals (**74.1%**, n=180), Gay/Lesbian (**2.1%**, n=5), Bisexual (**1.7%**, n=4), Queer (**1.7%**, n=4), Pansexual (**0.4%**, n=1), or another sexual orientation (**0.4%**, n=1). The remaining attendees declined to state (**19.8%**, n=48) their sexual orientation.

- Comprised of adults (26-59 years, **44.4%**, n=108), older adults (60+ years, **31.7%,** n=77), transition-age youth (16-25 years, **10.7%**, n=26), children (15 years and younger, **8.6%**, n=21), and unknown age (**4.5%**, n=11).

- Were primarily Tongan (**25.9%**, n=70), Samoan (**19.6**%, n=53), and more than one race (**18.1%**, n=49). (See **Exhibit B3**.)h

Exhibit B3. Attendees by Top Race/Ethnicity Category, FY 2020-2021
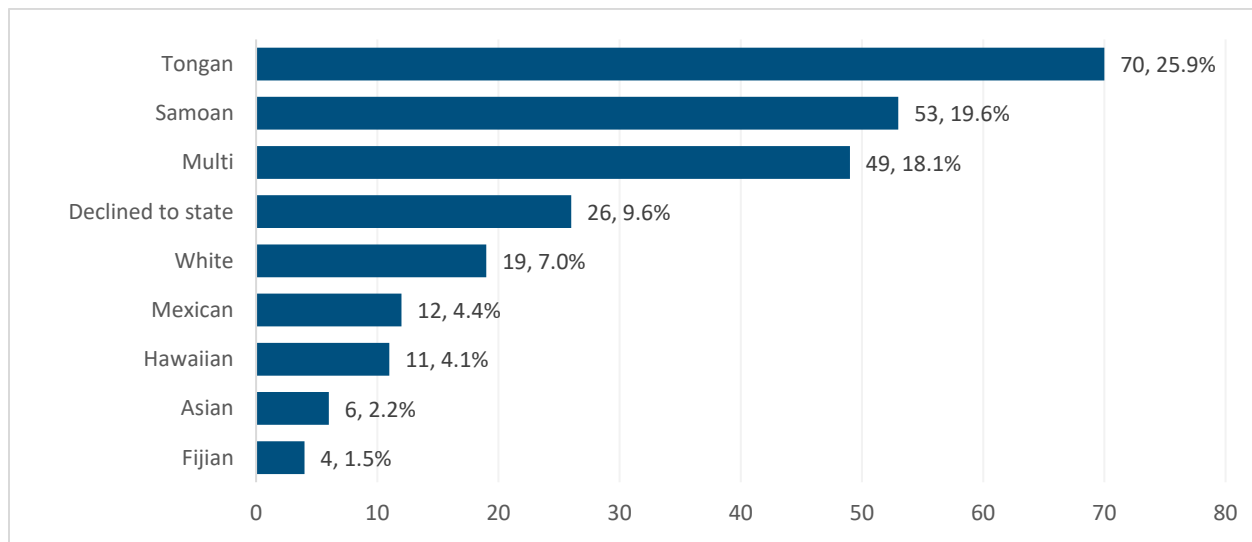
In FY 2020-2021, AARS attendees reported being in special populations groups. Out of the recipients in the special population groups, **32.4 percent** were visually impaired, **27.2 percent** at risk of homelessness, and **23.5 percent** had chronic health conditions (See **Exhibit B4**.) They also reported having a mobility disability, being hearing impaired, being homeless, having another disability, and having a developmental disability.

Exhibit B4. Service recipients by Special Population, FY 2020-2021
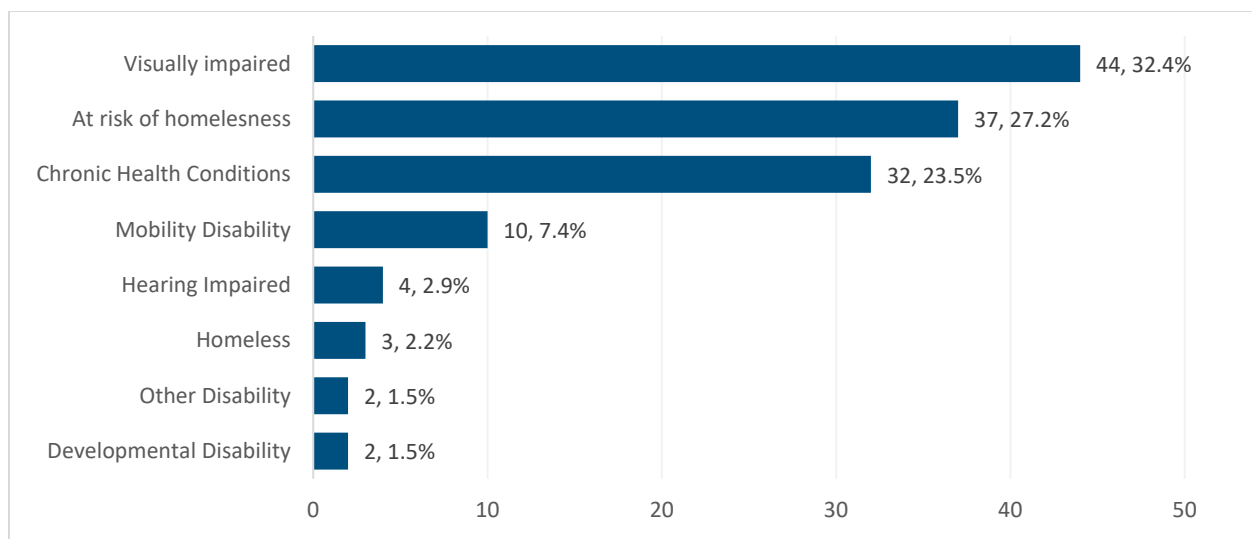
Appendix C. FY 2020-2021 Outreach, Daly City Peninsula Partnership Collaborative

For FY 2020-2021, Daly City Peninsula Partnership Collaborative reported a total of 221 outreach events, 197 individual events and 24 group events. There were 1,173 attendees. Individual outreach events lasted 45 minutes on average. The group outreach events lasted from 45 to 180 minutes and lasted on average 76 minutes.

Outreach events:

- Most frequently took place at another community location (**87.3%**, n=193), mostly through Zoom calls (n=187). Other locations of events and their respective percentages are shown in **Exhibit C1.**

Exhibit C1. Locations of Outreach Events, FY 2020-2021
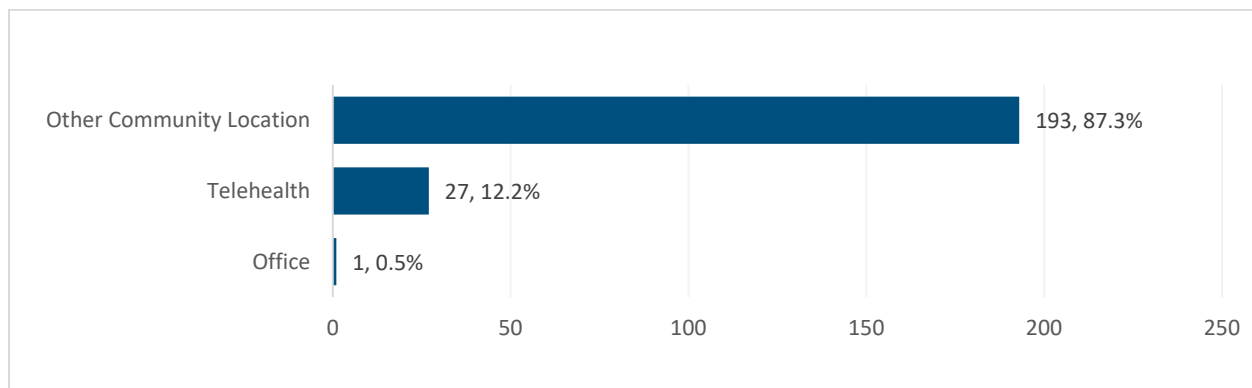
- Were conducted in English (**100%**, n=221).

- Resulted in 187 mental health referrals and 11 substance use referrals at the *individual* outreach events.

- Resulted in 492 social services referrals (**Exhibit C2**). An *individual* outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Referrals were primarily made to Food (**18.9%**, n=93), Medical Care (**17.5%**, n=86), Legal Referrals (**12.0%**, n=59), and Financial/Employment (**11.4%**, n=56) services.

Exhibit C2. Social Services Referrals, FY 2020-2021

Category	Value
Food	93, 18.9%
Medical	86, 17.5%
Legal	59, 12.0%
Financial	56, 11.4%
Other Services	53, 10.8%
Housing	47, 9.6%
Form Assistance	47, 9.6%
Transportation	46, 9.3%
Emergency	5, 1.0%
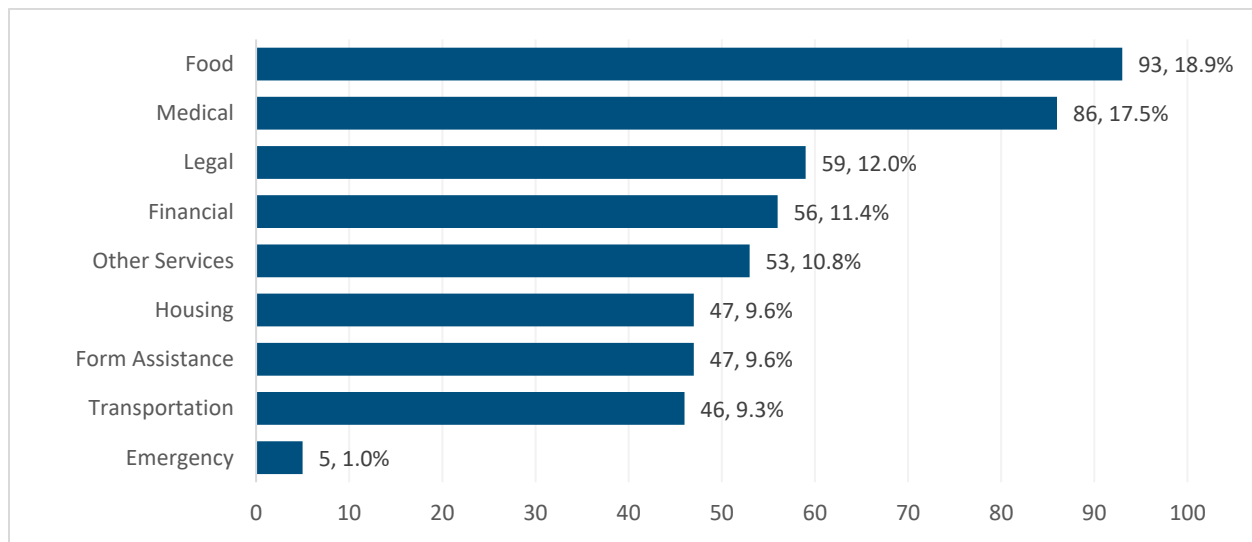
Outreach event attendees:

- Most often were female (**77.8%**, n=913). Twenty-two percent identified as male (**22.1%**, n=260).

- Identified their gender as female (**77.4%**, n=907), male (**22.5%**, n=264) and Questioning (**0.1%**, n=1).

- Identified as Heterosexuals (**97.2%**, n=1,140), Gay/Lesbian (**0.4%**, n=5), or Questioning (**0.1%**, n=1). Two percent of the attendees (**2.3%**, n=27) declined to state their sexual orientation.

- Comprised of adults (26-59 years, **33.2%,** n=390), transition-age youth (16-25 years, **32.6%**, n=382), and children (15 years and younger, **2.0%**, n=24). The remaining attendees (**19.3%**, n=226) declined to state their age.

- Were primarily Mexican (**48.3%**, n=582), Chinese (**14.6%**, n=176), or Filipino (**9.8%**, n=118) (See **Exhibit C3**.)

Exhibit C3. Attendees by Top Race/Ethnicity Category, FY 2020-2021

Race/Ethnicity	Value
Mexican	582, 48.3%
Chienese	176, 14.6%
Filipino	118, 9.8%
White	102, 8.5%
Declined to state	55, 4.6%
Multi	35, 2.9%
Black	28, 2.3%
Middle Eastern	25, 2.1%
Puerto Rican	25, 2.1%
South Asian	25, 2.1%
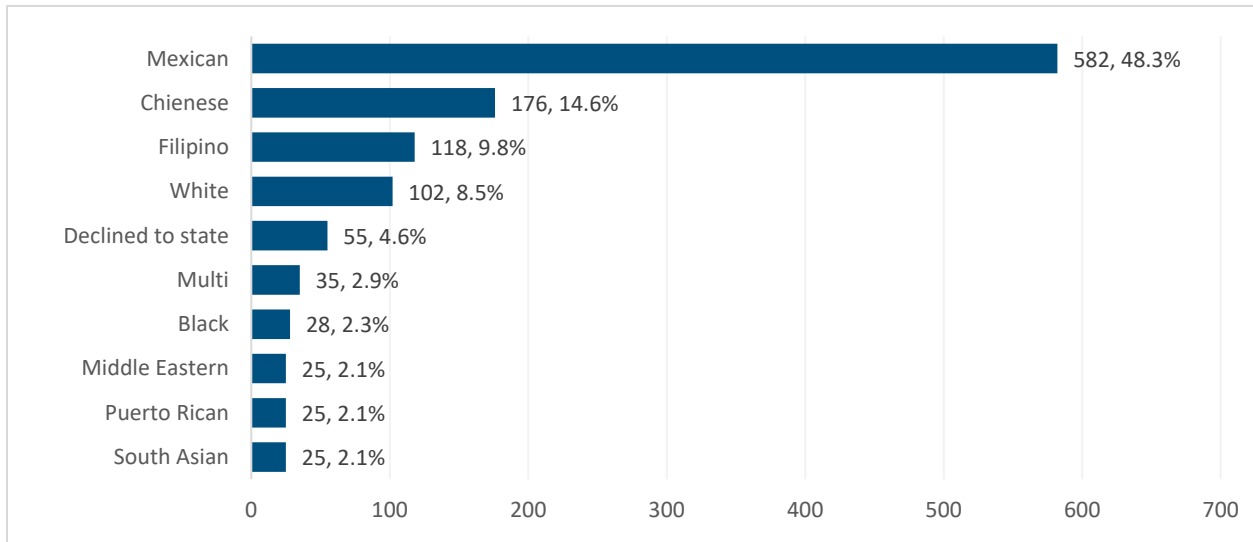
In FY 2020-2021, Daly City Peninsula Partnership attendees reported being in special populations groups. Out of the recipients in the special population group, **28.2 percent** had a mobility disability, **11.5 percent** were disabled in other ways, and **11.3 percent** had chronic health conditions. (See **Exhibit C4.**) They also reported being visually impaired, being at risk of homelessness, being homeless, having a developmental disability, and being a veteran.

Exhibit C4. Service Recipients by Special Populations, FY 2020-2021

| Special Population	Value
Mobility Disability	153, 28.2%
Other Disability	125, 11.5%
Chronic Health Conditions	51, 11.3%
Visually impaired	50, 4.3%
At risk of homelesness	19, 4.1%
Homeless	18, 4.1%
Developmental Disability	18, 1.8%
Veteran	8, 0.5%
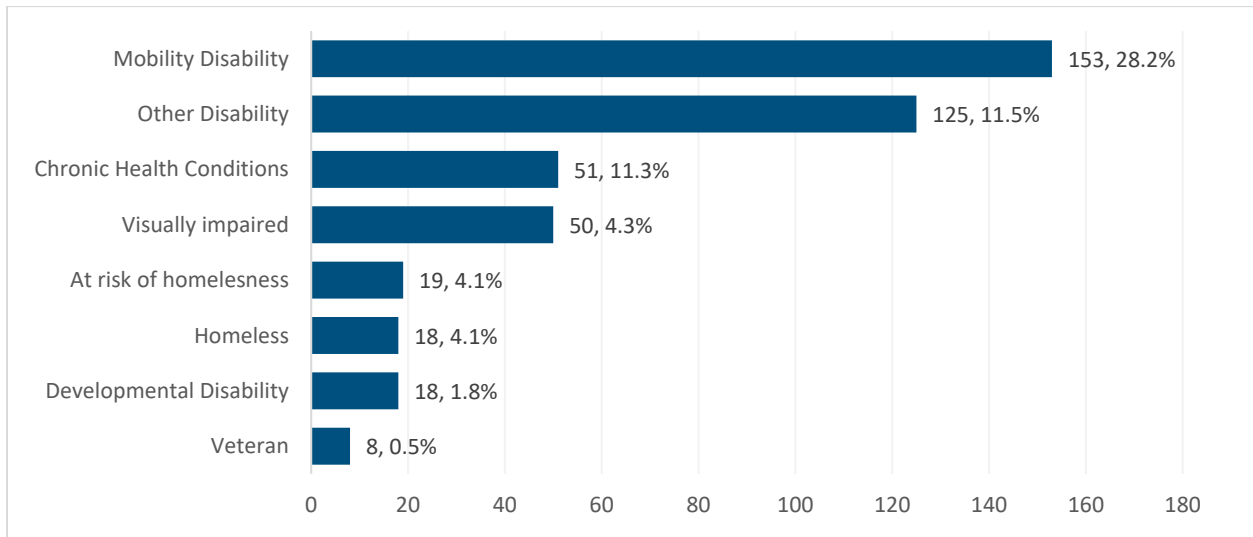
Appendix D. FY 2020-2021 Outreach, Daly City Youth Center

For FY 2020-2021, Daly City Youth Center reported a total of 61 outreach events, all group events. There were 1,636 attendees. Group outreach events lasted from 5 to 120 minutes and lasted on average 61 minutes.

Outreach events:

- Most frequently took place at a non-traditional location (**73.8%**, n=45). Other locations of events and their respective percentages are shown in **Exhibit D1.**
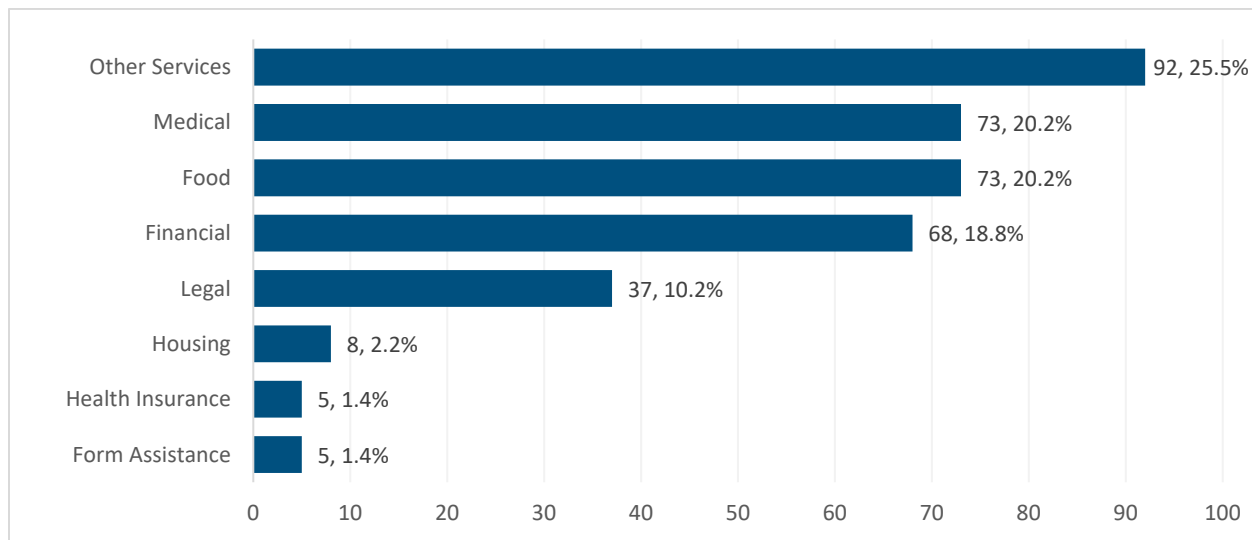
Exhibit D1. Locations of Outreach Events, FY 2020-2021
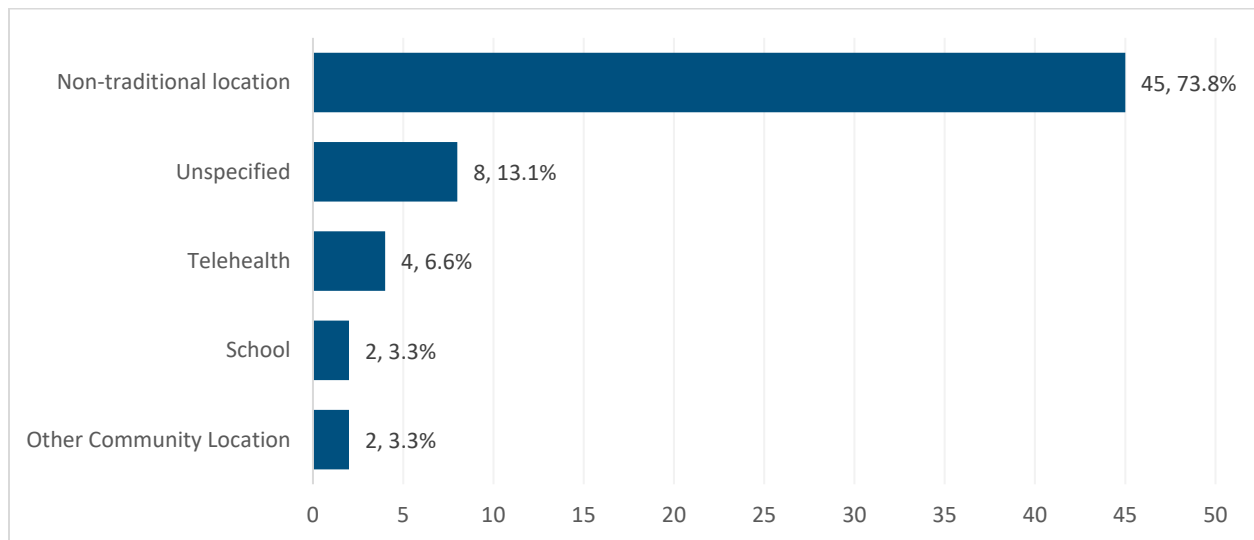
- Were conducted in English (**100%**, n=61).

- Resulted in no mental health referrals or substance use referrals at the *individual* outreach events.

- Resulted in no social services referrals.

Outreach event attendees:

- Most declined to state their sex at birth (**78.1%**, n=1,278). Twelve percent were female (**12.2%**, n=199). Ten percent were male (**9.7%**; n=159).

- Most declined to state their gender (**93.8%**, n=1,535). The remaining attendees identified their gender as female (**4.2%**, n=68) and male (**2.0%**, n=32).

- Most declined to state their sexual orientation (**96.4%**, n=1,449). The remaining attendees identified as Heterosexual (**1.9%**, n=29), Bisexual (**0.9%**, n=14), Gay/Lesbian (**0.4%**, n=6), Queer (**0.2%**, n=3), Asexual (**0.1%**, n=1) or questioning (**0.1%**, n=1).

- Comprised of children (15 years and younger, **67.8%**, n=1,109), transition-age youth (16-25 years, **17.8%**, n=292), and adults (26-59 years, **1.2%**, n=20). The remaining attendees (**13.1%**, n=215) declined to state their age.

- Most declined to state their race (**93.2%**, n=1,548). The remaining attendees were White (**2.3%**, n=38), more than one race (**1.4%**, n=24), or Filipino (**1.4%**, n=23). (See **Exhibit D3**.)

Exhibit D2. Attendees by Top Race/Ethnicity Category, FY 2020-2021
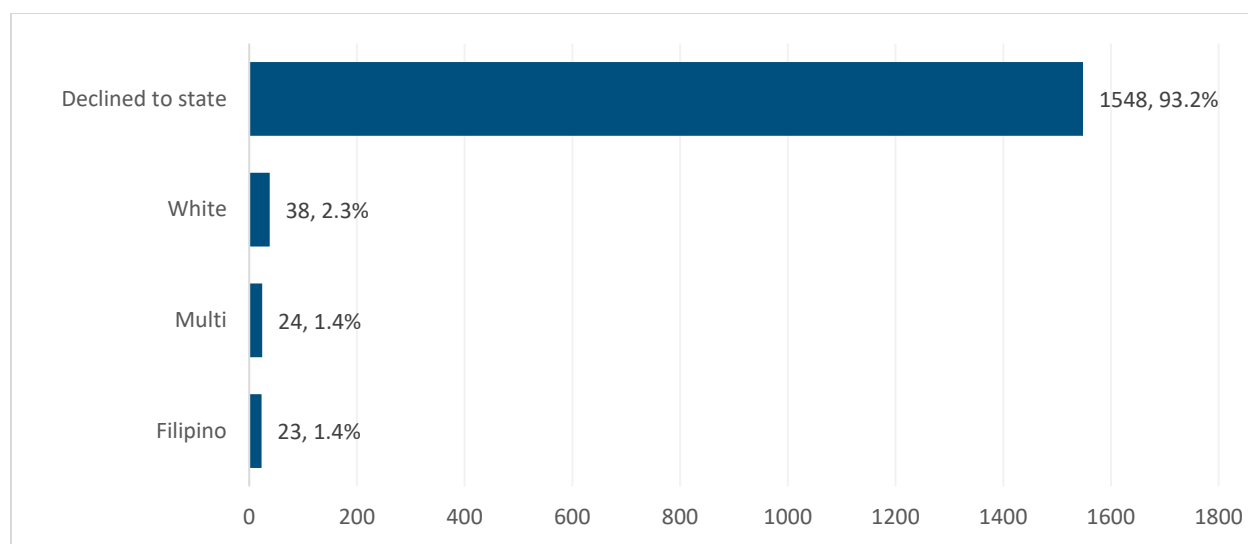
In FY 2020-2021, Daly City Youth Center did not report any special population data.

Appendix E. FY 2020-2021 Outreach, El Concilio

For FY 2020-2021, El Concilio reported a total of 101 outreach events, all individual events. There were 101 attendees in total. Individual outreach events lasted from 10 to 20 minutes and lasted on average 13.5 minutes.

Outreach events:

- Most took place in an office (**84.2%**, n=85). Other locations of events and their respective percentages are shown in **Exhibit E1**.

Exhibit E1. Locations of Outreach Events, FY 2020-2021
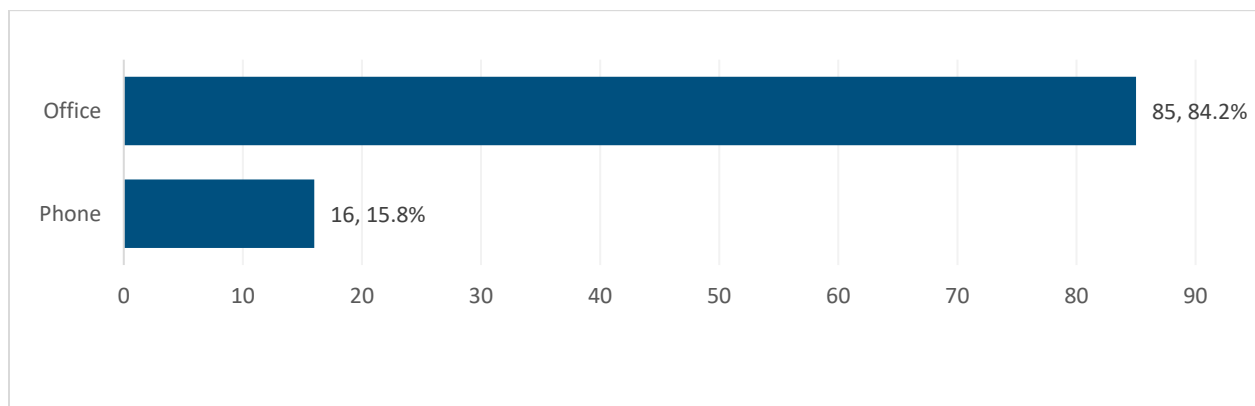
- Were conducted in Spanish (**91.1%**, n=92) and English (**8.9%**, n=9).

- Resulted in 22 mental health referrals and 0 substance use referrals at the *individual* outreach events.

- Resulted in 197 social services referrals. (See **Exhibit E2**.). An *individual* outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Referrals were made primarily to Other Services (**25.4%**, n=50, mostly HEAP n=46), Form Assistance (**24.9%**, n=49), Food (**23.4%**, n=46) and Financial/Employment (**10.7%**, n=21) services.

Exhibit E2. Social Services Referrals, FY 2020-2021

Category	Value
Other Services	50, 25.4%
Form Assistance	49, 24.9%
Food	46, 23.4%
Financial	21, 10.7%
Legal	15, 7.6%
Health Insurance	9, 4.6%
Housing	6, 3.0%
Medical	1, 0.5%
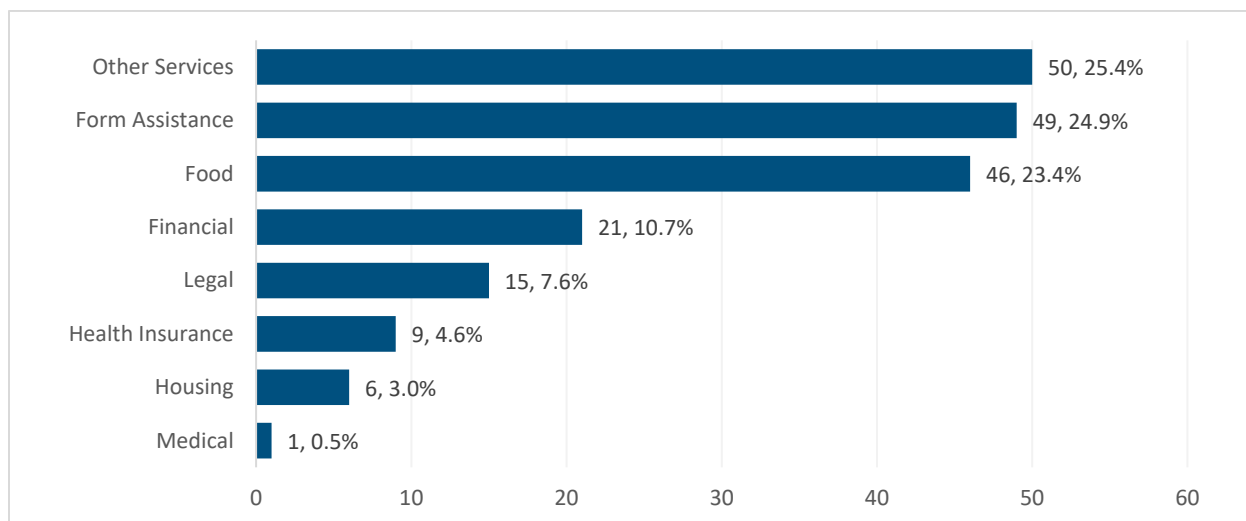
Outreach event attendees:

- Most often were female (**91.1%**, n=92). Eight percent were male (**8.9%**, n=9).

- Identified their gender as female (**91.0%**, n=91) and male (**9.0%**, n=9).

- Were Heterosexuals (**100.0%**, n=101).

- Comprised of adults (26-59 years, **84.2%**, n=85), older adults (60+ years, **10.9%**, n=11), and transition-age youth (16-25 years**, 5.0%**, n=5).

- Were primarily Mexican (**70.3%**, n=71), Central American (**14.9%**, n=15), or more than one race (**7.9%**, n=8) (See **Exhibit E3.**)

Exhibit E3. Attendees by Top Race/Ethnicity Category, FY 2020-2021

Category	Value
Mexican	71, 70.3%
Central American	15, 14.9%
Multi	8, 7.9%
White	3, 3.0%
Black	2, 2.0%
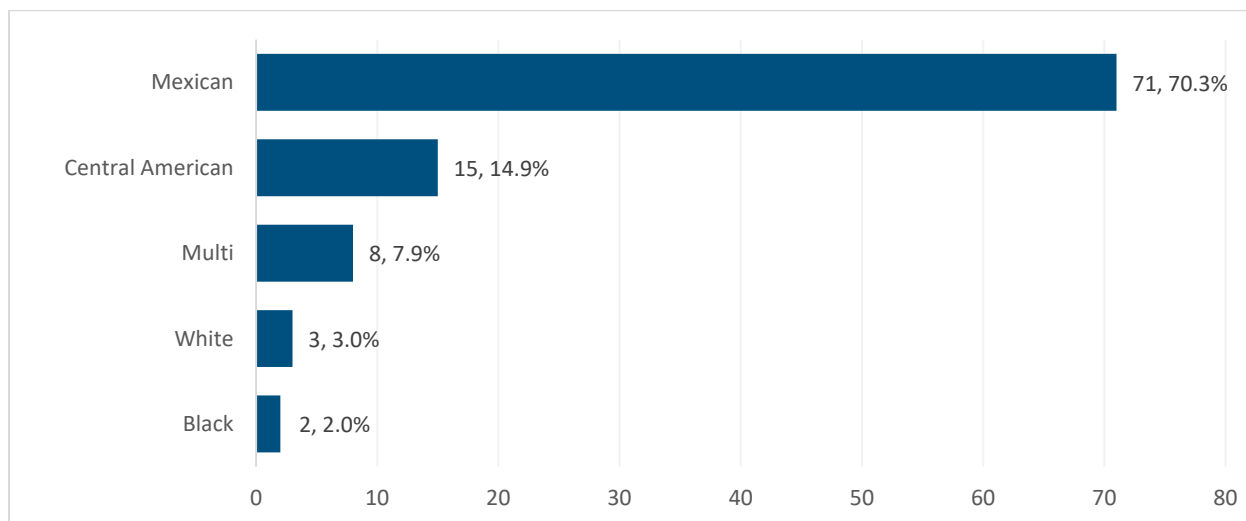
- In FY 2020-2021, El Concilio attendees reported being in special populations groups. Out of the service recipients in the special population group, **57.6 percent** had chronic health conditions, **25.0 percent** were at risk of homelessness, and **5.4 percent** were homeless. (See **Exhibit E4**.) They also reported having a learning disability, having a mobility disability, and being hearing impaired.

Exhibit E4. Service Recipients by Special Populations, FY 2020-2021
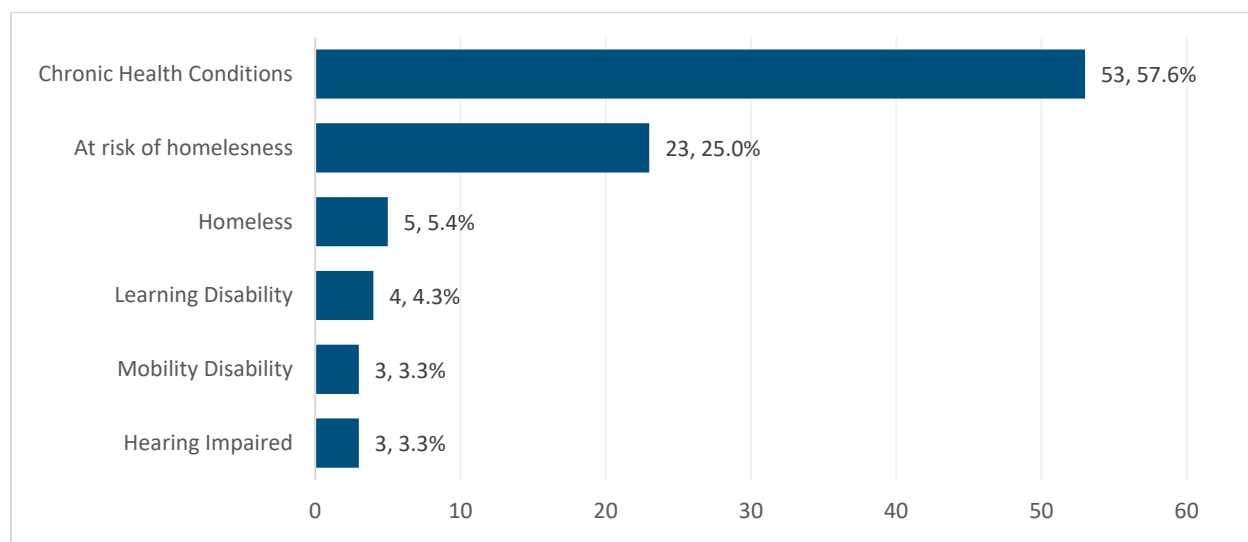
Appendix F. FY 2020-2021 Outreach, Free at Last

For FY 2020-2021, Free at Last reported a total of 69 outreach, all individual events. There were 69 attendees in total. The events lasted from 10 to 60 minutes and were on average 26 minutes.

Outreach events:

- Most frequently took place at an unspecified location (**37.7%**, n=26. Other locations of events and their respective percentages are shown in **Exhibit F1.**

Exhibit F1. Locations of Outreach Events, FY 2020-2021
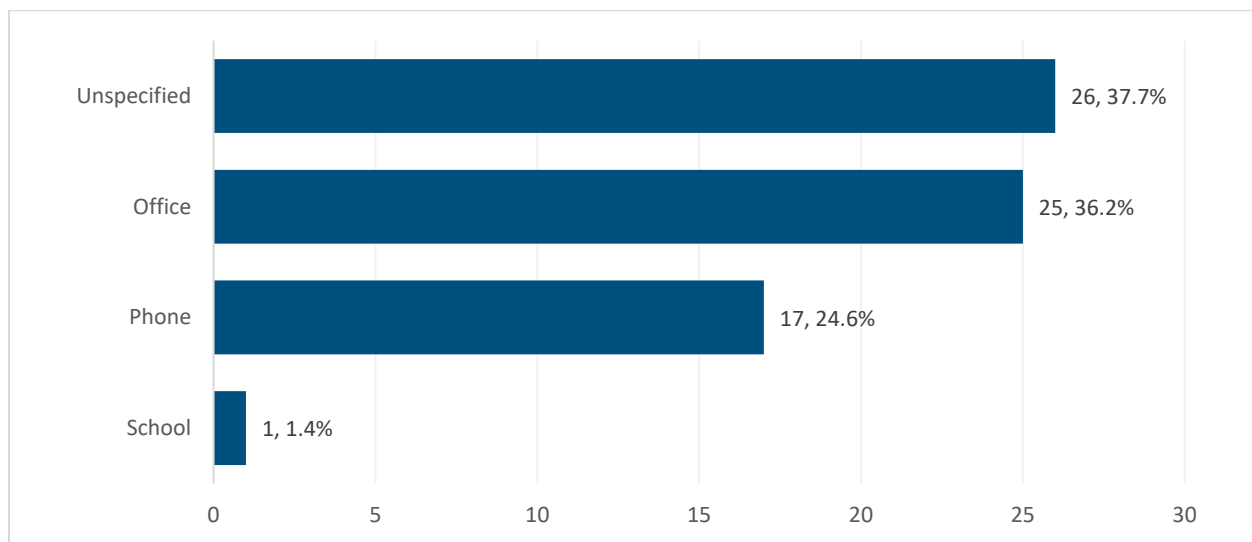
- Were conducted in English (**75.4%**, n=52), Spanish (**23.2%**, n=16), and Samoan (**1.5%**, n=1).

- Resulted in 25 mental health referrals and 40 substance use referrals at the *individual* outreach events.

- Resulted in 111 social services referrals. (See **Exhibit F2**.) An *individual* outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Referrals were primarily made to Housing (**49.5%**, n=55), Medical Care (**33.3%**, n=37), Legal Referrals (**9.9%**, n=11) and Other (**2.7%**, n=3) services.

Exhibit F2. Social Services Referrals, FY 2020-2021
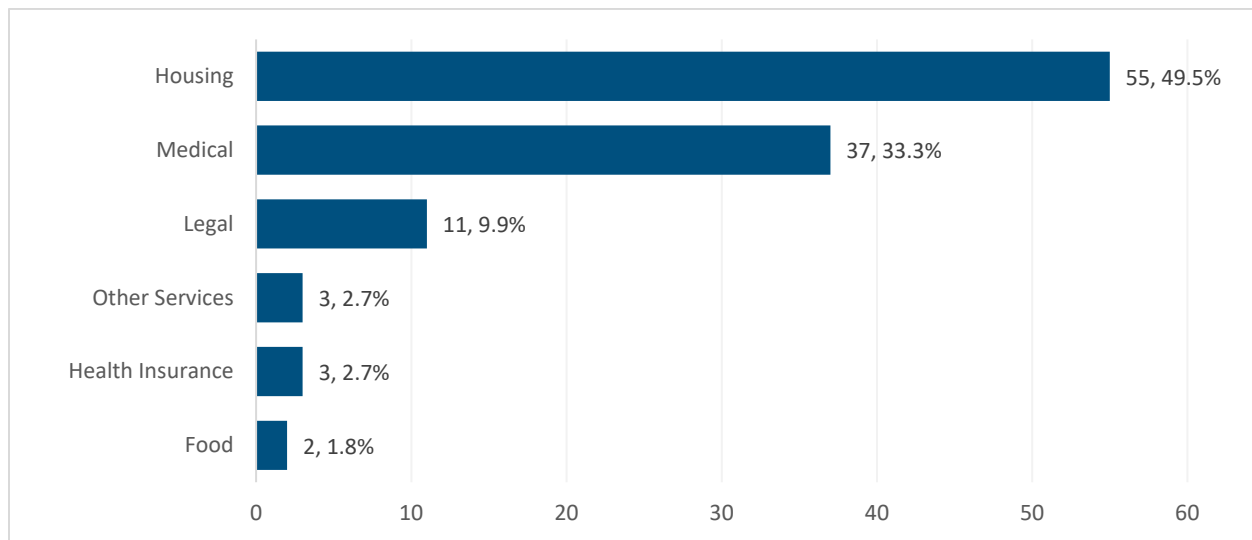
Outreach event attendees:

- Most often were male (**58.0%**, n=40). Forty-two percent were female (**42.0%**, n=29).

- Most identified their gender as male (**58.0%**, n=40). Forty-two percent identified as female (**42.0%**, n=29).

- Identified as Heterosexuals (**84.3%**, n=59), Gay/Lesbian (**7.1%**, n=5), or Bisexual (**7.1%**, n=5). One percent chose more than one sexual orientation (**1.5%**, n=1). One percent declined to state their sexual orientation (**1.4%**, n=1).

- Comprised of adults (26-59 years, **79.7%**, n=55), older adults (60+ years, **11.6%**, n=8) and transition-age youth (16-25 years, **8.7%**, n=6).

- Were primarily Mexican (**43.5%**, n=30), Black (**39.1%**, n=27), and White (**10.1%**, n=7). (See **Exhibit F3**.)

Exhibit F3. Attendees by Top Race/Ethnicity Category, FY 2020-2021
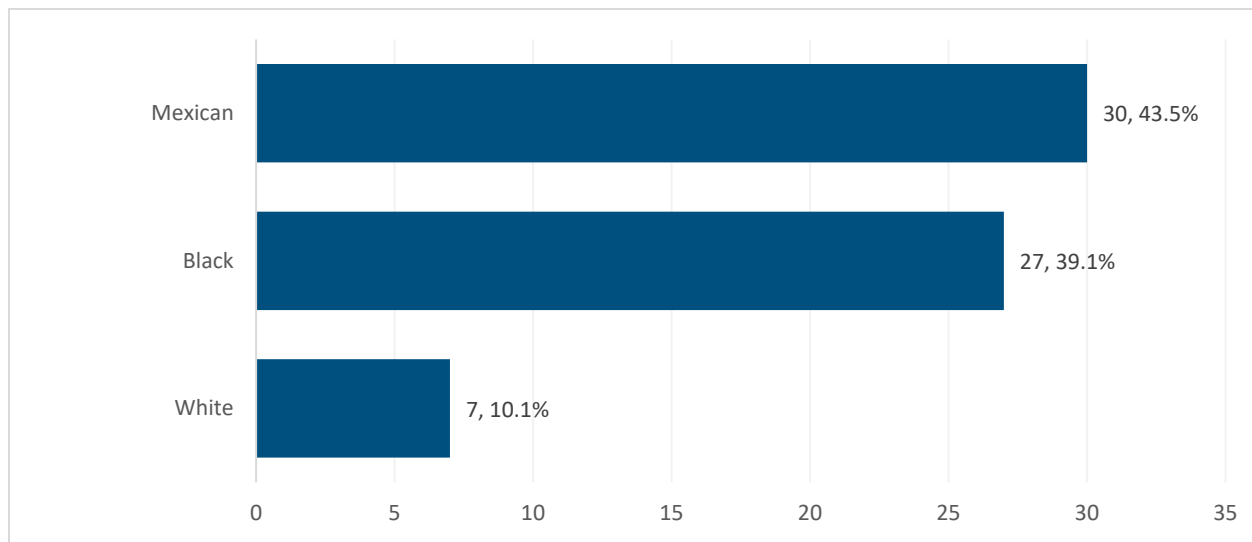
In FY 2020-2021, Free at Last attendees reported being in special populations groups. Out of the service recipients in the special population group, **59.7 percent** were homeless, **25.0 percent** were at risk of homelessness, and **4.2 percent** were veterans. (See **Exhibit F4**.) They also reported having a mobility disability and being hearing impaired.

Exhibit F4. Service Recipients by Special Populations, FY 2020-2021
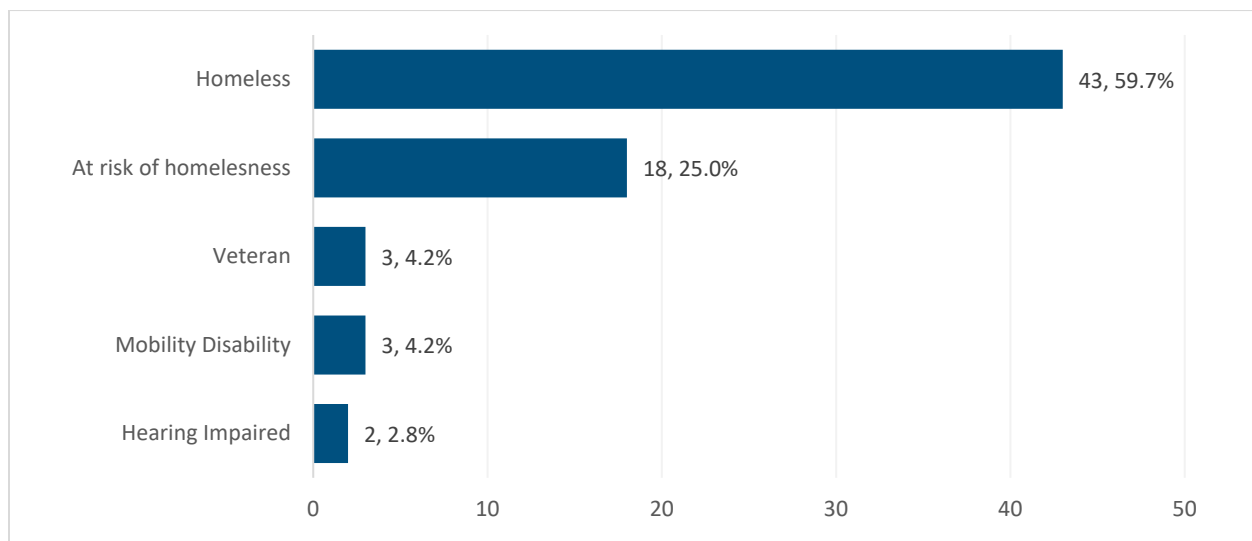
Appendix G. FY 2020-2021 Outreach, Pacifica Collaborative

For FY 2020-2021, Pacifica Collaborative reported a total of 17 outreach events, 4 individual outreach events, and 13 group outreach events. There were 3,925 attendees. Individual outreach events lasted an average of 30 minutes. Group outreach events lasted from 45 to 480 minutes and lasted an average of 192 minutes.

Outreach events:

- Most frequently took place at another community location (**76.5%**, n=13), mostly through Zoom calls (n=8). Other locations of events and their respective percentages are shown in **Exhibit G1.**

Exhibit G1. Locations of Outreach Events, FY 2020-2021
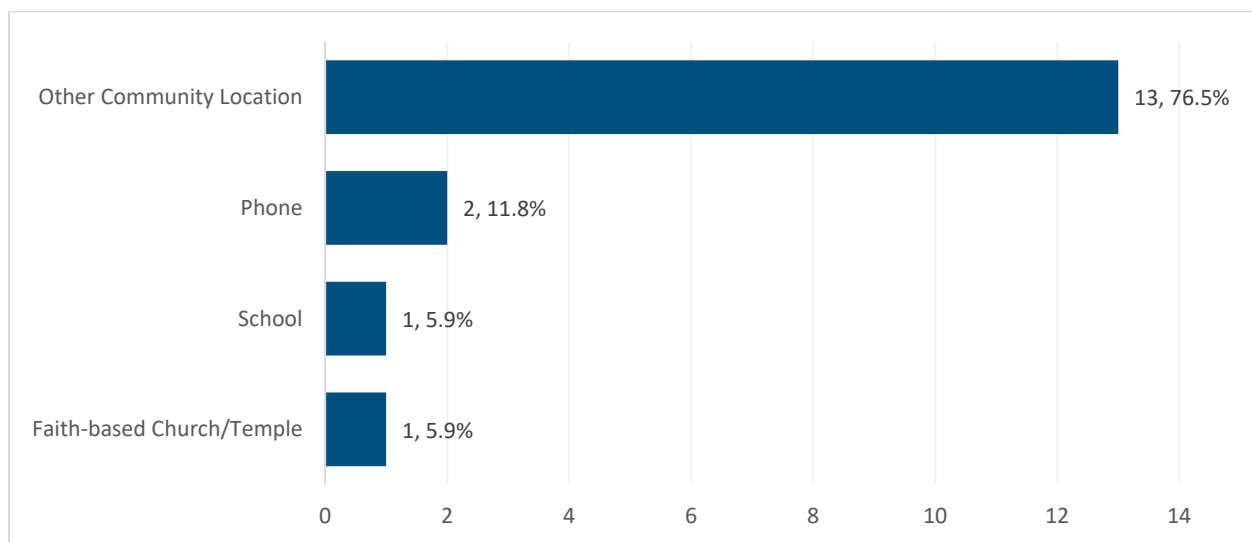
- Were conducted in English (**100.0%**, n=17).
- Resulted in 3 mental health referrals and 2 substance use referrals.
- Resulted in 7 social services referrals. (See **Exhibit G2**). An *individual* outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Referrals were made primarily to Housing (**28.6%,** n=2) and Food (**28.6%,** n=2) services.

Exhibit G2. Social Services Referrals, Fiscal year 2020-2021
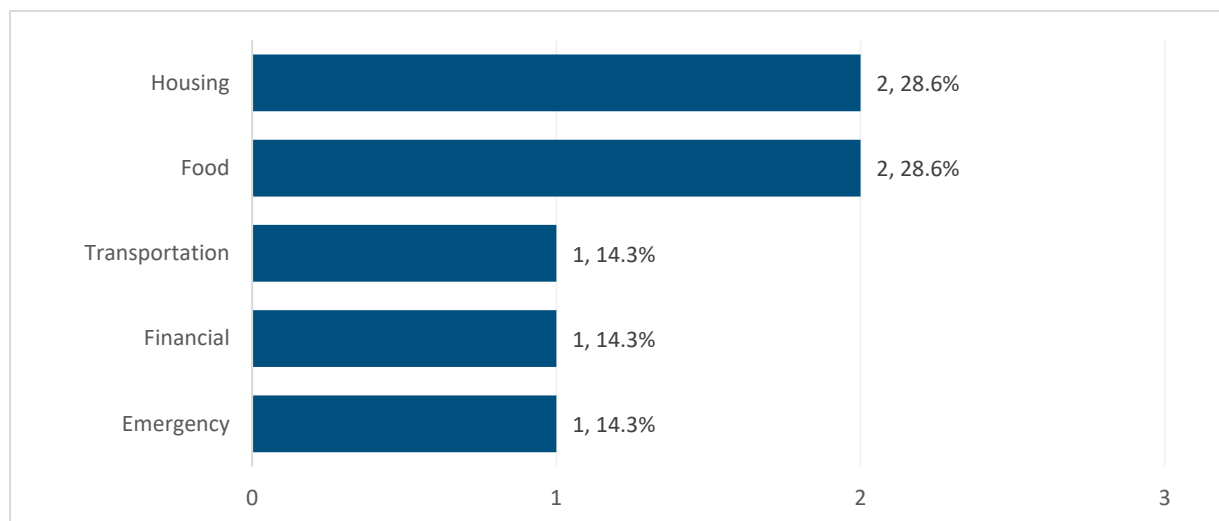
Outreach event attendees:

- Most often were female (**54.7%**, n=2,178). Thirty-nine percent were male (**39.25%**, n=1,563). There were 241 (**6.05%**) individuals who declined to state their sex at birth.

- Identified their gender as female (**53.7%**, n=1,857), male (**39.1%**, n=1,354), male to female transgender (**0.1%**, n=3), queer (**0.03%**, n=1), or gender questioning (**0.1%**, n=3).

- Identified as Heterosexual (**73.1%**, n=2,908), Gay/Lesbian (**5.9%**, n=236), Bisexual (**2.9%**, n=115), Queer (**0.1%**, n=4), or Questioning (**0.2%**, n=8). 17.8% participants (n=706) declined to state their sexual orientation.

- Comprised of adults (26-59 years, **45.6%**, n=1,824), older adults (60+ years, **17.1%**, 683). Outreach event attendees also include transition-age youth (16-25 years, **16.1%**, n=642) as well as children and teens (age 0-15 years, **15.8%**, n=633) The age of 5.4% (n=214) participants was unknown.

- Were primarily White (**44.0%**, n=2,036), Mexican (**13.4%**, n=619), or Asian (**12.5%**, n=578) (See **Exhibit G3**.)

Exhibit G3: Attendees by Top Race/Ethnicity Category, FY 2020-2021
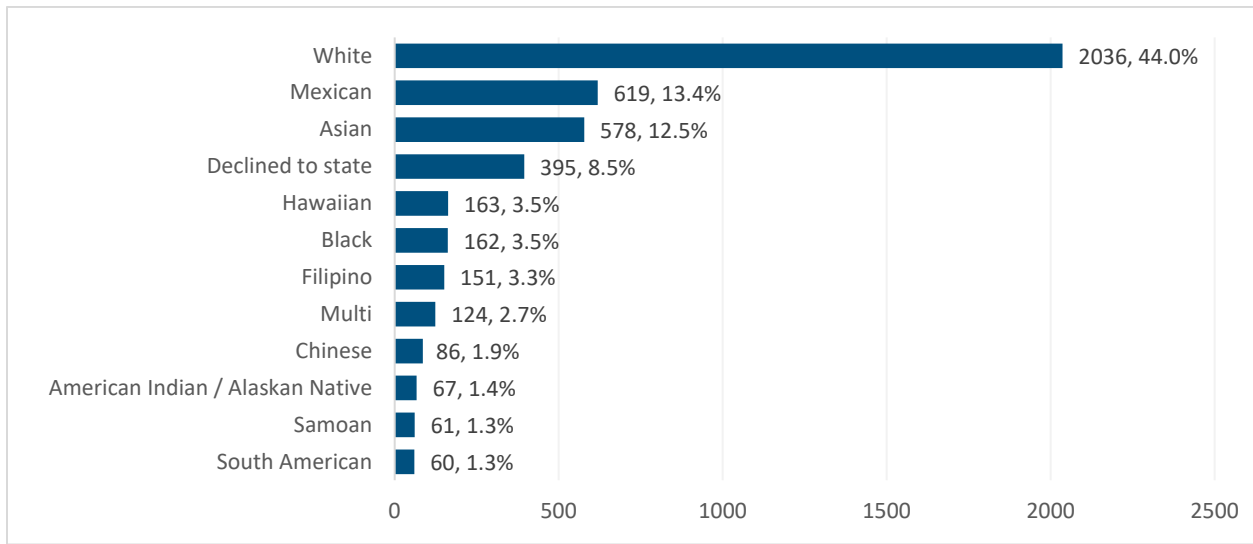
In FY 2020-2021, Pacifica Collaborative reported being in special populations groups. Out of the service recipients in the special population groups **48.4 percent** were at risk of homelessness, **18.8 percent** had a mobility disability, and **10.0 percent** had chronic health conditions. (See **Exhibit G4**.) They also reported being homeless, being a veteran, being visually impaired, being hearing impaired, having a developmental disability, and having a learning disability.

Exhibit G4. Service Recipients by Special Populations, FY 2020-2021
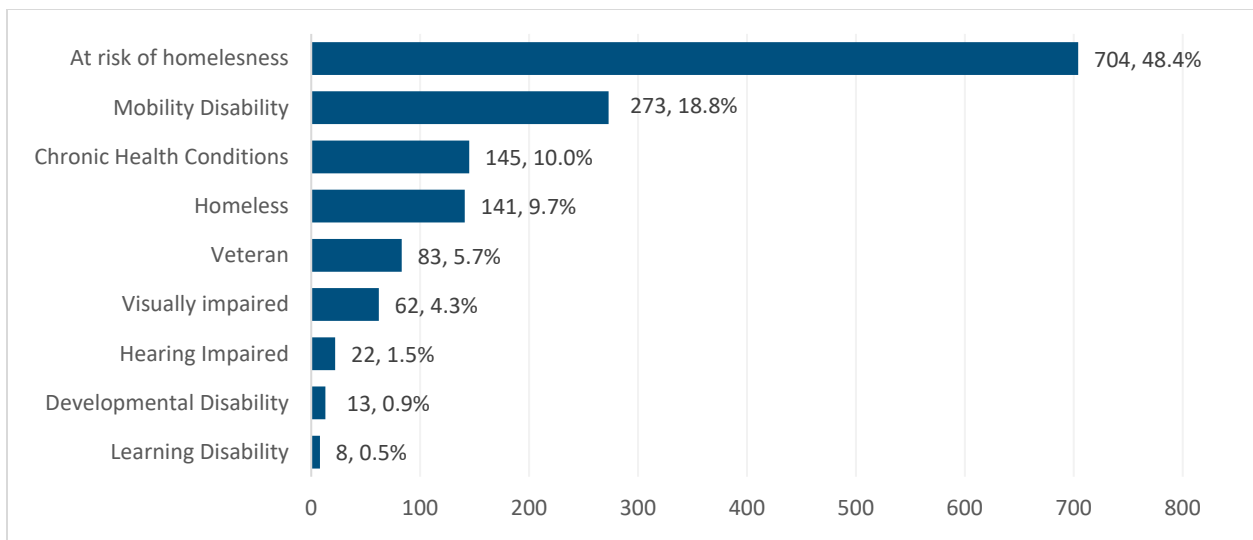
Appendix H. FY 2020-2021 Outreach, StarVista

For FY 2020-2021, StarVista reported a total of 24 outreach events, 14 individual outreach events, and 10 group outreach events. There were 277 attendees. Individual outreach events lasted on average 50 minutes. Group outreach events lasted from 45 to 150 minutes. and lasted on average of 106 minutes.

Outreach events:

- Most frequently took place at another community location (**70.8%**, n=17), mostly at Daily City Chinese Hospital (n=14). Other locations of events and their respective percentages are shown in **Exhibit H1**.

Exhibit H1. Locations of Outreach Events, FY 2020-2021
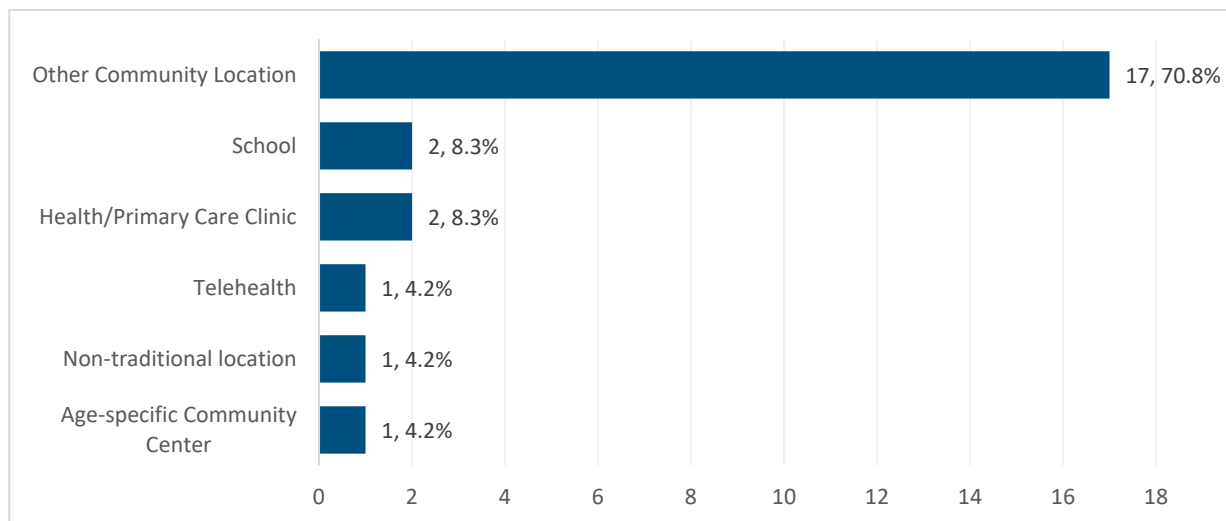
- Outreach events were conducted in English (**41.7%**, n=10), Cantonese (**29.2%**, n=7), and Mandarin (**29.2%**, n=7).

- Resulted in 1 mental health referrals and 1 substance use referrals.

- Resulted in 6 social services referrals. (See **Exhibit H2**.) An individual outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Referrals were made primarily to Form Assistance (**50.0%**, n=3).

Exhibit H2. Social Services Referrals, FY 2020-2021
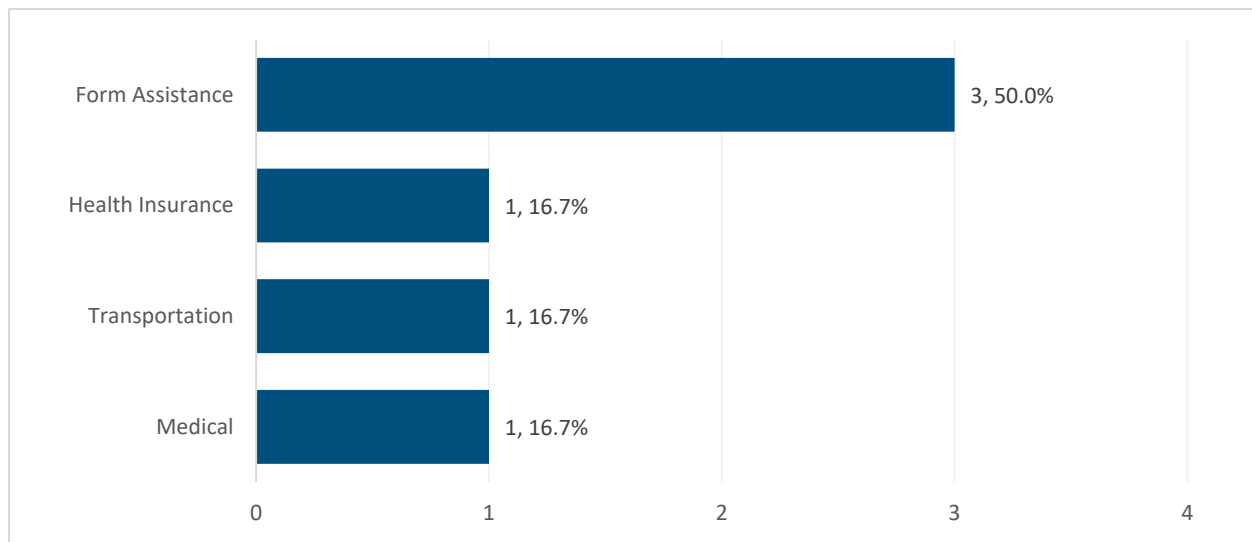
Outreach event attendees:

- More than half of the attendees were female (**50.2%**, n=139) while 48.4% were male (n=134). Four attendees did not indicate their gender at birth.

- Identified their gender as female (**38.5%**, n=87), male (28.3%, n=64), Queer (**12.8%**, n=29), Questioning (**12.8**%, n=29), and male to female transgender (**5.8%**, n=13). A few participants (**18%**, n=4) did not indicate their gender.

- Identified as Heterosexual (**54.5%**, n=151), Gay/Lesbian (**12.6%**, n=35), Questioning (**10.1%**, n=28), Queer (**7.2%**, n=20), Bisexual (**4.3%**, n=12), Pansexual (**2.2%**, n=6), or other sextual orientation (**7.6%**, n=21). About one percent of individuals declined to state their sexual orientation (**1.4%**, n=4).

- Were adults (26-59 years, **40.1%**, n=111), transition-age youth (16-25 years, **24.9%**, n=69), older adults (60+ years, **26.0%**; n=72), and children (15 years and younger, **5.8%,** n=16). A small percentage of individuals did not indicate their age (**3.4%**, n=9)

- Were primarily White (**48.1%**, n=141), Chinese (**11.9%**, n=35) or Filipino (**7.2%**, n=21). (See **Exhibit H3**.)

Exhibit H3. Attendees by Top Race/Ethnicity Category, FY 2020-2021

Category	Value
White	141, 48.1%
Chinese	35, 11.9%
Filipino	21, 7.2%
Asian	19, 6.5%
Multi	16, 5.5%
Declined to state	15, 5.1%
Mexican	13, 4.4%
South Asian	12, 4.1%
Black	8, 2.7%
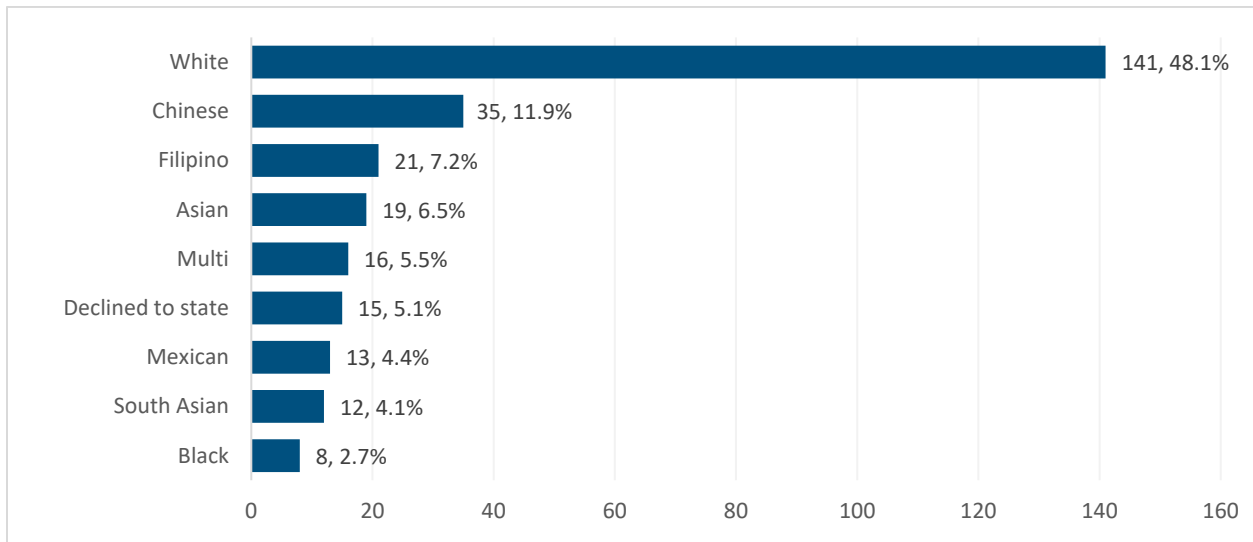
In FY 2020-2021, StarVista attendees reported being in special populations groups. Out of the service recipients in the special population groups, **21.8 percent** were veterans, **16.7 percent** had a mobility disability, and **15.4 percent** had a learning disability. (See **Exhibit H4**). They also reported being hearing impaired, having chronic health conditions, having another disability, being at risk of homelessness, being visually impaired, and having a developmental disability.

Exhibit H4. Service Recipients by Special Populations, FY 2020-2021

Category	Value
Veteran	17, 21.8%
Mobility Disability	13, 16.7%
Learning Disability	12, 15.4%
Chronic Health Conditions	9, 11.5%
Hearing Impaired	9, 11.5%
Other Disability	8, 10.3%
At risk of homelesness	4, 5.1%
Visually impaired	4, 5.1%
Developmental Disability	2, 2.6%
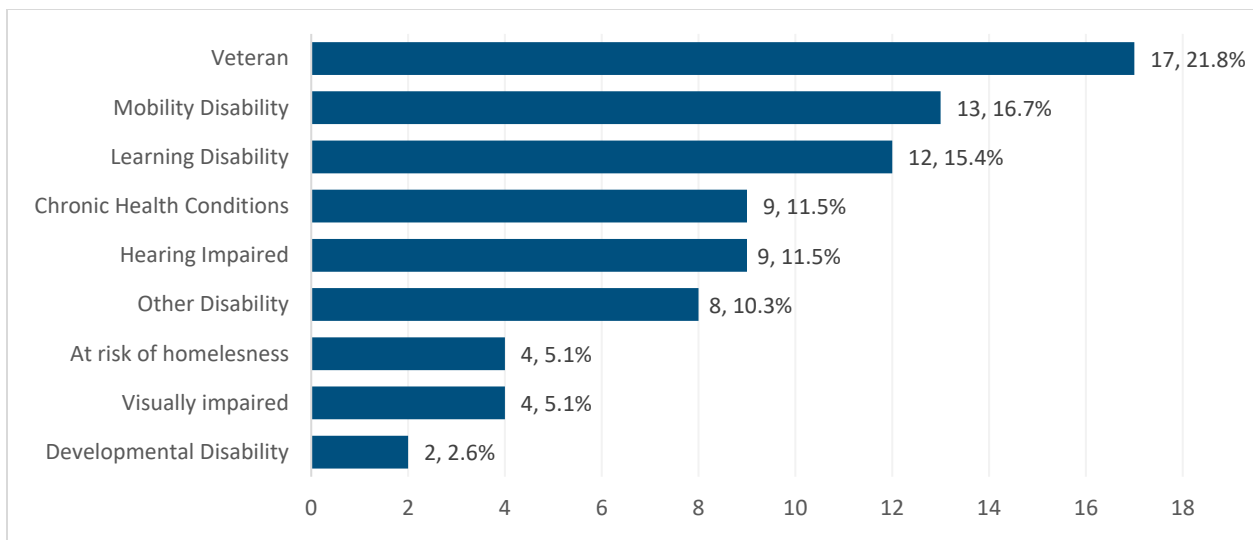
Appendix I. Attendees by Race/Ethnicity by Collaborative, FY 2014-2020

Race/Ethnicity	NCOC							EPAPMHO						
	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
Black	152 (4.1%)	153 (3.2%)	200 (2.7%)	249 (3.1%)	167 (3.0%)	685 (5.4%)	202 (2.4%)	150 (9.1%)	205 (24.5%)	164 (23.8%)	200 (36.5%)	152 (23.2%)	93 (17.9%)	29 (11.8%)
White	930 (25.2%)	1502 (31.5%)	2394 (32.0%)	1981 (24.8%)	1484 (27.0%)	2024 (16.0%)	2336 (27.2%)	444 (26.9%)	82 (9.8%)	54 (7.8%)	47 (8.6%)	55 (8.4%)	18 (3.5%)	12 (4.9%)
American Indian	7 (0.2%)	48 (1.0%)	94 (1.3%)	67 (0.8%)	56 (1.0%)	90 (0.7%)	67 (0.8%)	0 (0.0%)	8 (1.0%)	5 (0.7%)	1 (0.2%)	2 (0.3%)	1 (0.2%)	0 (0.0%)
Middle Eastern	7 (0.2%)	60 (1.3%)	66 (0.9%)	114 (1.4%)	28 (0.5%)	44 (0.3%)	30 (0.4%)	0 (0.0%)	0 (0.0%)	1 (0.1%)	0 (0.0%)	0 (0.0%)	2 (0.4%)	0 (0.0%)
Eastern European	0 (0.0%)	0 (0.0%)	10 (0.1%)	12 (0.2%)	2 (0.0%)	5 (0.0%)	1 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
European	0 (0.0%)	0 (0.0%)	6 (0.1%)	8 (0.1%)	21 (0.4%)	5 (0.0%)	3 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Mexican	147 (4.0%)	260 (5.5%)	1403 (18.7%)	816 (10.2%)	462 (8.4%)	2302 (18.2%)	1235 (14.4%)	43 (2.6%)	196 (23.4%)	90 (13.0%)	53 (9.7%)	156 (23.8%)	119 (22.8%)	101 (41.1%)
Puerto Rican	1 (0.0%)	6 (0.1%)	28 (0.4%)	4 (0.1%)	10 (0.2%)	44 (0.3%)	36 (0.4%)	1 (0.1%)	4 (0.5%)	0 (0.0%)	1 (0.2%)	2 (0.3%)	2 (0.4%)	1 (0.4%)
Cuban	0 (0.0%)	0 (0.0%)	9 (0.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.1%)	0 (0.0%)	0 (0.0%)	1 (0.2%)	0 (0.0%)	0 (0.0%)
Central American	0 (0.0%)	0 (0.0%)	79 (1.1%)	471 (5.9%)	32 (6.0%)	127 (1.0%)	13 (0.2%)	0 (0.0%)	0 (0.0%)	9 (1.3%)	7 (1.3%)	12 (1.8%)	19 (3.6%)	15 (6.1%)
South American	0 (0.0%)	0 (0.0%)	24 (0.3%)	51 (0.6%)	15 (0.3%)	27 (0.2%)	67 (0.8%)	0 (0.0%)	0 (0.0%)	1 (0.1%)	1 (0.2%)	1 (0.2%)	0 (0.0%)	1 (0.4%)
Caribbean	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (0.0%)	0 (0.0%)	5 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Other Latino	192 (5.2%)	87 (1.8%)	N/A	N/A	N/A	N/A	N/A	228 (13.8%)	0 (0.0%)	N/A	N/A	N/A	N/A	N/A
Asian	N/A	N/A	20 (0.3%)	1025 (12.8%)	550 (10.0%)	873 (6.9%)	604 (7.0%)	N/A	N/A	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.2%)	1 (0.4%)
Filipino	336 (9.1%)	678 (14.2%)	804 (10.7%)	1000 (12.5%)	331 (6.0%)	1170 (9.3%)	316 (3.7%)	248 (15.0%)	18 (2.2%)	17 (2.5%)	8 (0.1%)	9 (1.4%)	4 (0.8%)	0 (0.0%)
Chinese	96 (2.6%)	246 (5.2%)	308 (4.1%)	297 (3.7%)	212 (3.9%)	936 (7.4%)	304 (3.5%)	96 (5.8%)	2 (0.2%)	2 (0.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Japanese	11 (0.3%)	30 (0.6%)	59 (0.8%)	55 (0.7%)	26 (0.5%)	37 (0.3%)	42 (0.5%)	3 (0.2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Korean	17 (0.5%)	29 (0.6%)	45 (0.6%)	34 (0.4%)	12 (0.2%)	39 (0.3%)	25 (0.3%)	4 (0.2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.4%)
South Asian	15 (0.4%)	16 (0.3%)	44 (0.6%)	70 (0.9%)	17 (0.3%)	222 (1.8%)	50 (0.6%)	11 (0.7%)	2 (0.2%)	2 (0.3%)	1 (0.2%)	2 (0.3%)	1 (0.2%)	0 (0.0%)
Vietnamese	1 (0.0%)	23 (0.5%)	13 (0.2%)	13 (0.2%)	11 (0.2%)	84 (0.7%)	4 (0.0%)	35 (2.1%)	2 (0.2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Cambodian	18 (0.5%)	1 (<0.1%)	0 (0.0%)	8 (0.1%)	2 (0.0%)	8 (0.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Laotian	0 (0.0%)	2 (<0.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.1%)	4 (0.5%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Mien	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Other Asian	37 (1.0%)	0 (0.0%)	N/A	N/A	N/A	N/A	N/A	4 (0.2%)	0 (0.0%)	N/A	N/A	N/A	N/A	N/A
Tongan	287 (7.8%)	237 (5.0%)	176 (2.4%)	61 (0.8%)	47 (0.9%)	89 (0.75)	88 (1.0%)	172 (10.4%)	121 (14.5%)	121 (17.5%)	88 (16.1%)	97 (14.8%)	30 (5.8%)	15 (6.1%)
Samoan	280 (7.6%)	343 (7.2%)	347 (4.6%)	163 (2.0%)	201 (3.7%)	503 (4.0%)	137 (1.6%)	123 (7.5%)	90 (10.8%)	49 (7.1%)	35 (6.4%)	57 (8.7%)	26 (5.0%)	19 (7.7%)
Fijian	9 (0.2%)	24 (0.5%)	0 (0.0%)	8 (0.1%)	3 (0.1%)	21 (0.2%)	25 (0.3%)	1 (0.1%)	14 (1.7%)	3 (0.4%)	3 (0.5%)	5 (0.8%)	1 (0.2%)	0 (0.0%)
Hawaiian	31 (0.8%)	29 (0.6%)	40 (0.5%)	150 (1.9%)	188 (3.4%)	1521 (12.1%)	174 (2.0%)	16 (1.0%)	7 (0.8%)	2 (0.3%)	5 (0.9%)	15 (2.3%)	164 (31.5%)	40 (16.3%)
Guamanian	10 (0.3%)	26 (0.5%)	24 (0.3%)	5 (0.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Multi	72 (2.0%)	414 (8.7%)	651 (8.7%)	407 (5.1%)	369 (6.7%)	1228 (9.7%)	248 (2.9%)	39 (2.4%)	66 (7.9%)	74 (10.7%)	92 (16.8%)	86 (13.1%)	39 (7.5%)	9 (3.7%)
Other Race	402 (10.9%)	101 (2.1%)	151 (2.0%)	254 (3.2%)	140 (2.5%)	113 (0.9%)	113 (1.3%)	14 (0.8%)	2 (0.2%)	3 (0.4%)	4 (0.7%)	3 (0.5%)	0 (0.0%)	0 (0.0%)
Unknown Race	626 (17.0%)	446 (9.4%)	488 (6.5%)	671 (8.4%)	1106 (20.1%)	412 (3.3%)	412 (4.8%)	16 (1.0%)	12 (1.4%)	93 (13.5%)	2 (0.4%)	1 (0.2%)	1 (0.2%)	1 (0.4%)
Total**	3684	4761	7483	7996	5492	12614	8580	1650	836	690	548	656	521	245

Note: Percentages may not sum to 100% because of rounding. Total count for race/ethnicity reported may exceed the total number of attendees, because some providers may have reported individuals who are multi-racial as both multi-racial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percent is the sum of all race/ethnicity data reported. N/A indicates the category was not available or discontinued during the specific fiscal year.

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APPENDIX 9. OUTREACH COLLABORATIVE EVALUATION REPORT

SAN MATEO COUNTY HEALTH

BEHAVIORAL HEALTH & RECOVERY SERVICES

PREVENTION & EARLY INTERVENTION THREE-YEAR EVALUATION REPORT

FY 2018/2019, 2019/2020, & 2020/2021

CONTENTS

INTRODUCTION

Prevention and Early Intervention (PEI) is one of the five components of the Mental Health Services Act (MHSA). This component has its own reporting requirements, with the most updated reporting requirements being implemented in June 2018 by the California Mental Health Services Oversight and Accountability Commission (MHSOAC). PEI targets individuals of all ages prior to the onset of mental illness, except for the early onset of psychotic disorders. PEI emphasizes reducing the seven negative outcomes of untreated mental illness: (1) suicide; (2) incarceration; (3) school failure or pushout; (4) unemployment; (5) prolonged suffering; (6) homelessness; and (7) removal of children from their homes.

In June 2018, the PEI regulations were amended, and specific requirements were added that included indicators, data trackers, the explanation of a three-year evaluation plan, annual evaluation report, and the PEI component of a three-year plan.

San Mateo County Behavioral Health and Recovery Services (BHRS) funded 20 MHSA PEI programs across the fiscal years (FY) covered in this report, FY 2018-2019, FY 2019-2020, and FY 2020-2021. Most of PEI programs are delivered by community-based providers that serve children, adults, and older adults, as well as marginalized and diverse populations. Nearly 30,000 community members received services across the entire three-year period. The activities ranged from trainings, psycho-education workshops, community capacity development, advocacy, teacher and provider consultations, summer employment, early intervention and short-term treatment services, and cultural events.

PEI PROGRAM CATEGORIES

Prevention: A set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. Prevention program services may include relapse prevention for individuals in recovery from a serious mental illness.

Early intervention: Short-term treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including negative outcomes that may result from untreated mental illness. Early intervention program services may include services to parents, caregivers, and other family members of the person with early onset of a mental illness as applicable. Services shall not exceed 18 months, unless the individual receiving service is identified as experiencing first onset of a serious mental illness or emotional disturbance with psychotic features, in which case early intervention services shall not exceed four years.

Outreach for increasing recognition of early signs of mental illness: The process of engaging, encouraging, educating, and/or training and learning from potential responders (family, school

personnel, peer providers, etc.) about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness. Outreach for increasing recognition of early signs of mental illness may include reaching out to individuals with signs and symptoms of a mental illness so they can recognize and respond to their own symptoms.

Stigma and discrimination reduction program: The County's direct activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness and members of their families.

Access to linkage and treatment program: A set of related activities to connect children, adults, and seniors with severe mental illness, as early in the onset of these conditions as practicable, to medically necessary care and treatment including but not limited to care provided by county mental health programs (e.g., screening, assessment, referral, telephone help lines, and mobile response).

Suicide prevention program: Organized activities that the County undertakes to prevent suicide because of mental illness.

PEI STRATEGIES

All programs need to be designed and implemented to further at least one of these strategies:

Create access and linkage to treatment: See definition listed above.

Timely access to mental health services for individuals and families from underserved population: To increase the extent to which an individual or family from an underserved population that needs mental health services because of risk or presence of a mental illness received appropriate services as early in the onset as practicable through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available, and cost of services. Services shall be provided in a convenient, accessible, acceptable, culturally appropriate setting.

Non-stigmatizing and non-discriminatory practices: Promoting, designing, and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness, or seeking mental health services in ways that are accessible, welcoming, and positive.

DATA SOURCES AND ANALYSIS

A mixed-methods research framework was used to conduct this evaluation plan and included both qualitative and quantitative data that was provided by our contractors and staff. While a standardization of data is our goal, currently there are some variations across programs that reflect staffing capacity, technology access, and the differences between target populations. However, all our PEI programs have been implemented and designed to work towards reaching PEI goals consistent with MHSA legislation.

The data sources that were used for the completion of this report were the following:

1) MHSA Annual Report Templates

> Each contract provider is responsible for completing this report on an annual basis. Currently the report template collects metrics such as unduplicated number of clients served, demographics, and outcomes, as well as narrative regarding program activities, interventions, program successes and challenges. This template continues to be refined as we adhere to new PEI guidelines as well as customized to program needs.

2) Program Tracking Logs and Sign-In Sheets

> Internal PEI programs used tracking logs and sign-in sheets to document the number of clients, outreach, and referrals made. Some tracking sheets are also online through Survey Monkey and are analyzed by an external consultant.

3) Program Tools/Surveys

> Many of the PEI programs use pre-post test program surveys to collect outcome data as well as client satisfaction with the program. These surveys include Likert scales and open-ended questions and capture a variety of outcomes, such as changes in attitudes, knowledge, and behaviors. Measures also capture the increase in protective factors to mental illness as well as social-emotional wellbeing and use of new skills. The use of pre and post tests are being reviewed to make sure they align with the outcome metrics we hope to collect across programs.

CHALLENGES

San Mateo County has had extremely limited organizational capacity to support PEI program administrative and reporting requirements, due to the staff hiring constraints beyond the control of BHRS. Currently, MHSA administration is staffed only by the MHSA Manager, who contracts with external consultants to meet the minimum PEI regulations. A dedicated PEI Coordinator would provide greater capacity for ongoing day-to-day PEI program needs, monitor

PEI data collection and evaluation, as well as support adaptation to the constantly evolving MHSA PEI requirements and regulations. Contract monitoring for some PEI programs is carried out through clinical supervisors who are expected to meet with contractors regularly. However, due to increased workloads, this is not always possible and places a strain on our workforce's ability to engage in meaningful oversight.

The onset of the COVID-19 pandemic during FY 19/20 and mandates such as the stay-at-home order and social distancing proved to be challenging for staff in terms of providing excellent programs and services in ways that continue to engage, serve, and positively impact a wide range of client populations for which the PEI programs are intended. In many cases, the pandemic exacerbated many of the mental health issues and challenges experienced throughout San Mateo County. Nevertheless, in FY 19/20 and thereafter, most of the programs and supports across PEI successfully adapted to all-virtual service delivery models, while engaging and serving a similar annual number of clients comparable to the numbers served in previous fiscal years.

Additionally, standardized data collection did not exist in the period covered by this report. This has posed a challenge for data collection for various reasons. First, different contractors and internal programs had varying levels of understanding when it comes to data reporting, measurements, and the requirements for PEI-funded programs. A second reason is due to the lack of integration of PEI-required data in existing data collection and documentation systems. Furthermore, it is difficult to effectively make comparisons on a year-to-year basis, especially if programs submit different data each year. This affects our ability to report meaningful impact across PEI strategies and implement data-driven improvement strategies.

STRENGTHS

San Mateo County BHRS has implemented 20 different PEI programs that provide services to a variety of target populations located across the county and work to prevent the negative outcomes associated with mental illness and severe mental illness. The FY 20/21 PEI Budget is $7.7 million, with 53% allocation to children and youth ages 0-25.

Over the years, PEI programs have received evaluation supports. Data collection and analysis of outreach programs are carried out through a contract with an external consultant, American Institute for Research. The Office of Diversity and Equity (ODE), which runs several PEI programs, developed standardized indicators as part of a community and stakeholder-driven Theory of Change Process. The prioritized outcomes across all ODE programs are related to developing community capacity in the areas of: (1) self-empowerment, (2) community advocacy, (3) cultural humility, (4) access to treatment/prevention programs (reducing barriers), and (5) stigma discrimination reduction.

Additionally, starting in the spring of 2021, BHRS contracted with Resource Development Associates (RDA) to support PEI data collection, evaluation and reporting across all PEI

programs to satisfy PEI-legislative reporting and evaluation requirements and support local priority outcomes. RDA has continued to work with BHRS and its contracted providers to develop a standardized, county-wide PEI data collection and reporting system that will allow the reporting of aggregate data across programs and years. Although standardization of data collection and reporting on key demographic characteristics and outcomes across programs continues to be a focus of improvement for BHRS, many PEI programs have begun to collect demographic and outcomes that align directly with PEI requirements. Moving forward, BHRS will have a greater ability to present richer amounts of data and outcomes in the PEI Three-Year Evaluation Reports.

A second strength is that PEI programs continue to be either adapted or developed based on the identified community needs. For example, providers of the Seeking Safety program were reporting limitations with the curriculum due to the strict fidelity requirements given the challenges faced by high-risk youth in attending groups with consistency. Most providers had adapted to a more client-centered approach, responding to client needs and integrating Seeking Safety modules into broader programming. The percentage of participants that met the six-session threshold deemed impactful, ranged from 25% - 56% across providers. An alternate, more flexible, and trauma-informed curriculum was piloted with providers.

Between November 2018 and May 2019, focus groups were conducted that engaged primarily marginalized ethnic, linguistic, and cultural youth and adults. Participants were asked for feedback regarding the Mindfulness-Based Substance Abuse Treatment (MBSAT) curriculum and experiences implementing the skills developed in their personal lives. The findings of the pilot were used to inform the requirements of a new Request for Proposal (RFP) for Trauma-Informed Co-Occurring Services for Youth. The RFP allowed for alternate culturally responsive curricula to be proposed for piloting, which led to the funding of both MBSAT and the Panche Be Youth Program, a comprehensive indigenous-based, youth development curriculum focused on the prevention of substance use amongst youth of color. The RFP also included a foundational trauma-informed 101 trainings for the adults that interact with the youth program participants (parents, teachers, probation officers, service providers, community, etc.) to create trauma-informed supports for youth.

This is a testament of the County's ability to listen to the needs of the community and adapts its services and supports accordingly. The ability to adapt became especially important during the pandemic, when county leadership, staff, community providers, and community members banded together to ensure that they remained connected and to continually ensure that excellent services were provided.

After the review of PEI programs in this reporting period, another strength noted is related to the effectiveness of the programs overseen by the Office of Diversity and Equity (ODE), which results in all MHSA PEI programs being designed, implemented, and evaluated with an equity lens. Having MHSA housed under ODE enables the administrative team to stay close to community partners, stakeholders, and clients/consumers and their family members. These sustained relationships have developed into meaningful partnerships that optimize BHRS'

ability to stay connected to community so that the voice of marginalized communities is always at the center of all the work that is carried out; the three-year planning process, the design and implementation of programs, needs assessments, as well as advance systems change policies.

MOVING FORWARD

Based on the findings of this report, some system improvement needs, oversight limitations, and data collection needs were identified. First, we acknowledge that currently we do not have the staffing or structure to carry out an evaluation internally. To be able to comply with PEI requirements, some action steps are being implemented starting this current FY 21/22 to make the evaluation of PEI programs sustainable, meaningful, and community centered. There are several programs in this reporting period that only use number of clients served and qualitative success stories as their outcomes. The data reporting for these programs is out of compliance with new regulations that ask for specific metrics such as number of referrals, time from initial contact to engaging in services, etc. Further, the changes to an all-virtual service delivery model due to the pandemic have also prompted staff to think about other effective ways to collect data virtually that will continue to satisfy PEI requirements. Accordingly, below are the action steps that BHRS will take to ensure that data collection of the PEI programs remains in compliance and is used meaningfully to evaluate success as well as improvement.

- *Continue to Build Data-Informed Capacity:* In early 2020, San Mateo hired RDA, an external evaluation and consulting firm, to support its data collection, evaluation, and reporting efforts. RDA continues to work with contract monitors and contracted agencies to establish and implement outcome metrics for each of the programs. RDA is currently working with specific contracted agencies to ensure that outcomes are representative of the work being done, fulfill PEI requirements, and are meaningful to the community. This further enables San Mateo County to continue to be culturally competent and includes the perspective of diverse people with lived experience.

- *Standardize PEI Data Collection:* In this reporting period, data collection is not standardized. Many programs submit annual reports with quantitative data that changes from year to year based on their capacity/turnover, and many outcomes are based on what the agencies deem to be meaningful at the time. The standardization of outcome metrics and the parameters around how and when to collect these metrics will enable us to make data driven systems improvements, compare year-to-year outcomes, and comply with PEI regulations.

- *Hold Informational Meetings with Contract Monitors:* These meetings will be held with each of the contract monitors to update and provide them with any new PEI regulations. This will enable the MHSA Manager to gain understanding as to their involvement with the contractor, familiarity with the data requirements, and establish oversight procedures for data collection.

- *Hold Regular Meetings with PEI Programs and Contract Agencies:* These meetings will be held with each of the contractors regarding implementation, data collection, and analysis. One of the recommendations from our previous evaluator was that contract agencies needed training on data collection. These meetings can serve to gauge the capacity of the agency, obtain feedback on outcome measures and tools proposed, troubleshoot data collection challenges, and review any new PEI guidelines as well as updated expectations and potential contract amendments.

- *Create Customized PEI Program Reporting Crosswalks:* Formal written protocols are needed for PEI programs that would include the communication of PEI requirements and reporting templates, clear expectations of what needs to be completed by each program, data sources, as well as timelines for submission of data.

PREVENTION AND EARLY INTERVENTION (AGES 0-25) OVERVIEW

San Mateo County BHRS has made great progress over the past three fiscal years to provide quality programs, services, and activities to youth and transition age youth (TAY) clients. Most of these programs also include the engagement of caregivers, teachers, and other stakeholders who are involved in serving youth throughout San Mateo County. Approximately 2,300 individuals were either served or participated in PEI services and activities during the past three fiscal years, which is a 38% increase in the number of individuals served in comparison to the previous reporting period. One important program that has been particularly important during the pandemic is the youth crisis and suicide prevention hotline and texting service, the first of its kind in San Mateo County. It is estimated that over 12,000 individuals have used this service annually, a great proportion of those being youth and TAY.

Another important thing to note is the increasing diversity observed in the clients served each year. After a review of the demographic data over the past three fiscal years, some programs experienced a greater participation of Spanish-speaking populations, who comprise a significant proportion of the overall county population. This is another indicator that San Mateo County is increasingly becoming successful at engaging target marginalized communities to participate in these important programs.

RECOMMENDATIONS

Based on findings across the three-year period, one recommendation is to directly engage caregivers and youth into services, as appropriate. Due to the onset of the pandemic, the stay-at-home order resulted in school closures. Therefore, youth were required to attend school virtually. This resulted in programs experiencing a significant decrease in the number of referrals for youth services that have traditionally come from teachers and school counselors. The decrease in referrals was particularly observed for substance abuse and youth at risk for co-occurring disorders in MBSAT programming. This becomes concerning, given the increase of

overdose deaths throughout the country during the pandemic. Therefore, it is imperative that direct youth outreach efforts are carried out in ways that are innovative and will compel youth to seek help if needed. The use of technology and social media can be one primary way to outreach and engage youth. These efforts should be made in conjunction with direct caregiver outreach efforts. New referral sources will need to primarily come from direct communication with youth and caregivers in collaboration with other community-based providers who address other social determinants of health (SDoH) for families (e.g., medical offices, assistance for food, housing, education, employment, etc.). Lastly, additional training should be provided to teachers and counselors on increasing their ability to virtually detect signs of youth at risk for future maladaptive behaviors.

PEI: AGES 0-25 PROGRAMS

The following programs serve children and youth ages 0-25 exclusively. There are other PEI programs that serve both children/youth and adult populations, these programs are not included in this section. The MHSA guidelines require 19% of spending to fund PEI, and 51% of the PEI budget to fund programs for children and youth ages 0-25.

In San Mateo County, there are five programs that serve this age group as their primary service population. Other programs in our PEI category also serve this age group, although not exclusively. These programs serve several special populations and are found in geographically underserved areas of the county. These programs include consultations with teachers, parents, workshops, outreach, and employment activities.

PEI Ages 0-25

- Early Childhood Community Team (ECCT)
- Project SUCCESS
- Mindfulness-Based Substance Abuse Treatment (MBSAT, formerly known as Seeking Safety)
- Teaching Pro Social
- Crisis Hotline, Youth Outreach, and Intervention Team

There was a **38%** increase in the number of clients served throughout FYs 2018-2021 compared with the previous reporting period of FYs 2016-2018

EARLY CHILDHOOD COMMUNITY TEAM (ECCT)

ECCT employs both prevention (60%) and early intervention (40%) strategies. ECCT incorporates several major components that build on current models in the community to support the healthy social emotional development of young children.

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

ECCT focuses services in the Coastside community—a low-income, rural, geographically isolated community. To better serve this disperse community, ECCT has built strong relationships with key community partners and successfully refers families to the local school district, other StarVista services, Coastside Mental Health Clinic, and Pre-to-Three Program, among others.

METHODS

ECCT is a program with three service modalities, some of which are evidence based, and others are promising practices.

PROGRAM STRATEGIES

Timely Access to Mental Health Services for Individuals and Families from Underserved Populations

Non-Stigmatizing and Non-Discriminatory Practices

PROGRAM HIGHLIGHTS

455 total clients served

72 teachers served

117 families received mental health services

91 children and their families received weekly child-parent psychotherapy services

26 families received intensive case consultation

DEMOGRAPHIC DATA

EECT served a total of 516 clients across FYs 18/19, 19/20, and 20/21. The demographic data in this section represents unduplicated data provided by those who were active in the program.

The data across the three fiscal years shows that over time, an increasing proportion of clients across various backgrounds that best represent the diverse population of San Mateo County sought services from the ECCT program. Additionally, the data shows that those who were most served were Latinos, as well as Spanish speakers. This is congruent with the program's target population, as well as county-wide demographic data that shows that Latinos from this region experience mental health challenges at a higher rate than other ethnic groups. The increase of Latino clients served in FY 20/21 may be partially attributed to the onset of the pandemic in 2020, which may have also exacerbated these mental health challenges among the Latino population.

ECCT Total Clients Served

Clients Served, by Race/Ethnicity FY 2018-2021

18/19
- Hispanic/Latino: 49%
- Caucasian/White: 28%
- African-American/Black: 0%
- Asian/Pacific Islander: 1%
- Other: 4%
- Multi-Ethnic: 3%

19/20
- Hispanic/Latino: 63%
- Caucasian/White: 27%
- African-American/Black: 0%
- Asian/Pacific Islander: 6%
- Other: 3%

20/21
- Hispanic/Latino: 80%
- Caucasian/White: 3%
- African-American/Black: 2%
- Asian/Pacific Islander: 9%
- Other: 8%

Legend:
- Hispanic/Latino
- Caucasian/White
- African-American/Black
- Asian/Pacific Islander
- Other
- Multi-Ethnic

LANGUAGE PREFERENCE

Legend: Spanish, English, Other

FY 18/19
- Spanish: 66%
- English: 31%
- Other: 3%

FY 19/20
- Spanish: 63%
- English: 36%
- Other: 1%

FY 20/21
- Spanish: 80%
- English: 17%
- Other: 3%

OUTCOMES

To assess the effectiveness of the ECCT program, various outcome measures were used throughout the previous three fiscal years, including the Child Behavioral Checklist (CBCL) that is filled out by the client's teachers and parents. Teacher satisfaction surveys, parent satisfaction surveys, as well as informal conversation and observations are also gathered throughout each fiscal year. In FY 20/21, parents also were asked to complete the Parenting Stress Index (PSI) to assess for any ongoing chronic stress factors considering the stress brought on by the pandemic.

TEACHER SATISFACTION SURVEY RESULTS

Presented below are the results from teacher satisfaction surveys that are collected at the end of each fiscal year. Across all three fiscal years, a high proportion of teachers surveyed agreed that consultation services are effective in increasing their willingness to continue caring for an identified child, and in helping them think about children's development and behavior, classroom engagement activities, and supporting students and their families. During FY 20/21, several additional survey items were added to the teacher satisfaction survey that assessed teachers' satisfaction with consultants' ability to provide services virtually. Most teachers reported that the telehealth services provided were useful and that consultants were effective in supporting them through the COVID-19 pandemic.

FY 18/19, 19/20, and 20/21

% of Teachers Who Reported:	FY 18/19	FY 19/20	FY 20/21
Consultation was very effective or effective in contributing to their willingness to continue caring for an identified child (i.e., specific child with challenging behaviors)	90%	87%	100%
Consultation was very effective or effective in helping them think about children's development and behavior	100%		
Consultation was very useful or useful in helping them think about children's engagement in classroom activities	100%		
Consultation was very useful or very useful in thinking with them about supporting all children in their classroom	100%	87%	
Consultant was effective in helping them to find services that the child and/or family need(s)		83%	
Consultant was effective in contributing to their understanding of the family's situation and its effects on the child's current behavior		93%	
Consultant was effective in helping them think about how to support all children in their classroom		87%	
Would recommend consultation services to other programs		100%	100%
Consultant was effective in increasing their understanding of the child's experience and feelings		93%	100%
Consultation was very effective or effective in helping them in their relationship with this child's family	85%		100%
Consultant was very effective or effective in helping them to think about staff relationships and how they influence their program and the children and families in their program		N/A	83%

% of Teachers Who Reported:	FY 18/19	FY 19/20	FY 20/21
Consultant was very effective or effective in supporting them through the challenges of the COVID-19 pandemic		N/A	83%
Telehealth services offered by the consultant were either very useful or useful		N/A	83%
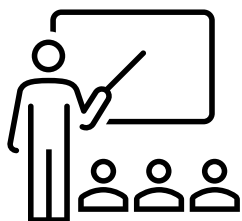
All teachers reported that they would recommend consultation services to other programs.

FAMILY CENTERED OUTCOMES

At the end of each fiscal year, parents are also invited to complete a satisfaction survey about their experiences with the ECCT program. It was a challenge obtaining high survey participation from parents, especially during FY 20/21. Due to the transition of social distancing and virtual-based services, it became even more challenging to obtain survey responses that were shared with parents at the end of the fiscal year. Therefore, no parent satisfaction surveys were returned during FY 20/21.

FY 18/19, 19/20, and 20/21 Family-Centered Outcomes

% of Respondents Who Reported:	FY 18/19	FY 19/20	FY 20/21
Consultation was effective in supporting their relationship with their child	100%	100%	N/A
Consultation effective was in increasing their understanding of their child's behaviors and needs	100%	100%	N/A
Consultation was effective in assisting the teachers in adapting and/or responding to their child's needs	100%	N/A	N/A
Consultation was effective in helping them think about their child's experience in daycare/pre-school	100%	N/A	N/A
Consultant was involved in finding additional services for their child	83%	100%	N/A
Additional services found by the consultant were helpful	N/A	100%	N/A
Consultant was effective in supporting their relationship with their child's teacher	N/A	100%	N/A
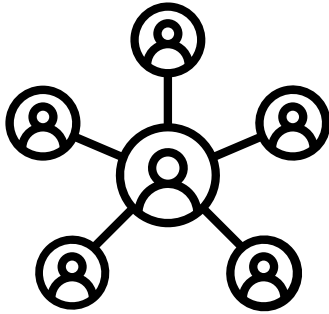
18 families have increased their capacity to understand their child's behaviors and respond effectively to their social-emotional needs.

18 families reported an improvement in multiple areas related to their child's development and/or behavior.

100% of families that engaged in parenting education in FY 18/19 reported an improvement in their child's behavior.

QUALITATIVE DATA

Mother has worked diligently in therapy on her acceptance of functioning like "a single parent" and minimizing the effects/emotional toll of her resentment and disappointment in her spouse. She has adjusted her expectations and the child and sister effectively function like a subset of the family. She sets better boundaries with child's father and her stepson.

"I have felt supported, assured, and very comfortable. I am very grateful for their work and commitment to me."

"My son knows that I am constantly here for him, I am firm and that makes him feel secure and he knows that I love him."

PROJECT SUCCESS

Project SUCCESS, or Schools Using Coordinated Community Efforts to Strengthen Students, is a research-based program that uses interventions that are effective in reducing risk factors and enhancing protective measures.

Project SUCCESS is designed for use with youth ages 9-18 and includes parents as collaborative partners in prevention through parent education programs. Clinical staff trained in culturally competent practices ran all the groups. The school district's small size provides an opportunity for every student in the district, ages 9-18, to participate in one or more Project SUCCESS activities. All groups were offered in English and in Spanish.

METHODS

Project SUCCESS is a SAMHSA model program that prevents and reduces substance use and abuse and associated behavioral problems among high risk, multi-problem youth ages 9-18. It is an evidence-based program.

PROGRAM STRATEGIES

Create Access to Linkage and Treatment

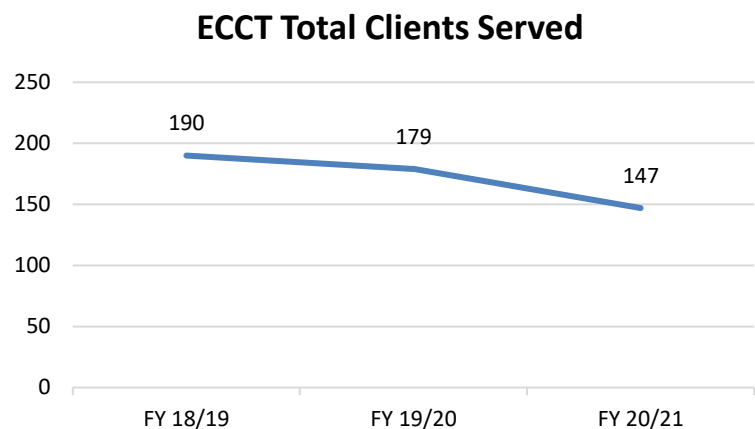## PROGRAM HIGHLIGHTS

703 clients served

280 families served

DEMOGRAPHIC DATA

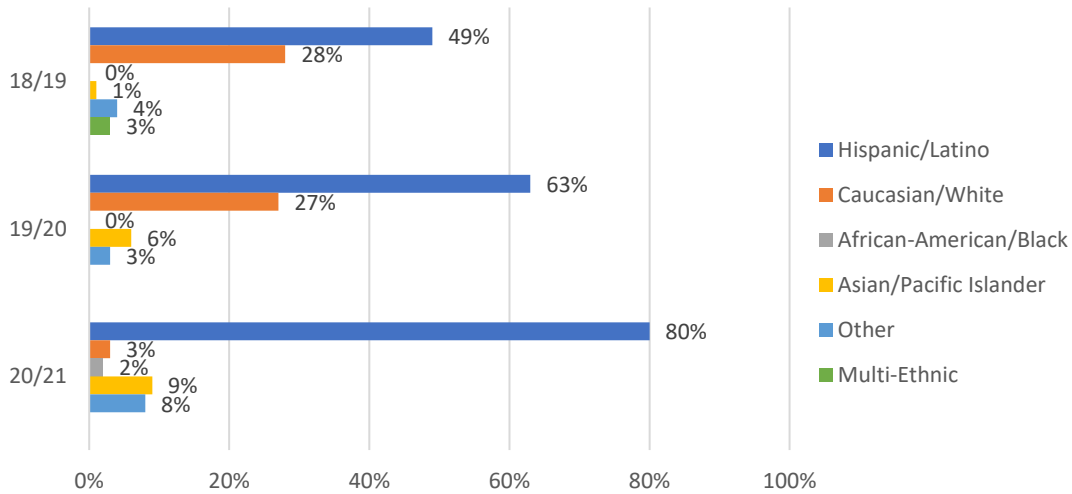Project SUCCESS served 703 clients in FYs 18/19, 19/20, and 20/21. The demographic data in this section represents unduplicated data provided by those who were active in the program. The data shows that those who were most served were Latinos. This is cong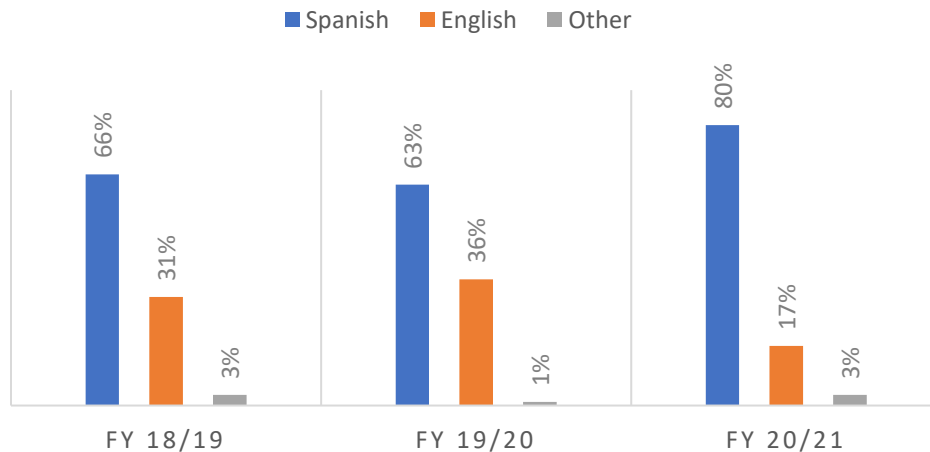ruent with the program's target population, as well as county-wide demographic data that shows that Latinos from this region experience mental health challenges at a higher rate than other ethnic groups.

Clients Served, by Race/Ethnicity FY 2018-2021

- Hispanic/Latino
- Caucasian/White
- African-American/Black
- Asian/Pacific Islander
- Other
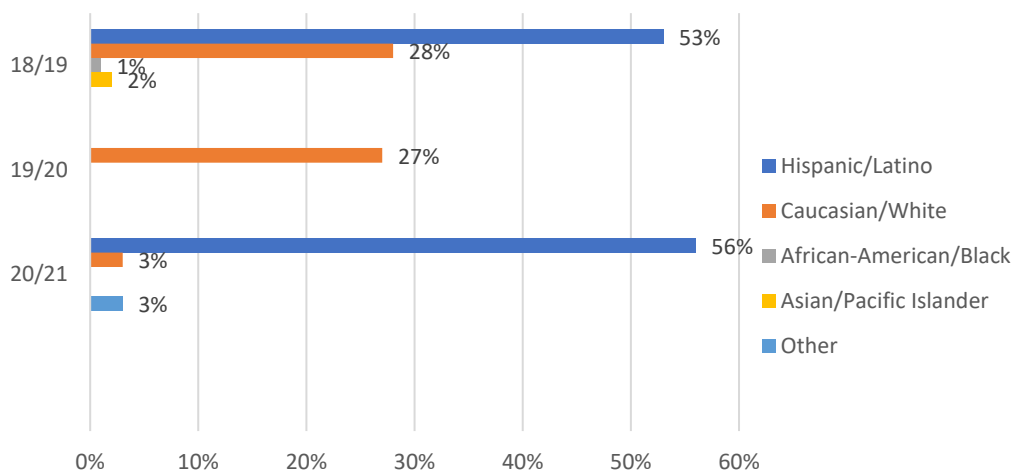
OUTCOMES

Project SUCCESS tracks outcomes via the Developmental Asset Profile (DAP) that is filled out by the students and analyzed by the Search Institute. The DAP incorporates 40 developmental assets into a framework that addresses the needs of young people in the community. This survey focuses on understanding the strengths and supports (or developmental assets) that young people experience in their lives. These assets are tied to young people making positive life choices. Research has shown that youth with higher level of assets are more likely to do better in school, be prepared for post-high school graduation and careers, contribute more to their communities and society, and avoid high risk behaviors such as violence, substance abuse, and sexual activity.

In spring of 2021, a teen who had close ties to the La Honda community overdosed and passed away. Puente's BHRS team, parents, and educators collaboratively decided an in-person Project SUCCESS group for the La Honda 5th grade students would support community healing. This group was provided in person at La Honda Elementary School to all 5th grade students. Pre-group and post-group quantitative data were collected for this 8-week group using the Developmental Assets Profile (DAP). Given the low number (N), a proper statistical analysis could not be conducted. Following are DAP results for FY 18/19 and FY 19/20 only.

COMPOSITE ASSETS SCORE

This score shows the percentage of youth who fall into each of four levels based on their survey results. Each score is out of 60: challenged (0-29); vulnerable (30-41); adequate (42-51); and thriving (52-60).

FY 18/19 PRE   **FY 18/19 POST**

Figure 1: Your Young People's Composite Assets Score
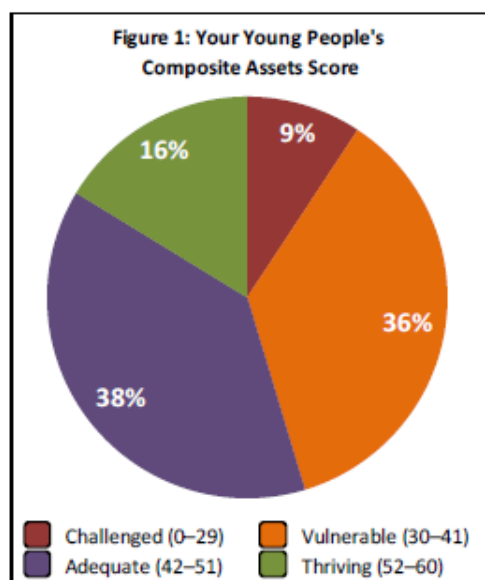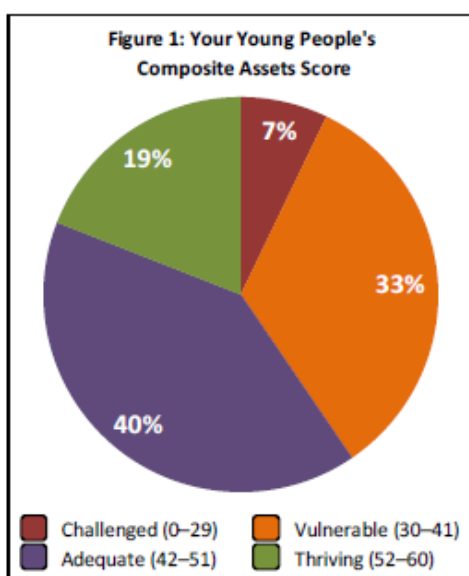
Before starting the program, 54% of the youth participants in FY 18/19 scored in the adequate or thriving level. This composite score sheds light on the foundation of assets that youth had at the beginning of program participation. After participating in the program, 57% of the youth scored in the adequate or thriving level.

FY 19/20 PRE

FY 19/20 POST

Figure 1: Your Young People's Composite Assets Score
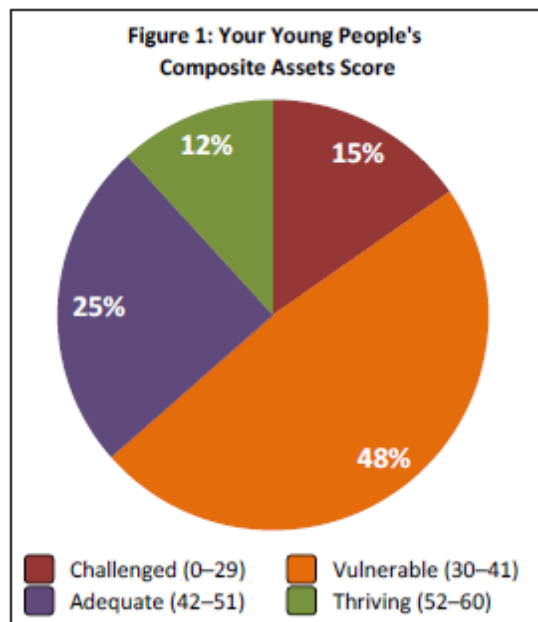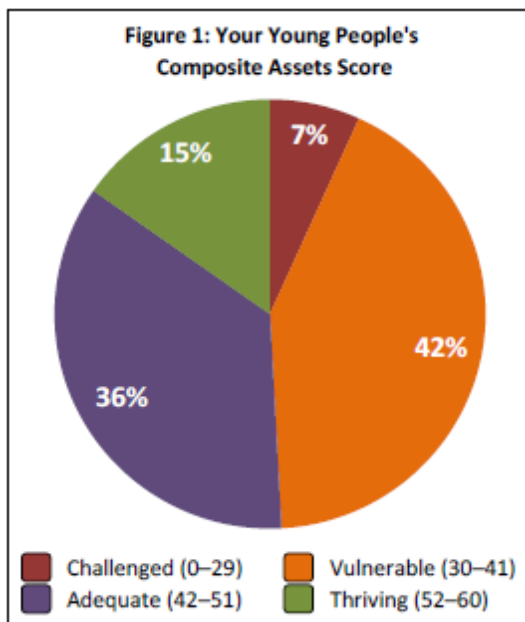
Before starting the program in FY 19/20, 37% of the youth participants scored in the adequate or thriving level. This composite score sheds light on the foundation of assets that youth had at the beginning of program participation. After participating in the program, over half (51%) of the youth participants scored in the adequate or thriving level.

Due to a low number of youths who completed a DAP during FY 20/21, a proper sample size to conduct a statistical analysis was not feasible. The data collected during FY 20/21 will be included in future data and reports.

ASSET CATEGORY SCORES

The framework of the DAP is organized into eight categories, which are shown below. These categories represent key supports (external assets) and strengths (internal assets) that young people need to have and develop in order to thrive. The external assets are relationships and opportunities provided by family, school, and community. The internal assets are internal values, commitments, skills, and self-perception that young people develop within themselves that lead to self-regulation, internal motivation, and personal character. A youth who can make positive life choices needs to have both external and internal assets.

THE EIGHT CATEGORIES OF DEVELOPMENTAL ASSETS

External Assets	Internal Assets
SUPPORT Young people need to be surrounded by people who love, care for, appreciate, and accept them.	**COMMITMENT TO LEARNING** Young people need a sense of the lasting importance of learning and a belief in their own abilities.
EMPOWERMENT Young people need to feel valued and valuable. This happens when youth feel safe and respected.	**POSITIVE VALUES** Young people need to develop strong guiding values or principles to help them make healthy life choices.
BOUDARIES AND EXPECTENCIES Young people need clear rules, consistent consequences for breaking rules, and encouragement to do their best.	**SOCIAL COMPETENCIES** Young people need the skills to interact effectively with others, to make difficult decisions, and to cope with new situations.
CONSTRUCTIVE USE OF TIME Young people need opportunities—outside of school—to learn and develop new skills and interests with other youth and adults.	**POSITIVE IDENTITY** Young people need to believe in their own self-worth and to feel that they have control over the things that happen to them.

FY 18/19 PRE

Overall DAP Scores

Total Assets (Range 0–60)	42.8
External Assets (Range 0–30)	21.9
Internal Assets (Range 0–30)	20.9

Mean Scores for 8 Categories of Assets (Range 0–30)

Support	22.7
Empowerment	22.1
Boundaries & Expectations	22.9
Constructive Use of Time	19.3
Commitment to Learning	21.7
Positive Values	21
Social Competencies	21.4
Positive Identity	18.9

Mean Scores for 5 Asset-Building Contexts (Range: 0–30)

Personal	20
Social	21.8
Family	23.2
School	22.5
Community	20.2

Key

- **Challenged** (lowest level)
- **Vulnerable**
- **Adequate**
- **Thriving** (highest level)

FY 18/19 POST

Overall DAP Scores

Total Assets (Range 0–60)	44.5
External Assets (Range 0–30)	22.5
Internal Assets (Range 0–30)	22.0

Mean Scores for 8 Categories of Assets (Range 0–30)

Support	23.1
Empowerment	22.6
Boundaries & Expectations	23.7
Constructive Use of Time	19.8
Commitment to Learning	22.2
Positive Values	22
Social Competencies	22.8
Positive Identity	20.9

Mean Scores for 5 Asset-Building Contexts (Range: 0–30)

Personal	21.4
Social	22.8
Family	23.3
School	23
Community	21.3

Key

- **Challenged** (lowest level)
- **Vulnerable**
- **Adequate**
- **Thriving** (highest level)

The FY 18/19 survey results show that the most youth scores fell in the adequate level across most asset types and asset-building contexts. The relative areas of strength at both pre and post survey were support, empowerment, and boundaries and expectations. Differences by age were observed, such that higher total, external, and internal asset scores were higher on average among 5th graders compared with youth who were in grades 8 and above. When analyzing the data more closely by race and ethnicity, Latino youth on average struggled with positive identity the most compared with other ethnic groups. When comparing average scores between pre and posttest, scores tended to slightly increase, remaining for the most part in the adequate level. The most notable increases observed between pre to posttest was that the personal asset-building context and the category positive identity average scores increased from the vulnerable to the adequate level.

FY 19/20 PRE
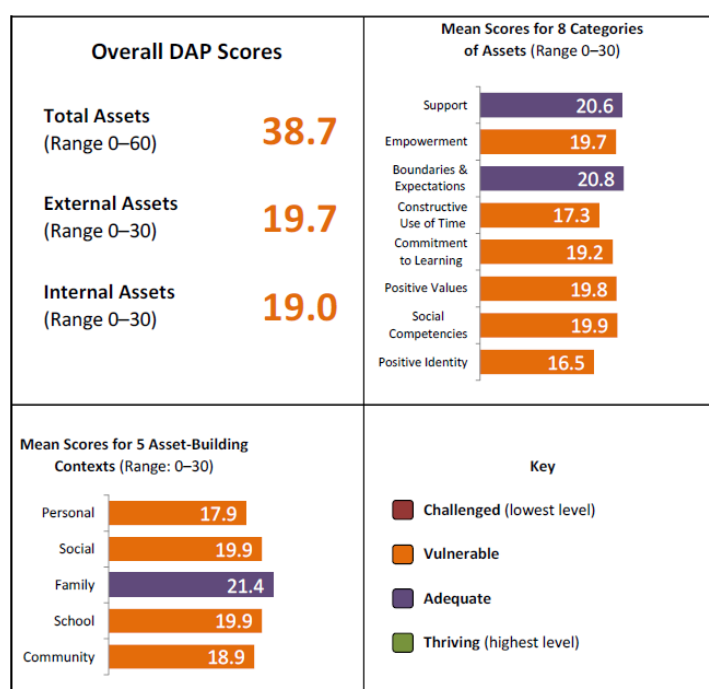
FY 19/20 POST
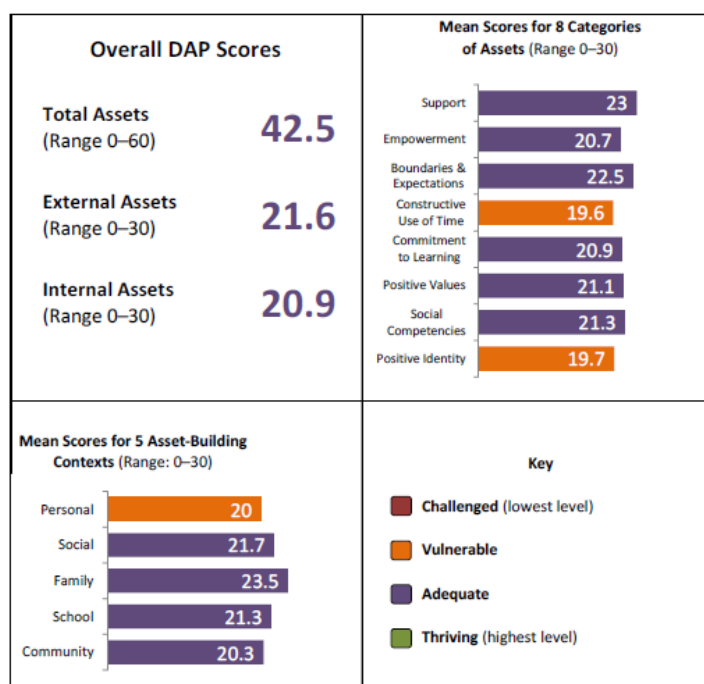
The FY 19/20 survey results show that at pretest, average scores fell under the vulnerable level across most asset types and asset-building contexts. The relative areas of strength at both pre and post survey were support, empowerment, and boundaries and expectations. Differences by age were observed, such that higher total, external, and internal asset scores were higher on average among 5th graders compared with youth who were in grades 8 and above. When analyzing the data more closely, Latino, male, and 8th grade youth on average struggled with positive identity the most compared with other demographic groups. When comparing average scores between pre and posttest, scores tended to increase, with posttest scores increasing from the vulnerable to adequate level. The asset categories with scores that increased from the vulnerable to adequate level were empowerment, commitment to learning, and social competencies. Among the five asset-building contexts, those that increased from the vulnerable to adequate score level were social, school, and community.

Due to a low number of youths who completed a DAP during FY 20/21, a proper sample size to conduct a statistical analysis was not feasible to attain. The data collected during FY 20/21 will be included in future data and reports.

Project SUCCESS has increased the composite asset scores as well as the asset category scores for two consecutive years. These results show that the foundations for youth assets is continuing to strengthen as youths go through the program. Puente was also able to extend their programs to all 5th to 12th graders in the school districts of Pescadero and La Honda, which gives the agency the potential to serve all the students in these school districts.

SATISFACTION SURVEY RESULTS

FY 18/20 Satisfaction Survey Results

Satisfaction surveys were administered throughout FY 18/19 after providing workshops that focused on drug and alcohol use across a variety of different at-risk populations and settings: parents, LGBTQ+ students, and elementary and middle school students. On average, 70% of participants reported that the workshop was effective in helping them understand how the use of alcohol and other drugs can have an effect.

FY 19/20 Satisfaction Survey Results

In FY 19/20, satisfaction surveys were administered among 21 youths who participated in a summer session with Project SUCCESS. Results demonstrate that most youth participants reported benefits from the program such as healthy coping skills, the practice of mindfulness, and healthy relationship skills. Most of the youths also reported that the topics covered were relevant to their individual situations. Lastly, all youths (100%) reported that they would recommend the program to others in their community.

Client Satisfaction Survey
Project Success Youth Summer Session; N=21
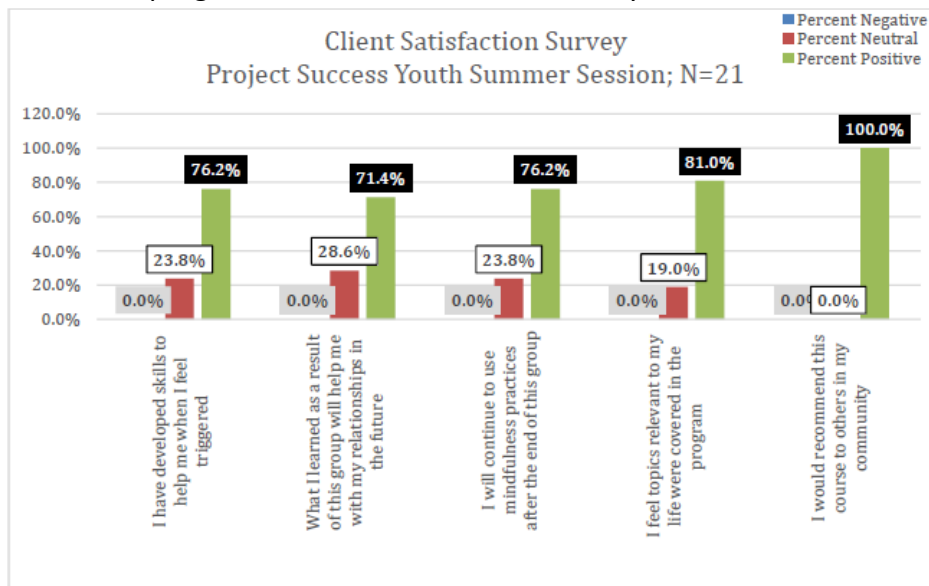
QUALITATIVE DATA

In FY 18/19, 40 youths participated in a summer session with Project SUCCESS. One of the activities included learning about "self-love," and the youths were invited to explore how their top love languages may differ

from parents, friends, or other family members and to be mindful of how they express love to others; do their actions match that person's needs (their top love language)? The youths were also given the chance to discover "self-love" (self-care) tools based on their top love language to be used as coping skills when they are going through hard times or feeling depressed or anxious. In addition, group leaders connected the value of love language awareness to the youth's workplaces and discussed how appreciation in the workplace is crucial to a successful and supportive work environment. The youths were asked to recognize ways in which their colleagues and supervisors showed them appreciation throughout the summer and were given tools to problem solve and advocate for their needs if a lack of appreciation was present.

As a representation of their newly learned relationship skills, the youths created artwork based on how they interpret love languages through their own personal experiences. The youths were given the opportunity to be creative and think outside the box to make multi-media panels, which combined to form a display of hanging umbrellas called "Love Reigns." This display represents the many ways in which love shelters them and is a protective factor in the youths' lives. Their art had the honor of being displayed at the town's local "Pescadero Arts and Fun Festival" in August 2019.

In December 2019 and January 2020, a total of 32 women participated in a series of Spanish-speaking workshops for women planned primarily to improve and reinforce relationships. The classes addressed such issues as the Five Love Languages (recognizing that we all feel love and

appreciation in different ways), trauma, alcohol and drugs (focusing on vaping), and self-care. Those women who attended two or more of the workshops were able to attend an evening of art and novelty. A bus full of women congratulated each other on finding other arrangements for their children and for getting out of work early on a Friday evening. The women repeatedly chorused that they rarely have self-care time on their own as they all have day jobs, children at home, and all kinds of commitments and responsibilities. Those who have been able to attend Puente events shared that the last time they were able to break free from their pressures of daily life was when Puente has done other workshops and field trips for overextended moms in the past. The bus pulled up to a ceramics studio in San Carlos where the women sat in a large circle sharing about their past and their present, while reinforcing the creative neuro-connections of their brain to design and paint. Many chose designs to honor their families, partners, and children. After two hours in the studio, the group walked down urban streets lined with trees adorned with white lights. They expressed joy as they promenaded the small downtown. The group then entered a new Vietnamese restaurant and, for the first time in their entire lives, tried Vietnamese soups, rolls, rice plates, and vermicelli bowls. Many said that due to the easy to order from menus and the reasonable prices, apart from the delicious fare, they would be able to come back on their own. On the bus ride back home, the women requested this program continue as it helps them to have improved connections with their peers and relieves a lot of stress that can lead to depressive periods and anxiety. One woman called the series a self-improvement series, as she reported making an effort towards positive change in different relationships she has. The women chimed in that it has been so great that Puente recognizes the need for programs that bring women together, support them, informs them, and exposes them to difference experiences, encouraging them to be a bit adventurous.

TRAUMA-INFORMED CO-OCCURRING SERVICES FOR YOUTH

In FY 18/19, an MBSAT pilot and Seeking Safety were curricula used to address trauma and substance abuse among at-risk TAY throughout San Mateo County. In FY 20/21, Seeking Safety ended and MBSAT became the curriculum that was used to address substance abuse needs among the TAY population. Accordingly, this section covers both programs.

SEEKING SAFETY

Seeking Safety is a curriculum that focuses on environmental and treatment solutions for substance use and post- traumatic stress disorder and relies on strong case management direction and referrals to community resources. Seeking Safety groups address the needs of TAY by utilizing a developmental framework that provides general supports for young adults, such as safety, relationship building, youth participation,

community resources, and skill building. By incorporating these practices into the group framework, youth learned to build upon internal and external assets which are essential for a healthy transition to young adulthood. The age group for this program is 18 to 25.

METHODS

Seeking Safety is an evidence-based program that is a present-focused model to help people attain safety from trauma and/or substance abuse. It is a safe model as it addresses both trauma and substance use, but without requiring clients to delve into trauma narrative.

MBSAT

MBSAT is a group-based curriculum incorporating mindfulness, self-awareness, and substance-abuse treatment strategies for use with adolescents dealing with substance use/abuse.

METHODS

MBSAT provides adolescents with the ability to improve their decision-making skills and reduce unhealthy behaviors—such as substance use—through learning emotional awareness and choosing how to respond (versus react) to stressful situations, how specific types of drugs affect the body and the brain, and how family, peers, and the external environment can contribute to drug use. MBSAT strives to offer youth an empowered approach to substance use prevention, rather than the norm that adolescents typically meet; programs that teach "just don't do (drugs)."

PROGRAM STRATEGIES

Timely Access to Mental Health Services for Individuals and Families from Underserved Populations

PROGRAM HIGHLIGHTS

974 clients served

92% on average report that they would recommend the MBSAT courses to others

DEMOGRAPHIC DATA

MBSAT and Seeking Safety served a total of 974 youths across FYs 18/19, 19/20, and 20/21.

For Seeking Safety, limited demographic data was collected during FY 18/19, although gender and language data were collected. 83% of participants identified as cis gender male. While the language preference data shows that most of the participants were English speaking, a significant proportion of participants were Spanish speakers and considered themselves bilingual. When looking closely at the data, most of the Spanish speakers who participated this program were from Redwood City compared with those who participated in Half Moon Bay, such that 65% of participants from Redwood City were bilingual, and 44% of participants from Half Moon Bay were bilingual.

The graphs presented below present race/ethnicity and preferred language data collected across the MBSAT programs for FYs 18/19, 19/20, and 20/21.
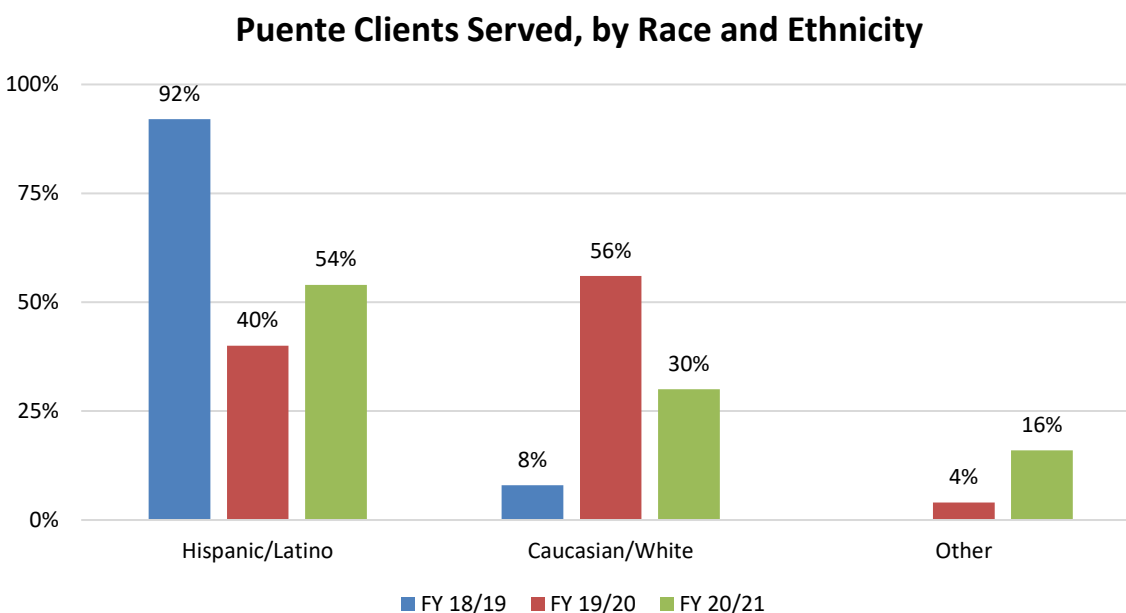
Puente Clients Served, by Race and Ethnicity
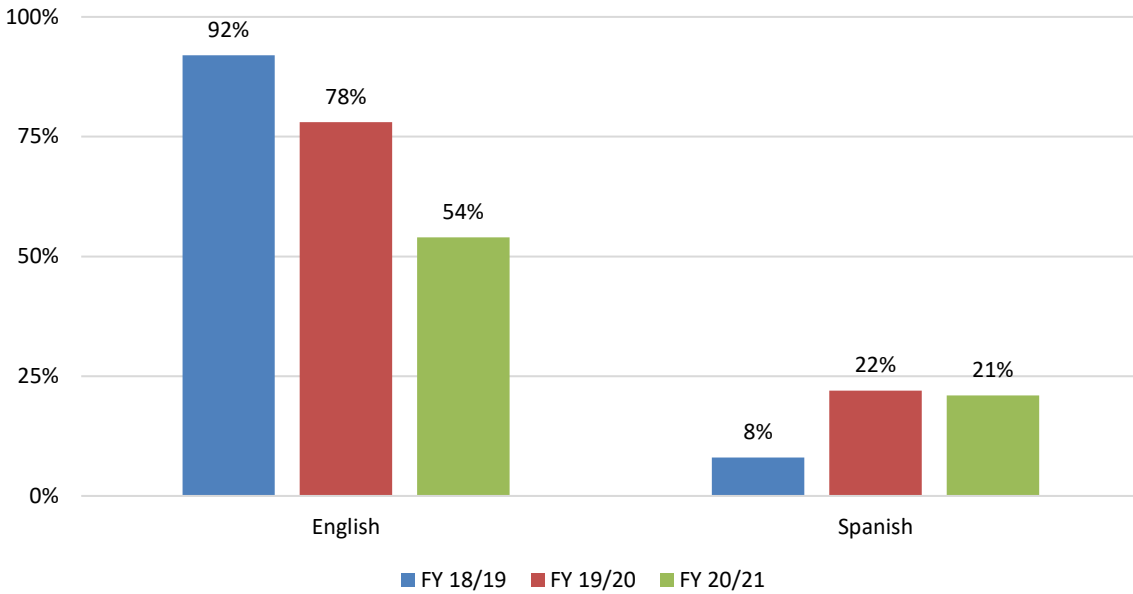
FY 18/19   FY 19/20   FY 20/21

Puente Clients Served, by Preferred Language

Legend: ■ FY 18/19 ■ FY 19/20 ■ FY 20/21

- English: 92%, 78%, 54%
- Spanish: 8%, 22%, 21%

StarVista Clients Served, by Race and Ethnicity

Legend: ■ FY 18/19 ■ FY 19/20 ■ FY 20/21

- Hispanic/Latino: 29%, 19%, 23%
- Caucasian/White: 18%, 30%, 49%
- African-American/Black: 47%, 19%, 10%
- Asian/Pacific Islander: 32%, 12%
- Other: 6%, 5%

StarVista Clients Served, by Preferred Language

	English	Spanish
FY 18/19	97%	3%
FY 19/20	100%	
FY 20/21	95%	5%
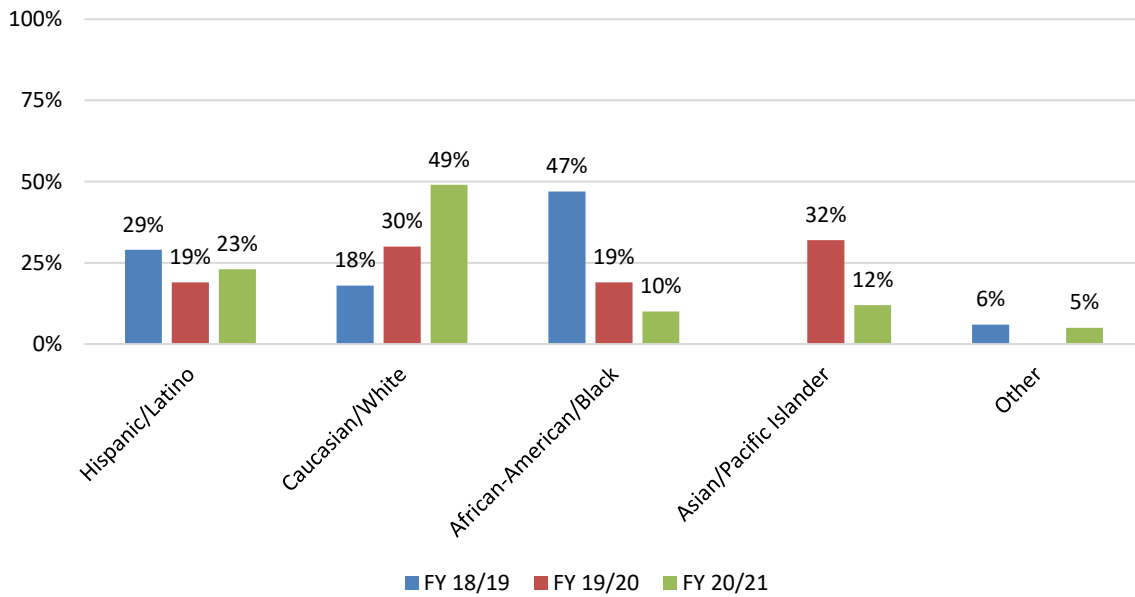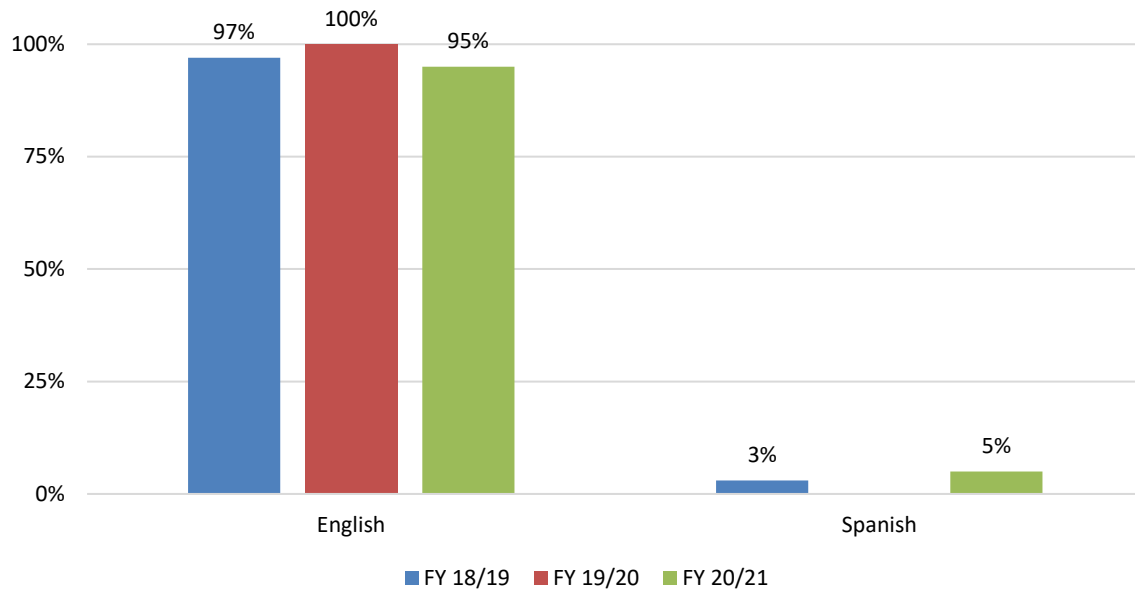
MBSAT OUTCOMES

The Seeking Safety program in FY 18/19 was able to provide us with only qualitative data for their evaluation in the form of a client story.

QUALITATIVE DATA
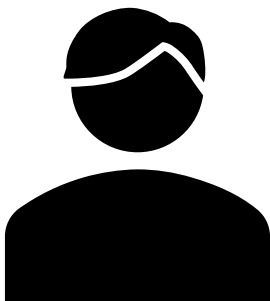
Joe* is a TAY client who had been using methamphetamines since the age of 16. He was homeless and came across the Seeking Safety program through the provider's outreach efforts.

After being MIA for 3 weeks, program staff reconnected with him, and he attended groups and individual sessions. In collaboration with the therapist, he set a treatment goal to rebuild his relationship with his family. His mother was also brought in as part of his treatment. She learned about addiction and ways to support her son in recovery.

After 6 months in treatment, Joe is now sober and continues to participate in recovery services. He has been given a place to live at home and has been working a full-time job.

*To protect client privacy and confidentiality, a pseudonym was used.

QUANTITATIVE DATA

For the MBSAT programs across FYs 18/19, 19/20, and 20/21, the two contracted providers, StarVista and Puente, administered both the Emotional Regulation Questionnaire (ERQ) and the Developmental Assets Profile (DAP) both before and after program involvement to assess the effectiveness of the MBSAT program. Below are available quantitative data presented by FY and by contract provider. Due to the onset of the COVID-19 pandemic in early 2020, the amount of quantitative data that is available and presented is limited starting in FY 19/20. For FY 20/21, COVID-19 related alterations to school programming meant that standard group programming was not possible. Puente clinicians were quick to adjust and offer services virtually. The principles and practices of MBSAT were incorporated into individual sessions with adolescents. The table below provides a summary of how many services from Puente were provided and the rate at which referrals were linked to a clinician within a timely manner.

Total Individuals Provided 1:1 Counseling Services	208
Total Teen Drop-In Group Participants	12
Timely Access to Services	**All (100%)** of counseling referrals were linked to a clinician within one week of being received

EMOTIONAL REGULATION QUESTIONNAIRE (ERQ) RESULTS

FY 18/19 - StarVista

FY 18/19 StarVista Emotional Regulation Outcomes
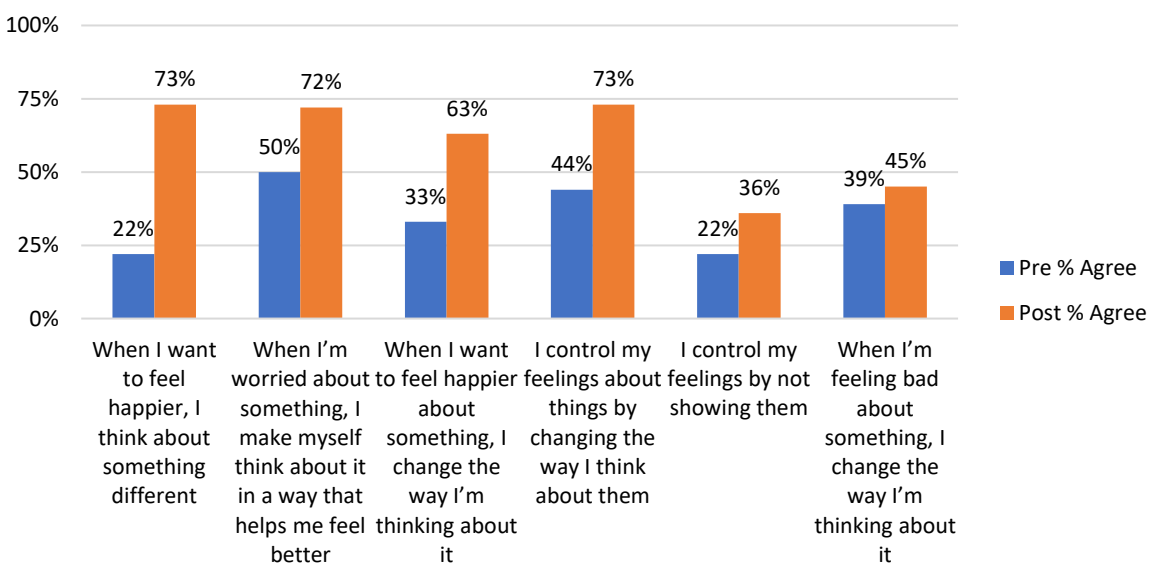
These results suggest that the StarVista MBSAT program helped TAY increase their emotional regulation skills by modifying their behaviors related to expressing and coping with their emotions in healthy and productive ways.

<u>Puente</u>

Emotional regulation outcomes were not available for FY 18/19 from this contract provider. Puente is working with RDA to standardize and streamline their data collection and reporting processes for future PEI reports.

<u>FY 19/20</u>

<u>StarVista</u>

Due to COVID-19 related challenges during FY 19/20, most group cycles were interrupted due to shelter-in-place orders. Thus, the data collected was insignificant for analysis as it is all consisting of pre surveys with only a handful of post surveys. The resounding self-report from participants was very positive. This provider has since shifted all quantitative data tools to an online platform. Since shifting to the online version, it appears that the youth have responded much more willingly to completing the survey. During StarVista's in-person groups, staff encountered significant resistance when doing multiple surveys. Youth would report that they did not fully read the questions and they just circled answers. It appears that the online model yields a bit more thoughtfulness in reading/answering due to not feeling any pressure around completing them with other people in the room or in a limited amount of time. They are, instead, able to maintain privacy while filling out the surveys with no time constraints.

<u>Puente</u>

The ERQ is a 10-item scale designed to measure respondents' tendency to regulate their emotions in two ways: (1) Cognitive Reappraisal and (2) Expressive Suppression. Respondents answer each item on a 7-point Likert-type scale ranging from 1 (strongly disagree) to 7 (strongly agree).

The ERQ consists of two domains: cognitive reappraisal (6 items) and expressive suppression (4 items). Cognitive reappraisal is considered a positive skill (higher average score is better) and expressive suppression is considered maladaptive (lower average score is better).

There were two cohorts, one in the fall and one in the spring. The data from both were combined to increase the N for analysis. The combined N for the pre-post comparisons is 17 pairs of completed ERQs.

Paired samples t-tests indicate that, although averages for both domains trended in the appropriate direction between pretest and post-test (increased cognitive reappraisal and decreased emotional repression), neither domain exhibited statistically significant change. This is likely due to the small N available for analyses. These data will be combined with those from future cohorts to develop a robust analysis that will more definitively assess the impact of the group prevention and treatment model.

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Dev.	Std. Error Mean	95% Confidence Interval of the Difference		t	df	Sig. (2-tailed)
					Lower	Upper			
Pair 1	Pretest Cognitive Reappraisal (higher is better) - Post-test Cognitive Reappraisal (higher is better)	-0.206	0.548	0.133	-0.488	0.076	-1.549	16	0.141
Pair 2	Pretest Emotional Suppression (lower is better) - Post-test Emotional Suppression (lower is better)	0.221	0.690	0.167	-0.134	0.575	1.319	16	0.206

Paired Samples Test

FY 20/21

StarVista

Due to continued COVID-19 related challenges during FY 20/21, most group cycles were interrupted due to shelter-in-place orders. The data collected is insignificant for analysis as it is all consisting of pre surveys with only a handful of post surveys. TSince the survey tools had been transferred to be online, the staff found it hard to get most youths to fill out the survey as they were not physically present to assist. It is hoped that during FY 21/22 with staff back to providing in-person services with COVID precautions that the completion of pre and post surveys will increase.

Puente

For FY 20/21, COVID-19-related alterations to school programming meant that standard group programming was not possible. Puente clinicians were quick to adjust and offer services through the telehealth platform. The principles and practices of MBSAT were incorporated into individual sessions with adolescents.

DAP RESULTS

FY 18/19

Puente

The DAP data was submitted to the Search Institute for analysis and the subsequent report is presented in the Project SUCCESS section of this report. The DAP report is very detailed and breaks down the developmental assets in a way that allows the team to look at specific categories and make changes to future MBSAT groups based on the results. Overall, the statistics show that those students who participated in the MBSAT group show an increase in external and internal assets. Areas of relative strength are the categories of support, and boundaries and expectations. Areas that are not as strong compared with other categories are positive identity and the constructive use of time. The area of positive identity is something that Puente's Behavioral Health and Recovery Services (BHRS) team focuses on. The team has developed some new tools to use trauma-focused interventions that involve art therapy, recreation, and movement-based mindfulness activities. The research points to early intervention and trauma-focused treatment to reduce risk factors and to build self-esteem. Because of the small number of participants and the Search Institute's requirement that the DAP include 30 or more participants, the MBSAT DAP report includes numbers from Puente's Project SUCCESS data for FY 18/19, which is presented above in the Project SUCCESS section of this report.

StarVista

In the post surveys, participants reported developmentally appropriate responses for their age range. Results indicated that a little over half (55%) the participants who completed the survey felt they had a family that provided them with clear rules (Q#52). Participants also reported that more than half (64%) reported their parents are good at talking with them about things (Q#56). These results indicated that participants could improve in communication with their parents/caregivers. The DAP is a 58-question survey and participants did not appear to appreciate the length of the survey nor the time it took to complete; therefore, there was less interest in this survey than the ERQ.

FY 19/20 and 20/21

Limited outcomes data are available for FYs 19/20 and 20/21 given the transition from providing services in an in-person group setting to providing services in a virtual, one-on-one format. The transition to an all-virtual model proved to be challenging for staff to collect data, who traditionally administered surveys manually and in person. Nevertheless, BHRS is currently working with RDA and the contract providers to ensure that standardized data collection systems and processes are in place to meet PEI reporting requirements in the future.

FY 18/19 Puente Satisfaction Survey Results
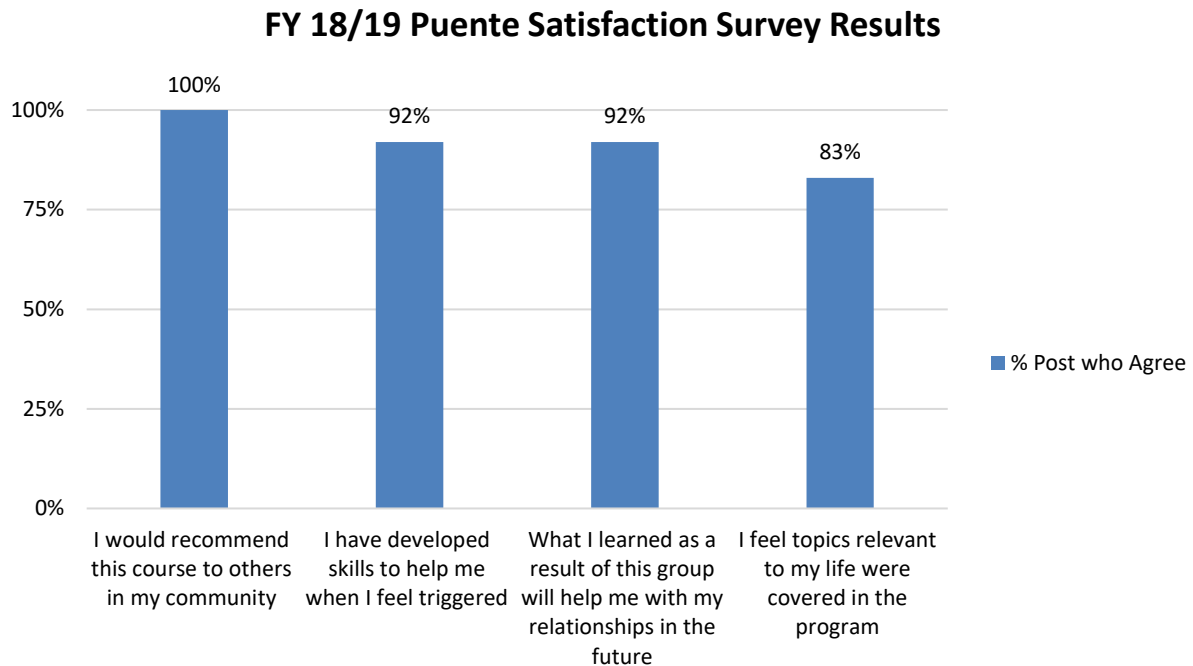
From November 2018 through March 2019, satisfaction surveys were administered among Puente participants from various workshops that took place during this time. The graph shown above presents the percentage of participants who agreed with each statement after participating in the workshops provided by Puente. Results indicate that most participants reported that they developed skills to help when feeling triggered, that what they learned from the group will help with their future relationships, and that the topics covered were relevant to their life. Lastly, 100% of participants reported that they would recommend the course to others in their communities.

Client Satisfaction Survey
Project Success Youth Summer Supervision
(Sep to Dec 2019; N=9)

Client Satisfaction Survey (Feb to May 2020; N=8)
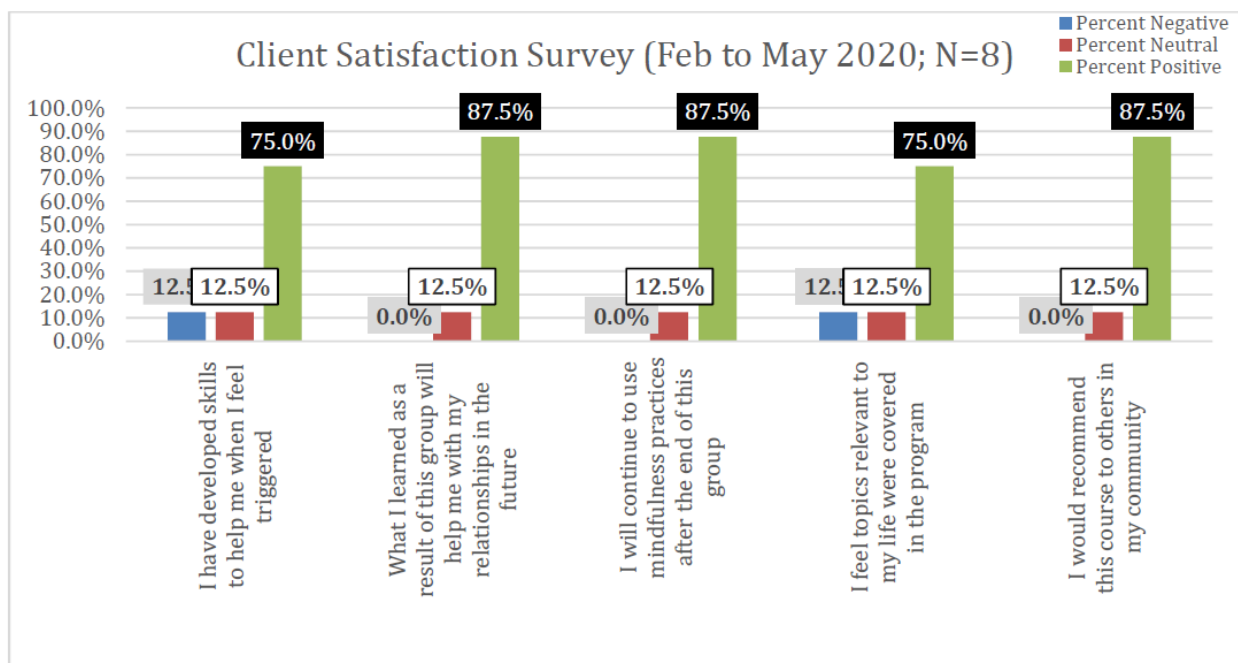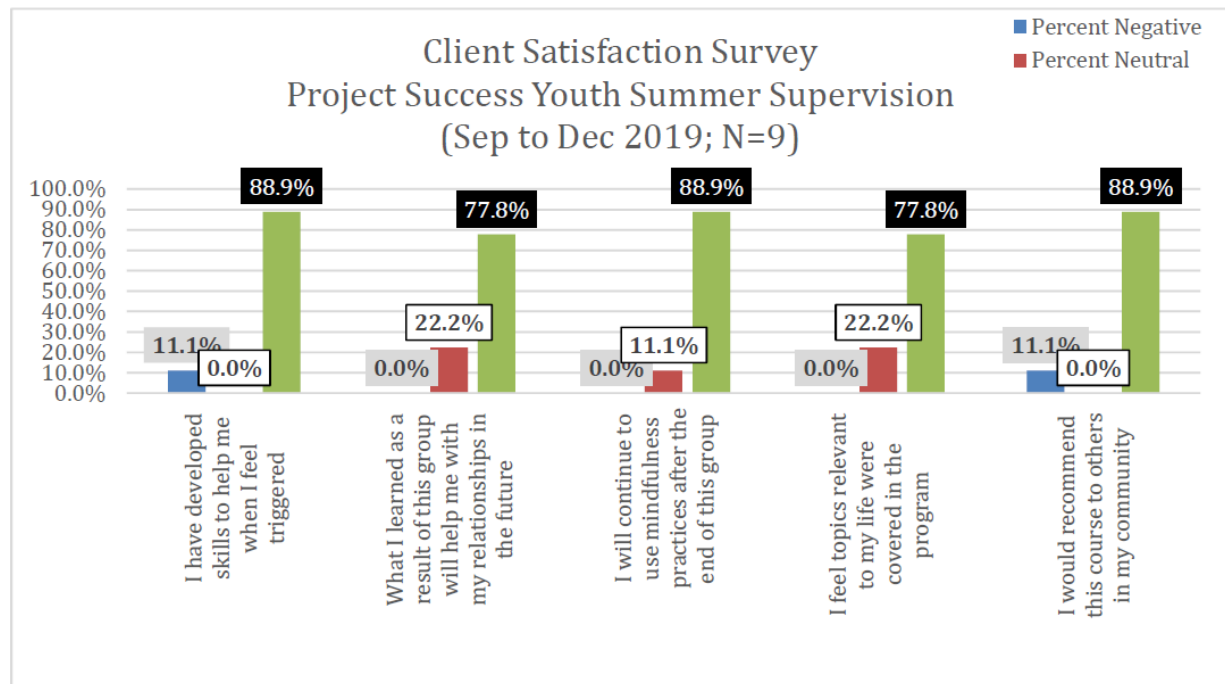
Puente's satisfaction results indicate that most group participants reported several benefits from the program, such that they developed skills to cope with triggers, assist with their relationships in the future, and will continue to use the mindfulness practices after the group. Further, most participants reported that the topics covered in the program were relevant to them, and that they would recommend the course with others in the community.

FY 20/21

StarVista

The self-report throughout the duration with the clients was positive. The MBSAT group provided youth with coping skills to increase positive decision making. Connection to mental health services and continued support/ case management. Clinicians for most of the fiscal year have co-facilitated groups to increase screening and support for clients individually and prevent mental illness from becoming severe and disabling. Staff have utilized client's input throughout their services to better support clients personally and arrive early and leave late to give them the individual support as needed. StarVista clinicians take part in weekly training to recognize and assess untreated mental illnesses. The clinicians also ensure to have regular communication with the program/school representative to learn more about what needs/areas of growth the clinicians can benefit from.

Puente

Due to the challenges related to all-virtual service delivery models, program staff were unable to collect and report on client satisfaction data for FY 20/21.

FY 20/21 YMCA Outcomes

In FY 20/21, a third contract provider, YMCA, was selected to provide MBSAT groups for the TAY population. Due to the nature of distance learning from home resulting in drastic decreases in school referrals for substance use on campus, no MBSAT groups took place during FY 20/21. Accordingly, data were not collected for MBSAT groups during this time.

The plans to collect data specifically for the MBSAT First Stop groups run on campus are ongoing. MBSAT First Stop groups are already underway for FY 21/22 and data will be captured and reported in upcoming reports.

TEACHING PRO SOCIAL (TPS)

The purpose of TPS is to help elementary school children learn prosocial skills to improve their social and behavioral functioning in school. TPS serves children in San Mateo County where Family Resource Centers (FRC) are located, and these centers include mental health programming. FRC's are available at schools that have high needs among the student population and a lack of other resources available to the broader community. Underserved students face greater academic and social struggles and benefit from a prosocial skills group that is culturally sensitive. Beginning FY 2020-21, Human Services Agency decided to no longer provide the Teaching Pro-Social Skills (TPS). The funding for TPS will be rolled into the Trauma-Informed Co-Occurring Service for Youth strategy for the next Request for Proposal (RFP) process to allow agencies to propose culturally responsive evidence-based and/or community defined best practices.

METHODS

TPS is a 10-week program that uses "skill streaming," an evidence-based, social skills training program designed to improve students' behaviors, replacing less productive ones.

PROGRAM STRATEGIES

Timely Access to Mental Health Services for Individuals and Families from Underserved Populations

Non-Stigmatizing and Non-Discriminatory Practices

PROGRAM HIGHLIGHTS

95 clients served

19 groups implemented at Family Resource Centers

DEMOGRAPHIC DATA

TPS served 95 clients in FYs 18/19 and 19/20. The demographic data in this section represents unduplicated data provided by those who were active in the program. The data shows that those who were most served were Latinos. TPS is implemented by bilingual staff. The most prevalent special populations were homeless, risk of homelessness, and those with a disability.

Clients Served, by Race/Ethnicity FY 2018-2020
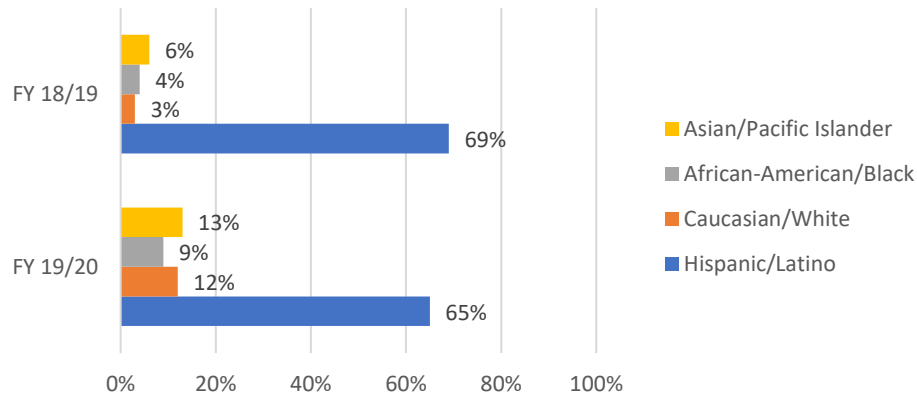
Clients Served, by Preferred Language FY 2018-2020
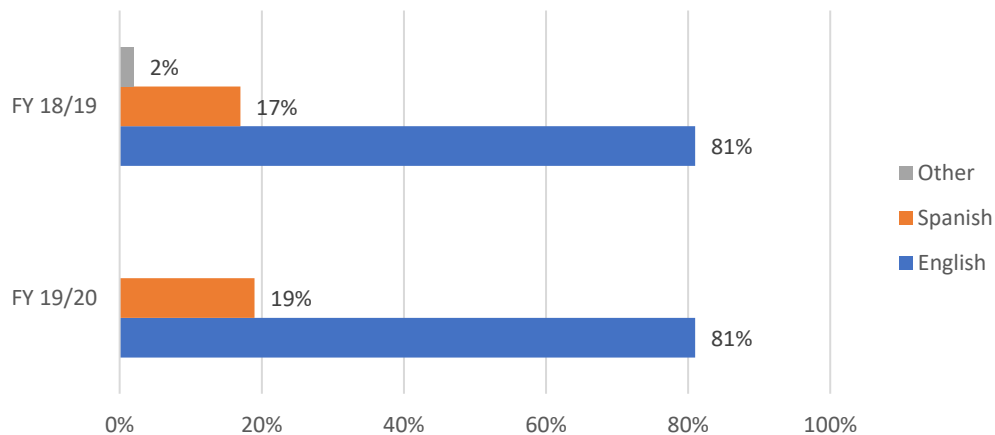
Number of groups and participants

Family Resource Center Site	Number of groups		Number of Participants	
	FY 18/19	FY 19/20	FY 18/19	FY 19/20
Bayshore	2	1	12	5
Belle	2	1	11	6
Hoover	2	2	11	7
Martin		1		4
Puente	2	2	9	12
Taft	2	1	9	5
Woodrow		1		4
Total	10	9	52	43

OUTCOMES

Students are referred to TPS by their teachers, who fill out the streamlining teacher behavior checklist. This tool is a 60-item survey that asks teachers to rank 60 positive behaviors. Then, based off this survey, the curriculum for the groups is implemented in a series of six to ten sessions each semester. The teachers choose their top 10 social skills from the survey and pretest their students in each skill included in the curriculum and then fill out a posttest after students' participation in the program has concluded.

FY 18/19: Top 10 Greatest Percentage Increases from Pre to Post

Bar chart showing percentages for each skill: Being Honest 78%, Accepting No 75%, Identifying Feelings 59%, Accepting Consequences 46%, Apologizing 43%, Sharing 43%, Asking Permission 42%, Recognizing Another's Feelings 41%, Expressing Affection 40%, Using Self-Control 40%.
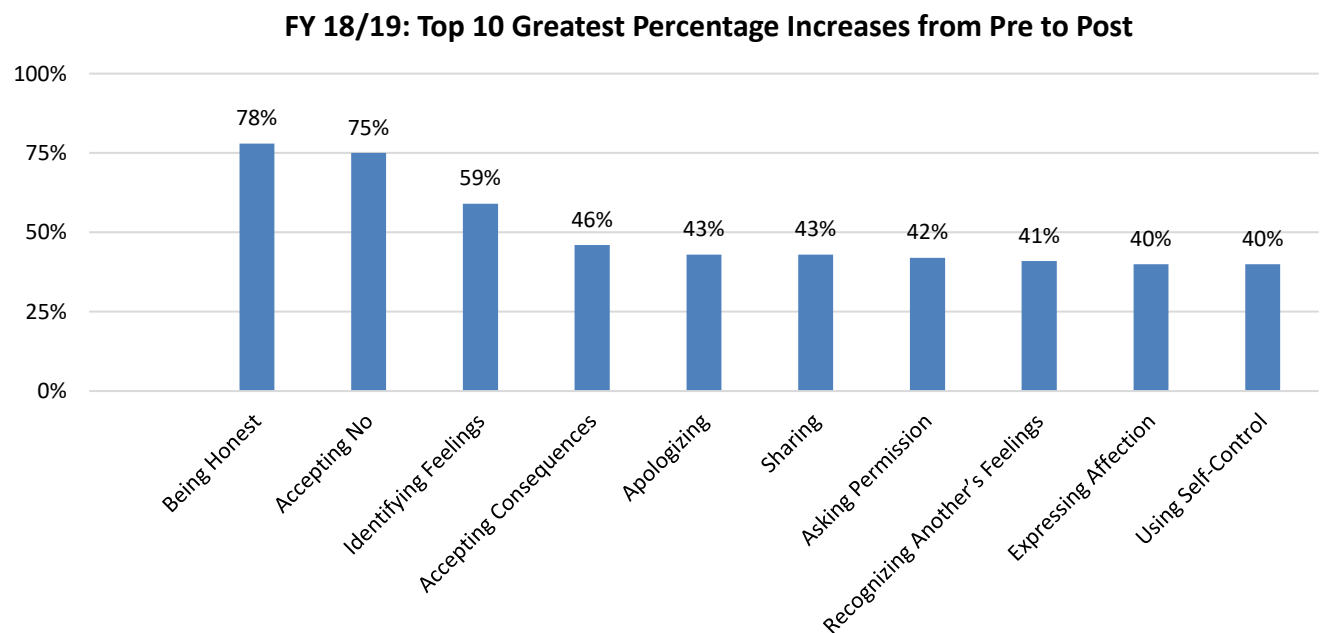
Participants during FY 18/19 experienced a variety of observed positive behavioral changes after completing the program. The graph above shows the top 10 behaviors in which participants experienced the greatest increases. The highest increase observed among participants was being honest, with students experiencing a 78% increase at posttest on average.

FY 19/20: Top 10 Greatest Percentage Increases from Pre to Post

Behavior	Percentage Increase
Avoiding Trouble	150%
Expressing Your Feelings	63%
Giving a Compliment	50%
Suggesting an Activity	45%
Making a Correction	30%
Beginning a Conversation	29%
Knowing Your Feelings	26%
Staying out of Fights	26%
Asking for Help	25%
Dealing with Fear	25%
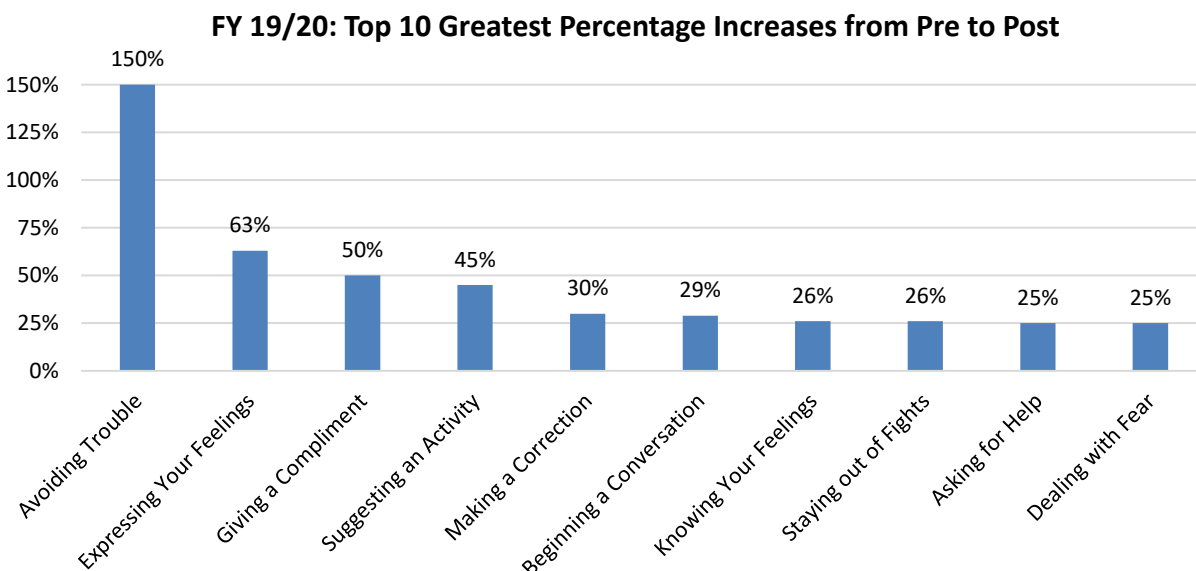
Participants during FY 19/20 experienced a variety of observed positive behavioral changes after completing the program. The graph above shows the top 10 behaviors in which participants experienced the greatest increases. The highest increase observed among participants was avoiding trouble, with students experiencing a 150% increase at posttest on average.
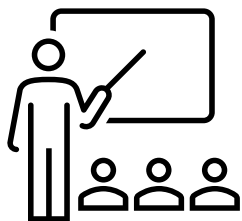
Positive behavior changes were demonstrated in **_93%_** of the skills taught in the program.

_27%_ increase in students' prosocial behavior scores after their participation in the program.

Lead facilitators observed improvements in classroom and playground behavior among students in the program as directly observed by faculty and staff.
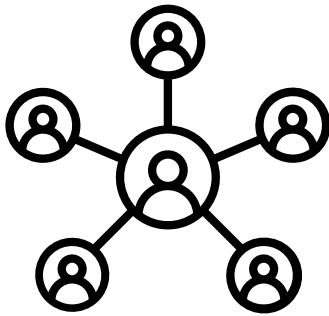
This program expanded to other schools in FY 19/20 based on increased demand after school staff saw the program's effectiveness during FYs 18/20.

Positive behavior changes such as friendship-making skills and decreases in aggression.

Greater self-awareness and self-regulation skills, such as identifying and expressing feelings, and apologizing.

FEEDBACK
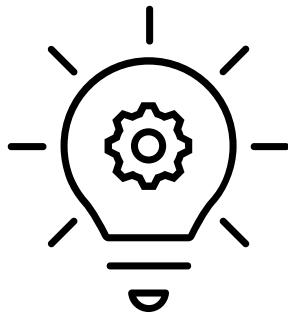
- Additional support was requested that would include monthly check-in meetings and cross-training other community workers to provide back up as needed.
- The greatest challenge in FY 19/20 was the school closures due to the pandemic.

YOUTH CRISIS RESPONSE AND PREVENTION

The StarVista Crisis Intervention & Suicide Prevention Center (CISPC) has four components with the sole purpose of providing crisis and suicide support to the San Mateo County community. The four components include: a 24/7 Crisis Hotline, a youth website and teen chat service, outreach and training, and mental health services. This team employs both early intervention (70%) and prevention (30%).

METHODS

Youth Crisis Response and Prevention is an evidence-based practice with components embedded that are promising practices.

PROGRAM STRATEGIES

Create Access to Linkage and Treatment

PROGRAM HIGHLIGHTS

231 new cases for case management consultation

268 sessions provided for case management/follow up consultation

38,246 calls received and answered

172 interventions with new youth

17% of monthly incoming crisis calls on average were related to the COVID-19 pandemic in FY 20-21

DEMOGRAPHIC DATA

Youth Crisis Response and Prevention did not report any demographic data for FY 18/19. The graphs shown below present the available demographic data that were collected among clients served during FY 19/20 and FY 20/21.

Clients Served, by Race/Ethnicity FY 2019-2021

FY 19/20
- 8%
- 2%
- 9%
- 3%
- 80%

FY 20/21
- 83%
- 1%
- 1%
- 10%
- 5%
- 0%

Legend:
- Unknown
- Other
- Black/African-American
- Asian/Pacific Islander
- White/Caucasian
- Hispanic/Latino
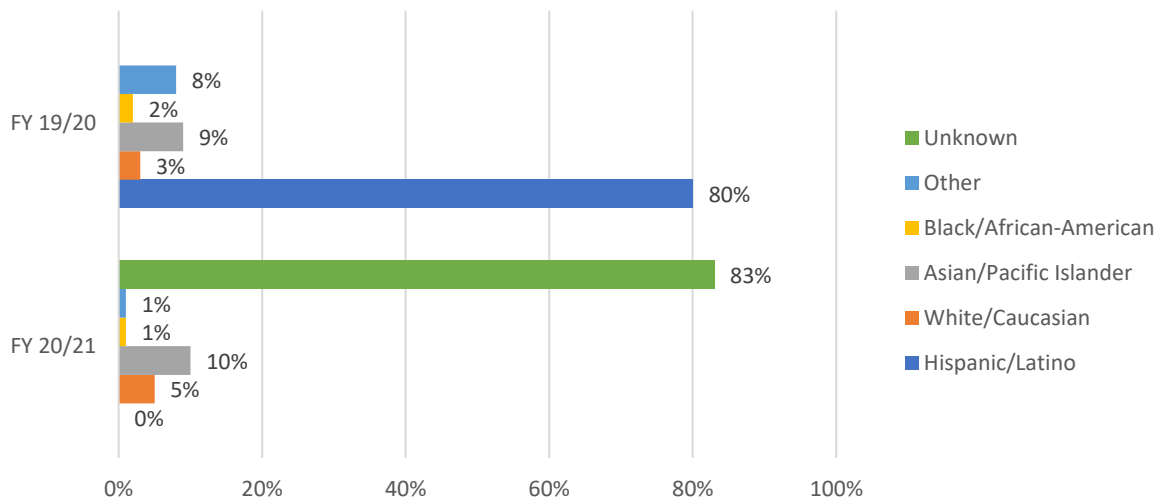
Clients Served, by Preferred Language FY 2019-2021
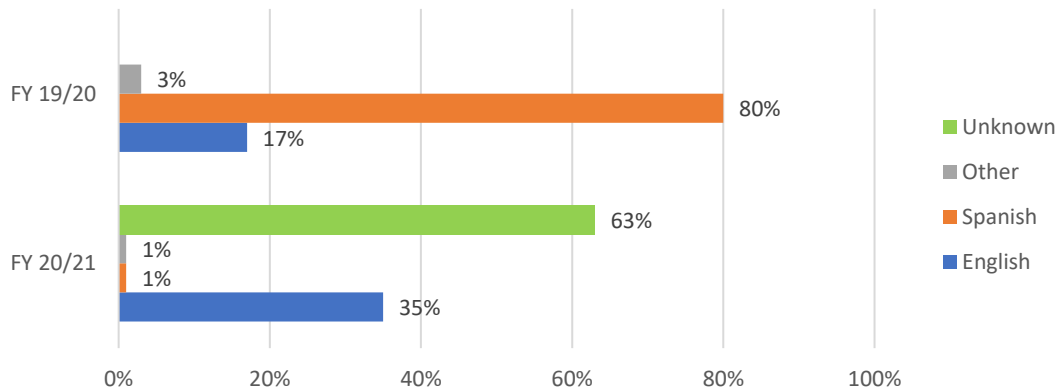
OUTCOMES

The CISPC program impacts the health outcomes of clients served in several ways, including the reduction of stigma, talking non-judgmentally about mental illnesses, mitigating undiagnosed mental illnesses, prevention and early recognition for youth, and suicide prevention. Below is the quantitative data recorded for delivery of each service.

CASE MANAGEMENT/FOLLOW-UP PHONE CONSULTATION (youth and adults)	FY 18/19	FY 19/20	FY 20/21
# of new cases	114	62	55
Total # of sessions provided	102	76	90
YOUTH OUTREACH INTERVENTIONS (evaluations at school sites)			
# of initial interventions (new youths served)	95	73	4
# of follow up sessions with youth	238	226	219
# of follow up contacts w/ collateral contacts	331	132	46
CLINICAL TRAINING/SUPERVISION (youth and adults)			
Hours provided (including prep. Time)	68	85	288
Number of trainings attended	43	24	44
CRISIS HOTLINE & CHAT ROOM			
Number of calls	12,255	13,515	12,476
Average monthly % of calls related to COVID-19	N/A	N/A	17%
Total number of chatters (group &/or private)	251	280	163
Teen Chat Room # of Private Chats this month	251	280	163
OUTREACH PRESENTATIONS			
# of presentations	115	62	151
# of people served	5535	2679	2861
School-community training in suicide prevention (# of presentations)	104	62	50
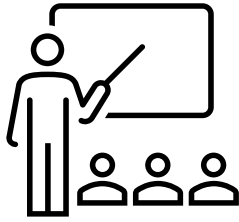
Reduction of stigma associated with mental illness through psychoeducational presentations, working with clients in crisis, and conversations with hotline callers.

100% of youth seen by crisis staff were successfully diverted from suicide consistently across all 3 FYs.

94% of youth on average score a 100% on post-outreach presentation assessments to test their knowledge of what they learned

QUALITATIVE DATA

A middle school student attended a virtual presentation through her school about suicide awareness, education, and prevention. This student reached out via the chat feature of the virtual call and asked about how she can support a sibling who might be thinking about suicide. After speaking one-on-one with the Crisis Center facilitator about her concerns about her sibling, additional resources were provided, including the teen chat, where the student can express her feelings and learn additional ways to support her sibling.

A mother called the mental health clinician at the crisis center concerned about her adolescent son who was chronically suicidal. The mother had exhausted all other options when a school partner directed her to our services. After determining that there was not an immediate danger to self, the clinician began working with the family for short-term therapy. It became apparent that a large factor for the student's suicidal ideation was school. His mother reported having attempted to get educational assessments done in the past but felt as though the language and cultural barriers had prevented the school from following through. The clinician worked with the mother and son to draft a formal letter of request for an Individualized Education Plan assessment. During the client's treatment, he had begun the IEP assessment process and reported that his suicidal thoughts had decreased to no thoughts of suicide in over a month.

EARLY INTERVENTION OVERVIEW

Early intervention programs are comprised of three programs that primarily focus on coordinating specialty care for clients with relatively higher acute needs compared with individuals served in Prevention programs. One program, the Early Psychosis Program – (re)MIND/BEAM program, has been particularly successful in providing data and outcomes consistently across the entire three years and has even exceeded most of their annual targets each year when it comes to preventing future occurrences of hospitalization and crises among their patients.

RECOMMENDATIONS

Because most of the programs in this category are lacking in terms of their data and outcomes, it is recommended that adequate data collection and reporting systems and processes are in place for these programs that meet PEI requirements. These systems and processes become especially important, so that staff can both simultaneously handle crises and collect the required data that appropriately describes their services and the types of clients they serve in real time.

EARLY INTERVENTION

The following programs are early intervention programs. These programs provide treatment and other services and interventions including relapse preventions to address and promote recovery and related functional outcomes for a mental illness early in its emergence. Programs in this category include emergency response teams, referrals, as well as programs.

Early Intervention

- Early Psychosis Program – (re)MIND/BEAM
- Primary Care Interface
- San Mateo County Mental Health Assessment and Referral Team

EARLY PSYCHOSIS PROGRAM – (RE)MIND/BEAM

The (re)MIND®/BEAM program is a coordinated specialty care model for prevention and early intervention of severe mental illness that specializes in early intervention for schizophrenia spectrum disorders. The BEAM program is an expansion on the (re)MIND model and specializes in the early intervention of bipolar and affective psychoses.

METHODS

(re)MIND and BEAM delivers comprehensive assessment and treatment grounded in wellness, recovery and resilience to youth and young adults experiencing early symptoms of psychosis with evidence-based and culturally responsive interventions. The (re)MIND/BEAM aftercare program—(re)MIND® Alumni—was

developed to provide program graduates and caregivers with a specialized safety net to sustain gains achieved through engagement in psychosis early intervention.

PROGRAM STRATEGIES

Timely Access to Mental Health Services for Individuals and Families from Underserved Populations

Non-Stigmatizing and Non-Discriminatory Practices

## PROGRAM HIGHLIGHTS

206 clients served

Met an average of over **70%** of annual program objectives across two years

DEMOGRAPHIC DATA

(re)MIND/BEAM served 206 clients in FYs 18/19, 19/20, and 20/21. The racial group that became increasingly engaged in services over time was the Hispanic/Latino population. The greatest proportion of clients across all three fiscal years were between the ages of 16 and 25 years of age.

(re)MIND/BEAM Clients Served by Race/Ethnicity

Legend: FY 18/19, FY 19/20, FY 20/21

Race/Ethnicity	FY 18/19	FY 19/20	FY 20/21
Hispanic/Latino	28%	34%	37%
Caucasian/White	31%	29%	24%
African-American/Black	10%	7%	6%
Asian/Pacific Islander	21%	29%	23%
Other	10%	1%	10%

(re)MIND/BEAM Clients Served by Age

Legend: FY 18/19, FY 19/20, FY 20/21

Age	FY 18/19	FY 19/20	FY 20/21
0-15	10%	10%	12%
16-25	74%	78%	70%
26-59	16%	12%	18%
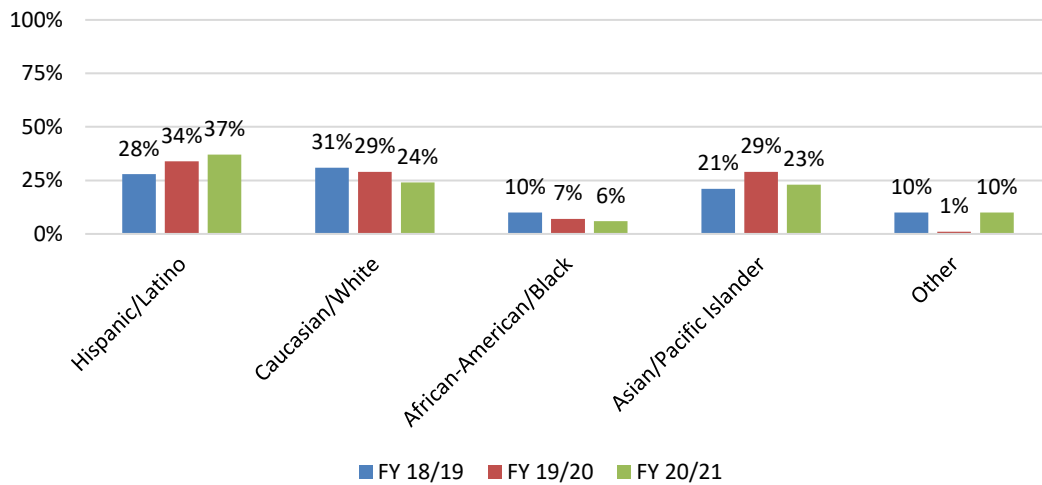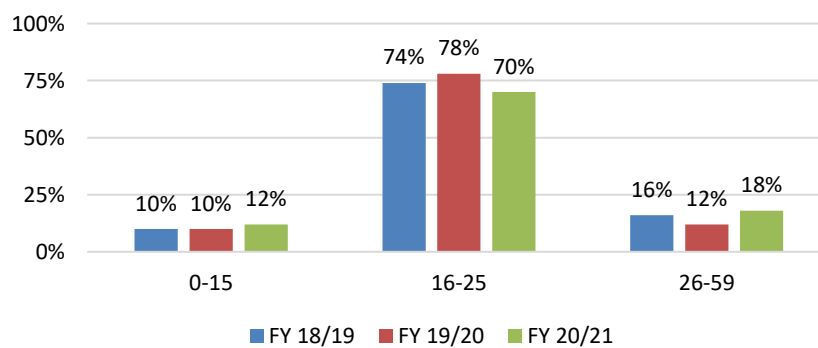
OUTCOMES

The BEAM program is evaluated via a series of surveys that include, California Department of Health Care Services (DHCS) Consumer Perception Survey (CPS) to evaluate participants satisfaction and quality of life. Hospitalization data are collected through the county database (AVATAR) and entered into Felton's EHR database. Medication adherence and symptom reduction data is collected using the Adult Needs and Strengths Assessment (ANSA). Supportive Employment and Education Services (SEES) are tracked via an internal tracker to provide education and employment data for participants. SEES staff and director work to update the spreadsheets and database monthly. Due to the onset of the COVID-19 pandemic, data collection of the DHCS CPS was put on hold and therefore unable to assess these survey results against the program's measurable objectives that pertain to clients' satisfaction and quality of

life. However, this program saw positive outcomes in hospitalization reduction, medication adherence increase, vocational and educational engagement, and service satisfaction.

Overall, the outcomes show that clients who participate in this program experience reduced acute hospitalizations, increase their medication adherence, and can engage in part time or full-time school or work. Additionally, the great majority are satisfied with services and report an increase in quality of life due to this program.

reMIND/BEAM Program Outcomes

Category	FY18/19	FY19/20	FY20/21
Participants with prior hospitalizations (12 months from enrollment) that experienced a reduction in acute hospitalizations within the first 12 months of engagement	88%	92%	94%
Participants with no history of hospitalizations (12 months from enrollment) that continued to not have hospitalizations within the first 12 months of engagement	69%	93%	82%
Participants engaged in part-time or full-time work during their first year of treatment	88%	85%	72%
Participants achieve new levels of employment or education		51%	89%
Participants that either improved or maintained high medication adherence with an ANSA score of 1 or 0	69%	88%	64%
Reported satisfaction with the program	100%	92%	
Maintained lower level of care		93%	88%

In FY 19/20, the (re)MIND®/BEAM Alumni Care program was launched, which provides ongoing care and support for program participants and family members who have completed the program and would benefit from additional safety net services as they journey forward into their recovery.

Program staff are now engaged in virtual outreach to promote access to the program and educate the community on serious mental illness while simultaneously reducing stigma. Staff are generating presentations for specific populations, including community members, families, students in middle and high school and clinical members to help everyone recognize psychosis signs and refer early.

PRIMARY CARE INTERFACE

Primary care interface focuses on identifying persons in need of behavioral health services in the primary care setting. BHRS clinicians are embedded in primary care clinics to facilitate referrals, perform assessments, and refer to appropriate behavioral health services if deemed necessary. The model utilizes essential elements of the IMPACT model to identify and treat individuals in primary care who do not have serious mental illness (SMI) and are unlikely to seek services from the formal mental health system. This program also provides services to those with Access and Care for Everyone (ACE) healthcare coverage, a locally funded program for low-income adults who do not quality for other health insurance and who otherwise would not be able to access these services. Services include harm reduction, psychoeducation, and motivational interviewing by case manager.

METHODS

Primary care interface is an evidence-based practice that uses elements of the IMPACT model.

PROGRAM STRATEGIES

Create Access to Linkage and Treatment

PROGRAM HIGHLIGHTS

2,566 clients served

DEMOGRAPHIC DATA

Demographic data was not collected for this program during FYs 18/19, 19/20, and 20/21.
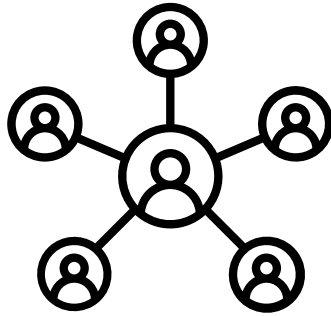
In FY 16/17, **620** clients were referred for co-occurring case management directly from their primary care physician and assessed by an interface IMAT case manager.

As a result of this service, clients were able to reduce or abstain from the use of substances, reconnect with family, secure housing or employment, and reduce symptoms of anxiety.

In FY 16/17, 21 SMI clients were transferred to BHRS regional clinics.

SAN MATEO COUNTY MENTAL HEALTH ASSESSMENT AND REFERRAL TEAM (SMART)

The SMART team is comprised of specially trained paramedics who are a part of the American Medical Response (AMR) West. They are trained to respond to law enforcement Code 2EMS which are requests for individuals having a behavioral health emergency. The SMART paramedic performs the mental health assessment, places a 5150 hold if needed, and transports the client to Psychiatric Emergency Services (or, if they do not meet criteria, another community resource such as a crisis residential facility, doctor's office, detox, shelter, home, etc.). This ensures increased connectivity and treatment for community members. Additionally, many individuals are more likely to be forthcoming with a psychologically trained medic about what they are experiencing as compared to law enforcement. This resource can only be accessed through the county's 911 system.

METHODS

SMART is a promising practice that provides the San Mateo County community with an alternative to law enforcement and having to go to the hospital for an assessment.

PROGRAM STRATEGIES

Create Access to Linkage and Treatment

PROGRAM HIGHLIGHTS

5,194 community members served

DEMOGRAPHIC DATA

The SMART program did not report demographic data for FYs 18/19, 19/20, and 20/21. The demographic data that is collected is inputted into a database that is not readily accessible.

OUTCOMES
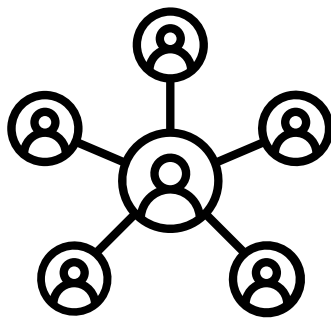
AMR consistently exceeded the annual target of diverting at least 10% of calls where a 5150 was not placed. Over the three fiscal years, AMR has successfully diverted nearly _40%_ of calls on average.

SMART evaluates people in the field and are able to connect people to behavioral health services that would otherwise not have occurred.

SMART is continuing to work and train law enforcement to wait before they place a 5150 hold.

SYSTEM TRANSFORMATION

SMART evaluates people in the field and are able to connect people to behavioral health services that would otherwise not have occurred. Being able to transport people right on the spot to the appropriate services has increased connectivity and treatment for many people. More people are likely to be forthcoming with a psychologically trained medic about what is going on than law enforcement.

SMART medics can evaluate both physical and mental health issues, including suicidal ideation, and direct people to the appropriate resources. SMART responds to many people under the age of 18 who are in crisis—often experiencing peer-related problems in school. By addressing the youth's concerns and getting supportive and protective factors in place, the youth is much more likely to remain in school. Getting supportive services to the youth's family helps the family unit to stay intact. This is also achieved when SMART responds to parents and get them directly involved in services so they can provide for their children.

SMART responds to many homeless and severely mentally ill adults. By getting them evaluated and getting the right level of medications and placements, this assists in reducing homelessness.

ACCESS AND LINKAGE TO TREATMENT OVERVIEW

The Access and Linkage to Treatment component across the three FYs comprises of five programs: Ravenswood Family Health Center, Senior Peer Counseling, LGBTQ Community Outreach Worker, North County Outreach Collaborative, East Palo Alto Partnership for Mental Health Outreach (EPAPMHO)/East Palo Alto Behavioral Health Advisory Group (EPABHAG). These programs are specifically designed to connect individuals from underserved populations with severe mental illness to medically necessary care and treatment, and to decrease stigma of seeking mental health care among these populations.

RECOMMENDATIONS

Recommendations for programs providing Access and Linkage services include the following:

Enhance Outreach

Continue to conduct outreach in languages other than English. In the most recent reporting year of FY 20/21, outreach events were conducted in languages that represented the residents served by the participating providers. For example, the EPAPMHO collaborative conducted outreach in Spanish, as the Mexican population was the largest racial/ethnic population attending these events. Similarly, EPAPMHO group sessions were offered in Tongan, as participants indicated it as their preferred language. Conducting outreach in languages other than English can ensure that the SMC BHRS outreach program is serving the needs of the county's non-English speaking population.

Continue to offer non-office locations for group and individual outreach events. The data for this year show that many outreach events were conducted in communities, in non-traditional locations such as virtual meetings, and through telehealth services. Although this may have been in response to the pandemic, the county should consider continuing to provide alternative locations or venues, including a virtual option. This will help with the outreach efforts and also

give county residents multiple options to avail themselves of the services offered through the program.

Improve Data Collection

Make "other"/unspecified categories clearer. Outreach staff have made an effort to provide better data collection and minimize missing data. For example, participants who selected the "other community location" were able to indicate the other locations in an open text field provided by the survey. The data show that, in many cases, attendees reported Zoom calls or similar virtual platforms for other locations. However, in some cases, it is difficult to assess the nature of the responses that fall under the "other" category. For example, for referrals, the "other" category (17%) included common responses such as "communication" or "check-ins" without any further detail. A next step could be providing more information related to these responses to better understand the nature of the referral. It will also be beneficial to offer more categories for respondents to use when describing the "location" of individual outreach events, as up to 13 percent of respondents served by the EPAPMHO collaborative selected "unspecified" field locations.

Improve efforts to collect outcomes. Program staff should follow through with the clients who received referrals and report back as to whether those linkages were deemed successful based on client self-report. For instance, did clients successfully get their mental health needs met because of the mental health referrals provided to them after attending an outreach event? If so, what is the success rate? The outcomes data that answers these questions will help to provide more evidence of Access and Linkage program effectiveness.

ACCESS AND LINKAGE TO TREATMENT OVERVIEW

The following programs provide access and linkage to treatment, connecting individuals with severe mental illness to medically necessary care and treatment, including but not limited to care provided by county mental health programs.

Access and Linkage to Treatment

- Ravenswood Family Health Center (40% CSS; 60% PEI)
- Senior Peer Counseling (50% CSS; 50% PEI)
- LGBTQ Community Outreach Worker
- North County Outreach Collaborative
- East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) and East Palo Alto Behavioral Health Advisory Group (EPABHAG)

RAVENSWOOD FAMILY HEALTH CENTER

Ravenswood Family Health Center is a community based Federally Qualified Health Center (FQHC) that serves East Palo Alto residents. Ravenswood provides outreach and engagement services to individuals presenting for healthcare services who have significant behavioral health needs. Many of the diverse populations that are underserved will more likely visit the doctor for a physical health concern. If Ravenswood identifies someone who could benefit from services, they provide them with a referral to be seen in the county clinic.

METHODS

This practice is evidenced based and a promising practice; it is not uncommon to see that physical and mental health services are integrated or offered in coordination with each other.

PROGRAM STRATEGIES

Timely Access to Mental Health Services for Individuals and Families from Underserved Populations

Non-Stigmatizing and Non-Discriminatory Practices

PROGRAM HIGHLIGHTS

1095 clients served

DEMOGRAPHIC DATA

Ravenswood Family Health Center did not report demographic data for FYs 18/19, 19/20, and 20/21.

OUTCOMES
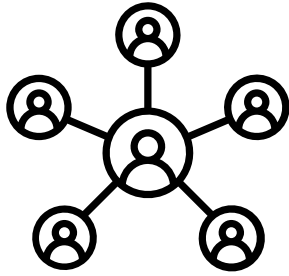
1095 clients served in FYs 18/19, 19/20, and 20/21

POSSIBLE OUTCOME METRICS

- Increase access to care
- Increase awareness of mental health, wellness, and recovery
- Improve participant engagement in services

SENIOR PEER COUNSELING

The Senior Peer Counseling program recruits and trains volunteers to serve homebound seniors with support, information, consultation, peer counseling, and practical assistance with routine tasks such as accompanying seniors to appointments, assisting with transportation, and supporting social activities.

METHODS

This practice is evidenced based and a promising practice; it is not uncommon to see that physical and mental health services are integrated or offered in coordination with each other.

PROGRAM STRATEGIES

Timely Access to Mental Health Services for Individuals and Families from Underserved Populations

Non-Stigmatizing and Non-Discriminatory Practices

1,579 clients served

DEMOGRAPHIC DATA

The Senior Peer Counseling program served a diverse population for FYs 18/19, 19/20, and 20/21 with the largest groups served being Latino, Chinese, Filipino, and Caucasian. The preferred languages included English, Spanish, Mandarin, and Tagalog. The largest age group served were those who were 60 years and older.

Senior Peer Counseling Number Served, by Race/Ethnicity

Legend: FY 18/19, FY 19/20, FY 20/21
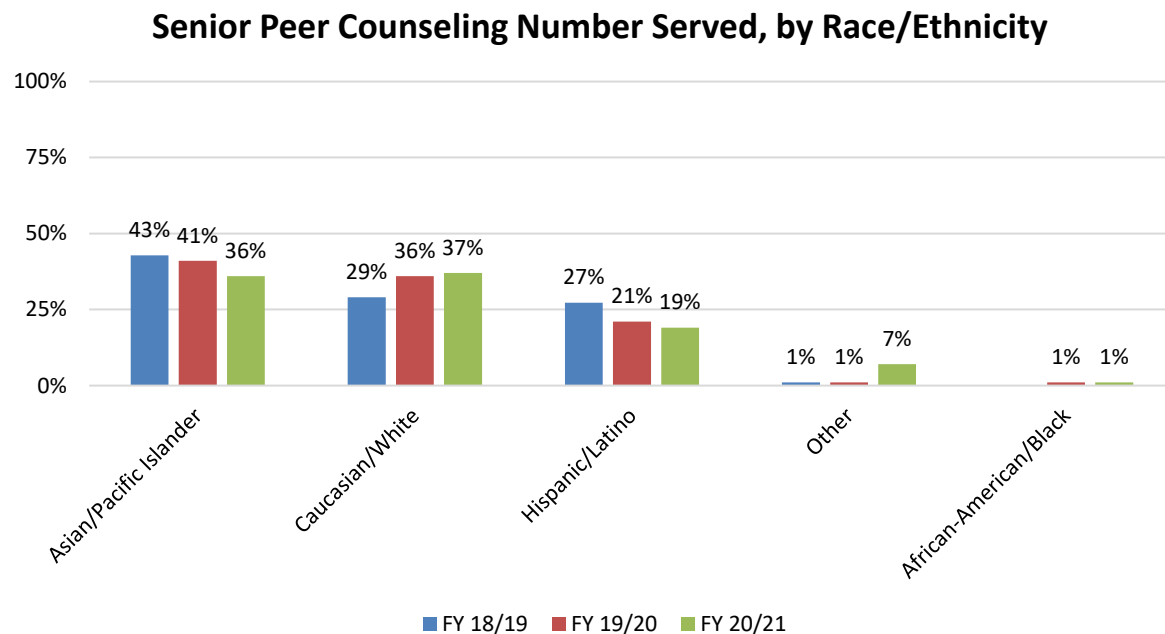
Senior Peer Counseling Number Served, by Preferred Language

	English	Spanish	Other
FY 18/19	50%	32%	18%
FY 19/20	45%	26%	29%
FY 20/21	56%	22%	22%

Senior Peer Counseling Number Served, by Age

	60+	26-59
FY 18/19	96%	4%
FY 19/20	95%	5%
FY 20/21	97%	3%
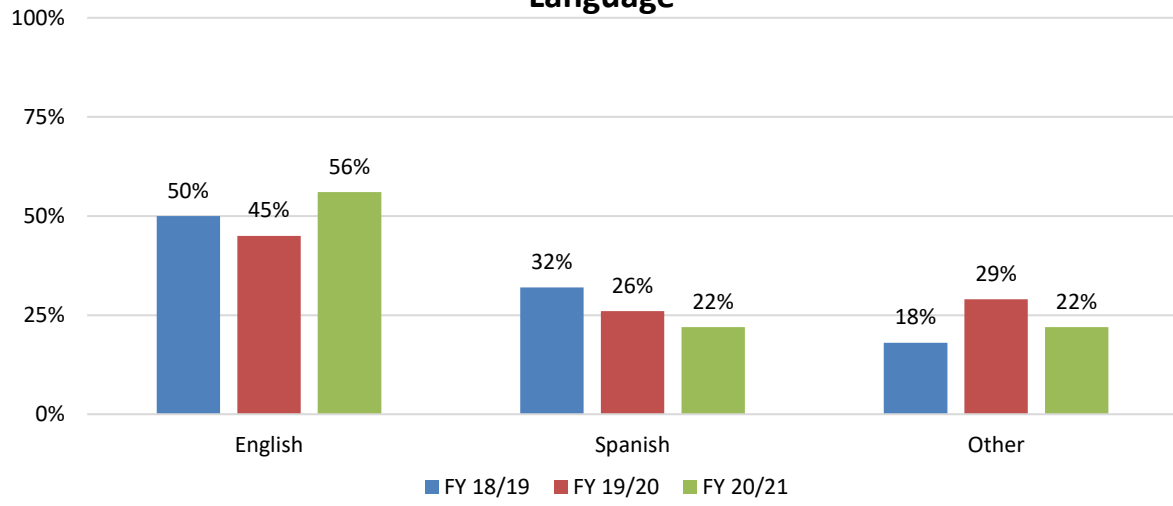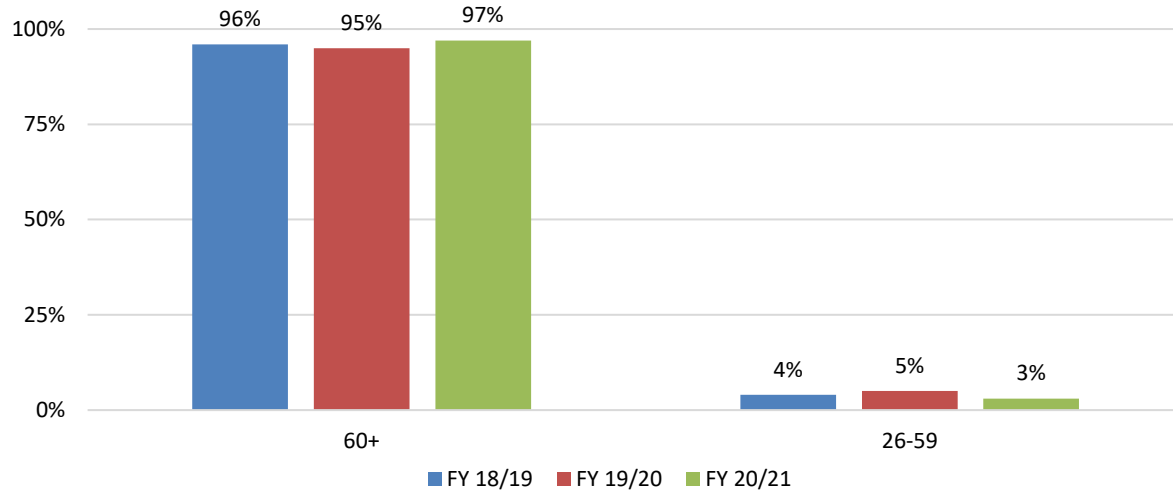
OUTCOMES
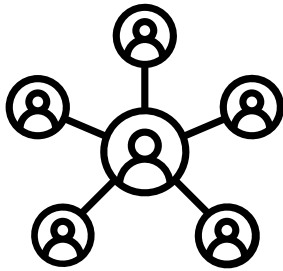
85% felt connected to others after the program

Trained **177** new peer counselors

88% of volunteers report feeling satisfied with the program on average

LGBTQ COMMUNITY OUTREACH WORKER

The LGBTQ Community Outreach worker program was designed to provide trainings, consultation, and to participate in collaborations that raise awareness of important issues in the LGBTQ+ community.

METHODS

The outreach methods used for the LGBTQ Community Outreach Worker program is rooted in promising practices of raising awareness in various community stakeholder groups and venues, as well as maintaining and fostering strong relationships throughout the community. This program increases the number of individuals receiving public health services and reduces disparities in access to care by creating greater awareness of the needs of LGBTQ+ clients, providing pathways and consultation in how to implement best practices, greater inclusivity and visibility of LGBTQ+ clients in brochures and publications, as well as by encouraging providers to display affirming symbols and LGBTQ+ specific resources within client settings. As public health services actively work to evolve the ways in which they provide services to be inclusive and affirming of LGBTQ+ experiences, community members are more likely to stay engaged in services and be open to additional public health services that are indicated for their care.

PROGRAM STRATEGIES

Timely Access to Mental Health Services for Individuals and Families from Underserved Populations

| | Non-Stigmatizing and Non-Discriminatory Practices |

Y

Total of **545** clients served

Participated in many countywide planning events, such as Transgender Day of Remembrance and the San Mateo Pride Celebration to represent and to bring awareness of the mental health needs within the LGBTQ+ community

In FY 19/20 outreach efforts expanded to a variety of other community settings across the county: school-based, countywide event planning, and criminal justice-based staff

In FY 19/20, **16** direct referrals were provided to community members to get connected to services such as: gender affirming medical care, housing resources, and the San Mateo County Pride Center

DEMOGRAPHIC DATA

Due to staffing limitations, the LGBTQ Community Outreach Worker Program did not collect and report demographic data during FYs 18/19 and 19/20 (the 2 fiscal years in which the program was active). The demographic data for the community members that this program worked closely with are contained within the PRIDE Initiative's annual report (funded by MHSA Innovation), given the close working relationship and collaboration on events. Please refer to the PRIDE Initiative's annual reports from FY 18/19 and 19/20 for demographic information.

OUTREACH COLLABORATIVES

Community outreach collaboratives include the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) and the North County Outreach Collaborative (NCOC). These collaboratives provide services in community advocacy, resident engagement, expansion of local resources, and education and outreach to decrease stigma related to mental illness and substance use. The collaboratives increase awareness of and access and linkages to behavioral health and social services and promote and facilitate resident input into the development of MHSA-funded services.

PROGRAM STRATEGIES

Timely Access to Mental Health Services for Individuals and Families from Underserved Populations

Non-Stigmatizing and Non-Discriminatory Practices

PROGRAM HIGHLIGHTS

28,810 clients served

1,051 referrals to mental health services

300 substance abuse referrals

DEMOGRAPHIC DATA

Outreach Attendees by Age Group

	Children (0-15)	TAY (16-25)	Adults (26-59)	Older Adults (60+)
NCOC FY 18/19 (n = 4,373)	13%	27%	40%	20%
EPAPMHO FY 18/19 (n = 636)	2%	30%	56%	11%
NCOC FY 19/20 (n =12,021)	13%	28%	46%	13%
EPAPMHO FY 19/20 (n =517)	12%	20%	58%	10%
NCOC FY 20/21 (n = 6,650)	27%	21%	37%	15%
EPAPMHO FY 20/21 (n =245)	12%	20%	57%	10%

Outreach Attendees by Race/Ethnicity

Legend: White, Asian, Mexican, Multi, Hawaiian, African American, Samoan, Tongan, Other, Filipino

Chart data labels:
- NCOC FY 18/19 (n = 3,111): 47%, 17%, 14%, 11%, 10%
- EPAPMHO FY 18/19 (n = 4,209): 8%, 24%, 13%, 23%, 9%, 15%
- NCOC FY 19/20 (n = 6,876): 16%, 18%, 10%, 12%, 9%
- EPAPMHO FY 19/20 (n = 6,879): 23%, 7%, 31%, 18%, 6%
- NCOC FY 20/21 (n = 3,371): 60%, 12%, 18%, 9%
- EPAPMHO FY 20/21 (n = 204): 50%, 20%, 14%, 9%, 7%

OUTCOMES

Providers have adapted their model of service to virtual and have been able to maintain connections with residents in the community. For instance, Anamotongi Polynesian Voices from the EPAPMHO program pivoted their outreach and referral process to include providing wellness checks via phone and email, delivering wellness packages to homes and providing referrals and warm hand-offs to community resources and assistance programs. They will continue to develop and adapt programming as the pandemic continues in order to meet the growing need in the community.
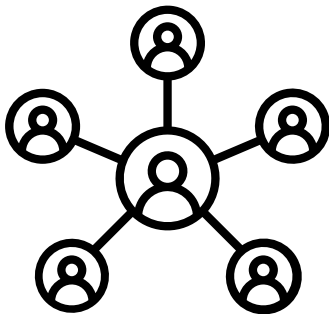
In FY 20/21, **78%** of individual outreach events provided by NCOC resulted in mental health referrals.

The top three types of social service referrals provided by EPAPMHO in FY 20/21 after providing individual outreach events were: housing (20%), food (17%), and Other (14%), most of which included the Housing Energy Assistance Program (HEAP).

Special populations served by NCOC were those at-risk of homelessness, currently homeless, veterans, and disabled. Special populations served by EPAPMHO were homeless and those at-risk of homelessness.
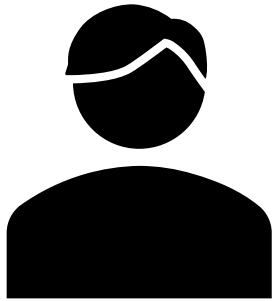
Client 'N' was a victim of domestic violence, which led the client and her children to seek shelter. After temporary refuge, the client found a new home with her children. Subsequently, the client had challenges maintaining her rent and providing for her family due to medical issues, taking time off work, and car repair expenses. The case worker worked with the client to find employment, obtain supplemental income to help support her monthly financial obligations, and connected her with ongoing therapy for her trauma. The client states, "I finally realized that I am no longer a victim but am a survivor. I realize that I am not alone. COVID-19 has me really scared and I think the world is coming to an end, but I am glad I have you to talk to."

SYSTEM TRANSFORMATION

The outreach collaboratives are the front line to the community; many times they are from the community in which they work, they have rapport with the community, and they culturally identify with the population that they serve. Through the outreach collaboratives' data collection, the most pressing social service referrals identified are around mental health as depression and anxiety have significantly increased because of the challenges faced by the ongoing pandemic. Other challenges related to the pandemic include lost jobs and the negative economic impact on low-income households. Program staff continue to put forth their best effort to conduct outreach and referral activities virtually and in-person settings when appropriate and safe to do so. The information gathered from the community by program staff is vital to MHSA because it allows us to think of prevention in an upstream approach and see the social determinants of health such as housing, food access/insecurity, political climate, and public health as factors that affect the mental health of the community. It guides our efforts as we expand our programs and provides ideas for new programming.

PREVENTION OVERVIEW

EXECUTIVE SUMMARY

Most of the programs categorized as prevention fall under the purview of the Office of Diversity and Equity (ODE). Based on the findings among these programs, we found that a rich amount of supportive evidence was provided that shows that the ODE and their programs are meeting their goals to reduce stigma and discrimination against mental illness, increase self-empowerment, community advocacy, access and linkage to mental health services, and cultural humility among San Mateo County's marginalized populations.

RECOMMENDATIONS

From the data collection and evaluation perspective, it is important that data collection processes continue to be refined and standardized in relation to the types of services and activities that have taken place, as many of the programs and activities under the ODE vary in terms of duration and subject matter. For example, an outreach event that takes place during a single session may entail conducting an expedited, shorter version of a PEI survey compared with a service or activity that entails several sessions over the course of a given timeframe.

Additionally, it is recommended that outreach, engagement, and education into and about mental health services is carried out among marginalized populations in spaces where they seek other types of services that address their various SDoH. For example, outreach and prevention efforts could take place in partnership with employment offices and public assistance centers. Additionally, as the pandemic, virus variants, and social distancing mandates continue, it is imperative that participants are engaged in mental health services and activities in innovative ways, using the power of technology and social media (TikTok, IG Live, Facebook) to hold virtual events around Prevention. The use of these various platforms could also facilitate some of the outcome data collection requirements for PEI (e.g., TikTok, IG, or Facebook polls).

PREVENTION

OFFICE OF DIVERSITY AND EQUITY (ODE)

ODE is committed to advancing health equity in behavioral health outcomes of marginalized communities. The office was established in 2009 via dedicated MHSA funding allocated to address cultural competence and access to mental health services to underserved communities. This office demonstrates a commitment to understanding and addressing how health disparities, health inequities, and stigma impact an individual's ability to access and receive behavioral health and recovery services. ODE works to promote cultural humility and inclusion with the county's behavioral health service system and in partnership with communities. The following programs are housed under ODE:

Prevention

- Health Equity Initiatives
- Health Ambassador Program (HAP and HAP-Y)
- Parent Project

Recognition of Early Signs of MI

- Adult Mental Health First Aid (AMHFA)

Stigma Discrimination and Suicide Prevention

- Storytelling Program
- Mental Health Awareness - Be the ONE Campaign
- San Mateo County Suicide Prevention Committee (SPC)

5,668 community members served

METHODS

The **evidence-based curricula** found under ODE are the following:

- Adult and Youth Mental Health First Aid
- Parent Project
- The Storytelling Program: Digital Storytelling and Photovoice

These three programs are curriculum-based with extensive research, validating their effectiveness and with minimum modifications from the originally designed curricula.

Programs that are a **promising practice** are the following:

- Health Ambassador Program: This program follows the ideology and evidence-based practice of a Promotora program with added trainings, workshops, and leadership development.
- Health Equity Initiatives: There are nine initiatives under ODE, each representing groups that are typically underserved in mental health services. These nine meeting groups allow for community, providers, and contractors to come together and decrease stigma, educate, and empower community members, support wellness and recovery, and build culturally responsive services.
- Stigma Free San Mateo County: An online social media campaign to raise awareness of mental health and substance use.

- Suicide Prevention Committee: A workgroup that coordinates efforts to prevent suicide in San Mateo County.

STRATEGIES

Timely Access to Mental Health Services for Individuals and Families from Underserved Populations

Non-Stigmatizing and Non-Discriminatory Practices

PROGRAM HIGHLIGHTS

Over **10,000** individuals were estimated to have come into contact with efforts put forth by the ODE across a three-year period

Nearly **6,000** community members served by the Health Equity Initiatives

Parent Project reached **286** graduates

96% of Parent Project graduates feel confident about their parenting skills because of their participation in the program

Adult Mental Health First Aid reached over **400** graduates

99% of Adult Mental Health First Aid graduates feel confident to recognize and correct misconceptions about mental health, substance use, and mental illness as they encounter them

DEMOGRAPHIC DATA

Available demographic data by each program and FY is presented in the section below.

Health Ambassador Program (HAP and HAP-Y)

Although demographic information was collected during various events that took place across all three fiscal years for the Health Ambassador Program, the way in which various demographic characteristics were not always categorized nor reported in the same way. Therefore, demographic data was difficult to obtain and aggregate in a standardized way across all events that took place across all three fiscal years for the Health Ambassador Program. However, when examining demographic characteristic trends of Health Ambassador Program participants across events and fiscal years, most participants identified as Hispanic or Latino, female, were from the City of San Mateo, represented either a consumer/client or a family member of a consumer/client, and were between 26-59 years of age. In FY 20/21, the Health Ambassador Program focused on the youth population (HAP-Y) where 100% of participants were TAY age (i.e., between 16 to 25 years of age). In this youth population, most HAP-Y participants identified as Hispanic or Latino, female, and represented either a consumer/client, family member of a consumer/client, or community member.

ODE Demographics

Demographics for the ODE was not collected during FY 18/19. However, demographic data collection began in FY 19/20 and was collected across all individuals who participated in ODE activities, which includes those who participated in and completed Parent Project and Adult Mental Health First Aid curricula.

ODE Clients Served by Race/Ethnicity
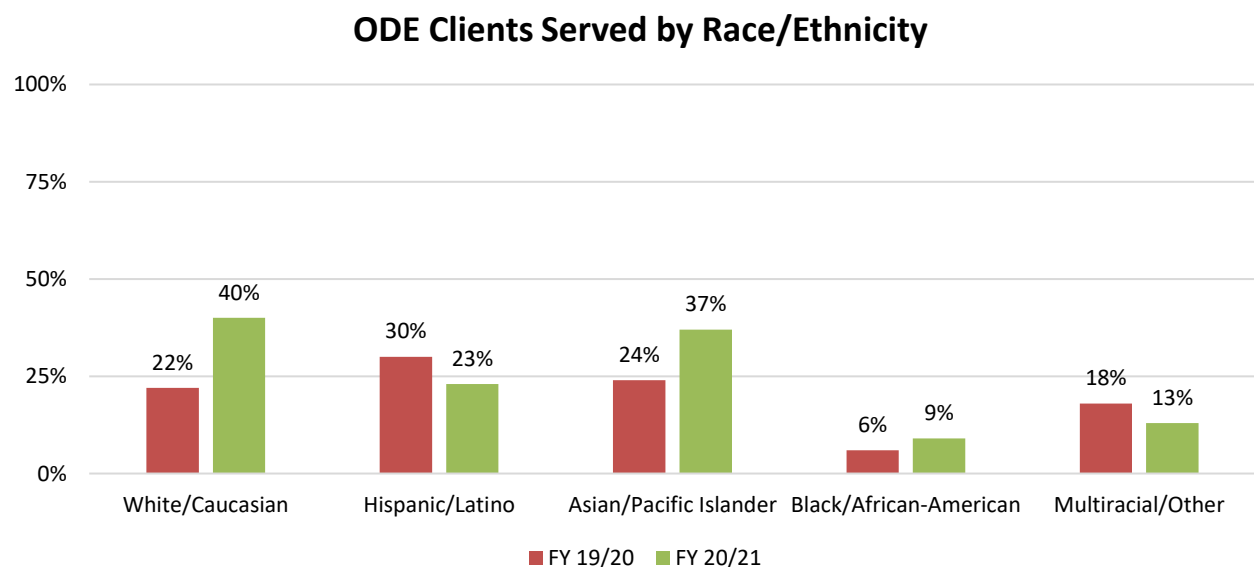
ODE Served by Preferred Language
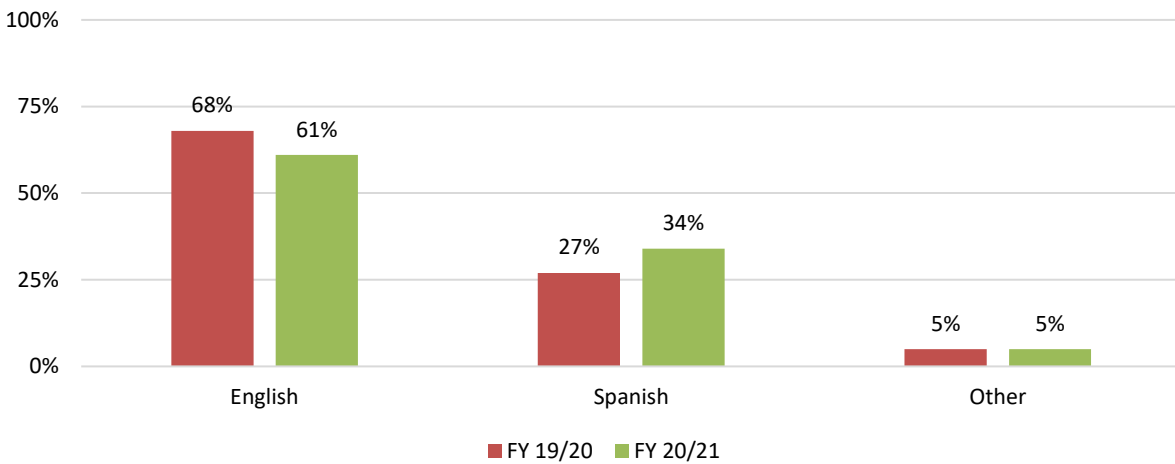
One interesting difference observed between clients served from FY 19/20 to FY 20/21 is that a greater proportion of Spanish-speaking clients participated in either the Parent Project or the Adult Mental Health First Aid curricula during FY 20/21 compared with FY 19/20.

Adult Mental Health First Aid (AMHFA)

The demographic information presented below represents participants who specifically completed the AMHFA curricula across FYs 18/19, 19/20, and 20/21.

AMHFA Clients Served by Race/Ethnicity

AMHFA Clients by Preferred Language
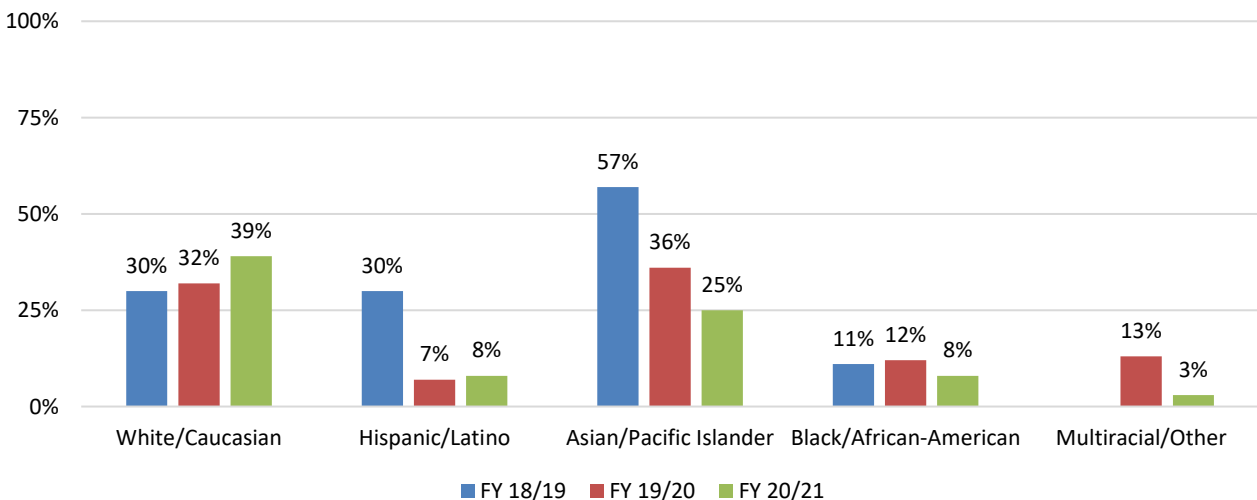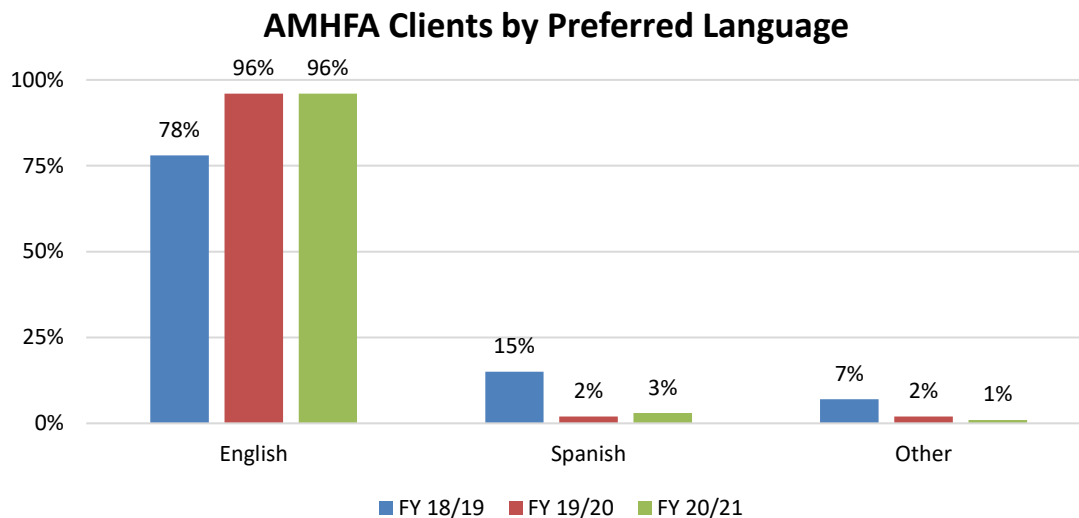
These data show that the proportion of English-speaking clients who participated in the AMHFA curriculum increased in the most recent FY 20/21. However, one caveat to the FY 20/21 demographic data is that a smaller percentage of clients responded to the demographic surveys and outcome measures due to the ongoing challenges of transitioning to an all-virtual service delivery model due to the pandemic.

Storytelling Program: Digital Storytelling and Photovoice

The Storytelling Program, which consisted of both Digital Storytelling and Photovoice temporarily ended after FY 18/19 due to staff hiring constraints. Accordingly, data for this program will only cover FY 18/19.

Digital Storytelling Clients Served by Race/Ethnicity
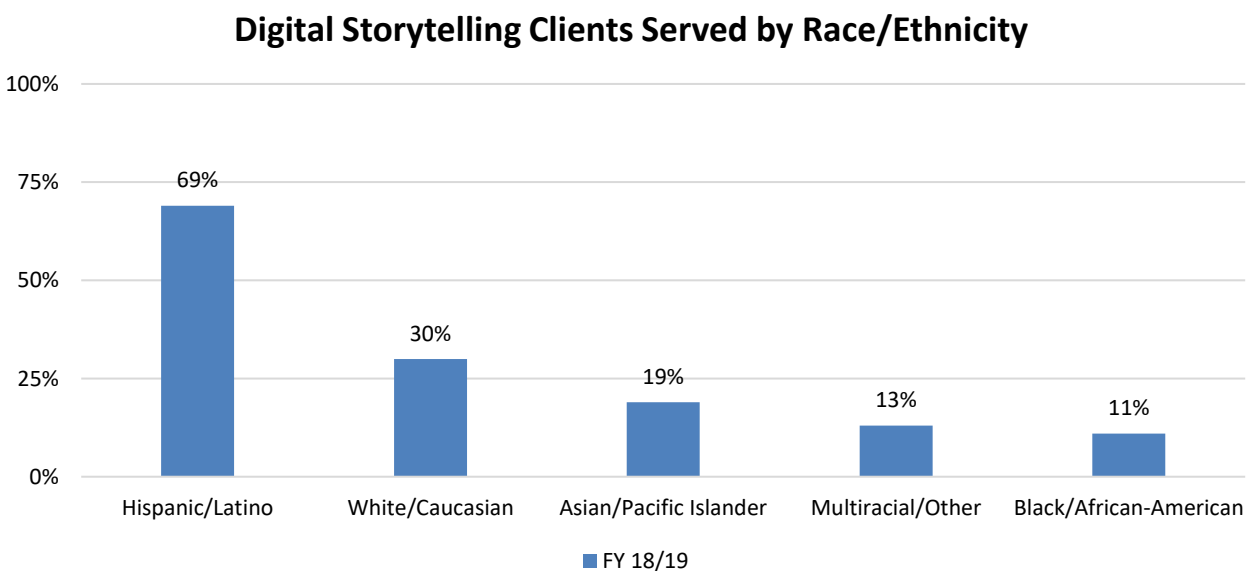
Digital Storytelling Clients by Preferred Language
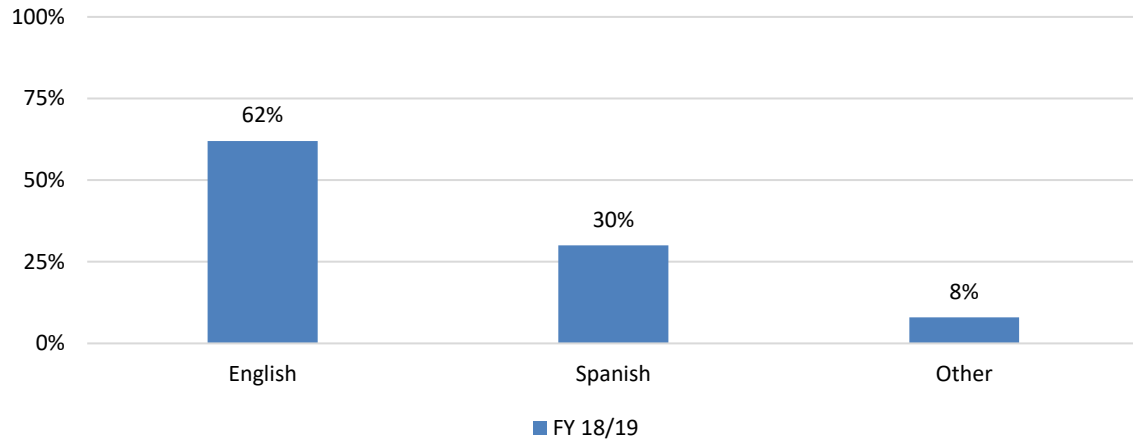
Mental Health Awareness – Be the One Campaign

Demographic data was not collected during FY 18/19 for the Mental Health Awareness – Be the One Campaign. However, demographic data collection began in FY 19/20 for participants who were willing to respond to the survey. Below are graphs that present some of the demographic characteristics reported among a portion of the clients who attended at least one of the Mental Health Awareness – Be the One Campaign events in FYs 19/20 and 20/21.

Mental Health Awareness Attendees by Race/Ethnicity
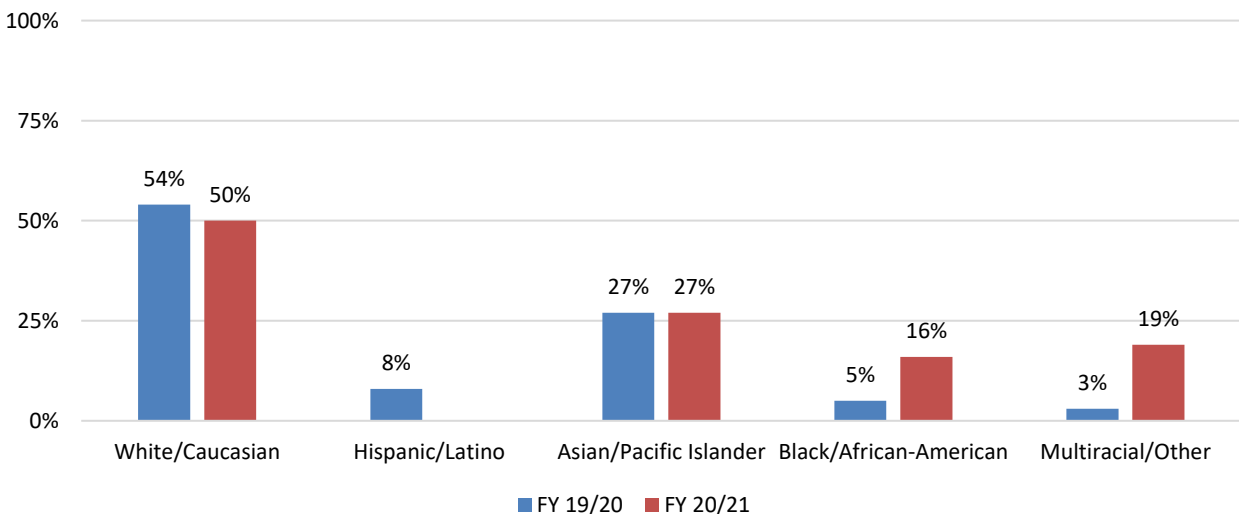
Mental Health Awareness Attendees by Gender Identity

Bar chart showing:
- Male: FY 19/20 = 21%, FY 20/21 = 20%
- Female: FY 19/20 = 72%, FY 20/21 = 74%
- Other: FY 19/20 = 2%, FY 20/21 = 4%

Legend: FY 19/20, FY 20/21

Mental Health Awareness Attendees by Age Group

Bar chart showing:
- Age 16-25: FY 19/20 = 14%, FY 20/21 = 6%
- 26-59: FY 19/20 = 58%, FY 20/21 = 60%
- 60+: FY 19/20 = 25%, FY 20/21 = 31%

Legend: FY 19/20, FY 20/21
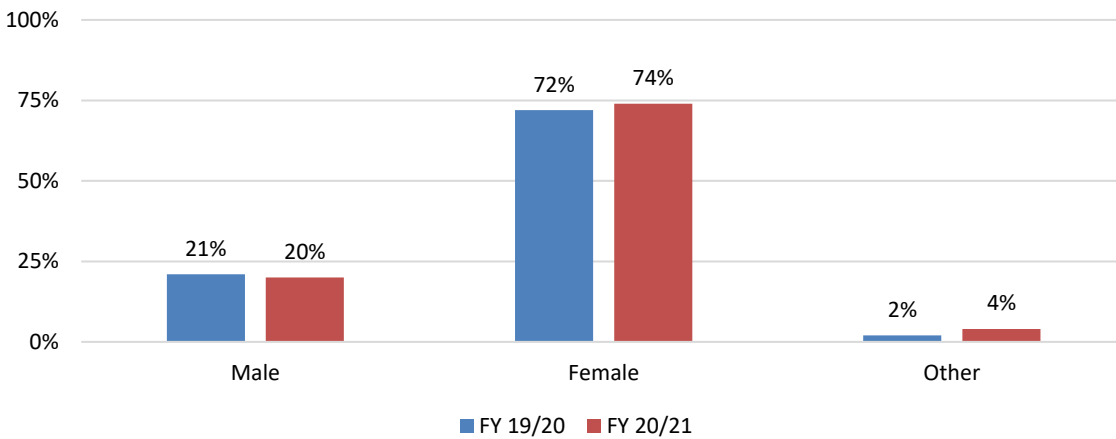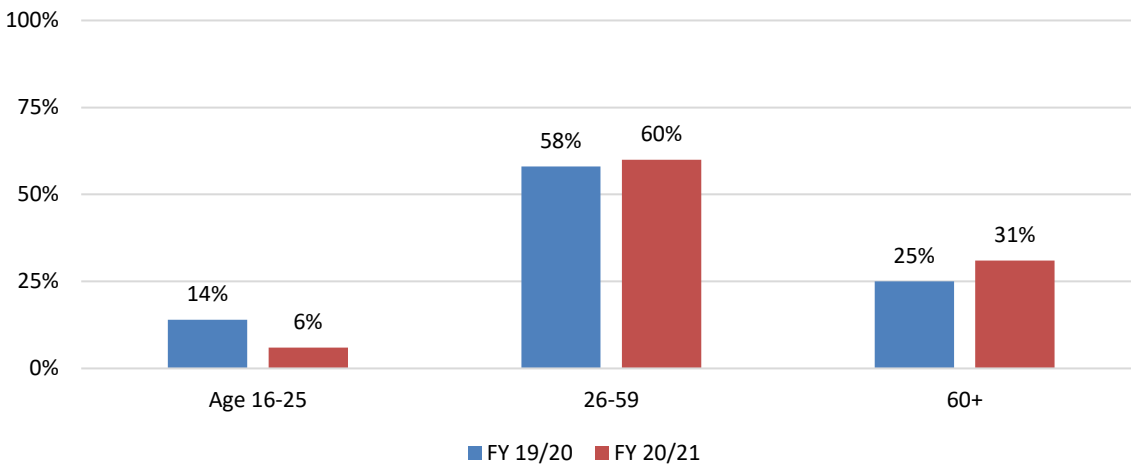
In comparing race/ethnicity, gender identity, and age groups across the two fiscal years, a slightly more ethnically diverse group was represented in FY 20/21, with a slightly higher proportion of attendees who identified as another gender aside from male or female, as well as seeing a slightly older group who represented the population that attended these events during FY 20/21.

San Mateo Suicide Prevention Committee

This program collected demographic data across all three fiscal years during the reporting period. Challenges related to collecting demographic data in FYs 19/20 and 20/21 decreased the sample size of those who responded to the demographic survey. Nevertheless, comparisons across fiscal years indicate that a growing number of the Hispanic/Latino Spanish-speaking population make up a higher percentage of attendees over a three-year period. This could be

an indicator that stigma reduction efforts are effective in engaging this historically underserved population.

Suicide Prevention Event Attendees by Race/Ethnicity
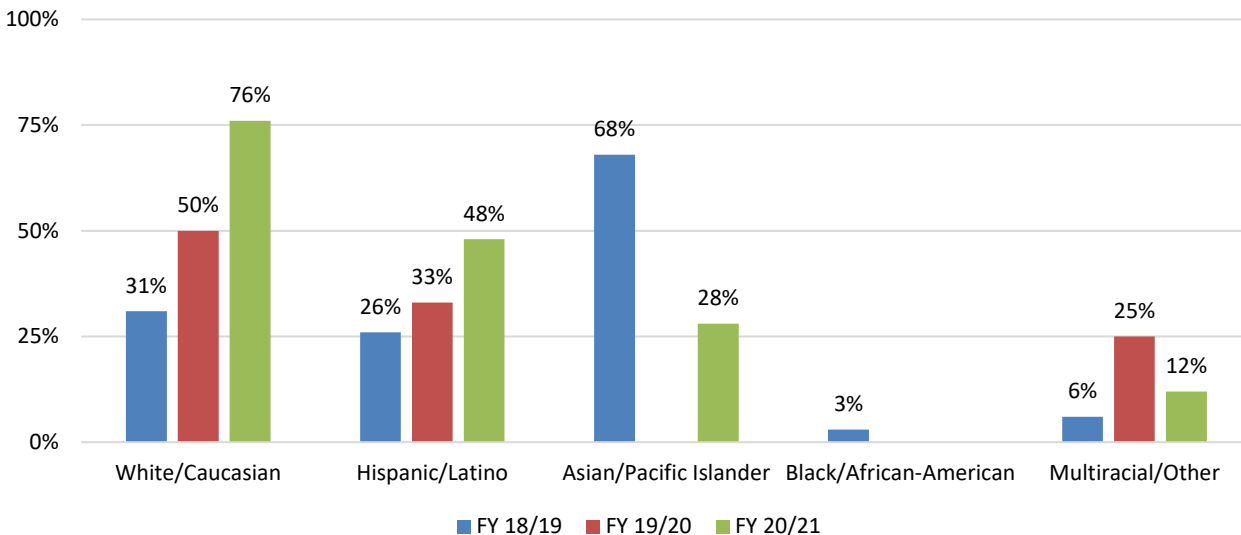
Bar chart showing Suicide Prevention Event Attendees by Race/Ethnicity, with FY 18/19 (blue), FY 19/20 (red), and FY 20/21 (green):
- White/Caucasian: 31%, 50%, 76%
- Hispanic/Latino: 26%, 33%, 48%
- Asian/Pacific Islander: 68%, (none), 28%
- Black/African-American: 3%, (none), (none)
- Multiracial/Other: 6%, 25%, 12%

Suicide Prevention Event Attendees by Gender Identity

Bar chart showing Suicide Prevention Event Attendees by Gender Identity, with FY 18/19 (blue), FY 19/20 (red), and FY 20/21 (green):
- Male: 23%, 42%, 40%
- Female: 67%, 25%, 56%
- Other: 3%, 33%, (none)

Suicide Prevention Event Attendees by Age Group

	Age 0-15	Age 16-25	26-59	60+
FY 18/19	0%	12%	69%	16%
FY 19/20	17%	17%	42%	
FY 20/21	4%	8%	68%	20%

■ FY 18/19 ■ FY 19/20 ■ FY 20/21
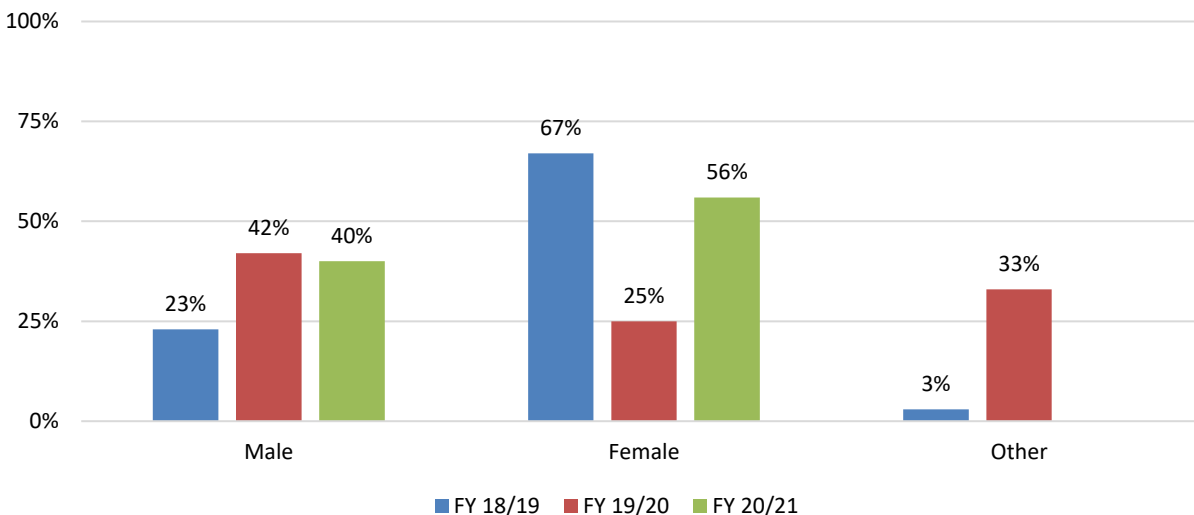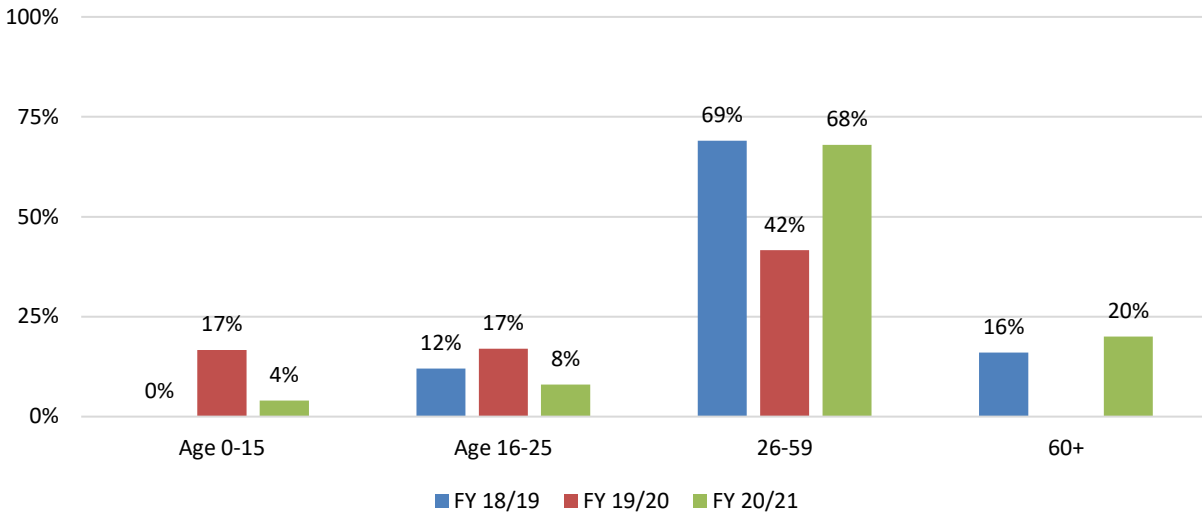
Suicide Prevention Event Attendees by Preferred Language

	English	Spanish	Other
FY 18/19	100%		
FY 19/20	50%	25%	
FY 20/21	64%	32%	4%

■ FY 18/19 ■ FY 19/20 ■ FY 20/21
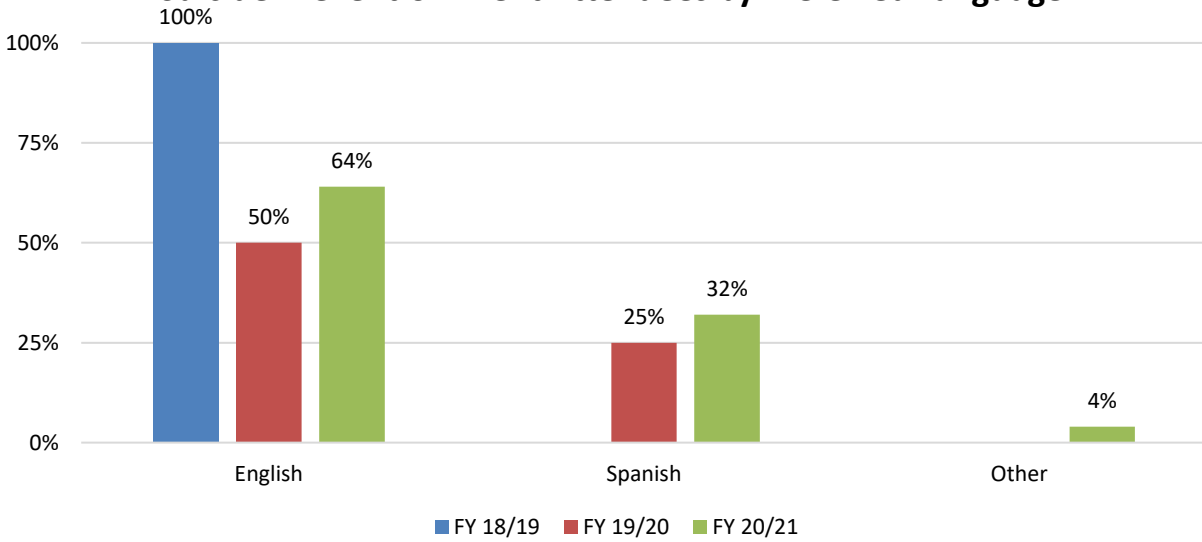
Suicide Prevention Event Attendees by Sexual Orientation

Gay, lesbian, homosexual: FY 18/19 5%, FY 19/20 17%, FY 20/21 4%
Straight or heterosexual: FY 18/19 76%, FY 19/20 25%, FY 20/21 80%
Bisexual: FY 18/19 3%, FY 19/20 17%, FY 20/21 8%
Queer: FY 18/19 1%, FY 19/20 8%, FY 20/21 4%
Pansexual: FY 18/19 4%
Asexual: FY 19/20 8%
Questioning or unsure: FY 18/19 3%, FY 19/20 8%
Another sexual orientation: FY 18/19 1%

Legend: FY 18/19, FY 19/20, FY 20/21
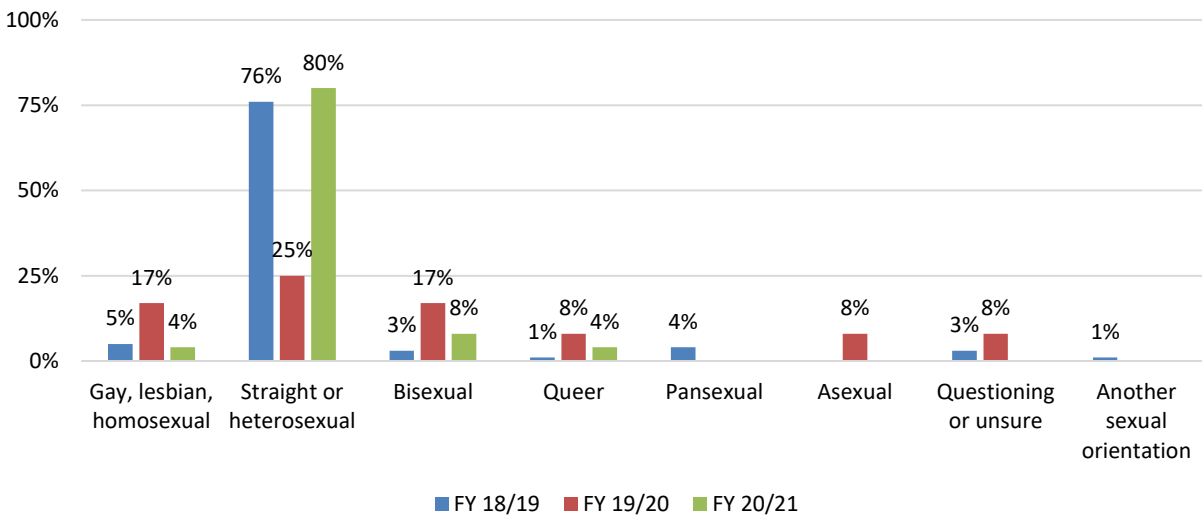
EVALUATION FRAMEWORK

The ODE measures progress along five evaluation indicators with definitions that are influenced by (1) public health frameworks and (2) ODE's mission, values, and strategy.

1. Self-Empowerment - enhanced sense of control and ownership of the decisions that affect your life
2. Community Advocacy - increased ability of a community (including peers and family members) to influence decisions and practices of a behavioral health system that affect their community
3. Cultural Humility
   - heightened self-awareness of community members' culture impacting their behavioral health outcomes
   - heightened responsiveness of behavioral health programs and services for diverse cultural communities served
4. Access to Treatment/Prevention Programs (Reducing Barriers) - enhanced knowledge, skills, and ability to navigate and access behavioral health treatment and prevention programs despite potential financial, administrative, social, and cultural barriers
5. Stigma Discrimination Reduction - reduced prejudice and discrimination against those with mental health and substance use conditions

Implementation of the five evaluation indicators were implemented with Adult Mental Health First Aid, the Parent Project, Digital Storytelling and Photovoice, Mental Health Awareness, and the Be the One Campaign.

Below are the results for the aggregated survey results across three of our evidence-based programs: HAP, Parent Project, and AMHFA. All the programs will ultimately feed into these five indicators to measure impact of the ODE as a whole.

HEALTH AMBASSADOR PROGRAM OUTCOMES

Outcomes are presented based on survey data that were collected across a variety of events and activities that took place across a three-year period. Results suggest that the various HAP trainings, workshops, and events helped participants gain greater knowledge and skills around coping and educating others about wellness.

HAP FY 18/19 WRAP Training Outcomes

A bar chart comparing Pre % Agree and Post % Agree across four indicators:
- I know triggers before an episode of illness: Pre 24%, Post 55%
- I believe that I can educate others about recovery health: Pre 37%, Post 65%
- I have a list of tools I use to increase my sense of well-being: Pre 8%, Post 75%
- I feel safe due to the wellness and crisis plans that I have in place currently: Pre 37%, Post 100%

Legend: ■ Pre % Agree ■ Post % Agree

NAMI Basics Course FY 19/20 Post Course Results

Statement	% Post Agree
I feel comfortable speaking with someone about their suicidal thoughts and plan	100%
I am confident in my understanding of suicide prevention and assessment	100%
I am comfortable assessing my ability to meet the needs of a person at risk for suicide	100%
I am able to directy ask an individual about their suicidal intent	100%
I understand how my own attitudes and experiences may impact my ability to help another individual	100%
I am aware of community resources to help myself and others when they are in crisis	100%
I am aware of the importance of my own need for self-care skills when helping others who are in crisis	89%
I am comfortable asking my family or friends for help when I am having a difficult time	89%

■ % Post Agree

HAP Family and Wellness during COVID-19 Workshop Post Presentation Results FY 20/21

Statement	% Post Agree
This program gave me the knowledge and skills that I will continue to use in my life	92%
I am comfortable in talking about mental health	81%
I increased my awareness and understanding of mental health issues	75%

■ % Post Agree
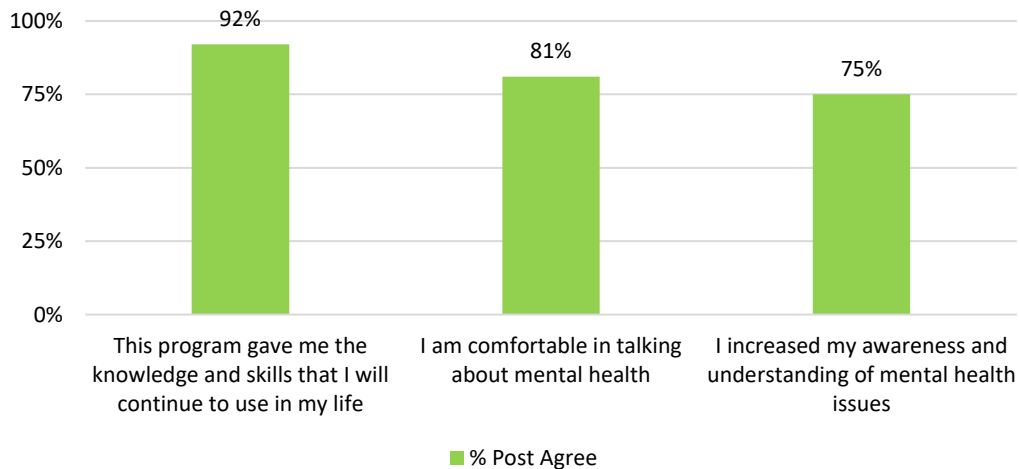
PARENT PROJECT OUTCOMES

Cultural Humility

67% agreed that the the Parent Project they participated in was sensitive/relevant to their cultural background.

Self-Empowerment

96% feel confident about their parenting skills as a result of taking Parent Project

Stigma Discrimination Reduction

75% agree that they are now more willing to seek behavioral health services for themselves and/or a loved one if needed.

Access to Treatment/Prevention Programs

83% reported that they now know where to go to receive behavioral health services.

Community Advocacy

68% feel that they can positively help their community after taking Parent Project

Results from the surveys completed among individuals after completing the Parent Project course indicate that most participants found the curriculum to be effective in building their parenting skills, gaining knowledge about where to seek behavioral health services if needed, increasing their willingness to receive behavioral health services if needed, and increasing their overall sense of connectedness to their community.

ADULT MENTAL HEALTH FIRST AID OUTCOMES

Cultural Humility

90% agreed that the program they participated in was sensitive/relevant to their cultural background.

Self-Empowerment

99% report confidence in recognizing the signs that someone may be dealing with a mental health problem, substance use challenge or crisis
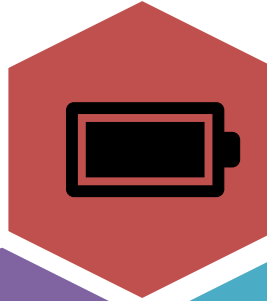
Stigma Discrimination Reduction

83% agree that they are more willing to take action to prevent discrimination against people with mental health conditions.
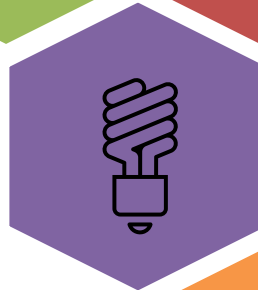
Access to Treatment/Prevention Programs

96% feel confident to offer a distressed person basic "first aid" level information and reassurance about mental health and substance use challenges.

Community Advocacy

99% feel confident to recognize and correct misconceptions about mental health, substance use and mental illness as they encounter them

Results from the surveys completed among individuals after completing the AAMHFA course indicate that most participants found the curriculum to be effective in building their skills to recognize early signs of mental illness and assist others who may be dealing with challenges related to mental health and/or substance use.

STORYTELLING OUTCOMES

Results from the surveys completed among individuals after completing Digital Storytelling and Photovoice workshop indicates that most participants found the workshop to be effective in improving their attitudes towards behavioral health, increased their coping skills, and how to create change in their communities using their stories.

Cultural Humility

78% agreed that this program was sensitive/relevant to their cultural background.

Self-Empowerment

96% reported that their Photovoice helps them express something that they cannot express in other ways.

Stigma Discrimination Reduction

87% agree that their attitudes about behavioral health were positively affected as a result of this program.

Community Advocacy

87% reported that they learned how to create change in their community with their story as a result of the workshop.

Storytelling Pre and Post Workshop Results

Statement	% Pre Agree	% Post Agree
I feel people with mental illness are persons of worth, at least on an equal basis	77%	91%
I see people with mental illness as capable people	69%	86%
People with mental illness are able to do things as well as other people	69%	82%
I'm kind to myself when I'm experiencing suffering	33%	70%
When I'm going through a very hard time, I give myself the caring and tenderness I need	25%	73%
I'm tolerant of my own flaws and inadequacies	34%	74%
I try to be loving towards myself when I'm feeling emotional pain	38%	87%

#BETHEONESMC STIGMA REDUCTION OUTCOMES

Results from the surveys completed among individuals who participated in various stigma reduction activities over a three-year period indicate that most participants found the workshop to be effective in improving their attitudes towards seeking behavioral health services if needed, taking action against discrimination against people with mental illness, and learning how to take better care of their mental health and seek help if needed.

Cultural Humility

88% were more likely to report that this program was relevant to them and other people of similar cultural backgrounds and experiences (race, ethnicity, gender, religion, etc).

Self-Empowerment

85% report that they learned how to better care for their mental health and seek help if they need it.

Stigma Reduction

88% report that they are more willing to take action to prevent discrimination against people with mental illness.
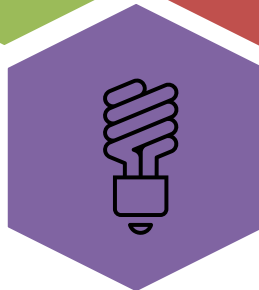
Access to Treatment Prevention Programs

83% are more willing to seek support from a mental health professional if they thought they needed it.

SUICIDE PREVENTION OUTCOMES

Outcomes from the suicide prevention program is presented in the form of success stories.
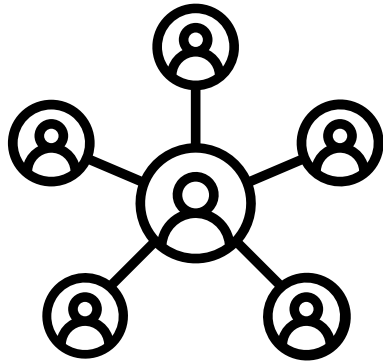
More than **400** individuals have been trained in Adult Mental Health First Aid. Those trained have been teachers, leadership from Family Health services, Second Harvest Food Bank, Peninsula Library System, and students from San Mateo Adult School.

The Suicide Prevention Committee held approximately 61 events across three fiscal years, touching over 2,100 lives.

The #BetheONE Campaign held 70 events across three fiscal years, touching an estimated 7,000 lives.

QUALITATIVE DATA

#BetheONE Campaign Trauma to Triumph Event

"Thank you all for hosting this inspirational event - I hope we can continue this broader conversation around mental health, including trauma and healing, with our loved ones and our communities. Thanks to each of you for having the courage to share your stories!"

Suicide Prevention Program Directing Change

"I started this project with a lot of pain and grief in my life because of how suicide had personally rocked my world in October because of my friend. This project helped me channel that grief into something that will make an impact and bring a little bit of closure and healing to the wound suicide had opened in me. I cannot thank you enough for that."

Health Equity Initiatives

Despite the pandemic, a virtual Drumming Event in collaboration with NIPI was hosted in May. Out of the chaos of the pandemic, the SI members kept their focus and continued to work with other HEI's. Finally, because of the more recent racist acts towards the Chinese community, a collaborative with CHI was created to present a virtual training on what they are facing as a community.

HAP Program

"Immediately after taking Parent Project, I was suggested to take Adult Mental Health First Aid and then other courses related to alcohol and other drugs offered by (BHRS), all trainings at no cost. I got hooked! This was the path I needed to take to understand and accept that life can be enjoyable while parenting two children with learning and behavioral challenges."

SYSTEM TRANSFORMATION

ODE is an integral part of BHRS in San Mateo County. It is the driver for many system transformation initiatives including the Government Alliance on Race and Equity (GARE), which is an initiative currently being carried out County departments. ODE is also tasked with leading the Multi-Cultural Organizational Development (MCOD) process within BHRS. Additionally, the ODE Director has oversight of MHSA administration, planning and evaluation activities. The MHSA Manager and staff integrate an equity lens in all MHSA decision-making and community program planning processes. This impacts the way we conduct our needs assessments, hours of operation and events, and co-location of services, and decision-making processes.

APPENDIX 10. INNOVATION EVALUATION REPORTS

Mental Health Service Act (MHSA) Help@Hand Evaluation

Innovation Annual Report, Fiscal Year 2020-21

Prepared by:

Resource Development Associates

December 2021

San Mateo County Mental Health Services Act

Help@Hand Evaluation

Innovation Annual Report, Fiscal Year 2020-21

Liz Harvey, MS

John Cervetto, MSW

About Resource Development Associates

Resource Development Associates (RDA) is a consulting firm based in Oakland, California, that serves government and nonprofit organizations throughout California as well as other states. Our mission is to strengthen public and non-profit efforts to promote social and economic justice for vulnerable populations. RDA supports its clients through an integrated approach to planning, grant writing, organizational development, and evaluation.

Table of Contents

Introduction

Help@Hand is a statewide Mental Health Services Act (MHSA) Innovation (INN) project that aims to bring technology-based solutions to county and city behavioral health systems. The project is administered by the California Mental Health Services Authority (CalMHSA) and funded and directed by local jurisdictions. San Mateo County Behavioral Health and Recovery Services (BHRS) identified technology as part of the fiscal year (FY) 2017-20 MHSA Three-Year Plan. In April and May of 2018, San Mateo conducted a Community Planning Process aimed to (1) inform community members about the proposed MHSA INN plan and (2) seek input and feedback from stakeholders to incorporate into the final plan. Stakeholders received background information about MHSA INN to ensure their ability to meaningfully participate.

In San Mateo County, this INN project is an opportunity for BHRS and its collaborative county partners to leverage technology, specifically behavioral health applications (apps), to reach and engage two priority populations, (1) transition age youth (TAY) and (2) older adults. Through the Help@Hand INN project, BHRS aims to:

Provide access and linkages to behavioral health services	Provide social connectivity through the use of virtual avatars and/or peers	Support self-directed mental wellness and recovery goals

This project also serves to reduce the stigma associated with mental health treatment by using virtual engagement strategies and provide alternative methods for engaging in behavioral health recovery and wellness activities. In order to assess these outcomes, the County originally identified the following locally defined Learning Goals:

Learning Goal 1

Does the availability and implementation of technology-based mental health apps **connect** transition age youth in crisis and older adults experiencing isolation to **in-person services**?

Learning Goal 2

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

Learning Goal 3

Does engaging with the apps **promote wellness and recovery**?

The Learning Goals have since been modified to better align with the Help@Hand implementation learnings, these modifications are presented under the Evaluation and Program Findings section of this report.

Implementation Timeline

Figure 1. Timeline and Phase of the San Mateo Help@Hand INN Project

Year 1: July - Oct 2019	Year 1 - Year 2: Nov 2019 - June 2020	Year 2: July 2020 - June 2021	Year 3: July 2021 - June 2022
•Identify and establish tech supports	•App vetting and selection	•App pilot and analysis	•App customization and deployment
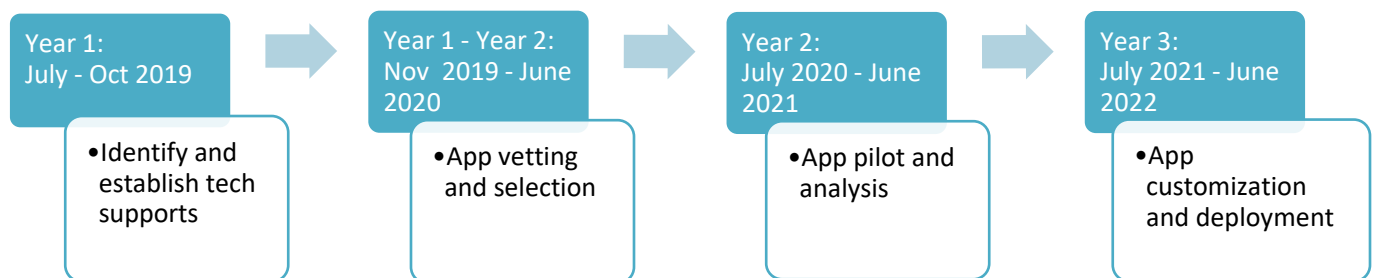
The implementation of the San Mateo Help@Hand project development includes four key phases of work as depicted in timeline above. Year 1 began with exploring what would need to be established to support the use of technology solutions in a behavioral health setting. Some of the needs identified and services established included: 1) Digital Mental Health Literacy (DMHL) train-the-trainer for peer staff that covered topics related to security and privacy measures and managing digital identity; 2) Get App-y Workshops for older adults to receive supports with basic 101 technology education and DMHL topics; 3) a Youth Advisory Group to guide priorities for Transition Age Youth; and 4) expanding the local crisis hotline and support resources to include text-based supports in preparation for the app. Additionally, as a result of phase 1 activities, Help@Hand Stakeholder and contractors identified a need to review additional tech

solutions beyond those provided by CALMHSA in the first round RFSQ processes. It is also important to note that the process to identify needs and establish supports began in Year 1 but has been an ongoing process throughout the entire two-year timeline and has included technology device distribution for behavioral health clients and Help@Hand participants that do not have the resources to purchase technology, technology 101 trainings for peer staff that would be distributing devices and Tech Cafés or workshops for clients and the community at large to receive basic technology supports, DMHL education and advanced Zoom topics.

In Phase 2, Help@Hand stakeholders and contractors reviewed available technologies—which were approved through a Request for Statement of Qualifications (RFSQ) process led by CalMHSA—and participated in various app vetting, testing, and selection activities to identify the app they would like to pilot with the target populations. Ultimately BHRS selected Wysa as an app to move forward with community piloting in Year 2.

During Year 2, from July 2020 to June 2021, San Mateo County implemented a pilot to define and measure success with the selected app and inform a deployment plan. After a successful app pilot, the product was included in the Help@Hand technology portfolio, thereby allowing other jurisdictions to more easily integrate the apps into their behavioral health systems. For Phase 3 BHRS begins working with the app developers to customize and refine the apps to fit the needs and priorities of the local population. In the second part of the year, the County launched the apps to the broader target populations while simultaneously evaluating app utilization and continued success. Simultaneously, in BHRS stakeholders and contracted reviewed the results of the pilot stage and further tests the app with behavioral health clients to determine if they want to integrate the app into their system of care.

The table below provides a comprehensive timeline of activities and major events that occurred over the two-year project timeline.

Table 1. San Mateo Help@Hand Timeline of Activities

Dates	Activities
YEAR 1	Identifying needs and establish targeted supports
July 2019	o PFS & YLI fully on boarded and begin developing focus groups with target populations to identify needs and outreach strategies; o Contracted StarVista to develop texting supports for youth in crisis to expand resources for wellness app user o CalMHSA facilitated focus groups in San Mateo to develop digital health literacy curriculum
August 2019	o Get App-y Workshops launch to support older adults in basic technology 101 and the development of the H@H Youth Advisory Group.
Sept. – Oct. 2019	o Identified need to research additional tech solutions o CalMHSA facilitated a second RFSQ process to broaden the pool of possible tech solutions; this resulted in 93 solutions to choose from
YEAR 1	App demonstrations vetting and selection

Nov. 2019 – Jan. 2020	o Completed first round of App demos, vetting and selection process included local focus groups with TAY and OA
Jan. 2020	o App exploration training to identify customization needs and inform app deployment needs. We selected Happify for older adults and Remente for TAY for the pilot phase
Feb. – April 2020	o COVID-19 led to Happify vendor backing out of the project and TAY stakeholders recognized that the needs of the population had changed. Both groups returned to the app vetting, selection and exploration process
May 2020	o Device procurement and deployment pilot begins with California Clubhouse and Heart & Soul
YEAR 2	**App demonstrations vetting and selection**
July – Oct. 2020	o Second round of App demos, vetting and selection process included local focus groups with TAY and older adults; Wysa app selected, began pilot proposal development
Sept. 2020	o Purchased 10,000 Headspace app licenses and distributed them rapidly to support SMC community mental health wellness during COVID-19
Oct. 2020	o Contracted with Painted Brain to provide tech 101 trainings for peer staff that would be distributing devices and Tech Cafés for clients and the community at large
Nov. – Dec. 2020	o Launched distribution of 250 tablets to network of providers, 50 tablets to Board and Cares and clinic sites, funding for 700+ devices for BHRS clients plus device accessories needed for engagement (headphones, covers, styluses, hotspots, etc.)
YEAR 2	**App pilot implementation, and analysis**
April – June 2021	o Launched Pilot with TAY and older adults to further test the selected app Wysa
May 2021	o Began exploration of needs for integration into BHRS system of care o Decided to wait until after the local customizations are completed and broad deployment of the app begins.
June 2021	o Added advanced Zoom topics to Painted Brain's contract. Held first training to address equitable practices while facilitating Zoom meetings

Evaluation Overview

In July 2019, BHRS contracted Resource Development Associates (RDA) to conduct a three-year evaluation of the local Help@Hand INN project. The purpose of the evaluation is to determine if technology-based wellness apps can:

1. Improve access to mental health services and supports for TAY and older adults
2. Improve wellness and reduce feelings of isolation for TAY and older adults
3. Improve wellness and recovery outcomes for individuals living with mental health challenges

RDA will assess the goals defined above to help San Mateo County BHRS understand the implementation of the apps and the outcomes of their utilization in the local context. The University of California Irvine (UCI) is also conducting a statewide evaluation of the County Behavioral Health Technology Collaborative

to explore app usage trends, linkages to care, and recovery outcomes across all jurisdictions participating in the Help@Hand project.

Evaluation Timeline

San Mateo County completed the first three stages outlined in Figure 1 above during FY 19-20 and FY 20-21. After various app vetting, testing, and selection activities, including much group discussion within the Help@Hand Advisory Committee—comprised of individuals from the older adult and TAY community as well as community-based partners Peninsula Family Service and Youth Leadership Institute—a consensus was reached on selecting the app Wysa to formally pilot with a group of older adults and TAY and collect further data about the app's impact, customization needs, and broad deployment considerations. Accordingly, the project is now in the app customization stage and preparing for a broad app deployment in partnership with the Wysa app developers and marketing consultants.

Given the project implementation timeline, this report focuses on the following activities undertaken by BHRS and local stakeholders throughout FY 20-21: (a) activities related to a second round of app vetting, testing, and selection, (b) a two-month pilot process with older adults and TAY (b) app exploration groups to identify customization needs, further testing among behavioral health consumers and broad deployment of the app to the target communities, (c) data collected and findings from the pilot, and (d) lessons learned, recommendations, and next steps for app customizations and deployment.

Evaluation Methods

Data Collection

RDA used both quantitative and qualitative evaluation methods in order to assess the influence of the app on pilot participants' well-being, feelings of isolation, mental health stigma and potential connections to further mental health supports if needed. Qualitative app exploration was also conducted to identify considerations for further testing with San Mateo County behavioral health consumers and broad deployment to the target populations.

Additionally, qualitative and quantitative data were collected from the perspectives of different stakeholders involved in implementation and decision-making processes. RDA collected data through interviews, surveys, and four focus groups with the following stakeholders:

Table 2. Qualitative Data Collection Activities and Participants

Method	Stakeholders
Interviews	Doris Estremera, MHSA Manager[1]
	Adam Wilson, Assistant Program Manager, Youth Leadership Institute (YLI)[2]

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[1] As the MHSA Manager and the Help@Hand project manager, Doris Estremera oversees all project activities.
[2] YLI is the contracted organization to conduct peer-led outreach to the TAY population for the Help@Hand project.

	Rubi Salazar, Peer Program Coordinator, YLI
	Susan Houston, Vice President of Older Adult Services, Peninsula Family Service (PFS)[3]
	Arlene Aquino, Peer Support Specialist, PFS
	Andrea Sobel, Peer Support Worker, PFS
Process Focus Group	Help@Hand Advisory Committee[4]
App Vetting and Selection Focus Groups	TAY app testers (5)
	Older adult app testers (7)
Pilot Participant Focus Groups	TAY app pilot participants (16)
	Older adult pilot participants (37)
App Exploration Groups	TAY participants (8)
	Older Adult participants (12)

Interviews with Help@Hand staff and contractors explored key activities, lessons learned about the app pilot process and stakeholder engagement, participation in the statewide collaborative, and the potential impacts of behavioral health technology on the TAY and older adult populations. The focus group with the Help@Hand Advisory Committee offered an opportunity to discuss the role of the committee, what has worked well and areas for improvement in the Help@Hand project activities, experiences working with different stakeholders, and changes in expectations of how technology can help meet the behavioral health and wellness needs of TAY and older adults in the county. RDA also attended monthly Help@Hand Advisory Committee meetings and documented the project's progress throughout the evaluation period.

RDA's role adapted as the needs of the project changed over time. When BHRS recognized the county would need to undergo an in-depth app pilot process, RDA worked with YLI and Peninsula Family Service to design and implement four focus groups with pilot participants. RDA, with the support of Peninsula Family Service, conducted one focus group with older adults, and YLI conducted a series of focus groups with TAY. Pilot participant focus groups were used to collect feedback on usage experiences with the Wysa app and the perceptions of each app's ability to meet the local Help@Hand learning goals and needs of the TAY and older adult populations. RDA also conducted two exploration groups, one with TAY and one with older adults to further explore specific app features of interest and inform the customization and app deployment phases of the Help@Hand project.

In addition, CalMHSA requires INN project evaluations to report on participant characteristics. San Mateo County defines participants of the Help@Hand project as pilot users of the Wysa app—individuals who participated in the pilot stage by downloading and using the Wysa app. Accordingly, demographic data were collected in the form of surveys that were completed by both TAY and older adult participants prior to downloading and using the selected apps for a total of two weeks.

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[3] Peninsula Family Service is the contracted organization to conduct peer-led outreach to the older adult population for the Help@Hand project.

[4] The Help@Hand Advisory Committee is made up of behavioral health clients and family members, peers, BHRS staff, stakeholders from different county departments (e.g., Information Technology, Aging and Adult Services), community organizations, and behavioral health providers and peer-run organizations across the county.

Individuals who participated in the pilot stage also completed surveys about their experiences with the app; they were assessed both before and after the pilot period to determine whether engaging with the app was related to any increase in particular favorable outcomes, and/or whether unfavorable outcomes or risk factors decreased after engaging with the app.

RDA will also continue to conduct interviews and focus groups with behavioral health consumers as the County moves forward with app deployment and integration into BHRS system of care.

Data Analysis

To analyze the qualitative data, RDA transcribed interview and focus group participants' responses to capture their sentiments and perceptions. RDA then thematically assessed responses from all participants and identified recurring themes and key takeaways.

To analyze the quantitative data, RDA tabulated frequencies and percentages of app testers' demographic information (i.e., age group, assigned sex at birth, gender identity, race/ethnicity, sexual orientation, employment status, etc.) as well as app testers' responses to survey questions developed to elicit feedback about the overall usefulness of the app's functionality, feelings of isolation, and perceptions about mental health.

Evaluation and Program Findings

Through interviews and focus groups with key stakeholders, RDA explored the potential impacts of specific behavioral health apps on the target populations' mental health and well-being, as well as the potential of the Help@Hand project to meet the local learning goals. During 2020, there were a total of two rounds of app selections that took place. Table 2 presents a list of the apps that were explored during the reporting period of this evaluation and considered for the pilot phase of the project:

Table 3. Apps Under Consideration After 2nd Round of Selection: January 2020

Older Adults	Transition Age Youth
• MyStrength • Wysa • Happify	• Headspace • MyStrength • Wysa

Ultimately, Wysa was the app that both the older adult and TAY community members decided to move forward with, given that Wysa (a) demonstrated positive preliminary outcomes during the vetting process, which involved the Help@Hand Advisory Committee and focus groups with older adults and the Help@Hand Youth Advisory Group (b) met the community's needs in terms of app customization and functionality, and (c) was identified as the vendor who was willing to work with the county and community-based providers in making these customizations.

Outreach and engagement took place to recruit older adult and TAY participants willing to pilot the Wysa app further. Overall, 37 older adults and 16 TAY participated in the pilot and remained engaged in the feedback gathering process that spanned across a two-month period during FY 20-21.

The demographic characteristics of pilot participants by target population are presented in Table 4 below:

Table 4. Older Adult and TAY Wysa Pilot Participant Demographics

Older Adults	TAY
• Average 69 years old (range: 55 to 89 years) • 78% were female • Majority identified as White/Caucasian (83%) • 87% identified as straight/heterosexual • Most held a bachelor's or graduate degree (38%) • 52% reported no mental health challenges • 51% retired • 28% made under $30k per year	• Average 17 years old (range: 14 to 24 years) • 75% were female • Majority identified as Asian (50%), followed by Hispanic/Latino (38%) • 67% identified as straight/heterosexual • 81% were high school students • 43% reported no mental health challenges • 50% were students • Came from various households with a wide range of annual household incomes

Wysa Pilot's Learnings

A central objective of the Wysa pilot was to contribute to outcomes related to the local learning goals. The following sections provide an overview of how the pilot process contributed to each of San Mateo County BHRS Help@Hand learning goals.

Learning Goal 1: Can an app promote mental health wellness and reduce feelings of isolation?

It is important to note that the first learning goal was originally intended to assess whether the availability and implementation of technology-based mental health apps connect TAY in crisis and older adults experiencing isolation to **in-person** services. Early stakeholder input prioritized the importance of in-person support and raised concerns about the idea of a technology-based solution replacing in-person connections. During the first year of Help@Hand needs assessments that involved youth, San Mateo County youth crisis service providers and other stakeholders, it was determined that promoting an app to potentially support TAY in crisis was not the most effective way to provide the early intervention necessary when a youth is in crisis. The addition of peer-to-peer texting capacity and social media outreach to the county's 24-hour crisis intervention services for youth, was prioritized instead. Additionally, given the restriction on in-person activities after the onset of the COVID-19 pandemic, in-person services were not a feasible resource. During the pandemic, a greater concern arose regarding feelings of isolation among

both older adult and TAY populations. Therefore, the learning goals were modified accordingly to assess whether the Wysa app can promote mental health wellness and reduce feelings of isolation.

Based on findings gathered from the pilot focus groups and survey responses, there are promising initial results that suggest that apps such as Wysa promote mental health wellness for both the older adult and TAY populations. Participants from both target populations reported the benefits of the Wysa apps' ability to prompt the user to practice self-care habits.

Program staff reported that the Wysa app was useful for the older adult population to support and practice healthy self-care and sleeping habits. The older adult pilot participants particularly enjoyed the benefits of using the Sleep Stories feature of the Wysa app.

For TAY, the youths who participated in the Wysa pilot reported that they liked how the app gave them the opportunity to focus on their self-care practice, such as mindfulness. As one TAY pilot participant reported, "I really liked having the opportunity to use an app focused on mental health and mindfulness, since it was my first time." A large majority of both TAY (86%) and older adult (81%) participants found the self-care tools extremely or moderately useful. While users overall found the tool packs useful and enjoyed the content and variety of topics, some users found it challenging to locate the exact topics they were interested in and wanted more topics relevant to older adults and TAY. The Wysa app also has a journaling feature. The majority (93%) of the TAY participants reported using this feature and 57% found it extremely to moderately useful.

Impacts on Overall Mental Health Well-Being

To further assess whether the Wysa app is helpful in promoting mental health well-being, survey responses were also collected among TAY and older adult pilot participants. **Error! Reference source not found.** and **Error! Reference source not found.** below depict TAY and older adult responses to how they felt the app impacted them in terms of well-being, mental health stigma, and social connectedness.

Based on these survey results, the Wysa app seemed to promote mental health well-being after its use for both target populations. For TAY, a greater number of participants reported feelings of life satisfaction and balance after using the Wysa app. Additionally, a lower number of TAY reported feelings of nervousness most or all of the time after using the Wysa app. In the post survey, 93% of TAY users reported that the app made them feel like they have support when feeling down, anxious, or stressed. Further, 67% of TAY users reported that the app helped improve their mental health and wellness, and 60% reported that the app helped them with their daily life.

Among older adults, a greater number of participants reported that they often or always feel cheerful and hopeful after they used the Wysa app. A greater number of older adults also reported zero (0) days of feeling nervous, depressed, or stressed after they used the Wysa app. In the post survey, 56% of older adults reported that the Wysa app helped improve their mental health and wellness and that the app made them feel like they had support when feeling down, anxious, or stressed. Further, a little over half (53%) reported that the Wysa app helped them in their daily life.

Figure 2. Survey Responses from TAY Respondents about Well-Being (n = 16)

Well-Being, TAY

- Often/Always Feel Life is Satisfying: Before Wysa 38%, After Wysa 60%
- Often/Always Feel Balanced: Before Wysa 25%, After Wysa 53%
- Most/All of the Time Feel Nervous: Before Wysa 44%, After Wysa 13%

■ Before Wysa ■ After Wysa
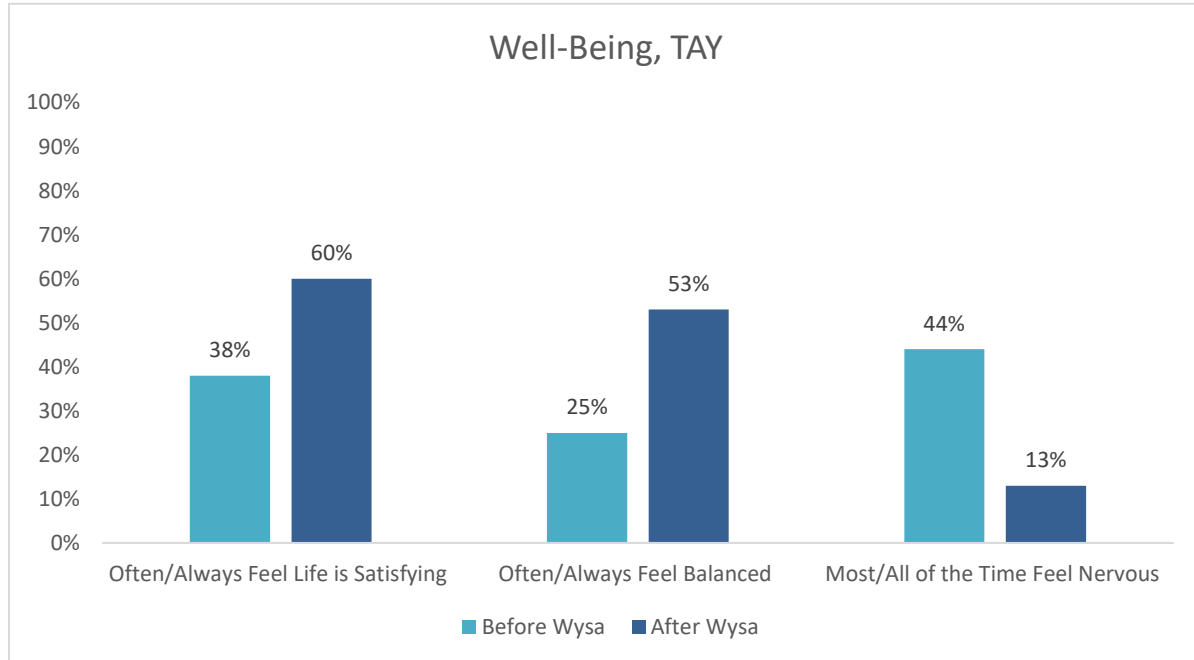
Figure 3. Survey Responses from Older Adult Respondents about Well-Being (n = 37)

Well-Being, Older Adults

- Often/Always Feel Cheerful: Before Wysa 60%, After Wysa 79%
- Often/Always Feel Hopeful: Before Wysa 62%, After Wysa 74%
- 0 Days Unable to Carryout Normal Activities Due to Feeling Nervous/Depressed/Stressed: Before Wysa 51%, After Wysa 77%

■ Before Wysa ■ After Wysa
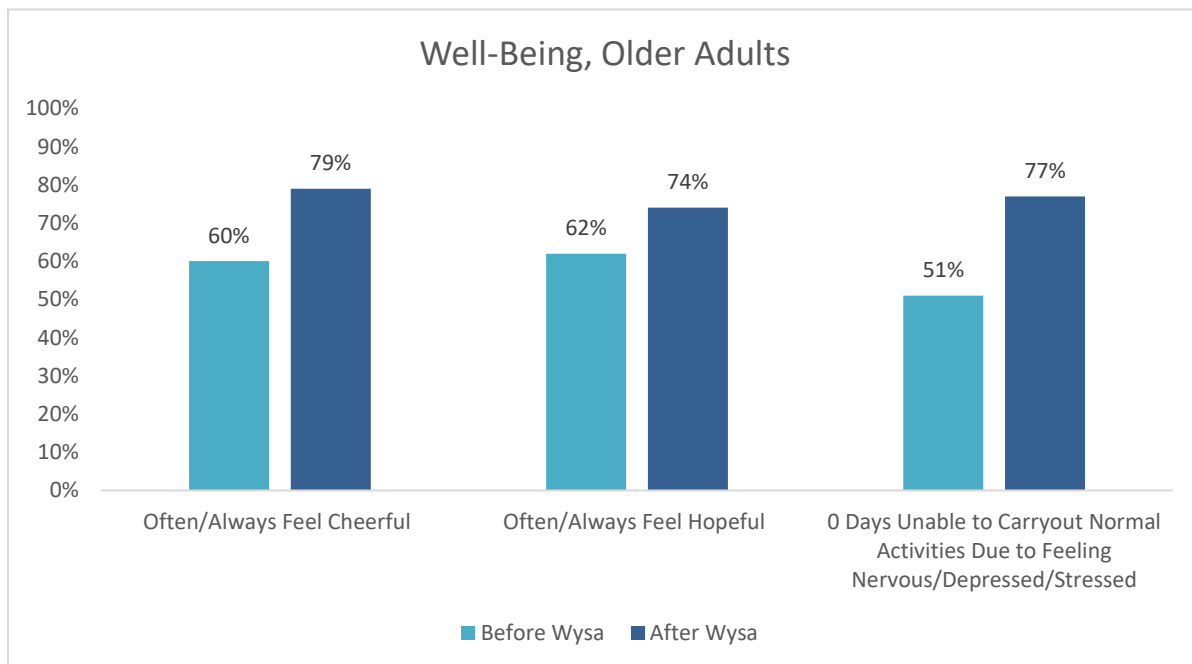
Mental Health Stigma

Mental health stigma seemed to decrease after TAY used the Wysa app. After using the Wysa app, all TAY agreed with the statements "Living with a mental illness made me a tough survivor," and "I can have a good, fulfilling life despite my mental illness." In contrast, among older adult participants, there was a slight decrease in positive measures related to self-stigma associated with seeking mental health services after using the app. These findings suggests that the app may have had less of an influence in decreasing mental health stigma for older adults.

Additionally, after the testing period, a greater proportion of TAY (47%) compared to older adult (31%) participants reported that they would reach out for help with their mental health and wellness because of using the app. Another indicator of help seeking behavior includes a greater self-awareness of when help might be needed, such as when symptoms related to mental health and wellness arise. A higher percentage of TAY (47%) compared to older adult (22%) participants in the post survey reported that they were more likely to detect symptoms related to their mental health and wellness. These findings suggest that the app may have had less of an influence on help seeking behavior in older adults.

An important learning lesson in collecting data related to mental health stigma arose during the pilot period. An older adult participant expressed that the mental health stigma questions in the pre-survey were triggering and led to emotional distress for them. After consultation with CalMHSA and partner evaluators at University of California, Irvine, and our local Help@Hand Advisory Committee, all but one of the negatively framed questions were excluded from the post survey. Additionally, an introduction was included in the survey to alert users to the potential triggering questions and offer supports as needed. Peers across the Help@Hand statewide collaborative, local stakeholders, and the San Mateo County Help@Hand Advisory Committee recommended that it would be important to include indicators that we can compare county and state-wide given that the negatively framed questions have been collected and reported in local and statewide large studies. For the TAY pre/post surveys, given this lesson learned, additional positive framed questions related to internalized stigma and stigma resistance were included.

Figure 4. Survey Responses from TAY respondents about Mental Health Stigma (n = 16)
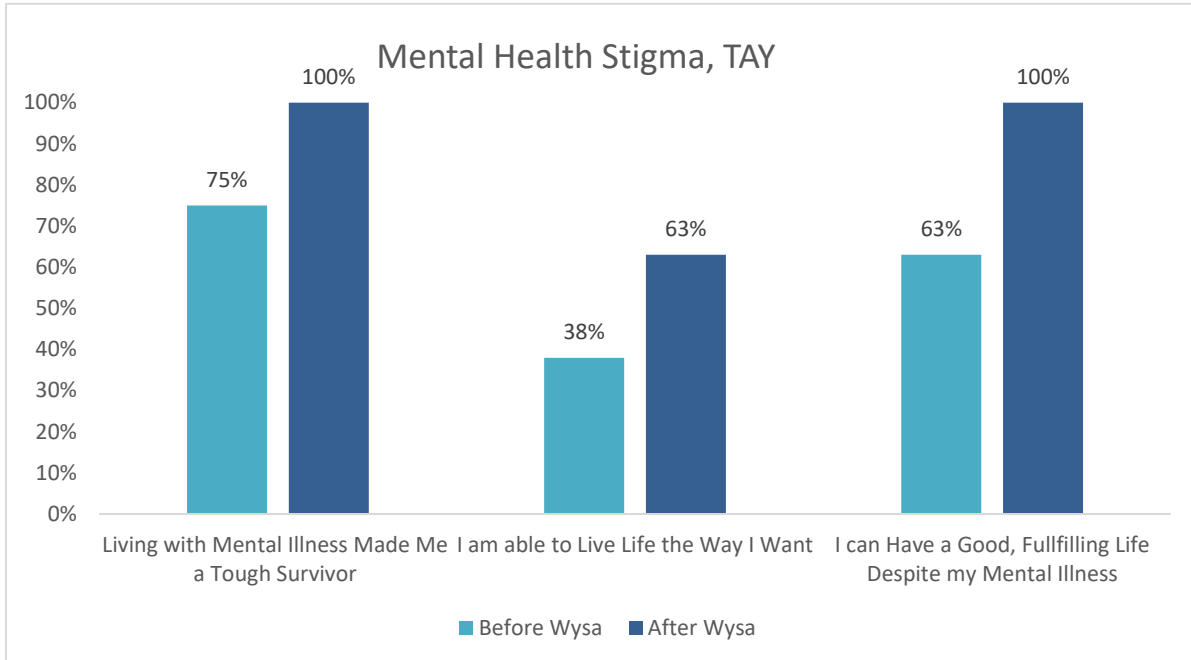
Figure 5. Survey Responses from Older Adult Respondents about Mental Health Stigma (n = 37)
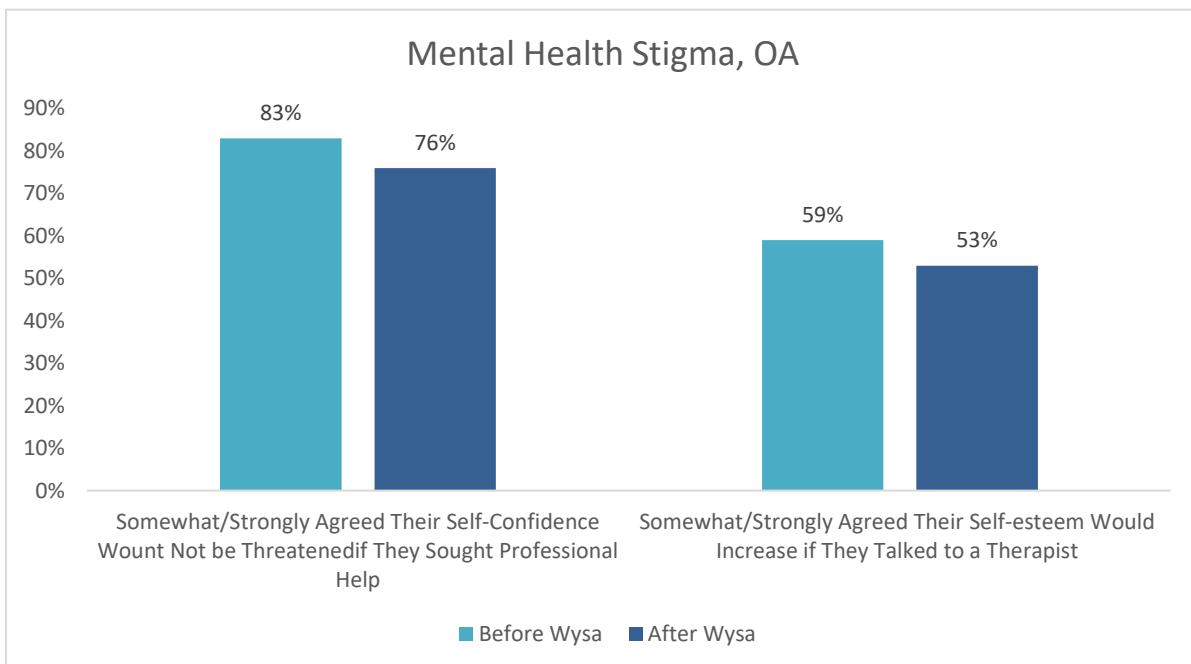
Connectedness

Findings from the focus group and survey data show initial promise that using an app like Wysa can reduce feelings of isolation and promote social connectedness. For TAY, one of the first positive outcomes that

staff highlighted from the piloting process was that the level of social connectedness increased after TAY participants' use of the app. Other benefits reported by the older adult program staff included Wysa's chatbot feature, which provides suggestions to the user and prompts them to carry out a specific wellness-oriented activity (e.g., positive affirmations, physical activity) in response to an issue that the participant reports while interacting with the chatbot. Program staff also noted that youth reported that the Wysa app provided youth a safe space to express any current issues or challenges that they were facing that day. Further, based on TAY participant feedback, program staff also noted that the Wysa app's chatbot features proved to be a valuable asset that TAY participants found helpful, especially after the onset of the pandemic.

Among survey respondents, a greater number of older adults compared to TAY pilot participants reported that they have two or more people they are close with and can depend on, hardly ever feel isolated and hardly feel left out. For both TAY and older adults, after using the app, a greater number reported they have two or more people they are close with and can depend on and that they hardly ever feel isolated. In the post survey results, only 20% of TAY and 29% of older adults agreed that the Wysa app made them feel connected to other people. TAY did see a modest decrease from 13% to 7% in the number of participants that hardly ever felt left out. It is also important to note that these numbers are already a small sample of TAY respondents.

Figure 6. Survey Responses from TAY Respondents about Connectedness (n = 16)
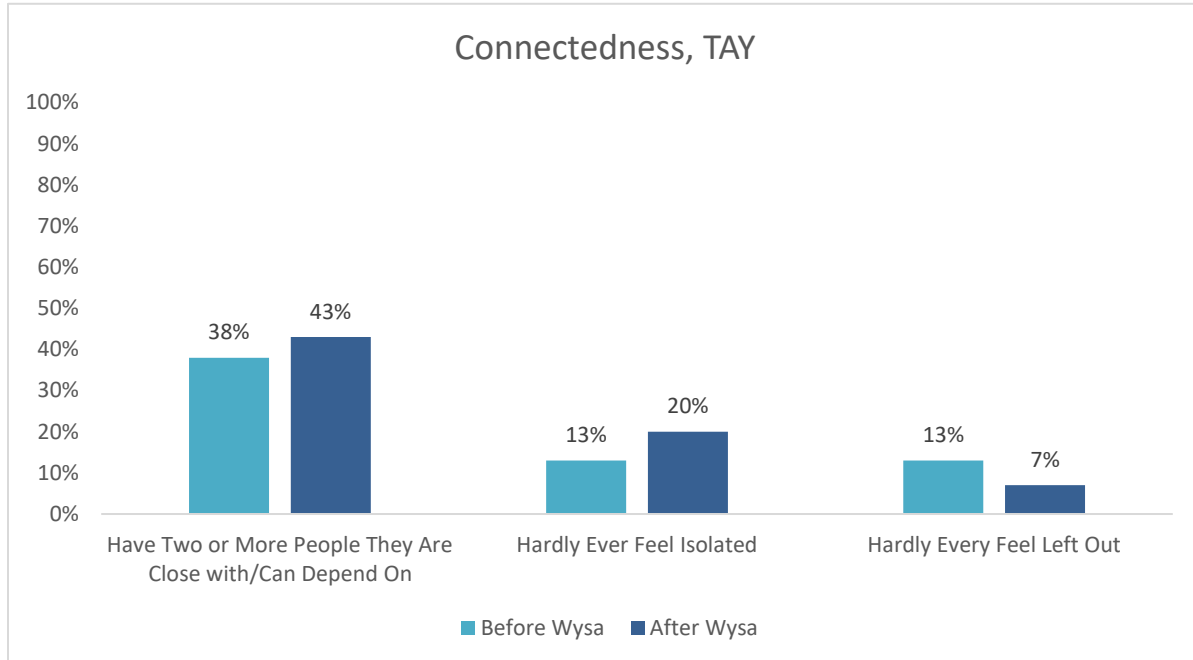
Connectedness, TAY

Figure 7. Survey Responses from Older Adult Respondents about Connectedness (n = 37)

Connectedness, OA
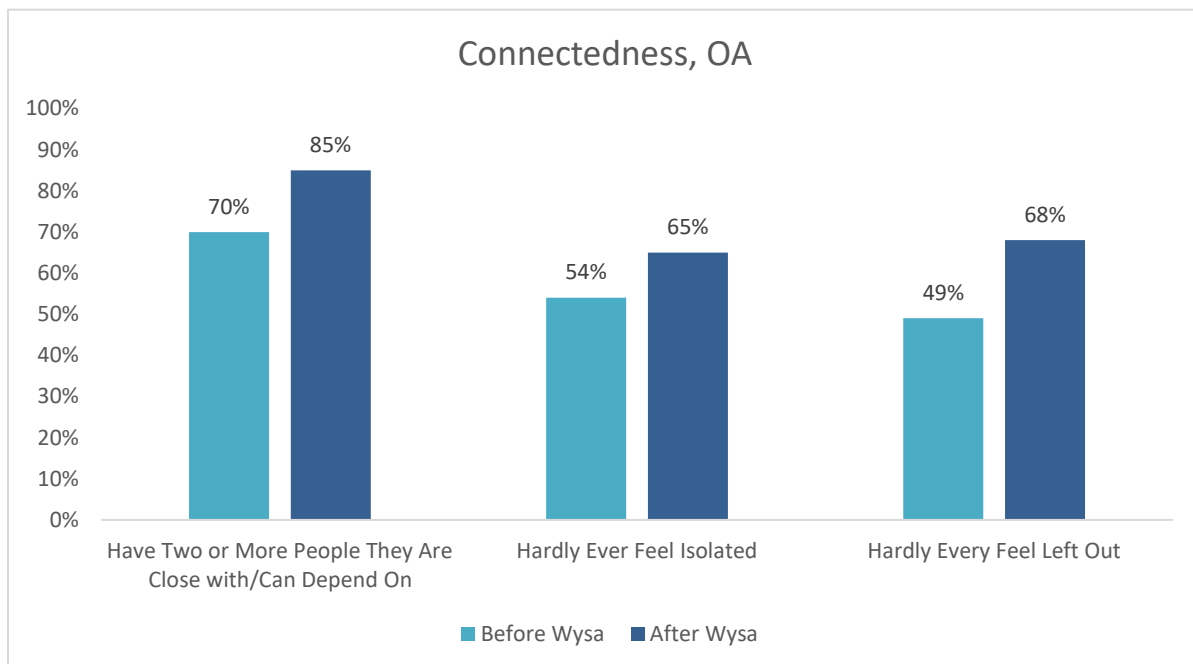
The Wysa app's secure and private chat functionality were also noted to enhance greater participation among TAY who may not otherwise engage in an in-person setting due to factors such as social anxiety or fear of being judged by peers. In Wysa, users can chat with an AI robot (i.e., chatbot), which then responds

and recommends several self-care practices, such as mindfulness or physical movement activities or other resources in response to the user's issues or challenges mentioned in the chat. These chat functionalities were noted to reduce feelings of isolation and enhance social connection. Program staff also noted that the TAY pilot participants seemed to value having access to chat-like features when using apps such as Wysa. In fact, 80% of TAY and 53% of older adult users found the chatbot to be extremely or moderately useful. Older adult users generally found the chatbot feature to be useful and enjoyed having a place to talk and share their feelings at any time of the day. They appreciated that the chatbot summarized what they wrote and referenced previous discussions.

Some users noted that the chatbot's responses felt generic, unhelpful, and redundant, particularly when they used more complex language. Some also found it challenging to type everything they were feeling. Recommendations to improve the chatbot function from both the older adult and TAY population include: expand the keywords to which the chatbot responds, offer more pre-populated responses to chatbot questions, improve the depth and variety of chatbot responses, offer users the option to save or discard their chat history, ask users during the chat if the information is helpful and direct them to other features or resources as needed, and offer customization options such as personalities, voices, characters, and chat colors.

Learning Goal 1: Does the availability and implementation of technology-based mental health apps connect transition age youth in crisis and older adults experiencing isolation to in-person services?

Learning Goal 1 Recommendations

1. Identify specific methods to engage TAY in ways that make them feel socially connected, as this app is promoted amongst youth for individual wellness.
2. Identify specific methods to reduce stigma amongst older adults related to mental illness and seeking help for mental health challenges.

Although these findings indicate that apps such as Wysa can promote mental well-being and may reduce some feelings of isolation, the Wysa app helps individuals promote these positive outcomes at an individual level. From the pilot evaluation, two considerations emerged related to this learning goal:

First, **continue to find ways to engage TAY in more group and social settings**. This is informed by the TAY survey findings where the connectedness survey item "Hardly Ever Feel Left Out" did not seem to improve after the use of the Wysa app and only 20% of TAY agreed that the Wysa app made them feel connected to other people. On the other hand, initial findings suggest an improvement in reducing mental health stigma and well-being. Given both the small sample of TAY participants surveyed and the mixed results, it

is important that program staff continues to focus efforts on engaging TAY in virtual settings, despite concerns that TAY may be less willing to engage in virtual social settings due to social anxiety. Some solutions include encouragement of using the chat functions in lieu of feeling pressure to verbally interact with a group in a Zoom meeting.

Second, **efforts should be made to address internalized stigma of mental illness and seeking mental health services among the older adult population to supplement the use of a wellness app such as Wysa.** Based on the mental health stigma survey responses after the use of the Wysa app, a fewer number of older adults somewhat or strongly agreed with seeking professional help and speaking with a therapist that wouldn't put their self-esteem or confidence in jeopardy. Further, only 31% agreed that they were likely to seek help for their mental health and wellness because of using the Wysa app.

Learning Goal 2: Does engaging with the app promote access to mental health services and supports?

Learning Goal 2 Recommendations
1. Capitalize on TAY's willingness to seek additional help for their mental health and wellness, as well as their desire to connect with other youth. Ensure that the local resources are included in the Wysa app so that they can stay connected.
2. Continue to focus efforts on normalizing seeking mental health services and supports in the community, as well as the use of wellness apps among the Older Adult population by featuring other Older Adults modeling this behavior in media and other marketing materials and peer support networks to promote the app. Realistic and accurate portrayals to represent Older Adult community members is important, especially when destigmatizing the pursuit of mental health resources and services among this population.

Although there is more evidence to suggest that the Wysa app promotes access to mental health services and supports, it is important to note that this evaluation is a study of a small sample of participants and most participants did not use app feature to seek additional resources if needed. Further evaluation will be needed to fully assess whether the Wysa app promotes greater access to mental health services and supports.

The Wysa app does offer users a high level of accessibility to its services and resources. Participants noted that the Wysa app provides access that is uniquely available 24 hours per day, and that virtual access, while not a replacement for in-person services, is particularly important at this time given the challenges of social isolation due to COVID-19. The Wysa app offers an "SOS" feature where users can seek out additional resources if needed. During the pilot process, almost two-thirds of the TAY and older adult participants did not use the SOS feature over concerns that this feature would contact emergency services

immediately. Among the users that did use this feature, only 34% of TAY and 9% of older adult users found this feature to be extremely to moderately helpful.

One primary recommendation that came out of this process is to ensure that the Wysa app will include local county resources that users can access if additional services are needed. BHRS is working with the Wysa app developers to include local resources to facilitate connections to mental health supports for those who do engage with the apps, should they be interested in exploring services beyond the app itself. The ability to customize a local resource option aside from the SOS feature will continue to be a priority of BHRS to ensure the apps promote access to further supports.

From a usability standpoint, the Wysa app appears to be easy and intuitive to use and navigate. All of the TAY and 88% of older adults agreed that the app's language was easy to understand. Further, 93% of TAY and 88% of older adults agreed that the app was easy to use. Lastly, 87% of TAY and 69% of older adults reported that they would recommend using the app to others. The availability of the app's content in various languages continues to be a concern among stakeholders. Stakeholders noted that BHRS did not identify a minimum viable product language requirement,[5] and that they are concerned about moving forward with an app that has limited, or no, features for monolingual Spanish or Chinese speakers given the strong presence of these communities in San Mateo County. BHRS had initially hoped to include monolingual Spanish and Chinese speakers as target populations; however, they realized early in the Help@Hand project that they did not have the capacity to have priority populations in addition to older adults and TAY. However, reaching these two subgroups within the older adult and TAY populations continues to be an expressed interest of a number of stakeholders involved in San Mateo County's Help@Hand project. To address concerns, the Wysa app developers are currently working on a Spanish version of the app for future testing.

TAY Population

Given the results from the survey that was completed by the TAY pilot participants, there is some evidence to suggest that TAY users would be more willing to seek help for their mental health and wellness because of using the Wysa app, and that seeking help would not negatively impact their confidence and self-esteem. Therefore, one of the critical components of developing the Wysa app for this population should ensure that local resources within San Mateo County are included as part of the app for TAY, should users from this target population have a desire to seek additional help. This is also crucial for TAY users, given that using the app itself did not seem to decrease their feelings of being left out after its use.

Older Adult Population

While older adults slightly increased in their feelings of social connection and reduced their feelings of isolation after using the app, this population did not seem to increase in their willingness to seek additional

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[5] A minimum viable product is the most basic version of a product that will still satisfy users. In this case, the minimum viable language requirements are the languages that the apps must offer to meet the fundamental linguistic needs of the target populations.

help for their mental health and wellness, based on survey findings. Therefore, it is important that the Wysa app continues to also be developed in ways that incorporate older-adult-specific topics that are relevant for this population. Further, it is important that marketing and promotion efforts of this app help to destigmatize and normalize the use of this app in terms of seeking additional mental health and wellness resources among this population. Strategies to normalize the app using and help-seeking behavior among the Older Adult population is through app demonstrations and modeling these behaviors in marketing and promotion materials and among other Older Adult peers in peer support networks.

Learning Goal 3: Does engaging with the apps effectively promote wellness and recovery for individuals living with mental health challenges?

Learning Goal 3 Recommendation

1. Ensure future consumer engagement activities include representation from older adults of diverse age ranges, to understand the different wellness and recovery needs of this population.

Given what was learned for Learning Goals 1 and 2 during FY 20-21, this learning goal will be of particular focus as the project moves into a testing stage for San Mateo County BHRS clients. In previous focus groups, stakeholders noted that behavioral health apps are one of many supports for individuals in their wellness and recovery. One member of the Advisory Committee commented that apps are "a tool in the toolbox, not the only solution." Stakeholders generally felt that it is helpful to have more options for individuals to address and support their mental health, and that the Wysa app should provide additional resources local to the community.

Key Program Implementation and Operational Learnings

From the evaluation activities, the three key program implementation and operational learnings were identified. Key learnings are described in detail in the sections that follow

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Key Learnings

1. **Ensure local resources are included in the Wysa app and social inclusion efforts are enhanced for** TAY as a supplement to using the Wysa app for wellness supports.
2. **Ensure that the Wysa app includes mental health and wellness topics that are relevant** to older adults, TAY, and for specific target populations throughout the county.
3. **Continue to focus on** accurate and realistic portrayals of Older Adult consumers to promote seeking mental health and wellness services among this population.

Finding 1: Ensure local resources are included in the Wysa app and social inclusion efforts are enhanced as a supplement to using the Wysa app for wellness supports.

Based on survey findings, TAY were less likely to report feeling socially included after using the Wysa app. Coupled with the finding that TAY users were more likely to seek additional help for their mental health and wellness, it is important that the Wysa app includes local resources to mental health and wellness services for TAY to feel more connected. In addition, it is important for stakeholders to identify additional ways to socially engage TAY consumers in activities that supplement the app's use. Recommendations from focus groups included the suggestion that holding virtual social events such as Bingo or raffles to incentivize users to continue using the app while also socially engaging users could be impactful.

Finding 2: Ensure that the Wysa app includes mental health and wellness topics that are relevant to older adults, TAY, and for specific target populations throughout the county.

As the Wysa app continues to be developed and customized to fit the needs of the County's target populations, it is important that topics and resources relevant to specific target populations are included to enhance accessibility and representation, as well as to reduce the stigma of seeking mental health services and supports. While both older adults and TAY do report that the Wysa app was helpful with increasing self-care habits, such as meditation and sleeping, both groups reported that they would like to see more

> "It was a really good experience overall and I learned a lot of things. It was also rewarding to see and hear other people's experiences reviewing the app."
> - TAY Pilot Participant

topics included in the app that are relevant to their specific population. For example, TAY participants reported that they would like to learn more about how to handle procrastination. Other recommendations included improvements related to being more culturally relevant, such as including topics that focus on wellness, self-care, and resiliency within minority communities Making the app more culturally relevant and accessible to Spanish speakers, which is another target population in San Mateo County. Wysa's developers are currently working on a Spanish version of the app.

Finding 3: Continue to promote the app in peer networks and promotional materials by featuring accurate and realistic portrayals of Older Adults modeling app-usage and help-seeking behaviors.

> "The Wysa app was useful for the older adult population to support participants to practice healthy self-care and sleeping habits."
> - Program Staff

Based on post-pilot survey findings, older adults were less likely to seek additional help for their mental health and wellness because of using the app, despite feeling a little more socially connected and supported in their mental health and wellness after using the app. These findings suggest that stigma remains a major factor among the Older Adult population when it comes to using an app related to mental health and wellness. However, in the interest of targeting our efforts in promoting the app, we must first identify the many underlying reasons why this stigma remains within the Older Adult population, such as: not having the knowledge and skills of using mobile devices and app technology, not being connected with others who can help them use this technology, the app's content focusing on mental health and wellness, reluctance to seek mental health and wellness resources, or any of these reasons combined. This is reflected in the finding discovered from an Older Adult program staff focus group, where it was noted that the participants who engaged in the app's piloting process may have been more relatively technologically savvy than other Older Adults representative of the community. Additionally, staff indicated that there are other Older Adults who may be at even greater risk of social disengagement and social isolation, remain reluctant to seek mental health and wellness resources, and may be even more reluctant if they are not digitally connected and have negative perceptions of mental illness. One future challenge that Older Adult program staff foresee is the ability to conduct outreach and engagement around using the Wysa app among the vast number of Older Adults who are currently not connected digitally at all. Therefore, the next steps for the Older Adult program as the county adopts the Wysa app for implementation is to continue to outreach and engage Older Adults who are unfamiliar with the use of mobile devices and app technology, who may be at significant risk of social disengagement and isolation, and who do not normally seek mental health services and supports. For this Older Adult population, there may be an even greater reluctance to use a mental health and wellness app for multiple reasons based on perceived or real barriers related to technology use and/or seeking help. Therefore, it is possible that this population continues to experience an even greater stigma when it comes to seeking mental health and wellness services, as well as possibly feeling as though using technology such as an app to achieve this goal might be irrelevant to them. To address these concerns, the plan for Older Adult programs moving forward is to collaborate with community partners to promote the app in places where Older Adults seek other types

of services that address other Social Determinants of Health (e.g., food bank, housing, employment, education, etc.). Another recommendation that arose from an Older Adult Focus Group that can help break down the barrier of reluctance to use the app was to develop a Wysa Ambassador Program, in which Older Adults can assist their fellow peers by conducting Wysa app trainings, either in person or developing videos featuring an Older Adult demonstrating the use of the Wysa app. The benefit of featuring other Older Adults model app-using behavior can destigmatize and normalize using the app, despite one's age. Additionally, de-stigmatizing and normalizing help-seeking behavior among Older Adults is important and should also be demonstrated in both peer networks and in marketing and promotional materials for the app. Marketing and promotion efforts should also feature Older Adults using the section of the app that contains the county's local resources for mental health and wellness and should feature Older Adults reaching out to one of those local resources to seek help. Therefore, it is important that efforts to engage older adults in using the Wysa app to support their mental health and wellness continue, as well as efforts to reduce stigma associated with seeking mental health services. These efforts may enhance older adults' willingness to download and use the app and have a greater connection to the local resources and supports that San Mateo County has to offer among this harder to reach population.

Future Directions

San Mateo County is purchasing 7,000 Wysa app licenses for older adults and TAY who live, work, or go to school within San Mateo County. San Mateo County has also hired a marketing consultant to promote the app's usage to its target audiences. Over the next fiscal year, San Mateo County will continue to work with the Wysa app developers to tailor the app based on stakeholder feedback gathered during the pilot process. From there, San Mateo County plans to test the Wysa app with consumers who are currently receiving services throughout the county. This will allow us to further assess whether the Wysa app is effective in achieving our learning goals and to obtain feedback from a much larger group representative of the consumer population. RDA will support this process by developing an evaluation framework that ensures data collection activities gather information to continue to build a deeper understanding towards San Mateo County BHRS's local learning goals.

Based on current findings, future efforts and research are needed to identify other best practices to increase social engagement among the TAY population in ways that are safe, adhere to social distancing guidelines, enhance their mental health and wellness, and enact strategies to mitigate any other barriers or stigmas to achieve this goal. For Older Adults, more research is needed to focus on the various stigmas experienced within this population in order to tease apart the possible reasons as to why older adults, especially those between the ages 75 to 90,might be reluctant to seek mental health and wellness resources, and whether using an app in the first place might be associated with this reluctance. For instance, is the stigma experienced within the Older Adult population associated with the use of the app itself, the use of the app because of its content related to mental health and wellness, seeking help related to mental health and wellness in general, or any of these reasons combined?

The considerations and key learnings provided in this report are positioned to help guide project activities over the next fiscal year. San Mateo County will continue to lean on the identified strengths, including the

robust advisory committee, opportunities for collaboration with local and statewide stakeholders, and the strong internal peer network they have developed. BHRS can also identify opportunities to address the emerging barriers, including establishing an ongoing shared understanding of the project goals and requirements amongst all key stakeholders; recruiting a diverse consumer sample to participate in further testing of the Wysa app and qualitative data collection activities; and ensuring the behavioral health technology can effectively meet the current needs of the target populations. With these considerations in mind, San Mateo County is strongly positioned to move into the deployment stage of the Help@Hand project and to continue to employ a BHRS integration process that is thoughtful, responsive, and consumer centered.

San Mateo County Pride Center
Final MHSA Innovation Evaluation Report

San Mateo County Pride Center
Final MHSA Innovation Evaluation Report

Alison Hamburg, MPH, MPA

Stephanie Bimar, MA

Nimisha Narayanan, BS

Acknowledgments

The San Mateo County Pride Center—partner organizations StarVista, Peninsula Family Service, and Outlet—have demonstrated unparalleled dedication and engagement to serving the LGBTQ+ community in San Mateo County. Over the five years of the MHSA Innovation project, the Pride Center has shown up with a consistent commitment to gathering data and learning about what the Pride Center has done well and what it could improve. Pride Center staff provided data, time, and interpretation to strengthen the evaluation.

Participants and clients of the Pride Center have been incredibly generous in opening up about personal experiences with mental health services before and after the Pride Center, sharing perspectives about Pride Center programs and services, and offering insights to continually improve the way the Pride Center and San Mateo County serve, include, and lift up the LGBTQ+ community.

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Introduction

Project Description

The San Mateo County Pride Center is an Innovation (INN) program under the Mental Health Services Act (MHSA) that is funded by the San Mateo County Behavioral Health Recovery Services (BHRS) department. The San Mateo County Pride Center (Pride Center or the Center) is a formal collaboration of three partner organizations: StarVista, Peninsula Family Service (PFS), and Adolescent Counseling Services (ACS).

- **MHSA INN Project Category:** Introduces a new mental health practice or approach.

- **MHSA Primary Purpose:** 1) Promote interagency *collaboration* related to mental health services, supports, or outcomes and 2) Increase *access* to mental health services to underserved groups.

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

Pride Center Learning Goals	Learning Goal 1 (Collaboration): Does a coordinated approach improve service delivery for LGBTQ+ individuals at high risk for or with moderate to severe mental health challenges?
	Learning Goal 2 (Access): Does The Pride Center improve access to behavioral health services for LGBTQ+ individuals at high risk for or with moderate or severe mental health challenges?

As a coordinated service hub that meets the multiple needs of high-risk LGBTQ+ individuals, the Pride Center offers services in three components:

1. *Social and Community Activities*: The Pride Center aims to outreach, engage, reduce isolation, educate, and provide support to high-risk LGBTQ+ individuals through peer-based models of wellness and recovery that include educational and stigma reduction activities.

2. *Clinical Services*: The Pride Center provides mental health services focusing on individuals at high risk of or with moderate to severe mental health challenges.

3. *Resource Services and Training*: The Pride Center serves as a hub for local, county, and national LGBTQ+ resources. Pride Center staff host year-round trainings and educational events for youth, public and private sector agencies, community service providers, and other community members. Common topics include understanding sexual orientation and gender identity, surveying common LGBTQ+ issues and mental health challenges, and learning how to provide culturally affirmative services to LGBTQ+ clients.

Summary of Need

Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, and other (LGBTQ+) individuals commonly experience depression, anxiety, suicidal thoughts, substance use, homelessness, social isolation, bullying, harassment, and discrimination. LGBTQ+ individuals are at higher risk of mental health issues compared to non-LGBTQ+ individuals given that they face multiple levels of stress, including subtle or overt homophobia, biphobia, and transphobia.[1] Across the United States, a majority (70%) of LGBTQ+ students report having experienced harassment at school because of their sexual orientation and/or gender identity, and suicide is the second leading cause of death for LGBTQ+ youth ages 10-24.[2]

These nationwide trends are no less evident in San Mateo County. According to the San Mateo County LGBTQ Commission's 2018 countywide survey of 546 LGBTQ+ residents and employees, nearly half of adult respondents (44%) identified a time in the past 12 months when they felt like they needed to see a professional for concerns about their mental health, emotions, or substance use. At the same time, 62% of adult respondents felt that there were not enough local health professionals adequately trained to care for people who are LGBTQ+, and fewer than half (43%) felt their mental health care provider had the expertise to care for their needs. Among LGBTQ+ youth who responded to the survey, three-quarters (74%) reported that they had considered harming themselves in the past 12 months, and two-thirds (65%) did not know where to access LGBTQ+ friendly health care.[3]

In this context, BHRS developed the San Mateo County Pride Center as a coordinated behavioral health services center to address the need for culturally specific programs and mental health services for the LGBTQ+ community. The establishment of the Pride Center also fulfills the MHSA principle to promote interagency collaboration and increase access to mental health services for underserved groups.

Project Timeline and Implementation Update

This report covers the full period of Pride Center implementation from June 1, 2017 – June 30, 2021. The Mental Health Services Oversight and Accountability Commission (MHSOAC) approved the project on July 28, 2016. In fiscal year (FY) 2016-17, the Pride Center undertook foundational activities related to the planning and startup of the Pride Center (see Figure 1). The Pride Center secured a site in December 2016 and was in a period of "soft opening" from March through May 2017. The Pride Center opened to the public on June 1, 2017. In March 2019, the MHSOAC unanimously approved a two-year funding extension for the Pride Center as an MHSA Innovation Program, with the goal of strengthening internal and countywide collaboration efforts, measuring clients' clinical outcomes, and develop a set of best practices for others to replicate the Pride Center's service delivery model.

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[1] King, M., Semlyen, J., Tai, S. S., Killaspy, H., Osborn, D., Popelyuk, D., & Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self-harm in lesbian, gay and bisexual people. BMC Psychiatry, 8:70
[2] GLSEN, *2017 National School Climate Survey*; The Trevor Project, "Facts About Suicide."
<<https://www.thetrevorproject.org/resources/preventing-suicide/facts-about-suicide/>>
[3] San Mateo County LGBTQ Commission, "Survey Results of San Mateo County LGBTQ+ Residents and Employees," 2018 ed.

Figure 1. Pride Center Implementation Timeline

Start-Up (July 2016-March 2017)
- StarVista and its partner agencies identified and secured a site centrally located in downtown San Mateo
- The Pride Center identified and obtained start-up items and systems: furniture, computers, office supplies, décor, etc.
- The Pride Center hired its key staff members

Opening (March-June 2017)
- The Pride Center launched supportive social and educational community events and activities (soft opening)
- The Pride Center conducted outreach, education, and community engagement to prepare for its Grand Opening
- The Pride Center held its Grand Opening and Ribbon Cutting Celebration

Full Operation (June 2017-June 2019)
- Regular drop-in hours
- Multiple peer support groups
- Widespread training
- Clinical services

Innovation Extension (July 2019-June 2021)
- Collected clinical data
- Expanded countywide trainings and collaboration
- Adapted to remote services during COVID
- Developed best practice toolkit

Changes to Innovation Project

Initially, when BHRS released its request for proposals (RFP) for the administration of the Pride Center, BHRS was concerned that the applicants did not demonstrate the capacity to effectively serve the community of interest, thus BHRS did not award the grant at this point and instead re-released the RFP. The second time, five partner agencies applied as a collaborative: StarVista, a San Mateo County mental health nonprofit, as the lead agency, along with Daly City Partnership, Peninsula Family Service, Outlet–a Program of Adolescent Counseling Services, and Pyramid Alternatives.

There were some changes to the composition of partner agencies during the project. FY2016-17, Pyramid Alternatives merged with StarVista. In FY2019-20, the director of the Daly City Partnership transitioned out of their position, and without the presence of the Director, Daly City Partnership made the decision to withdraw from the collaborative model. Given that the Pride Center no longer had a partner agency located in North County, Pride Center staff examined the needs in North County and strategized to fill this gap by developing targeted outreach plans and strengthening existing connections and referral pathways to service providers and resources in that area (e.g., Daly City Youth Health Center).

Evaluation Overview

Learning Goals and Evaluation Questions

In accordance with the requirements for MHSA INN programs, BHRS selected two Learning Goals—Collaboration and Access—as priorities to guide the development of the Pride Center. BHRS sought to explore how this innovative model of coordinated service delivery and community engagement could enhance access to mental health services within underserved LGBTQ+ populations, particularly for individuals at high risk for, or with, acute mental health challenges. In turn, the program domains of Collaboration and Access are areas in which the Pride Center might serve as a model to expand of mental health services for LGBTQ+ individuals in other regions.

BHRS contracted Resource Development Associates (RDA) to conduct the evaluation of the Pride Center implementation and outcomes. RDA collaborated with BHRS and Pride Center leadership and staff to develop data collection tools measure program and service outcomes. To maximize RDA's role as a research partner and fulfill MHSA Innovation evaluation principles, the evaluation used a collaborative approach throughout, including Pride Center staff and partners in operationalizing the evaluation goals into measurable outcomes and interpreting and responding to evaluation findings.

BHRS sought to learn how the Pride Center enhanced access to culturally responsive services, increased collaboration among providers, and, as a result, improved service delivery for LGBTQ+ individuals at high risk for or with moderate to severe mental health challenges. To guide the evaluation, RDA and BHRS developed evaluation questions in three categories (see Figure 2).

Figure 2. Evaluation Domains and Questions

Process: Services and Operations

- To what extent is the Center reaching its intended target population and numbers?
- What activities and services does the Center provide in the social and community, clinical, and resource components?
- What successes and challenges has the Center experienced in implementing services as designed?
- To what extent are Center staff prepared to provide services that are culturally responsive to the LGBTQ community?

Outcomes: Collaboration and Access

- To what extent does the Center improve communication, coordination, and referrals for LGBTQ individuals at high risk for or with moderate or severe mental health challenges?
- To what extent does the Center improve access to behavioral health services for individuals at high risk for or with moderate or severe mental health challenges?

Outcomes: Service Delivery

- To what extent do clients experience the Center's services as helpful, culturally responsive, and reflective of MHSA values?
- Do clients receiving clinical services experience improved behavioral health indicators from intake to closure?

Evaluation Methods

The mixed methods evaluation incorporated both a process evaluation (what services were provided and how well) and an outcome evaluation (the extent to which the project contributed to positive changes). The evaluation team used the following quantitative and qualitative data sources to explore the evaluation measures listed in Table 1.

Quantitative Data

- Attendance and demographic reporting collected on an ongoing basis
- Participant Experience Survey administered annually
- Clinical Assessment collected at intake, six-month follow-ups, and exit
- Client Self-Assessment collected at intake, six-month follow-ups, and exit
- Staff Collaboration Instrument[4]

Qualitative Data

- Focus groups and interviews with Pride Center participants annually
- Focus groups with Pride Center staff, partners, and Community Advisory Board annually
- Interviews with Pride Center and partner agency leadership annually
- Interviews with external partner agencies in FY2020-21

Table 1. Evaluation Measures

Outreach and Implementation of Services
Number of individuals reached
Types of activities and services provided in the social and community, clinical, and resource components
Successes and challenges of implementing services as designed
Cultural responsiveness of services
Collaboration and Access to Services
Effectiveness of communication, coordination, and referrals for LGBTQ+ individuals with moderate to severe mental health challenges
Improved access to behavioral health services for individuals with moderate to severe health challenges
Service Delivery Outcomes
Client service experience (e.g., experience with services, facility, and service providers)
Improved health outcomes among clients

Data Analysis

To analyze the quantitative data from demographic data and clinical data, RDA examined frequencies and ranges. To analyze qualitative data, RDA transcribed focus group and interview participants' responses to appropriately capture the responses and reactions of participants. RDA thematically analyzed responses from participants to identify commonalities and differences in participant experiences within and across demographic characteristics and identity groups. It should be noted that the number of baseline and follow-up clinical assessments represented a small proportion of clinical clients and therefore should not be generalized to all clients.

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[4] After reviewing results and consulting with BHRS staff, the evaluation team determined that the data provided by the survey was not as relevant to the evaluation as initially intended and discontinued its use in FY19-20.

Population Served

This section presents the number of participants served by the Pride Center in two ways:

- **Non-clinical reach**: The Pride Center reported demographic information for participants in trainings, social events, drop-in hours, and peer support groups. These numbers are duplicated.
- **Clinical participants**: The Pride Center collected individual-level data for each participant in therapy and/or case management. The number of clinical clients is unduplicated.

Table 2 below shows the Pride Center's **reach** over the course of implementation. FY2016-17 was a startup year; the numbers represent the Pride Center's inaugural "30 Days of Gay" in June 2017. FY2019-20 services were partially online and FY2020-21 services were fully online and there were some challenges documenting the total numbers served. Therefore, the Pride Center estimates they served more people than were counted. In all, the Pride Center reached at least 2,000-3,000 people per year through trainings, social events, drop-in hours, and peer support groups.

Table 2 also shows the unduplicated **clinical participants** in each fiscal year beginning in FY2017-18. Because some clients received services for multiple years, the numbers are duplicated across fiscal years. The Pride Center increased its clinical capacity over the years, from 93 clients in the first year of clinical services to 169 clients in the most recent year—which included the transition to telehealth services. The total unduplicated number of clinical clients served across all fiscal years was 395.

BY THE NUMBERS: FY2020-21

2,000+

Participants served through clinical, social, training, and drop-in services

169

Unique individuals received clinical services

2,700

Hours of clinical services delivered

359

Community members served across 10 different peer support groups

300+

LGBTQ+ older adults contacted on a regular basis via emails, calls, and support groups

Table 2. Count of Participants by Fiscal Year

	FY2016-17 (startup)	FY2017-18	FY2018-19	FY2019-20	FY2020-21
Duplicated Count of Non-Clinical Participants	1,197	3,056	3,000*	3,395	2,312
Unduplicated Count of Clinical Participants	N/A	93	153	132	169

* Approximate count

Participant Demographics

Below are key highlights and trends from the demographic information from non-clinical participants and clinical clients.[5,6,7] Full demographic data tables are included in the Appendix.

Table 3. Demographic Highlights and Trends

	Non-Clinical Participants	Clinical Participants
Age	• Between 30-40% of participants each year were youth and transition age youth • Between 50-60% were adults ages 26-59 • Between 8-10% were adults age 60 and older	• Compared to non-clinical participants, clinical clients were younger—49% were youth or transition age youth • Fewer older adults were served in clinical services (5%)
	County Comparison: • *The Pride Center saw a lower percentage of older adults than represented in the county (17% of the county is age 65 and older)*	
Race	• Over 50% of participants each year identified as either multiracial or people of color—about 60% of participants in FY2017-18 and 2018-19, and a lower proportion (51%) in FY2019-20 • Between 50-60% of participants each year identified as White, with this proportion increasing over time (46-51% identified as White only)[8] • Hispanic/Latinx was the next highest racial group served (21-23% each year), followed by Asian or Asian American (17-20%)	• Compared to non-clinical participants, the proportion of clinical clients who identified as White only was lower (40%) • The proportion Latinx clients in most years was higher (29-34%) and declined somewhat in FY20-21 (24%) • The proportion of Asian or Asian American clients was lower (11%)
	County Comparison: • *The Pride Center saw a higher percentage of non-clinical participants who were White and a similar percentage of clinical participants who were White compared to the county overall (39% of the county identified as only White)* • *The Pride Center saw a lower percentage of Asian participants (31% of the county, vs. around 18% of Pride Center participants and only 11% of clinical clients)* • *One-quarter (24%) of county residents are Hispanic or Latino/a/x, which is nearly consistent with Latinx representation at the Pride Center (21%). An even higher proportion of clinical clients identified as Latinx (26%)* • *While only around 6% of Pride Center participants identified as Black, this is higher than the percentage of Black residents in the county (3%)* • *Native Hawaiian, Pacific Islander, Native American, and Alaska Native participants were represented at rates comparable to the population of San Mateo County (2% and 1% of county residents, respectively)[9]*	

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[5] Demographic data for non-clinical participants was available from FY2016-17 through FY2019-20. Data from FY2020-21 was not available because of data limitations resulting from the COVID-19 pandemic. In the analysis of trends over time, data from FY2016-17 are not included because the Pride Center had only been open for one month at that point. It is also important to note that the latter part of FY2019-20 was during the COVID-19 shelter-in-place, therefore it is likely that not all participants are represented.

[6] Demographic data for clinical clients was available beginning in FY2017-18 (when clinical services began) and continuing through FY2021-21.

[7] The Pride Center made several modifications to the demographic form in 2019 to expand response options available. Therefore, some data is not comparable across years.

[8] Because participants could select more than one race, over half of participants identified as White and over half identified as another race.

[9] "U.S. Census Bureau Quick Facts: San Mateo County, California," *U.S. Census Bureau website.*
<<https://www.census.gov/quickfacts/sanmateocountycalifornia>>

	Non-Clinical Participants	Clinical Participants
Sex	• A majority of participants each year identified their sex at birth as female (55-61%)	• A majority of clinical clients identified their sex at birth as female (56%) and 44% responded that they were assigned male at birth
Gender Identity	• A majority of participants identified as cisgender (between 62-69%) and about 36% identified as transgender/gender expansive • Cisgender women made up about 40% of participants each year • Cisgender men and transgender or genderqueer/gender nonconforming participants were the next highest groups, each making up somewhat even proportions of participants (between 20-30%)	• Compared to non-clinical participants, there was a higher percentage of transgender clinical clients • 43% of participants identified as cisgender; 49% identified as transgender, genderqueer, or gender non-conforming • There was a slight increase during FY2020-21 in clients who identified as either nonbinary or questioning or unsure about their gender identity
Sexual Orientation	• LGBQ+ individuals made up over 70% of participants; the percent identifying as heterosexual was between 20-30% each year • Around 30% of participants each year identified as gay or lesbian • The percent identifying as bisexual more than doubled from FY2017-18 (9%) to FY2018-19 (21%) • Around 20% of participants each year identified as queer or pansexual, with this percentage increasing over time	• Compared to non-clinical participants, there was a higher percentage of LGBQ+ clinical clients (86%) and a lower percentage of heterosexual clients (14%) • A higher percentage of clinical clients identified as queer or pansexual (29%) • There was a slight increase in FY2020-21 in clients who reported that they were questioning or unsure of their sexual orientation
	County Comparison: • *The County of San Mateo LGBTQ Commission's 2017-18 LGBTQ Wellness Survey estimated that 4% of the San Mateo County population, or 30,000 people, were LGBTQ+.*[10]	
Disability	• Between 58-67% of participants reported that they did not have a disability • For those identifying with a disability, chronic health conditions, mental health conditions, and other disabilities or conditions were the most commonly reported	• Compared to non-clinical participants, a lower percentage of clinical clients reported not having a disability (45%) • Mental health and chronic health conditions were most common; 13% reported a combination of disabilities
Income	• The proportion of participants at the lowest end of the income range (under $50,000/year) doubled from FY2017-18 (32%) to FY2018-19 (64%), and then declined in FY2019-20 (49%)	• Clinical clients had even lower incomes than non-clinical participants, with 79% reporting incomes under $50,000/year
	County Comparison: • *Among participants ages 18 or older, over half are considered Extremely Low Income (less than $38,400) or Very Low Income (less than $63,950) for San Mateo County, based on 2021 US Department of Housing and Urban Development (HUD) individual income levels*[11]	

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[10] SMC LGBTQ Wellness Survey. https://lgbtq.smcgov.org/smc-lgbtq-wellness-survey
[11] 2021 San Mateo County Income Limits as determined by HUD. Retrieved from https://housing.smcgov.org/sites/housing.smcgov.org/files/2021%20Income%20Limits%20revised%20042721.pdf

Project Outcomes

This section discusses the outcomes of the Pride Center INN project in terms of its two learning goals and clinical outcomes. A summary of key findings is below followed by a discussion of each outcome area.

Highlights: Coordinated Service Delivery Model

Internal Collaboration: The Pride Center's passionate staff have fostered collaboration with each other to serve clients and facilitate linkages to services within and outside of the Pride Center.

Community Reach: The Pride Center's model of collaboration with partner agencies has expanded the Pride Center's reach both geographically and demographically.

External Provider Network: External collaboration efforts positioned the Pride Center as a leader in advancing LGBTQ+ inclusion and visibility in San Mateo County and has become well integrated in the county's external network of providers.

Organizational Model: Several factors emerged as core needs for an effective collaborative service delivery model: clarity of roles and responsibilities; involvement from leadership of all partner agencies; formal venues for cross-training and communication with partner agencies; a robust staffing structure for program planning, management, and administration; strategies to support staff wellness; and proactive fundraising and sustainability.

Highlights: Access to Mental Health Services

Mental Health Outcomes: The Pride Center has substantially increased access to mental health services for LGBTQ+ individuals, and this access appears to have led to improvements in mental health wellbeing and clinical outcomes.

Protective Factors: The evaluation consistently found that having access to a safe space to build cultural identity and community for LGBTQ+ individuals is an important protective factor against negative mental health outcomes.

Clinical Service Capacity: The Pride Center has used various strategies to increase clinical capacity to serve the LGBTQ+ community. The Pride Center qualified for Medi-Cal reimbursement, serves as a training placement for clinical interns, and engages in training and partnerships with external organizations. The Pride Center has prioritized clinical services for members of underserved and marginalized communities and is working to engage more racially/ethnically diverse clients, older adults, individuals who speak languages other than English, and those outside central San Mateo.

Access and Engagement: The key facilitators of continued engagement with the Pride Center were feeling a sense of community, feeling welcome and safe, feeling connected to staff, and enjoying the services and programs. Community members were less inclined to engage when they did not feel their identities were represented among Pride Center staff or in Pride Center programming and when the timing of events did not work with their schedules. Shifting to fully virtual programming during COVID-19 allowed the Pride Center to maintain a touchpoint for the LGBTQ+ community regardless of their geographic proximity to the Pride Center, although some participants, including older adults, tended not to engage in virtual programming. Access to in-person services has been influenced by the geographic spread of the county, limited public transportation, and accessibility barriers within the Pride Center space.

Overall Mental Health: Clinical participants reported improved mental health since they started receiving services. The proportion of clinical clients who rated their mental health and their ability to cope with stress as "good" or "excellent" doubled from baseline to follow-up. Clients shared that receiving care from LGBTQ+ clinicians reduced anxiety and depression by increasing their sense of belonging and acceptance.

Targeted Mental Health Needs: Clinical participants saw improvement in areas of their mental health targeted by the Pride Center. While it is not possible to attribute improvements solely to clinical services, assessment results suggest that clinical clients—including those with lower and higher needs at baseline—showed improvement in key needs at follow-up, including anxiety, depression, adjustment to trauma, and family relationships.

Client Strengths: Across both adults and youth, the biggest change at the domain level was an improvement in the Strengths Domain. Youth saw the greatest improvements in this domain, with the greatest gains in interpersonal skills, cultural identity, resourcefulness, natural supports, and optimism. The biggest improvements in adults' strengths were in talents/interests, optimism, spiritual/religious, community connection, and resiliency.

Impact of Social-Political Environment: Some findings from clinical data suggest impacts of trauma and COVID-19. One-third of adults and nearly one-third of youth were in the actionable range for "cultural stress," which includes circumstances in which the individual's cultural identity is met with hostility. From initial to follow-up assessment, job history and vocational strengths saw the greatest *decline* of any area (needs or strengths), which may be an indication of the economic effects of COVID-19.

Coordinated Service Delivery Model

Learning Goal 1: Does a coordinated approach improve service delivery for LGBTQ+ individuals at high risk for or with moderate to severe mental health challenges?

Benefits of Collaboration at Multiple Levels

Pride Center's passionate staff have fostered collaboration with each other to serve clients and facilitate linkages to services within and outside of the Pride Center. Staff have developed positive working relationships within the Pride Center, supported by regular team meetings and clear communication. The clinical team and Case Manager have worked together to establish care plans for clients. The longer staff work at the Pride Center, the more familiar they become with the local network of services, and the more effective they can be in connecting participants with supportive services. Respondents to the Participant Experience Survey consistently found it easier to connect to services *within* the Center than *outside* the Center. With the transition to virtual programming during COVID-19, it has not been as easy for participants in one type of service to find out about the other types of services the Pride Center offers; this is easier when participants are in the physical space and can see flyers and hear about other services.

> *"Staff have dynamic collaborations working with case management, mental health; [in a] one-stop-shop, we can do warm handoffs, introduce [clients] to someone on staff, bring them in gently to a new environment."*
>
> *–Pride Center staff*

> *"The partners [are each involved] in specializations… one organization could never have done it [alone]."*
>
> *– Community Advisory Board member*

Collaboration among Pride Center partner agencies has expanded the Pride Center's reach both geographically and demographically. When the Pride Center was formed, the partner organizations, which had existed long prior in San Mateo County, offered the fledgling Pride Center a stamp of approval as a trustworthy institution. Bringing together multiple organizations to operate the Pride Center has helped ensure that programming and services accommodate a wide range of participants. Pride Center partner agencies agreed that being part of a collaborative model has not only contributed to the Pride Center's success; it has also enhanced their individual organizations' services. As the lead agency, StarVista reported that they have been better able to reach youth, older adults, and the northern part of the county because of their partnerships with PFS and ACS. In turn, PFS reported that being a partner agency has expanded the population they serve and increased their agency's cultural sensitivity to the LGBTQ+ community.

The Pride Center has positioned itself as a leader in advancing LGBTQ+ inclusion and visibility in San Mateo County and has become well integrated in the county's network of providers. The Pride Center's outreach efforts and organizational partnerships have helped the Pride Center build a large, countywide network. Behavioral health providers, health care providers, legal service providers, and more have relied on the Pride Center for guidance on LGBTQ+ inclusion, community building, and mental health care. Pride Center staff have trained hundreds of county staff members on sexual orientation, gender identity and expression (SOGIE) and LGBTQ+ inclusion. On a regular

> *"The Center has gotten LGBTQ out of the closet [in San Mateo County]."*
>
> *–Partner Agency*

basis, the Pride Center has been brought in for consultation with behavioral health service providers, BHRS, and other County departments on organizational policies and practices related to LGBTQ+ responsive service delivery. The Pride Center consistently receives and makes referrals to other providers, and in FY2020-21 the Pride Center developed a roadmap of services to help transgender and non-binary community members identify and navigate gender-affirming resources. All partners agreed that the Pride Center has increased LGBTQ+ visibility in San Mateo County, ultimately creating a more welcoming and inclusive environment for LGBTQ+ individuals to live and participate in the larger community. As evidence of the changing atmosphere of inclusion, in FY2019-20 and FY2020-21, each of the cities in San Mateo County observed Pride Month and raised the Pride flag.

Components of Collaborative Organizational Model

Through the INN project, the Pride Center, partner agencies, and BHRS gained firsthand experience in implementing a collaborative, multi-service center from the ground up. There were numerous lessons learned along the way. These centered on the importance of having:

- Clear expectations for the roles and responsibilities of partner agencies;
- Support and involvement from leadership across partner agencies;
- LGBTQ+ competency and racial/ethnic diversity among staff at all levels;
- Venues for cross-training and communication channels between partners;
- Time and space for strategic planning and program planning;
- A staffing structure that supports reasonable workloads and minimizes burnout;
- Staff to support program management and administrative duties; and
- Designated roles and responsibilities for fundraising and sustainability planning.

The accompanying LGBTQ+ Pride Center Best Practice Toolkit **reflects key considerations and resources for building an effective collaborative service delivery model to serve the LGBTQ+ community**.

Access to Mental Health Services

Learning Goal 2: Does the Pride Center improve access to behavioral health services for LGBTQ+ individuals at high risk for or with moderate or severe mental health challenges?

Impacts of LGBTQ+ Centered Clinical Model

With a clinical model of therapy *by and for* LGBTQ+ individuals, the Pride Center has improved access to mental health services for LGBTQ+ individuals who would be less likely to seek or remain in care with non-LGBTQ+ providers. Having a LGBTQ+ therapist has supported many participants' mental health treatment, as participants feel more understood and supported compared to previous experience with non-LGBTQ+ therapists. Many clients noted that they struggled to find adequate mental health care locally beforehand and faced issues when their providers were not trained to work with LGBTQ+ clients. According to participants, LGBTQ+ therapists are more likely to understand their lived experiences; this means that participants are not spending valuable treatment hours explaining terminology, identities, or types of relationships that non-LGBTQ+ therapists may not understand. Not having to worry about whether their therapist will understand them relieves anxiety that many LGBTQ+ individuals experienced when receiving services from non-LGBTQ+ providers. As a result, participants have been able to begin treatment with a fundamental sense of trust that they may not have been able to establish with their previous mental health care providers. This trust sets a foundation for a strong patient/provider relationship, which ultimately supports a productive treatment process.

"When I went to cisgender, heteronormative therapists, I got a blank look. They didn't get it. The [therapists] here understand it on the inside."

– Adult participant

The Pride Center has filled a particular gap in access to mental health services and supports for participants who identify as transgender or nonbinary. The Pride Center's clinical services, peer support groups, and other programs have been responsive to participants across the LGBTQ+ spectrum, particularly those who are marginalized within health care and public systems, such as transgender and nonbinary individuals. Transgender and nonbinary individuals made up a higher proportion of the Pride Center's clinical clients compared to all Pride Center clients. Pride Center staff regularly support transgender or nonbinary participants through the Pride Center's Name Change Clinic, a process than can be difficult and frustrating when undertaken alone. The Pride Center's Resource Library also includes chest binders that are made available free of charge to participants. In addition to these regular programs and resources, the Pride Center has also sponsored events such as the annual Transgender Day of Remembrance and a photo project and social media campaign.

"I don't feel like I need to hide things from [the therapists]. It was a major step in my life…I've had transphobic therapists in the past."

– Youth participant

Staff members' warmth and client-centered approach encouraged participants to engage in and remain connected with Pride Center services. The Pride Center's hardworking and passionate staff have bolstered the LGBTQ+ community in the county. Many participants and outside partners with the Pride Center named specific people as the epicenters of initiatives, services, or the overall welcoming nature of the Center itself. Before the COVID-19 shelter-in-place, participants of all ages credited the Pride

Center staff—clinicians, program staff, and administrative staff alike—for fostering the Pride Center as a welcoming environment.

Cultural Identity as a Protective Factor

Providing a physical location and inclusive space for LGBTQ+ individuals has improved mental health and wellbeing by reducing social isolation, ameliorating stigma, and creating a sense of community. The Pride Center demonstrated how having a safe space to build cultural identity and community is a significant protective factor for LGBTQ+ residents. Many participants feel that the Pride Center is a therapeutic experience, including many community members who do not use the Pride Center for formal clinical services. Prior to the opening of the Center, many participants had to travel to San Francisco, the East Bay, or San Jose to find an LBGTQ+ friendly community space. Other participants cited that the Pride Center was valuable simply as a space where they could go to find a peaceful, quiet environment. During COVID-19, the Pride Center successfully shifted to fully virtual programming, maintaining a touchpoint for LGBTQ+ community members during this difficult time.

> *"What I really like about the Pride Center is that it's a safe space, and it's not triggering."*
>
> *– Youth participant*

Social events and peer support groups have offered opportunities to build community within and across identity groups. The Pride Center supported up to 10 peer support groups at any given time. These peer-led groups offered a space of belonging and social support. The Pride Center also held a multitude of events like the county's first queer youth prom, an adult prom, movie nights, book clubs, and co-sponsored events with outside partners for cultural heritage months. While many peer groups were centered around specific identities or age groups (e.g., Latinx, transgender, Filipinx, youth, older adults), social events offered an opportunity for people across the LGBTQ+ spectrum to share space. Participants of all ages cited the Pride Center's intergenerational events as some of their favorite programs. In this way, the Pride Center's collaborative service model has helped to create an environment where participants who might never otherwise interact could find commonality. Unfortunately, many of these events have not been able to happen during COVID-19, so virtual activities have tended to focus on specific identities.

Clinical Service Capacity and Reach

Through direct services, coordination with outside providers, and training and consultation, the Pride Center has expanded clinical capacity throughout the county to serve LGBTQ+ clients with all levels of mental health need. The Pride Center alone cannot—and was not intended to—meet the mental health treatment needs of all LGBTQ+ individuals in the county. In the four years that clinical services were offered, the Pride Center served nearly 400 clients, increasing the number of clinical clients served each year and consistently maintaining a full caseload with a waitlist. The Pride Center has largely served clients with low to moderate mental health needs. The Pride Center can bill Medi-Cal for services to clients with serious mental illness (SMI) and receives Medi-Cal referrals from the County, though the multi-step referral process has caused some delays in receiving referrals. The Pride Center has also played a role in preventing the escalation of SMI by providing therapy and case management to higher-need clients who may have avoided seeking services (e.g., psychiatric or medical services) because of negative past experiences with non-LGBTQ+ providers and fear of discrimination. It is also important to note that because there is no tool that specifically assesses LGBTQ+ clinical needs, it may be that the CANS/ANSA underestimate some clients' level of need—for example, LGBTQ+ clients may be severely impacted by cultural and family issues, but as those are only a few items on the assessment, clients may not appear to be high need.

The Pride Center has reached a diverse clientele through its staffing structure, payment options, and dedication to serving members of underserved and marginalized communities. The Pride Center has served clients of diverse ages, racial/ethnic groups, gender identities, sexual orientations, and incomes. To achieve its clinical reach, the Pride Center hired clinical providers who identified as LGBTQ+, secured contractors to serve as clinical supervisors, hired clinical trainees, offered services on a sliding scale to private pay clients, and qualified to receive Medi-Cal reimbursement for services. Below is a summary of the Pride Center's clinical capacity and reach by race/ethnicity, language, and age.

- *Race/ethnicity*: The Pride Center's clinical staff has generally been racially and ethnically diverse, though there were no Black/African American clinicians. Compared to non-clinical participants, the Pride Center served a higher percentage of Latinx clients and lower percentages of White clients and Asian or Asian American clients in clinical services.
- *Language*: At different points in time, the Pride Center had Spanish-speaking and Cantonese-speaking clinicians. The Pride Center recruited for, but was unable to fill, a bilingual Spanish language clinical position in FY2020-21, which may account for the slightly lower proportion of Latinx clients served that year.
- *Age*: The Pride Center faced administrative barriers in serving older adult clients as there was not a licensed clinical social worker (LCSW) on staff to bill Medicare. Additionally, as discussed below in the *Factors Influencing Access and Engagement*, the Pride Center generally struggled to engage older adults in clinical and non-clinical services.

Factors Influencing Access and Engagement

This section discusses factors that facilitated and hindered participant access (their ability to participate in services) and engagement (their desire to begin or continue participating) in the Pride Center.

Facilitators of Access. Having information about the Pride Center, whether through social media, email lists, word of mouth, or referrals is the first step to accessing services. The Pride Center employed a community engagement and outreach specialist, and the Center built a strong referral network with providers, schools, and employers. The Pride Center has offered services at no or low cost. All social and community activities are free; case management services are free; and clinical services are offered on a

sliding scale, though the Pride Center recognizes the sliding scale may still be a challenge for some clients. The Pride Center also offered services at different times of day, including daytime and evening programming. In the past two years, Coast Pride (another LGBTQ+ organization) started offering services in Half Moon Bay, which lessens barriers to access for individuals in that part of the county. To address technology barriers to address among older adults, the Pride Center started hosting an "App-y hour" tech workshop for older adults as a collaboration with PFS. Remote services offered an opportunity for clients to engage in services without a need for transportation. Online services have also facilitated access for individuals who have disabilities or chemical sensitivities. To maintain access, it is likely the Pride Center will offer a hybrid model even after in-person services resume.

Facilitators of Engagement. A sense of community, rapport with staff, enjoyment of services and programs, and feeling their identity is affirmed were primary facilitators of continued engagement. Among survey respondents who had engaged less frequently with the Pride Center, around three quarters reported that they planned to continue participating.

Barriers to Access. Despite intensive outreach efforts on the part of the Pride Center, a number of participants expressed that they had only recently become aware of the Pride Center and perceived that many others in the community are not aware of the available services. The geographic spread of the county and limited public transportation were a challenge to ensuring access to in-person services.

> Top reasons for continuing to participate in the Pride Center:
>
> - Feeling a sense of community at the Pride Center
> - Feeling welcome and safe at the Pride Center
> - Enjoying the services and programs
> - Feeling connected to staff
> - Feeling their identity is affirmed at the Pride Center
>
> Source: Participant Experience Survey

The Pride Center offered services at different times of day to accommodate different schedules, but it is difficult to meet everyone's needs. One of the main reasons survey respondents reported not participating in services was that the timing of events did not work with their schedules. Additionally, as in previous years, some participants mentioned the physical accessibility of the Pride Center, noting that some areas can only be accessed via stairs, and some furniture is difficult for older adults and people with disabilities to access comfortably. While services were virtual for much of FY2019-20 and all of FY2020-21, some participants, including older adults, struggled to engage in virtual programming. Language is also a barrier to access. In FY2020-21, the Pride Center was only able to offer services in English and Cantonese; there were Spanish speaking in the past, but not during the most recent fiscal year. There were no staff who spoke Mandarin or Tagalog, the other threshold languages in San Mateo County.

"Getting info in time out to community—that has been one of the biggest issues…struggling so hard to get info to community."

–Partner Agency

Barriers to Engagement. Survey, focus group, and interview participants highlighted several factors that influenced their engagement in the Pride Center.

BIPOC representation among staff and participants. The Pride Center has espoused a commitment to be an inclusive space for LGBTQ+ community members of color and has continued to offer dedicated programming for Black, Indigenous, and other people of color (BIPOC). Pride Center staff, partners, and participants alike acknowledged that in large part, being a welcoming and inclusive space necessitates having staff who represent the racial/ethnic and cultural backgrounds of prospective participants. Some focus group and survey respondents shared a perception that the clientele and staff of the Pride Center are mostly White. While participant demographic data show that approximately half of all Pride Center

participants are non-White, it may be that participation in certain programs is predominantly White. Staff shared that establishing and retaining a racially diverse staff has been a challenge, particularly Black/African American staff. Though the racial/ethnic makeup of Pride Center staff shifted across the years, in FY2020-21, six staff identified as White, two as multiracial, and one person each as Asian/Asian American, Black/African American, Latinx, and Pacific Islander.

Programming reflective of participants' identity. The Pride Center has continued to prioritize serving BIPOC residents, including holding events in partnership with the African American Community Initiative of San Mateo County. Staff and partners reported challenges specifically around engaging Black/African American individuals. Demographic data from participant sign-in indicate that, proportionally, the Pride Center is serving a higher percentage of Black/African American clients (around 6%) than the overall San Mateo County population (3%). That said, demographic forms do not contain information about participants' level and consistency of engagement. The abovementioned barriers speak to the context of intense and public racial oppression across the country, which disproportionately impacts queer people of color. Pride Center clinical data also appeared to reflect this reality: in the clinical assessment, the "cultural stress" item—which includes circumstances in which an individual's cultural identity is met with hostility—was scored as an area of high need and did not see improvements from baseline to follow-up.

> *"I would like to see more POC at events, but we need to have more POC on staff first."*
>
> *–Partner Agency*

> *"My experience has been a little rocky. The first year I tried coming, it was hard, because it was a predominantly white space and didn't feel okay, as a queer person of color in a white space… Throughout the years the Pride Center has been evolving, there's been other queer people of color here, and spaces for queer people of color. Not just queer people or people of color, but both—I don't have to choose."*
>
> *-Adult participant*

Engagement with older adults. In both social and clinical spaces, the Pride Center had difficulty attracting and maintaining engagement with older adults. In the clinical sphere, the Pride Center consistently attempted to reach the older adult population without much success. In the social sphere, the Pride Center struggled to maintain participation despite having a dedicated staff person from PFS for 12 hours per week. Older adults tend to be more socially isolated in general. When programming became virtual during COVID-19, it was even harder to engage older adults. The Pride Center hosted technology education courses for older adults and connected older adults to smart phones and tablets with one-year paid internet services; however, it remained consistently difficult to engage LGBTQ+ older adults. Older adult participants and some partner agency staff perceived that the Pride Center catered to a younger crowd, noting that the staff tend to be younger and the physical location was more appropriate for youth in terms of aesthetics and physical accessibility. As mentioned above, the Pride Center building is not fully physical accessible. Additionally, some older adults described that they were not comfortable going to a visibly LGBTQ center—coming from a different generation that endured intense discrimination for their sexuality, stigma remained a barrier.

Engagement during COVID-19

As described above, the Pride Center made a quick transition to virtual programming during COVID-19. The Pride Center has been able to maintain therapy services through telehealth platforms. Online peer support groups have become accessible for people outside of the central San Mateo area and outside of the county itself. Virtual Pride Week garnered views from thousands of people. Online services have facilitated access for individuals who have disabilities, chemical sensitivities or live outside the central San

Mateo area. Two-thirds of clinical clients in FY2020-21 were new, which highlights the level of mental health need during COVID-19. In FY2020-21 when programming was fully online, the Pride Center reported:

- Providing new programming for people of color such as a Queer, Trans, BIPOC group for folks 14-25 and events for Filipinx Pride Month
- Doubling the number of trainings including adding a Trans 101and Pronouns 101 training
- Contacting over 300 LGBTQ+ older adults on a regular basis, via emails, calls, and support groups
- Delivering over 2,700 hours of service with therapy and case management clients
- Serving 359 community members in peer support groups
- Training over 500 people

Of course, there have been challenges as well. Staff reported that it has been difficult to maintain engagement in peer support groups due to "Zoom fatigue." Online services have increased barriers for older adults, lower income individuals, individuals who are unstably housed, and those living in a hostile environment. In addition, not all clients have access to devices with video calls or a safe place to have private conversations. Further, virtual services make it more difficult for staff to maximize the "one-stop-shop" model; they cannot simply walk to the office next door and introduce a client to another staff person.

"Even though shelter in place is in order and COVID is scary, the Pride Center has helped make me feel like I'm still part of a community, and it means so much to me to not feel as if I've been forgotten."

–Participant

Respondents to the Participant Experience Survey were asked to report on their online engagement during the pandemic in FY2019-20 and FY2020-21. Most respondents reported being informed about and satisfied with the Pride Center's online services: in both years, 81% agreed or somewhat agreed that the Pride Center offered online options for the services that were most important to them. Of those who participated in online services in FY2019-20 and FY2020-21, most agreed or somewhat agreed that online services have been engaging (90% and 85%, respectively), gave them a sense of community (87% and 82%, respectively), and were easy to access (81% and 89%, respectively).

The Pride Center conducted a survey during the fall and winter of 2020 to better understand the impact of COVID-19 on the LGBTQ+ community in San Mateo County. The survey received 532 responses and the key findings are reflected in the Pride Center's **LGBTQ+ COVID-19 Impact Survey Report**.
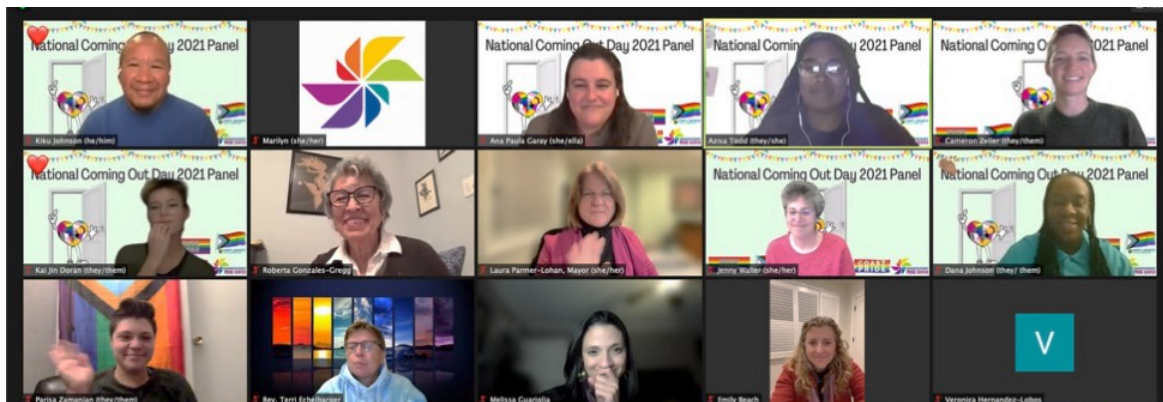
Clinical Outcomes

This section presents data on the participants who received clinical services, which included therapy and case management, from FY2017-18 through FY2020-21. Findings include data from the following sources: 1) Client Self-Assessment, which asks clinical clients to rate how they felt about their mental health and their ability to cope with stress in the last 30 days; and 2) the Adult Needs and Strengths Assessment (ANSA) for adults and the Child and Adolescent Strengths and Needs (CANS) for youth.[12]

Client Self-Assessment

The Client Self-Assessment asks clinical clients to rate how they felt about their mental health and their ability to cope with stress in the last 30 days.

Baseline Data

Baseline data were available for **122 clients**. At initial assessment, two-thirds of the clients (67%) rated their mental health as poor or fair and rated their ability to cope with stress as poor or fair (see Figure 3). For both self-assessment questions, "fair" was the most common response at baseline. Only 3% of clients rated their mental health as "excellent" and 2% rated their ability to cope with stress as excellent at baseline. Suggesting impacts of COVID-19, self-assessment data during FY2020-21 showed a somewhat higher percentage of clients rating their mental health as fair or poor (72%).

Figure 3. Clients' Initial Screening Experiences (n=122)

How would you rate your mental health in the last 30 days? — Fair/Poor: 67%, Excellent/Good: 33%

How would you rate your ability to cope with stress in the last 30 days? — Fair/Poor: 62%, Excellent/Good: 38%

Legend: ■ Fair/Poor ■ Excellent/Good
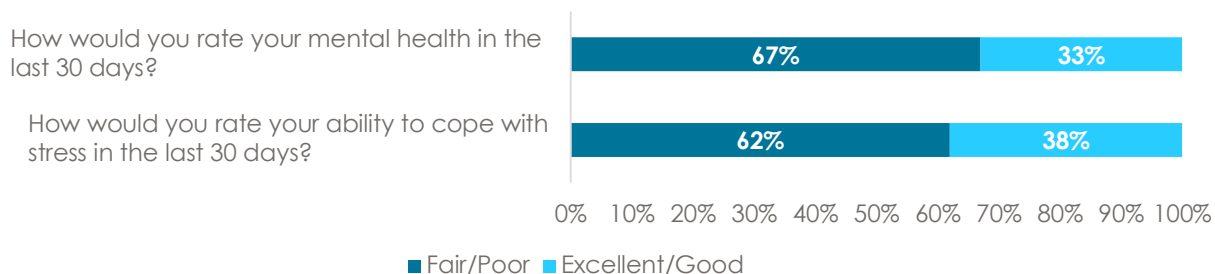
Follow-up Data

Follow-up assessments (either a 6-month or discharge assessment) were available for **48 clients**. For individuals who had multiple follow-up assessments, the most recent assessment was used to determine change. The data below includes the 48 clients who had both an initial and a follow-up assessment. Figure 4 and Figure 5 indicate that at follow-up, a higher percentage of clinical clients reported positive mental health and ability to cope with stress. At baseline, 31% of clients rated their mental health as "excellent" or "good" in the past 30 days, which increased to 50% at follow up. Clients also reported an increased ability to cope with stress in the past 30 days (31% at baseline and 58% at follow up).

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[12] There are several reasons why the number of clinical assessments recorded is lower than the number of clinical clients. Due to start-up needs, most clinical data collection began in FY2018-19. Some clients may have terminated services before a discharge assessment was completed. During COVID-19, there were data gaps as the Pride Center shifted to telehealth. In addition, there may have been gaps in onboarding and training for clinical staff around data collection. The Pride Center is taking steps to improve clinical data collection and documentation, including establishing training protocols, developing reports to identify gaps in assessment data, and incorporating data review in clinical supervision meetings.

Figure 4. Clients' Mental Health in Last 30 Days (n=48)

Initial	69% / 31%
Follow-up	50% / 50%

0% 20% 40% 60% 80% 100%

■ Fair/Poor ■ Excellent/Good
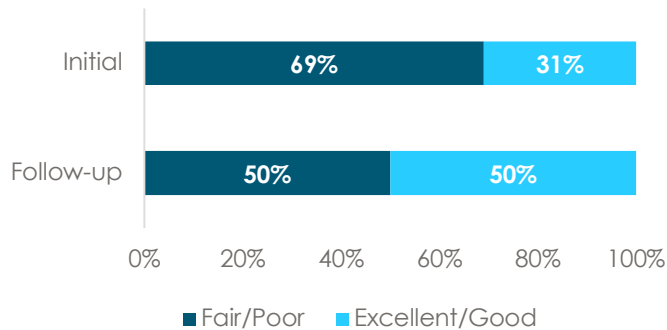
Figure 5. Clients' Ability to Cope with Stress in Last 30 Days (n=48)

Initial	69% / 31%
Follow-up	42% / 58%

0% 20% 40% 60% 80% 100%

■ Fair/Poor ■ Excellent/Good
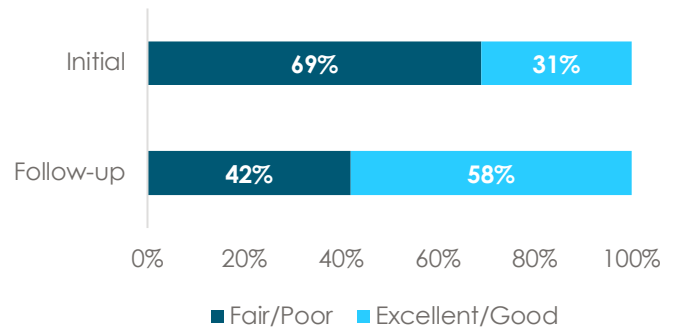
Client Strengths and Needs

This section summarizes the results of the assessments administered to clinical service participants—the Child and Adolescent Strengths and Needs (CANS) for youth and the Adult Needs and Strengths Assessment (ANSA) for adults.[13]

- **88** adults had an initial ANSA
  - **61** had an initial and follow-up
- **24** youth had an initial CANS
  - **11** had an initial and follow-up

The follow-up analysis includes only individuals who had both an initial and follow-up assessment (e.g., a 6-month, 12-month, or 18-month subsequent assessment or discharge assessment) between FY2017-18 and FY2020-21. For individuals who had multiple initial assessments, the earliest assessment was used to determine the baseline. For individuals who had multiple follow-up assessments, the most recent subsequent assessment was used to determine change. For the ANSA, the average time between assessments was 321 days (10.5 months), ranging from 14 to 993 days. For the CANS, the average time between assessments was 197 days (6.4 months), ranging from 119 to 378 days.

The ANSA/CANS "actionable range" is defined as a score of 2 or 3. To interpret change over time, a positive change is indicated by a decrease in score.

The analysis included the primary domains of the assessments: Functioning Domain, Strengths Domain, Cultural Factors, Behavioral/Emotional Needs, Risk Behaviors, and Caregiver Resources and Needs (CANS). The ANSA and CANS scoring rubric is as follows: 0 = no evidence; 1 = history, suspicion; 2 = action needed; and 3 = disabling, dangerous, immediate action. To explore clients' needs from multiple angles, the analysis examined average ANSA and CANS scores for each domain and for the individual items within each domain. In addition, the analysis examined the percent of clients who received ANSA scores in the actionable range.[14] Key takeaways from the analysis are presented below. For full assessment results, see the Appendix.

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[13] The CANS/ANSA was not administered if: a) the client only attended a one-off Name and Gender Change Workshop or was a drop-in client seeking out resources; b) the client was only a participant in the Kennedy Middle school group; or c) the client was active for less than 1-2 months or had several no-shows that prevented staff from gathering enough data for a proper assessment.

[14] Because of the small number of follow-up CANS assessments, this analysis was only conducted for the ANSA.

Overall Level of Need

At both the initial and follow-up assessment, each needs domain had an average score of less than 1, which falls between "no evidence" and "history or suspicion" and is below the actionable range (see Table 4 and Table 5). See below for a note on interpreting the Strengths Domain.[15]

Table 4. Average ANSA Domain Scores and Change Over Time

Domain	Baseline Avg Score	Follow-up Avg Score	Avg Change
Functioning Domain	0.62	0.61	-0.01
Strengths Domain	1.71	1.59	-0.12
Cultural Factors	0.53	0.50	-0.03
Behavioral/Emotional Needs	0.70	0.68	-0.02
Risk Behaviors	0.20	0.20	0.00

Table 5. Average CANS Domain Scores and Change Over Time

Domain	Baseline Avg Score	Follow-up Avg Score	Avg Change
Functioning Domain	0.55	0.47	-0.08
Strengths Domain	1.61	1.30	-0.31
Cultural Factors	0.50	0.36	-0.14
Caregiver Resources and Needs	0.35	0.31	-0.04
Child Behavioral/Emotional Needs	0.46	0.45	-0.01
Risk Behaviors	0.11	0.15	0.04

Areas of Highest Need at Baseline

Although the average baseline score at the domain level was less than 1, several items within the domains had average scores between 1 and 2 ("action needed"), indicating that a higher proportion of clients had a score in the actionable range for these items. Table 6 and Table 7 below ranks the ANSA and CANS items that had the highest average score at intake across all domains and show the percent that received a score of 2 or 3 (the actionable range) for these items.

Table 6. Items with Highest Average Need at Baseline: ANSA (N=88)

ANSA Item	Average Baseline Score	Percent of Clients in Actionable Range
Anxiety	1.51	59%
Depression	1.47	57%
Family Relationships	1.38	50%
Adjustment to Trauma	1.26	48%
Social Functioning	1.07	33%
Cultural Stress	1.01	31%

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[15] The Strengths Domain uses the following rubric: 0 = centerpiece strength, 1 = useful strength, 2 = identified strength, and 3 = no evidence. Unlike the needs domains, a score of 2 may not indicate that action is needed.

Table 7. Items with Highest Average Need at Baseline: CANS (N=24)

CANS Item	Average Baseline Score	Percent of Clients in Actionable Range
Anxiety	1.35	43%
Depression	1.17	39%
Cultural Stress	1.04	30%
Social Functioning	1.00	33%
Sleep	1.00	30%

The data above demonstrate that mental health issues, particularly anxiety, depression, and trauma, were prevalent among Pride Center's clinical clients. Anxiety and depression were indicated as the highest areas of need for both adults and youth. Family and social relationships also rose to a high level of need. Youth also had higher needs with respect to sleep at baseline compared to adults. It is also notable that cultural stress was indicated as an area of need for both adults and youth.[16]

Changes in Needs Over Time

While it is not possible to attribute improvements solely to clinical services, results suggest that clinical clients showed improvement in key needs, including anxiety, depression, adjustment to trauma, and family relationships.

Average Domain and Item Scores

Between the initial and follow-up assessment, the average scores for each domain showed slight positive changes (Table 4 and Table 5 above). While changes in average domain scores were small, several items within the domains saw improvements. Items that saw an improvement of 0.20 points or more are shown in Table 8 and Table 9. For adults, the highlighted rows show that three of the items with the highest need at baseline (anxiety, adjustment to trauma, and family relationships) were among those with the most improvement. High-need items at baseline that did not show improvement at follow-up were social functioning and cultural stress; however, there was improvement in the cultural identity item.[17]

Table 8. Items with Highest Changes in Average ANSA Scores (N=61)

ANSA Item	Baseline Avg Score	Follow-up Avg Score	Avg Change
School*	0.61	0.23	-0.38
Cultural Identity	1.00	0.67	-0.33
Anxiety	1.57	1.32	-0.26
Family Relationships	1.41	1.19	-0.22
Adjustment to Trauma	1.30	1.08	-0.21
Sexual Development	0.60	0.40	-0.20

Note that this item was completed for only 33 of the clients, as it was not applicable to all adult clients.

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[16] Cultural Stress refers to "circumstances in which the individual's cultural identity is met with hostility or other problems within his/her environment due to differences in attitudes, behavior, or beliefs of others (this includes cultural differences that are causing stress between the individual and his/her family). Racism, homophobia, gender bias and other forms of discrimination would be rated here.) See: http://www.acbhcs.org/providers/CANS/docs/ANSA/ANSA_25_Manual.pdf
[17] Cultural Identity refers to "an individual's feelings about her/his cultural identity, including race, religion, sexual orientation, gender identity, and ethnicity.

For youth, the highlighted rows show that two of the items with the highest need (anxiety and social functioning) were among those with the most improvement.

Table 9. Items with Highest Changes in Average CANS Scores (N=11)

CANS Item	Baseline Avg Score	Follow-up Avg Score	Avg Change
Social Resources	0.70	0.27	-0.43
Anxiety	1.50	1.09	-0.41
Social Functioning	1.00	0.73	-0.27
Recreational	0.45	0.20	-0.25
Language	0.30	0.09	-0.21
Residential Stability	0.30	0.09	-0.21
Psychosis (Thought Disorder)	0.20	0.00	-0.20

Percent of Clients in Actionable Range

As mentioned above, an additional analysis was conducted with ANSA and CANS data. Figure 6 and 7 below depict the items for which at least twenty percent of adults and youth received a score in the actionable range. For each item, the first column represents the percent of clients with an actionable score at baseline, and the second column represents the percent of clients with an actionable score at follow-up.

As shown on the left-hand side of the chart, there were substantial decreases (i.e., improvements) in the percentage of clients with an actionable score for key items such as anxiety, adjustment to trauma, family relationships, depression, sleep, and social functioning. This suggests that some clients with higher need achieved greater stability during the time that they received clinical services.

As shown in the right-hand side of each chart, some items with a substantial percentage of clients in the actionable range did not show any change, or showed negative change, from the initial to follow-up assessment. For adults, this included interpersonal problems, living situation, social functioning, and cultural stress. For youth, this included cultural stress, sexual development, adjustment to trauma, and family functioning.

Figure 6. Percent of Adult Clients with Score in Actionable Range

High-need areas with more people improving

High-need areas with fewer people improving

	Anxiety	Adjustment to Trauma	Family Relationships	Depression	Interpersonal Problems	Living Situation	Social Functioning	Cultural Stress
■ Baseline	66%	49%	53%	62%	22%	24%	35%	25%
■ Follow-up	40%	32%	31%	47%	28%	28%	39%	28%
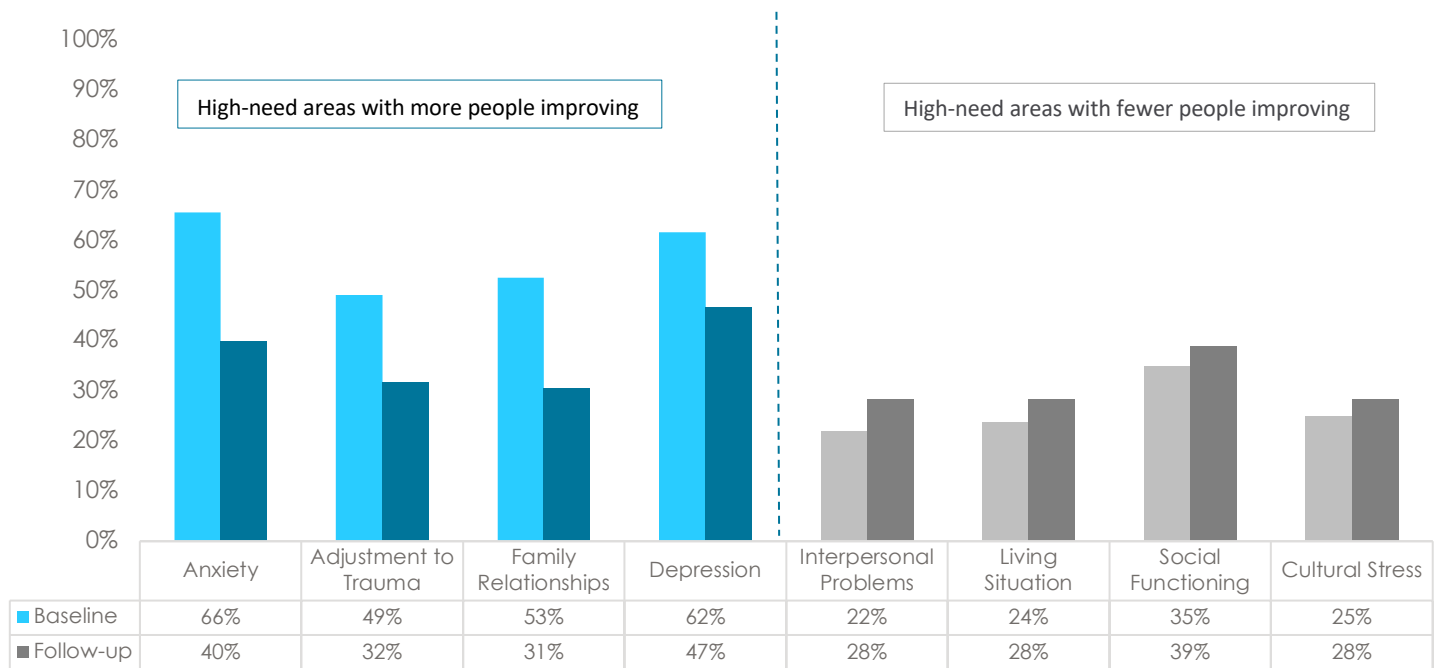
Figure 7. Percent of Youth Clients with Score in Actionable Range

High-need areas with more people improving

High-need areas with fewer people improving

	Anxiety	Sleep	Depression	Social Functioning	Cultural Stress	Sexual Development	Adjustment to Trauma
■ Baseline	60%	40%	40%	36%	30%	27%	20%
■ Follow-up	27%	18%	18%	18%	45%	27%	18%
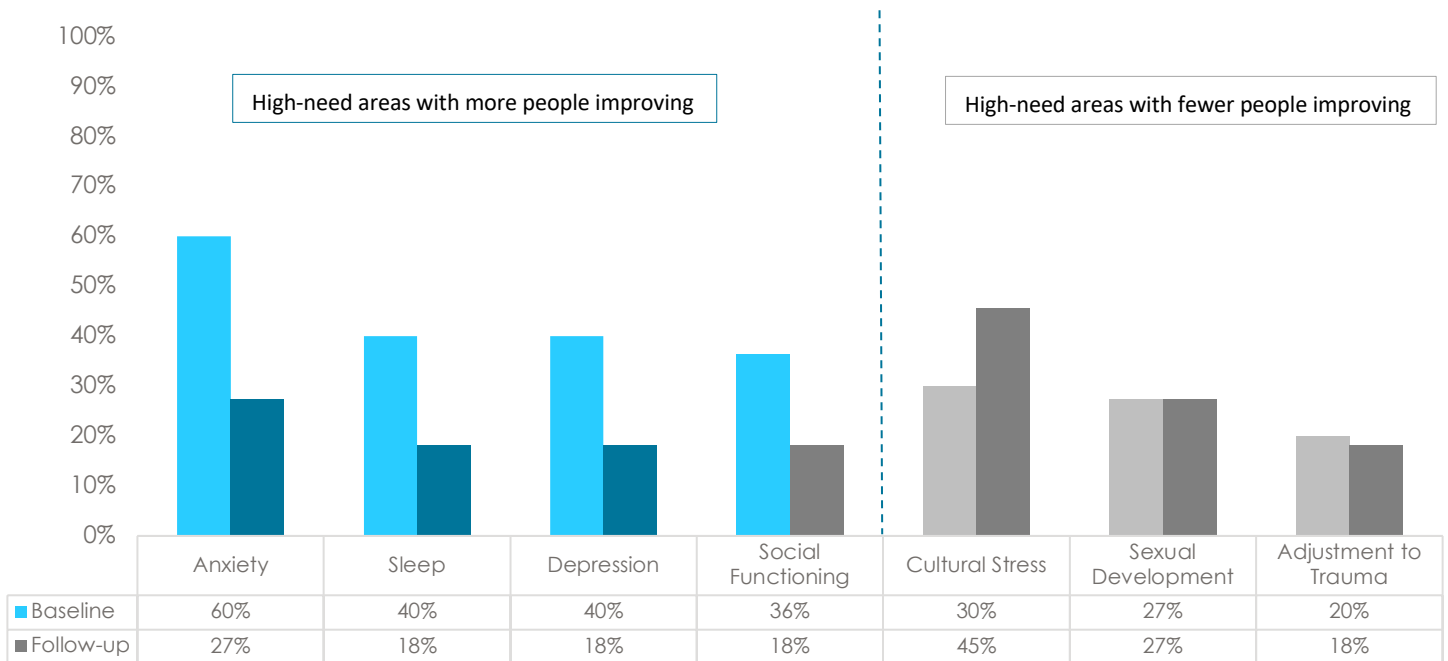
Strengths

For adults and youth, the strengths with the most positive average scores at baseline were as follows:

Adults

- Volunteering
- Spiritual/Religious
- Community Connection
- Educational Setting
- Family Strengths
- Vocational

Youth

- Spiritual/Religious
- Community Life
- Vocational
- Cultural Identity
- Interpersonal
- Resourcefulness

At follow-up, the largest improvements in adults' strengths were seen in the talents/interests, optimism, spiritual/religious, community connection, and resiliency items. Notably, from initial to follow-up assessment, job history and vocational strengths saw the greatest *decline* of any item (needs or strengths), which may be an indication of the economic effects of COVID-19.

Across both adults and youth, the biggest change at the domain level was an improvement in the Strengths Domain for youth. The largest improvements in youths' strengths were seen in the interpersonal, cultural identity, resourcefulness, natural supports, and optimism items.

Next Steps

Sustainability

The Pride Center has had an invaluable impact on San Mateo County LGBTQ+ inclusion and visibility and the evaluation data presented in this report supports the importance of sustaining this innovative approach to addressing LGBTQ+ individuals' mental health needs. Stakeholders across various sectors unanimously supported the long-term sustainability of the Pride Center. BHRS is committed to supporting sustainability efforts ongoing, which includes providing continued MHSA funding for the Pride Center.

Sustainability has been a core function of the Pride Center since inception. The Pride Center includes a "Development" Program component, which consists of one part-time grant writer with the goal of diversifying funding sources for the Pride Center. The grant writer researches and applies to prospective philanthropic organizations' grant opportunities, works with corporate sponsors, and cultivates donors. Most recently, this position was transitioned under StarVista's Development team to help streamline communication and efforts; the grant writer works collaboratively with StarVista's Development team and the Pride Center Program Director. The Pride Center Program Director is actively involved in establishing long-term sustainability and working collaboratively with BHRS to address a $130,000 deficit anticipated in FY2022-23. Revenue opportunities that will be explored by the Pride Center include increasing fee-based trainings for organizations looking to improve LGBTQ+ inclusivity and client outcomes, room rental and community event donation requests, monthly donor campaigns, grant opportunities, and increasing clinical billing.

Stakeholders have been involved in the decision to sustain and fund the Pride Center with MHSA monies starting in April 2019. A Pride Center update on progress toward the INN learning goals and client outcomes was presented to the MHSA Steering Committee, the Mental Health Substance Abuse Recovery Commission (MHSARC), and stakeholders. A proposal to support the Pride Center was first presented in October 2019 following input sessions conducted July-August 2019 with the MHSARC Older Adult, Adult, and Youth Committees, as well as the Contractor's Association, the Office of Consumer and Family Affairs Lived Experience Workgroup, and the Peer Recovery Collaborative. The proposal at the time included a one-time contribution of $700,000 to the Pride Center to begin FY2021-22. This was as an interim solution, given inability to increase the MHSA ongoing budget at the time, and with the intention to incorporate the Pride Center ongoing sustainability as part of the FY2020-23 MHSA Three-Year Plan Community Program Planning process. An estimated 40 members of the public attended the presentation on October 2019 and had the opportunity to ask questions and provide public comment. Additionally, The MHSARC held a public hearing and voted to close a 30-day public comment on February 2020 and subsequently voted to recommended approval of the interim solution to use one-time unspent funds for the Pride Center. Our local Board of Supervisors approved this plan on April 7, 2020.

With the COVID-19 pandemic, significant revenue decreases were initially projected for MHSA statewide. Given this uncertainty, the Pride Center was not included in the approved FY2020-23 MHSA Three-Year Plan ongoing budget but remained in the one-time unspent fund commitment. Actual revenue received in FY2020-21 and future projections for MHSA increased significantly, which allowed stakeholders to propose updates to the MHSA budget and this included moving the $700,000 funding for the Pride Center to the MHSA ongoing budget as of FY2021-22.

Stakeholder input continued through June 30, 2021 and engaged the MHSA Steering Committee; the Coastside, East Palo Alto, and North County Collaboratives; the Contractor's Association; the MHSARC Youth, Adult and Older Adult Committees; the Diversity and Equity Council; and the Lived Experience

Workgroup. On July 7, 2021, the MHSARC reviewed the public comments received and held a public hearing and vote to submit the plan to the Board of Supervisors for approval.

Future Considerations

As the Pride Center partnership continues with MHSA and external funding, the following key considerations emerged from the five-year evaluation.

Operations and Governance

1. Continue to restructure staff positions so that responsibilities and workloads are manageable and consider ways to increase staff compensation and incentives. These actions will help promote long-term staff retention and may also help the Pride Center recruit more BIPOC staff.

2. Align the clinical need in the community with the number of clinical hours available from Pride Center clinical staff. Consider hiring full-time clinicians and examine pay rates for clinical supervisors, clinicians, and pay differentials for bilingual and licensed staff.

3. Continue to document organizational policies and procedures and ensure staff onboarding and exit procedures are in place.

4. Solidify practices to collect and record clinical assessment data for all clients and regularly analyze and review clinical outcomes by age, race/ethnicity, and language.

5. Leverage the CAB to support strategic planning and fundraising. This may include recruiting new community members to serve on the CAB and identifying resources to deliver coaching to the CAB on board operations.

6. Continue to strengthen development efforts with the goal of diversifying funding sources for the Pride Center and establishing long-term sustainability and growth.

7. Secure funding to hire Program Manager(s) to develop and oversee a high-level vision for the Pride Center's programming, including aligning the volume of programming to staff capacity; and Administrative Coordinator(s) to support general operations, the clinical team, and marketing and communications.

Programs and Services

1. Continue hiring and partnership strategies to reach racially/ethnically and culturally diverse clients, older adults, and clients who speak languages other than English.

2. Continue to build the network of LGBTQ+ responsive mental health providers to meet the needs of clients with serious mental illness (SMI).

3. Continue to explore how the Pride Center can support satellite locations and/or other LGBTQ+ organizations in North and South County, while considering the Pride Center's staff capacity.

4. Build the Pride Center's sliding scale therapy practice by attracting clients who can pay full fee to subsidize others.

5. Offer some services virtually even after in-person services resume to maintain expanded access.

6. In virtual programs, showcase the different types of services the Pride Center offers to increase awareness about the multi-service model.

7. Identify ways that some Pride Center resources can be directed toward Pride Center staff, as staff are also affected by ways the LGBTQ+ community is marginalized.

Summary and Conclusion

The Pride Center achieved its intended outcomes of operating as a collaborative model to increase access to services and contribute to positive clinical outcomes for LGBTQ+ individuals who have experienced or are at risk of mental health challenges.

Summary of Outcomes

Having a physical location for the Pride Center dramatically increased visibility for the LGBTQ+ community and created a safe space for LGBTQ+ community members. The impacts of the Pride Center were above and beyond the initial intention for the project, as the fact of having a space designed for and by the LGBTQ+ community proved exceptionally valuable in creating a sense of community, belonging, and safety for community members. In this way, the mere existence of the Pride Center served as a protective factor for the LGBTQ+ community.

"Just knowing [the Center] is here [is important]… Just having it here and being in the news, seeing the flags…It's that visibility, creating a norm."

– Adult participant

"I want you to know that it was one of the best trainings that I have attended, and it shifted in how I think about the work now."

–Training participant

Through education and training, the Pride Center built capacity of existing services to serve the LGBTQ+ community. The Pride Center was highly successful in this aspect of their services. They served as the leader in introducing the use of SOGIE questions in the county at large, provided many ad hoc trainings and workshops on gender and sexuality, collaborated with other partners on workshops, and provided consultation to other organizations. In this way, the Pride Center greatly expanded the capacity of behavioral health and other service providers to offer LGBTQ+ responsive services.

The clinical team supported the wellbeing of individuals experiencing mental health challenges. The Pride Center was largely successful in this aspect of their services and continues to grow its clinical capacity. Pride Center therapists and clinical trainees provided individual therapy to LGBTQ+ community members with mild-to-moderate and moderate-to-severe mental health challenges. On average, participants in clinical services experienced improvements in their overall mental health, including depression, anxiety, trauma, and family issues, during their time receiving clinical services. The Pride Center has also provided case management to help connect community members to needed services such as health care, housing, and employment. The impact of clinical services for the transgender community was particularly strong. The Pride Center is working to improve its reach with the older adult community, marginalized racially and ethnically diverse clients, clients who speak languages other than English, and clients outside the central part of the county.

"The clinical services here are great. [Gender] transitions are scary, so it's great to come here— where people remember your pronouns, your name. My home situation isn't validating, so having a place that is safe helps me continue to transition when otherwise I might not have and would still suffer from the mental health issues that I was going through."

–Adult participant

The Pride Center's social activities, resources, and peer support groups provided a space to build community and resilience. The Pride Center saw much success in this area and continues to expand programming to improve engagement with BIPOC communities and older adults. The Pride Center engaged hundreds of LGBTQ+ community members and family members in events including movie nights, book clubs, 10 peer support groups, a youth prom, and the community's first ever adult prom. The Pride Center's Name Change Clinic was one of the first of its kind and impacted the lives of transgender and nonbinary clients in San Mateo County and beyond. The Pride Center continues to develop strategies to engage members of the community who do not see themselves reflected in the race/ethnicity of staff, who live outside the central San Mateo area and face transportation barriers, and who are over age 60 and may not feel comfortable visiting an openly LGBTQ+ space and may have challenges with transportation or technology access for virtual services.

"I found out about the Pride Center from my school therapist. I talked to her about my sexuality and how I feel about it, she recommended the peer groups for me. Since I've started coming, I feel happy and I'm accepting myself more."

–Youth Participant

Through intentional marketing and community engagement, the Pride Center increased awareness about the Pride Center's services among community members and community partners. The Pride Center invested highly in this effort and the Pride Center became increasingly well known. At the same time, there is more work to be done to ensure the Pride Center's array of service offerings widely known in the LGBTQ+ community.

Key Components of Collaborative Service Delivery Model

The following factors emerged as essential to an effective collaborative service delivery model. These factors inform the accompanying **toolkit**.

- **Clear roles and responsibilities** of partner agencies, who should be selected based on geographic reach, racial/ethnic and linguistic diversity, and be LGBTQ+ centered and/or have a high level of LGBTQ+ competency.
- **Involvement from leadership** of all partner agencies to support continued engagement in the partnership.
- **Formal venues for cross-training and communication** with partner agencies to ensure clear lines of communication and a high level of competency in LGBTQ+ topics.
- **Aligned staffing structure and program portfolio** such that the number and types of programs is scaled based on the capacity of the staff.
- **Robust staffing for program planning, management, and administration**, including staff to manage an overall programmatic plan, policies and procedures, staff onboarding, billing for clinical services, and data collection.
- **Strategies to support staff wellness** and prevent burnout, including realistic staff position descriptions, compensation, and wellness incentives.
- **Proactive fundraising and sustainability planning** to ensure long-term success.

Resources Developed

The Pride Center **best practice toolkit** is designed to disseminate lessons learned from Pride Center implementation and helpful resources to other counties wishing to implement a collaborative multi-service center for the LGBTQ+ community.

The **LGBTQ+ COVID Impact Report** of San Mateo County is the first known data on how the pandemic has impacted sexual and gender diverse people in the state of California.

The **Best Practices for Community Surveys** document contains recommendations for collecting data on sexual and gender identities.

Conclusion

The Pride Center fundamentally changed the network of services available to the LGBTQ+ community. In doing so, the Pride Center promoted LGBTQ+ visibility and belonging, and filled gaps in culturally responsive mental health treatment services for the LGBTQ+ community. Participants overwhelmingly stated that the Pride Center provided a novel space where they feel at home in their identity, and its physical space provided a sanctuary. In this way, the Pride Center demonstrates how having a safe space to build community can be a significant protective factor for LGBTQ+ residents.

"The impact of the Pride Center is felt across the entire health system."

–Partner Agency

With the conclusion of the INN project, the Pride Center will continue being funded by the County's MHSA strategy and will continue to seek public and private funding. As the Pride Center progresses and grows, leadership and staff remain committed to their efforts to be a safe and welcoming space for all members of the LGBTQ+ community, particularly BIPOC and low-income individuals. The Pride Center has been a monumental effort and success in San Mateo County and the hope is that it will lead to similar efforts in other counties.

"I remember living in the County without the Pride Center existing—it felt like I was alone, very alone…. Just knowing the Pride Center is here in my community makes me feel more comfortable. The fact that it's supported by the County, the Board of Supervisors, I feel more welcome in this county, more comfortable to be who I am. It's empowering." - Participant

LGBTQ+ Pride Center Best Practice Toolkit

The San Mateo County Pride Center was formed as an Innovation (INN) program under the California Mental Health Services Act (MHSA) funded by the San Mateo County Behavioral Health Recovery Services (BHRS) department. The San Mateo County Pride Center is a collaboration of three partner organizations. As a coordinated service approach that meets the multiple needs of LGBTQ+ individuals, the Pride Center offers services in three categories:

1. *Clinical Services*: The Pride Center provides mental health and case management services focusing on individuals at high risk of, or with moderate to severe, mental health challenges.

2. *Social and Community Services*: The Pride Center aims to outreach, engage, reduce isolation, educate, and provide support to high-risk LGBTQ+ individuals through peer-based models of wellness and recovery that include educational and stigma reduction activities.

3. *Training and Resources*: The Pride Center serves as a hub for local, county, and national LGBTQ+ resources. Pride Center staff host year-round trainings and educational events for youth, public and private sector agencies, community service providers, and other community members. Common topics include understanding sexual orientation and gender identity, surveying common LGBTQ+ issues and mental health challenges, and learning how to provide culturally affirmative services to LGBTQ+ clients.

The following considerations are based on lessons learned from the implementation of the San Mateo County Pride Center. These considerations are intended to support other cities, counties, and regions that wish to start a collaborative multi-service center for the LGBTQ+ community. Not all considerations will apply to everyone as not every program will be the same. However, we hope these tips and considerations will be supportive for others wishing to create collaborative programming for the LGBTQ+ community.

Please see the San Mateo County Pride Center Evaluation Report for a detailed description of the Pride Center services and what we learned through five years of evaluation of our progress and outcomes.

1. Organizational Model

Building an effective model includes many considerations, and there should be significant time spent planning before starting any program.

A. Concept Development

☐ **Involve the local community.** An LGBTQ+ Center should arise from the needs and desires of the community. There should be efforts to hear from diverse LGBTQ+ community members about what they would like to see in their community, and LGBTQ+ community members should be involved in developing the initial concept.

☐ **Garner support from stakeholders and decision-makers.** Key decision-making bodies, such as a Board of Supervisors, City Council, County Health departments or local LGBTQ commission are critical for building a foundation of support and buy-in for an LGBTQ+ Center. Build relationships, and keep in mind that it may take years to progress from a concept to reality.

☐ **Design the collaborative model.** A collaborative model is not simply a collection of organizations working together; the benefit of a collaborative model is that it is more than the sum of its parts. For the model to be successful, it is important to be intentional about how the partners will work together. It may be beneficial to contract with a consultant to design the model and work with the selected partners to learn how to operate as a partnership.

B. Selection of Partner Agencies

☐ **Choose partner agencies with diverse reach** in terms of the demographic groups (e.g., age, gender, race/ethnicity, language) and the geographic areas they serve.

☐ **Choose partner agencies with capacity to participate and contribute to the partnership.** This includes ensuring that executive leadership are fully invested and that the agency has the capacity and willingness to be part of a long-term partnership. Of course, sometimes circumstances change, so be prepared to adapt to changes to the composition of partners.

☐ **To the extent possible, choose partner agencies that have a foundational knowledge of and cultural humility regarding LGBTQ+ issues and language**, such as an understanding of the differences between gender identity and sexual orientation, the importance of pronouns, and a willingness to learn and take feedback.

☐ **Partner agencies should also have foundational knowledge of and cultural humility around race/ethnicity, disability, income, and other diverse qualities**.

C. Organizational Planning

☐ **Begin with a strategic planning phase before launching programming**. To establish a shared vision, cohesive strategies, and achievable programming with the resources available, it is essential to start with a planning process led by a qualified facilitator who is experienced in guiding a strategic plan.

o The strategic planning process should include a community needs assessment to gather input on the types of programs and services the Center could provide.

☐ **Formalize partner roles and responsibilities through Memoranda of Understanding**. There are many options for the types of responsibilities and level of involvement of each partner in the collaborative model. Without clear roles and duties, the partnership can run into trouble if one partner feels they are taking on more than their reasonable share and other partner agencies are not clear about their expected involvement. Creating a Memorandum of Understanding (MOU) with each partner agency should be a prerequisite to starting the partnership.

o Roles and responsibilities should make it clear which agency has the authority to make final decisions regarding the partnership.

o MOUs should include a grievance and conflict resolution procedure.

☐ **Create a Board/Community Advisory Board.** An advisory board can support planning, fundraising, and program design. When recruiting board members, consider their experience to support these tasks and identify resources to deliver coaching on Board operations.

☐ **Begin planning for financial sustainability early.** A collaborative multi-service center is a complex endeavor with a multitude of fundraising and development needs. Hiring an experienced, full-time development professional will best position the Center for long-term sustainability with public and private funding. Also consider how partner agencies can be involved in each other's fundraising efforts.

D. Partnership Operations

☐ **Create written policies and procedures to support clear processes and accountability.** Policies and procedures may include, but are not limited to: clinical procedures; procedures for referrals to and from partner agencies; standardization of data collection; communication and meetings; training; and conflict resolution.

☐ **Ensure regular communication among partner agencies.** Each partner agency has its own organizational culture. While this is not necessarily something negative, it is important that partners are aligned in the areas of cultural humility and communication agreements.

o It is important for leadership from all partner agencies to have meetings on a regular basis to keep leadership up to date and seek input on organizational planning.

o It is important to have regular staff meetings that include frontline staff from partner agencies to discuss the day-to-day work. Smaller subsets of staff, such as a Program Team or Clinical Team, should also meet regularly.

2. Staffing and Training

To fulfill a vision of creating a collaborative hub for the LGBTQ+ community, staff should have 1) knowledge and understanding of issues impacting the LGBTQ+ youth, families, and older adults; 2) experience and passion for serving the LGBTQ+ community; 3) understanding of social justice and cultural humility; and 4) lived experience, cultural identities, and linguistic abilities that are reflective of the county's LGBTQ+ community and enhance the Center's capacity to provide culturally responsive services.

A. Staffing Model

☐ **Determine staff assignments**. Whether staff from partner agencies provide services on site at the Pride Center and whether any services are provided outside the Center (either at partner agency locations or satellite locations) shapes the sense of team identity and cohesion, affects workloads, and influences the community's understanding of the Center's model. Consider these factors in the context of your community and partnership and plan accordingly.

☐ **Guarantee a competitive compensation and benefits structure** that will attract and retain qualified staff. In addition to competitive compensation, offer benefits such as professional development and opportunities for growth (e.g., promotions, clinical training pathways).

☐ **Ensure that staff at all levels are reflective of the community's diversity** at the intersections of sexual orientation, gender identity, race/ethnicity, disability, age, and other diverse qualities. Identify language capacities needed to effectively serve the community.

☐ **Consider the number of program staff and the positions required to achieve the desired reach.** In concert with the strategic plan, map out an organizational chart that details each staff position and their role. Ensure that the number and type of planned staff is sufficient to manage program responsibilities with reasonable workloads. If it is not, consider how to narrow down the strategic plan so it is feasible with the available resources for staffing, or consider how to fundraise to support additional staffing.

☐ **Hire staff to oversee and support programming** so that these duties do not fall on frontline or direct service staff.

   o Hire a Program Manager(s) to oversee program planning, design, and quality improvement.

   o Hire an Administrative Coordinator(s) to support general Center operations, the clinical team, and the marketing and communications team. For example, this position could coordinate with agency facilities to address on-site needs, forward new client service inquiries, oversee clinical duties including Medicaid/Medi-Cal reimbursement and data collection and data entry processes for clinical data, and assist in distributing marketing and communications materials.

B. Staff Training and Support

☐ **Ensure there are processes for staff onboarding and exit**. Solid onboarding makes a huge difference in staff understanding their roles and expectations. Similarly, having processes when staff exit helps to tie loose ends in terms of client services and helps retain institutional knowledge that staff may be taking with them when they leave.

☐ **Create a staff training plan that includes cross-training** among partner agency staff. Identifying a staff training plan helps ensure that staff have the information and tools to carry out their roles effectively. At a minimum, the staff training plan must go beyond standard diversity trainings, and should cover topics including anti-racism, cultural humility, anti-oppression, disability and accessibility, and intersectionality.

☐ **Promote staff retention through compensation, promotion pathways, benefits, feasible roles, and attention to self-care**. Longevity of staff is vital to developing partnerships and institutional knowledge that facilitate high quality service delivery. As noted in the Staffing Model section, it is critical to offer staff competitive compensation and benefits, ensure that staff's workloads are feasible, and offer options for self-care such as flexible schedules and mental health days.

☐ **Identify supportive resources for staff.** Staff are not immune to the challenges that the LGBTQ+ community faces. Identify programmatic resources and/or service referrals and make them available for staff to support their own resilience and wellbeing.

3. Location and Physical Space

For in-person services, having a thoughtful physical space for a Pride Center builds community for LGBTQ+ individuals and impacts accessibility to much needed services.

☐ **Select a central location**. A location that is accessible via public transportation is a must.

☐ **As much as possible, select a visible location**. While the visibility—whether the Center is located on a main street and building signage/flags—is critical to building a sense of community for LGBTQ+ individuals, consider strategies to reach those who may not feel comfortable attending a visibly LGBTQ+ organization.

☐ **Ensure an accessible space**. It is important to have a space that is accessible to all, a physically accessible building for persons with disabilities, as well as accessibility considerations for individuals with chemical and sensory sensitivities, such as fragrance-free products.

☐ **Create a welcoming ambiance and feel in the physical space.** It is important to consider how you can use decorations, colors, and furniture to create a welcoming space for all. For example, certain styles may appeal more to youth participants, while other styles may appeal to older adults. Visuals such as art and posters within the space should be reflective of the diverse and intersectional identities within the LGBTQ+ community.

4. Programming

In any multi-service center—sometimes called a "one-stop shop"—there will be many options for programming, and it is important to be intentional and avoid overcommitting. Overall, the recommendation is to start small and then expand once programs are established and there is capacity to add more.

A. Program Planning

☐ **Define service types based on community interest.** The Pride Center has services in three areas: clinical services, social and community services, and training and resources. Programming that the Pride Center has not provided, but that other models could incorporate, include social services, such as housing and legal services.

☐ **Maximize program accessibility.** Consider how the Center will facilitate access to programs in the areas of program cost, transportation assistance, providing services at partner locations in other regions of the County, services in multiple languages, and in-person and virtual services.

☐ **Keep equity and inclusion at the forefront.** Program planning should prioritize equity and inclusion by continuously asking the question, "Who is not here?" The Center should gather data and reflect on which populations programs are reaching; identify potential disparities by race/ethnicity, gender, age, disability, or other characteristics; and seek to understand the reasons for disparities or exclusion.

☐ **Engage in self-reflection**. As discussed in the section on Data and Evaluation below, it is important for the Center to engage in critical self-reflection on a regular basis, gather feedback to identify areas for program improvement, and follow through on that feedback by modifying programs to be increasingly relevant, equitable, and accessible.

B. Clinical Services

☐ **Define the focal populations and services based on community interest and need.** Identify whether there are certain groups based on need, region, or demographics that the Center intends to serve.

　o Consider the level of mental health need (e.g., mild-to-moderate, serious mental illness) the Center will serve.

　o Ensure the Center can meet the needs of clients who speak languages other than English.

　o Consider whether the Center will include services such as Letters of Support for gender affirming health care.

　o Consider whether the Center will serve parents of LGBTQ+ children.

　o Consider whether the Center will offer group therapy in addition to individual therapy.

☐ **Develop clear referral pathways to clinical services** including multiple points of entry (e.g., phone, email, website); referral processes to and from external partners; and a

waitlist system. Consider how the referral and waitlist process may differ for individuals with or without insurance.

- o Assign the role of Intake Coordinator to a Program Manager or a clinician on staff to track requests for services, complete phone screenings, and add clients to a caseload or a waitlist.

☐ **Identify responsive clinical staffing composition**. There are a number of strategies to staff responsive clinical services.

- o Clearly define the role of each position, including the expected balance between administrative tasks and direct clinical services and/or supervisory expectations of clinical staff.

- o Ensure staff demographics are reflective of the community the Center seeks to serve.

- o Consider the number of clinical hours needed to serve the population and hire accordingly.

- o Offer full-time employment to clinicians (rather than part-time) to attract more candidates.

- o Consider how the Center will use clinical trainees to factor into a realistic caseload goal for their training term.

- o Consider what level of supervisor is needed for different clinical degrees (MFT, LASW, PCC, PsyD/PhD students/associates/interns) and create a plan to hire clinical supervisors.

- o Offer competitive pay rates for clinical supervisors and clinicians at all levels (associates, psychological interns/assistants, licensed clinicians) such that the Center can attract qualified staff.

- o Offer a competitive pay differential for bilingual staff.

- o Consider whether case management will be included in the clinical service array and how many case managers are needed to meet the need.

- o Consider whether the Center will have a psychiatrist (either on staff or as a consultant on retainer).

☐ **Include an external capacity development strategy**. No single Center can meet all of the clinical needs of the LGBTQ+ community. Having a training program is critical to expand culturally responsive clinical capacity across providers.

- o Identify a designated trainer within the clinical team to offer training to other behavioral health service providers.

- o Develop a consultation strategy to offer varying means for clinical providers to receive ongoing support beyond the initial trainings.

☐ **Develop an equitable sliding fee scale** that will enable higher income clients to subsidize clients who cannot pay full fee and are not covered by insurance, and periodically re-evaluate the scale. Consider reserving limited slots for pro-bono services.

☐ **Plan for the supportive and administrative functions of running a clinical program** including but not limited to: accounting, insurance billing, creating billing statements for clients to submit to private insurance, electronic health record (EHR)

management, information technology, and contracting with external clinical supervisors and/or trainees.

☐ **Develop a crisis plan** before beginning clinical services to ensure all clinicians are aware of crisis protocols. Plan for various reasonable scenarios that might occur at a community mental health facility.

C. Social and Community Services

☐ **Be intentional about program offerings.** With numerous, intersectional identities in the LGBTQ+ community, there are infinite possibilities for programming. It is critical to consider the ratio of programs to staff and narrow down the list of programs that will be offered, which should be based on a community needs assessment.

☐ **Create a balance of programming within and across identities**. There can be benefits to programming for specific groups within the LGBTQ+ umbrella and by certain age or cultural groups. For example, peer support groups for transgender and nonbinary youth, or for Filipinx adults, can provide a needed safe space. Additionally, it can be meaningful to offer opportunities for individuals across identity groups to socialize and build community. For example, intergenerational dinners or book groups can be a way for older and younger LGBTQ+ community members to learn from one another's experiences.

☐ **Co-sponsor social events with outside agencies that reach diverse populations.** For example, partner with a local, Black-led organization for an event related to Black and queer liberation.

☐ **Consider developing a volunteer program**. Having volunteers can be mutually beneficial as it can engage community members in a meaningful activity and support Center activities. It is important to consider that the volunteer program will need a staff assigned to support it so that there is a reliable contact for prospective and current volunteers.

D. Training and Resources

☐ **Identify a designated clinical trainer** with expertise in clinical services to provide training and consultation specifically around providing LGBTQ+ responsive behavioral health services.

☐ **Develop a training manual** with clear instructions, steps, and guidance on how to organize and facilitate trainings. The manual should be available to adapt based on changes to the training structure/procedures.

☐ **Offer diverse LGBTQ+ training topics** for community groups and service providers that include standard LGBTQ+ 101, and population specific trainings such as trans and non-binary 101 & 201, LGBTQ+ 201, Pronouns 101, etc.

☐ **Consider how to make trainings accessible to diverse audiences**. If possible, have trainings available in multiple languages, in-person and virtual formats. Offer closed captioning and other accessibility options.

☐ **Support audience in applying new knowledge** by having interactive components such as games and exercises and allotting time to practice newly learned skills.

5. Marketing and Outreach

Marketing and outreach to the community and external partners is key in getting the word out about services. It is a challenge to achieve community-wide awareness and recognition, so involving all partner agencies to help with outreach is important.

☐ **Outreach widely in the community**. Partner with communities of color and non-explicitly LGBTQ+ organizations, such as art spaces, racial/ethnic identity groups, libraries, schools, senior centers, faith-based organizations, and health care providers.

☐ **Allocate funding for advertising** in the forms of newspapers, ads, flyers, and social media, and staffing resources designated to conduct outreach and advertising.

☐ **Tailor outreach strategies for different populations**. Older adults may prefer print advertisement, such as fliers, newspapers, journals, magazines, and places of worship. Younger participants may respond well to online outreach in non-traditional venues, such as Instagram and dating apps. Outreach materials should be in multiple languages to meet the needs of the community and should include image descriptions for individuals who use accessibility technology.

☐ **Use social media and technology for outreach**. In addition to Facebook, Instagram, and other social media sites, consider partnering with an agency that could create an app for the Center to list events and programs.

6. Data and Evaluation

Regular data collection and evaluation is vital to support organizational process improvements, understand program outcomes, and report to funders. It is important to set up data collection processes from the beginning. Data collection for a multi-service center will require several ways of measuring participation, as some participants will be one-time or occasional participants, and some will be regular clinical clients. If possible, work with a data and evaluation consultant.

☐ **Determine processes to measure *non-clinical* participant reach and demographics.** For participants who attend social events, drop-in groups, and trainings, it will be difficult, or nearly impossible, to get a unique count of the number of people who attend, since people may attend multiple events and activities. However, it is still useful to have a rough count of the number of people the Center reaches via programming. Consider a way to document registration and attendance that balances information-gathering while respecting that one-time or sporadic participants may not want to share a wealth of personal information.

   o Attendance sign-ins should include basic demographic questions (e.g., race/ethnicity, sexual orientation, gender identity) so the Center can assess whether programs are reaching their intended audience.

☐ **Determine processes to gather unique data for *clinical* clients.** For clients who receive clinical services, the Center will need a system to gather and record information for each individual client. It will be important to develop an intake process that includes

necessary personal and demographic information as well as clinical assessments of clients' needs, strengths, and mental health status. The Center will likely want a process to collect baseline, follow-up, and exit data to understand changes in clients' mental health during the period they are receiving services.

☐ **Determine a data management system and process**. The Center will need a system to store participant data in a protected and confidential manner. It will be important to identify whether the sponsoring agency has an electronic health record (EHR) that can be modified for the Center or whether a new system is needed. The process for collecting and entering data into the system is as important as the system itself—ensure that clear processes are written for when data will be collected, by whom, how frequently, and who is responsible for data entry and quality assurance, and review and refine processes on a regular basis.

  o If there is no current system, consider working with a consultant to develop a data tracking system.

  o Develop and maintain easy-to-use reports that help track participant data.

☐ **Set up processes to learn about participant experience and outcomes**. In addition to collecting participant information, it is essential to gather information to understand whether and how the Center is improving people's lives. Consider both of the following opportunities to gather feedback directly from Center participants.

  o **Post-activity feedback**: Determine the events/programs/services for which the Center will collect feedback—likely in the form of a short survey—directly after or shortly after the activity. The Center will have many programs and events and it may not be feasible to gather participant feedback after every activity—select the key activities about which the Center would like feedback.

  o **Point-in-time feedback**: Consider an annual participant satisfaction/participant feedback survey to administer to all participants who have attended programs in the previous year. Outreach and publicity for this survey will be essential to receiving responses from a wide range of participants. Whenever possible, offer incentives (e.g., gift cards or prize raffles) for participation.

☐ **Collect data on service requests,** regardless of whether those services are delivered at the time, to measure the capacity of the Center to meet the community's need.

☐ **Consider data collection requirements across partner agencies** as partners may have distinct reporting requirements for different funders.

Appendix

Demographic Data – Non-Clinical Participants

Note: Some options on the demographic form were changed in FY2018-19

AGE	FY16-17 (N=36)	FY17-18 (N=400)	FY18-19 (N=199)	FY19-20 (N=426)
0-15	17%	5%	15%	7%
16-25	28%	29%	25%	22%
26-39	22%	30%	24%	38%
40-59	17%	26%	29%	23%
60+	17%	8%	8%	10%
Decline to answer	0	3%	0	0

RACE	FY16-17	FY17-18	FY18-19	FY19-20
White/Caucasian	50%	54%	59%	60%
Hispanic/Latino	65%	23%	23%	21%
Asian or Asian American		20%	19%	17%
Black or African American		5%	7%	6%
Native American or Native Alaskan		3%	5%	2%
Native Hawaiian or Pacific Islander		4%	2%	2%
Other		4%	4%	3%
Decline to answer		2%	N/A	N/A

ETHNICITY	FY16-17	FY17-18	FY18-19	FY19-20
European	Not enough data to report ethnicity breakdown	28%	35%	45%
Mexican/Chicanx/a/o		13%	21%	15%
Other		9%	14%	13%
Chinese		7%	8%	8%

Filipinx/a/o	8%	11%	7%
Eastern European	5%	5%	7%
African	4%	4%	4%
Central American	2%	N/A	3%
Pacific Islander	N/A	N/A	3%
South American	5%	4%	3%
Indigenous Nation	N/A	N/A	2%
Japanese	N/A	N/A	2%
Middle Eastern	3%	N/A	2%
Puerto Rican	N/A	N/A	2%
Vietnamese	N/A	N/A	2%
Decline to answer	9%	N/A	N/A

SEX	FY16-17 (N=38)	FY17-18 (N=400)	FY18-19 (N=193)	FY19-20 (N=193)
Female	76%	61%	59%	55%
Male	21%	31%	40%	45%
Decline to answer	3%	9%	N/A	N/A

GENDER IDENTITY	FY16-17 (N=39)	FY17-18 (N=400)	FY18-19 (N=181)	FY19-20 (N=400)
Cisgender Woman/Woman	44%	39%	40%	39%
Cisgender Man/Man	21%	23%	22%	30%
Genderqueer/Gender nonconforming/Neither exclusively male nor female	3%	9%	9%	13%
Trans Woman/Transgender Female/Trans-feminine/Male-to-Female (MTF)/Woman	36%	3%	10%	9%

Trans Man/Transgender Male/Trans-masculine/Female-to-Male (FTM)/Man		4%	9%	9%
Questioning or unsure of gender identity		3%	5%	3%
Another Gender Identity	N/A	2%	4%	2%
Indigenous Gender Identity	N/A	N/A	N/A	2%
Decline to answer	N/A	18%	N/A	N/A

SEXUAL ORIENTATION	FY16-17 (N=37)	FY17-18 (N=400)	FY18-19 (N=186)	FY19-20 (N=405)
Gay or Lesbian	46%	30%	26%	33%
Bisexual	19%	9%	21%	18%
Heterosexual or Straight	36%	30%	23%	26%
Queer		12%	9%	13%
Pansexual		5%	12%	11%
Asexual		3%	3%	6%
Questioning or unsure of sexual orientation		2%	5%	4%
Another sexual orientation		2%	N/A	2%
Decline to answer		9%	N/A	N/A

DISABILITY STATUS	FY16-17	FY17-18	FY18-19	FY19-20
None	73%	59%	67%	58%
Mental health condition	N/A	N/A	N/A	30%
Chronic health condition	14%	6%	9%	10%
Learning disability		4%	6%	7%
Limited physical mobility		2%	6%	5%
Difficulty hearing or having speech understood		3%	N/A	4%

Another challenge with communication		1%	N/A	4%
Another disability or condition	14%	8%	13%	3%
Difficulty seeing	N/A	5%	4%	3%
Developmental disability	N/A	N/A	N/A	2%

EDUCATION	FY16-17 (N=39)	FY17-18 (N=400)	FY18-19 (N=188)	FY19-20
Less than a high school diploma	18%	7%	15%	N/A
High school diploma or GED, Some college, vocational or trade certificate	15%	22%	35%	N/A
Bachelor's or Associate's Degree	38%	32%	34%	N/A
Graduate Degree	18%	28%	17%	N/A
Decline to answer	10%	10%	N/A	N/A

INCOME	FY16-17 (N=32)	FY17-18 (N=265)	FY18-19 (N=139)	FY19-20 (N=329)
$0-$24,999	34%	16%	41%	30%
$25,000-$50,000	16%	16%	23%	19%
$50,001-$75,000	19%	16%	12%	16%
$75,001-$100,000		13%	10%	12%
Above $100,000	16%	14%	14%	22%
Decline to answer	16%	26%	N/A	N/A

EMPLOYMENT	FY16-17 (N=38)	FY17-18 (N=400)	FY18-19 (N=186)	FY19-20 (N=387)
Full time employment	34%	44%	38%	58%
Student	26%	17%	24%	22%

Part time employment	13%	14%	17%	19%
Retired	26%	5%	6%	5%
Unemployed and looking for work		10%	10%	4%
Unemployed and not looking for work		N/A	5%	4%
Unable to work due to disability or illness	N/A	N/A	N/A	4%
Decline to answer	N/A	11%	N/A	N/A

HOUSING STATUS	FY16-17 (N=36)	FY17-18 (N=265)	FY18-19 (N=188)	FY19-20 (N=414)
Stable housing	69%	79%	77%	85%
Temporarily staying with friends or family	28%	5%	12%	5%
Another housing status		4%	10%	3%
Renting with a subsidy, voucher, or supportive services	N/A	N/A	N/A	2%
Homeless and unsheltered	N/A	N/A	3%	4%
Decline to answer	3%	10%	N/A	N/A

Demographic Data – Clinical Participants

AGE	FY17-18 (N=93)	FY18-19 (N=153)	FY19-20 (N=132)	FY20-21 (N=169)	TOTAL (N=395)
0-15	8%	16%	20%	14%	17%
16-25	34%	31%	29%	36%	32%
26-39	30%	25%	27%	28%	26%
40-59	17%	24%	20%	17%	20%
60+	17%	5%	4%	5%	5%
Decline to answer	1%	0	0	0	1%

RACE	FY17-18	FY18-19	FY19-20	FY20-21	TOTAL (N=394)
White/Caucasian	37%	44%	40%	54%	47%
Hispanic/Latino	34%	29%	29%	24%	26%
Asian or Asian American	8%	16%	11%	11%	11%
Black or African American	5%	6%	8%	5%	6%
Other	3%	5%	6%	5%	5%
Native American or Native Alaskan	2%	4%	5%	2%	2%
Native Hawaiian or Pacific Islander	0%	1%	2%	2%	1%
Decline to answer	15%	5%	12%	7%	10%

ETHNICITY	FY17-18	FY18-19	FY19-20	FY20-21	TOTAL (N=395)
European	32%	35%	32%	39%	36%
Mexican/Chicanx/a/o	17%	10%	15%	13%	13%
Other	12%	16%	11%	9%	11%

Eastern European	8%	7%	11%	16%	11%
Central American	6%	6%	6%	5%	6%
Filipinx/a/o	3%	5%	5%	7%	5%
African	4%	3%	7%	5%	5%
Chinese	3%	5%	3%	3%	4%
South American	3%	3%	4%	5%	4%
Middle Eastern	1%	3%	2%	2%	2%
Pacific Islander	0%	2%	3%	1%	1%
Indigenous Nation	1%	3%	2%	1%	1%
Japanese	0%	1%	0%	0%	1%
Puerto Rican	0%	0%	0%	0%	0%
Vietnamese	0%	0%	0	0%	0%
Decline to answer	19%	14%	18%	13%	15%

SEX AT BIRTH*	FY17-18 (N=15)	FY18-19 (N=50)	FY19-20 (N=114)	FY20-21 (N=131)	TOTAL (N=207)
Female	60%	56%	55%	57%	56%
Male	40%	44%	45%	43%	44%

*Those who stated "decline to answer" were not included in the analysis

GENDER IDENTITY*	FY17-18 (N=87)	FY18-19 (N=145)	FY19-20 (N=127)	FY20-21 (N=162)	TOTAL (N=376)
Cisgender Woman/Woman	23%	28%	17%	23%	23%
Cisgender Man/Man	33%	21%	17%	13%	20%
Genderqueer/Gender nonconforming/Neither exclusively male nor female	11%	13%	13%	9%	11%
Trans Woman/Transgender Female/Trans-feminine/Male-to-Female (MTF)/Woman	14%	17%	22%	21%	18%

Trans Man/Transgender Male/Trans-masculine/Female-to-Male (FTM)/Man	14%	15%	23%	25%	20%
Questioning or unsure of gender identity	5%	3%	6%	6%	5%
Another Gender Identity	0%	1%	2%	4%	2%
Indigenous Gender Identity	N/A	N/A	N/A	N/A	N/A

*Those who stated "decline to answer" were not included in the analysis

SEXUAL ORIENTATION*	FY17-18 (N=79)	FY18-19 (N=140)	FY19-20 (N=186)	FY20-21 (N=156)	TOTAL (N=342)
Gay or Lesbian	46%	27%	29%	32%	32%
Bisexual	6%	17%	20%	18%	14%
Heterosexual or Straight	14%	14%	12%	17%	14%
Queer	18%	20%	20%	30%	19%
Pansexual	9%	12%	12%	17%	10%
Asexual	1%	3%	3%	5%	2%
Questioning or unsure of sexual orientation	6%	7%	10%	22%	12%
Another sexual orientation	1%	1%	1%	1%	1%

*Those who stated "decline to answer" were not included in the analysis

DISABILITY STATUS*	TOTAL (N=252)
None of the above	45%
Mental health condition	28%
Chronic health condition	11%
Learning disability	6%
Limited physical mobility	4%

Difficulty hearing or having speech understood	1%
Another challenge with communication	1%
Another disability or condition	3%
Difficulty seeing	2%
Developmental disability	2%
Decline to answer	17%

*Data was only calculated for the total across fiscal years

INCOME*	FY17-18 (N=15)	FY18-19 (N=43)	FY19-20 (N=85)	FY19-20 (N=115)	TOTAL (N=161)
$0-$24,999	80%	67%	58%	65%	60%
$25,000-$50,000	7%	21%	21%	17%	19%
$50,001-$75,000	13%	5%	10%	11%	10%
$75,001-$100,000	0	7%	11%	3%	8%
Above $100,000	0	0	1%	3%	3%

*Those who stated "decline to answer" were not included in the analysis; data only calculated for ages 16 and older

EMPLOYMENT*	FY17-18 (N=15)	FY18-19 (N=54)	FY19-20 (N=123)	FY20-21 (N=159)	TOTAL (N=239)
Full time employment	7%	17%	25%	23%	24%
Student	20%	30%	37%	31%	33%
Part time employment	33%	22%	12%	19%	15%
Retired	7%	2%	2%	3%	3%
Unemployed and looking for work	20%	15%	11%	13%	12%
Unemployed and not looking for work	N/A	2%	2%	5%	3%
Unable to work due to disability or illness	N/A	15%	11%	8%	8%

*Those who stated "decline to answer" were not included in the analysis

HOUSING STATUS*	FY17-18 (N=15)	FY18-19 (N=53)	FY19-20 (N=120)	FY20-21 (N=154)	TOTAL (N=192)
Stable housing	67%	68%	72%	80%	73%
Temporarily staying with friends or family	N/A	11%	13%	10%	13%
Another housing status	N/A	2%	1%	2%	2%
Renting with a subsidy, voucher, or supportive services	13%	6%	3%	2%	3%
Staying in an emergency shelter or transitional housing program	13%	8%	6%	6%	7%
Homeless and unsheltered	7%	6%	5%	1%	3%

*Those who stated "decline to answer" were not included in the analysis; data only calculated for ages 16 and older

Clinical Assessment Data

ANSA Baseline Data (N=88)

Domain	Avg Score
Functioning Domain	0.61
Strengths Domain	1.67
Cultural Factors	0.53
Behavioral/Emotional Needs	0.67
Risk Behaviors	0.18

Domain/Characteristic	Avg Score
Functioning Domain	0.61
Family Relationships	1.38
Physical/Medical	0.67
Employment/Functioning	0.66
Social Functioning	1.07
Recreational	0.61
Developmental/intellectual	0.21
Sexual Development	0.68
Living Skills	0.35
Residential Stability	0.60
Legal	0.25
Sleep	0.71
Self-Care	0.76
Medication Compliance	0.26
Transportation	0.24
Living Situation	0.83
School	0.42
Strengths Domain	1.67
Family Strengths	1.77
Interpersonal/Social Connectedness	1.55
Optimism	1.52
Educational Setting	1.87
Job History	1.59
Talents and Interests	1.54
Spiritual/Religious	2.07
Community Connection	1.99
Natural Supports	1.66
Resilience	0.99
Resourcefulness	1.14

Domain/Characteristic	Avg Score
Volunteering	2.39
Vocational	1.72
Cultural Factors	**0.53**
Language	0.10
Cultural Identity	0.90
Traditions and Rituals	0.16
Cultural Stress	1.01
Behavioral/Emotional Needs	**0.67**
Psychosis (Thought Disorder)	0.30
Impulse Control	0.37
Depression	1.47
Anxiety	1.51
Interpersonal Problems	0.73
Antisocial Behavior	0.02
Adjustment to Trauma	1.26
Anger Control	0.32
Substance Abuse	0.44
Eating Disturbances	0.23
Risk Behaviors	**0.18**
Suicide Risk	0.57
Non-Suicidal Self-Injurious Behavior	0.17
Other Self-Harm	0.22
Exploitation	0.31
Danger to Others	0.03
Gambling	0.01
Sexual Aggression	0.00
Criminal Behavior	0.10

ANSA Pre/Post Data (N=61)

Domain	Baseline Avg Score	Follow-up Avg Score	Avg Change
Functioning Domain	0.62	0.61	-0.01
Strengths Domain	1.71	1.59	-0.12
Cultural Factors	0.53	0.50	-0.03
Behavioral/Emotional Needs	0.70	0.68	-0.02
Risk Behaviors	0.20	0.20	0.00

Domain/Characteristic	Baseline Avg Score	Follow-up Avg Score	Avg Change
Functioning Domain	**0.62**	**0.61**	**-0.01**
School	0.61	0.23	-0.38
Family Relationships	1.41	1.19	-0.22
Sexual Development	0.60	0.40	-0.20
Sleep	0.73	0.70	-0.03
Self-Care	0.85	0.72	-0.13
Social Functioning	1.17	1.17	0.00
Recreational	0.58	0.55	-0.03
Medication Compliance	0.32	0.27	-0.06
Transportation	0.22	0.20	-0.02
Living Situation	0.80	0.90	0.10
Residential Stability	0.51	0.55	0.04
Developmental/intellectual	0.25	0.32	0.07
Legal	0.22	0.27	0.05
Living Skills	0.34	0.47	0.13
Employment/Functioning	0.77	0.98	0.21
Physical/Medical	0.63	0.73	0.10
Strengths Domain	**1.71**	**1.59**	**-0.12**
Spiritual/Religious	2.14	1.85	-0.29
Talents and Interests	1.53	1.22	-0.32
Resilience	0.92	0.73	-0.18
Optimism	1.53	1.22	-0.32
Volunteering	2.52	2.34	-0.17
Natural Supports	1.71	1.68	-0.03
Interpersonal/Social Connectedness	1.59	1.52	-0.08
Community Connection	1.95	1.69	-0.25
Resourcefulness	1.15	1.02	-0.13
Family Strengths	1.77	1.77	0.00
Educational Setting	2.26	2.14	-0.11
Job History	1.66	1.76	0.10

Domain/Characteristic	Baseline Avg Score	Follow-up Avg Score	Avg Change
Vocational	1.83	2.02	0.19
Cultural Factors	**0.53**	**0.50**	**-0.03**
Cultural Identity	1.00	0.67	-0.33
Language	0.08	0.08	0.00
Traditions and Rituals	0.17	0.23	0.07
Cultural Stress	0.98	1.05	0.07
Behavioral/Emotional Needs	**0.70**	**0.68**	**-0.02**
Anxiety	1.57	1.32	-0.26
Depression	1.57	1.40	-0.17
Adjustment to Trauma	1.30	1.08	-0.21
Psychosis (Thought Disorder)	0.38	0.27	-0.11
Substance Abuse	0.44	0.48	0.04
Interpersonal Problems	0.83	0.95	0.12
Antisocial Behavior	0.02	0.08	0.07
Eating Disturbances	0.21	0.22	0.01
Anger Control	0.21	0.38	0.17
Impulse Control	0.36	0.52	0.15
Risk Behaviors	**0.20**	**0.20**	**0.00**
Exploitation	0.38	0.31	-0.07
Other Self-Harm	0.25	0.22	-0.03
Suicide Risk	0.66	0.59	-0.06
Gambling	0.00	0.00	0.00
Criminal Behavior	0.12	0.12	0.00
Non-Suicidal Self-Injurious Behavior	0.21	0.27	0.06
Sexual Aggression	0.00	0.02	0.02
Danger to Others	0.02	0.08	0.07

CANS Baseline Data (N=24)

Domain	Avg Score
Functioning Domain	0.56
Strengths Domain	1.33
Cultural Factors	0.48
Caregiver Resources and Needs	0.33
Child Behavioral/Emotional Needs	0.50
Risk Behaviors	0.14

Domain/Characteristic	Avg Score
Functioning Domain	0.56
Family Functioning	0.92
Living Situation	0.63
Social Functioning	1.00
Recreational	0.63
Developmental/intellectual	0.25
Job Functioning	0.10
Legal	0.13
Medical/Physical	0.46
Sexual Development	0.71
Sleep	1.00
School Behavior	0.52
School Attendance	0.22
School Achievement	0.74
Decision-making	0.48
Strengths Domain	1.33
Family Strengths	0.83
Interpersonal/Social Connectedness	1.43
Optimism	1.13
Educational Setting	1.17
Vocational	1.63
Talents and Interests	1.04
Spiritual/Religious	2.17
Community Life	1.78
Relationship Permanence	1.00
Resiliency	0.83
Resourcefulness	1.43
Cultural Identity	1.52
Natural Supports	1.35

Domain/Characteristic	Avg Score
Cultural Factors	**0.48**
Language	0.17
Traditions and Rituals	0.13
Cultural Stress	1.04
Caregiver Resources and Needs	**0.33**
Supervision	0.22
Involvement with Care	0.52
Knowledge	0.87
Organization	0.30
Social Resources	0.70
Residential Stability	0.17
Medical/Physical	0.13
Mental Health	0.39
Substance Abuse	0.17
Developmental	0.04
Safety	0.13
Child Behavioral/Emotional Needs	**0.50**
Psychosis (Thought Disorder)	0.30
Impulsivity/Hyperactivity	0.30
Depression	1.17
Anxiety	1.35
Oppositional	0.26
Conduct	0.04
Adjustment to Trauma	0.48
Attachment Difficulties	0.61
Anger Control	0.39
Substance Use	0.13
Risk Behaviors	**0.14**
Suicide Risk	0.52
Non-Suicidal Self-Injurious Behavior	0.39
Other Self-Harm	0.13
Danger to Others	0.00
Sexual Aggression	0.00
Runaway	0.04
Delinquent Behavior	0.09
Fire Setting	0.00
Intentional Misbehavior	0.04

CANS Pre/Post Data (N=11)

Domain	Baseline Avg Score	Follow-up Avg Score	Avg Change
Functioning Domain	0.55	0.47	-0.08
Strengths Domain	1.61	1.3	-0.31
Cultural Factors	0.50	0.36	-0.14
Caregiver Resources and Needs	0.35	0.31	-0.04
Child Behavioral/Emotional Needs	0.46	0.45	-0.01
Risk Behaviors	0.11	0.15	0.04

Domain/Characteristic	Baseline Avg Score	Follow-up Avg Score	Avg Change
Functioning Domain	0.55	0.47	-0.08
Recreational	0.45	0.20	-0.25
Decision-making	0.50	0.36	-0.14
Sexual Development	1.00	1.00	0.00
Social Functioning	1.00	0.73	-0.27
Sleep	1.10	0.91	-0.19
Medical/Physical	0.00	0.18	0.18
Living Situation	0.45	0.36	-0.09
School Achievement	0.60	0.55	-0.05
Developmental/intellectual	0.36	0.18	-0.18
School Behavior	0.40	0.27	-0.13
Job Functioning	0.11	0.10	-0.01
Legal	0.18	0.09	-0.09
Family Functioning	0.82	0.91	0.09
School Attendance	0.00	0.27	0.27
Strengths Domain	1.61	1.3	-0.31
Interpersonal	1.70	0.82	-0.88
Natural Supports	1.40	0.91	-0.49
Cultural Identity	2.00	1.18	-0.82
Resourcefulness	2.00	1.18	-0.82
Optimism	1.40	0.91	-0.49
Community Life	2.30	2.00	-0.30
Family Strengths	0.80	0.73	-0.07
Educational Setting	1.50	1.45	-0.05
Talents and Interests	1.10	1.09	-0.01
Relationship Permanence	1.20	1.18	-0.02
Vocational	2.29	2.80	0.51
Spiritual/Religious	2.60	2.73	0.13
Resiliency	0.80	0.73	-0.07

Domain/Characteristic	Baseline Avg Score	Follow-up Avg Score	Avg Change
Cultural Factors	0.50	0.36	-0.14
Language	0.30	0.09	-0.21
Traditions and Rituals	0.10	0.00	-0.10
Cultural Stress	1.10	1.00	-0.10
Caregiver Resources and Needs	0.35	0.31	-0.04
Social Resources	0.70	0.27	-0.43
Organization	0.40	0.36	-0.04
Residential Stability	0.30	0.09	-0.21
Knowledge	1.00	1.00	0.00
Involvement with Care	0.40	0.36	-0.04
Mental Health	0.50	0.45	-0.05
Substance Use	0.20	0.27	0.07
Safety	0.10	0.09	-0.01
Supervision	0.30	0.36	0.06
Developmental	0.00	0.09	0.09
Medical/Physical	0.00	0.18	0.18
Child Behavioral/Emotional Needs	0.46	0.45	-0.01
Anxiety	1.50	1.09	-0.41
Adjustment to Trauma	0.50	0.64	0.14
Depression	1.10	0.91	-0.19
Anger Control	0.20	0.18	-0.02
Substance Use	0.20	0.18	-0.02
Oppositional	0.10	0.09	-0.01
Psychosis (Thought Disorder)	0.20	0.00	-0.20
Impulsivity/Hyperactivity	0.20	0.27	0.07
Conduct	0.00	0.18	0.18
Attachment Difficulties	0.60	0.91	0.31
Risk Behaviors	0.11	0.15	0.04
Other Self-Harm	0.20	0.09	-0.11
Suicide Risk	0.60	0.64	0.04
Non-Suicidal Self-Injurious Behavior	0.20	0.27	0.07
Sexual Aggression	0.00	0.00	0.00
Runaway	0.00	0.00	0.00
Fire Setting	0.00	0.00	0.00
Danger to Others	0.00	0.09	0.09
Delinquent Behavior	0.00	0.18	0.18
Intentional Misbehavior	0.00	0.09	0.09