



San Mateo County Health System

Behavioral Health and Recovery Services Division



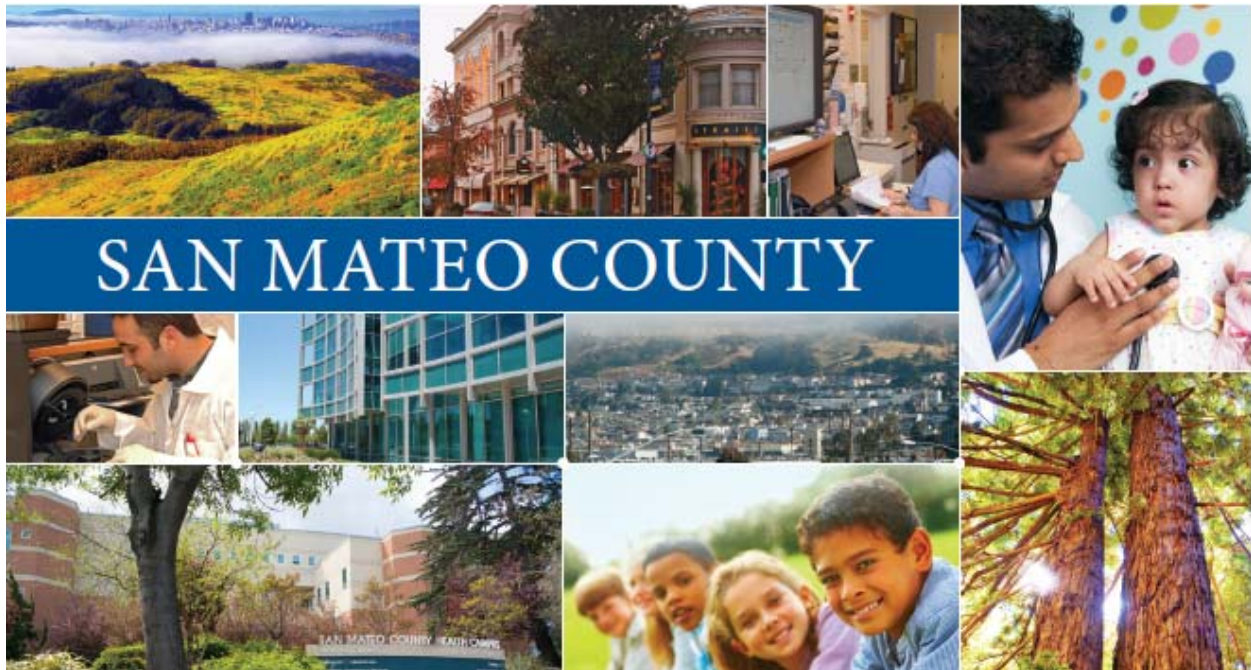
Mental Health Services Act (MHSA) FISCAL YEAR (FY) 2013/2014

UPDATE TO THE THREE-YEAR PROGRAM
AND EXPENDITURE PLAN

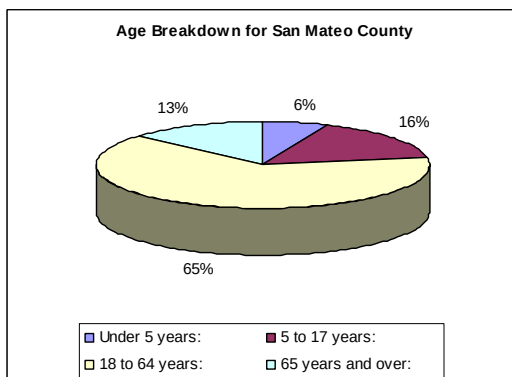
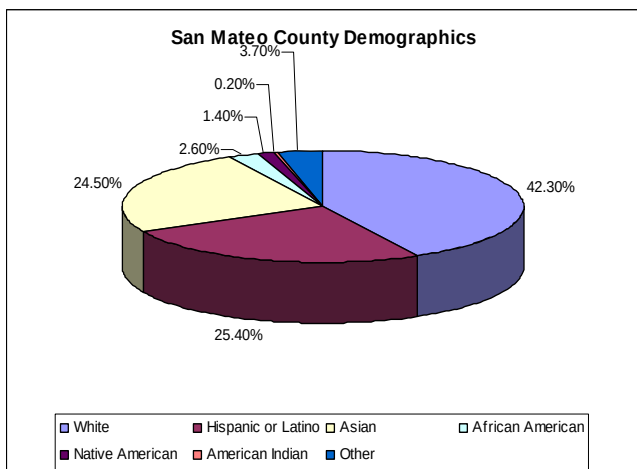


WELLNESS • RECOVERY • RESILIENCE

About San Mateo County



Home to 727,209 people (estimated Census 2012), San Mateo is one of the most diverse counties in California, both in terms of population and geography.



Threshold languages are English and Spanish, however, the San Mateo County Health System has identified Chinese, Russian, Tagalog, and Tongan and as priority languages based on the clients served by the System. Data indicate that 44.9% of individuals served by the Health System speak a language other than English at home (19.8% Spanish and 17.6% Asian and Pacific Islander languages).

(See charts for racial/ethnic and age makeup of the County.)

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

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

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



CRYSTAL SPRINGS RESERVOIR

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

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



**SAN FRANCISCO INTERNATIONAL AIRPORT (LEFT)
PORT OF REDWOOD CITY (BELOW)**



Community Planning Process

INTRODUCTION

In mid 2011, the Substance Abuse and Mental Health Services Administration (SAMHSA) developed a concept paper¹ outlining what a *good and modern* behavioral health system would look like in a transformed healthcare environment like the one envisioned by the imminent full implementation of the Patient Protection and Affordable Care Act (health care reform).

The Behavioral Health and Recovery Services (BHRS) Division of the San Mateo County Health System wanted to take a good look at the way in which it is organized through the lens of the attributes of a *good and modern* system as delineated by SAMHSA. Some of those attributes include:

- Continuum of effective treatment and support services spanning healthcare, employment, housing, and educational sectors;
- Integration of primary care and behavioral health;
- The system should be:
 - Accountable;
 - Organized;
 - In control of costs;
 - Constantly striving to improve quality;
 - Accessible;
 - Equitable;
 - Effective; and
 - A public health asset that improves lives and lengthens the lifespan.

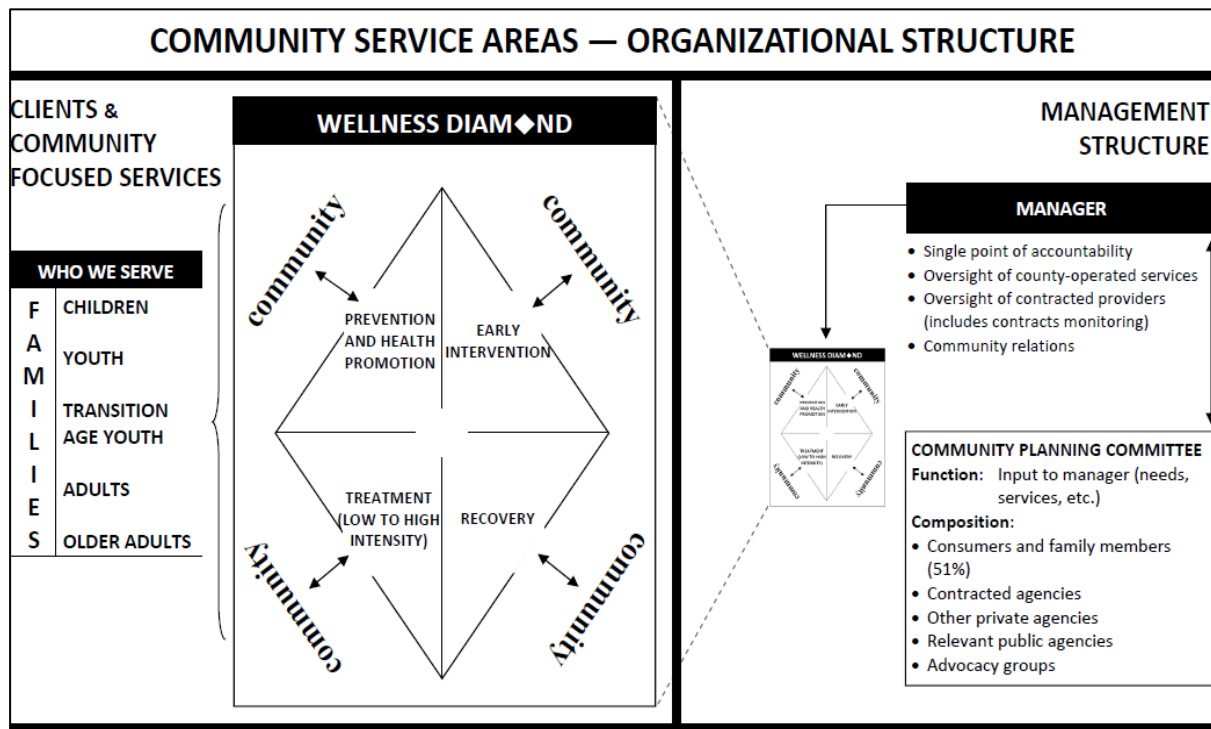
When these key elements are in place:

- People avoid illnesses that can be prevented;
- People get well and stay well;
- The continuum of services supports recovery and resilience, includes prevention and early intervention, and has an emphasis on cost-effective, evidence-based and best practice service approaches; and special consideration is given to un-served and underserved populations;
- Integrated, high quality medication management and psychosocial interventions are available and provided in the appropriate “therapeutic dose;”
- Promotion of program standards, utilization management measurements/criteria, quality requirements, performance expectations and consumer/family/youth outcomes. Data are used to improve care; and
- Adequate number and distribution of appropriately credentialed primary care and behavioral healthcare providers (emphasis on workforce development).

¹ “Description of a Good and Modern Addictions and Mental Health System,” Substance Abuse and Mental Health Administration, April-June 2011.

We then posed the question: Is ours *a good and modern* system of care? We came to the conclusion that, while ours is a solid system that has been at the forefront of innovation, there is always room for improvement.

Our next step involved the development of a theoretical model aligned with the vision in which we all share the resources and the responsibility for caring for our community, especially those who have been traditionally marginalized or underserved. We call the model a “Community Service Area,” and here is a depiction of its central elements:



(For more on this model please visit www.smchealth.org/BHRSGoodModern)

The challenges we are trying to address tie directly to issues central to the Mental Health Services Act: How do we better provide a seamless service experience for our clients? How do we ensure we provide what is needed, when it is needed, in the dose in which it is needed? How do we improve our outreach to and engagement of those who experience greater barriers in access—especially those who tend to be underrepresented in our system? How do we avoid overrepresentation in our system of marginalized populations? How do we make sure that all who need access can have it in equal measure?

In search for the answers to these and other questions, BHRS engaged the community of stakeholders to obtain input on ways to improve the quality and delivery of our services across the board, regardless of the funding source. We asked the community for input regarding our proposed model, and we asked about priorities for those connected to our system, whether they are clients, family members, staff, community partners, government partners, traditional or non traditional behavioral health service providers, and partners in other fields.

We held 17 community sessions throughout the County, and received a wealth of input; in addition, our Director hosted three live webinars on different days and at different times of the day in order to make it accessible to more people.

January 4, 2012 – BHRS Leadership
March 7, 2012 – Mental Health and Substance Abuse Recovery Commission (MHSARC)
March 9, 2012 – Co-Occurring Steering Committee
March 15, 2012 – Provider Coalition
March 19, 2012 – Community Workers & Family Partners
March 22, 2012 – Consumer Recovery Coalition/Voices of recovery/Heart& Soul
March 28, 2012 – Change Agents
April 5, 2012 – North County Outreach Collaborative
April 18, 2012 – Cultural Competence Committee
April 19, 2012 – Central Region Session #1
April 19, 2012 – South County
April 26, 2012 – Coastside Clinic
April 26, 2012 – Meet and Greet with Families
April 27, 2012 – Central Region Session #2
May 3, 2012 – North County
May 4, 2012 – East Palo Alto Clinic
May 31, 2012 – East Palo Alto Mental Health Advisory Group

The input received was incorporated into the Community Service Area Model (or CSA), and a weeklong workshop with 39 people representing the breadth of behavioral health stakeholders fine-tuned the model, November 2-6, 2012. As we were getting ready for the release of the MHSA Plan Update, a second weeklong event took place March 11-15, 2013, aimed at tailoring the CSA Model to the needs of one geographic area of the County (South/Fair Oaks), which was chosen as a pilot site. In the next year, we expect to hold similar workshops in the five remaining areas of our County, hence officially shifting to this new service delivery approach.

As we look to the future, the word “integration” becomes more and more relevant: not only integration between mental health and substance use (which our Division undertook in 2007), but integration with primary care. The Mental Health Services Act also calls for an integrated plan, which will be formalized in the near future. We thought that this process was a perfect opportunity to explore new ways to serve our clients and re-assess the community needs and expectations, extending the notion of coordination of efforts deeper than ever to the network of community-based partners that provide mental health and non-mental health services.

BACKGROUND

The Behavioral Health and Recovery Services Division of the San Mateo County Health System devised a local planning process and structure to seek input from the broad San Mateo stakeholder community for the initial component of the Mental Health Services Act (MHSA) to be implemented, namely Community Services and Supports. This planning structure has

remained in place and has since framed all our planning activities related to any component of the MHSA, with adjustments as needed.

It is our belief that “planning” is an ongoing endeavor, therefore we make it a point to seek input and offer information throughout the year. The Mental Health and Substance Abuse Recovery Commission (MHSARC, formerly the Mental Health Board), as a whole and through its committee structure, is involved in all MHSA planning activities providing input and receiving regular updates. The meetings of the MHSARC are open to the public, and attendance is encouraged through various means: notice of meetings (flyers, emails) are sent to a broad, ever-increasing network of contacts including community partners and County agencies, as well as consumer and advocacy organizations, and the general public. There is an MHSA report at virtually every MHSARC monthly meeting. In addition, opportunities for input are publicized at different internal and external meetings and venues; presentations and ongoing progress reports are provided by BHRS, and input is sought on an ongoing basis at the different committees of the MHSARC (they meet monthly); at the monthly MHSARC meeting; at meetings with community partners and advocates; and internally with staff.

The MHSA Steering Committee created at the very beginning (2005) to spearhead the implementation of the MHSA is co-chaired by a member of the San Mateo County Board of Supervisors and by the Chair of the Mental Health and Substance Abuse Recovery Commission. Comprised of over 40 community leaders representing the diverse San Mateo community including behavioral health constituencies (clients, advocates, family members, community partners, County and CBO staff), and non behavioral health constituencies (County leadership, Education, Criminal Justice, Probation, Courts, among others), the MHSA Steering Committee greenlights MHSA proposals and approves the programmatic direction of MHSA-funded activities. All members of the Mental Health and Substance Abuse Recovery Commission are members of the MHSA Steering Committee.

A multiyear approach to planning underlies San Mateo County’s MHSA strategy, which facilitates stable programming, ensures a balanced approach when considering programmatic changes, and utilizes higher revenue years to cushion lower revenue years.

MHSA-specific priorities identified in FY 11/12 remain top priorities for FY 13/14:

- Creation of Full Service Partnership slots for Psychiatric Emergency Services and our Medical Center’s Psychiatric Inpatient Unit (3AB) (Transition Age Youth and Adults);
- Expansion of slots for Transition Age Youth, with housing;
- Expansion of integrated Full Service Partnerships (FSP) to the Central Region (Adults);
- Expansion of Wraparound services for children and youth;
- Additional housing for existing FSP Adults;
- Pre-crisis response services;
- Expansion of supports for youth transitioning to adulthood;
- Expansion of assessment, supported employment, and financial empowerment for clients;
- Expansion of Teaching Pro-social Skills; and
- Expansion of the Parent Project.

These priorities will be implemented as dollars become available. Since the disbursement of MHSA dollars to counties has shifted to an accrual basis, we want to make sure we balance revenue with our multiyear approach so that the level of programming is not at the mercy of revenue fluctuations.

PUBLIC COMMENT AND PUBLIC HEARING

The MHSA Steering Committee heard the FY 13/14 MHSA Plan on March 6, 2013, when the MHSARC also released it for public comment. The public comment period closed on May 1, 2013; on that day, the MHSARC held a public hearing.

Outreach strategies used to circulate information and to seek public comment include: posters and flyers created and sent to/placed at County facilities, as well as other venues like family resource centers and community-based organizations; the numerous internal and external meetings mentioned above; e-mails disseminating information about the availability of plans open for public comment are sent to over 1,000 electronic addresses in our ever-expanding database; notices are published in the local paper of largest circulation; word of mouth on the part of our committed staff and active stakeholders, among other dissemination strategies. Proposals are also posted on our MHSA website smchealth.org/mhsa.

STAKEHOLDER ENTITIES INVOLVED IN THE COMMUNITY PROGRAM PLANNING PROCESS

As mentioned above, the Mental Health Services Act implementation is very much a part of BHRS' day-to-day business. Information is shared with a diverse group of stakeholders on an ongoing basis through progress reports, and by sharing successes and challenges. In this way, input is provided and collected on a regular basis at various venues. All the MHSA information is made available to stakeholders on the San Mateo County Behavioral Health and Recovery Services website, which contains a MHSA webpage. The MHSA webpage is the hub of information for all-things MHSA. The site includes a feature that allows interested parties to sign up to receive an automated email every time the website is updated. This is a convenient and hassle-free way for stakeholders to keep apprised of MHSA developments, and learn about meetings and opportunities for input. The current list of subscribers to that page has grown to 571, up from 412 last year. Hard copies of all our materials are made available upon request.

BHRS's e-journal, *Wellness Matters*, which is published the first Wednesday of each month and distributed electronically to over 700 stakeholders, is also utilized as an information dissemination and educational tool, with a standing column written by the County's Manager of Strategic Operations (MHSA Coordinator).

MENTAL HEALTH SERVICES ACT STEERING COMMITTEE

Maya Altman Executive Director Health Plan of San Mateo	Dan Becker Representative for the Hospital Council Mills Peninsula Hospitals	Clarise Blanchard Director of Substance Abuse and Co-occurring Disorders, Star-Vista; Representative BHRS Contractors Association
Rodina Catalano Deputy Court Executive Officer of Operations, County of San Mateo	Susan Ehrlich, MD CEO San Mateo Medical Center	Patrick Field Consumer
Randall Fox Holistic Health Advocate	Carmen Lee Stamp Out Stigma	Peter C. Lee Interim Executive Director First 5 San Mateo County
Don Mattei Law Enforcement	Sharon McAleavey AFSCME	Mary McMillan Deputy County Manager County of San Mateo
Raymond Mills Consumer, Voices of Recovery	Dave Pine Supervisor, District 1 Board of Supervisors	Melissa Platte Executive Director Mental Health Association
Calvin Remington Interim Chief Probation Officer, Probation Department	Steve Robison National Alliance on Mental Illness	Louise Rogers Health System Deputy Chief San Mateo County
Joan Rosas Associate Superintendent, Student Services, San Mateo County Office of Education	Deborah Torres Director, Collaborative Community Outcomes Human Services Agency	Steve Wagstaffe District Attorney
Teresa Walker Family Member	Patricia Way National Alliance on Mental Illness	Laurie Wetzel Executive Director Women's Recovery Association
Greg Wild Executive Director, Heart & Soul	Gina Wilson Financial Services Manager County of San Mateo	

MENTAL HEALTH AND SUBSTANCE ABUSE RECOVERY COMMISSION (MHSARC)

(FORMERLY MENTAL HEALTH BOARD)

Edmund Bridges Consumer	Dan DeSmidt Law Enforcement	Michael Eipp Family Member
Valerie Gibbs Member of the Public	Cameron Johnson, Chair Family Member	Laura Martinez Consumer
Dave Pine Supervisor, District 1	Samantha Fell Youth Commission	Sharon Roth Family Member
Judy Schutzman Family Member	Maureen Sinnott Member of the Public	Katherine Sternbach Member of the Public
Wanda Thompson Consumer	Josephine Thompson Family Member	Nancy Wilson Consumer
ALL MHSARC MEMBERS ARE MEMBERS OF THE MHSA STEERING COMMITTEE		

PUBLIC COMMENT RECEIVED

George Culores, Consumer

The most important thing is freedom and being safe.

When it comes to medicine and the patient and they're turning out fine, then they think themselves they don't need it because they're thinking they are normal, but that's because the drug has worked and is working and they turn against it, but what we need to do, is to try to tell them the medicine is what's making them normal and actually normal, there's a different definition of normal for each and every client or patient there is. And so what we need to do is make sure that they figure that it is making them normal all the way up and down the ladder of being well.

When I was first brought into a mental health facility, I had no idea that the medicine was making me feel good or better. I assumed automatically that I didn't need any of the medicines they are offering me. I was thinking to myself that this is all bogus; I don't need it so why should I take it. I talked myself into not taking the medicine when actually I should have been told the medicine is going to make me feel this way, so when the person feels that way, it's important to let them know that's exactly what is happening.

Answer: Thank you, George. We agree that it is critically important that patients/consumers have education regarding their medications in order to participate as fully as possible in their treatment. As part of the implementation of the Affordable Care Act, we are required—through electronic health records—to provide clients with access to their health information. Over the next couple of years, this will be a priority project for BHRS.

At the MHSA Steering Committee meeting held on March 6 we had the opportunity, as part of our ongoing stakeholder education process, to discuss in some detail, three MHSA-funded programs included in the MHSA plan: PREP (PEI), Total Wellness (Innovation) and Older Adults System of Care Development (CSS/PEI).

The following four questions are about the PREP program.

Louise Rogers, Deputy Chief of the Health System

We're really interested in this question of the people who get weeded out because after all if they've made it all the way to the point of following through with the program, there's something very much needed. And yet, on the other hand knowing with this EBP and protocol, the results have been demonstrated with a very certain population, it's very specific treatment for schizophrenia. So, what I'm really interested in, are the people who are getting weeded out, falling into any particular category that we should be prioritizing to address?

Answer from Kate Hardy, PREP Clinical Director, Family Service Agency – San Francisco, a BHRS contract provider: If someone has been found ineligible for the program, we don't just drop the person then, we still do a feedback session with the individual, with the family, with whatever support person or treating provider they find to be useful to have in that feedback. That feedback is really a review of what we found through the diagnosis and also our recommendations for treatment and we'll follow up and try to connect them with the appropriate providers in the county as well.

Pat Way, MHSA Steering Committee

From your presentation, I observed that there are no African Americans being served.

Kate Hardy: I think it says to us that we need to improve our outreach to that community in this County it's much lower than I would expect because certainly in our other PREP programs we see a higher percentage. That's another future direction for us.

Jairo Wilches, Office of Consumer and Family Affairs

Could you talk a little bit about the technology-based cognitive trainings?

Kate Hardy: It's a computer-based training program that's been developed very specifically to focus on the domains of attention, concentration and problem solving. It's been researched at UCSF to be found pretty effective in individuals with more chronic presentations and we've been researching at UCSF with those with recent onset and those who may be at risk of developing psychosis.

Cameron Johnson, MHSARC Chair

Is your entire budget covered by the MHSA?

Kate Hardy: Yes, it is.

The following three questions are related to a presentation about Total Wellness.

Pat Way, MHSA Steering Committee

First of all, I applaud the fact that you have the whole holistic thing going. It's very, very important that the whole person be treated. We've been advocating for that as family members for many, many years and we see it coming. I do have just a couple of questions, however, how many were enrolled, only 100?

Answer from Chris Esguerra, BHRS Deputy Medical Director: No, so we have, as of this morning, about 360. Our goal is to get it to 600 by the end of our fourth year. But the goal ultimately after this pilot is to disseminate it to the whole system.

Ok, that's excellent. Much better than the 100 I somehow picked up in my head. How do clients, what is the outreach and how do you get them enrolled in this very esteemed program?

Chris Esguerra: We try to outreach everywhere we can. The best time—this is one of the things we found out in partnering with our clinic—is when clients enter into our system, they come in through a welcome and registration group. Really it's an orientation to the clinic, to BHRS in general. We're part of that. We want to plant the seed of Total Wellness to get them to start thinking about, well yes we know you're here to work on your symptoms, maybe just to manage your meds, but we'd like you to start thinking about all the parts of their health, physical and emotional. We still connect them to primary care, and we're embedded in the clinical team meetings at the various clinics—Central and South. What we want to get to is word of mouth from clients and consumers. So on January 31, we had a celebration, we celebrated clients who have met their wellness goals and who have very much been participating and showing, so it's a showcase for people of "here's some people who've been able to do this, so can you." We want to continue to do that advertising.

That's great, thank you. So is that going to continue to filter into the contract providers also so that they will be offering the same thing?

Chris Esguerra: Yes, we've been working with some contract providers already doing some trainings.

The following two questions are related to a presentation about services to older adults.

Patrick Field, MHSA Steering Committee Member

What's unique to this population as well is for them are most life goals have passed, they're approaching death, losing friends and just not having the same joys in life that many young people have. I say this because I used to work in a retirement community many years ago. I learned that this population is different from us those are younger, they have these types of problems, is this true?

Answer from Diane Dworkin, BHRS Manager for Older Adults: So it's different, we do a lot of end of life work, but we also help people have goals and opportunities in this stage of life as well, like this person I talked about in her early 90s, she met her great-grandchild for the first time and now she's spending time with him. The goal of someone who's bedbound to be able to actually listen to a talking book and be contacted or use senior centers without walls where they can do a phone-calling program. So it's about different goals. It's both end of life and helping people have quality and meaning in the life they have at this stage.

Judy Schutzman, MHSARC, Family Member

Can you tell us what percentage were, how many people were housed in supportive housing versus independent living?

Answer from Judy Davila, BHRS Deputy Director of Adult and Older Adult Services: That's a good question, off the top, are we referring only to the FSP population? My guess is that a larger number, a significant percentage has some level of supportive housing. And that's sort of a full range of different opportunities but we have a few people who truly live independently but they still get a level of support where they're living.

The following are general questions and comments from the March 6, 2013 Steering Committee Meeting.

Patrick Field, MHSA Steering Committee Member

I just wanted to bring up today that constantly mental illness is seen in the light of violence, constantly it is related to violence and media and society. And I think the police do welfare checks now, they check on someone's welfare, wouldn't it be better if they could do assessments of people in the same way? If someone is going online to buy guns, so forth, if they did some sort of welfare check to have that person assessed so that it won't add another violent person.

Answer from Stephen Kaplan, BHRS Director: This county has done a really fine job in their crisis intervention training with law enforcement and the sheriff's office and Terry Wilcox-Rittgers and Sharon Roth have been instrumental. We have a SMART Team, trained paramedics who can respond in the field for people who are having some crisis and hopefully mitigate any violence. So I think there are a number of strategies in place.

So I will be more specific about it. These guys in Aurora, Colorado and Tucson, Arizona these are people who hadn't been in the MH system, hadn't been diagnosed, I'm reading the paper, that someone commits a crime they can't be open to mental health. So what I'm saying is that I was watching the news on TV and how do we detect these people so they don't fall through the cracks? Wouldn't it be good if there were a way for potentials to get assessed before they move to that step?

Stephen Kaplan: Our pre-crisis response team, will target approximately 80 people, family members and others, who have a loved one who may or may not been diagnosed yet, and they feel that person is experiencing a psychiatric crisis. This intervention can prevent police intervention or a psych emergency.

When it comes to Housing, how much are you spending on these board and care homes? Does it take the whole \$900 or something?

Stephen Kaplan: Those on SSI who also live in Board and Care homes, receive a higher level of support, of which the board and care portion is roughly 90%.

I'm just wondering in comparison if you know the difference between an SRO and a board and care home.

Stephen Kaplan: A meaningful comparison is difficult as there is no consistency in the costs between a SRO and a board and care home. Thanks.

Pam Ward, Office of Diversity and Equity

Yes, this might be somewhat self-serving because I am from the Office of Diversity and Equity. But, I noticed that there was expenditure for the Parent Project, is that correct?

Answer from Stephen Kaplan, BHRS Director: Yes.

And how much will that increase?

Stephen Kaplan: \$20,000

For this coming year?

Stephen Kaplan: The plan calls for continued support of the Parent Project at current year levels.

And is there a plan for more Mental Health First Aid classes?

Stephen Kaplan: Not in this proposal. Just as an aside, one of the things we've been talking to the Board of Supervisors about since they've been holding these hearings on Measure A funding, we've been talking to them about possibly expanding the Parent Project and Mental Health First Aid.

And I'll just take another minute on a personal note to say, when I first came to the department of Behavioral Health and Recovery, I was basically non-verbal. I came, I sat, I didn't speak. I didn't speak because I was very, very depressed. And I hope that opportunities will continue for people who come into this system on one level and grow and develop themselves along with mentors with Steve and Jei Africa and Louise, so that they have a place in this system so that we represent the consumers on an employment level.

Stephen Kaplan: Thanks, Pam.

The following are questions and comments that were received after the March 6 meeting.
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Raja Mitry, California Stakeholder Process Coalition* Steering Committee Member

I heard (from a colleague) about the public meeting of the MHSA Steering Committee for the Annual Update one day before it was held. Because I must not be in your database to receive the information, I was not able to attend due to a previously scheduled meeting out of town and so submit this public comment.

Let me begin by saying your vision for a good modern system of care is admirable.

The question you ask on P. 4, "How do we avoid over representation in our system of marginalized populations?" is confusing because if a group is marginalized, is it not under represented in your system? Would you please clarify?

Answer: Thank you for both the comments and the question. To support a good and modern system of care, we must continue improving our outreach to and engagement with those who experience barriers to access. And, as the community changes, we must adapt our services to meet the needs of new populations, particularly, marginalized populations. In this context, we mean those populations that do not or have not historically had high levels of social influence.

As planning is an ongoing endeavor, outreach must likewise be a continuous endeavor. New names need to be identified and reached to speak for and involve still under-served and under-represented constituencies residing in this county. Some of these constituencies are: Arab communities from different countries of the Arab world, a diverse population here that has been generally unreached; also Armenians; Iranians. There are refugees and immigrants from different countries who are increasingly visible in this county; and people from the Japanese community, Native Americans, the Burmese community need to be involved. Reaching these individuals and marginalized groups eight years after the MHSA roll-out is much needed to

strengthen and ensure the effectiveness of stakeholder engagement as an essential element of quality improvement and accountability of the behavioral health service system locally. Hopefully, individuals from the mentioned groups will be involved on the MHSA Steering Committee, which is described as being "comprised of over 40 community leaders representing the diverse San Mateo community including mental health constituencies (clients, advocates, family members, community partners, County and CBO staff), and non-mental health constituencies (County leadership, Education, Criminal Justice, Probation, Courts, among others)."

Besides these ethnic groups, I want to bring attention to our aging and older adults from cultural communities and their relevant caregivers; single aging adults, especially aging single males and aging/older LGBTQQ individuals; single parents with young children and youth, especially single custodial dads. Without access to appropriate PEI and culturally congruent services, they can become inappropriately served and under served. Some are from under represented groups at risk of being lost to the gaps and fall into severely fragile mental, physical and emotional distress. Like expansion of supports for youth transitioning to adulthood, there can be well-crafted PEI supports included in the priorities for adults (especially single adults) transitioning into the older years. All of the aforementioned are some of whom must be reached in order to reduce health disparities. They and others, like young adults from different cultures, must have a voice on at least the MHSA Steering Committee and other more frequent venues.

BHRS has been effective engaging targeted populations. Outreach beyond the county's identified cultural communities in the initial years after the roll-out of the MHSA needs robust expansion to be more broad and inclusive of individuals and families from diverse backgrounds and those with lived experiences of mental health and co-occurring conditions. Efforts to involve communities and groups of the wider diversity of this County's composition can reflect much greater inclusion of cultural and linguistic representation from under-served, under-represented, and un-served groups. To ensure involvement of stakeholders from diverse groups of different cultural heritages, the outreach must be vigilant enough to establish reciprocal information-sharing with communities and to identify any behavioral health needs, particularly for PEI.

The Mental Health & Substance Abuse Recovery Commission offers opportunity for diverse representation. Currently, there are no individuals from the Chinese, Japanese, Pacific Islander, Filipino, Arab communities on the Commission. Besides lack of these and other cultural representation, there is no young adult person nor anyone speaking for the LGBT population. There must be a strong voice for aging single adults moving into the older years - this is an at-risk group that has been given little attention. All the Commission's members are part of the MHSA Steering Committee, so it is vital that the Commission have broader diverse representation from this county. Trust has to be established and relationships developed with the unreached communities so that leaders and cultural brokers are identified; and there must be a structure for leadership development within the Commission to support individuals who express interest in participation.

Thank you for what the plan offers and kudos for what has been accomplished, with hopes for timely development of fulfilling the mental and behavioral health needs of our diverse community members.

Answer: Thank you for your input and recommendations to help us ensure that all who need access have it in equal measure. Over the last year, we conducted 17 community "listening" sessions to gather information from a broad base of stakeholders, including 1,000 individuals, including

clients, community members and others. In that process, we described the plan for the implementation of Community Service Areas (CSA). Through these meetings and other communications we provided vital information about system change and will continue to provide that information.

We will also take the opportunity to use our ongoing CSA planning process to recruit members. The Commission continues to actively seek applications for new members and works with the Board of Supervisors to create a commission that is as diverse as possible, recognizing the importance of a commission that can represent a diversity of viewpoints.

Ray Mills, Voices of Recovery, AOD Client/Consumer

I did not hear anything about peer-to-peer support services.

Answer: Thank you for your feedback. Peer supports and peer services are an important part of the MHSA plan and our service delivery system. Throughout the plan, peer services and supports are often referred to by their program names: Total Wellness, Lived Experience Academy, After School Intensive Services Program, Senior Peer Counseling, among others. We will continue to look for ways to advance and expand the peer support services that are available.

Jose Antonio

I work in Daly City and I am very active in volunteering for the Filipino Community. Can we have more available services for the Filipino community in terms of services or outreach? Thanks.

Answer: Through the Office of Diversity and Equity (ODE), specifically with the Filipino Mental Health Initiative (FMHI), we continue to partner with stakeholders to identify needs, priority areas and appropriate services for the Filipino community. This year we've sponsored numerous events, such as health forums, focus groups, provider trainings, and partnered with schools and other service providers to help address the needs of the Filipino community. We will continue to support the work of FMHI (and other partners) to learn about how to best service the needs of the Filipino community.

Over the course of the next year, we will continue to redesign our system using the Community Service Area model which incorporates stakeholder feedback in an intensive process to identify and solve for specific service needs. We hope that you continue to share your ideas with us through ODE or FMHI.

Elsa Agasid, Family Member & Geriatric Nurse Practitioner

I am a Filipino-American mother, foster parent, and grandmother as well as a Family Nurse Practitioner who works in San Mateo County providing health services; medical treatment to geriatric population. There is a great disparity of resources available to Filipino-Americans in San Mateo County across the generations. More funding and services are needed in mental health for youth, young adults, and elderly.

Answer: We are actively trying to improve in this area and through the Filipino Mental Health Initiative have reached out to Filipino community members. Our partnership with HPSM's Outreach Team and Family Service Agency hopes to bolster our outreach activities for adults and the elderly in the North County area.

Robert Uy, Uy Lan Group/Alice Group, DV Attorney/Immigration Attorney

Please support the Office of Diversity and Equity to increase victim/survivor support for the Filipino and Asian American Community. Please provide more services to the Filipino Community. There is currently a lack of mental health services for this community.

Answer: Through the Office of Diversity and Equity(ODE), specifically with the Filipino Mental Health Initiative and the Chinese Health Initiative, we continue to partner with stakeholders to identify needs, priority areas and appropriate services for the Filipino and the Chinese community. We will also continue to support our partnerships with other services providers like the North County Outreach Collaborative in their efforts to provide appropriate victim/survivor support.

Also, our North County Clinic continues to be a behavioral health resource to residents in Daly City. Our continuing partnership and collaborations with other services providers such as the North County Outreach Collaborative continue to also be a resource to in the northern part of San Mateo County.

Edna B. Murray, Alice Group, Social Services

I am a volunteer of the Alice Group for six years now. We need more funds to continue to help Filipino Community.

Answer: Through our work with FMHI, we will continue to connect with stakeholders in the community to identify needs and services that are culturally congruent to the Filipino community.

Over the course of the next year, we will continue to redesign our system using the Community Service Area model which incorporates stakeholder feedback to help address and solve for unique service needs.

Erlinda Galeon, PBRC, Social Services/Service Provider

I live in Daly City in San Mateo County. I am suggesting and asking that more service be give to the Filipino Community especially in Daly City. Thanks.

Answer: Our North County Clinic continues to be a behavioral health resource to residents in Daly City. Our continuing partnership and collaborations with other services providers such as the North County Outreach Collaborative continue to also be a resource to in the northern part of SMC. Through the Office of Diversity and Equity (ODE), specifically the Filipino Mental Health Initiative, we will continue to reach out to the Filipino community and engage different stakeholders to help identify appropriate strategies and services that best fits their needs. We encourage you to keep sharing your ideas and feedback through ODE or FMHI.

Randall Fox, Holistic Heath Advocate, MHSA Steering Committee

Reaching and engaging our Clients/Family members is in my opinion still one of the most challenging tasks in-front of us, as we transition to a more Holistic paradigm in our strive for a "seamless system" in the continuum of care.

Answer: Thank you for your feedback and input. We agree with you: reaching out to and engaging clients and family members is one of our most important and challenging tasks as we strive for a more holistic system. This work is ongoing.

Also we need to make sure and work hard at bringing together our somewhat fragmented infrastructure. Effectively a "circling of the wagons" type synergy, of our existing services and providers to achieve hegemonic stability.

Answer: As part of our Community Service Area planning structure, we will integrate our administrative and clinical functions to achieve a more cohesive system.

I think this is absolutely essential before reaching out to the community.

We need to have strong continuous oversight of our contracted providers, which are even less connected to BHRS and fail to comply with policies and practices that are already in place.

Answer: Over the past few years, we have implemented a number of quality improvement measures with our contractors including: training on Lean methodology (a quality improvement technology), contract language requirements and a review of our monitoring policies and procedures. Within the next six months, we are implementing a software program that will provide us with broad range of performance information that will assist us in monitoring contract providers.

In addition, the above stated, should not consume any MHSA funds, as it is already the responsibility of BHRS Management to achieve.

Answer: MHSA funds are integrated with other funding resources in order to maximize the available revenue to serve our clients. The administrative responsibilities are necessary and legitimate expenditures to support the delivery of services.

We still need to work hard at expanding diversity and outreach to those already being served including, but not limited to, our underserved, identified and unidentified populations.

Answer: We continue to support our Office of Diversity and Equity, the East Palo Alto Partners, the North County Outreach Collaborative as well as the Community Service Area planning process, all of which help bring issues of diversity and equity to the fore.

I also have suggested an important modification to the Wellness Diamond pictograph, which in its present form is meaningless/ too abstract.

I suggest the following; add by shortening the horizontal and vertical line within the diamond enough room to include a dashed circle. What this represents from a visual and conceptual perspective is a contiguous permeable membrane [fabric] so to speak of our already in place systemic availability of programs and contractors.

The key then, is to put in the center of that circle, a symbol whatever that might be representing our clients/family members.

I have been told on several occasions “ at the end of the day it is not about the...” in one case “words” and in this case the “Wellness Diamond” “but blah blah blah...” When one is communicating, I would put forth in both cases that indeed it is about the words and here the pictograph. I would gladly explain and welcome the opportunity to expand on these points.

Answer: Thank you for your feedback. We have found the Wellness Diamond to be useful in our Community Service Area planning discussions, with a broad spectrum of stakeholders.

I have asked for specific budget numbers of how we are spending our MHSA funds without results. Transparency is a concern under our current top management.

Answer: There is additional budget-related information than was available at the MHSA Steering Committee meeting in March.

I will end my remarks with a question: Why are we spending valuable funds on a system that should already exist? As most of you already know, my intensive push for more clinical use of not only best practice, but also evidence-based practices using new and older (brain imaging) technologies for both diagnostic and therapeutic applications. I guarantee these will be, not only the best use of funds, but do the most good for our clients and family members.

Answer: Thank you for your recommendation. Our goal is to continuously improve and to adopt evidence-based practices in our work. During our planning process, the recommendation to use this specific technology did not present itself, but through the ongoing planning process, there are opportunities for this recommendation to emerge.

Saving and improving our clients/family members lives and decreasing morbidity and mortality rates in a dramatic way should be San Mateo Counties top priority. Let's lead the Country in fighting Stigma, excel at early intervention/prevention, and significantly reduce incarceration and suicide.

Answer: We share your goals of saving and improving our clients'/family members' lives and decreasing morbidity and mortality rates in a dramatic way. This is one of our highest priorities and we believe that the Total Wellness Innovation program is leading the way in the development of effective, efficient efforts in that regard. We have a strong commitment to fight stigma and that will be a continued priority.

Community Services and Supports

The following are highlights of our programmatic activities during FY 11/12, per program:

FULL SERVICES PARTNERSHIPS (FSPs)

Fred Finch Youth Center and Edgewood Center for Children and Families were awarded the contracts to expand the Children, Youth and Transition Age Youth FSPs. These programs started in March of 2010. The expansion design has allowed us to serve more youth while providing a fuller array of intensive services.

Fred Finch Youth Center provides strength-based wraparound and crisis response services to San Mateo County youth ages 6 to 17 placed in foster care or in relatives' homes temporarily outside of the County. Most of these youth reside in the East Bay. The services are tailored to meet the specific mental health, educational, social and cultural needs of youth with severe emotional disturbance (SED) and who may have co-occurring alcohol and/or substance use issues. Clinical and non-clinical services promote wellness, resilience and stability in their foster care placements, and as applicable, to prepare for transition back to a family/community placement. Services are also available to the enrollee's foster parents/caregivers and/or parents/family members.

This FSP also supports older adolescents transitioning out of foster care (18 years old and above), while assisting them in their journey toward young adulthood. It is worth noting that this FSP builds upon the foundation of the "Visiting Therapist Program" provided to the same population by Fred Finch in the community setting.

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

The Fred Finch treatment team is comprised of two Care Coordinators, one Youth Partner and one Parent Partner. Both the Youth Partner and Parent Partner have lived experience as a consumer or family member.

The program served youth in a variety of locations including: Oakland, San Francisco, Hayward, San Jose, San Leandro, Pittsburg, Antioch, Modesto and Benicia.

Twenty slots are available for this program. In FY 11-12, Fred Finch served 28 youth.

Edgewood was awarded the contract to provide integrated clinic-based FSP services for the Central/South Youth Clinic (outpatient), as well as the integrated FSP for our intensive school-based services which are provided in the Therapeutic Day School (TDS) setting, school-based milieu services, and the Non-Public School setting. Youth served are 6 to 21 years old. These two integrated FSPs provide a full array of wraparound services to support our existing mental health teams. With this expansion of FSP slots, Edgewood began operating a drop-in center for children ages 6 to 15 in San Carlos, which complements the existing one in San Bruno for youth 16 to 24 years old. The drop-in centers provide a full array of social and therapeutic activities that support children and families.

The focus of these services is to increase school success, stability, and to maintain clients' placements in their respective communities. Services are open to all at-risk clients, however, they are specifically targeted to clients among underserved Asian/Pacific Islander, Latino, and African American populations.

The After School Intensive Services Program within the San Carlos Youth Center served youth between the ages 6 to 14 years old and continues to be open to provide supports for youth Monday through Friday, 2:00-6:00 p.m. every week, and one Saturday per month 11:30 a.m.-3:30 p.m. The Center continues to offer a multitude of services including: youth groups, independent living skills, educational support, social skills building, recreational groups and outings, peer-to-peer support, transportation assistance and healthy meals. In addition to this programming, there is a weekly Aikido (non-violent Japanese martial art) group being facilitated for interested youth.

The integrated FSP program continues to have many successes with maintaining youth in their homes and school placements. Both integrated FSPs have 20 slots each. In FY 11-12, Edgewood served 46 youth, 24 clinic-based and 22 school-based.

“Turning Point” for Child/Youth/Transition Age Youth (TAY) FSP

This Comprehensive FSP program helps our highest risk children and youth with serious emotional disorders (SED) remain in their communities, with their families or caregivers while attending school and reducing involvement in juvenile justice and child welfare. Specialized services to transition age youth (TAY) aged 16 to 25 with serious emotional disorders are also provided to assist them to remain in or return to their communities in safe environments, support positive emancipation including transition from foster care and juvenile justice, secure, safe, and stable housing and achieve education and employment goals. The program helps reduce involuntary hospitalizations, homelessness, and involvement in the juvenile justice system.

The 80 slots are divided between two 40-slot teams, one for children/youth and one for transition age youth. Supervision of both teams by a single person assures consistent vision across both teams and collaboration between them, which intends to create a more seamless relationship between services for children and services for TAY. Enrollees do not experience multiple transitions between programs as they age; they have access to the expertise across teams and the entire continuum of resources for children, youth and transition age youth as their needs change over time. Enrollees benefit from the shared resources across the program including the cultural and linguistic diversity of staff, parent partners, existing collaborative relationships with Juvenile Justice, Child Welfare, Education, Housing and Employment Services, and the expertise of individual clinicians in co-occurring disorders as well as on other evidence-based practices.

The program reflects the core values of the Wraparound model: to partner with families and other important people in developing service strategies and plans; to assess family, child/youth and community strengths rather than weaknesses; to assist children/youth and families in becoming the authors of their own service plans; to encourage and support a shift from professionally-centered to family-centered practice and resources; and to also assess child/youth and family needs and areas of growth. Embedded in these core values is recognition of the importance of the family’s cultural values as a strength, a source of resilience, and an integral component of service delivery. It is worth noting that the transition age youth team emphasizes the individual consumer’s role in developing their own wellness and recovery plan. This FSP also offers a drop-in center and supported education to engage TAY, which serves the FSP participants as well as other SED transition age youth in the community that are receiving mental health services. The focus is to provide self-help supports, social activities, and skill building, as well as support for those seeking to enter the college system, all aimed at enhancing ability to manage independence.

Eighty slots are available for this program. In FY 11-12, Edgewood served 51 children/youth and 40 transition age youth.

Enhanced Supported Educational Services for Transition Age Youth

BHRS contracted with Caminar starting in 2006 to provide enhanced supported education services to approximately 40 TAY ages 18 to 25 with emotional and behavioral difficulties and/or alcohol or substance use issues, 20 referred by FSP provider Edgewood and 20 TAY identified by Caminar. Caminar outreaches to TAY who are still in high school or who have

dropped out to engage each TAY in educational or vocational activities that lead to completion of educational plans and employment.

Supported Education includes the following components:

- 1) Summer Academy: Caminar provides a "Summer Academy" which is a quasi-educational program to help students build their confidence and self-esteem so that they will have a better chance of being successful in school and employment. A team teaching model is employed which utilizes peer counselors, a core instructor, case management services, and guest speaker/mentors.
- 2) Transition to College classes: Caminar provides two "Transition to College" classes, in addition to the classes that Caminar provides as part of its supported education services. Caminar also teaches three specialized classes on a rotating basis throughout the year: Wellness and Recovery, Peer Counseling, and Advanced Peer Counseling.
- 3) Academic Counseling: Caminar coordinates with Disabled Students Programs (DSPS) to provide a Master's level academic counseling intern to offer academic counseling, develop student individual educational plans (IEP), oversee completion of required DSPS paperwork, and provide personal support to TAY students.
- 4) Linkage to employment: Caminar provides services that link students with employment services.

There are a total of 40 slots available for this program - 20 through Edgewood and 20 through Caminar. In FY 11-12, 40 clients were served by this program.

Supported Housing

Mental Health Association secures and manages 20 units of high quality housing for TAY FSP enrollees. Populations served include:

1. Twenty individuals made up of youth ages 18 to 25 and emancipated minors ages 16 to 18 (collectively referred to as "Transition Age Youth" or "TAY").
2. Transition Age Youth with SED with alcohol and/or substance use issues at risk of or returning from residential placement or emancipating, with past juvenile justice or child welfare involvement.
3. Transition Age Youth with SED with alcohol and/or substance use issues exiting school-based, individual educational plan (IEP) driven services.
4. Newly identified Transition Age Youth that 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.

In FY 11-12, 20 TAY were served through this program.

Adult and Older Adult/Medically Fragile FSP

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

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

The FSP is open to all Adults and Older Adults clients who have a severe mental illness (SMI) meeting the population criteria below, however, it is specifically targeted to unserved and underserved Asian/Pacific Islander, Latino and African American populations.

Telecare, Inc. was contracted in October 2009 for a total of 200 members: 75 Adult, 75 Older Adult/Medically Fragile, 40 Community Case Management and ten in a new Wellness category. In February 2011, there was an amendment to the Telecare FSP to more effectively align needs with BHRS resources: ten case management slots were reduced in order to add seven intensive slots, and the rest of the savings was shifted to support the Housing Support Program for a total of 187 slots.

There are a total of 187 slots in this program. In FY 11-12, Telecare served 133 adults and 89 older adults/medically fragile.

Housing Support Services

Telecare provides up to 90 housing units of mixed types including augmented board and care, dormitory, congregate and supervised living, single room occupancy hotels, shelter and independent living.

REACH FSP and Housing Support Program

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

In FY 11-12, Caminar provided services to 39 adults/older adults/medically fragile.

South County Mental Health Clinic (SCC) Integrated Full Service Partnership Program

Mateo Lodge was contracted to provide a 1.0 FTE Mental Health Counselor and a 0.25 FTE Community Worker assigned to the South County Clinic to provide case management services to a small caseload (up to 15 clients) of high risk, marginally engaged clients for six months to a year, with the goal of stabilizing and engaging clients in services at the SCC.

There can be up to 15 clients in the caseload for this program. In FY 11-12, Mateo Lodge provided services to 15 clients.

FSP Performance Outcomes

We track year-to-year outcomes for individual clients. Our data through December 31, 2012, demonstrate notable improvements across two key dimensions: average number of days spent in hospitals and average number of PES visits.

The majority of FSP participants, across all age groups, have experienced shorter hospitalizations. On average, the number of days hospitalized has decreased by eight days, or 39.52%.

The majority of FSP participants, across all age groups, have also seen a reduction in the number PES visits. On average, the number of PES visits has decreased by 14.23%.

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

Based on currently contracted amounts:

The FSP cost per adult/older adult is \$19,572;

The FSP cost per child/youth is \$27,263; and

The FSP cost per TAY is \$39,931.

We feel that cost-per-person figures do not fully reflect the span or quality of services available to clients either through BHRS or through contracted providers and may overlook important local issues such as the cost of housing.

COMMUNITY OUTREACH AND ENGAGEMENT

CSS Outreach and Engagement partially funds **SMART**, a program developed by the Health System and American Medical Response West in December 2005 in which a specially trained paramedic responds to law enforcement Code 2 EMS requests for individuals having a behavioral emergency. This SMART paramedic performs a mental health assessment, places a 5150 hold if needed and transports the client to psychiatric emergency services or, in consultation with County staff, arranges for other services to meet the individual's needs. Access to the SMART program is only through the County's 9-1-1 system.

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

In addition, this Work Plan also partially funds BHRS staff positions, such as two Older Adult System of Care Development staff positions, one Family Partner in the Office of Consumer and Family Affairs, one Program Coordinator in Insurance Enrollment, a Patient Services Assistant at ACCESS, a Clinical Services Manager at ACCESS, and a Supervising Mental Health Clinician at SMART.

OLDER ADULT SYSTEM OF CARE DEVELOPMENT

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

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

In FY 11-12, this program served 247 clients.

Senior Peer Counseling Services Program

The target population for these services include older adults experiencing mental health issues such as depression or anxiety which impact their functioning and overall quality of life. The focus of these services is serving clients from the following cultural backgrounds or groups: Chinese, Pacific Islander, Filipino, and other Asian; Latino/Spanish-speaking and Lesbian/Gay/Bisexual/Transgender (LGBT) community.

Senior Peer Counseling is provided in English, Mandarin, Spanish and Tagalog. Counseling is also available to the Lesbian/Gay/Bisexual/Transgender (LGBT) community. In 2011-2012, the Family Service Agency changed its name to Peninsula Family Service.

Senior Peer Partners provide support, information, consultation, peer counseling, and practical assistance with routine tasks such as accompanying seniors to appointments, assisting with transportation, and supporting social activities. They also recruit and participate in training volunteers to expand our existing senior peer counseling volunteer-based program in order to build additional bilingual/bicultural capacity. Senior peer counseling works with individuals and groups. Senior Peer Partners serve homebound seniors through home visits and create or support the development of activities for mental health consumers at community sites such as senior centers. In addition, and as desired by older adults with SMI, Senior Peer Partners facilitate consumers to attend client-run, self-help centers.

Forty-five counselors were recruited in FY 11-12, 75% of goal. The Senior Peer Counseling Program had 104 participating senior peer counselors. Twenty have retired during this program year to bring the total of active peer counselors to 84.

As of June 30, 2012, 261 senior peer counseling clients were active in the program.

The breakdown of total clients served by ethnicity culture is:

- Latino - 166 clients, 44%;
- LGBT - 19 clients, 5%;
- English-speaking-129 clients, 34% ;
- Chinese - 34, 9%; and
- Filipino - 28, 8%.

Staff were stationed at booths at health fairs and community fairs to distribute program flyers and recruit new potential volunteers. New brochures were also developed for the program, targeting each underserved cultural group in the program.

The LGBT support group continues to thrive. The LGBT Coordinator resigned from the position. Volunteer group members took over the leadership of the group in order to keep the group going. A volunteer also submitted an article about the program to various LGBT entities within the county in order to recruit new group members.

The biggest challenge continued to be recruitment of new volunteers in the program. In our desire to recruit as many volunteer peer counselors as possible, staff found that a few of the volunteers from the last class were not the best match for the program. For upcoming classes, all new recruits will also be interviewed by the program manager for appropriateness for the position and staff will focus on the qualities of the volunteers versus the quantity of volunteers to be trained.

The second challenge has been in finding a Coordinator for the LGBT position. As with the other coordinator positions, this position is only 20 hours per week and does not provide benefits.

In FY 11-12, the Senior Peer Counseling Program served 376 clients.

Pathways, Court Mental Health Program (Adults)

The Pathways Mental Health Treatment Court Program is a partnership of San Mateo County Courts, the Probation Department, the District Attorney's Office, the Private Defender Program, the Sheriff's Department, Correctional Health, and the Behavioral Health and Recovery Services division. It is comprised of key people in each of these organizations who play an active role in the planning and support of the Pathways clients including participating in special yearly activities for the clients.

The Pathways Program began in late 2006 and serves seriously mentally ill (SMI) nonviolent offenders with co-occurring disorders - mental health and substance use/abuse. The program

was designed to be appropriate to the issues and needs of Latino, African American and Pacific Islander populations, as they are over-represented in the criminal justice system.

The goal of the Pathways Program is to avoid incarceration for seriously mentally ill individuals and help them to live more successfully in the community. Defendants who are eligible are admitted after they enter a guilty or no contest plea, but prior to sentencing on their charges. People who are on probation with modifiable sentences and who meet the criteria for the program may also be considered for participation.

In order to augment evaluating some of the more complex referrals to the Pathways Program, Behavioral Health and Recovery Services and Stanford University have developed and implemented the Pathways-Stanford Forensic Experience Rotation for Residents in Psychiatry. These examinations are conducted under the direct supervision of forensic psychiatrists who are members of Stanford University's Adjunct Clinical Faculty. These assessments are helping the Pathways Program to assess the appropriateness of admission and are providing recommendations of treatment considerations.

Typically, a Pathways client is sentenced to three years probation and remains as an active member of the Pathways Program for the three years. When they graduate from Pathways there is a formal ceremony in court where their case and their accomplishments are shared with all in the courtroom including prisoners who may become Pathways clients. Graduates receive a Pathways Certificate signed by the Pathways Judge. Pathways Graduates are no longer on probation but remain in the Pathways Program as Alumni for activities and to help guide and support others in the program.

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

The Clubhouse was added in June 2011 located at Heart & Soul, a peer support organization, in downtown San Mateo with the goal of providing peer support, psychosocial education and creative arts. This space has allowed a supportive setting for Pathways clients to feel safe, develop friendships and mature in their wellness and recovery.

In October 2011, the State changed how credit for time served was calculated (a change which has since been rescinded). This impacted all treatment courts and enrollment decreased. Inmates who were not interested in treatment served their time for faster release. However, we continued to promote the benefits of our program and to identify clients who were already sentenced and could be modified into Pathways. We have been successful in enrolling clients this way.

In April 2012, we had our Annual Pathways Picnic, which both clients and staff attend. This invitation is also extended to our judges. Pathways gatherings provide an excellent opportunity for bonding, having fun and celebrating successes. These successes included graduations from Pathways, Women's Recovery Association, Women's Enrichment Center, Our Common Ground and El Centro de la Libertad.

Pathways also started a Men's Group in order to provide a safe place to talk about men's issues and provide resources as seen appropriate. A student from Cal State East Bay co-facilitated this group and managed a small caseload of clients.

As of FY 11-12, there were 29 Pathways graduations. None of these graduates have picked up any new criminal charges! Many of them began in Pathways with drug/alcohol problems and have benefited from treatment programs such as Women's Recovery Association, Project Ninety and Women's Enrichment Center. Two of the Pathways Alumni are in the Consumer Hall of Fame. Several Pathways clients have also received Hope Awards.

In FY 11-12, Pathways served 166 individuals.

Pathways - Co-occurring Housing Services

Shelter Network is contracted to provide two dedicated transitional beds per night, one fee-for-service one bedroom apartment on an as-needed basis; supported housing services for families with children; programmatic support; childcare services for women in the Pathways for Women program while they are attending clinical activities and meetings.

A representative from Women's Recovery Association participates three hours a week in the Pathways for Women program meetings.

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

SYSTEM TRANSFORMATION AND EFFECTIVENESS STRATEGIES

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

Peer Consumer and Family Partners (All Ages)

San Mateo's consumer and family member initiative has been identified as a best practice by the Bay Area Mental Health Workforce Collaborative. The Office of Consumer and Family Affairs (OCFA) provides support and education by phone or in person in English and Spanish. Some of the ways the OCFA assists families include: explaining the BHRS system in plain language, facilitating linkages with resources within the BHRS system and in the community, providing general information about mental illness, helping families to understand HIPAA and how to provide information even when there is no consent. BHRS Consumer and Family Partners provide support and education to family members through Pathways, a North County multi-family group in Tagalog, and a multi-family group in Spanish in Central County. At each regional clinic, there are BHRS staff with Lived Experience as a Peer Consumer or Family Partner, in some clinics we have both.

Peer Partners served 1,293 clients and Family Partners served 232 clients in FY 11-12.

Puente Clinic

This specialty clinic sponsored by Behavioral Health and Recovery Services, Golden Gate Regional Center and Health Plan of San Mateo serves the special mental health needs of clients with developmental disabilities. Successes include the transition of clients of a retiring psychiatrist either to the Puente Clinic's psychiatric nurse practitioner, or to their primary care physician if the clients were stable. Most clients have been able to maintain their placement in the community. Psychiatric emergency service visits have been significantly reduced by clients who were formerly high users of emergency services. Other successes have been the maintenance of sobriety and successful smoking cessation, along with the stabilization of sleep cycle rhythms.

Some challenges include lack of cooperation in follow-through with Puente recommendations (from specialized group home staff or family resistance).

In FY 11-12, the Puente Clinic served 148 clients.

Vocational Rehabilitation Services

An interagency agreement initiated in September 2006 outlines services between the Human Services Agency Vocational Rehabilitation Services and Health Services to provide ten MHSA job placements and 1,141 hours of job coaching as part of the Financial Empowerment Pilot Project. This is an ongoing agreement with no end date.

The significance of jobs created for these mentally ill individuals whose histories of hospitalization and other challenges stack the deck against them are not lost in the San Mateo County behavioral health community.

In FY 11-12, VRS provided 12 MHSA job placements.

Co-Occurring Contracts with Alcohol and Other Drug Providers

Summary: In FY 11-12, El Centro de la Libertad provided 336 hours of co-occurring mental health and AOD treatment service to clients with Co-Occurring Disorders (COD) (132% of the contracted amount). Pyramid Alternatives provided an additional 826 hours of service (100% of contracted amount). Sitike provided an additional 497 of service hours (115% of contracted amount). Service League provided 1,260 hours (100% of contract) and StarVista provided 3,600 hours of service to youth in their Girls program (142% of contract). Free At Last provided an additional 434 co-occurring mental health and AOD treatment days to clients with COD using MHSA funds (104% of contract). Our Common Ground provided an additional 1,323 treatment days (212% of contract). Project 90 provided 574 additional treatment days (104% of contract) and Women's Recovery Association provided 677 additional treatment days (97% of contract).

Evidence-based practice expansion (All Ages)

MHSA funding supports staffing specialized in the provision of evidence-based services throughout our system, for youth and adult clients. In FY 11-12, clinicians served 2,395 youth and adult clients.

Prevention and Early Intervention Activities

Primary Care Interface

Changing the staffing pattern of the Youth Primary Care Interface team and adding a Spanish-speaking psychiatrist increased the engagement of monolingual Spanish-speaking parents. This was a very important addition because monolingual Spanish-speaking parents need assurance that their concerns about medication are understood and addressed. Additionally, more Spanish-speaking youth come to their appointment with the Spanish-speaking psychiatrist. At the end of the fiscal year we added a part-time Alcohol, Drug and Other Drug (AOD) Specialist to the Adult Interface team.

The Chronic Pain Management group did not prove to be successful and this has been dropped. We started a “drop in” skill building stress reduction group for adults that focused on coping without substances. This is successful as a drop in group and patients can ask for additional treatment.

A psychiatric resident joined the team part-time for the year. This is the first resident to receive this kind of specialized training. The Medical Director plans to implement this training as an elective for BHRS residents that will last three to 12 months. A second adult psychiatrist was added to the team midyear. This psychiatrist is also co-located part-time at community substance use treatment programs. This psychiatrist also has some expertise assessing for ADHD in adults. We developed the first draft of a protocol for assessing adults for ADHD. At the end of the year, we were informed that we would fill a vacant youth position and hire a new full-time Spanish-speaking AOD Specialist.

Challenges: Over the last year, Interface has experienced a delay in transferring Seriously Mentally Ill Children into Youth Regional Treatment in San Mateo and Redwood City. It is unclear why this has happened. The Youth Manager for the Interface Team resigned and the new Youth Manager has not been hired and this may be the core problem.

Next steps include a review of the psychiatrist role; hiring a part-time program specialist, and redesigning the way referrals are made.

In FY11-12, MHSA Primary Care Interface served 796 clients.

Office of Diversity and Equity FY 2011-2012

The Office and Diversity sponsored the eight trainings below serving a total of 413 individuals.

Mental Health First Aid (94 participants) - Four 12-hour trainings: August 2011-January 2012 (San Mateo), October 2011 (Philippine Consulate), November 2011 (East Palo Alto), April 2012 (East

Palo Alto). WET provided \$7,700 in funding for three people to receive MHFA Instructor Training. The four trainings held in FY 11-12 were funded by the Office of Diversity and Equity and trained 94 participants.

California Brief Multicultural Competence Scale (CBMCS) Training Program (20 participants) - Four days, 32 hours total, September-October 2011, trained 20 participants.

How to Effectively Use an Interpreter in a Behavioral Health Setting (92 participants) - Two sessions: September 2011 for 54 participants, February 2012 for 38 participants.

Parent Project (52 participants) - Trained Parent Project Facilitators: One African American, Two Spanish-speaking, One Filipino. Pacific Islander focused Parenting Project: September - December 2011 (North County) served 24 parents/caregivers. Latino Parent Project March - May 2012 (South County) served 28 parents/caregivers.

Photovoice (62 participants) - Two Facilitator Trainings led by Youth Leadership Institute, each training was three sessions, 10.5 hours total - November-December 2011 for 21 participants; April 2012 for 14 participants. Facilitators led Photovoice sessions at: Canyon Oaks Youth Center February-April 2012 for eight participants, BHRS Chinese Health Initiative March - April 2012 for five participants, Sequoia High School May-June 2012 for five participants, Half Moon Bay Youth March-June 2012 for four participants, BHRS Spirituality Initiative April - May 2012 for 16 participants, Daly City Youth/Asian American Recovery Services June 2012 for three participants.

Digital Storytelling (nine participants)- Three-day workshop led by the Center for Digital Storytelling for BHRS staff and individuals with lived experience of behavioral health issues, May 2012 for nine participants.

Health Equity Initiatives Leadership Academy (21 participants) - Five sessions, nine hours total training for Health Equity Initiatives Co-Chairs, June - September 2011.

Cultural Humility in the Era of Cultural Competence: Addressing Health and Health Care Disparities with Dr. Melanie Tervalon, MD, MPH - June 2012 for 63 participants.

Additional activities/trainings provided by Office of Diversity and Equity Health Equity Initiatives:

African American Community Initiative - Brown Bag Culturally Relevant Conversation on HIV/AIDS in the African American Community, African American Parents Night, October 2011. African American Women and Depression, November 2011. Fifth Annual Black History Month Summit, Making the Connection: Health Disparities and Economic Hardships, February 2012 for 60 participants.

Chinese Health Initiative - Traditional Chinese Healing Practices, November 2011 with 50 participants. Chinese-speaking Wellness and Recovery Action Plan workshop January - June 2012 included nine classes in both Cantonese and Mandarin. Chinese Family Support Group meets monthly providing psychosocial education, benefits, community resources support to Cantonese and Mandarin-speaking individuals.

Pacific Islander Initiative - Youth Fishbowl Forum, August 2011 for 46 participants. Pacific Islander Parent Focus Group at Los Cerritos Elementary School for 18 participants. Provider Training, January 2012.

Filipino Mental Health Initiative - Outreach at Sister Cities Festival in Daly City, September 17-18, 2011, shared booth with Tuberculosis Team, borrowed spin wheel from HIV/STD unit - big "attraction" for FMHI booth outreach to approximately 300 attendees. Co-sponsored ALLICE Alliance for Community Empowerment Seventh Annual Free from Violence October 2011 with approximately 150 attendees. Mental Health First Aid, Philippine Consulate, October 2011. San Mateo County Multicultural Employee Fair, November 2011, with 100 attendees. Anti-Stigma Event, November 2011, 100 attendees. Presented at WRAP Facilitators Meeting, March 2012. Outreach at Filipino Cancer Collaborative, March 2012, 30 attendees. Community Forum "Behind the Smiles," April 2012. Working with Filipinos: History, Culture and Perspectives, June 2012 for 73 participants. Strategic Planning Meeting, June 2012.

Latino Collaborative - Strategic Planning Meeting, July 2011. Mentoring Diversity with Workforce Development with 13 participants; Intern Orientation, September 2011. Latino Provider Networking, February 2012 for 43 participants. Drumming and Spirituality as a Method of Healing and Recovery training, March 2012 for 80 participants. Monthly Spanish-speaking consultation team. Finalized Latino Collaborative brochure. Produced a Latino Collaborative banner for Community Events.

PRIDE Initiative - In September 2011, the PRIDE Initiative had a strategic planning day to hear from the community the needs and potential areas of focus of our work. A few lessons learned from that day: there are three higher risk LGBT populations - adult/older adults, youth and transitional age youth and Latino men; and there are three specific areas of concern - alcohol, tobacco and other drugs, mental health, and overall health.

To address the above findings, the PRIDE Initiative's activities included: Monthly active PRIDE meetings; a Queer and Questioning Q2 youth group was started; the Trevor Project gave a suicide prevention training; an adult/older adult survey was disseminated; a PRIDE Initiative presentation to the Wellness Recovery Action Plan for better collaboration and cultural competence; outreach at Westmoor High School Health Fair with 200 attendees, San Mateo County Multicultural Fair with 200 attendees, the first LGBT Community Night in Daly City with approximately 50 participants, December 2011; GSA Yes Conference in San Francisco presentation to 40 participants, presentation to the San Mateo County Youth Conference in March 2012 for 100 attendees, the first LGBT older adult film festival; a committee started to look specifically at the needs of our Transgender clients and consumers within BHRS; LGBT Senior Peer Counseling contracted by Peninsula Family Service and a Celebration of Life for a transgender Latina youth who died by suicide.

Spirituality Initiative - July 2011 - Six-hour training for 45 clinicians on integrating Spirituality and Mental Health treatments. September 2011 - Grand Rounds Presentation at a Geriatric In-patient program. October 2011 - Planning meetings with San Mateo County clergy regarding training for clergy. November 2011 - Presentation of spirituality and mental health at College of San Mateo. March 2012 - Co-Sponsor of Drumming event with Latino Collaborative for 80 participants. We had a monthly meeting of staff, clients and family members on the fourth Tuesday of each month during this period of time. We participated in

a monthly call in with the Statewide Spirituality Initiative on the fourth Wednesday of each month. Here, many county liaisons shared ideas and thoughts about spirituality in mental health. Spirituality Initiative Photovoice with 16 participants was done during this fiscal year. Developed the Spirituality Assessment card for San Mateo County clients to assist them with exploring their own spirituality. Presented at important state and national conferences, including Alternatives 2011, the Cultural Competence & Mental Health Summit and the California Network of Mental Health Clients Forums. Developed resource materials, such as "Integrating Spirituality into Psychiatric Care," a resource for providers, started a comprehensive upgrade of our webpage, which will include a Spirituality Resource Guide, the California and San Mateo County surveys, and links to valuable online resources, among others. Energized the work using mindfulness as a tool for recovery countywide; for example, our members have started a mindfulness group attended by both clients and providers, and we sustain a meditation group at the Barbara A. Mouton Multicultural Wellness Center in East Palo Alto, among others.

The **Stigma Initiative** was transitioned into the Office of Diversity and Equity in August of 2012. In FY 11/12 numerous educational presentations were held targeting official bodies such as the Mental Health and Substance Abuse Recovery Commission; community-based organizations (staff of Cordilleras residential facility and Edgewood FSP staff); staff (Public Health Nurses, BHRS Leadership); among many others. A total of 1,000 individuals have been reached by this initiative since inception. We are currently working on holding culture-specific community education forums utilizing the seven theatrical vignettes developed by the Initiative.

Crisis Hotline - StarVista (formerly YFES) provides a free, confidential 24-hour hotline to callers in San Mateo County. The mental health clinician provided services to 760 individuals in FY 11-12 through case management/phone consultation, youth outreach interventions (evaluations at school sites) and outreach presentations.

Early Childhood Community Team - Mental health consultation services provided to 163 children and 25 staff, and parent groups in the Coast. Also serving 11 families in Daly City. Clinician and community workers are trained in Touchpoints, Parents as Teachers, and Circle of Security, which are evidence-based practices that have proven effective with this population.

Community Interventions for School Age and Transition Age Youth - There are four programs under this category: Teaching Pro-social Skills, Project SUCCESS, Seeking Safety, and the Middle School Initiative. Project SUCCESS provided by PUENTE served 117 adults and youth and conducted 132 screenings at the middle school and high school in FY 11-12. Seeking Safety provided by El Centro served 37 clients in FY 11-12.

North County Outreach Collaborative and East Palo Alto Outreach - East Palo Alto - outreach by El Concilio of San Mateo County, Live in Peace, Free at Last, and Pacific Ma'a Tonga served 4,076 individuals in FY 11-12.

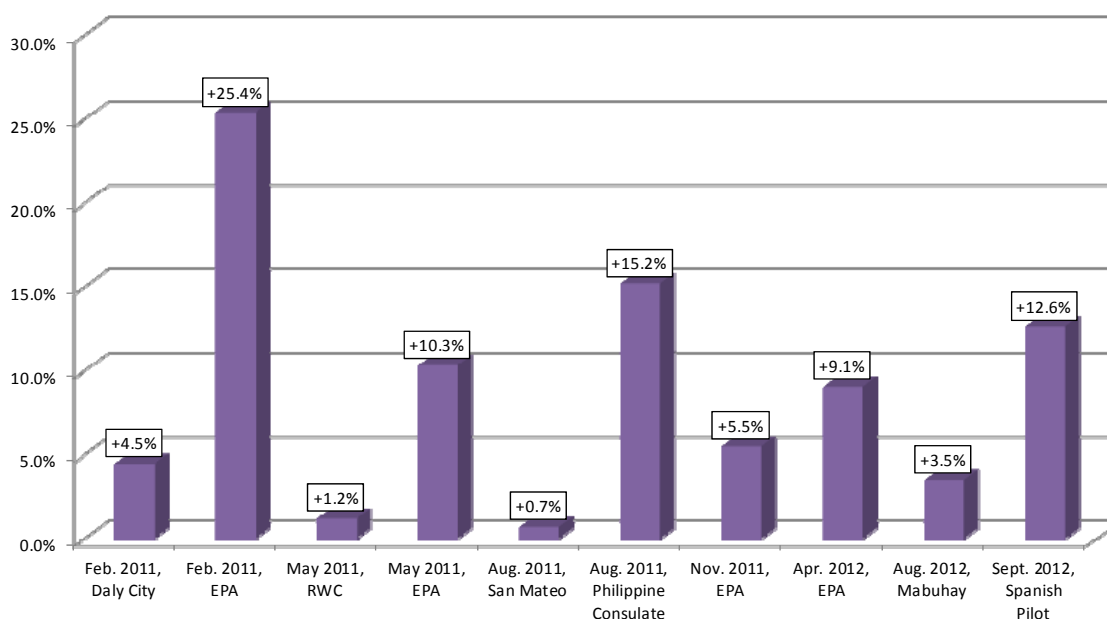
North County Outreach Collaborative - outreach by Asian American Recovery Services, Daly City Peninsula Partnership Collaborative, Pacifica Collaborative, and Pyramid Alternatives served 4,928 individuals in FY 11-12.

Total Wellness for Adults and Older Adults - PEI funds training of primary care providers for Total Wellness. These activities are blended into the Total Wellness program, which is funded through additional sources such as MHSA Innovation and a grant from the Substance Abuse and Mental Health Services Administration.

Performance Outcomes for PEI

PEI performance outcomes include a broad diversity of services, programs, trainings and interventions with very different outcomes and populations served. From this reporting period, we would like to highlight the following:

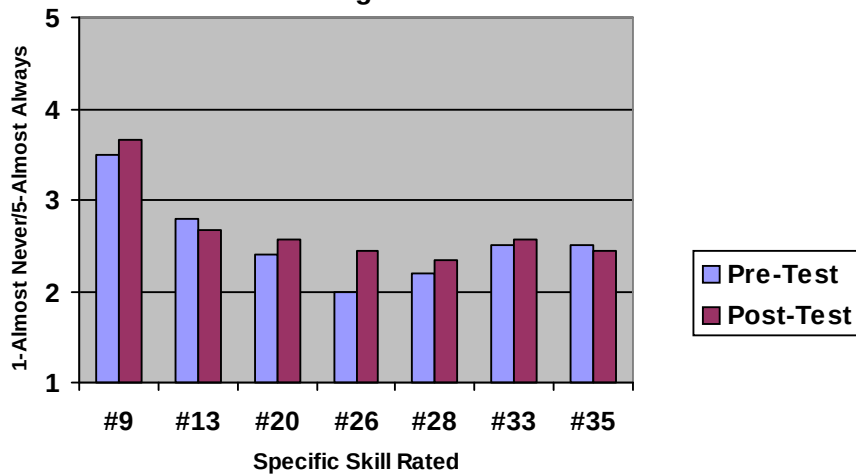
Mental Health First Aid: Of the first ten cohorts in Mental Health First Aid, all saw an increase in Mental Health Literacy based on pre- and post-tests.



Teaching Pro-Social Skills: Pre-test and post-data was collected utilizing the “Teacher/Staff Skillstreaming Checklist.” The teacher is asked to indicate the frequency a child demonstrates a particular skill, and can select from “Almost Never;” “Seldom;” “Sometimes;” “Often;” or “Almost Always.” The average score per group before the intervention was compared to the average score per group after the intervention. Although the sample sizes are too small to draw conclusions, this effort is an important step toward developmentally-appropriate program evaluation in a variety of school settings.

Despite the small sample sizes, positive trends were evidenced at all sites. The data indicate improved group average scores on the TPS skills that were focused on for that particular group. Typical of the improvements at various sites are those of the Garfield Family Resource Center, April - June 2012.

**Garfield Family Resource Center
Teacher/Staff Checklist*
Average Score**



Group Score	#9	#13	#20	#26	#28	#33	#35
Pre-Test	3.50	2.80	2.40	2.00	2.20	2.50	2.50
Post-Test	3.67	2.67	2.56	2.44	2.33	2.56	2.44
Improvements	+ 0.17	+ 0.13	+ 0. 16	+ 0.44	+ 0.13	+ 0.06	+ 0. 06

Skill #	Question asked of rater regarding specific skill
9	<u>Asking for Help</u> "Does the youngster request assistance when he/she is having difficulty?"
13	<u>Apologizing</u> "Does the youngster tell others that he/she is sorry after doing something wrong?"
20	<u>Dealing with Fear</u> - "Does the youngster figure out why he/she is afraid and do something to reduce the fear?"
26	<u>Using Self-Control</u> "Does the youngster control his/her temper so that things do not get out of hand?"
28	<u>Responding to Teasing</u> "Does the youngster deal with being teased by others in ways that allow him/her to remain in control of himself/herself?"
33	<u>Being a Good Sport</u> "Does the youngster express an honest compliment to others about how they played a game?"
35	<u>Dealing with Being Left Out</u> "Does the youngster decide whether he/she has been left out of some activity and then do things to feel better about the situation?"

Workforce Education and Training

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

Training/Education:

Mindfulness-based cognitive behavioral interventions continue to be implemented in various locations throughout the system of care. The focus on such training is in response to staff and stakeholder request for such training, as well as an increasing evidence base supporting the use of such techniques. Mindfulness-Based Cognitive Therapy for Depression (MBCT) was provided to Brief Treatment staff so individuals seeking effective treatment for depression could have access to MBCT groups. A series of trainings were provided to 15 staff and MBCT groups were initiated in English and Spanish through the Access Brief Treatment team. Additionally, a monthly mindfulness-based practice for staff and consumers was developed to help staff develop and maintain mindfulness practice. One of the unique features of this group is it is open for both staff and consumers to practice together. Such a “mixed” group allows for the creation of a community around mindfulness practice which it is hoped will interest and engage more staff and consumers.

Training on Co-Occurring Substance Abuse and Mental Health Disorders: In addition to ongoing in-house training and consultation on the Seeking Safety model, additional training on co-occurring disorders focused on the practice and principles of Harm Reduction. Patt Denning, internationally-known trainer and developer of the Harm Reduction theory of care, spoke to over 50 providers on implementing the model in their respective programs.

Graduates of the **Lived Experience Training Academy** participated in a number of trainings as consultants with their unique lived experience perspective. They participated in a second production of Case Management from a Strengths Perspective in which they provided attendees with opportunities for immediate feedback on their strength-based skills practice. Additionally, leadership from throughout BHRS were able to learn from the group their experiences with the Academy, and how becoming speakers has allowed them to gain confidence, take risks and combat stigma. Three of the group members spoke at a two-day Motivational Interviewing training and covered topics including their personal experience with MI, the importance of the client centered approach in creating change and applying skills of Motivational Interviewing.

The second **Lived Experience Academy** graduated four transitional age youth to be speakers at trainings. Each graduate completed their participation in the Academy by completing a final presentation on a topic of their personal expertise. Topics presented included self-advocacy, homelessness, surviving trauma, and living in foster care and group homes. Each speaker made a powerful contribution to the training event. The new trainers immediately became involved in a number of trainings, speaking on issues such as early intervention for psychosis and trauma-informed care.

The second Lived Experience Education Workgroup continued to build on success by involving new Lived Experience Speakers Bureau graduates into current training and forums. The group also worked on planning and staffing two additional Lived Experience Training Academies in Summer 2012. A special effort will be made to involve family members among the diverse academy experiences in an effort to continue to round out and diversify the speakers.

Motivational Interviewing (MI) was provided in a two-day introductory format to over 60 BHRS staff and staff from community-based organizations. Although offered annually for five years, the MI large and small group training continued to evolve. As the originators of the model update their work, these changes are added into the presentation. Additionally, new group exercises and media clips are also used to provide a more relevant, in-depth training experience. In October 2011, Motivational Interviewing for Interns/Trainees was provided. Motivational Interviewing for Adolescents and Youth was provided in January 2012. Advanced Motivational Interviewing (in partnership with San Francisco) was provided over two days in February 2012.

The **11/12 Intern/Trainee group** started with a two-day orientation to the basic structure of BHRS and the opportunity to meet managers and line staff. This year's orientation also included additional skills training in wellness and recovery approaches, assessment and response to crisis, suicide and trauma, cultural competence, integrated primary and behavioral health care and co-occurring mental health and substance use disorders. The end of the event culminated in a high energy, interactive activity which required the new trainees to interact and learn from members of the BHRS Health Equity Initiatives and other systems-change initiatives. Interns and trainees in attendance found the contributions of consumers and family members, as well as participating in cultural competency exercises, to be especially relevant and informative. The intention of the training was to increase new interns' awareness of the practice and structural priorities of BHRS, and to expose new members of the workforce to basic practices that allow them to work in a way which promotes such priorities. BHRS Interns and Trainees from 11/12 typically finished their training between April and August. Due to new practicum configurations in some MFT graduate programs, as well as the structure of the doctoral practicum curricula, many intern/trainees will start the new academic year over the summer. Cultural competence stipends (up to \$5,000) were awarded to students who met the criteria for cultural diversity and/or skill sets.

Supervision Update: "Approaches for Successful Supervision in Community Mental Health" training attendees stated they would like to have an ongoing check-in meeting to discuss supervision concerns among peers, problem-solve supervision policy and practice, and obtain support from each other. The meeting allowed for discussion and problem-solving around best practice for working with relationship, attitude and behavioral issues, as well as skill development among interns. Additionally, the group was able to develop ideas for program planning in the upcoming year to address trainee/intern trainee and orientation needs to ensure a smoother training year for both the supervisors and their trainee/interns. Trauma Informed Supervision was provided in November 2011.

In response to recent changes in how mental health services are provided in the public school system, BHRS Youth Team leaders organized and provided a two-part training (two sessions for each part) on **Educationally Related Mental Health Services (ERMHS)**. Part one focused on the history and current status of ERMHS and how the provision of youth mental health services has changed. The second session in December 2011 provided information on the process and practice changes as the result of the new legislation.

Training offered by the Spirituality Initiative, a Health Equity Initiative, included **Spirituality 101**, an innovative training carefully thought out and presented by members of the Spirituality Initiative to convey the importance of spirituality as one recovers.

Case Management from a Strengths Perspective was offered for the second time to BHRS and community-based organizations. The training included philosophical approaches to wellness and recovery as discussed in the Strengths Model (Rapp, et al. University of Kansas). About 30 attendees participated in practicing how to complete a strengths assessment, find resources and provide linkage using this model. Financial case management was not featured as part of this training, but an additional training on applying for Social Security for high needs clients was provided in July for BHRS and other Health System staff who assist with SSI applications.

Introduction to Acceptance and Commitment Therapy, an evidenced-based practice, training was provided in December 2011. Acceptance and Commitment Therapy for Anxiety and Panic was provided in April 2012.

Peer-to-peer Tobacco Dependence and Well Body Training was provided over three days in February 2012.

Neurosequential Model of Therapeutics Kick Off: Trauma-Informed Art Therapy was provided in February 2012. Neurosequential Model of Therapeutics Phase I Training and Implementation was provided on February, March, April and May 2012, and ten additional webinars were viewed by staff.

MAP Training for Anxiety and Panic was provided in March 2012. This is an evidence-based practice for Anxiety and Panic. Anxiety and Panic were current treatment topics chosen by BHRS and contractor staff and consumers/family members for training.

Ethics and Confidentiality was provided in April 2012.

Prevention and Recovery in Early Psychosis (PREP) - Introduction to PREP, a Promising Practice for treating psychosis and innovative early treatment for TAY, was provided in May and June 2012.

Trauma-Informed Care: Systems and Supervision - Sessions for all and for clinical supervisors, May 2012. Partnered with National Center for Trauma-Informed Care to provide evidence-based practice training to line staff and supervisors regarding implementing and sustaining trauma-informed care in practice.

Pharmacology of Addiction, June 2012.

Ongoing trainings included:

- The **Avatar Super-Users** electronic documentation training;
- **Online:** Critical Incident Management & Mandated Report, 5150 Certification and Basic Documentation Training for BHRS staff;
- **Family Partner Training** - Weekly, 1.5 hours on Tuesdays. Family Partners received Trauma 101 training;
- Youth teams continued to attend the **Complex Case Conference** meetings available every Thursday afternoon for consultation;

- **Applied Suicide Intervention Skills Training (ASIST)** - Seven trainings, with an additional 110 people trained. This training provided ASIST to more regional providers including the staff members of San Mateo Crisis Center; Monterey County Behavioral Health; Skyline Community College; staff from Marin, Alameda and Santa Clara Counties, San Mateo County Probation; and staff from local community colleges;
- **Spanish-Speaking Providers Consultation** - monthly meeting;
- **Working Effectively with Interpreters** - September 2;
- **Psychiatric Grand Rounds** - September 2011: Integrating Primary Care into Mental Health; Evolution of Behavioral Health. October 2011: EBP for Bipolar Disorders; Furthering the Integration of Substance Abuse Treatment. January 2012: Trauma 101; Data: Lust and Romantic Love Not Enough. March 2012: Survival Strategies for Clinicians. April 2012: Mental Health in Homeless Populations. May 2012: Complimentary and Alternative Treatment in Psychiatry; Meditative Techniques to Improve Patient Outcomes: Early Psychosis: Preliminary Findings Associated with Early Treatment. June 2012: Healing Complex Trauma: Treating, Physical, Sexual and Relational Abuse and Trauma; Cognitive Behavioral Therapy-Nuts and Bolts;
- **Motivational Interviewing Brown Bags** - Once a month coaching meeting and to review and practice Motivational Interviewing skills;
- **Mental Health First Aid** - At the Barbara A. Mouton Multicultural Wellness Center in East Palo Alto from November-December 2011. At the Silicon Valley Community Foundation in San Mateo, this series met monthly completed in January 2012;
- **CBMCS Multicultural Training Program** - A training cycle in September - October 2011;
- **Suicide Prevention Initiative** - Monthly meeting often includes a training component. In September 2011, Rona Hu, MD, spoke about addressing suicide in the Chinese Community. BHRS Chinese Health Initiative co-sponsored this event. Suicide Risk Assessment and Crisis Intervention; Trevor Project – Suicide Prevention for LGBT youth (leadership session October 25, community session October 26, high school and youth group sessions, October 25). Additionally, training webinars were purchased through PEI Technical Assistance and Capacity Building funds for San Mateo and regional partners. *Recognizing and Responding to Suicide Risk for Primary Care (RRSR-PC)* and *Bullying and Suicide*, both provided by the American Association for Suicidology. RRSR-PC is an evidence-based practice currently used for training primary care providers throughout the US. As the webinars have been purchased by San Mateo, they will be used for training throughout the year, and can be accessed by individuals at their convenience;
- **Trauma 101 (T-101)** continues to be offered throughout the community. San Mateo Medical Center had six sessions of the training over two days in August 2011 so members from various Psychiatric Emergency Services and Psychiatric Inpatient units could attend the two-hour version of the training. Additional T-101 training was provided to staff at BHRS South County Clinic and the Youth Services Center. The continued success and demand for T-101 training is the result of growing awareness of the importance of addressing trauma in all aspects of healthcare for the best clinical outcomes. Special Education Staff received two 1.5 hour segments of the training in October and November 2011. The presentation was adjusted to speak to the issues of traumatized youth in the educational system and included ways teachers and support staff could effectively address traumatized children in the classroom. Staff from San Mateo Medical Center (Psychiatric Emergency Services and Psychiatric Inpatient) received two segments of the training in February and March 2012. The presentation was adjusted to speak to the issues of traumatized patients in the hospital system and included ways nurses and support staff

could effectively address traumatized patients presenting for psychiatric treatment. The Trauma 101 segments were part of larger trauma-informed care presentations organized by hospital staff;

- **Seeking Safety** - Ongoing consultation (once per quarter) for providers who are incorporating Seeking Safety model to address trauma and addiction. Seeking Safety was started in a number of locations that are typical entry points to obtaining behavioral health care such as BHRS contracted detoxification services and shelters, including family shelters. Seeking Safety is also the model of choice for transitional age youth prevention and early intervention efforts in targeted locations. The Seeking Safety consultation is provided to build on a formalized Seeking Safety training in April 2011 with Dr. Lisa Najavits, and is an effort to fully implement the model through coaching and problem-solving at each location;
- **Mindfulness Practice** - Monthly group on fourth Friday to build mindfulness practice skills. Services to build skill base for evidence-based cognitive behavioral therapies and helps build self-care skills for employees;
- **BHRS Programs and contractors** requested training helpful for their implementation of relevant EBPs. StarVista received two days of thorough Motivational Interviewing review (October), and the Puente Clinic received training and case consultation on adapting DBT to developmentally disabled clients (November). StarVista sponsored Janina Fisher, a nationally-recognized trainer on somatic-based psychotherapy. Her contribution added to the ongoing development of trauma-informed practice and allows clinicians to develop further skills in the area of trauma-informed care. Mindfulness and Neuroplasticity in the Treatment of Trauma, went beyond the introductory discussion of trauma-informed care, and explored further approaches and innovations;
- **Lived Experience Forums** - Ongoing programming in which people with lived experience design the topic and the presentation. "The Power of Lived Experience" was presented as part of a change agent meeting and inspired "Power of Lived Experience: Coming Out as Consumers and Family Members" in March 2012. "Forum on Housing and Homelessness" was presented as part of a Affordable Housing Week, and "Behavioral Health is Public Health" in April 2012 as part of National Public Health Month;
- **NAMI Peer-to-peer** - Started March 2012 for ten weeks. Peers educate other peers on self-care, advocacy and acquiring resources;
- Through **Office of Diversity and Equity** the following training and workforce development activities were offered: Serving the Pacific Islander Communities - Provider Training (January 20), Honoring Veterans Service (February 9), Annual Black History Month Summit - Making the Connection: Health Disparities and Economic Hardships (February 23), Latino Mixer (February 17), Working Effectively with Interpreters in a Behavioral Health Setting (February 24), Drumming and Spirituality as a Method of Healing and Recovery (March 9), Working with Filipinos: History, Culture and Perspectives (June 7th), Cultural Humility (June 18); and
- Ongoing training at the Youth Services Center included "**Complex Conditions within a Generational Family System**" (February); **LGBTQQI Youth** (April) and **Self Harming Behavior in Girls** (May).

Workforce Development:

Mentoring Project - Mentors and mentees from the prior year have been encouraged to continue meeting, and other staff have been encouraged to participate in mentoring. In September, 2011 Mentoring for Diversity was co-hosted by Workforce Development and the Latino Collaborative, a Health Equity Initiative. This was the first workshop of the year and was intended to bring more individuals in to the discussion of the role of mentoring and to encourage ongoing mentoring connections. Time was given for staff to connect with possible mentors and the group discussed options for future mentoring workshops. The group indicated in this meeting and in follow-up surveys that the mentoring workshop is valuable. The group requested ongoing workshops as a way to provide and receive mentorship, as many have difficulty finding time to meet with an individual mentor, and they find the educational forum valuable. Mentoring Project - Hosted by WET along with the Latino Collaborative presented Mentoring for Leadership. Deborah Torres from Human Services presented on her advancement in County health and human services system, and her use of mentors along the way. Hosted by WET with the Latino Collaborative presented Mentoring for Leadership - Reverse Mentoring. Three staff members under 30 years of age presented on a panel regarding the mentoring and communication needs of young adults. The group also discussed how the most current group of youth employees could contribute to the success of the behavioral health care system through their own cultural youth-oriented perspective, skills and talents.

One East Palo Alto and Daly City Youth Health Center (DCYHC) started to work in the classrooms as creators and leaders of the behavioral health care career pathways curriculum at Terra Nova High in Pacifica and East Palo Alto Academy in Menlo Park. BHRS continues to work collaboratively with these agencies to find ways to incorporate career technology and content matter focused on behavioral health into the already existing courses. At the beginning of the year, the students completed a career interest and knowledge survey which included a measure for attitudes around stigma. The students were also introduced to career technology, information on mental illness, addiction, culturally competent care, providing care in the community and combating stigma. Twenty-seven students participated in the EPA classes and staff at DCYHC is working with well over 100 students on behavioral health career education.

Students had additional field trips which they stated were very beneficial in their understanding of the field of behavioral health and the professionals who work in the field.

- Students from Terra Nova visited South County BHRS for a tour, discussion with consumers and meeting with providers to discuss careers.
- Students at East Palo Alto Academy met with consumers and community workers at Barbara A. Mouton Multicultural Wellness Center to learn firsthand about behavioral health conditions. Students actively interviewed consumers and were able to use what they learned in a final class project. Additionally, East Palo Alto Academy hosted a career fair which was well-attended by behavioral healthcare professionals, and provided several classes the opportunity to learn firsthand about behavioral healthcare careers.
- Students from Terra Nova visited San Mateo County Drug Court for a tour and an opportunity to see court in action.
- Students at East Palo Alto Academy met with consumers from the Lived Experience Speakers bureau and the community. Students will continue to work with the consumers during the course of the semester to learn firsthand about behavioral health issues and challenge assumptions regarding stigma.

Five students participated with their adult advisors in the BHRS All Leadership Meeting on May 2. The leadership group was impressed with the students' ability to articulate the profound impact the behavioral health care oriented curriculum had on the students' impression of individuals with behavioral health challenges, and their developing interest in the field of behavioral healthcare. Over the summer, the high school pathways organizers will meet to prepare for the upcoming academic year. Both Daly City Youth Health Center and One East Palo Alto intend to participate in pathways programs in the 12/13 school year, and adjustments will be made this summer to make sure the programs are increasingly sustainable, engage students, and help them learn about behavioral healthcare careers while challenging stigma.

Intern and Trainees start their placements for the academic year in September. Much effort is made to attract diverse students, and the Cultural Competence Stipend helps to provide incentive for those applicants with diverse cultural, lifestyle and/or life experience backgrounds to apply. The Workforce Education and Training Team worked with the Office of Diversity and Equity and were able to select 20 students, mostly graduate students in counseling, social work or psychology, to receive the stipend. In addition to participating on their clinical teams, the recipients of the stipends agreed to participate in one BHRS Health Equity Initiative or systems change initiative.

The **Mental Health Loan Assumption Program (MHLAP)** awards opened the new cycle in September with applications due December 10 to apply for these awards. In the last cycle, nine well-qualified awardees completed a comprehensive and highly competitive screening process and were chosen from a pool of well-qualified, talented clinicians. MHLAP awarded a total of \$77,000 to these nine San Mateo County behavioral health staff, all of whom provide cultural and/or linguistic diversity in their clinical roles. Participation in the MHLAP has provided an important incentive for staff in hard to fill and hard to retain positions remain in these jobs.

Students with lived experience applied for the **Lived Experience Scholarship** for their ongoing education to prepare them for jobs in the behavioral health care field. Each scholarship is \$500 and must be spent on educational related supplies or services.

Innovation

Total Wellness

A total of 271 unduplicated clients were enrolled by the end of June 2012. A client must meet the following criteria to be eligible for Total Wellness:

- a) Receive behavioral health services at the South and Central County Clinics or one of BHRS' contract agency partners;
- b) Receive their primary care services from the Total Wellness (TW) Primary Care team or from the County's Primary Care Providers.

By adding new staff, we increased our enrollment capacity. Staff included the full-time Unit Chief, one full-time nurse care manager, one half-time data assistant, two 0.375 FTE enrollment assistants, and five contracted Peer Wellness Coaches (four hours/week). The Wellness Coaches conduct peer-to-peer Smoking Cessation and Well Body/Weight Management groups, lead

walking groups, and make reminder and wellness check-in calls. They work under our contracts with Heart & Soul and Voices of Recovery.

At the system level, we conducted multiple presentations and outreach at various organizations to promote our program. These organizations include Telecare Adult Full Service Partnership (FSP), Cordilleras (one of the largest locked subacute Residential Care Facilities), Innovative Care Clinic at San Mateo Medical Center (the largest primary care site), Older Adult System of Integrated Services (OASIS), and the South County BHRS Clinical Team.

At the clinic level, the TW nurse care managers have been consistently attending both the South and Central County Clinics' weekly "Welcome/Registration" meetings in addition to our continuous attendance at the Central County Clinic's clinical staff meeting. Our presence at these meetings has reinforced and strengthened our collaboration and integration with the BHRS Clinical Team. The Welcome/Registration meeting is the first access point for all new behavioral health clients to meet a BHRS staff after a request for behavioral health services is initiated; hence, our nurse care manager's presence at this meeting has become very crucial for introducing and promoting TW to everyone that enters the BHRS system. The nurse care manager enrolls any new client (or schedules a return appointment if it is indicated) who consents to our services during the meeting. For those who are not ready to commit to TW program, they are provided with our brochure and information as well as a face-to-face connection with the nurse care manager.

We established a client flow in which an actual warm hand-off can take place from primary care to Total Wellness (TW). This referral process requires flexibility on all parties involved, such as TW nurse care managers making themselves available during primary care's clinic hours, arranging staff to back up nurse care managers in situations where there will be a foreseeable potential for multiple new client referrals, and the medical assistants helping to make outreach and engagement pitches to the patients after their primary care appointment, etc.

At the client level, continuous efforts are made to reach out to all our enrollees to participate in our program's services. These efforts include reminder calls and mailing of TW monthly activities schedules, health classes and group flyers, as well as updating the bulletin boards in the waiting area of the South and Central County Clinics. With these outreach efforts, our services are made known to the community and have been showing increasing client attendance.

We provided various health and wellness activities to all our enrollees:

- a) Weekly Walking Group and Physical Activities at the Central and South County Clinics rain or shine. Since February 2012, TW has offered a weekly walking group for the Central County and South County. The walk and subsequent physical activities last for about one hour and are led by two Peer Wellness Coaches at all times. The group participants typically stay after the hour for socialization, networking, staff support, light refreshments.
- b) Total Nutrition: A weekly ten-week workshop which is focused on healthy eating habits and basic nutrition. Topics include "How to Read a Food Label," "Portion Sizes," "Sugar, Fat & Cholesterol," "Eating a Balanced Diet," "Eating Mindfully," etc. This workshop is held at both Central County and South County Clinics and is limited to

individuals enrolled in the TW Program. This workshop is well attended by a consistent number of clients.

- c) Peer-to-Peer Well Body Group: Successfully completed two six-week peer-led Well Body (Weight Management) groups at Central and South County Clinics using Dr. Chad Morris' curriculum. We plan to continue offering this group at both County Clinics on an ongoing basis. The six sessions featured the following topics: healthy eating habits, the truth about nutrition, changing behaviors, coping with cravings, managing stress, and planning ahead.
- d) Peer-to-Peer Smoking Cessation Group: We completed our trial run of two peer-led Smoking Cessation groups at South County and at Cordilleras residential care facility. The lesson we learned from this initial trial run was that this model works very well with our seriously and persistently mentally ill population who find quitting "detrimental" due to their biological, emotional, psychological, and social dependence on smoking despite their awareness of multiple serious health consequences. The participants, however, have found this group model extremely supportive, encouraging, and helpful which spoke a lot about their state of readiness. A number of consumers have requested more groups be available to them. Furthermore, on a system level, the group itself means as much as a cultural change instigator in our community as its actual mission of providing coaching and support for those who are considering quitting.

With these lessons learned, our tobacco cessation strategies will include collaborating with other models to provide a systematic approach with a continuum of interventions. Our peer-led smoking model will set the stage by providing a safe environment for those who are "contemplating" quitting and thus has been named "Ash Thinkers." We are collaborating with Central County staff that provides a six-week series of "Ash Kickers" group adopting Breathe California model for those who are ready to set a quit date. There will be some fluidity between these two groups. Participants in Ask Thinkers who are ready to "move on" to a quit group will be referred to the Ash Kickers, and participants in Ash Kickers that are not ready to set a quit date will be referred to Ash Thinkers for booster encouragement and motivational work. In the future, we would like to implement the next stage of this service continuum for those who have successfully stopped smoking but will benefit from continuous supportive measures such as coaching and/or medication intervention to maintain their accomplishment.

- e) Monthly Health Classes: Each class highlights a specific health topic with didactic education from the speaker, tips on prevention and intervention, as well as in-class demonstration if feasible. The health classes are offered to all TW clients at Central and South Clinics. Topics covered include "Healthy Hair & Skin Care," "Foot Care," and "Blood Pressure," "Happy Mouth," an oral care and oral hygiene class.
- f) Diabetes Group: We have partnered with a certified nurse from Fair Oaks, one of the County Primary Care Centers, to conduct a new four-week Diabetes Class for our TW clients at the Central County. The four-week topics include: Introduction to Diabetes, Medication Treatment for Diabetes, Diet and Diabetes, and Planning Ahead.

University of Colorado Behavioral Health and Wellness Program Training: On February 8-10, 2012 we provided a three-day training for all interested peer consumers on Peer-to-Peer Smoking Cessation and Well Body groups. This training was conducted by Dr. Chad Morris and Cindy Morris of the University of Colorado Behavioral Health and Wellness Program. A total of 46 peer consumers participated in the three day training. In addition to the peer training, Dr. Chad Morris also held a half-day training session on February 7, 2012 for staff, clinical providers, and prescribers to learn about the curricula; a portion of this half-day session focused on pharmacologic tobacco cessation aids and their use with psychiatric medications. Both the provider and peer trainings were well received and highly evaluated by all the attendees. Soon after the training, TW rolled out peer-led Smoking Cessation and Well Body groups adopting Dr. Morris' training materials and curricula.

Two peer-led Smoking Cessation groups have started at South County and at Cordilleras residential care facility. The Smoking Cessation group is designed for six weeks adopting the peer-to-peer curriculum of Dr. Chad Morris. The group provides ample opportunities for onsite support with the peer advocates who have a shared behavioral health history. Further, some have actually successfully quit using tobacco. It also promotes healthy social networking and complements other services such as those by BHRS addressing client's psychiatric symptoms (possibly compounded by smoking addiction in some instances), TW staff doing one-on-one motivational interventions and the primary care physician prescribing tobacco cessation medications. We plan to develop a range of tobacco cessation strategies combining all of the above efforts in a more systematic approach after evaluating the trial run of these first two groups.

Our Central County nurse care manager has continued her monthly visits to Portobello, a nearby RCF to do health education presentations and activities. Her presentations included: Blood Pressure, Healthy Lifestyle, and Smoking Cessation. These presentations were well attended by the residents of Portobello.

Monthly Peer Consultation Group: TW established a consultation group for all interested peers who attended the three-day, peer-to-peer training in February 2012. This group met once in March, and will continue to meet on a bimonthly basis to provide support for those who are conducting (or plan to conduct) peer-to-peer smoking cessation or weight management group as well as to facilitate feedback and input on any clinical or administrative barriers encountered by the group leaders during their process of implementation. This consultation group is facilitated by Chris Esguerra.

Total Wellness Consumer and Family Advisory Committee: We reorganized and reinstated the TW Consumer and Family Advisory Committee with the mission of including ideas and voices of the consumers in various aspects of TW services implementation. Half of the membership of the Advisory Committee are consumers and their family members. Our members currently feel they have a greater stake and influence in how TW programs and efforts are shaped and implemented.

The TW primary care team continues to make primary care linkages and appointment slots available to all new patients. As such, there is no wait time for primary care new referral appointments at the South County; and the wait time at the Central County has been reduced to less than three weeks. Furthermore, all clients without health insurance coverage are

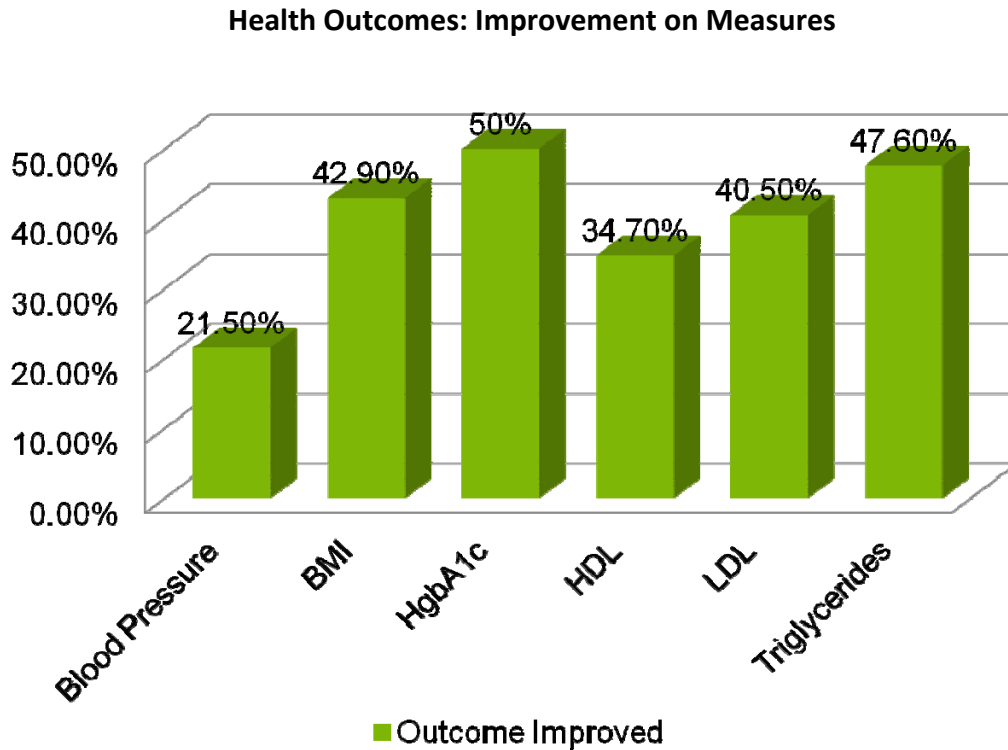
automatically linked with our benefits analysts who are also located where the TW teams are to ensure access to health insurance such as Medi-Cal, Medicaid Expansion (MCE), and our county insurance – Access to Care for Everyone (ACE).

The following items are challenges experienced during program implementation:

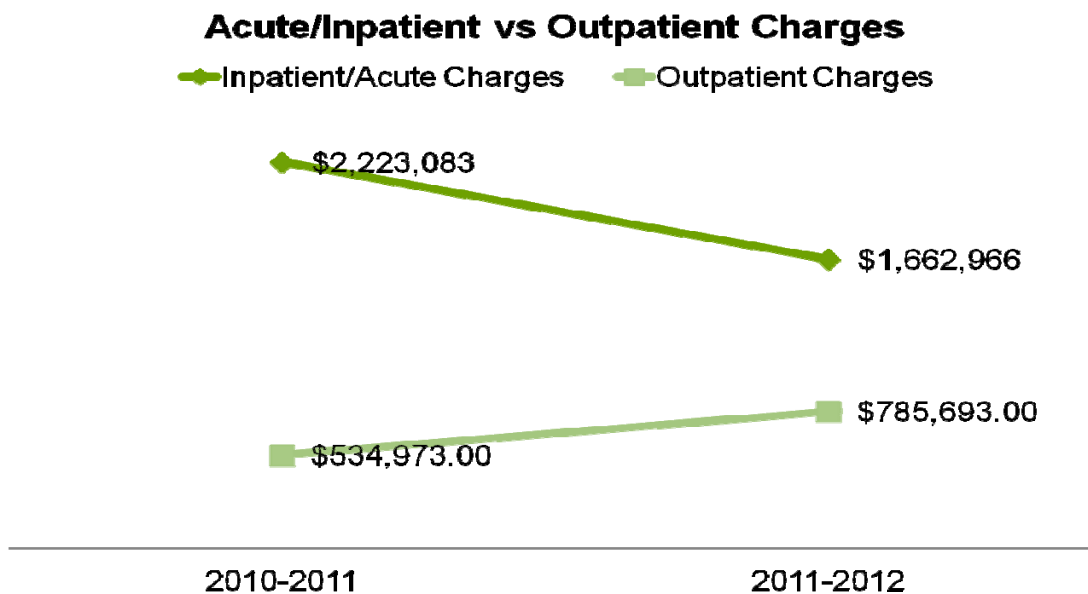
- A. EHR Data: Having to utilize multiple EHR systems such as Avatar for behavioral health and eCW for primary care in order to get the client-level data needed. We have adopted and are piloting Apixio in order to pull pertinent clinical/medical and administrative information from Avatar and eCW to improve efficiency. All TW staff have been trained in the use of Apixio. Staff has also provided feedback and suggestions to Apixio for modifications to better meet the needs of the project. Currently, we are in an RFP process to select the best vendor for a health information exchange solution since word from our pilot with Apixio resulted in competition and four vendors are currently competing in the RFP process.
- B. Lab data: It has been a phenomenal effort to obtain lab data for our clients due to the following issues: lack of coordination among multiple providers such as psychiatrist and PCP who need to order different kinds of lab and for different reasons (Clozaril lab and SAMHSA lab data) for the same client served, a need to utilize multiple EHR systems (including eCW, LabCorp, NetAccess, scanned lab documents in Avatar) in order to obtain lab data, lack of a “lab flow” process between TW staff and PCP, client’s inability to follow-through with lab order, etc. Multiple discussions have been taking place at TW staff meetings in order to develop a much simpler process, if at all possible. Updates will be provided as soon as available.
- C. Data: As SID has been built into Avatar, the ability to collect, and report client-level data has much improved. The next goal of the project is to be able to analyze these data from SID and communicate to all TW staff so that these data can be utilized for clinical intervention purposes. To this extent, there has been a continuous discrepancy in the “total number of valid cases” between TRAC and TW database, which was brought up at the PBHCI Webinar on “Grantee Evaluator Call” in March. To date, we are still awaiting a clarification response on this issue so that it will help direct our data analysis efforts.

Performance Outcomes for INN

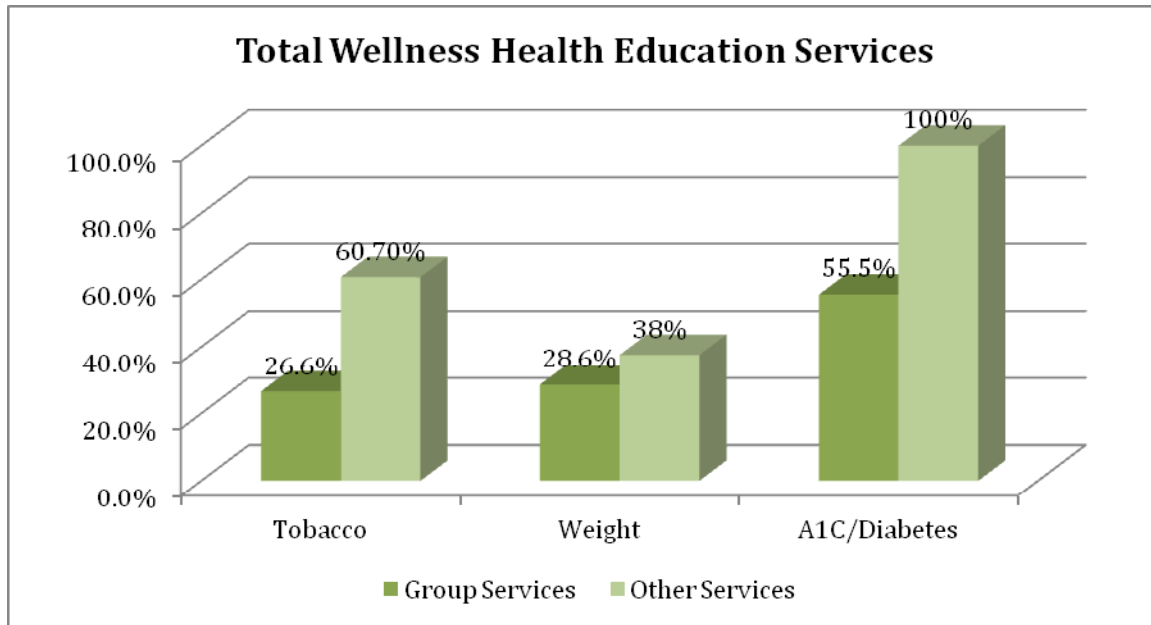
We are closely tracking a variety of performance outcomes for Total Wellness, which, even in its nascency, demonstrates significant promise. We will continue to monitor and develop performance outcomes as we refine processes to better understand the full potential of this pilot. This table (page 46) indicates the percentage of clients who have seen improvements in measures including high blood pressure, body mass index, HgbA1C, HDL, LDL and triglycerides. These data reflect the baseline and improvements after six months.



The utilization data below compares federal fiscal year to federal fiscal year. The direction is very promising and we look forward to continued research and a more comprehensive understanding of the totality of the implications for this pilot.



We have also seen impressive levels of engagement in services to address specific health issues. Of those with an addiction to tobacco, 26.6% are receiving group services and 60.7% are receiving another form of support.



PROGRAMMATIC ACTIVITIES FOR FY 13/14

The list of priorities for funding is developed and updated on an ongoing basis. Uncertainty about total revenue for FY 12/13, the projected decrease in revenue for FY 14/15, and current legislative efforts at the State level to appropriate MHSA funds for specific purposes call for a cautious approach.

In light of this, the FY 13/14 Plan mirrors our plan for the previous year. Implementation of prioritized items will be kick-started as revenue becomes available, and ongoing reports will be provided through our regular reporting and communication avenues.

For Community Services and Supports, priorities for funding continue to include:

- Creation of Full Service Partnership (FSP) slots for Psychiatric Emergency Services and our Medical Center's Psychiatric Inpatient Unit (3AB) (TAY and Adults)
- Expansion of FSP slots for Transition Age Youth, with housing
- Expansion of integrated FSP to the Central Region (Adults)
- Expansion of Wraparound services for children and youth
- Additional housing for existing FSP Adults
- Pre-crisis response services to offer targeted outreach to clients at risk of destabilizing
- Expansion of supports for youth transitioning to adulthood
- Expansion of assessment, supported employment, and financial empowerment for clients.

For Prevention and Early Intervention, priorities for funding continue to include:

- Expansion of Teaching Pro-social Skills; and
- Expansion of the Parent Project.

PROJECTED EXPANSION				
CATEGORY	ITEM	# UNITS	COST PER UNIT	TOTAL ANNUAL COST
CSS FSP	Slots for psychiatric emergency services and 3AB (TAY and Adults)	10	\$22,193	\$221,930
CSS FSP	Slots for TAY, with housing	5	\$46,000	\$230,000
CSS FSP	Expansion of integrated FSPs to Central (Adults)	5	\$8,733	\$43,665
CSS FSP	Expansion of Wraparound services for children and youth	5	\$36,000	\$180,000
CSS FSP	Additional housing for existing FSP Adults	25	\$5,774	\$144,350
CSS FSP TOTAL				\$819,945
CSS NON- FSP	Pre-crisis response services	80	\$3,125	\$250,000
CSS NON- FSP	Expansion of supports for youth transitioning to adulthood	1	\$135,000	\$135,000
CSS NON- FSP	Expansion of assessment, supported employment, and financial empowerment for clients	1	\$100,000	\$100,000
CSS NON-FSP TOTAL				\$485,000
TOTALS				\$1,304,945
PEI 0 TO 25	Expansion of Teaching Pro-social Skills	1	\$200,000	\$200,000
PEI OTHER	Expansion of Parent Project	1	\$20,000	\$20,000
PEI TOTAL				\$220,000

The figures above constitute our best estimation of the potential cost at the present time. Actual figures will be known as implementation unfolds.

PROGRAMS DESCRIPTIONS

Below is a detailed narrative of the breadth of our programmatic offerings.

COMMUNITY SERVICES AND SUPPORTS

Program: Full Service Partnership for Children, Youth and Transition Age Youth

Description:

Priority populations to be served by the program are: Seriously emotionally disturbed children, youth and their families, who are at risk of out-of-home placement or returning from residential placement, with juvenile justice or child welfare involvement; seriously emotionally disturbed and dually diagnosed transition age youth at risk of or returning from residential placement or emancipating, with juvenile justice or child welfare involvement; seriously emotionally disturbed children, youth and transition age youth with multiple psychiatric emergency services episodes and/or frequent hospitalizations and extended stays are also eligible, including homeless youth and youth exiting school-based, IEP-driven services. In addition to these children and youth that are known to one or more of the systems, the program also serves newly identified transition age youth that are experiencing a “first break.” The programs are open to all youth meeting the criteria described above, but targeted to Asian/Pacific Islander, Latino and African American children/youth /transition age youth as they are over-represented within school drop out, child welfare and juvenile justice populations. Asian/Pacific Islander and Latino populations are under-represented in the mental health system.

This program helps our highest risk children and youth with serious emotional disorders (SED) remain in their communities, with their families or caregivers while attending school and reducing involvement in juvenile justice and child welfare. Specialized services to transition age youth (TAY) aged 16 to 25 with serious emotional disorders are also provided to assist them to remain in or return to their communities in safe environments, support positive emancipation including transition from foster care and juvenile justice, secure safe and stable housing and achieve education and employment goals. The program helps reduce involuntary hospitalizations, homelessness, and involvement in the juvenile justice system. The 80 initial slots were divided between two 40-slot teams, one for children/youth and one for transition age youth. The expansion added a total of 50 new slots. Supervision of both teams by a single person assures consistent vision across both teams and collaboration between them, which intends to create a more seamless relationship between services for children and services for adults. Enrollees do not experience multiple transitions between programs as they age; they have access to the expertise across teams and the entire continuum of resources for children, youth and transition age youth as their needs change over time. Enrollees benefit from the shared resources across the program including the cultural and linguistic diversity of staff, parent partners, existing collaborative relationships with Juvenile Justice, Child Welfare, Education, Housing and Employment Services, and the expertise of individual clinicians in co-occurring disorders as well as on other evidence-based practices. The program reflects the core values of the Wraparound model: to partner with families and other key people in the life of clients in developing service strategies and plans; to assess family, child/youth and community strengths rather than weaknesses; to assist children/youth and families in becoming the authors of their own

service plans; to encourage and support a shift from professionally-centered to family-centered practice and resources; and to also assess child/youth and family needs and areas of growth. Embedded in these core values is recognition of the importance of the family's cultural values as a strength, a source of resilience, and an integral component of service delivery. It is worth noting that the transition age youth team emphasizes the individual consumer's role in developing their own wellness and recovery plan.

This FSP also offers drop-in center services and supported education services to engage TAY; these serve the FSP participants as well as other SED transition age youth in the community that are receiving mental health services. The focus is to provide self-help supports, social activities, and skill building, as well as support for those seeking to enter the college system, all aimed at enhancing ability to manage independence. Emphasis is placed in outreaching to LGBTQI SED youth.

As mentioned in previous plan updates, an expansion in FY 09/10 allowed for a new focus on San Mateo County youth ages 6 to 17 placed in foster care temporarily outside of the County. Services are designed to support and stabilize youth in the foster home, support the foster family, and facilitate the return of the youth to the family of origin in San Mateo County when feasible. This FSP also supports older adolescents transitioning out of foster care (18 years old and above), while assisting them in their journey toward adulthood. The program design allows BHRS to serve more youth while providing a fuller array of intensive services.

In addition, the expansion allowed for the provision of integrated clinic-based FSP services for the Central/South Youth Clinic (outpatient), as well as the integrated FSP for our intensive school-based services, which are provided in the Therapeutic Day School (TDS) setting, school-based milieu services, and the Non-Public School setting. Youth served are 6 to 21 years old.

These two integrated FSPs provide a full array of wraparound services to support our existing mental health teams. In addition, with the expanded FSPs, a second drop-in center for children ages 6 to 15 is currently operating in San Carlos, supplementing the one in San Bruno for youth 16 to 24 years old. As mentioned above, the drop-in centers provide a full array of social and therapeutic activities that support children and families.

Program: Full Service Partnership for Adults

Description:

Seriously mentally ill adults who may also have co-occurring disorders to be served by the FSP include: those eligible for diversion from criminal justice incarceration if adequate multi-agency community supports can be provided; currently incarcerated individuals for whom early discharge planning and post-release partnership structure and support may prevent recidivism and/or re-hospitalization; individuals placed in locked mental health facilities who can succeed in the community with intensive supports; and individuals whose mental illness results in frequent emergency room visits, hospitalizations, and homelessness that puts them at risk of criminal justice or institutional placement. The program focuses on engagement of Latino, African American and Pacific Islander populations that are over-

represented in the criminal justice system and underrepresented in the mental health system.

The Full Service Partnership for Adults offers “whatever it takes” to engage seriously mentally ill adults, including those who are dually diagnosed, in a partnership to achieve their individual wellness and recovery goals. Services are focused on engaging people on their terms, in the field and in institutions. While services provided through this program address the individual’s underlying mental health and behavioral health problems that may have led or contributed to involvement in the criminal justice system and institutionalization, a wide range of strategies and supports beyond mental health services are essential. The overall goal of the program is to divert from the criminal justice system and/or acute and long term institutional levels of care (locked facilities) seriously mentally ill and dually diagnosed individuals who can succeed in the community with sufficient structure and support. The program is grounded in research and evaluation findings that demonstrate that diversion and post incarceration services reduce incarceration, jail time and re-offense rates for offenders whose untreated mental illness has been a factor in their criminal behaviors. The program also follows the model and philosophies of California’s AB 2034 Homeless Mentally Ill Adult programs and the assertive community treatment approach, aiming to use community-based services and a wide range of supports to enable seriously mentally ill and dually diagnosed adults to remain in the community and to reduce incarceration, homelessness, and institutionalization.

The Full Service Partnership provides the full range of mental health services including medication support with a focus on co-occurring mental health and drug and alcohol problems. Staff are trained in motivational interviewing and develop dually focused programming, including groups. Medication services include psychiatry and nursing support for ongoing dialogues with consumers about their psychiatric medication choices, symptoms, limiting side effects, and individualizing dosage schedules. Staff is available to consumers 24/7, and service plans are designed to utilize exceptional community relationships. Peer partners play a critical role, modeling personal recovery, helping consumers establish a network of peer, family, and cultural supports and, in particular, helping consumers connect with a non-profit network of peer-run self-help centers.

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

Program: Full Service Partnership for Older Adults and Medically Fragile Individuals

Description:

This Full Service Partnership serves seriously mentally ill older adults and medically fragile individuals who are either at risk of institutionalization or currently institutionalized and who, with more intensive supports, could live in a community setting. In many instances these individuals have co-occurring medical conditions that significantly impact their ability

to remain at home or in a community-based setting. The program outreaches especially to Asian, Pacific Islander and Latino individuals, as these populations are under-represented in the current service population.

Similar to the FSP for Adults, the goal of this program is to facilitate or offer “whatever it takes” to ensure that consumers remain in the least restrictive setting possible through the provision of a range of community-based services and supports delivered by a multidisciplinary team. The program targets seriously mentally ill older adults and medically fragile individuals who either would be at risk of placement in a more restrictive setting without intensive supports or who could be moved to a less restrictive setting with these additional supports. The program works with board and care facilities and with consumers living in the community to prevent them from being placed in locked or skilled nursing facilities, and with residents of skilled nursing and locked facilities to facilitate their returning to a less restrictive setting. Referrals to the program are received from locked facilities, skilled nursing facilities, acute care facilities, board and care facilities, primary care clinics, Aging and Adult Services, community agencies, and from individuals/family members themselves. For many of the consumers targeted by this Full Service Partnership, their mental illness impedes their ability to adhere to essential medical protocols, and their multiple medical problems exacerbate their psychiatric symptoms. As a result, these individuals need support and assistance in following up on medical appointments, medical tests/treatments, and close day-to-day supervision of medications. Difficulties managing these issues as well as shopping, meal preparation and other routine chores often lead to institutional placements so that these basic needs can be met. The goal of the FSP is to make it possible for the consumer’s care to be managed and his/her needs to be met in a community setting. A full-time nurse enables the treatment team to more effectively collaborate with primary care providers and assist consumers in both their communications with their primary care doctors and in their follow-up on medical procedures and treatments. The licensed clinicians in the team oversee the completion of the multidisciplinary assessment and the development and implementation of a comprehensive service plan that involves all members of the team, the consumer and the family, contingent on the consumer’s wishes. Peer Partners provide support, information and practical assistance with routine tasks, and cultivate a system of volunteer support to supplement what the Peer Partner can provide. Similarly, when a family is involved and the consumer is supportive of their involvement, a Family/Caregiver Partner works with the family to build their capacity to support the consumer. With these strategies, the Full Service Partnership helps to mobilize natural supports in the consumer’s system and contributes to building those natural strengths to maintain the consumer in the least restrictive setting. In addition to the FSP staff, each FSP member receives the supports of their “virtual team” that includes the individuals/family members in their lives as well as any other needed health or social services supports for which they are qualified such as In-home Supportive Services, Meals on Wheels, senior centers/day programs, etc. These formal and natural supports are identified and integrated into the consumer’s individual service plan.

Similar considerations apply as with the previous program regarding integrated services.

Program: Outreach and Engagement

Description:

Targeted populations include African American, Chinese, Filipino, Latino, LGBT and Pacific Islander individuals. Strategies include population-based community needs assessment, planning and development of materials to identify and engage diverse populations in services. Special emphasis is given to building relationships with neighborhood and cultural leaders to ensure that unserved and underserved communities are more aware of the availability of behavioral health services, and that these leaders and their communities can have more consistent input about how their communities are served.

This program strategy identifies and engages individuals by building bridges with ethnic and linguistic populations that experience health disparities and may experience behavioral health services as unresponsive to their needs. Strategies include population-based community needs assessments, planning and materials development as well as community-based “navigators”, and primary care-based behavioral health services to identify and engage diverse populations.

Initially fully funded through the Community Services and Supports (CSS) component of the MHSA in FY 09/10, we commenced a redirection of most of the services within this program that are fundable under the Prevention and Early Intervention component.

Program: Pathways, a Mental Health Court Program

Description:

The Pathways Program serves seriously mentally ill (SMI) nonviolent offenders with co-occurring disorders - mental health and substance use/abuse. The program was designed to be appropriate to the issues and needs of Latino, African Americans and Pacific Islander populations, as they are over-represented in the criminal justice system.

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

The program aims at:

- Reducing recidivism and incarceration;
- Stabilizing housing;
- Reducing acute care utilization; and
- Engaging and maintaining active participation in personal recovery.

Anyone can refer someone to Pathways, including self-referrals. Eligibility criteria are:

- San Mateo County residency;
- A diagnosis of a serious mental illness (Axis I), with functional impairments;

- Statutory eligibility for probation; and
- Agreement to participate in the program voluntarily.

The referrals are sent to a centralized location in the Probation Department. They are then forwarded to the client's lawyer, at which point the client and the lawyer decide on whether they are interested in the Pathway services. If they are, the lawyer has the case directed to the Pathways Court calendar. Many people get screened out for not meeting the criteria for admission specified above or choose not to be considered for some of the following reasons:

- The lawyer presents the client with a "better deal" involving less jail/probation time;
- The person referred does not identify with being seriously mentally ill; and
- The person referred has no desire to work toward recovery.

Program: Older Adult System of Care Development

Description:

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

This program focuses on creating a coherent, integrated set of services for older adults in order to assure that there are sufficient supports to maintain the older adult population in need in their homes and community, and in optimal health. The intent is to assist seniors to lead dignified and fulfilling lives, and in sustaining and maintaining independence and family/ community connections to the greatest extent possible. Peer Partners provide support, information, consultation, peer counseling, and practical assistance with routine tasks such as accompanying seniors to appointments, assisting with transportation, and supporting social activities. They also recruit and participate in training volunteers to expand our existing senior peer counseling volunteer-based program in order to build additional bilingual/bicultural capacity. Senior peer counseling works with individuals and groups. "La Esperanza Vive" - a component of the current Senior Peer Counseling program, is a well-developed Latino-focused program in existence for over 25 years that recruits and trains volunteers, and provides peer counseling for Latino older adults. "La Esperanza Vive" provides a model for the development of other language/culture-specific senior peer counseling components. Senior Peer Partners serve homebound seniors through home visits and create or support the development of activities for mental health consumers at community sites such as senior centers. In addition, and as desired by SMI older adults, Senior Peer Partners facilitate consumers to attend client-run self-help centers. Staff are bilingual and bicultural. The Senior Peer Counseling program has been expanded to include a Chinese-focused component, a Filipino-focused component and a LGBT-focused component. The field-based mental health clinical team provides in-home mental health

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

The program has a very significant and robust outreach and engagement component that aims at identifying seniors in need through the various avenues described above.

Program: System Transformation and Effectiveness Strategies

Description:

All populations served by Behavioral Health and Recovery Services benefit, with an emphasis on improving services to ethnic and linguistic populations that experience disparities in access and appropriateness of services, and assuring integrated and evidence-based services to those with co-occurring disorders.

Throughout the MHSA outreach and planning processes, participants have spoken repeatedly about the need to fundamentally transform many aspects of the system to truly enact wellness and recovery philosophy and practice, and more successfully engage unserved ethnic and linguistic populations in services.

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

PREVENTION AND EARLY INTERVENTION (LOCAL)

Program: Early Childhood Community Team

Description:

The Early Childhood Community Team project incorporates several major components that build on current models in our community, in order to support healthy social emotional development of young children. A Team comprises a community outreach worker, an early childhood mental health consultant, and a licensed clinician and targets a specific geographic community within San Mateo County, in order to build close networking relationships with local community partners also available to support young families. Per the recommendation of our planning workgroup, the initial BHRS PEI team site was targeted to serve communities with a high proportion of Latino and/or isolated farm worker families, and communities or communities experiencing a significant degree of interpersonal violence, which has significant impact on families and young children.

The community outreach worker is a key team member, who networks within the community and community-based services to identify young families with children between birth and age three and connects them with necessary supports. Another role includes offering groups for families with young children, using the Touchpoints Program. This approach, developed by Brazelton, is based on the concept of building relationships between children, parents and providers around the framework of “Touchpoints,” or key points in early development. Participants learn how to use relationship-building and communication strategies when they deliver care and interact with children and families.

The second team member (Early Childhood Mental Health Consultant) focuses on supporting social emotional development in child care settings by providing early childhood mental health consultation. This service typically consists of the following activities:

- Observing the interaction of the caregiver(s) with young children;
- Observing a child’s interaction with caregiver(s) and other young children;
- Consulting with the caregiver(s) regarding overall support of positive social emotional development;
- Consulting with the caregiver(s) on developmental or behavioral concerns regarding a specific child;
- Facilitating family and caregiver meetings; and
- Facilitating referrals for additional services for children and families.

Child care is provided by licensed family day care providers, license exempt providers, and family/friends/neighbors. The child care resource and referral agency in San Mateo works with all of these types of child care settings and manages a database with all types of providers, searchable by specific community. It provides support for the county’s child care providers and preschool programs, investing in professional development and helping improve program quality through a variety of workshops, programs and support services—however, most services are offered in central San Mateo and may not be attended by providers from other parts of the county. By making early childhood mental health consultation available to more child care providers, the team reaches families at risk and in distress at an early point in the developmental process. The outreach worker is also able to identify and connect with family/friend/neighbor providers that may not have been previously known to the resource and referral agency and facilitate their connection to ongoing supports.

The third team member is a licensed clinician who provides brief, focused services to families that are identified with a need by the community outreach worker, the early childhood mental health consultant or partners in the network of community services such as primary care providers (note that brief services are defined as less than one year). The clinician screens for postpartum depression and facilitates appropriate service plans with primary care and/or mental health services.

Program: Community Interventions for School and Transition Age Youth

Description:

This project focuses on school age and transition age youth, reaching out to them in schools and community-based agencies, such as substance abuse programs, drop-in centers, youth

focused and other organizations operating in communities with a high proportion of underserved populations. The project provides population and group based interventions to at-risk children and youth ages 6 to 25.

The first intervention, Teaching Pro-social Skills (TPS), addresses the social skill needs of students who display aggression, immaturity, withdrawal, or other problem behaviors. Students are at risk due to issues such as growing up poor; peer rejection; low quality child care and preschool experiences; afterschool care with poor supervision; school failure, among others. Teaching Pro-social Skills is based on Aggression Replacement Training (ART). ART was developed by Arnold P. Goldstein, Barry Glick and John C. Gibbs, and takes concepts from a number of other theories for working with youth, and incorporates them into a comprehensive system. Peer learning and repetition are elements of the model. ART is an evidence-based program broadly utilized. Social skills training, anger control, and moral reasoning are the main components of both ART and TPS.

The second intervention, Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students), is considered a SAMHSA model program that prevents and reduces substance use and abuse and associated behavioral issues among high risk, multi-problem adolescents. It works by placing highly trained professionals (Project SUCCESS counselors) in the schools to provide a full range of prevention and early intervention services.

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

The third intervention, Seeking Safety, is an approach to help people attain safety from trauma/PTSD and substance abuse. It targets Transition Age Youth through their contacts with community-based organizations. Seeking Safety is a manualized intervention (also available in Spanish), providing both client handouts and guidance for clinicians. It is conducted in group and individual format; with diverse populations; for women, men, and mixed-gender groups; using all topics or fewer topics; in a variety of settings; and for both substance abuse and dependence. It has also been used with people who have a trauma history, but do not meet criteria for PTSD. The key principles of Seeking Safety are:

1. Safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions);
2. Integrated treatment (working on both PTSD and substance abuse at the same time);
3. A focus on ideals to counteract the loss of ideals in both PTSD and substance abuse;

4. Four content areas: cognitive, behavioral, interpersonal, case management; and
5. Attention to clinician processes (helping clinicians work on countertransference, self-care, and other issues).

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

Program: Prevention and Recovery in Early Psychosis (PREP)

Description:

PREP aims at achieving remission through early detection, meticulous diagnosis and an array of evidence-based treatments; rehabilitation by providing clients with the tools that they need to keep their illness under control for the long term; recovery, by restoring clients to a normal, productive life; and respect through including the client and seeking his or her consent, as well as involving the family - whichever way the client defines "family."

The PREP Program is among the most comprehensive programs of science-based early diagnosis, treatment, and rehabilitation services for schizophrenia available in the United States. Unlike older treatments - which aim primarily at palliative care - the PREP Program aims to prevent the onset of full psychosis, and, in cases in which full psychosis has already occurred, seeks to remit the disease and to rehabilitate cognitive capacities damaged by the disease. PREP carefully braids together five evidence-based practices into one integrated treatment approach, and uses community education and outreach to facilitate early identification of individuals at risk of psychosis, a huge factor in preventing the ravages associated with untreated psychosis and schizophrenia. Once the clients are engaged, PREP provides Cognitive Behavioral Therapy to help them manage their symptoms and better understand their condition. When medication is needed, PREP uses algorithm medication management to identify the lowest possible dosage creating the least possible side effects. PREP engages the client and family in Multifamily Groups that create a supports system and promote a positive therapeutic community within the family. PREP uses Strength-Based Care Management to help the client and family develop relapse prevention plans and a life plan that builds upon strengths and provides goals for the future. Finally PREP provides vocational planning that reinforces the life plan with tangible goals for a career.

Program: Primary Care/Behavioral Health Integration

Description:

This program supports BHRS' efforts toward becoming more effectively integrated to better serve our clients. Services funded include system wide co-location of BHRS practitioners in Primary Care settings to facilitate referrals, perform assessments, and refer to appropriate behavioral health services if deemed necessary. The model utilizes essential elements of IMPACT model to identify and treat individuals in primary care who do not have Serious Mental Illness, and are unlikely to seek services from the formal mental health system. Some of these elements are listed below.

Collaborative care, which functions in two main ways:

- The individual's primary care physician works with a care manager/behavioral health consultant to develop and implement a treatment plan (medications and/or brief, evidence-based psychotherapy); and
- Care manager and primary care provider consult with psychiatrist to change treatment plans if individuals do not improve.

Care Manager/Behavioral Health Consultant. The care manager:

- Educates the individual about depression/other conditions;
- Supports medication therapy prescribed by the individual's primary care provider if appropriate;
- Coaches individuals in behavioral activation and pleasant events scheduling/self management plan;
- Monitors symptoms for treatment response; and
- Completes a relapse prevention plan with each individual who has improved.

Psychiatrist:

- Consults to the care manager and primary care physician on the care of individuals who do not respond to treatments as expected.

Program: Total Wellness for Adults and Older Adults

Description:

Prevention and Early Intervention funds a few key program elements of a larger initiative called Total Wellness. More details of the Total Wellness project can be found under the Innovation Component program description (page 71). Included in the Total Wellness project is an integrated training piece; it entails a universal prevention strategy that focuses on education of professionals on co-morbidity and related issues. The trainings target all types of providers (county clinics and contract providers serving that population).

The trainings aim at providing professionals with the necessary information to help them understand the interconnectedness and the interdependence between mental and physical health. Such trainings help bridge a much needed gap in knowledge.

Program: Community Outreach and Engagement, and Capacity Building

Description:

This program strategy identifies and engages individuals by building bridges with ethnic and linguistic populations that experience health disparities and may experience behavioral health services as unresponsive to their needs. Strategies include population-based community needs assessments, planning and materials development as well as hiring of community-based “navigators,” and primary care-based behavioral health services to identify and engage diverse populations. This program includes Health Equity Initiatives targeting African American; Chinese; Filipino; Latino; Pacific Islander; LGBTQI; and

Spirituality and the Anti-Stigma Initiative. The program includes two regional collaborative enterprises: the East Palo Alto Behavioral Health Advisory Group and the North County Outreach Collaborative.

Target population: Individuals who are currently unserved and need behavioral health services.

Prevention and Early Intervention (Statewide)

Program: Training, Technical Assistance, and Capacity Building

Description:

Three areas of focus for this component were identified through our stakeholder process: The first area involves training BHRS and contractors' staff to become trainers in the ASIST model. The funding for this training for trainers allows such staff to provide clinical and "Gatekeepers" training for providers and community members in San Mateo and neighboring communities. Making these training opportunities available has greatly increased the capacity of community members and providers to respond, among other things, to suicidality. The second area involves an outreach and education effort aimed at providing primary care practitioners with training in evidence-based practices, in order to help them address in their offices an array of mental illness identification strategies including suicidality. This area of focus recognizes the fact that individuals across cultural groups and ages tend to have a connection with a primary care provider; it also recognizes that the majority of individuals who completed suicide had a recent primary care visit. The third area of focus involves technical assistance collaboration with stakeholders from non-traditional mental health settings in order to develop community capacity building strategies targeting broad audiences through different topics addressing public perception on behavioral health issues (stigma, suicide, etc.).

All three areas have created and realized opportunities for neighboring counties to participate and benefit.

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.

The County's Behavioral Health and Recovery Services Division (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.

Approved projects include:

- Cedar Street Apartments (14 units)
- El Camino Apartments (20 units)
- Delaware Street Apartments (10 units).

BHRS' MHSA Housing Program Request for Applications may be viewed at:
http://www.smchealth.org/sites/default/files/docs/1327533978MHSAHousingProgram_RFA.pdf

Here are some visuals of these projects:



**Cedar Street Apartments -
 Approved in 2009 (14
 units) - Original Sketch**



**El Camino Apartments - Approved
 in 2010 (20 units) - Original Sketch**





← El Camino Apartments **before**

El Camino Apartments After →



Delaware Street Apartments - Approved in 2011 (10 units) - Original Sketch

Workforce Education and Training

FUNDING CATEGORY: WORKFORCE STAFFING SUPPORT

Program: Workforce Education and Training Plan Coordination and Implementation

Description:

The plan and all BHRS training activities are overseen by a Workforce Development Director. The Director supervises a 0.5 FTE Community Resource Specialist. This team serves as staff to the BHRS Training Committee and has system wide responsibility for:

- Managing implementation of the MHSA Education and Training Plan, and of the BHRS Training Plan;
- Managing the BHRS training budget;

- Providing research, data, and communication to the BHRS Training Committee to assist in oversight of the annual work plan;
- Recruiting and orienting Training Committee members to ensure that the Committee includes both, consumers and family members, and that it represents the cultural composition of the population served;
- Developing, maintaining and strengthening relationships with a wide range of regional stakeholders in education and training and workforce development, as well as among the provider, consumer and family communities, and cultural communities;
- Organizing and scheduling training events, including identifying trainers and consultants;
- Collaborating with consumer and family members staff to expand availability of consumer-family focused training;
- Developing strategies and modalities to provide training to staff, including use of team-based training experiences, the use of consultants, and electronic training resources (video/web) to expand access to training;
- Managing intern recruitment, placement, and training;
- Liaising with the Bay Area Regional Collaborative and other regional and statewide relevant bodies and initiatives; this includes collaborating to expand training resources available locally;
- Collaborating with the Manager of Strategic Operations (MHSA Coordinator) regarding relevant cross-cutting MHSA activities and reporting requirements;
- Participating in the development of pipeline workforce development strategies;
- Evaluating training activities and reporting outcomes to the Training Committee;
- Developing an annual report for staff, clients and family members to determine the extent to which training and workforce development activities are contributing to the transformation of the system of services and supports; and
- Preparing and submitting periodic reports to all internal and external organizations to ensure compliance with existing guidelines.

FUNDING CATEGORY: TRAINING AND TECHNICAL ASSISTANCE

Program: Targeted Training For and By Consumers and Family Members

Description:

This program aims at providing a range of trainings activities, as follows:

- Trainings delivered by and for consumers and family members. Examples include Paving the Way, a San Mateo model that provides training and supports for consumers and family members joining our workforce, and that also supports existing staff to welcome new consumer/family staff; Hope Awards, which highlight personal stories while educating consumers, families, staff, and the general public about recovery and stigma; Inspired at Work, which provides a framework for consumers and family members to get support and to explore issues involved with entering and remaining in the workforce;
- Trainings provided by consumers and family members to providers and the general public designed to increase understanding of mental health issues and to reduce stigma. Examples include Stamp Out Stigma, a community advocacy and educational outreach

program dedicated to eradicating the stigma associated with mental illness through forum-type presentations in which individuals with mental illness share their personal experiences with the community at large; Breaking the Silence, a training activity designed to address issues of gender identification in youth and the effects of community violence; consumer-led trainings by youth/TAY, directed to audiences of all ages. Youth/TAY will be targeted as an audience for these trainings as well;

- Trainings provided by consumers and family members to increase understanding of mental health issues and substance use/abuse issues, recovery and resilience, and available treatments and supports. Examples include NAMI's Provider Education Training, an intensive training to providers led by consumers, family members, and experts; In Our Own Voice, NAMI-sponsored consumer-to-consumer presentations about their experiences, which is usually presented in a number of settings, including hospitals; Family to Family, a NAMI-sponsored twelve-week course taught by families to families of consumers about mental health, treatments, and how to focus on self-care; Peer to Peer, a NAMI-sponsored nine-week course taught by consumers to consumers about mental health, treatments, and recovery; Voices of Recovery, a client and family driven-advocacy and support effort for those who have been affected by addiction;
- In addition, this program also provides for selected consumers and family members to attend leadership trainings to support increased involvement of consumers and family members in various committee, commission, and planning roles. Examples include: CMHACY (California Mental Health Advocates for Children and Youth) Conference; educational visits to The Village; attendance to NAMI, Heart & Soul, and other community-based training activities to help perfect the leadership skills of consumers and family members; and
- Trainings for the community to reduce stigma and increase understanding of behavioral health consumer and family issues. One example is the Crisis Intervention Training (CIT), which provides training to police officers in local communities about the nature of behavioral health issues, and is designed to increase understanding, reduce stigma, and lay the groundwork for more appropriate responses to consumers and family members by local police. Consumers and family members present to first responders regarding their experience of mental illness, as well as the role and concerns of family members and consumers in promoting wellness and working with law enforcement. Consumers and family members also address issues of stigma, and raise awareness regarding appropriate law enforcement interventions for consumers and their families.

Program: Trainings to Support Wellness and Recovery

Description:

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

Program: Cultural Competence Training

Description:

Training in the area of cultural competence is designed to reduce health disparities in our community, to provide instruction in culturally and linguistically competent services, and to increase access, capacity, and understanding by partnering with community groups and resources. Educational and training activities are made available to consumers, family members, providers, and those working and living in the community. The Training Plan has identified a number of components designed to address these issues, such as the use of the CBMCS Multicultural Training Program to assess our system of services; trainings to increase the effective use of interpreters in service delivery; creation of a clinical consultation resource for providers working with Filipino consumers; addressing cultural issues when providing services to consumers suffering from co-occurring disorders and domestic violence. Trainings are also used to help support key Health Equity Initiatives (HEI) currently underway as part of our work on reduction of disparities. The different HEI funded through PEI have been focused on the following populations: African American, Chinese, Filipino, Latino, LGBTQI, Pacific Islander, Spirituality and Anti-Stigma.

Program: Evidence-Based Practices Training for System Transformation

Description:

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

The Workforce Development Director routinely contacts participants in various EBPs (and other) training activities six months after training has been completed to assess the degree to which the training has resulted in changed treatment practice.

FUNDING CATEGORY: MENTAL HEALTH CAREER PATHWAY PROGRAMS

Program: Attract prospective candidates to hard to fill positions via addressing barriers in the application process

Description:

Multiple workgroup discussions concluded that strategies are necessary to address ongoing vacancies in positions which are difficult to fill. Psychiatry and community mental health nurses were identified as job classifications in which qualified staff has been challenging to obtain and retain. Cultural diversity in all positions across the board was also identified as an ongoing deficit. Consideration was given to how to address these shortages in partnership with the County's Human Resources Division in order to strategize solutions.

Strategies include creating an expedited application process by:

- Working with the County's Human Resources Division to remove barriers to the application process e.g. the protracted length of time between recruitment, interviewing, and hiring;
- Designating hard to fill positions for a fast track application process;
- Reviewing and revising current job classifications/descriptions as necessary, in partnership with the County's Human Resources Division; and
- Identifying barriers in the application process including: where and how positions are advertised; elimination of duplications in fingerprinting requirements whenever possible; streamlining of civil service requirements as permitted; and broadening employment opportunities for targeted hard-to-fill disciplines such as child and gerontology psychiatrists, nurses, etc.

Program: Attract prospective candidates to hard to fill positions through incentives

Description:

San Mateo County competes with other similar organizations and the private sector to hire employees with specialized, needed skills into a number of positions that are difficult to fill. Offering financial incentives to attract and retain candidates to these positions was identified as an important tool, since such incentives increase the appeal of working for community mental health services among potential job candidates.

Strategies include the development of incentives to encourage the application and retention of qualified individuals into hard to fill positions by:

- Prioritizing hard to fill applicants in the loan assumption approval process;
- Supporting child and gerontology psychiatry positions with part-time work as they complete fellowship;
- Encouraging nurse employees in direct service and contract provider agencies to take advantage of MHSA statewide stipend program for advanced nursing training; and
- Being flexible when tailoring practicum requirements to the needs of candidates for hard to fill positions (in coordination with contracted educational agencies).

Program: Promote mental health field in academic institutions where potential employees are training in order to attract individuals to the public mental health system in general, and to hard to fill positions in particular

Description:

In addition to incentives and breaking down application barriers, workgroup members identified positive marketing of mental health careers as an important objective in attracting qualified individuals to hard to fill positions.

Strategies include increasing exposure to the mental health field and to County employment opportunities, by:

- Working with institutions of higher education such as UCSF, Cal State East Bay, and San Mateo Community College system - among others, to coordinate direct and

indirect outreach including tailoring recruitment information and participation at career fairs;

- Expanding and/or creating pipeline relationships between prospective feeder institutions (high school, undergrad, grad) and providers;
- Strengthening partnerships with professional development programs (e.g. ,Nursing, MSW, MFT, etc.);
- Promoting County placements to fulfill practicum requirements;
- Partnering with nurse practitioner student practicum to promote the mental health field, and provide career mentoring; and
- Promote interest among and provide opportunities for youth/Transition Age Youth (TAY) in pursuing careers in behavioral health.

Focus groups and informal discussions have revealed a consistent interest in behavioral health careers among youth, including Transition Age Youth (TAY). Through these discussions, youth/TAY revealed the barriers to entering the behavioral health field, and were able to describe ways in which they believed youth could be engaged and retained in the behavioral health pathways. Such barriers included TAY not knowing what jobs are available in behavioral health settings, what such jobs entailed, what positions they qualified for, and how to train/apply for such positions. Once youth interest in the behavioral health field has been achieved, youth have indicated it is essential for them to have ongoing learning experiences to deepen their understanding and commitment to the field. Such experiences also provide early training, and assist with creating a more competent and diverse pool of trainees and applicants to the field.

Strategies include informing youth/TAY, including those not in school, of opportunities to engage in exploring a career in behavioral health, by:

- Promoting BHRS activities, including workforce development activities on social networking and popular blog sites;
- Providing information and shadowing to high school students regarding careers in behavioral health;
- Delivering BHRS presentations in schools, promoting BHRS's campus tours, providing fliers promoting careers in behavioral health;
- Developing informational materials that reflect youth informed language and learning styles;
- Establishing mental health job fairs for middle and high school youth;
- Connecting with high school community service programs to provide BHRS site opportunities that meet the community service requirements;
- Providing opportunities for youth to be trained by and work with seasoned professionals; and
- Broadening outreach to community colleges outside San Mateo County (e.g., Foothill College and San Francisco City College).

Strategies also aim at creating exposure to BHRS programs and providing work experience opportunities for youth/TAY by:

- Developing behavioral health training academies in high schools to include psychology, health and/or rehab/social work course work, and internship placements;

- Implementing a mentoring/summer internship program similar to local summer jobs programs already established in the community;
- Working with High School Career Centers on pipeline strategies;
- Providing management and leadership skills development opportunities;
- Building on existing peer education programs in High Schools;
- Connecting with School counselors;
- Attending schools' career and job fairs to do outreach;
- Sponsoring summer internships;
- Developing a list of internships/volunteer experiences; and
- Developing a paraprofessional training program for youth (e.g., conflict resolution for youth).

Program: Increase diversity of staff to better reflect diversity of client population

Description:

A concentrated effort needs to be made to create a workforce that is more reflective of the communities served, and that has the skills and knowledge needed to best provide services to these individuals. Traditional efforts to attract diverse workers into mental health jobs have had limited success, and it has become clear by discussions with relevant stakeholder groups, that strategies can be employed to increase interest in these positions.

Some of these strategies include recruiting diverse populations (targeting language skills in addition to specific minority groups), by:

- Utilizing existing cultural initiatives and outreach collaboratives to deliver information regarding potential career opportunities;
- Developing appropriate recruiting materials relevant to specific populations;
- Utilizing media outlets that target specific populations;
- Creating structures/processes to oversee implementation of recruiting efforts;
- Contacting and engaging with culture-specific organizations such as the Historically Black Organizations or HBOs regarding career opportunities;
- Outreaching to college fraternities and sororities with diverse memberships;
- Targeting schools that have a high concentration of diverse students for outreach and recruitment;
- Ensuring diverse hiring and promotion panels (for both recruitment and retention); and
- Participating in community events (e.g., health fairs, county fairs and ethnic events to promote BHRS career opportunities).

Program: Retain diverse staff

Description:

Current input from existing diverse staff, as well as from the participants in the workforce development group, indicate that diverse staff want to be promoted in behavioral health care, but are not always sure how, or if they have the skills necessary to move up in the organizations. The following interventions are designed to address the issue of ongoing skills development as well as staff understanding of the systems and opportunities to participate in these systems.

Strategies include achieving diverse staff retention by:

- Creating exposure and interest across job classes, including administrative/clerical staff, via mentoring;
- Promoting cross-training and temporary job changes;
- Providing exposure to management and executive level staff;
- Developing a leadership academy for supervisors;
- Offering “promotion readiness” workshops for current staff; and
- Re-examining workload distribution and bilingual pay differential of staff receiving such differential.

Program: Expand existing efforts and create new career pathways for consumers and family members in the workforce to allow for advancement within BHRS and in other parts of the County system

Description:

San Mateo County BHRS and contracted agencies have been successful in hiring, promoting and fully utilizing dozens of community workers and family partners in their respective systems of care. In addition to providing essential practical support, guidance and training, recruitment and hiring teams have also worked hard to battle stigma, and to create a safe working culture for these essential new employees. That said, much more work remains to be done in relation to the issue of stigma and how it impacts the recruitment and retention of consumers and family members. As consumers and family members become more fully integrated into the system, it is imperative that these valuable workers be retained, and that their skills and leadership needs be brought to all levels of their respective organizations.

Strategies include enhancing current and creating new professional development opportunities for consumers and family members - from entry level to top leadership positions, by:

- Considering consumer and family member role in developing career paths (e.g., personal experience);
- Using youth/young adults as peer partners in order to help with engagement, support and peer education;
- Providing financial support for consumers and family members pursuing education, in order to assist with expenses not covered by other sources;
- Creating a mentorship program especially developed for consumers and family members, with participation from supervisors and management;
- Broadening employment opportunities;
- Offering and supporting consumer and family volunteer opportunities;
- Providing technical assistance to BHRS contractors not currently employing consumer/family members;
- Building upon/expanding existing collaborations (e.g., College of San Mateo), and creating new ones, to support consumers and family members in their pursuit of certifications and advanced degrees;
- Offering paid or unpaid internships for consumers/family members;
- Creating a Family Partner Certification Program;
- Empowering current and former mental health consumers to seek employment opportunities in the BHRS system; and

- Expanding support of consumers and family members during the application process in order to guide them through it by providing assistance on how to understand the HR lingo, and/or by conducting “mock interviews” to assist in the development of interviewing skills.

Program: Ongoing engagement and development of client and family workers

Description:

Consumer and family member employees are a precious resource within the behavioral health system of care. They are not only essential in providing sensitive, appropriate services to highly diverse populations, but they are also inherently transforming the systems of care by their presence in the workforce. Their empathy, experience and advocacy skills are creating the shift toward total health and wellness which reinforces every aspect of the San Mateo County mission to provide high quality, community-based health care.

Strategies include increasing retention rates for consumer and family partner employees, by:

- Building upon/expanding WRAP and similar current initiatives to support physical and emotional health of consumers and family members;
- Building upon/expanding BHRS’s efforts to successfully integrate consumer and family members in the workforce as essential to providing meaningful services and supports;
- Utilizing the BHRS Stigma Initiative as a vehicle to address workplace issues; and
- Supporting flexible work schedules.

FUNDING CATEGORY: FINANCIAL INCENTIVE PROGRAMS

Program: Stipended Internships to Create a More Culturally Competent System

Description:

This action provides stipends to trainees from local universities who contribute to expand the diversity as well as the linguistic and cultural competence of our workforce. Our stipend program for interns offers a fixed amount to students in our system to assist in covering their expenses in hopes they will pursue careers in public mental health. The Workforce Development Director conducts the outreach to graduate schools to identify a diverse pool of trainees, and works with mental health programs to develop placements and provide ongoing training. The objectives of this program include increasing the availability of culturally and linguistically competent services to all consumers and family members of BHRS; and increasing the knowledge and understanding of trainees of the values and commitments of recovery-based, strength-based services offered in BHRS.

Capital Facilities and Information Technology

Program: eClinical Care

Description:

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

Through a robust stakeholder process it was decided to focus the 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.

Innovation

Program: Total Wellness

Description:

We build on several emerging, innovative practices for this program we have called Total Wellness. Research shows that people with serious mental illness have a range of healthcare issues that compromise their ability to pursue recovery, and the behavioral health system should function as their entry point into primary healthcare - if they are not already being served or if they are underserved. Building on learnings from practices that have been successful in the primary care setting, Total Wellness aims at improving the health status of seriously mentally ill individuals who suffer chronic health conditions, adapting some of the strategies in those practices for use in the behavioral health system.

Total Wellness also builds upon and supports the practices of the Nurse Practitioners that have for almost two decades have been located in BHRS clinics, providing assistance and backup to their provision of general healthcare services in the behavioral health setting.

The incorporation of nurse care manager and peer health and wellness services aims to assure the smooth and seamless collaboration of all care providers, primarily by the coordinating function of the Nurse Care Managers, the follow up/direct assistance function of the Peer Health and Wellness Coaches, and the overall communication and close collaboration of the entire care team. This aims to ensure a seamless service experience for clients.

Nurse Care Managers, in partnership with Peer Health and Wellness Coaches and other care team members as needed work with individuals who have elevated levels of blood pressure, glucose and lipids, assuring that:

- They are connected to ongoing healthcare in a primary care medical home (using the mental health/substance use entry point as the entry point into primary healthcare as well as access to other services);
- They get clinical preventive screenings (for example, mammograms and other cancer screenings), as well as appropriate primary and specialty healthcare for chronic health conditions (by coaching and/or supporting them in primary care visits or arranging for peers to accompany them);
- They follow up on medications prescribed for physical health conditions;
- They engage in a Chronic Disease Self Management Program; and
- The nurse care managers also link people to benefits counseling, the Smoking Cessation classes, and plan and co-lead with Peer Health and Wellness Coaches ongoing groups that support weight management and physical exercise.

A key feature of this innovative approach is the utilization of peers as health and wellness coaches, assisting seriously mentally ill individuals in the management of their health conditions.

MHSA FUNDING SUMMARY, FY 2013-14

County: San Mateo

Date: 6/3/2013

	MHSA Funding					
	CSS	WET	CFTN	PEI	INN	Local Prudent Reserve
A. Estimated FY 2013/14 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	\$6,955,736	\$1,890,718	\$0	\$5,415,017	\$1,380,192	
2. Estimated New FY 2013/14 Funding	\$16,299,669			\$4,074,767	\$1,072,307	
3. Transfer in FY 2013/14 (a)	\$0	\$0	\$0			\$0
4. Access Local Prudent Reserve in FY 2013/14	\$0			\$0		\$0
5. Estimated Available Funding in FY 2013/14	\$23,255,405	\$1,890,718	\$0	\$9,489,784	\$2,452,499	\$0
B. Estimated FY 2013/14 Expenditures	\$15,470,447	\$416,706	\$0	\$5,928,136	\$970,110	
C. Estimated FY 2013/14 Contingency Funding	\$7,784,958	\$1,474,012	\$0	\$3,561,648	\$1,482,389	

(a) Per 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.

D. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2013	\$600,000
2. Contributions to the Local Prudent Reserve in FY 2013/14	\$0
3. Distributions from the Local Prudent Reserve in FY 2013/14	\$0
4. Estimated Local Prudent Reserve Balance on June 30, 2014	\$600,000

Estimated FY 2013/14 Expenditures	
Community Services and Supports By Program	
Full Service Partnerships	\$9,239,114
General System Development	\$5,387,897
Outreach & Engagement	\$843,436
Prevention and Early Intervention By Program	
Early Childhood Community Team	\$472,143
Community Interventions for School Age Youth, TAY	\$1,064,755
Primary Care Interface	\$1,933,639
Community Outreach, Engagement, Capacity Bldg	\$1,349,493
PREP	\$810,000
Total Wellness	\$298,106
Innovation By Project	
Total Wellness	\$970,110

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

- When the new modality for the disbursement of MHSA revenue to counties was first implemented, there were funds in the Mental Health Services Funds (State level) waiting to be disbursed. These funds became a "one time" allocation that was sent in September of 2012 along with receipts from July, August and September.
- Due to changes in the tax law that took effect on January 1, 2013, several taxpayers filed their taxes in December 2012 in order to avoid paying higher taxes. This will result in an additional "one time" increase in funding, but the exact amounts for these "one time" revenue increases cannot be determined at this time. They will be known in the months to come.
- Revenue is scheduled to decrease in FY 14/15.
- Our prudent reserve has only \$600,000. Our County has been reluctant to build up the reserve because the process for accessing was initially unclear. The prudent reserve concept was included in the MHSA as a provision to ensure that unforeseen decreases in the revenue would not cause program to cease. We believe in this concept, and have actually managed the wild fluctuations in MHSA funding with this same philosophy. However, we have preferred to leave our unspent funds in our MHSA Trust Fund instead of constituting a reserve we weren't sure we would be able to access if/when needed.