Sonoma County Takes Action FOR MENTAL HEALTH

SONOMA COUNTY MENTAL HEALTH SERVICES ACT (MHSA)

Program and Expenditure Plan Update for FY 2022-2023 with FY 2020-2021 Annual Report

Participants take action for mental health through Zumba offered at La Luz Center.

The County takes action for mental health by initiating a new Innovative program, Crossroads to Hope.

MHSA's new Innovative project, *Nuestra Cultura Cura* takes action for mental health by kicking off their project.

Community Baptist Church Collaborative takes action for mental health through community event planning.

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA

WELLNESS · RECOVERY · RESILIENCE

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MHSA COUNTY COMPLIANCE CERTIFICATION

County: Sonoma

Local Mental Health Director	Program Lead
Name: Jan Cobaleda-Kegler	Name: Melissa Ladrech
Telephone Number: 707-565-5157	Telephone Number: 707 565-4909
E-mail: Jan.Cobaleda-Kegler@sonoma-county.org	E-mail: melissa.ladrech@sonoma-county.org
County Mental Health Mailing Address: Sonoma County Department of Health Services, Behavioral Health Division 1430 Neotomas Avenue Suite 203. Santa Rosa CA 95405 United States.	

I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the County has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this annual update, including stakeholder participation and nonsupplantation requirements.

This annual update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft annual update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on January 24, 2023.

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

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

Jan Cobaleda-Kegler
Local Mental Health Director/Designee (PRINT)

Jan Cobaleda-Kegler 1-25-23
Signature Date

County: Sonoma

Date: January 25, 2023

Enclosure 1

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Sonoma

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

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Jan Cobaleda-Kegler	Name: Erick Roeser
Telephone Number: 707-565-5157	Telephone Number: 707 565-3295
E-mail: Jan.Cobaleda-Kegler@sonoma-county.org	E-mail: Erick.Roeser@sonoma-county.org>

Local Mental Health Mailing Address:
Sonoma County Department of Health Services, Behavioral Division
1430 Neotomas Avenue Suite 203.
Santa Rosa CA 95405 United States.

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

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

Jan Cobaleda-Kegler
Local Mental Health Director (PRINT)

Jan Cobaleda-Kegler 1-25-23
Signature Date

I hereby certify that for the fiscal year ended June 30, 2022, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated 1/13/23 for the fiscal year ended June 30, 2022. I further certify that for the fiscal year ended June 30, 2022, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

Erick Roeser
County Auditor Controller / City Financial Officer (PRINT)

Signature 1/27/23
Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)

EXECUTIVE SUMMARY

Purpose of this Document

As per the California Welfare and Institutions Code (WIC) Title 9, Section 331 the Sonoma County 2022-2023 Mental Health Services Act (MHSA) Annual Program Update and Expenditure Plan provides Stakeholders with:

- The Annual Program Update and Expenditure Plan for Fiscal Year (FY) 2022-2023.
- The Annual Program Report for FY 20-21 which includes the activities, services, and programs funded through MHSA and the program outcomes for FY 20-21.

History of MHSA

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA), placing a one percent tax on personal income above $1 million to be used to expand mental health services. In FY 22-23, it is estimated that over $3 billion in MHSA funds will be collected statewide, and it is estimated that Sonoma County will receive over $25 million. MHSA funds are not guaranteed, and the amount of MHSA funds the County of Sonoma Department of Health Services Behavioral Health Division (DHS-BHD) receives varies each year.

The passage of Proposition 63 created the first opportunity in many years for California to increase funding, personnel, and other resources to support County mental health programs and monitor progress toward statewide goals for:

Youth | Transition Age Youth | Adults | Older Adults | Families

The MHSA addresses a broad continuum of prevention, early intervention, service needs, and the necessary infrastructure, technology, and training elements that will effectively support this system.

MHSA challenges communities throughout California to utilize MHSA resources to support the transformation of our mental health systems.

THE FIVE COMPONENTS OF MHSA

MHSA consists of five funding components, each of which addresses specific goals for priority populations, key community mental health needs, and age groups which require special attention. The programs and services of this report will be presented in the context of these components.

Community Services and Supports (CSS) *76% of MHSA funds*

Provides funds for direct services to individuals with severe mental illness. There are three subcomponents under CSS:

- **Full Service Partnerships (FSPs)** provide wrap-around services or "whatever it takes" services to consumers. *(A **majority** of CSS funds are to be expended on FSPs.)*
- **General System Development (GSD)** provides funds to improve the mental health service delivery system.
- **Outreach and Engagement (OE)** is designed to reach, identify, and engage unserved individuals and communities in the mental health system and reduce disparities.

Prevention and Early Intervention (PEI) *19% of MHSA funds*

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

Innovation (INN) *5% of MHSA funds*

Funds new approaches that increase access to unserved and/or underserved communities, promotes interagency collaboration, and improves the quality of services.

Workforce, Education and Training (WET)[1]

Provides funding to improve and build the capacity of the mental health workforce to meet the needs of unserved and underserved populations, and provide linguistically and culturally relevant services.

Capital Facilities and Technological Needs (CFTN)[2]

Provides funding for building projects and increasing technological capacity to improve mental health service delivery.

[1] Pursuant to WIC 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.

[2] Ibid.

HIGHLIGHTS OF CHANGES TO THE MHSA PROGRAM & EXPENDITURE PLAN FY 22-23

MHSA Program Changes and Impacts for FY 22-23

The table below highlights the substantial changes to MHSA funded programs from the FY 21-22 Annual Plan Update and Expenditure Plan (FY 21-22 Plan Update) to the FY 22-23 Annual Plan Update and Expenditure Plan (FY 22-23 Plan Update). There may be additional changes to the FY 22-23 Plan Update after the Sonoma County Board of Supervisors finalizes the County budget in June 2022. In the event there are additional changes, Stakeholders will be notified, the amendments to the FY 22-23 Plan Update will be posted for 30 days and then an MHSA Public Hearing will be hosted by the Mental Health Board.

CHANGES	IMPACTS
MENTAL HEALTH SERVICES ACT PLANNING	
MHSA Community Program Planning (CPP) Strategic Action Plan: MHSA Annual Planning is increased by $150,000.	$150,000 has been allocated for the implementation of the MHSA Community Program Planning (CPP) Strategic Action Plan. This will empower the County to significantly increase stakeholder participation in the CPP process. Please see page 254 of the appendix to review the CPP Strategic Action Plan.
COMMUNITY SERVICES AND SUPPORTS (CSS)	
Buckelew Programs – FACT: Buckelew is receiving $40,007 to supplement supportive housing for the Forensic Assertive Community Treatment (FACT) team clients.	This will provide gap funds for housing for FACT clients.
Adult Services Contractor: An additional contractor for Adult Services is being added. A $1,250,000 Release for Proposals (RFP) for Adult Services is seeking a CBO to provide treatment for non-FSP (Full Service Partnership) adult clients.	This will expand the capacity of the Adult Services programs, which will increase access and improve timeliness of appointments.
Youth Services Contractor: An additional contractor for Youth and Family Services is being added. A $250,000 RFP for Youth Services is seeking a CBO to provide treatment for non-FSP youth clients.	This will expand the capacity of the Youth and Family Services programs, which will increase access and improve timeliness of appointments.
Whole Person Care (WPC) is transitioning at the end of the year. The	The County will not be subcontracting with the following contractors for WPC: Community Development

State mandates that County Behavioral Health will no longer be funding the WPC outreach subcontractors. This is a reduction of 8 contractors totaling $329,469 annually.	Commission, COTS, Drug Abuse Alternatives Center, Petaluma Health Center, Reach for Home, Santa Rosa Community Health Centers, West County Community Services, West County Health Centers. A community partner will be contracting for the services and no impact to services is expected.
Foster Youth Team (FYT): The DHS-BHD FYT is receiving $47,535 additional funding.	This funding will expand the FYT team to improve access to services and timeliness of appointments.
CSS Housing Program Assigned Funds ($48,788) will be used in FY 22-23.	This funding will allow additional housing support for FSP clients.
PREVENTION AND EARLY INTERVENTION (PEI)	
No Changes	No impacts
INNOVATION (INN)	
Crossroads to Hope: A total of $2.5 million in Innovation dollars over five years will be used to fund Crossroads to Hope. $500,000 will be used in FY 22-23.	This will expand supportive housing for individuals with serious mental health concerns who are diverted from jail and the program utilizes peer providers to provide the supportive services.
CalMHSA's Semi-Statewide Electronic Health Record: $1,789,665 will be used in FY 22-23	DHS-BHD is proposing to use MHSA Innovation (INN) funds to contract and participate with California Mental Health Services Authority (CalMHSA) to implement a Semi-Statewide Electronic Health Record (EHR) that meets the new CalAIM requirements. See page 29 for proposal.
WORKFORCE, EDUCATION AND TRAINING (WET)	
WET Activities: Increasing WET Activities by $250,000 for training	California Institute for Behavioral Health Solutions (CIBHS) will provide Strengths Model Care Management training for clinical staff. This training will empower clinical staff to improve the quality of case management and client outcomes.
WET Senior Office Assistant (SOA): Adding $6,156 to partially fund the WET SOA position.	The WET SOA will support all of the WET activities and the Diversity, Equity, and Inclusion Development Manager.
CAPITAL FACILITIES AND TECHNOLOGY NEEDS	
No Changes	No impacts

PROJECTED MHSA REVENUE FOR FY 22-23

Sonoma County estimates that it will receive over $30 million in MHSA revenue in FY 22 23. The complete FY 21 22 Expenditure Plan is on pages 49 58.

INTRODUCTION

MHSA BACKGROUND

The Mental Health Services Act (MHSA) creates local mental health systems that are consumer and family member driven, focused on wellness and resiliency, hold a vision in which recovery is possible, and deliver culturally competent and linguistically appropriate services. MHSA aims to facilitate change—along a continuum of care—that helps identify emerging mental illness and prevents it from becoming severe, to providing treatment for children, transition age youth, adults, and older adults through supporting mental health recovery.

Since the passage of MHSA in 2004, the County of Sonoma Department of Health Services Behavioral Health Division (DHS-BHD) has undertaken an ongoing, robust community planning process for each MHSA component. The process began in FY 05-06 to plan for the implementation of the Community Services and Supports (CSS) component of MHSA. In FY 06-07, Sonoma County, along with community Stakeholders, began to identify Workforce Education and Training (WET) needs. In FY 07-08, the MHSA housing plan was funded. In FY 09-10, the Prevention and Early Intervention (PEI) Community Planning Process began. In FY 10-11, Sonoma's Capital Facilities and Technology Needs (CFTN) plan was finalized; and in FY 11-12, the initial plan for Innovation was finalized.

Each of these planning processes involved countless Stakeholders throughout Sonoma County. The Stakeholders participated in various capacities, such as in community planning meetings, as questionnaire respondents, advisory committee members, focus group participants, request for proposal review panels, etc. These processes required a tremendous commitment of time and skill that demonstrates the thought and care which went into each plan. These plans have ultimately resulted in the development of essential programs, activities, and services that make up Sonoma County's current behavioral health continuum of care.

MHSA TODAY

Today, Sonoma County has a well-developed behavioral health system of care. It has been implemented in phases and now runs as a full continuum of care. MHSA services, activities, and programs are reviewed and approved by Sonoma County Stakeholders each year. For more information on programs and services operating during FY 20-21, please see the Annual Program Report section of this document on pages 59 - 144.

MHSA provided Sonoma County the opportunity to enhance new partnerships and to strengthen continuing partnerships with community-based organizations, and has supported inclusion of the voices of more clients, family members, and unserved and underserved populations in the planning and implementation of mental health activities, programs, and services. As a consequence, Sonoma County residents now have a more accessible, integrated, comprehensive, and compassionate behavioral health system of care. The system of care was founded on and continues to develop in concert with the MHSA Guiding Principles cited below:

Community Collaboration	• Individuals, families, agencies, and businesses work together to accomplish a shared vision.
Cultural Competence	• Adopting behaviors, attitudes, and policies which enable providers to work effectively in cross-cultural situations.
Client and Family Driven System of Care	• Adult clients and families of children and youth identify needs and preferences which result in the most effective services and supports.
Focus on Wellness, Including Recovery and Resilience	• People diagnosed with a mental illness are able to live, work, learn, and participate fully in their communities.
Integrated Service Experiences	• Services for clients and families are seamless. Clients and families do not have to negotiate with multiple agencies and funding sources to meet their needs.

MHSA defines four consumer age groups to reflect the different mental health needs associated with a person's age. Counties are directed to provide age-appropriate services for each:

- **Children:** 0-15 years
- Transition Age Youth: (TAY): 16-25 years
- **Adults:** 26-59 years
- **Older Adults:** 60 years and older

Additionally, MHSA intends to serve individuals who are historically unserved or underserved by the public mental health care system. The California Code of Regulations defines these individuals as follows:

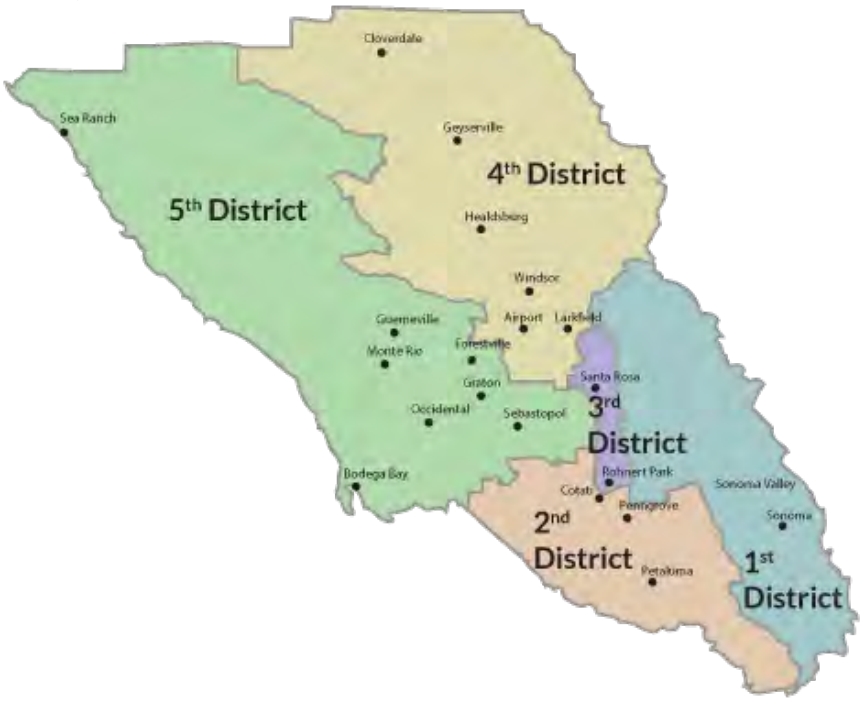
- **Unserved.** "Individuals who may have serious mental illness and/or serious emotional disturbance and are not receiving mental health services. Individuals who may have had only emergency or crisis-oriented contact with and/or services from the County may be considered unserved."
- **Underserved.** "Individuals who have been diagnosed with a serious mental illness and/or serious emotional disturbance and are receiving some services but are not provided the necessary or appropriate opportunities to support their recovery, wellness, and/or resilience."

Sonoma County recognizes the historical disparities in access and quality of care which additional populations in the County have experienced, thus including them into the unserved and underserved definition. One common factor that contributes to these disparities is language barriers which prohibit people from engaging in services available only in English. Cultural backgrounds also influence individuals' experiences of mental health treatment. Some practices are more effective to engage people in services or provide effective treatment for one culture than for others. Furthermore, individuals experiencing poverty, individual and institutional discrimination based on race, ethnicity, gender identity, or sexual orientation may be more likely to face difficulty navigating the system of care. Finally, lack of transportation, geography, and location affect access and utilization of services.

DESCRIPTION OF SONOMA COUNTY

Sonoma County, located within the San Francisco Bay Area, about 45 minutes north of San Francisco has a population of 488,863 people across a region of 1,576 square miles. (U.S. Census Bureau, 2020) The severe wildfire seasons of recent years coupled with the Covid-19 pandemic have transformed the lives of many Sonoma County residents which most likely led to a decrease in population from 2019 through 2020. Within the last few years, many Sonoma County residents have experienced of displacement, job loss, educational disruption, significant mental health challenges, and have witnessed an increase in deaths not only to the coronavirus, but also to drug overdose. While Sonoma County ranks high in top places to live and Santa Rosa has been ranked as one of the healthiest places to live in the U.S, (McCann, 2021) the County continues to face a shortage in affordable-housing, economic insecurity, and disproportionate harm falling on communities of color. (Measure of America, 2021) Over one fourth (130,665) of the population is eligible for Medi-Cal. (DHCS, 2022) 7.8% of the population has an income below the Federal Poverty Level (FPL). (U.S. Census Bureau, 2020) Santa Rosa is the county's most populous city with 178,127 people and is home to over one-third of county residents, and that is why the Department of Health Services, Behavioral Health Division's (DHS-BHD) main campus is located in Santa Rosa. (U.S. Census Bureau, 2020) Beyond Santa Rosa, the main population centers are Petaluma (population 59,776) and Rohnert Park (population 44,390) to the south, and Windsor to the north (population 26,344). (U.S. Census Bureau, 2020) Sonoma County is geographically dispersed with limited public transportation and bicycle and pedestrian infrastructure which can make it challenging for individuals living in more rural areas and those without a personal vehicle.

Map 1: Map of Sonoma County



DEMOGRAPHICS

In 2020, 62.9% of residents identified as White with 27.3% identifying as Hispanic or Latinx, the County's largest minority population. The County's poverty rates vary significantly by ethnicity with disparities affecting the Latinx community in particular. While Hispanic or Latinx residents were about a quarter of the population, this group accounted for 40% of Sonoma County's Medi-Cal beneficiaries in 2021. The County is also home to five federally recognized Native American tribes, including the Cloverdale Rancheria of Pomo Indians of California, the Dry Creek Rancheria Band of Pomo Indians, the Federated Indians of Graton Rancheria, the Kashia Band of Pomo Indians of the Stewarts Point Rancheria, and the Lytton Band of Pomo Indians. Native Americans make up just over 2% of the County's total population and about 1% of Medi-Cal beneficiaries. Over 25% of Sonoma County households speak a language other than English at home, of which almost 20% speak Spanish—the County's only threshold language. About 11% of residents speak English less than "very well," suggesting possible linguistic isolation for this population. Additionally, there are an estimated 27,000 undocumented residents in the County. Individuals who are undocumented and/or linguistically isolated may experience unique challenges accessing medical, transportation, and social services. If services are limited by language, it can reduce access as well as the quality of services available—particularly for individuals with lower levels of income.

Sources:

1. U.S. Census Bureau. (2020). Quick Facts, Sonoma County, California.
2. California Department of Health Care Services (2018). Medi-Cal Enrollees and Beneficiaries https://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal-Certified-Eligibles.aspx
3. Tribal affairs. Retrieved from https://sonomacounty.ca.gov/CAO/Public-Reports/Legislative-Program/Tribal-Affairs/
4. U.S. Census Bureau. (2020). Quick Facts, Sonoma County, California.
5. https://www.census.gov/library/visualizations/interactive/people-that-speak-english-less-than-very-well.html

https://www.migrationpolicy.org/data/unauthorized-immigrant-population/county/6097

ECONOMICS

The County's major industries include agriculture, healthcare, hospitality, and manufacturing. The top employers are Kaiser Permanente, Sutter Medical Center of Santa Rosa, St. Joseph Health System, and Graton Resort & Casino. Like most California counties, Sonoma was severely affected by the COVID-19 pandemic, As a result of COVID-19 job losses, Sonoma County's unemployment rate peaked at 14.5% in April 2020. The rate has since then decreased to just over 5%. According to the U.S. Census Bureau, in 2019 just over 7% of County residents lived in poverty—a little less than half of California's rate of almost 12%. The median household income was $81,018. The economic impacts from the pandemic are currently being analyzed. While Sonoma County begins to recover from the COVID-19 pandemic, rising housing costs continue to be a key driver of economic instability. Over 60% of Sonoma County residents who rent their homes and over 30% of residents who own their homes experience housing-cost burden (i.e., spend 30% or more of their household income on rent or mortgage). Historic chronic underbuilding of housing created a disparity between supply and demand and limited the growth potential of the County's economy. Housing costs and underbuilding have the greatest impact on individuals and families with less financial security or who are experiencing home instability. Economic challenges in Sonoma County were exacerbated not only by the current COVID-19 global pandemic, and also due to an unprecedented number of natural disasters.

In the last five years, Sonoma County recovered from five major and devastating fires and a flood event. The 2017 Complex Fires burned over 112,000 acres, destroyed over 5,000 homes, and took 24 lives. One in six households reported lost wages or employment and one in ten households reported an increase in housing or rent costs as a direct result of the fires. In 2019 an atmospheric river brought up to 20 inches of rain to Sonoma County over three days. The heavy rains caused the Russian River to raise 13 feet above flood stage to 45.4 feet in Guernevillle which resulted in the worst flood event in Sonoma County in 24 years. The flood impacted Russian River communities including Guerneville, Jenner, Rio Nido, Monte Rio, Sebastopol, and Healdsburg. Over 40 people were rescued, 3,600 residents were evacuated and 8,000 were without power. Additionally, more than 2,000 homes and businesses were flooded, with 527 structures damaged and 31 declared uninhabitable due to flood damage. The flood impacted 578 businesses, totaling $35 million in damages.

After the flood in 2019, came the largest wildfire to burn in Sonoma County the – Kincade Fire – which was also the largest fire of the 2019 California wildfire season. The Kincade Fire burned over 77,000 acres in Geyserville, Windsor, and Healdsburg and resulted in the evacuation of 90,000 residents. The fire destroyed 174 homes and 200 additional structures, including winery facilities.

In the midst of the COVID-19 pandemic, California experienced rare thunderstorms in August of 2020, which sparked 376 fires across the state. Two of those fires had grown in Sonoma County: the Walbridge Fire and the Meyers Fire. In total, the Walbridge and Meyers Fires destroyed 298 structures, including 150 residences

and 9 motor homes. A third major fire of 2020 started in September – the Glass Fire. The Glass fire burned over 67,484 acres and destroyed 1,555 structures, including 334 homes in Sonoma County. Approximately 2.5% of Sonoma's total housing units were lost only in the 2017 fires, leading the County to require a total of 26,000 new units by 2020 to account for employment growth, fire losses, and overcrowding.

MENTAL HEALTH

COVID-19, the fires, and the flood have impacted Sonoma County economically, and have also brought mental health impacts across the county. 40% of households in Sonoma County reported individual and collective trauma experiences, such as being separated from a family member or suffering a significant disaster-related illness or injury. Recently, 45% of Americans said the virus and pandemic had a negative effect on their mental health. Young adults have experienced a number of pandemic-related consequences, such as closures of universities and loss of income, which may contribute to poor mental health. During the pandemic, a larger than average share of young adults (ages 18- 24) report symptoms of anxiety and/or depressive disorder (56%). Compared to all adults, young adults are more likely to report substance use (25% vs. 13%) and suicidal thoughts (26% vs. 11%). Prior to the pandemic, young adults were already at higher risk of poor mental health and substance use disorder, though many did not receive treatment.

Research during the pandemic points to concerns around poor mental health and well-being for children and their parents – particularly mothers, as many are experiencing challenges with school closures and lack of childcare. Women with children are more likely to report symptoms of anxiety and/or depressive disorder than men with children (49% vs. 40%). In general both prior to and during, the pandemic, women have reported higher rates of anxiety and depression compared to men.

The pandemic has disproportionately affected the health of communities of color. Non-Hispanic Black adults (48%) and Hispanic or Latinx adults (46%) are more likely to report symptoms of anxiety and/or depressive disorder than Non-Hispanic White adults (41%). Historically, these communities of color have faced challenges accessing mental health care. The pandemic also disproportionately affected LGBTQ+ youth; almost 70 % reported feeling so sad or hopeless almost every day that they stopped doing some usual activities, compared to just over 25 percent of straight youth. (Kids Data, 2020) Vulnerable populations, such as individuals enrolled in Medi-Cal and those with a serious mental illness, are disproportionately impacted by these events as they add to their cumulative trauma.

The combination of everyday stressors and these recent disasters led to increased demand for mental health services in Sonoma County. Additionally, it was reported that over 40% of jail inmates have a mental health issue which reiterates the need of additional mental health services to meet the demand and break the cycle

in Sonoma County. (Chambers et al., Sonoma County MHSA FY 2016–2019 Capacity Assessment, January 2020)

MEDI-CAL BENEFICIARIES AND THRESHOLD LANGUAGES

California External Quality Review Organization (CalEQRO), BHC Behavioral Health Concepts, reports that Sonoma County's average monthly unduplicated number of Medi-Cal enrollees by Race/Ethnicity and language during Calendar Year 2021 are as follows:

Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees	% Enrollees
American Indian or Alaska Native	1,244	0.95%
Black	2,054	1.55%
Not Reported	34,919	26.7%
Total	130,665	100%

The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently. California's Department of Health Care Services (DHCS) Information Notice 13-09 reports Spanish as a threshold language for Sonoma County. DHCS defines "Threshold Language" as a language identified as the primary language, as indicated on the Medi-Cal Eligibility Data System (MEDS), of 3,000 beneficiaries or 5% of the beneficiary population – whichever is lower – in an identified geographic area, per Title 9, CCR Section 1810.410 (a)(3).

Language	Average Monthly Unduplicated Medi-Cal Enrollees	% Enrollees
English	84,554	64.7%
Other/Unknown	2,633	2%
Spanish	43,478	33.3%
Total	130,665	100%

COMMUNITY PROGRAM PLANNING PROCESS

STAKEHOLDER ENGAGEMENT AND STRUCTURE

Since 2019, Sonoma County refined the Behavioral Health Division's system and structure for the Mental Health Services Act (MHSA) Community Program Planning (CPP) process as a basis for developing the Three-Year Program and Expenditure Plans, Annual Plan Updates, and other MHSA programs – including Innovation proposals and Ad Hoc panels for Request for Proposals.

This structure is anchored by the MHSA Steering Committee and includes the Community Program Planning Workgroup, Department of Health Services, Cultural Responsiveness Committee, Mental Health Board, Board of Supervisors, individuals with lived experience, family members, MHSA contractors, mental health providers community committees, and all other Stakeholders.

Definition of MHSA Stakeholders:

Clients (AKA consumers of mental health services), individuals with lived mental health experience, family members of individuals with lived mental health experience, health providers, social services, criminal justice, education, law enforcement, contractors, providers of the health department and behavioral health division, veterans and/or representatives from veterans' groups, college-age youth, other community groups (faith-based, aging and adult services, youth advocates) and interested members of the public.

The chart below illustrates the many different stakeholder groups that interact collaboratively in Sonoma County.

The table below provides more detailed information about the committees and governing boards who contribute to the MHSA CPP process.

Committee or Board	Open, appointed or elected	Composition of members	Number of seats	Meeting Frequency
MHSA Stakeholders	Open to the public	All Stakeholders are welcome	Undefined	Bi-annually
MHSA Steering Committee: Meeting minutes are posted here: MHSA Steering Committee	Application and selection process managed by the MHSA Coordinator and Department of Health Services, Behavioral Health Division administration	Members must represent the following: · Clients and consumers · Families of clients/consumers · Providers of mental health, substance use, and social services · Persons with disabilities, including providers · Education field · Health care · Law enforcement · Veterans and/or representatives from veterans' groups · College-age youth · Other interests (faith-based, aging and adult services, youth advocates) · Individuals from diverse cultural and ethnic groups	20-25 seats	Quarterly
MHSA Workgroups: Capacity Assessment, CPP, Innovation, PEI and RFP	Combination of voluntary and appointed	MHSA Steering Committee members, Mental Health Board, Stakeholders, DHS-BHD staff	4–8 members	As needed workgroups
Mental Health Board (MHB)	Appointed by Board of Supervisors	Members of the public vested in mental health services; 50% of the Board membership shall be consumers or the family members of consumers who are receiving or have received mental health services. At least 20% of the total membership shall be consumers and at least 20% shall be family members of consumers.	16 members with 3 representatives for each of the 5 county districts and one Supervisor	Monthly, third Tuesday at 5:00 p.m. Check MHB calendar.
Committee or Board	Open, appointed or	Composition of members	Number of seats	Meeting Frequency

	elected			
Board of Supervisors (BoS)	Elected		5 district representatives	Weekly on Tuesday, 8:30 a.m.

California Code of Regulations, Title 9 states that counties must ensure that Stakeholders reflecting the diversity of the demographics of the county, including, but not limited to, geographic location, age, gender, and race/ethnicity, have the opportunity to participate in the CPP process (CCR § 3300). The County is committed to continual quality improvement, and therefore the CPP process is ever evolving as the County strives to meaningfully engage Stakeholders who mirror the population of the County in the CPP process.

MHSA STEERING COMMITTEE

In December of 2018 the Department of Health Services, Behavioral Health Division (DHS- BHD) invited community members to submit applications for appointment to the MHSA Steering Committee. Over 50 applications were received and reviewed by staff using criterion to assure diverse representation of people with lived experience, family members, gender, race/ethnicity, veterans, LGBTQ+, and diverse industry sectors per CCR § 3200.270 and CCR § 3200.300. Twenty-five members were initially selected and received in-depth training on MHSA history, regulations, current programs, and the Expenditure Plan.

In the spring of 2019, the MHSA Steering Committee established two subcommittees which were time limited: Capacity Assessment and Innovation Subcommittees. These subcommittees were instrumental in working on the 2019 Capacity Assessment which served as the foundation for the FY 20-23 MHSA Three-Year Integrated Plan and the Sonoma Innovation 2020 project, which resulted in the development of five new Innovation programs.

In FY 21-22 several individuals resigned from the Steering Committee due to relocation and/or changes in positions or career. A recruitment for new members is going to start at the beginning of FY 22-23. The chart below contains the past and current list of Steering Committee members who have significantly contributed

to the growth and development of the Community Program Planning Process. The County is very grateful for the knowledge, insight, and passion that all of the Steering Committee members have given to the committee.

The table below lists all of the MHSA Steering committee members.

Name	Subcommittee	Representation
Claudia Abend	(New member Jan 2020)	Consumer, Family member
Mechelle Buchignani		Law Enforcement
Gene Calhoun		Social Services, Youth, African American
Jessica Carroll	(New member Jan 2020), CPP Subcommittee	Consumer, LGBTQ+, MH, Social Services
Stephanie Chandler	Capacity Assessment, Innovation (Resigned)	Healthcare
Sophie Marie Clifford	(New member Jan 2020)	Consumer, Latina, LGBTQ+, MH/SA
Mandy Corbin		Family Member, Education
Christy Davila	Innovation	Social Services
Angie Dillon-Shore	Capacity Assessment	0-5, LGBTQ, First 5 Sonoma
Jeane Erlenborn	(New member Jan 2020)	Education
Michael Gause		Housing, homeless
Cynthia Kane Hyman	(New member Jan 2020)	Education
Ozzy Jimenez		LGBTQ, Latino, Business, philanthropy
Erika Klohe	Innovation, Capacity Assessment, CPP Subcommittee	Family Member, Healthcare, MH
Claire McDonell	(New member Jan 2020)	Family Member, TAY, Education
John Mackey	Capacity Assessment	Veterans, Healthcare
Debbie Mason	Innovation (Resigned)	Philanthropy
Shannon McEntee	(New member Jan 2020)	Consumer, TAY
Mike Merchen	(New member Jan 2020)	Family Member, Law Enforcement
Allison Murphy		Family Member, 0-5 years
Ernesto Olivares	Capacity Assessment	Latino, Social Services
Matt Perry		Law Enforcement
Jill Ravitch	(Resigned)	Law Enforcement
Ellisa Reiff		Disabilities
Kate Roberge	(New member Jan 2020), CPP Subcommittee	Consumer, Peer, Disabilities, Workforce
Andy Salas	(Resigned)	Law Enforcement

Name	Subcommittee	Representation
Kurt Schweigman	(Resigned) Capacity Assessment, Innovation	Native American, Healthcare, MH/SA
Karen Silver	(Resigned)	Law Enforcement
Kathy Smith	Innovation, CPP Subcommittee	Family member, Mental Health Board
Susan Standen	Innovation, CPP Subcommittee	Consumer, MH peers
Angela Struckmann		Family Member, Social Services
Katie Swann	(New member Jan 2020), CPP Subcommittee	Family Member, LGBTQ+, TAY, MH
Jacqueline Torres	(Resigned)	TAY, Latina, Health Action Sonoma Valley
Katie Tunstall Lunatti	(Resigned)	Health Action Cloverdale
Sam Tuttleman	Innovation, Capacity Assessment (Resigned)	Family member
Carol Faye West	(New member Jan 2020), CPP Subcommittee (Resigned)	Consumer, Family member, Peer

Establishing the CPP Workgroup

In July 2020 the MHSA Steering Committee, participants expressed interest in setting up a subcommittee to work on involving greater numbers of more diverse Stakeholders the Community Program Planning (CPP) Process.

In August 2020 the MHSA Steering Committee established the MHSA Community Program Planning (CPP) Process Subcommittee which progressed into the CPP Workgroup. The workgroup has redesigned, planned, and co-facilitated two Stakeholder meetings. The Stakeholder meetings still provide Stakeholders with information about MHSA in Sonoma while making time for break out room discussions, larger conversations, and input. The workgroup developed a CPP Strategic Action Plan over the past year and, starting in FY 22-23, $150,000 in MHSA Planning funds will be available to implement the CPP Strategic Action Plan (Action Plan) in FY 22-23. The Action Plan is in the appendix on page 254.

The Action Plan details the benefits of having a structured Community Program Planning model. Programs designed with and for the members of the community are more relevant, culturally-appropriate, and are oriented to cost-effectiveness. The CPP Strategic Action Plan incorporates Community-Based Participatory Research (CBPR) practices into a local community program planning process to assure the voices of individuals with lived mental health experience, family members of individuals with lived mental health experience, and all interested Stakeholders are represented in the planning process.

The CPP workgroup which adopted values as guiding principles in growing a sustainable, inclusive community engagement plan that echoes the intensions and spirit of the MHSA:

- Practice deep listening: Listen to learn, listen to understand, listen without judgement.
- Be strategic: Leveraging community and financial resources, respond to opportunities expediently, plan for long-term impact.

- Recognize and support community resilience: Encourage healthy communities to work collectively for greater impact, acknowledge historical trauma, self-determination.
- Respect/ honor individual expertise about their needs and solutions: Focus on strengths and aspirations.
- Act with transparency: Make the purpose, expectations, and impacts of Stakeholder participation explicit.
- Be inclusive: Commit to diverse multicultural, unserved, and underserved populations.
- Utilize the MHSA principles as foundational guidance.
- Build capacity of community members: Advocate for meaningful Stakeholder participation, promote public education, and training in CPP activities.

Key Actions for 2022-2023

- Refine objectives and messaging of CPP.
- Expand list of Stakeholders to increase diversity.
- Support and improve existing opportunities for community engagement.
- Identify and define additional opportunities for community engagement and input.
- Develop community relationships, build, and expand network.
- Develop outreach toolkit (skills, resources, and workbook).
- Host outreach and education events.
- Conduct a series of community focus groups with trained co-facilitators from the communities we seek to engage.

In FY 22-23 the CPP Workgroup will also be engaged with assisting the Sonoma County MHSA Capacity Assessment, Stakeholder meetings and providing input on the Crossroads to Hope Peer Advisory Council.

COMMUNITY PROGRAM PLANNING PROCESS FY 21-22 CALENDAR

The table below lists the MHSA Community Program Planning meetings and Stakeholder participation for FY 21-22.

MHSA Community Program Planning Calendar for FY 2021-2022		
Date	**Meeting/Activity**	**Topics**
Aug 5	CPP Workgroup	Developing Draft CPP Strategic Plan, and reviewed feedback from the MHSA Stakeholder meeting in May 2021.
Aug 8	Steering Committee	CPP Strategic Plan Development, Lived Experience Discussion from Multiple Perspectives, Innovation Updates including Crossroads to Hope, MHSA activities.
Sep 14	Innovation Contractors	Implementing INN Reporting Regulations and Building Connections.
Sep 16	PEI Contractors	Implementing PEI Reporting Regulations and Building Connections.
Oct 4	Posted FY 21-22 MHSA Annual Plan Update	Posted for 30-day public review period.
Oct 6	CSS Contractors	Reviewing MHSA updates, impact statements, and preview of RBA (Results Based Accountability).
Oct 7	CPP Workgroup	Developing CPP Strategic Plan.

Oct 14	All DHS-BHD Staff Meeting	MHSA 101, Updates, Highlighting First Episode Psychosis Services.
Oct 21	CPP Workgroup	Developing CPP Strategic Plan.
Nov 4	CPP Workgroup	Developing CPP Strategic Plan.
Nov 4	Mental Health Board MHSA Public Hearing	Review of FY 21-22 MHSA Annual Plan Update & Expenditure Plan and Annual Report for FY 19-20.
Nov 10	Steering Committee	Diversity, Equity, and Inclusion; Changes in Leadership; MHSA INN Crossroads to Hope Program.
Dec 1	Posted Crossroads to Hope Innovation Proposal	Posted for 30-day public review period.
Dec 2	CPP Workgroup	Finalizing CPP Strategic Plan.
Dec 7	Board of Supervisors	Review and Approval of FY 21-22 MHSA Annual Pan Update & Expenditure Plan and Annual Report for FY 19-20.
Dec 7	All MHSA Contractors	Introduction to Results Based Accountability.
Dec 22	DHS-BHD Quality Improvement Committee	MHSA INN Crossroads to Hope Program.
Jan 18	Mental Health Board MHSA Public Hearing	MHSA INN Crossroads to Hope Program.
Feb 3	CPP Workgroup	Finalizing CPP Strategic Plan and preparation for Stakeholder meeting.
Feb 8	All MHSA Contractors	Implementing Results Based Accountability for FY 22-23.
Feb 9	Steering Committee	Discuss priority populations for CPP focus groups; recruit Steering Committee members for CPP; review MHSA updates and draft WET Plan.
Feb 17	Stakeholder Committee	Increase awareness and engagement of Stakeholders in MHSA CPP processes planned for 2022; recruit Stakeholders to serve on MHSA Steering Committee, Community program planning workgroup; Capacity Assessment planning workgroup, Peer Advisory Council for Crossroads, and increase understanding of MHSA programs through updates and dialogue.
Mar 15	CPP Workgroup	Discuss and plan May Stakeholder meeting; recruit additional CPP members.
Apr 7	CPP Workgroup	Review MHSA FY 22-23 Annual Update and Expenditure Plan and prepare for May Stakeholder meeting.
Apr 14	Post MHSA Annual Plan	FY 22-23 MHSA Annual Pan Update & Expenditure Plan and Annual Report for 20-21.
Scheduled Activities		
May 11	Steering Committee	Review of FY 22-23 MHSA Annual Pan Update & Expenditure Plan and Annual Report for 20-21.
May 17	Mental Health Board MHSA Public Hearing	Review of FY 22-23 MHSA Annual Pan Update & Expenditure Plan and Annual Report for 20-21.
Jul 12	Board of Supervisors	Review and Approval of FY 22-23 MHSA Annual Pan Update & Expenditure Plan and Annual Program Report for FY 20-21.

Sonoma County MHSA FY 2018-2021 Capacity Assessment

A county capacity assessment is required by MHSA as part of California counties' Program and Expenditure Plans, for Annual Updates, and Three-Year Plans [California Code of Regulations, title 9, § 3650(a)(5)]. The County will conduct and submit an assessment of the mental health needs in the community for those who qualify for MHSA services. In particular, the County will identify the number of clients across age groups by gender, race/ethnicity, and other demographics and use these findings to analyze any population disparities. In the second half of 2022, Sonoma County DHS-BHD will engage an evaluation/consultation firm to assess the effectiveness, structure, quality, and impact of their MHSA funded system of care**.** A primary purpose of this assessment is to prepare for and inform the Community Program Planning (CPP) process for next year's Three-Year MHSA Program and Expenditure Plan for FY 23-26. The assessment team will explore the landscape of MHSA funded services and examine accomplishments, opportunities to address service gaps, and remaining community needs.

This assessment—formally titled ***Sonoma County MHSA FY 2018-2021 Capacity Assessment***—will include the following:

- **Overview of the capacity assessment process,** data collection activities and analytical methods. DHS-BHD's assessment process will be built upon the meaningful involvement and participation of mental health clients, family members, County staff, providers, and many other Stakeholders.

- **Description of Sonoma County's public mental health system** including MHSA components and the two service systems – Youth and Family Services, Transition Age Youth services, and Adult and Older Adult Services. The assessment will present the demographics and survey results of client populations served by these systems.

- **Assessment of mental health needs and current capacity** that identifies both strengths and opportunities to improve the mental health service system in Sonoma County. The findings and recommendations will be presented to Stakeholders and posted on the DHS-BHD website and included in the FY 23-26 Three-Year MHSA Program and Expenditure Plan.

CROSSROADS TO HOPE PROPOSAL DEVELOPMENT & PROCESS

In June of 2016, a group of community Stakeholders—including clients, peers, mental health providers, and County representatives—met to discuss the lack of services and supports for those who were on the precipice of a crisis. With limited beds at the Crisis Stabilization Unit (CSU), the group proposed a peer respite residential center. This proposal to provide immediate short-term housing staffed and led by peers would intervene prior to crisis and focus on wellness and recovery. Unfortunately, funding stalled and the project was not realized, but this effort set the stage for continued interest and determination for peer-led services and supports.

In March of 2018, Sonoma County held a two-day meeting of a Sequential Intercept Model planning process used by communities to assess the circumstances of people with behavioral health needs in the justice system and identify opportunities for linkages to services which can prevent deeper penetration into the criminal justice system. The County brought together over 40 Stakeholders from multiple systems, including mental health clients and professionals, substance abuse, law enforcement, pretrial services, courts, jails, community corrections, housing, health, social services, and family members to identify gaps, resources, and opportunities for individuals with mental illness and co-occurring disorders in the criminal justice system. Among all of the alternative strategies, the highest number of participants named "Expand Housing with Supportive Services" as the top priority for the County.

This was also a finding contained in Sonoma County's Housing Needs Assessment, April 2018. The Housing Needs Assessment report recommended the consideration of the types of supports and services needed for individuals with a history of incarceration and/or inpatient psychiatric services. Given that survey respondents indicated difficulty with either securing housing upon their release or finding housing considered safe and secure, additional services and supports may be needed to help individuals secure housing upon their release from inpatient psychiatric facilities or incarceration.

In the Sonoma County MHSA FY 16-19 Capacity Assessment Report released in January 2020, community Stakeholders praised peer providers and programs noting the effectiveness of engaging individuals into treatment and empowering a community of recovery which could not be achieved by clinicians alone. The 2019 MHSA Capacity Assessment report continues to state that clients, as well as providers, expressed support for peer-led programs at all levels of care. Integrating peer providers who embody recovery and what is possible for clients is aligned with MHSA values and can create a cultural shift in the way mental health services are delivered throughout the system.

Specific to this innovation project, a few members and consultants from the Sonoma County Peer Council participated in the development and planning of Crossroads to Hope. Interviews with three peer providers

with lived mental health and criminal justice experience and two mental health providers at local mental health agencies were conducted in April and May 2020.

The chart below lists those individuals and their affiliations.

Name	Affiliation	Organization
Sean Bolan	Peer provider	Manager, Wellness and Advocacy Center
Sean Kelson	Peer provider	Manager, Interlink and Petaluma Peer Recovery Center
Kate Roberge	Peer provider	Consumer Affairs Coordinator, Wellness and Advocacy Center
Steven Boyd, LCSW	Clinician	Clinical Director to Napa and Sonoma Programs, Progress Foundation
Sid McColley, RN, CNS	County	Section Manager, Acute and Forensic Services Sonoma County Behavioral Health Services

In addition, the Crossroads to Hope Innovation proposal and program highlights have been presented to MHSA Stakeholders at the meetings listed on the table below.

Date	Stakeholder Group
2021	
May 7	MHSA Community Program Planning Workgroup
May 11	MHSA Steering Committee
May 27	MHSA Stakeholder Meeting (comprised of a broad group of stakeholders)
Sep 13	Innovation Contractors
Sep 16	Prevention and Early Intervention Contractors
Oct 6	Community Services and Supports Contractors
Oct 14	DHS-BHD Staff
Nov 4	Mental Health Board
Dec 1	Posted Crossroads to Hope on DHS-BHD webpage for 30 Day Public Review Period
2022	
Jan 18	Mental Health Board Public Hearing
Feb 8	Approved by the County Board of Supervisors
Feb 24	Approved by the Mental Health Services Oversight and Accountability Commission

All of the comments received about Crossroads to Hope from Stakeholder groups have been positive and include the following themes:

- Creates transitional housing.
- Helps individuals to develop skills that will promote their ability to get and keep permanent housing.
- Diverts people with mental health concerns from jail.
- Integrates supportive peer services to help individuals move towards recovery.

The 30-day public review period commenced on December 1, 2021 with the publication of the Crossroads to Hope application posted on the Department of Health Services Behavioral Health website; publicized in the MHSA newsletter; and emailed to list of over 2000 on the MHSA listserv, Stakeholders, and contractors. The Mental Health Board hosted the public hearing on Crossroads to Hope on January 18, 2022, and the Board of Supervisors reviewed the proposal for approval on February 8, 2022.

The Mental Health Services Oversight and Accountability Commission granted Sonoma's Crossroads to Hope Innovation proposal conditional approval on February 24, 2022.

While the Crossroads to Hope proposal moved through the approval project, the County released an RFP (Release for Proposal) for peer provider services and an evaluator. This process resulted in Felton receiving the intent to award. The historic home is currently being repaired, and the program will begin after the repairs are completed.

Finally, a Peer Advisory Council specific to Crossroads will be re-convened to receive updates to the project's progress and provide input to the final design and implementation of the project's evaluation and program modifications.

ELECTRONIC HEALTH RECORD PROPOSAL DEVELOPMENT & PROCESS

Sonoma County Behavioral Health Division is proposing to use MHSA Innovation (INN) funds to contract with California Mental Health Services Authority (CalMHSA) to implement a Semi-Statewide Electronic Health Record (EHR) that meets the new CalAIM requirements.

California Mental Health Services Authority (CalMHSA) is a Joint Powers of Authority (JPA), formed in 2009, for the purpose of creating a separate public entity to provide administrative and fiscal services in support of County Behavioral Health Departments. They serve California Counties in the dynamic delivery of behavioral health and supportive services by promoting efficiency, effectiveness, and enterprising among all 58 Counties. In response to CalAIM, CalMHSA has proposed a Semi-Statewide Electronic Health Record.

Sonoma County Behavioral Health currently utilizes 3 primary systems (Avatar, SWITS, and DCAR) to manage clinical documentation, mandated data reporting, and billing/claiming (primarily Medi-Cal).

Within the last year, CalMHSA has developed a plan to procure and administer a Semi-Statewide Electronic Health Record (EHR) for California Counties. The goal of CalMHSA's effort is to partner with the EHR Contractor and participating counties to configure a California-centric Enterprise Health Record that will then be implemented across multiple counties.

In addition, CalAIM is requiring all California counties to implement various goals and milestones. With this comes several new requirements which will need to be addressed through updates and modification to each County's EHR such as payment reform, data exchange, and behavioral health policy changes (i.e. screening tools and clinical documentation).

Since April of 2022 the County has been discussing the project with a variety of stakeholders including MHSA Community Program Planning (CPP) Workgroup, MHSA Steering Committee, Mental Health Board, Department of Health Services leadership, Division Management Team, Division CBO contractors and Board of Supervisors.

The chart below lists presentations and discussions on EHR where feedback was received:

Date	Committee	Feedback
4/7/22	MHSA Community Program Planning (CPP) Workgroup	One CPP Workgroup member stated that she supported the plan since it was being designed to help retain staff and allow staff to focus on clients and spend less time on entering data.
5/11/2022	MHSA Steering Committee	One member stated that she was an intern at the county and Avatar, the county's current EHR, was very difficult and time consuming to use. She was very exited about the project.
5/22/22	CBO CalAIM Stakeholder Meeting	Many CBOs indicated a desire to participate in the semi-statewide EHR project to increase interoperability and efficiency of care coordination. They identified challenges that multi-county CBOs encounter when attempting to interface with different county EHRs. They stated their need for support from the County on implementation and requested inclusion in the project. They were invited to the Quality Improvement Committee as the forum to continue discussions on CalAIM changes and EHR project updates.
5/26/22	Department of Health Services Leadership	Department Director, Tina Rivera, reviewed the proposal, including the budget and the risks and benefits associated with the project. After reviewing all of the data the Department Director approved moving forward with the project.
6/20/2022	Posted on Behavioral Health Division Website and notified over 2000 MHSA stakeholders via the MHSA listserv	No comments were received about the posting. The Steering Committee, CPP Workgroup and MHB were provided with the proposal to review.
6/22/2022	Quality Improvement Committee	Announcement of upcoming changes through CalAIM and inclusion of

		additional members of QIC
7/19/2022	Mental Health Board Public Hearing	One member was very interested in the client portal capacity that the new EHR is planned to have. This member stated how important a client portal is to transparency.
7/26/22	Quality Assessment and Performance Improvement Section Meeting	Announced plans to collaborate with CalMHSA and other counties to implement new semi State-wide EHR. Received requests for further details about system and support for implementing new, improved system.
7/27/22	Quality Improvement Committee	Focused discussion of CalAIM and EHR Project. Participants identified the importance of meaningful participation from peers and family members in the project.
8/10/2022	MHSA Steering Committee	One member had questions about the use of CFTN funds and how the county was funding Avatar. Avatar and the County staff are currently both being funded by CFTN.
9/13/2022	Sonoma County Board of Supervisors Meeting	Agenda item detailing EHR plan and receiving approval to enter into Participation agreement with CalMHSA for development and implementation.

ADDITIONAL STAKEHOLDER OUTREACH

DHS-BHD also publishes an MHSA Newsletter, featuring relevant MHSA news, information, and events. An email version of the newsletter is produced every 2-3 months and is shared with a variety of community groups and Stakeholders, including the Mental Health Board, Sonoma County Board of Supervisors, DHS-BHD program managers, and contractors. An archive of the newsletter PDFs is available on the MHSA website.

To subscribe to the MHSA newsletter via the MHSA website at: http://service.govdelivery.com/service/subscribe.html?code=CASONOMA_181

Sonoma County
MENTAL HEALTH SERVICES ACT
Newsletter
DECEMBER 2021 | 48TH EDITION
Happy Holidays from Sonoma County's Behavioral Health Division!

THE ELIZABETH MORGAN BROWN CENTER – A ONE MIND ASPIRE CLINIC

In the summer of 2016, David and Seong Brown, were faced with the challenges of trying to help their teenage daughter, Elizabeth, with her anxiety and depression that was getting more and more severe. They were struck with how disconnected our health care providers were when it came to Mental Health. Elizabeth was an exceptionally intelligent, highly accomplished and poised young woman with a kind heart. Despite her mental health symptoms, she volunteered her time helping people in need including with the National Alliance on Mental Illness (NAMI) sharing her story with her peers in an attempt to end silence, end stigma and change attitudes toward mental illness. Unfortunately in 2018, Elizabeth died by suicide which led David and Seong to help bring better treatment options to Sonoma County.

Thanks to generous donors like the Staglin family, Kaiser Permanente Northern California and MHSA funding, the Elizabeth Morgan Brown Center is now open! This inaugural clinic is part of One Mind's ASPIRe initiative. ASPIRe - Accelerating Serious Psychiatric Illness Recovery - aims to enable 100 percent of youth with early serious psychiatric illness to access gold-standard care, compared to only 8 percent today, and for the proportion of clients who recover from serious psychiatric illness to rise from 22 percent today to 75 percent by 2040.

This unique Center is operated by Aldea Children & Family Services, and housed and supported by Buckelew. The clinic is staffed by mental health professionals, including psychiatrists, nurse practitioners and others who provide early intervention resources for the community to connect families to additional care options. This innovative clinic is part of EPI-CAL and the University of California Davis Early Psychosis Learning Health Care Network, which helps share data and best practices to improve mental health care across the state. It employs the UC Davis Coordinated Specialty Care (CSC) EDAPT (Early Diagnosis and Preventive Treatment) model, a recovery-based treatment approach which has demonstrated efficacy with individuals within the first two years of the onset of full psychosis and those at risk of developing psychosis.

Through early detection, assessment, and treatment of psychotic illness, this clinic hopes to empower clients and families to understand psychotic illness in general and the client's illness in particular, to fully engage clients and families in their own recovery process, and thereby to reduce their symptoms so they may reach their personal, educational, and occupational goals. To learn more about The Elizabeth Morgan Brown Center visit: https://www.aldeainc.org/services/behavioral-health/the-elizabeth-morgan-brown-center

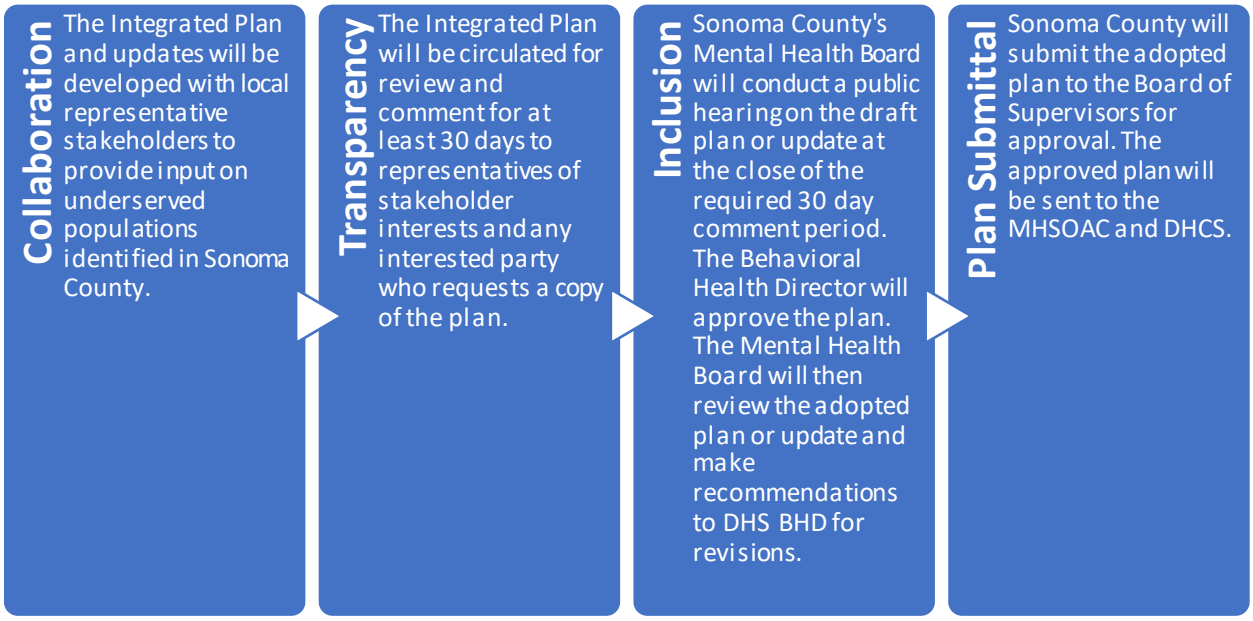
County of Sonoma, Mental Health Services Act

Pictured above: MHSA December 2021 Newsletter. See Appendix 2 on page 215 for the MHSA Newsletters distributed during FY 21-22.

THE PUBLIC REVIEW AND PUBLIC HEARING PROCESS

Per Title 9, CCR Section 3315, Sonoma County conducted a local review process for the community to review and comment on the MHSA Three-Year Program and Expenditure Plan.

Graphic 1: The Public Hearing Process



Sonoma County's Draft MHSA FY 22-23 Annual Plan Update and Expenditure Plan and Program Report for FY 20-21 will be posted and emailed for public review on April 14, 2022. The virtual meetings in the chart below presented the draft Plan to Stakeholders for review and feedback.

Date	Activity	Subject Matter
Apr 14	Post MHSA Annual Plan	FY 22-23 MHSA Annual Pan Update & Expenditure Plan and Annual Report for 20-21.
Scheduled for May 5	CPP Workgroup	Review of FY 22-23 MHSA Annual Pan Update & Expenditure Plan and Annual Report for 20-21 and prepare for Stakeholder Meeting
Scheduled for May 11	Steering Committee	Review of FY 22-23 MHSA Annual Pan Update & Expenditure Plan and Annual Report for 20-21.
Scheduled for May 12	Stakeholder Committee	Review of FY 22-23 MHSA Annual Pan Update & Expenditure Plan and Annual Report for 20-21.
Scheduled for May 17	Mental Health Board MHSA Public Hearing	Review of FY 22-23 MHSA Annual Pan Update & Expenditure Plan and Annual Report for 20-21.
Scheduled for Jul 12	Board of Supervisors	Review and Approval of FY 22-23 MHSA Annual Pan Update & Expenditure Plan and Annual Program Report for FY 20-21.

DHS-BHD requests that Stakeholders review the draft Plan and submit comments and questions before May 17, 2022 to:

Melissa Ladrech, LMFT, MHSA Coordinator
Sonoma County Department of Health Services
Behavioral Health Division
2227 Capricorn Way, Suite 207
Santa Rosa, CA 95407
or email at: MHSA@sonoma-county.org

MHSA Plan Distribution and/or to Stakeholders for 2022-2023

Date	Action
April 15	Posted Draft Plan on DHS-BHD and Mental Health Board (MHB) web pages with invitation to the MHSA Public Hearing.
April 15	Sent notification to the 2000+ MHSA listserv group with the Draft Plan and invitation to the MHSA Public Hearing.
April 15	Emailed the Draft Plan and invitation to the MHSA Public Hearing Mental Health Board, MHSA Steering Committee, MHSA CPP Workgroup, MHSA Stakeholder group, MHSA Contractors and DHS-BHD Staff with a link to the draft plan.
April 15	Sent notice to 2000+ MHSA Update subscribers.
April 18	Provided hard copy of Annual Update to the West County Community Services Peer Centers: Interlink, Wellness and Advocacy Center, Petaluma Peer Recovery Services and Russian River Empowerment Center.

MHSA ANNUAL PROGRAM UPDATE FOR FY 22-23

FY 22-23 Changes from FY 20-23 Three Year Work Plan and FY 21-22 Annual Program Update

Sonoma County Department of Health Services, Behavioral Health Division (DHS-BHD) is pleased to present this Mental Health Services Act (MHSA) Program Work Plan for Fiscal Year 2022-23 (FY 22-23). This is the second Annual Update to occur in the current 3-Year MHSA planning period. The primary function of the Annual Update is to update the expenditure plan and inform stakeholders about any program changes. On June 9, 2020, the Sonoma County Board of Supervisors approved the FY20-23 MHSA 3-Year Program and Expenditure Plan (MHSA Plan). This document can be found on our MHSA webpage at the following link: https://sonomacounty.ca.gov/Ektron%20Documents/assets/Sonoma/Sample%20Dept/Sample%20Dept/Divisions%20and%20Sections/Behaviorial%20Health/Projects/Notifications%20and%20Certificatio/_Documents/mhsa-three-year-program-and-expenditure-plan-for-2020-2023.pdf

The MHSA Program Work Plan for FY 22-23 (Program Plan) has been developed in collaboration with MHSA stakeholders as detailed in the Community Program Planning section which starts on page 24. The theme for this year's plan is **"Sonoma County Takes Action for Mental Health"**. This program work plan details all of the MHSA funded programs, and the pictures on the cover of the MHSA Plan Update highlights four newer programs which take action to improve mental health in our county:

La Luz: Providing Prevention & Early Intervention services for the broader Latinx community in Sonoma Valley to reduce risk factors for developing a potentially serious mental illness, build protective factors, and improve timely access to mental health services.

Nuestra Cultura Cura: Operated by On the Move/VOICES in partnership with community leaders: A partnership of community organizations will engage a diverse cohort from the Latinx communities to determine root causes of mental health stigma and inaccessibility for their communities. Facilitators support the team in determining a strategic direction with specific actions to address defined issues.

Crossroads to Hope: provides transitional housing to individuals with serious mental health concerns who have been diverted from the criminal justice system. Peer support specialists with lived mental health and criminal justice involvement will provide supportive services to clients, along with the DHS-BHD Mental Health Diversion team.

The content of this Program Work Plan includes:

- **Overview of changes**
- **Impacts of substantial changes from the MHSA FY 21-22 Annual Plan Update and FY 21-23 MHSA 3-Year Program and Expenditure Plan**
- **Detailed description of MHSA programs and services planned for FY 22-23 by component:**
  - Community Services and Supports (CSS) modifications
  - Prevention and Early Intervention (PEI) modifications
  - Innovation project updates
  - Workforce Education and Training (WET) FY 19-20 Plan Update
  - Capital Facilities and Technology Needs (CFTN) FY 19-20 Plan Update
- **Update on No Place Like Home**

OVERVIEW OF CHANGES

During 2020 it was anticipated that tax revenue would decrease due to the economic impacts of the pandemic. The County cautiously approached budgeting during that time of unprecedented uncertainty. California Tax revenues unexpectedly increased over the past two years and the Sonoma County MHSA fund distributions also increased. It is anticipated that Sonoma County will receive over $30 million in MHSA distributions during FY 22-23. Because of the unpredictability of the MHSA tax revenue that is based on collecting taxes from individuals in California who earn over $1 million annually, the Department strategically plans the use of the volatile MHSA revenue over time.

Department leadership thoughtfully considered how to best utilize resources to serve the community while incorporating feedback from Stakeholders'. Additional funds will be used to increase access to services, expand service capacity and reduce wait times. Programming to expand Adult Services, Youth and Family Services, Stakeholder engagement and implementing strength-based services training is being added. The Department is also adding programming to reduce homelessness and reduce justice system involvement for individuals with serious mental health concerns.

IMPACTS OF SUBSTANTIAL CHANGES

The table below highlights the substantial changes to MHSA funded programs. There may be additional changes to the FY 22-23 Plan Update after the Sonoma County Board of Supervisors finalizes the County budget in June 2022. In the event there are additional changes Stakeholders will be notified, the amendments to the FY 22-23 Plan Update will be posted for 30 days, and then an MHSA Public Hearing will be hosted by the Mental Health Board.

CHANGES	IMPACTS
MHSA PLANNING	
MHSA Community Program Planning (CPP) Strategic Action Plan: MHSA Annual Planning is increased by $150,000.	$150,000 has been allocated for the implementation of the MHSA Community Program Planning (CPP) Strategic Action Plan. This will empower the County to significantly increase stakeholder participation in the CPP process. Please see page 254 of the appendix to review the CPP Strategic Action Plan.
COMMUNITY SERVICES AND SUPPORTS	
Buckelew Programs - FACT - Supplemental Patch for Unlicensed Supportive Housing is receiving $40,007 to supplement supportive housing for the Forensic Assertive Community Treatment (FACT) team clients.	This will provide gap funds for housing for FACT clients.
Adult Services Contractor: An additional contractor for Adult Services is being added. A $1,250,000 Release for Proposals	This will expand the capacity of the Adult Services programs, which will increase access and improve timeliness of appointments.

(RFP) for Adult Services is seeking a CBO to provide treatment for non-FSP (Full Service Partnership) adult clients.	
Youth Services Contractor: An additional contractor for Youth and Family Services is being added. A $250,000 RFP for Youth Services is seeking a CBO to provide treatment for youth clients.	This will expand the capacity of the Youth and Family Services programs, which will increase access and improve timeliness of appointments.
Whole Person Care (WPC) is transitioning at the end of the year. The State mandates that County Behavioral Health will no longer be funding the WPC outreach subcontractors. This is a reduction of 8 contractors totaling $329,469 annually.	The County will no longer subcontract with the following contractors for WPC: Community Development Commission, COTS, Drug Abuse Alternatives Center, Petaluma Health Center, Reach for Home, Santa Rosa Community Health Centers, West County Community Services, West County Health Centers. A community partner will be contracting for the services and no impact to services is expected.
Foster Youth Team (FYT): The DHS-BHD FYT is receiving $47,535 additional funding.	This funding will expand the FYT team to improve access to services and timeliness of appointments.
CSS Housing Program Assigned Funds ($48,788) will be used in FY 22-23.	This funding will allow additional housing support for FSP clients.
INNOVATION	
Crossroads to Hope: A total of $2.5 million in Innovation dollars over five years will be used to fund Crossroads to Hope. $500,000 will be used in FY 22-23.	This will expand supportive housing for individuals with serious mental health concerns who are diverted from jail and the program utilizes peer providers to provide the supportive services.
CalMHSA's Semi-Statewide Electronic Health Record: $1,789,665 will be used in FY 22-23	DHS-BHD is proposing to use MHSA Innovation (INN) funds to contract and participate with California Mental Health Services Authority (CalMHSA) to implement a Semi-Statewide Electronic Health Record (EHR) that meets the new CalAIM requirements. See page 29 for proposal.

WORKFORCE, EDUCATION AND TRAINING (WET)	
WET Activities: Increasing WET Activities by $250,000 for training.	California Institute for Behavioral Health Solutions (CIBHS) will provide Strengths Model Care Management training for clinical staff. This training will empower clinical staff to improve the quality of case management and client outcomes.
WET Senior Office Assistant (SOA): Adding $6,156 to partially fund the WET SOA position.	The WET SOA will support all of the WET activities and the Diversity, Equity, and Inclusion Development Manager.

DETAILED DESCRIPTIONS OF MHSA PROGRAMS AND SERVICES PLANNED FOR FY 22-23 BY COMPONENT:

The program descriptions for the majority of the MHSA funded programs are in the FY 20-21 MHSA Program Report section on pages 59-144. The program descriptions for newer programs are located in the component work plan.

COMMUNITY SERVICES AND SUPPORTS (CSS) UPDATE

Provides enhanced mental health services for adult populations with Severe and Persistent Mental Illness (SPMI) and Seriously Emotionally Disturbed (SED) children and youth

Full Service Partnerships (FSPs)

Intensive programs with a collaborative relationship between the County and the client, and when appropriate, the client's family, through which the County plans for and provides the full spectrum of community services so that the client can achieve the identified goals with a "whatever it takes" approach.

The following are the County's FSPs for FY 22-23:

FSP Program (DHS-BHD)	Estimated # to be served in FY 22-23	Children and Youth (0-15)	Transition Age Youth (16-25)	Adults (26-59)	Older Adults (60+)	Estimated MHSA cost per person in FY 22-23
Family Advocacy, Stabilization & Support Team (FASST)*	200	105	95	0	0	$10,839
Transition Age Youth (TAY) Team*	70	0	70	0	0	$11,310
Forensic Assertive Community Treatment (FACT)*	70	0	3	64	3	$8,508
Integrated Recovery Team (IRT)	150	0	0	144	11	$4,610
Adult Full Service Partnership (AFSP)*	100	0	0	100	0	$11,516

FSP Program (DHS-BHD)	Estimated # to be served in FY 22-23	Children and Youth (0-15)	Transition Age Youth (16-25)	Adults (26-59)	Older Adults (60+)	Estimated MHSA cost per person in FY 22-23
Older Adult Intensive Team (OAIT)	60	0	0	0	60	$12,590

**Includes contracted services*

General System Development (GSD)

The County may develop and operate programs to provide mental health services to clients specified in WIC Section 5600.3 (a-c), and, when appropriate, the clients' families. The following are the County's GSD programs for FY 22-23:

Provider/Program	Estimated # to be served in FY 22-23	Children and Youth (0-15)	Transition Age Youth (16-25)	Adults (26-59)	Older Adults (60+)	Estimated MHSA cost per person in FY 22-23
National Alliance on Mental Illness (NAMI) - Family-based Education, Advocacy and Support	5,164 (service contacts)	0	416	2,142	2,605	$44
Buckelew Programs - Family Service Coordination	1,499 (service contacts)	0	26	669	804	$93
DHS-BHD - Mobile Support Team*	300	36	63	147	53	$2,713
DHS-BHD - Collaborative Treatment and Recovery Team*	185	0	25	143	18	$1,881
Council on Aging - Senior Peer Support	477 (service contacts)	0	0	0	477	$176
WCCS - Senior Peer Counseling	326 (aggregate of quarterly reports)	0	0	0	326	$221
Sonoma County Human Services Department (HSD) - Job Link	379 (service contacts)	0	66	204	109	$3,970
WCCS - Crisis Support	229 (service contacts)	66	26	94	44	$44

**Includes contracted services*

Outreach and Engagement (OE)

The County may develop and operate outreach programs/activities for the purpose of identifying unserved individuals who meet the criteria of WIC Sections 5600.3 (a), (b) or (c) in order to engage them, and when appropriate their families, in the mental health system so they receive the appropriate services, including access to services.

The following are the County's OE programs for FY 22-23:

Provider/Program	Estimated # to be served in FY 22-23	Children and Youth (0-15)	Transition Age Youth (16-25)	Adults (26-59)	Older Adults (60+)	Estimated MHSA cost per person in FY 22-23
DHS-BHD - Whole Person Care*	1,200	0	100	842	258	$335
Sonoma County Indian Health Project (SCIHP) - Community Programs	346 (service contacts)	26	35	196	89	$234
DHS-BHD Foster Youth Team	176	125	51	0	0	$270
Youth RFP	TBD	TBD	TBD	0	0	TBD
Adult RFP TBD	TBD	0	TBD	TBD	TBD	TBD

*Includes contracted services

Adult Contractor TBD (to be determined): The contractor will provide a suite of Specialty Mental Health Services to adult clients that will include:

- Rehabilitative Mental Health Services (community and/or home-based)
- Outpatient Therapy and Mental Health Services
- Targeted Case Management Services to assist clients with connecting to:
    - Financial support services
    - Housing programs and resources
    - Medical/Physical Health services
    - Transportation supports

Youth Contractor TBD: Sonoma County Behavioral Health staff will access additional supportive services from the youth contractor as necessary to meet the unique needs of children, youth, and families.
The contractor will provide individual, family, and group therapy services to children who meet criteria for Specialty Mental Health Services. The contractor may also provide rehabilitation, case management, and/or Therapeutic Behavioral Services (TBS) via this RFP. The children who will be referred for services under this RFP are children who:

- Are engaged in the County's Full-Service Partnership (FSP) teams and/or;
- Are receiving medication services from the County's Medication Clinic and who do not require FSP level of care and/or;
- Meet criteria for Specialty Mental Health Services, do not require FSP level of care, and are not receiving medication services from the County's Medication Clinic.

Foster Youth Team: The Foster Youth Team (FYT) staff provide services to address the mental health needs of foster youth in Sonoma County, working in conjunction with Human Services Department staff and community partners as part of a multi-disciplinary team.

Prevention and Early Intervention (PEI)

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations, including access to services. The majority of PEI expenditures should go to programs addressing the needs of individuals who are ages 0-25.

The following are the County's PEI programs for FY 22-23 (grouped by required service categories):

Service Category	Provider/Program	Estimated # to be served in FY 22-23	Children and Youth (0-15)	Transition Age Youth (16-25)	Adults (26-59)	Older Adults (60+)	Estimated MHSA cost per person in FY 22-23
Promotion*	California Mental Health Services Authority (CalMHSA) – Statewide PEI Program	N/A (not applicable)	N/A	N/A	N/A (not	N/A	N/A
Prevention	Action Network - Across Ages and Cultures	676 (aggregate of quarterly reports)	120	5	36	515	$88
Prevention	Community Baptist Church Collaborative - PEI Programs	2,390 (service contacts)	674	594	822	300	$50
Prevention	Sonoma County Human Services Department - Older Adult Collaborative	3251	0	0	0	3251	$68
Prevention	Sonoma County Indian Heath Project (SCIHP) – GONA Program	718	403	315	0	0	$56
Prevention & Early intervention	La Luz Center – PEI Program	632 (est. from quarterly reports)	210	210	212	0	$125

Service Category	Provider/Program	Estimated # to be served in FY 22-23	Children and Youth (0-15)	Transition Age Youth (16-25)	Adults (26-59)	Older Adults (60+)	Estimated MHSA cost per person in FY 22-23
Prevention & Early intervention	Latino Service Providers of Sonoma County - PEI Program	73,641 service contacts, including weekly email newsletters	2,349	18,275	49,078	3,938	$46
Prevention & Early intervention	Positive Images - PEI Program	6,125 (service contacts)	2,006	2,651	1,150	317	$17
Early Intervention	Child Parent Institute (CPI) – PEI Program	516 (aggregate of quarterly reports)	220	44	252	0	$384
Early Intervention	Early Learning Institute (ELI) – PEI Program	2,006	824	108	952	122	$22
Stigma and Discrimination Reduction	Santa Rosa Junior College - People Empowering Each other to Realize Success	1,064 (service contacts)	3	668	355	39	$188
Suicide Prevention*	Buckelew Programs - North Bay Suicide Prevention Program	11,552 (calls received)	220	1,291	6,225	3,816	$17
Access and Linkage to Treatment	DHS-BHD - Youth Access Team	387	298	89	0	0	$3,369
Access and Linkage to Treatment	DHS-BHD - Adult Access Team	497	0	104	343	50	$2,666
Outreach for Increasing Recognition of Early Signs of Mental Illness	Crisis Intervention Training (CIT) with Law Enforcement Personnel	112	N/A (not available)	N/A (not available)	N/A (not available)	N/A (not available)	$145

*These service categories are not required

Child Parent Institute (CPI): CPI will provide a continuum of direct services to children and families at risk for mental illness and for women and their children identified with Perinatal Mood Disorder. Services

include risk assessment/screening, case management, parent education (Triple P Parenting), and brief psychotherapy.

Early Learning Institute (ELI): Early childhood mental health is a critical component of healthy development and well-being, and foundations laid during this formative time period set the course for success in later life. ELI's Watch Me Grow program includes professional social-emotional screenings and navigation for children 2-5 years of age; community access to an ECMH on-line screening tool for children birth to 5, with live follow-up and navigation services and basic phone navigation support for families who might need help from early identification through treatment options.

La Luz: La Luz is providing Prevention & Early Intervention services for the broader Latinx community and age-specific, 0-5 years and their caregivers in Sonoma Valley to reduce risk factors for developing a potentially serious mental illness, build protective factors, and improve timely access to mental health services. La Luz will recruit and train community health workers, known as *Las Luchadoras*, to conduct quarterly workshops to prevent the onset of stress, anxiety, and depression, develop adaptive skills, and share valuable resources and information in a culturally sensitive manner. A case management component will utilize a trauma-informed approach and work in tandem with a therapeutic team to provide individual and family therapy when indicated. Finally, the *Luchadoras* will be able to refer the community to our internal wellness programming and community engagement activities.

Innovation (INN) Project Updates

Novel, creative, and/or ingenious mental health practices/approaches that are expected to contribute to learning, which are developed within communities through a process that is inclusive and representative, especially of unserved and underserved individuals. Innovation pilot programs are time limited, and MHSA regulation (9 CCR § 3910.010) requires that the end date is not more than five years from the start date of the Innovative Project.

DHS-BHD's implemented five new Innovation programs in FY 22-23.

Provider/Program	Estimated # to be served in FY 22-23	Children and Youth (0-15)	Transition Age Youth (16-25)	Adults (26-59)	Older Adults (60+)	Estimated MHSA cost per person in FY 22-23
Early Learning Institute –Instructions Not Included	150	0	50	100	0	$1,523
Early Psychosis Learning Healthcare Network (EP-LHCN)	276	50	126	75	25	$479
On The Move – Nuestra Cultura Cura	166	20	40	80	26	$1,649
Human Services Department - Collaborative Care Enhanced Recovery Project (CCERP)	75	0	0	50	25	$4,733
First 5 Sonoma County –New Parent TLC	450	0	100	300	50	$336

Provider/Program	Estimated # to be served in FY 22-23	Children and Youth (0-15)	Transition Age Youth (16-25)	Adults (26-59)	Older Adults (60+)	Estimated MHSA cost per person in FY 22-23
Contractor TBD – Crossroads to Hope	TBD	TBD	TBD	TBD	TBD	TBD
CalMHSA's Semi-Statewide Electronic Health Record:	N/A	N/A	N/A	N/A	N/A	N/A

Early Psychosis Learning Health Care Network (EP LHCN): Elizabeth Morgan Brown One Mind ASPIRe Program of Sonoma County: EP LHCN is the first treatment program specifically for youth with First Episode Psychosis in Sonoma County. This project will be part of the Statewide Early Psychosis Learning Collaborative (a Mental Health Services Oversight and Accountability Commission's [MHSOAC] Incubator Project) as approved by the MHSOAC.

Instructions Not Included (INI) - Dads Matter operated by Early Learning Institute**:** Home visiting program for first time fathers combining three curricula: Promoting First Relationships, Partners for a Health Baby, and Nurturing Fathers with enhancements from Dad's Matter, Adverse Childhood Experiences (ACEs) and depression screening and lessons learned from National Father's Initiative.

New Parent TLC operated by First 5 Sonoma County: *New Parent TLC* seeks to address the lack of screening, identification, and necessary referrals for parents with unidentified and untreated parental depression from pregnancy through the first 12-months after birth. "Gatekeeper" training for early intervention of maternal and paternal mental health issues, preventing progression of more serious depression and/or suicide by parents and reducing the exposure of infant ACEs resulting from parental depressions and associated disruption of optimal infant brain development. To promote community collaboration among nontraditional points of entry for individuals needing mental health support, developing a public health education movement encouraging possible policy change.

Collaborative Care Enhanced Recovery Project (CCERP) operated by HSD Older Adult Division: Combines an established short-term intervention with an additional 9- months of in-home case management, resulting in positive impacts for adults from 50 - 64 years old with depression.

Nuestra Cultura Cura Social Innovations Lab operated by On the Move/VOICES in partnership with community leaders: A partnership of community organizations will engage a diverse cohort from the Latinx communities to determine root causes of mental health stigma and inaccessibility for their communities. Facilitators support the team in determining a strategic direction with specific actions to address defined issues. Resources are be provided for team members by the various CBO partners. The Social Innovations Lab will create more culturally relevant mental health strategies to will reduce depression and anxiety and promote cultural protective factors.

Crossroads to Hope: Crossroads provides transitional housing to individuals with serious mental health concerns who have been diverted from the criminal justice system. Peer support specialists with lived mental health and criminal justice involvement will provide supportive services to clients along with the DHS-BHD Mental Health Diversion team.

CalMHSA's Semi-Statewide Electronic Health Record: This innovative project brings participating counties together to co-create a new health record solution, designed to support optimal care for Medi-

Cal beneficiaries and to address counties' unique behavioral health business needs. This collaborative solution empowers CA Counties to pool their considerable expertise and resources to create a solution during a time of rapid change. This project is pending MHSOAC approval. See page 29.

Workforce, Education and Training (WET)[1]

The goal of the WET component is to develop a diverse workforce. Individuals with lived mental health experience and DHS BHD staff and contractors are given training to promote wellness and other positive mental health outcomes. WET funds are also used to promote and expand the cultural responsiveness of DHS BHD system of care. In order to improve cultural responsiveness and continue to develop the Division's workforce, the Division has created a new position: Diversity, Equity, and Inclusion Development Manager.

Ethnic Services, Inclusion, and Training Coordinator

The Sonoma County Behavioral Health **Ethnic Services,** Inclusion, and Training Coordinator position is responsible for ensuring BH services are provided in a culturally appropriate manner to the diversity of our clientele. This involves participation in a number of cross-cutting areas in the division. That includes:

- Policy Development: ensuring division policies are nondiscriminatory and inclusive;
- Workforce, Education, and Training: developing a workforce pipeline to diversify the incoming behavioral health workforce which includes participation in the development of strategies related to recruitment, hiring, on-boarding, training, support, and retention practices and ensuring the current behavioral health workforce is appropriately attending to the needs of our diverse clientele.
- Program Design and Development: participation in program design and development to control for bias and ensure equity and cultural relevance in service provision.
- Leadership Development: Strengthening management and administrative performance.

System Level Support

The **Ethnic Services,** Inclusion, and Training Coordinator will manage training programs and community events to further DHS-BHD's goals in the following Domains: System Level Support, Career Pathways and Pipeline Program, Staff Skill Development, and Workforce Diversification.

Domain	Programs/events/goals
System Level Support	• Accreditation (BRN, CAMFT, CCAPP)
Career Pathways	• Pipeline Programs • Career & Internship Fairs
Staff Skill Development	• Staff Development Trainings
WET Activities	• Strengths Model Care Management: an evidence-based practice demonstrating positive outcomes in the areas of psychiatric hospitalization, competitive employment, education, and a range of quality of life indicators.

[1] Pursuant to WIC 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.

Accreditation

The Division will continue to maintain accreditation through the Board of Registered Nursing (BRN), the California Association of Marriage and Family Therapists (CAMFT), and California Consortium of Addiction Programs and Professionals (CCAPP) for the license types listed below, and provides Continuing Education Units (CEUs) for these license types:

BRN	CAMFT	CCAPP
• Licensed Vocational Nurse (LVN) • Licensed Psychiatric Technician (LPT) • Registered Nurse (RN) • Public Health Nurse (PHN) • Nurse Practitioner (NP) • Psychiatric Nurse Practitioner (PNP)	• Licensed Clinical Social Worker (LCSW) • Licensed Marriage and Family Therapist (LMFT) • Licensed Professional Clinical Counselor (LPCC) • Licensed Educational Psychologist (LEP)	• Registered Alcohol Drug Technician (RADT) • Certified Alcohol Drug Counselor I (CADC-I) • Certified Alcohol Drug Counselor II (CADC-II) • Licensed Advanced Alcohol Drug Counselor (LAADC) • Licensed Advanced Alcohol Drug Counselor Supervisor (LAADC-S)

Career Pathways and Pipeline Program

The Ethnic Services, Inclusion, and Training Coordinator will continue the Internship and Traineeship program to assist staff in obtaining clinical licensure and to develop pipeline programs with participating universities. This includes a Group Clinical Supervision and Educational Outreach Events.

Pipeline Program

The Ethnic Services, Inclusion, and Training Coordinator will participate in several community career events at both the high school and college level. Particular focus will be given to encouraging Latino and bilingual students to consider Behavioral Health as a career option.

Participating Universities

Program Category	Participants
Nursing Programs	• Sonoma State University (SSU) • Santa Rosa Junior College (SRJC)
Social Work Programs	• California State Long Beach • San Francisco State University (SFSU) • Humboldt State • San Jose State University • University of Southern California • Berkeley
MFT Programs	• SSU • University of San Francisco • SFSU
Mental Health Worker Programs	• SSU • SRJC

The following programs and activities will be funded through WET in FY 22-23:

Provider/Program	Estimated # to be served in FY 21-22	Children and Youth (0-15)	Transition Age Youth (16-25)	Adults (26-59)	Older Adults (60+)	Estimated MHSA cost per person in FY 21-22
West County Community Services - Peer Education and Training	195 (aggregate of quarterly reports)	0	12	145	38	$715
Ethnic Services, Inclusion, and Training Coordinator	N/A	N/A	N/A	N/A	N/A	N/A
0.5 Full Time Equivalent (FTE) Senior Office Assistant (SOA)	N/A	N/A	N/A	N/A	N/A	N/A
DHS-BHD (and contractors) - WET activities	N/A	N/A	N/A	N/A	N/A	N/A

Capital Facilities and Technological Needs (CFTN)[2]

This component works towards the creation of facilities that are used for the delivery of MHSA services to mental health clients and their families, or for administrative offices. Funds may also be used to support an increase in peer-support and consumer-run facilities, development of community-based settings, and the development of a technological infrastructure for the mental health system to facilitate the highest quality and cost-effective services and supports for clients and their families. The following projects will be funded through CFTN in FY 22-23:

Provider	Project	Description
NetSmart	Avatar Electronic Health Record (EHR)	Implementing fully integrated Electronic Health Record.
FEI	Sonoma Web Infrastructure for Treatment Services (SWITS)	Database for tracking demographics and outcomes.
A.J. Wong, Inc.	Data Collection Assessment and Reporting (DCAR)	Database for client CANS (Child and Adolescent Needs and Strengths) and ANSA (Adult Needs and Strength Assessment) assessments, reassessment and closing assessments.
DHS-BHD	Avatar Electronic Health Record (EHR) - DHS staff	DHS-BHD staff to administer Avatar.

[2] Ibid.

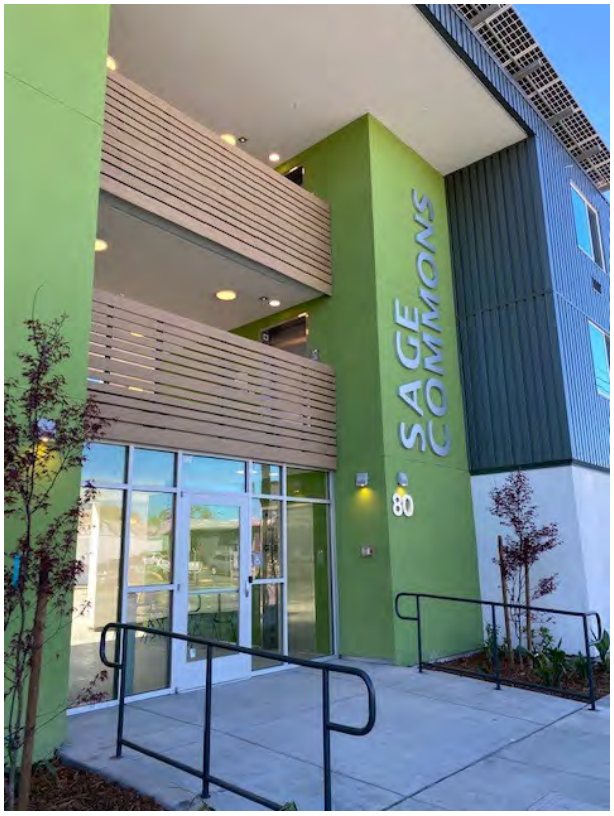
No Place Like Home

Background Information

On July 1, 2016, Governor Brown signed landmark legislation enacting the No Place Like Home (NPLH) program to dedicate up to $2 billion in bond proceeds to invest in the development of permanent supportive housing for persons who need mental health services and are experiencing homelessness, chronic homelessness, or who are at risk of chronic homelessness. The bonds are repaid by funding from the Mental Health Services Act (MHSA). In November 2018, voters approved Proposition 2, authorizing the sale of up to $2 billion of revenue bonds and the use of a portion of Proposition 63 taxes for the NPLH program.

Purpose

To acquire, design, construct, rehabilitate, or preserve permanent supportive housing for persons who are experiencing homelessness, chronic homelessness or who are at risk of chronic homelessness, and who need mental health services.



Population to be Served

Adults with serious mental illness; or children with severe emotional disorders and their families; and persons who require—or are at risk of requiring—acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality, or violence and who are homeless, chronically homeless, or at risk of chronic homelessness.

The definition of "at risk of chronic homelessness" includes persons who are at high risk of long-term or intermittent homelessness, including persons with mental illness exiting institutionalized settings with a history of homelessness prior to institutionalization, and transition age youth experiencing homelessness or with significant barriers to housing. For more information about NPLH please follow this link: https://www.hcd.ca.gov/grants-funding/active-funding/nplh.shtml

NPLH in Sonoma County

The table below, provided by Sonoma's Community Development Commission, lists the NPLH projects in Sonoma County. Sage Commons opened in April 2022 and two other projects, Caritas Home and Boyd Street Housing will open in the spring and summer of 2022.

Project Sponsor	Project Name	Project City	Total Project Units	NPLH Units	Current Status
Burbank Housing Development Corp.	**Caritas Home, Phase 1**	Santa Rosa	64	30	Received 30 Project Based vouchers from City of Santa Rosa and $8.5 million in Community Development Block Grant funds. Approved in November 2021 by BOS. Occupancy anticipated in spring of 2022.
Danco Communities	**Sage Commons**	Santa Rosa	54	29	All efficiency units for formerly homeless housing. **Opened April 2022**
Danco Communities	**Boyd Street Housing**	Santa Rosa	45	15	Under construction. Occupancy anticipated in spring/summer of 2022.
Burbank Housing Development Corp.	**Petaluma River Place Apartments**	Petaluma	50	15	Approved by BOS in November 2021.
Mid-Pen Housing	**Petaluma Blvd. North**	Petaluma	40	15	Received Tax Credit Allocation and PBVs from City of Petaluma. Needs BOS approval of resolution.

Supportive Housing Services for NPLH Residents:

The County and Sage Commons are providing supportive housing services for NPLH residents to help ensure residents are able to make a smooth transition from no housing, temporary or insecure housing into long-term permanent housing.

- DHS-BHD is providing supportive services to individuals who have been certified as eligible prospective tenants in NPLH-funded units. These services focus on three areas:
  Move-In Process
- Ongoing Tenancy and Lease Violation Intervention
- Eviction Prevention

Move-In Process

- Assist the NPLH tenants with the leasing process.
- Meet with incoming tenants at the time of move-in.
- Orient new tenants to the services available on-site and provide them with information on community resources.
- Offer tenants the opportunity to participate in supportive services and receive mental health services.

Ongoing Tenancy

- Conduct needs assessments, develop recovery focused service plans, and establish appropriate linkage to community-based services such as health care, child care, alcohol and other substance use

treatment, education and/or employment services, self-help groups, and other services essential for achieving and maintaining independent living.

- Provide mental health services including assessment, individual and group therapy, rehabilitative groups, case management, crisis intervention, medication support, and psychiatric services as needed and agreed upon by the NPLH tenant.
- Facilitate community-building activities for NPLH tenants when possible (i.e., educational workshops, trainings, garden projects, support groups, discussion groups, volunteer opportunities) to establish peer support systems.

Lease Violation Interventions and Eviction Prevention

- Help NPLH tenants to understand and meet their obligations with respect to NPLH tenant agreements and community rules.
- Establish plans to help tenants obtain the appropriate support and services they need to maintain their permanent housing in times of crisis.

Pictured above: One of three Community Recreation Rooms at Sage Commons

SONOMA COUNTY MHSA

EXPENDITURE PLAN

FY 2022-2023

A summary of Sonoma County's MHSA estimated funding and expenditures for FY 2022-2023.

Draft Addendum to Sonoma County's DHS-BHD (Department of Health Services, Behavioral Health Division) Mental Health Services Act (MHSA) FY 22-23 Annual Plan Update Expenditure Plan Narrative

DHS-BHD is making an addendum to the MHSA FY 22-23 Annual Plan Update Expenditure Plan. Sonoma County DHS-BHD is amending the plan following the MHSA local review process (Title 9 CCR § 3315) which included a 30-day public comment period and a public hearing hosted by the Mental Health Board that was held on May 17, 2022. The Sonoma County MHSA Fiscal Year 22-23 Annual Plan Update is pending approval by the Board of Supervisors (BOS) on January 24, 2023.

This addendum will be posted on February 17, 2023 for a minimum of 30 days followed by a Public Hearing hosted by the Mental Health Board on March 21, 2023.

Sonoma County received $48,788 in MHSA Returned Housing Funds from the state of California following the California Housing and Finance Agency (CalHFA) discontinuation of the Local Government Special Needs Housing Program (SNHP) in 2020. Sonoma County will use the released MHSA Housing Funds to provide housing assistance to the target populations identified in W&I Section 5600.31[1] that need housing assistance that is related to their treatment. The Housing Assistance can include rental assistance or capitalized operating subsidies; security deposits, utility deposits, or other move-in cost assistance; utility payments; moving cost assistance for homeless, mentally ill persons or mentally ill persons who are at risk of being homeless. (DHCS BHIN 19-047: 19-047)

[1] **Welfare and Institution Code (W&I) Section 5600.3**: Serious mental disorder means a mental disorder which is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. Serious mental disorders include, but are not limited to, schizophrenia, as well as major affective disorders or other severely disabling mental disorders. This section shall not be construed to exclude persons with a serious mental disorder and a diagnosis of substance abuse, developmental disability, or other physical or mental disorder.

MHSA Expenditure Plan for FY 22-23

FY 22-23 Estimated Funding and Expenditures Summary

Category	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs
Estimated FY 2022/23 Funding					
Estimated Unspent Funds from Prior Fiscal Years	$16,927,713	$13,332,864	$3,517,257	$0	$0
Estimated New FY 22/23 Funding	$25,830,533	$6,457,633	$1,699,377	$0	$0
Transfer in FY 2022/23*	($2,186,445)	$0	$0	$755,216	$1,431,229
Access Local Prudent Reserve in FY 2022-2023	$0	$0	$0	$0	$0
Estimated Available Funding for FY 2022-2023	$40,571,801	$19,790,497	$5,216,634	$755,216	$1,431,229
Estimated FY 22-23 MHSA Expenditures	$20,815,375	$4,594,430	$3,621,514	$755,216	$1,431,229
Estimated FY 22-23 Unspent Fund Balance	$19,756,426	$15,196,067	$1,595,120	$0	$0

D. Estimated Local Prudent Reserve Balance	Amount
1. Estimated Local Prudent Reserve Balance on June 30, 2022	$944,981
2. Contributions to the Local Prudent Reserve in FY 22-23	$0
3. Distributions from the Local Prudent Reserve in FY 22-23	$0
4. Estimated Local Prudent Reserve Balance on June 30, 2022	$944,981

* Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

FY 21-22 Estimated Community Services and Supports (CSS) Funding and Expenditures

Category/Program	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
Forensic Assertive Community Treatment (FACT) Team						
County of Sonoma Department of Health Services Behavioral Health Division (DHS-BHD)	$1,432,815	$674,294	$668,176	$0	$0	$90,345
Buckelew Programs - FACT - Independent Living Skills (ILS) [contractor]	$130,092	$68,212	$61,880	$0	$0	$0
Buckelew Programs - FACT - Supplemental Patch for Unlicensed Supportive Housing Units [contractor]	$60,007	$40,007	$20,000	$0	$0	$0
Family Advocacy, Stabilization & Support Team (FASST)						
DHS-BHD FASST	$3,741,367	$1,512,064	$2,171,066	$0	$0	$58,237
Seneca Family of Agencies [contractor]	$200,000	$89,974	$110,026	$0	$0	$0
Lifeworks of Sonoma County [contractor]	$100,000	$46,474	$53,526	$0	$0	$0
Social Advocates for Youth (SAY) [contractor]	$245,000	$111,185	$133,815	$0	$0	$0
Integrated Recovery Team (IRT)						
DHS-BHD IRT	$1,257,561	$691,425	$546,819	$0	$0	$19,317
Older Adult Intensive Team (OAIT)						
DHS-BHD OAIT	$1,093,958	$755,421	$324,820	$0	$0	$13,717
Transition Age Youth (TAY) Team						
DHS-BHD TAY	$802,094	$436,981	$346,964	$0	$0	$18,149
Buckelew Programs - TAY - Sonoma County Independent Living (SCIL) [contractor]	$106,306	$85,045	$21,261	$0	$0	$0
SAY - Tamayo Village [contractor]	$164,500	$31,059	$133,441	$0	$0	$0
VOICES [contractor]	$238,587	$238,587	$0	$0	$0	$0
Adult Full Service Partnership (AFSP)						

DHS-BHD	$1,176,505	$1,151,601	$0	$0	$0	$24,904

Category/Program	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Non-FSP Programs						
General Systems Development (GSD)						
National Alliance on Mental Illness (NAMI) Sonoma County - Family-based Education, Advocacy and Support (FEAS) [contractor]	$203,398	$203,398	$0	$0	$0	$0
Buckelew Programs - Family Service Coordination [contractor]	$85,182	$63,009	$0	$0	$0	$22,173
DHS-BHD Mobile Support Team (MST)	$2,973,283	$814,025	$0	$0	$0	$2,159,258
Support Our Students (SOS) Community Counseling - MST Internship Program [contractor]	$212,672	$79,672	$0	$0	$0	$133,000
DHS-BHD Collaborative Treatment and Recovery Team (CTRT)	$852,076	$434,441	$409,713	$0	$0	$7,922
Buckelew Programs - CTRT System Navigation [contractor]	$455,674	$201,317	$254,357	$0	$0	$0
DHS-BHD Community Mental Health Centers	$2,505,688	$1,342,579	$1,062,697	$0	$0	$100,412
Council on Aging - Senior Peer Support [contractor]	$83,951	$83,951	$0	$0	$0	$0
WCCS - Senior Peer Counseling [contractor]	$72,149	$72,149	$0	$0	$0	$0
Sonoma County Human Services Department (HSD) - Job Link [contractor]	$67,500	$67,500	$0	$0	$0	$0

Category/Program	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WCCS - Crisis Support [contractor]	$10,000	$10,000	$0	$0	$0	$0
WCCS - Interlink [contractor]	$24,187	$24,187	$0	$0	$0	$0
WCCS - Wellness & Advocacy Center [contractor]	$538,392	$538,392	$0	$0	$0	$0
WCCS - Russian River Empowerment Center [contractor]	$130,471	$130,471	$0	$0	$0	$0
WCCS - Petaluma Peer Recovery Center [contractor]	$58,717	$58,717	$0	$0	$0	$0
DHS-BHD Medication Support Services for Adult Programs	$4,143,590	$3,457,666	$645,025	$0	$0	$40,899
DHS-BHD Medication Support Services for Youth Programs	$2,656,387	$2,030,188	$592,488	$0	$0	$33,711
DHS-BHD Foster Youth Team	$1,052,696	$539,037	$83,415	$0	$0	$430,244
Youth RFP – Alternative Family Services [contractor]	$250,000	$250,000	$0	$0	$0	$0
Adult RFP – Siyan Clinical Research [contractor]	$1,250,000	$1,250,000	$0	$0	$0	$0

Category/Program	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Outreach and Engagement (OE)						
DHS-BHD Whole Person Care (WPC)	$1,599,318	$401,548	$1,185,411	$0	$0	$12,359
Sonoma County Indian Health Project - Community Programs [contractor]	$81,040	$81,040	$0	$0	$0	$0
CSS Annual Planning	$268,722	$262,177	$0	$0	$0	$6,545
CSS Administration	$2,464,604	$2,438,794	$0	$0	$0	$25,810
CSS MHSA Housing Program Assigned Funds	$48,788	$48,788	$0	$0	$0	$0
Total CSS Program Estimated Expenditures	$32,837,277	$20,815,375	$8,824,900	$0	$0	$3,197,002

FY 22-23 Estimated Prevention and Early Intervention (PEI) Funding and Expenditures

Category/Program	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
Action Network [contractor]	$60,000	$60,000	$0	$0	$0	$0
Community Baptist Church Collaborative [contractor]	$120,000	$120,000	$0	$0	$0	$0
Sonoma County Human Services Department - Older Adult Collaborative [contractor]	$220,000	$220,000	$0	$0	$0	$0
Sonoma County Indian Health Project [contractor]	$40,000	$40,000	$0	$0	$0	$0
PEI Programs - Prevention & Early Intervention						
La Luz [contractor]	$33,000	$33,000	$0	$0	$0	$0

Category/Program	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Latino Service Providers of Sonoma County [contractor]	$107,000	$107,000	$0	$0	$0	$0
Positive Images [contractor]	$102,000	$102,000	$0	$0	$0	$0
PEI Programs - Early Intervention						
Child Parent Institute (CPI) [contractor]	$198,000	198,000	$0	$0	$0	$0
Early Learning Institute (ELI) [contractor]	$44,000	44,000	$0	$0	$0	$0
La Luz [contractor]	$46,000	$46,000	$0	$0	$0	$0
PEI Programs - Stigma & Discrimination Reduction						
Santa Rosa Junior College [contractor]	$200,000	$200,000	$0	$0	$0	$0
PEI Programs - Suicide Prevention						
Buckelew Programs - North Bay Suicide Prevention Program [contractor]	$160,000	$160,000	$0	$0	$0	$0
PEI Programs - Access and Linkage to Treatment						
DHS-BHD Youth Access Team	$1,765,808	$1,303,972	$356,053	$0	$0	$105,783
DHS-BHD Adult Access Team	$1,934,149	$1,325,149	$376,936	$0	$0	$232,064
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
Crisis Intervention Training (CIT) with Law Enforcement Personnel	$16,250.00	$15,870	$0	$0	$0	$380
PEI Annual Planning	$47,026	$45,881	$0	$0	$0	$1,145
PEI Administration	$407,363	$402,829	$0	$0	$0	$4,534
PEI Assigned Funds (CalMHSA Statewide PEI Project)	$172,673	$172,673	$0	$0	$0	$0
Total PEI Program Estimated Expenditures	$5,673,269	$4,594,430	$732,989	$0	$0	$345,850

FY 22-23 Estimated Innovation (INN) Funding and Expenditures

Category/Program	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
Collaborative Care Enhanced Recovery Project (CCERP) aka *Unidos Por Nuestro Bienestar* [Sonoma County Human Services Department]	$412,569	$412,569.	$0	$0	$0	$0
Crossroads to Hope - Peer Program Provider [Felton Institute - contractor]	$458,683	$458,683	$0	$0	$0	$0
Crossroads to Hope - Evaluation Consultant [Behavioral Health Outcomes Data Services - contractor]	$11,750	$11,750	$0	$0	$0	$0
Early Psychosis Learning Health Care Network (EP LHCN) - [Buckelew - contractor]	$76,761	$76,761	$0	$0	$0	$0
Early Psychosis Learning Health Care Network (EP LHCN) - [UC Davis - contractor]	$51,987	$51,987	$0	$0	$0	$0
Instructions Not Included (INI) - Dads Matter [Early Learning Institute - contractor]	$230,382	$230,382	$0	$0	$0	$0
New Parent TLC - [First 5 Sonoma County - contractor]	$166,372	$166,372	$0	$0	$0	$0
Nuestra Cultura Cura Social Innovations Lab - [On The Move - contractor]	$278,285.00	$278,285.00	$0	$0	$0	$0
CalMHSA Electronic Health Record	$1,789,665	$1,789,665	$0	$0	$0	$0
INN Annual Planning	$0	$0	$0	$0	$0	$0
INN Administration	$147,850	$145,060	$0	$0	$0	$2,790
Total INN Program Estimated Expenditures	$3,624,304	$3,621,514	$0	$0	$0	$2,790

FY 22-23 Estimated Workforce, Education and Training (WET) Funding and Expenditures

Category/Program	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
Diversity, Equity, & Inclusion Development Coordinator	$163,418	$150,829	$0	$0	$0	$12,589
DHS-BHD WET Activities	$279,304	$279,304	$0	$0	$0	$0
0.5 FTE Senior Office Assistant (SOA)	$130,203	$130,203	$0	$0	$0	$0
West County Community Services - Peer Education and Training [contractor]	$139,414	$139,414	$0	$0	$0	$0
WET Annual Planning	$6,718	$6,554	$0	$0	$0	$164
WET Administration	$49,610	$48,912	$0	$0	$0	$698
Total WET Program Estimated Expenditures	$768,667	$755,216	$0	$0	$0	$13,451

FY 22-23 Estimated Capital Facilities and Technological Needs (CFTN) Funding and Expenditures

Category/Program	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Technological Needs Projects						
Avatar Electronic Health Record (EHR) - Netsmart	$1,032,034	$1,032,034	$0	$0	$0	$0
Avatar Electronic Health Record (EHR) - DHS staff	$247,992	$247,480	$0	$0	$0	$512
Sonoma Web Infrastructure for Treatment Services (SWITS) - FEI	$2,200	$2,200	$0	$0	$0	$0
Data Collection and Reporting (DCAR) - AJW	$35,000	$35,000	$0	$0	$0	$0
CFTN Annual Planning	$13,436	$13,109	$0	$0	$0	$327
CFTN Administration	$102,452	$101,406	$0	$0	$0	$1,046
Total CFTN Program Estimated Expenditures	$1,433,114	$1,431,229	$0	$0	$0	$1,885

SONOMA COUNTY MHSA

ANNUAL PROGRAM REPORT

FY 2020-2021

Summary report and highlights from MHSA funded programs in 2020-2021.

Notes about the Data in the Report:
In order to ensure the protection of personally identifiable information, some data in this section of the report have been suppressed or "masked" to prevent re-identification (e.g. "Data suppressed due to small cell counts", "Multiple categories") as per California Department of Health Care Services (DHCS) Data De-identification Guidelines.

For more information visit:
https://www.dhcs.ca.gov/dataandstats/Pages/PublicReportingGuidelines.aspx

Sonoma County

MHSA ANNUAL PROGRAM REPORT

FY 2020-2021

COMMUNITY SERVICES AND SUPPORTS (CSS)

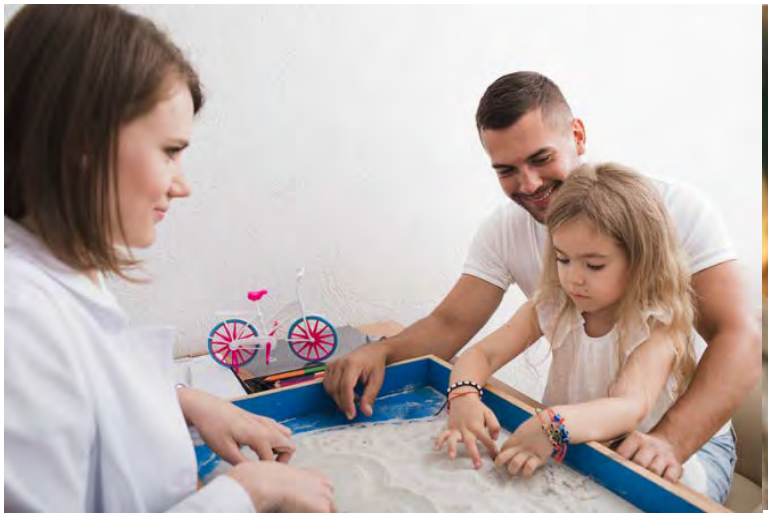
Programs provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

FULL SERVICE PARTNERSHIP PROGRAMS (FSPs)

Full Service Partnership programs are designed specifically for children diagnosed with severe emotional disturbances and for transition age youth, adults and seniors who have been diagnosed with a severe mental illness that would benefit from an intensive service program.

The foundation of FSPs is utilizing a "whatever it takes" approach to help individuals on their path to recovery and wellness. FSPs embrace client-driven services and supports, with each client choosing services based on individual needs. Unique to FSP programs are a low staff-to-client ratio, a 24/7 crisis availability, and a team approach that is a partnership between mental health staff and consumers. Embedded in Full Service Partnerships is a commitment to deliver services in ways that are culturally and linguistically responsive and appropriate.

In FY 20-21, there were over 835 unique clients served by Sonoma County FSPs.



MHSA Component: Community Services & Supports (CSS)

Family Advocacy, Stabilization and Support Team (FASST)

Takes Action FOR MENTAL HEALTH

WELLNESS • RECOVERY • RESILIENCE

Service Category: *Full Service Partnership Services*

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM INFORMATION

Program Name: Family Advocacy, Stabilization and Support Team (FASST)
Population served: Sonoma County youth ages 5-18.
Website: www.sonomacounty.ca.gov/Health/Behavioral-Health/Youth-Services
Phone: (707) 565-4850
Program location:
2227 Capricorn Way, Suite 207
Santa Rosa, CA 95407

PROGRAM STATISTICS

- **Total number of clients served:** 258

PROGRAM DESCRIPTION:

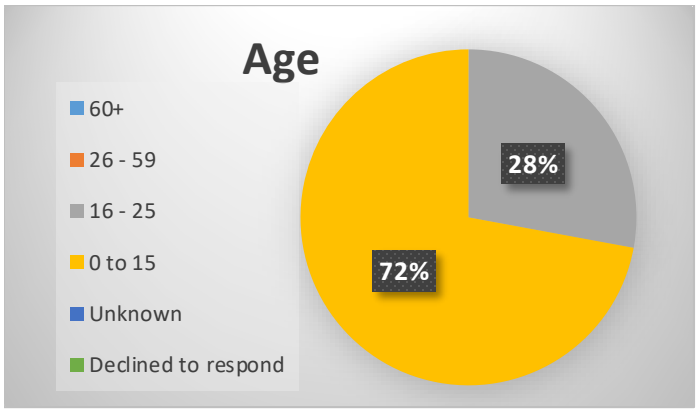
FASST is an intensive enrollee-based program that serves high-risk Seriously Emotionally Disturbed (SED) children (ages 5-18) who have not responded to traditional levels of service.

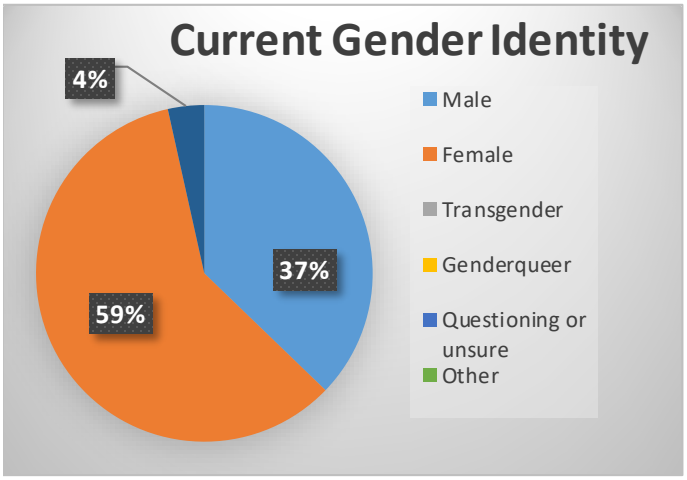
In FY 20-21, this program included contracted services from:

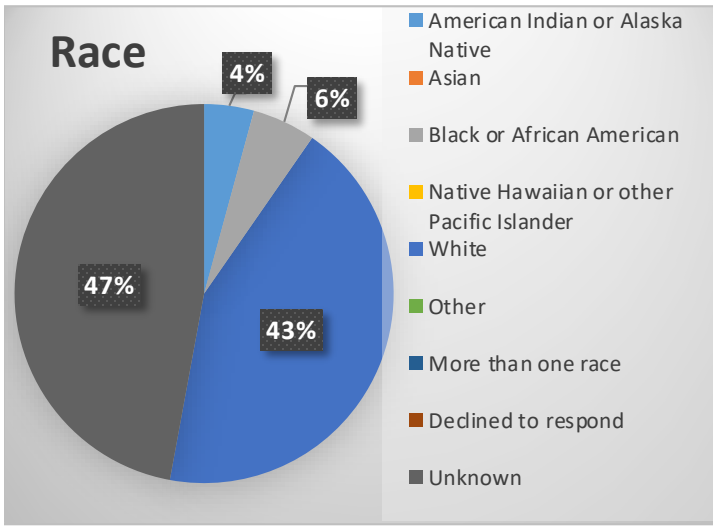
- Seneca
- Lifeworks
- Social Advocates for Youth (SAY)

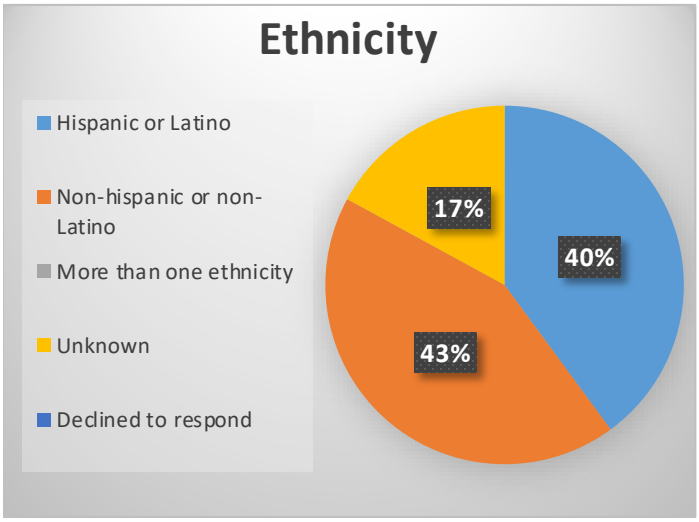
sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

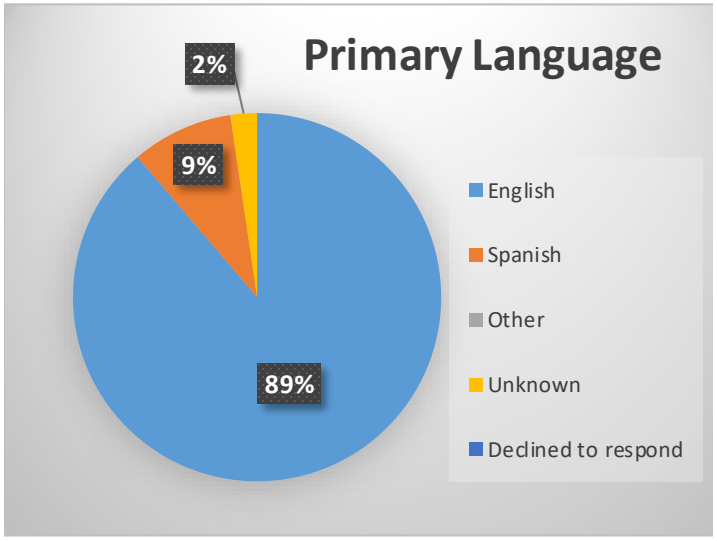
FY 2020-2021
Program Demographics:











MHSA Component: Community Services & Supports (CSS)

Transition Age Youth (TAY) Team

Takes Action FOR MENTAL HEALTH

WELLNESS • RECOVERY • RESILIENCE

Service Category: *Full Service Partnership Services*

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM INFORMATION

Program Name: Transition Age Youth (TAY) Team

Population served: Sonoma County youth ages 18-25 diagnosed with a serious and persistent mental illness and their families.

Website: https://sonomacounty.ca.gov/Health/Behavioral-Health/Transition-Age-Youth-Team/

Phone: (707) 565-4850, however, to request mental health services call: (707) 565-6900

PROGRAM DESCRIPTION:

Sonoma County's TAY Team is an intensive, integrated service program for Transition Age Youth (ages 18-25), providing mental health services, intensive case management, housing support services, and independent living skills.

Individuals are:

- Aging out of children's mental health services, and are at risk of homelessness, hospitalization, or incarceration.
- Aging out of Child Welfare.
- Leaving placement.
- Experiencing First Episode Psychosis.

Includes contracted services from the following community partners:

- Buckelew Programs – Sonoma County Independent Living (TAY-SCIL) (housing)
- Social Advocates for Youth (SAY) – Tamayo Village (housing)
- VOICES Youth Center (peer support and mentoring)

Services include:

- Mental health services
- Intensive case management
- Housing and employment support services
- Independent living skills

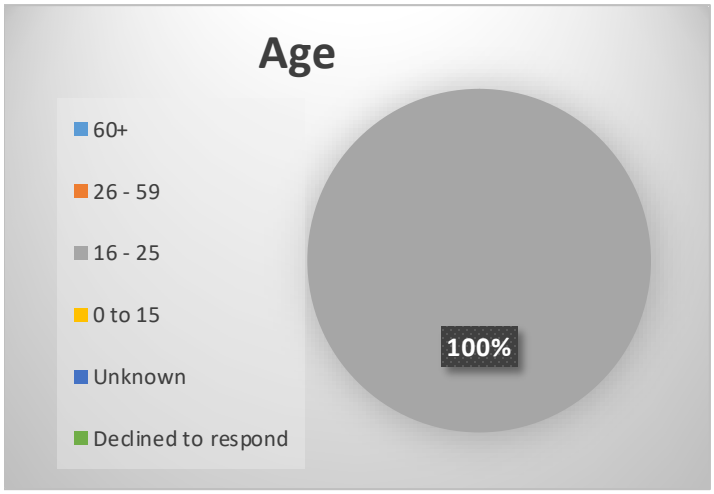
PROGRAM STATISTICS

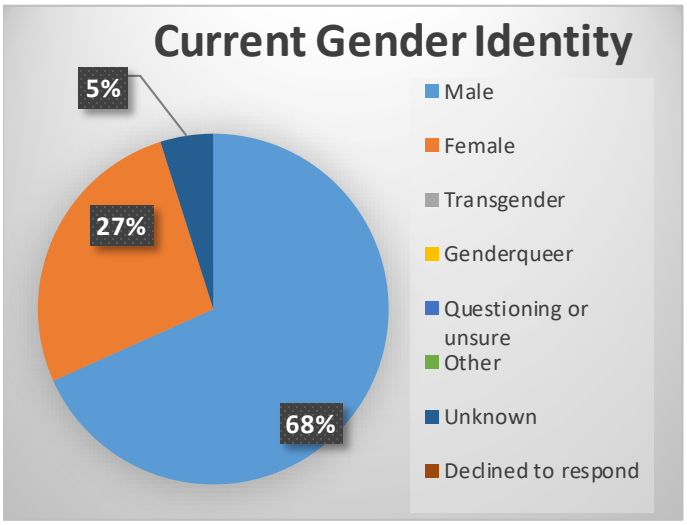
Total unique clients served in FY 20-21: 39

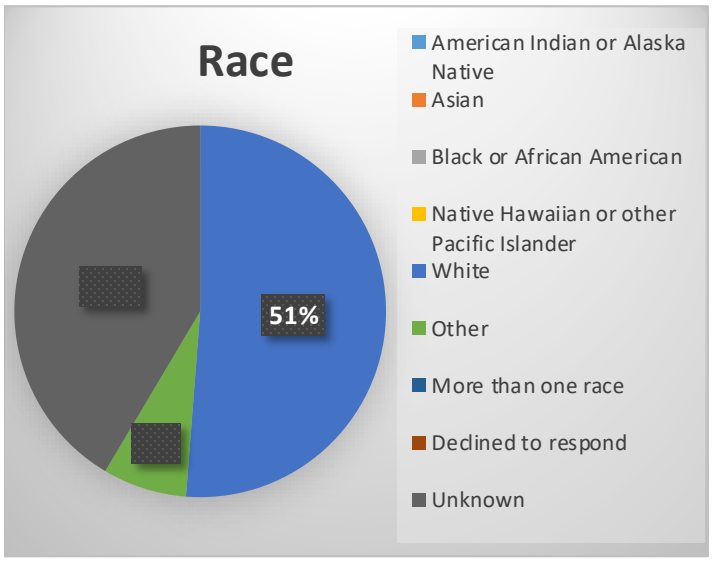
- **Total unique clients that were also served by Buckelew TAY-SCIL in FY 20-21: 21**
- **Total unique clients that were also served by SAY Tamayo Village in FY 20-21: 5**
- **Total unique clients that were also served by VOICES in FY20-21: 37**
- **Total unique clients that were also served by Sonoma County Behavioral Health in FY 20-21: 21**

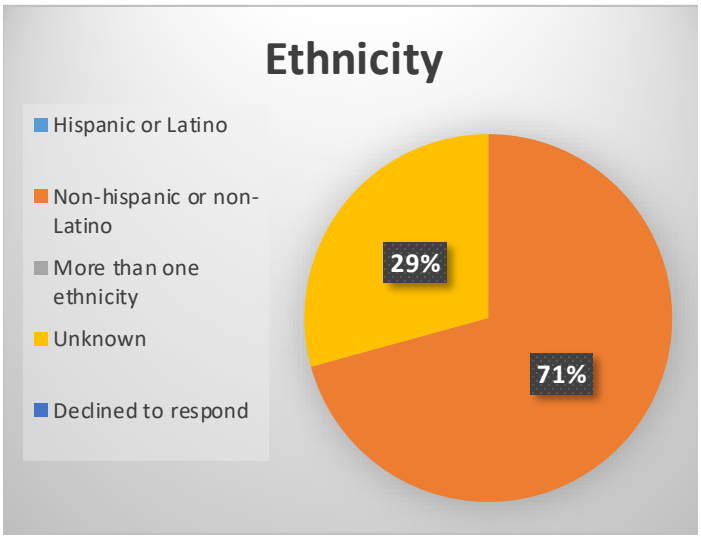
sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

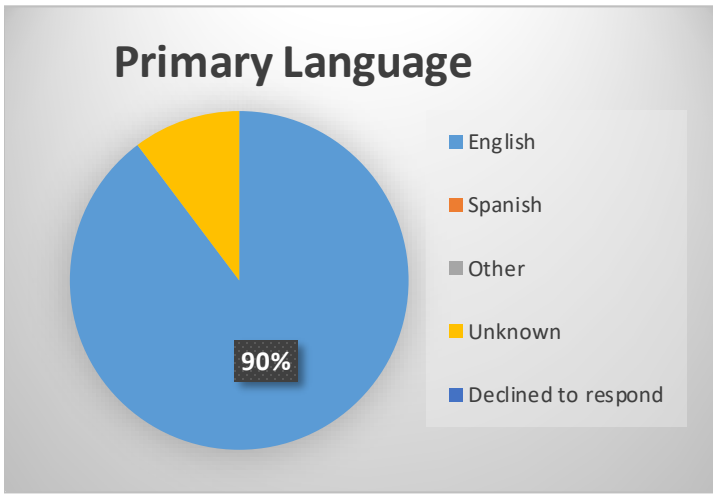
FY 2020-2021
Program Demographics:











The Alchemy Project (VOICES)

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM IMFORMATION

Program Name: The Alchemy Project (VOICES)

Population served: Transitional Aged Youth (18-25) who have a diagnosed severe and persistent mental illness.

Website: www.voicesyouthcenter.org
Phone: (707) 338-7184
Program location:
714 Mendocino Avenue,
Santa Rosa, CA 95401

PROGRAM STATISTICS

- **Total number of clients served:** 37
- **Total number of encounters:** 726
- **Approximate numbers reached through outreach:** 726

PROGRAM DESCRIPTION:

VOICES' Alchemy Project is a partnership between VOICES Youth Centers and Sonoma County Behavioral Health Division aimed at increasing engagement levels of transition age youth within the mental health system. The Alchemy Project is a comprehensive support program for Sonoma County transition age youth experiencing severe mental health challenges that leverages VOICES' one-of-a-kind youth engagement model to assist young adults in the cultivation of hope, safety, and stability—creating community while discovering their unique gifts, talents, and skills.

PROGRAM Accomplishments:

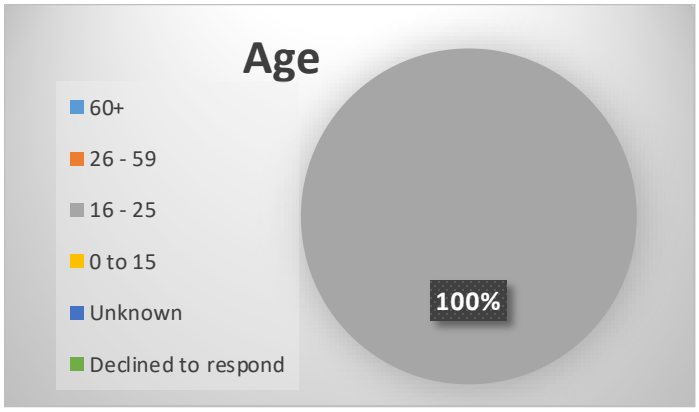
Despite the challenges of the on-going pandemic, The Alchemy Project was able to have 726 separate encounters with youth to provide therapy, group events, peer mentoring, education assistance, housing support, and much more! We have integrated hybrid platforms to reach youth both in-person and at home to adapt to the challenges of providing mental health services in the context of a global pandemic.

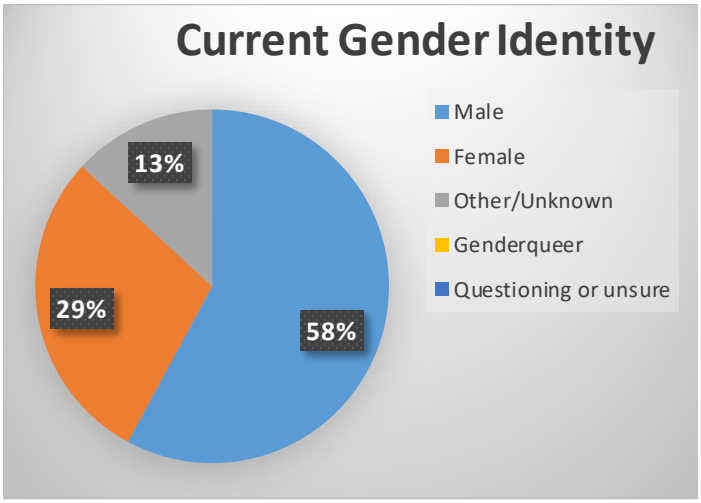
Testimonials:

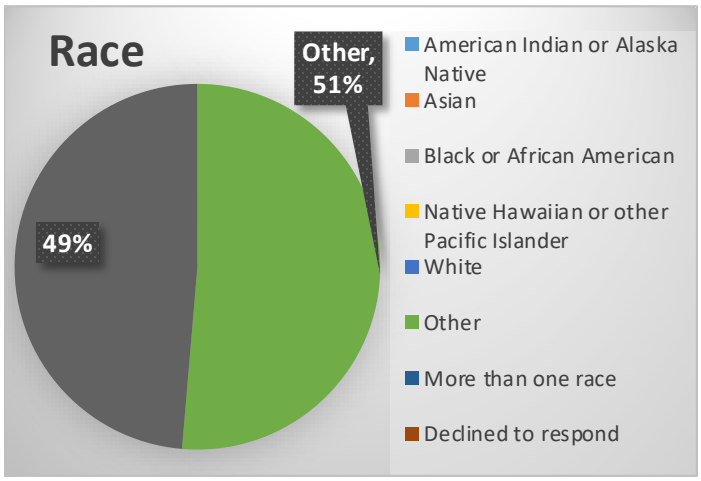
"Every social worker, caseworker, or whatever you're called, wants me to get straight into the good stuff. And I'm like wait, I don't even know you! I love being able to do therapy outside of offices. It's helped me so much with being isolated during the pandemic."

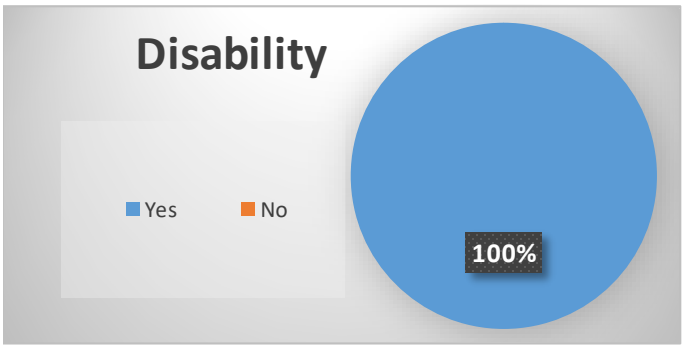
"Peer mentoring through The Alchemy Project allows me to feel fully in my element. It's like there is no agenda. Someone just wants to spend time with me and help me grow. You all have helped me get through some really hard times!"

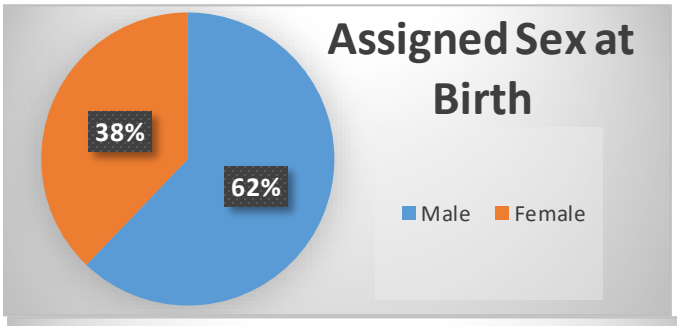
FY 2020-2021 Program Demographics:

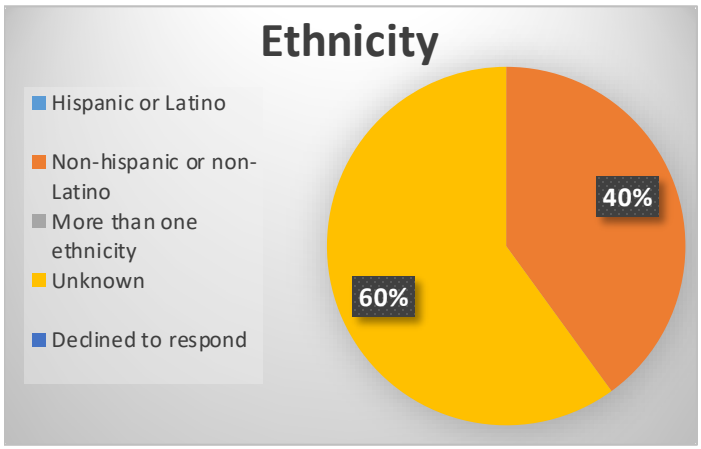


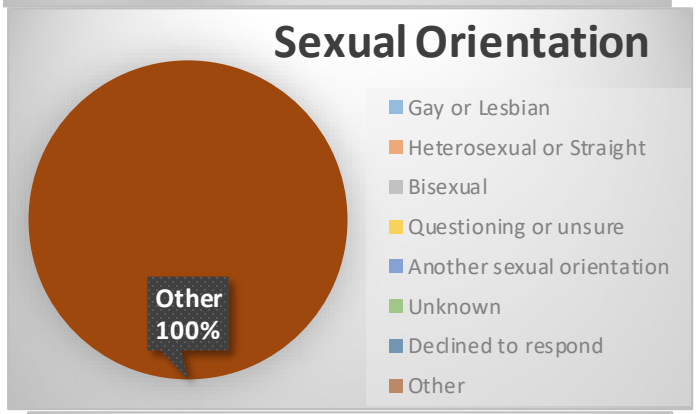


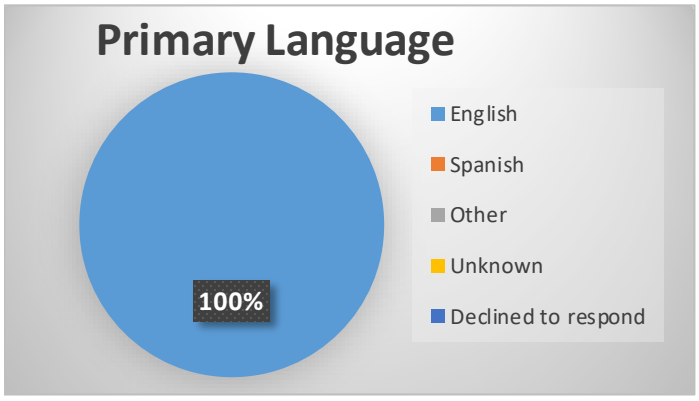


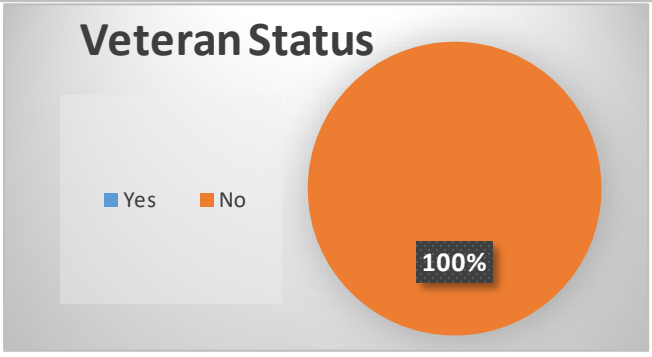












MHSA Component: Community Services & Supports (CSS)

Forensic Assertive Community Treatment (FACT) Team

Takes Action for Mental Health

Wellness • Recovery • Resilience

Service Category: *Full Service Partnership Services*

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM STATISTICS

- **Total unique clients served in FY 20-21:** 63

  Total unique clients that were also served by Buckelew FACT-ILS in FY 19-20: 23

PROGRAM DESCRIPTION:

The FACT Team serves adult offenders with Serious Mental Illness (SMI) by providing a community-based treatment team as an alternative to incarceration.

In FY 20-21, this program included contracted services from:

- Buckelew Programs – Independent Living Skills (ILS) (housing)

PROGRAM INFORMATION

Program Name: Forensic Assertive Community Treatment (FACT) Team

Population served: Sonoma County adult offenders with serious mental illness.

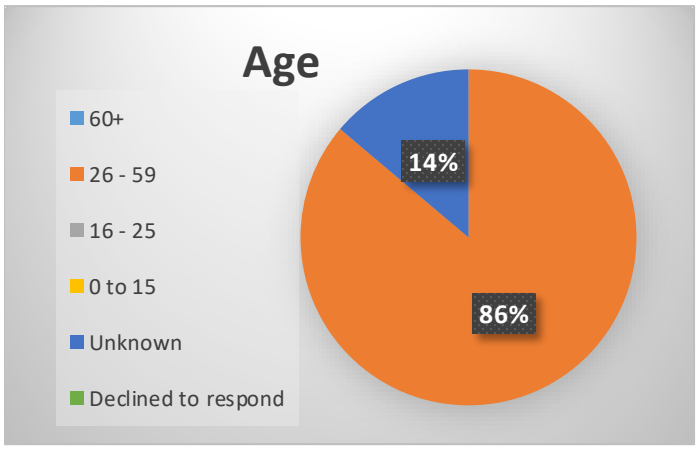
Website:
www.sonomacounty.ca.gov/Health/Behavioral-Health/Adult-Services/Forensic-Assertive-Community-Treatment-Team/

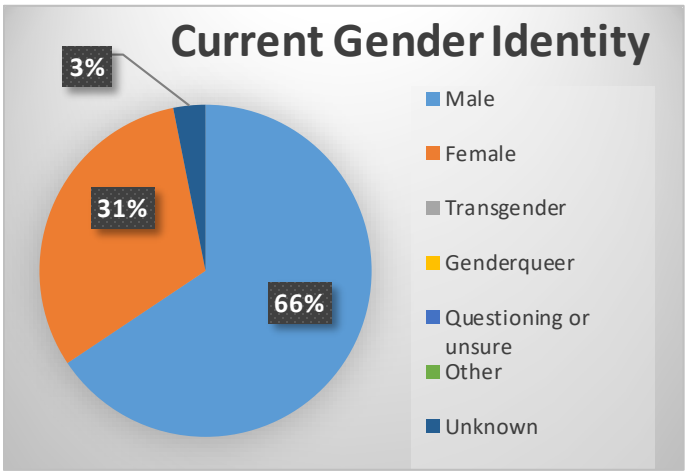
Phone: (707) 565-4850

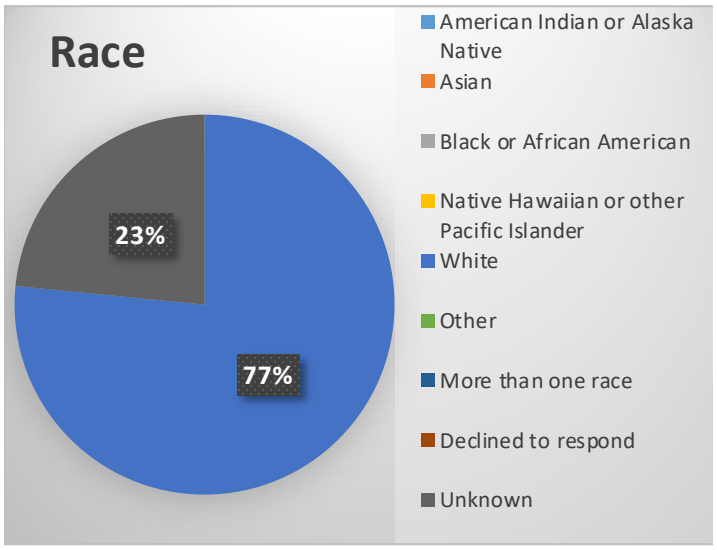
Program location:
2227 Capricorn Way, Suite 207
Santa Rosa, CA 95407

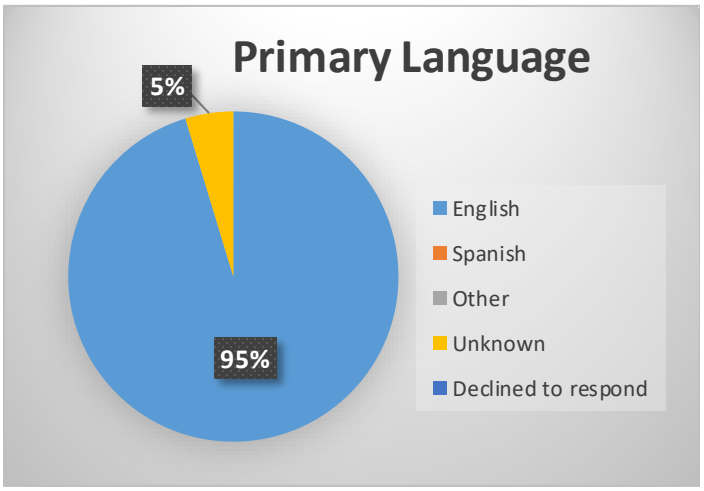
Sonoma County Department of Health Services
Behavioral Health Division

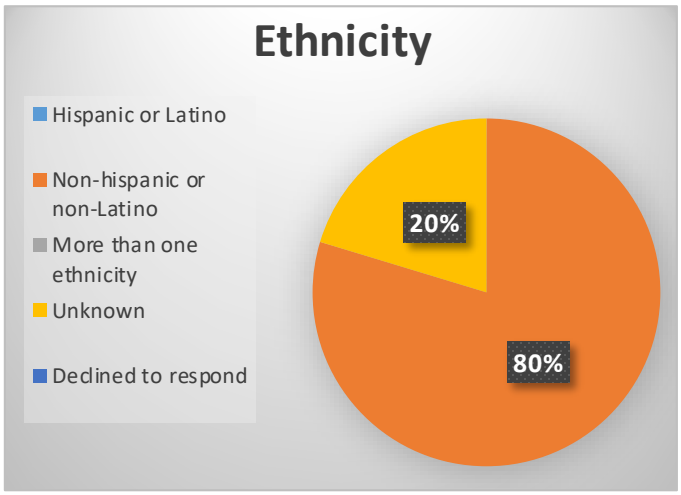
FY 2020-2021
Program Demographics:











MHSA Component: Community Services & Supports (CSS)

Integrated Recovery Team (IRT)

Takes Action FOR MENTAL HEALTH

WELLNESS • RECOVERY • RESILIENCE

Service Category: *Full Service Partnership Services*

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM INFORMATION

Program Name: Integrated Recovery Team (IRT)

Population served: Sonoma County adults with serious mental illness and substance use disorders

Website: https://sonomacounty.ca.gov/Health/Behavioral-Health/Integrated-Health-Team

Phone: (707) 565-4850, however, to request mental health services call: (707) 565-6900

Location:
2227 Capricorn Way, Suite 207
Santa Rosa, CA 95407

PROGRAM DESCRIPTION:

Sonoma County's Integrated Recovery Team (IRT) serves adults with serious and persistent mental illness and co-occurring substance use disorders, who currently do not receive comprehensive services.

IRT uses an integrated treatment approach that addresses mental health and substance use conditions at the same time to ensure better overall health outcomes. Treatment focuses on the stages of change, utilizing a harm reduction approach, and motivational interviewing.

PROGRAM STATISTICS

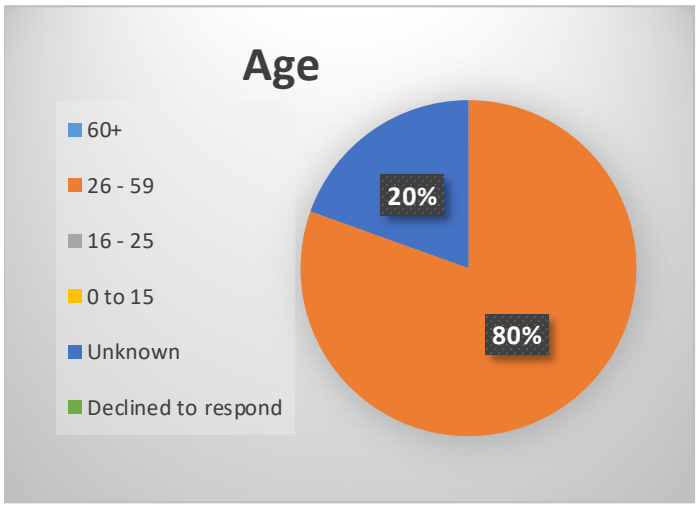
- **Total number of clients served:** 54

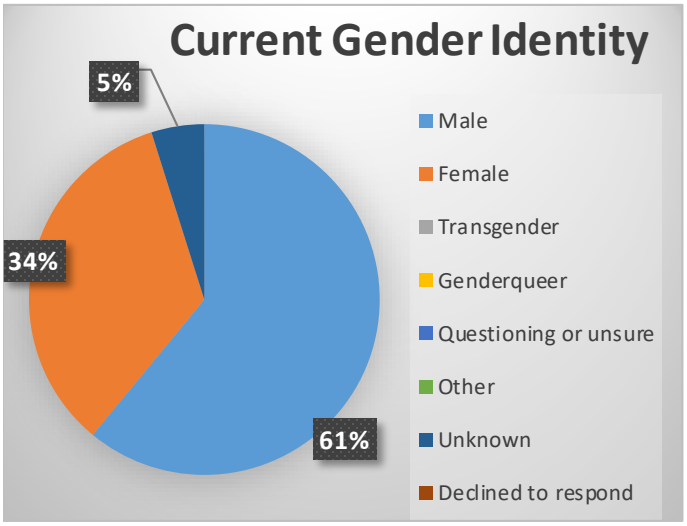
Services include:

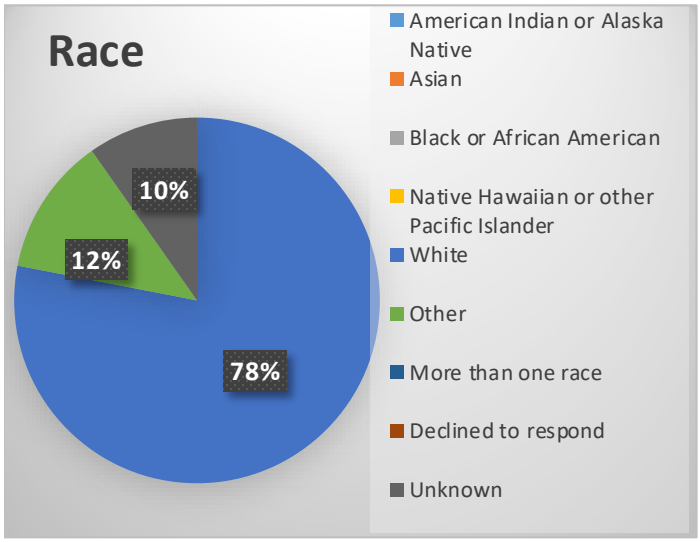
- Pharmacological treatment
- Case management
- Self-help groups run by peers
- Family education
- Housing and employment services
- Aftercare services

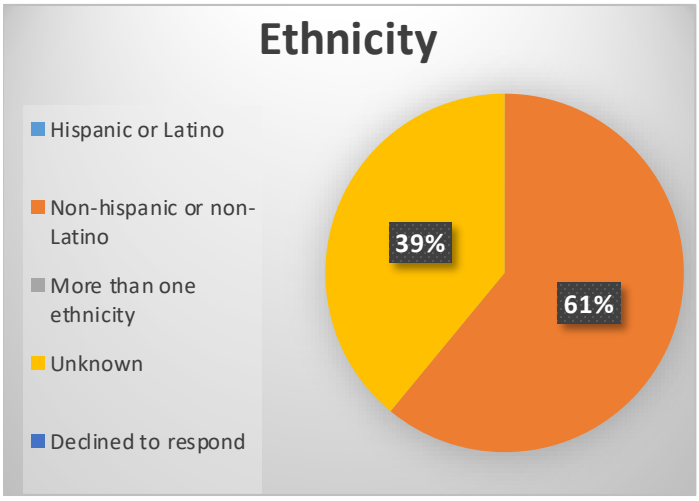
sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

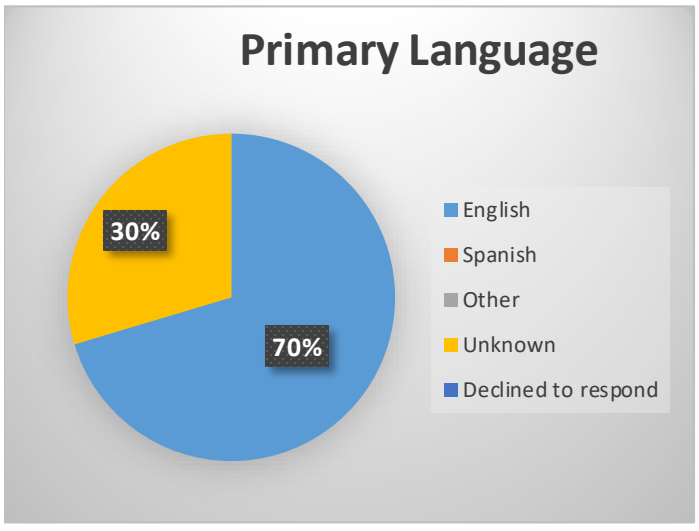
FY 2020-2021
Program Demographics:











MHSA Component: Community Services & Supports (CSS)

Adult Full Service Partnership (AFSP)

Takes Action for Mental Health

Wellness • Recovery • Resilience

Service Category: *Full Service Partnership Services*

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM INFORMATION

Program Name: Adult Full Service Partnership (AFSP)

Population served: adults from 26-59 years old with severe and persistent mental illness and at risk of institutionalization, homelessness, incarceration, or psychiatric in-patient services.

PROGRAM STATISTICS

AFSP was scheduled to begin services in FY 20-21, but was unable to meet this goal due to the pandemic.

PROGRAM DESCRIPTION:

AFSP is a new FSP which will provide intensive services for adults from 26-59 years old with severe and persistent mental illness and at risk of institutionalization, homelessness, incarceration, or psychiatric in-patient services. Every AFSP client will participate in the development of a treatment plan focused on wellness and recovery. Low caseloads of no more than 20 clients will be maintained.

The AFSP team is made up of mental health professionals who work in partnership with the clients they serve to explore individual mental health wellness and recovery using a “whatever it takes” approach to case management. The treatment team is available to provide crisis services to the client and can be provided to individuals in their homes, the community, and other locations. Peer and caregiver support are available. Embedded in Full Service Partnerships is a commitment to deliver services in ways which are culturally and linguistically competent and appropriate.

Sonoma County Department of Health Services Behavioral Health Division

MHSA Component: Community Services & Supports (CSS)

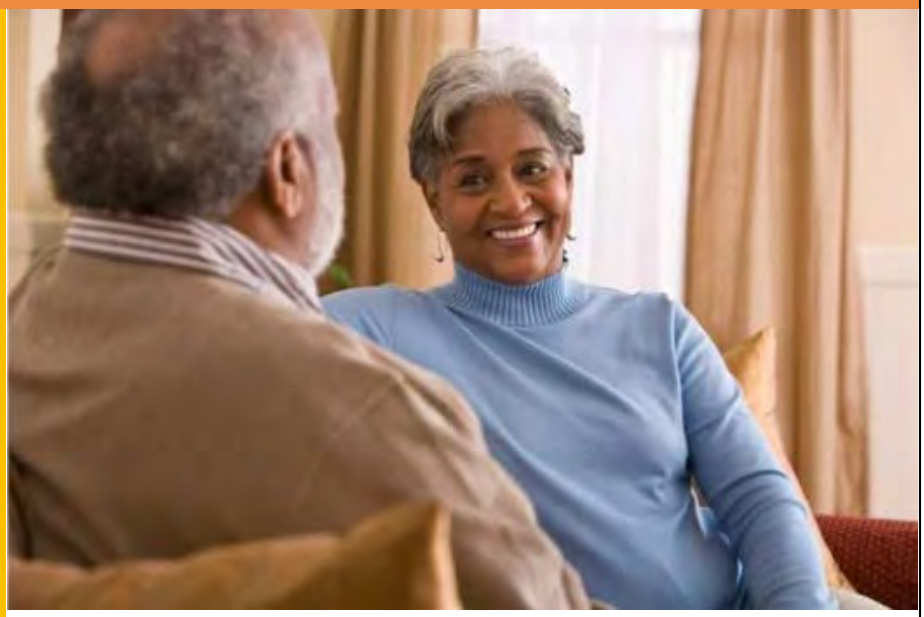
Older Adult Intensive Team (OAIT)

Takes Action FOR MENTAL HEALTH

WELLNESS • RECOVERY • RESILIENCE

Service Category: *Full Service Partnership Services*

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.



PROGRAM INFORMATION

Program Name: Older Adult Intensive Team (OAIT)

Population served: Sonoma County adults ages 60 and older with serious mental illness coupled with more complex medical conditions requiring close coordination between mental health and primary or specialty medical providers.

Website: https://sonomacounty.ca.gov/Health/Behavioral-Health/Older-Adult-Team

Phone: (707) 565-4850, however, to request mental health services call: (707) 565-6900

PROGRAM DESCRIPTION:

Sonoma County's Older Adult Intensive Team OAIT provides intensive, integrated services for older adults with serious mental illness coupled with more complex medical conditions requiring close coordination between mental health and primary or specialty medical providers. Includes contracted services from the following community partners:

- West County Community Services – Senior Peer Counseling
- Council on Aging – Senior Peer Support

PROGRAM STATISTICS

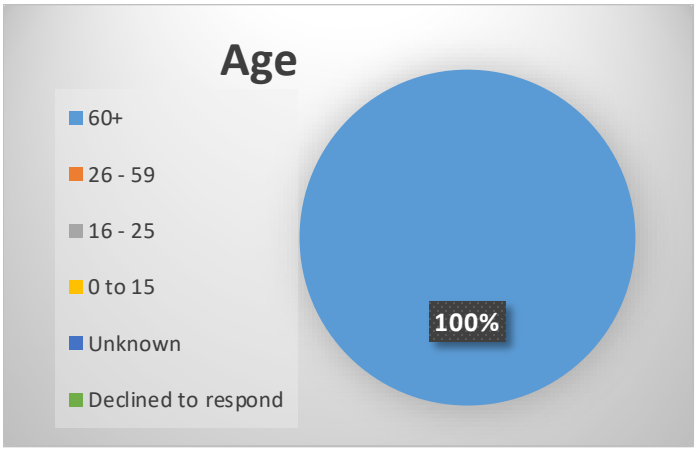
- **Total number of clients served:** 41

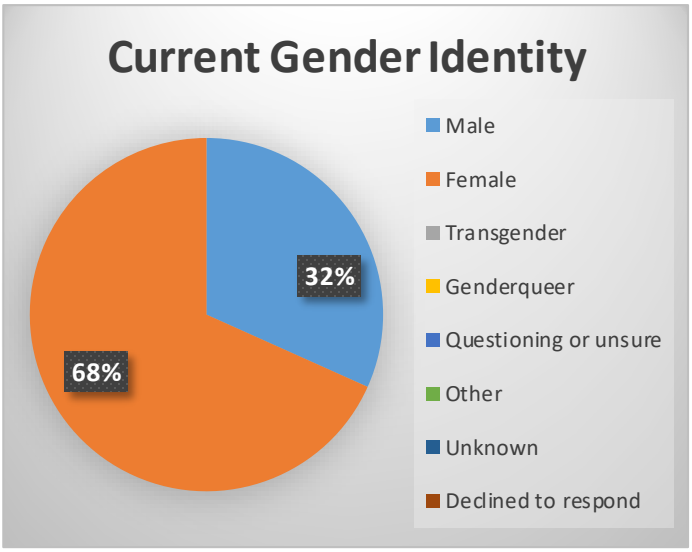
Services include:

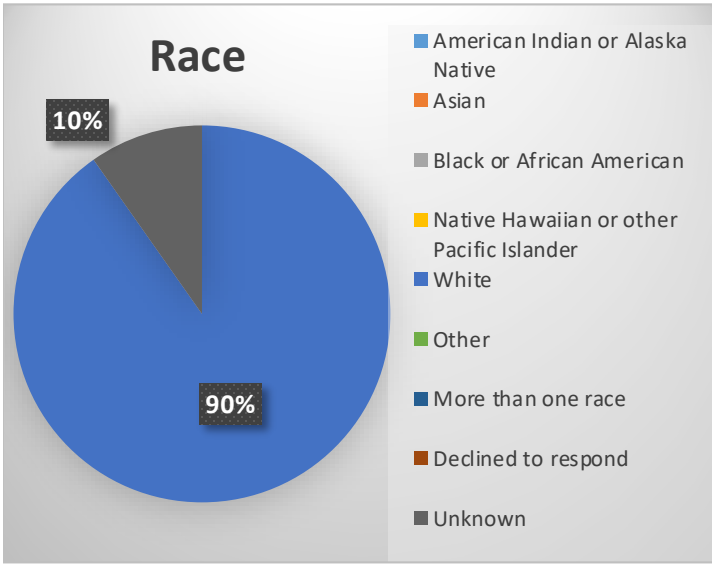
- Medication education, monitoring, and delivery.
- Case management.
- Referrals.
- Visiting clients when hospitalized (either medically or psychiatrically) and facilitating communications between the medical and psychiatric staff for care and follow-up planning.
- Transportation services, including attending important doctor's appointments, having routine laboratory work, and participating in community-offered services to reduce isolation.

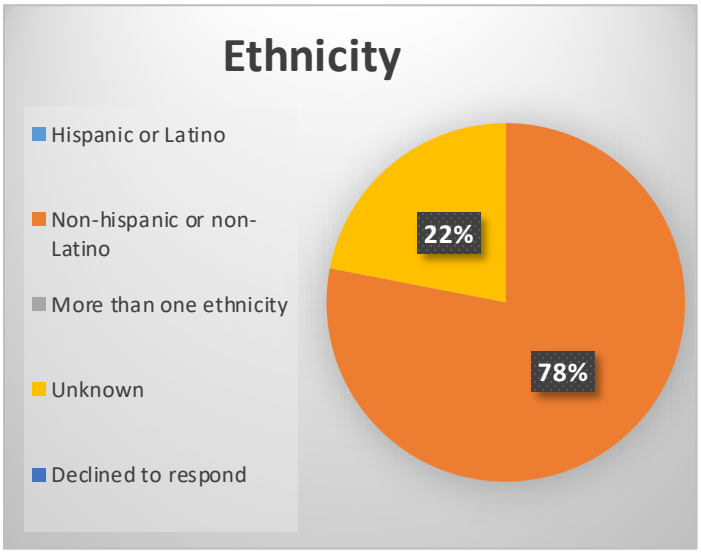
sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

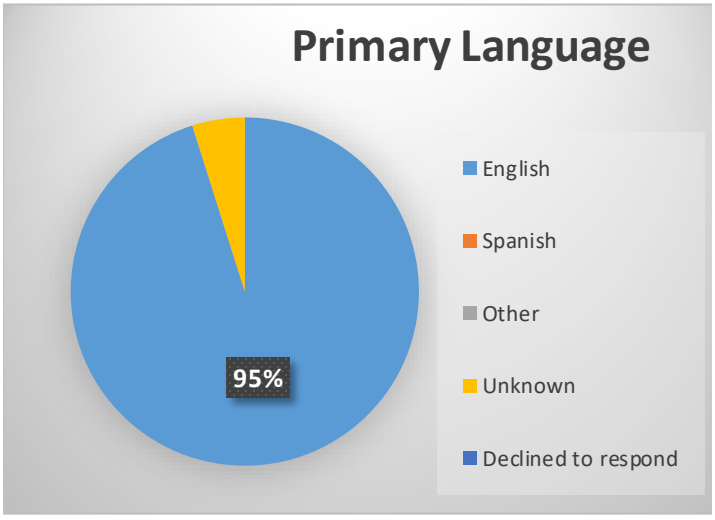
FY 2020-2021
Program Demographics:











WCCS Senior Peer Counseling

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM IMFORMATION

Program Name: Senior Peer Counseling
Population served: Adults ages 55+ throughout Sonoma County
Website: www.westcountyservices.org/senior-peer-counseling-older-adult-collaborative/
Phone: (707) 823-1640 x301
Program location: Santa Rosa, CA

PROGRAM DESCRIPTION:

Senior Peer Counseling is supportive counseling (not therapy) between two people who have something in common. Our Senior Peer Counselors provide goal-oriented counseling on a short-term basis to address problems and life adjustments. Emphasis is on developing coping skills and expanding one's knowledge and use of resources. The program strives to reach at-risk seniors before they experience crisis, helping them to remain self-sufficient, independent, and out of the institutional care system. WCCS works with clients to instill hope and promote wellness through providing in home peer support as well as groups accessibly located in different areas of the County.
Volunteer Senior Peer Counselors are caring individuals who offer listening and support to help other seniors share concerns, and gain a healthier perspective and better emotional balance. 12 sessions of supportive counseling is offered free of cost (services currently offered remotely via telephone/Zoom or FaceTime).

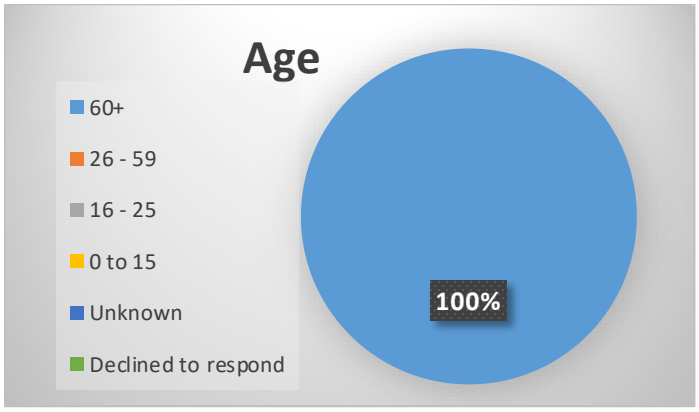
PROGRAM STATISTICS

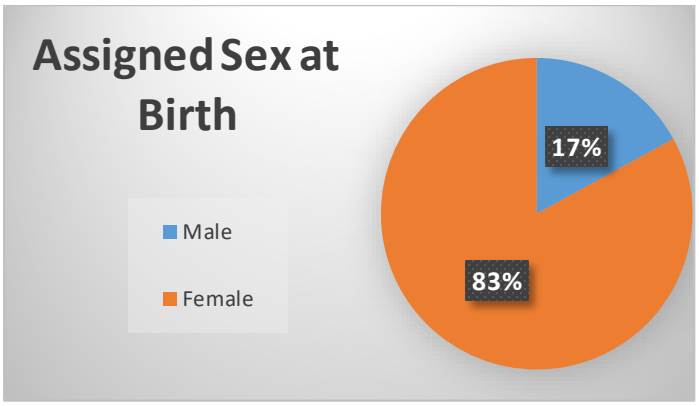
- **Total number of clients served:** 94
- **Total number of encounters:** 1047
- **Approximate numbers reached through outreach:** Unknown

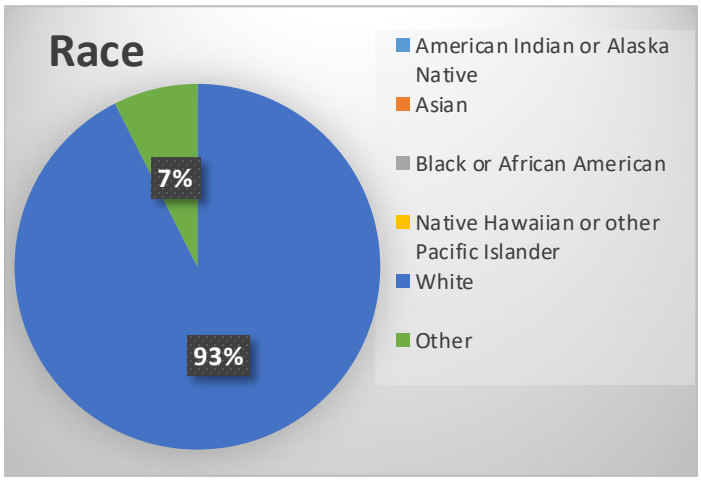
PROGRAM ACCOMPLISHMENTS:

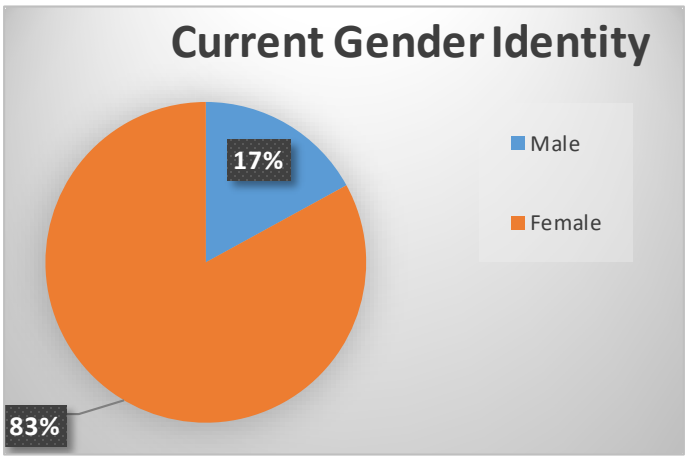
- "Your organization is a real-life saver for seniors struggling with various challenges of aging. You are doing an amazing job. You are immensely helpful & right on target! Thank you with all my heart for your dedication, expertise & generosity."
- "I gained tools and different ways to look at and maneuver through situations & issues. This experience was wonderful and very helpful. Thank you."
- "My counselor gave me positivity and hope."
- 75% of clients showed improvement on the Geriatric Depression Scale administered at the beginning and end of services.
- 100% of individual clients reported being satisfied with the services they received through the Senior Peer Counseling Program.

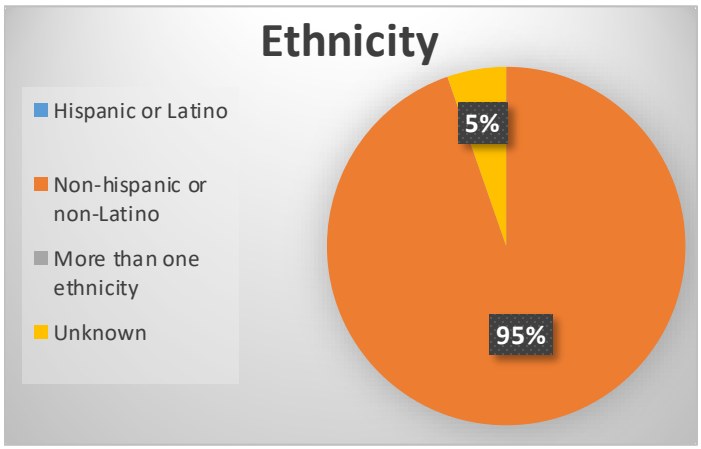
FY 2020-2021 Program Demographics:

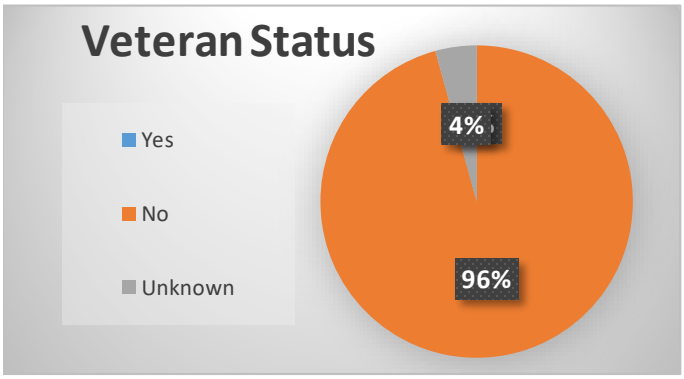


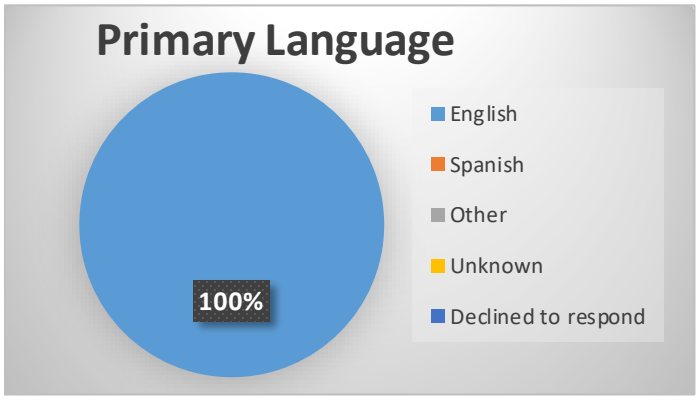


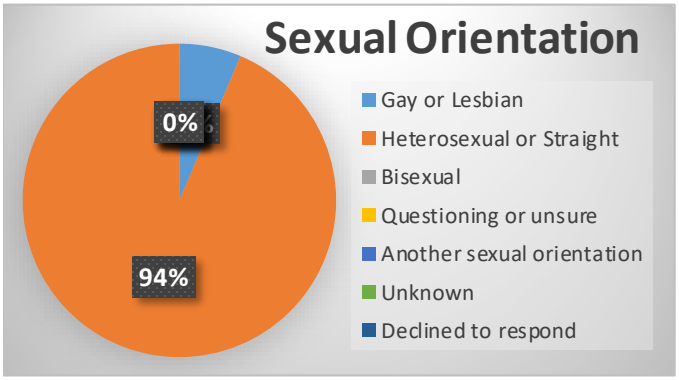












MHSA Component: Community Services & Supports (CSS)

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

DHS-BHD Medication Support Services for Adult Programs

Takes Action FOR MENTAL HEALTH

MENTAL HEALTH SERVICES ACT PROPOSITION 63 CALIFORNIA
WELLNESS • RECOVERY • RESILIENCE

Service Category: *General System Development*

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM DESCRIPTION:

Describe The Adult Medication Support Service (Med Support) provides psychiatric and medication services to residents of Sonoma County who meet Medi-Cal guidelines for Target Population. Clients are referred to Med Support from the SCBH Access team, after a thorough assessment using the Adult Needs and Strengths Assessment has shown that the client requires this level of care. Med Support clients are linked to psychiatric services and receive psychiatric assessments and treatment, including psychiatric RN support, medication management, monitoring, and coordination. In cases where the Med Support clients are open to other SCBH mental health programs, Med Support staff coordinates care as necessary with the client's primary SCBH case manager. Periodically, staff from the Med Support program may provide other specialty mental health services, including case management, mental health services, and crisis intervention on an as needed basis.

PROGRAM IMFORMATION

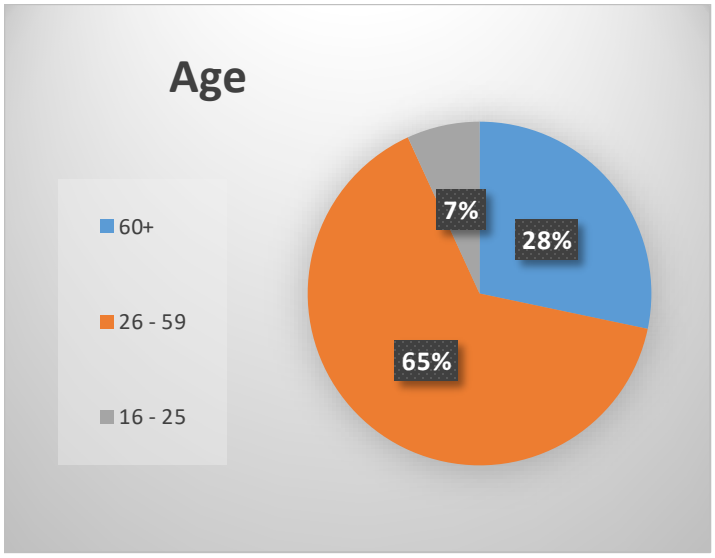
Program Name: DHS-BHD Medication Support Services for Adult Programs
Population served: Adults (18 years and older) in Sonoma County who meet Medi-Cal guidelines for Target Population. Clients must be referred through the Access team after an Adult Needs and Strengths Assessment.
Phone: (707) 565-6900

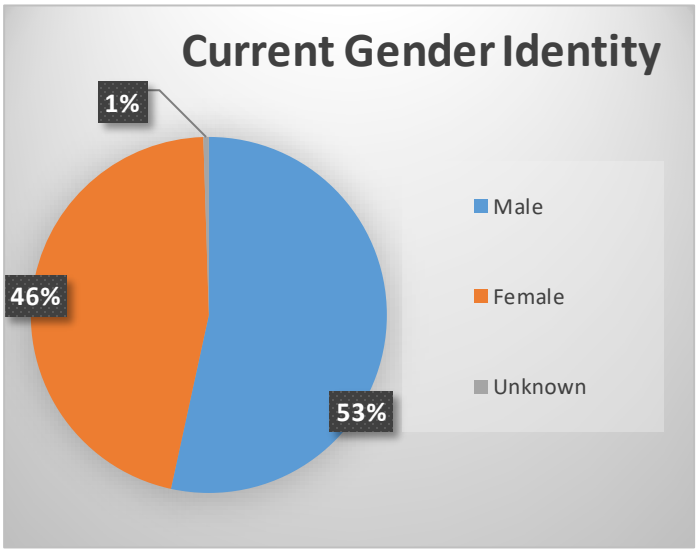
PROGRAM STATISTICS

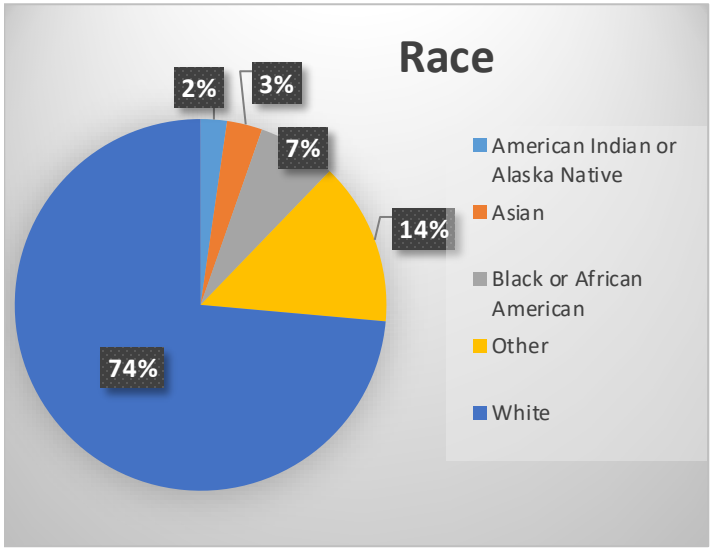
- **Total number of clients served:** 1,007

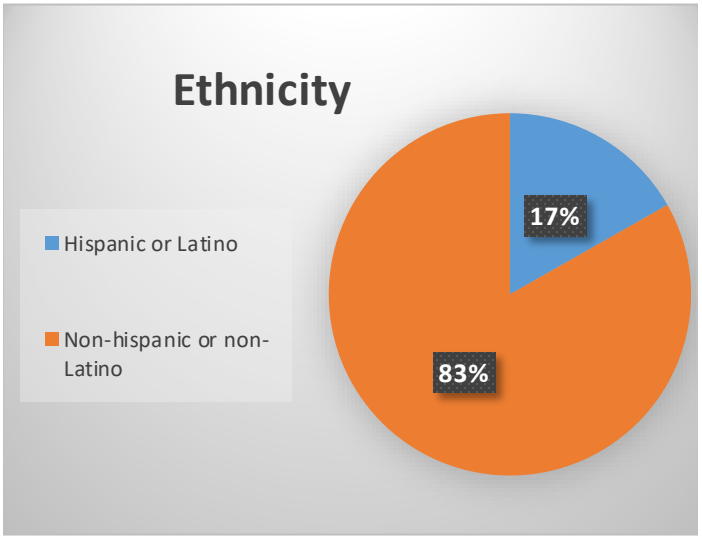
sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

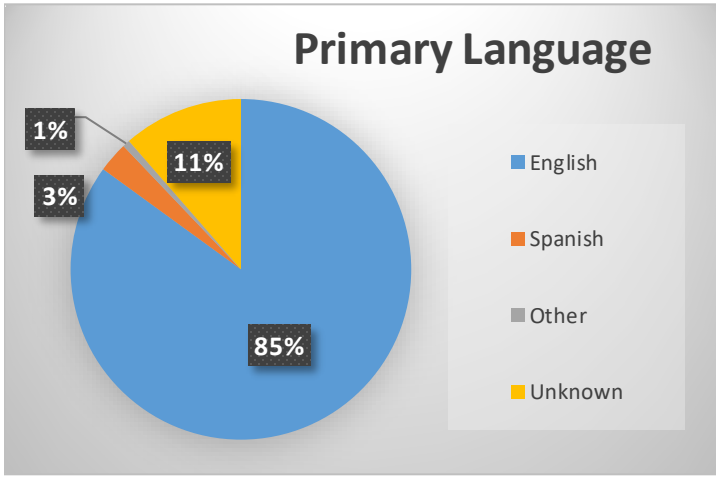
FY 2020-2021
Program Demographics:











MHSA Component: Community Services & Supports (CSS)

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

DHS-BHD Medication Support Services for Youth Programs

Takes Action FOR MENTAL HEALTH

MENTAL HEALTH SERVICES ACT PROPOSITION 63 CALIFORNIA
WELLNESS • RECOVERY • RESILIENCE

Service Category: *General System Development*

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM STATISTICS

- **Total number of clients served:** 489

PROGRAM DESCRIPTION:

The Youth Medication Support Service (Youth Med Support) is a separate outpatient program which provides psychiatric and medication services to Sonoma County youth who meet Medi-Cal guidelines for Target Population. Clients are referred to Med Support from the SCBH Access team, after a thorough assessment using the Child and Adolescent Needs and Strengths (CANS) has shown that the client requires this level of care. Youth Med Support clients are linked to psychiatric services and receive psychiatric assessments and treatment, including psychiatric RN support, medication management, monitoring, and coordination. In cases where the Youth Med Support clients are open to other SCBH mental health programs, Youth Med Support staff coordinates care as necessary with the youth's primary SCBH case manager. Periodically, staff from the Youth Med Support program may provide other specialty mental health services, including case management, mental health services, and crisis intervention on an as needed basis.

PROGRAM IMFORMATION

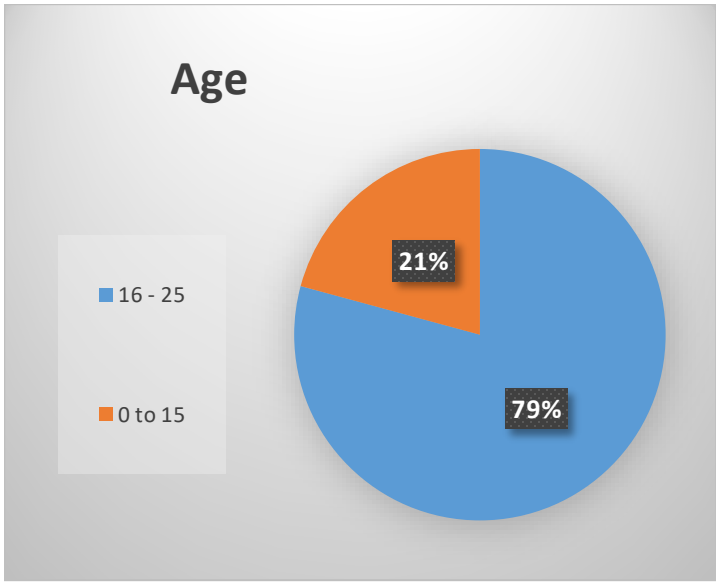
Program Name: DHS-BHD Youth Medication Support Service (Youth Med Support)

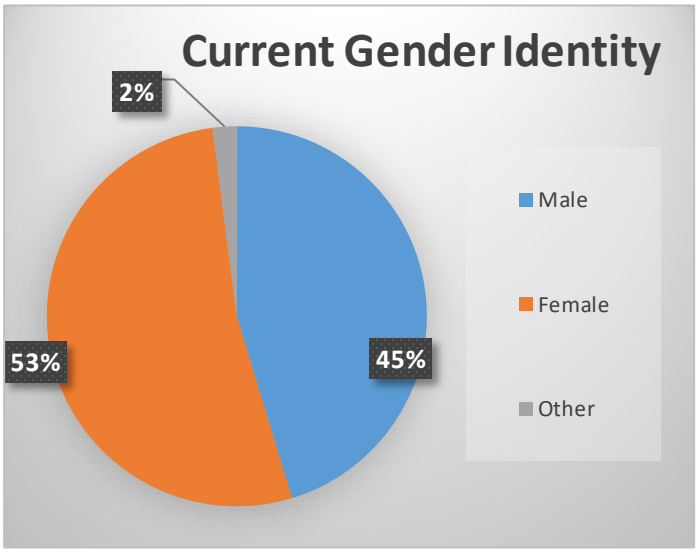
Population served: Youth in Sonoma County who meet Medi-Cal guidelines for Target Population. Clients must be referred through the Access team after an Child and Adolescent Needs and Strengths (CANS).

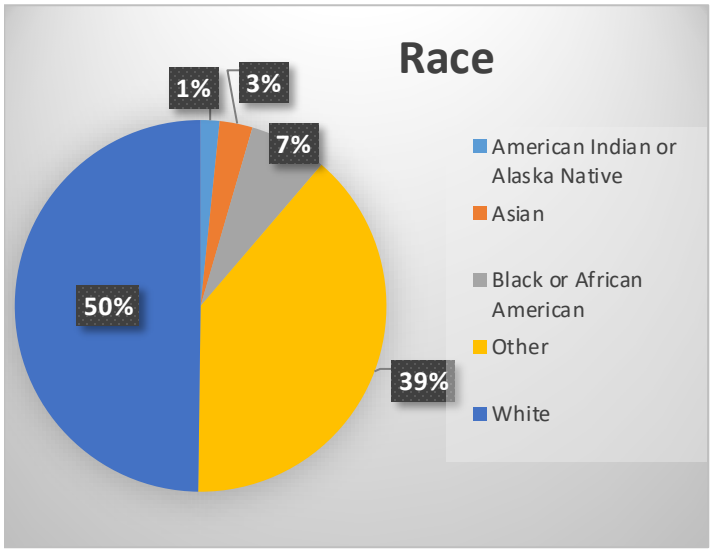
Phone: (707) 565-6900

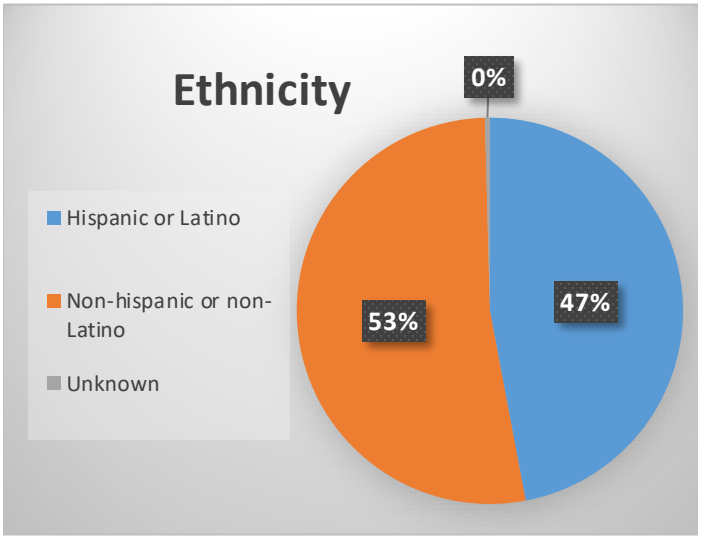
sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

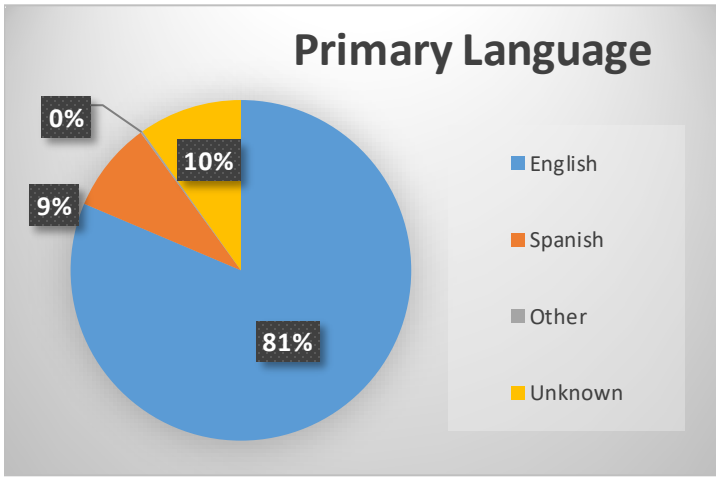
FY 2020-2021
Program Demographics:











MHSA Component: Community Services & Supports (CSS)

Council On Aging's Senior Peer Support

Service Category: *Full Service Partnership Services*

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM INFORMATION

Program Name:
Council on Aging
Senior Peer Support
Population served: Sonoma Count
Adults, age 60+
Website: councilonaging.com
Phone: (707) 525-0143
Program location:
Home Visits and Community Locations
Social Media: Facebook, Twitter:
@councilonaging.sonoma
@SonomaCOA

PROGRAM DESCRIPTION:

The Senior Peer Support program offers confidential, no-cost support to older adults in Sonoma County who are experiencing mental health challenges related to aging. Community volunteers who have faced similar concerns receive training and supervision from a licensed mental health professional as they are matched with clients to offer structured one to one emotional support, guidance and empathy to those confronting mood disorders, the death of a spouse, the stress of an illness, isolation from family and friends, or other life transitions. Volunteers visit with their "matches" over a 12 week session to discuss progress toward mutually agreed upon goals.

PROGRAM STATISTICS

- **Total number of clients served:**
  66 Clients
  16 Volunteers
- **Total number of encounters:**
  603
- **Approximate numbers reached through outreach:**
  8000

PROGRAM ACCOMPLISHMENTS:

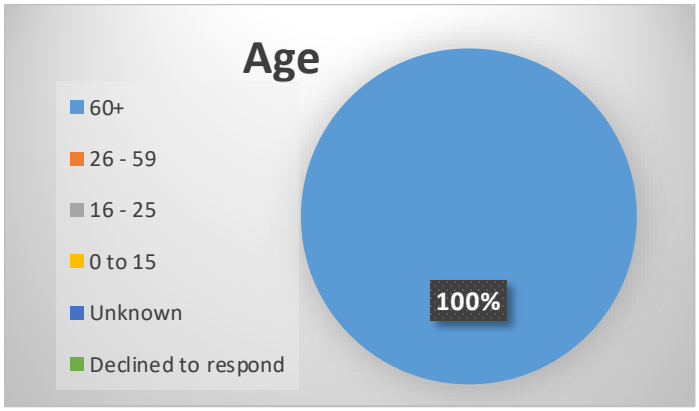
From our clients:

"Thank you for being who you are and providing a safe and supportive space."

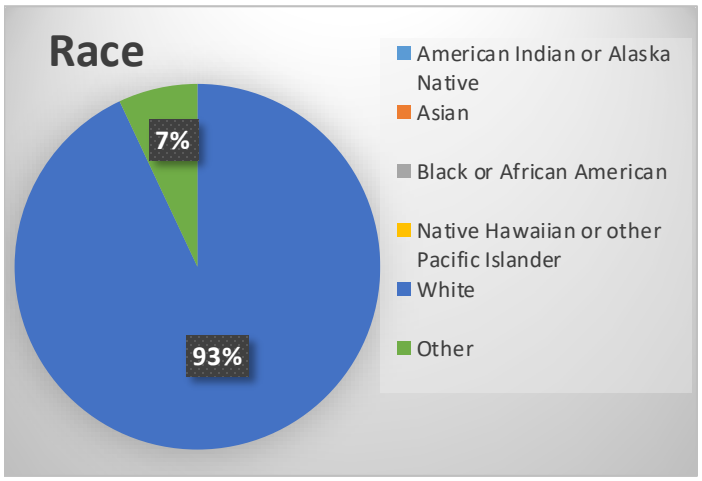
"I just want to say that I am really grateful to have been a part of the group and it put me out into the world. I think it's a great program!"

FY 2020-2021 Program Demographics:

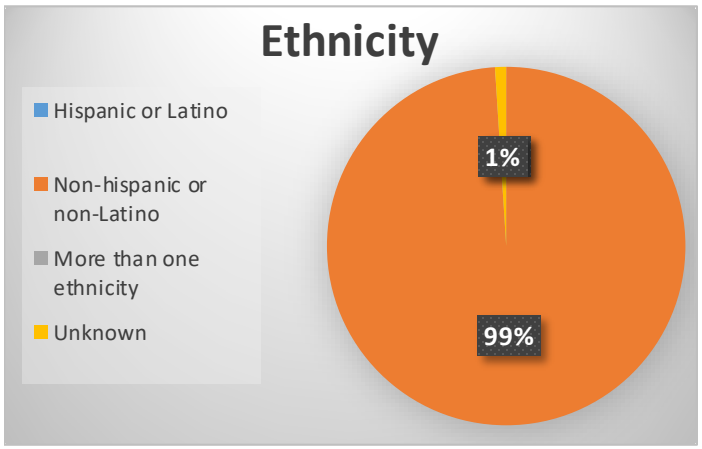
Age



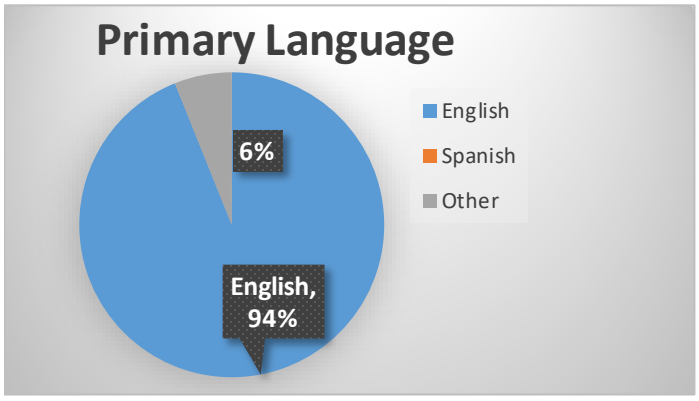
Race



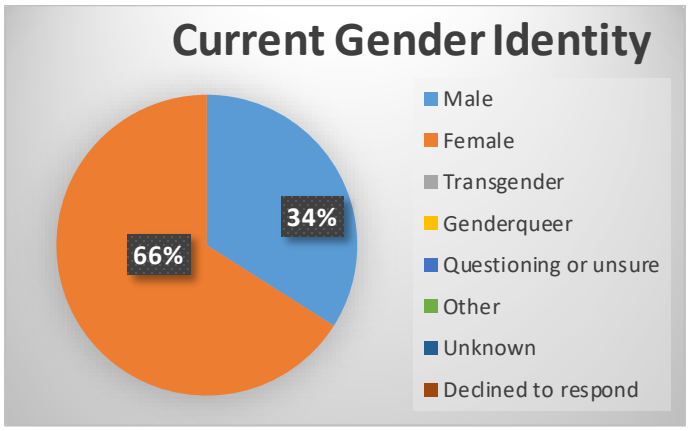
Ethnicity



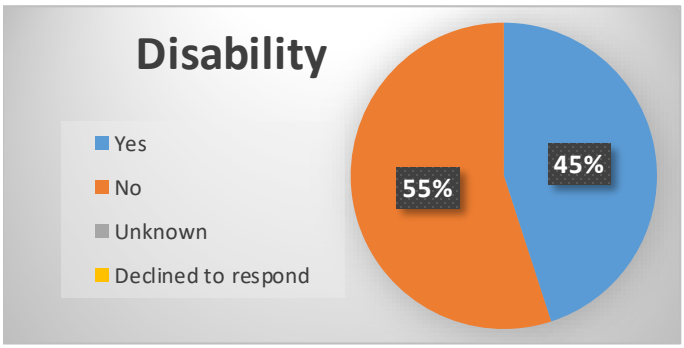
Primary Language



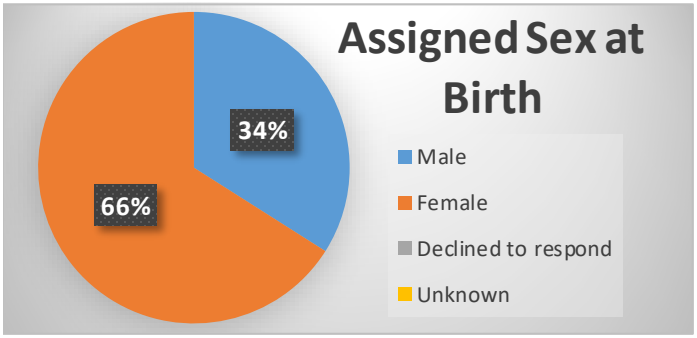
Current Gender Identity



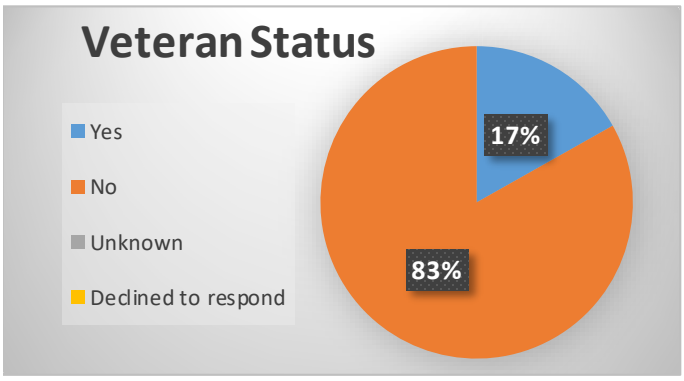
Disability



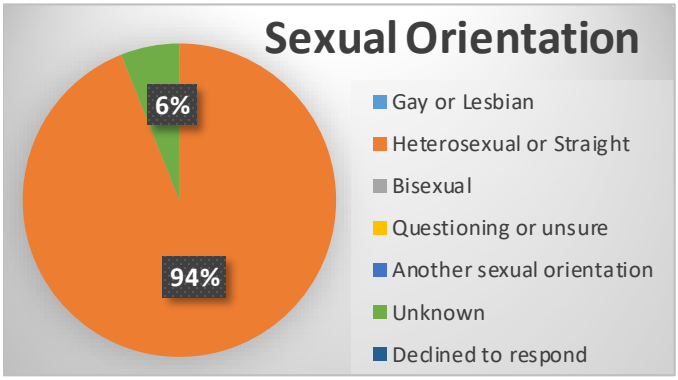
Assigned Sex at Birth



Veteran Status



Sexual Orientation



COMMUNITY SERVICES AND SUPPORTS (CSS)

Programs provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

General Systems Development (GSD)

A service category of the CSS component used to improve the County's mental health service delivery system for all clients and/or to pay for specified mental health services and supports for clients, and/or when appropriate their families.

MHSA Component: Community Services & Supports (CSS)

NAMI Sonoma County

Takes Action FOR MENTAL HEALTH

WELLNESS • RECOVERY • RESILIENCE

Service Category: *General System Development*

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM DESCRIPTION:

As an affiliate of the National Alliance on Mental Illness (NAMI), we help individuals affected by mental health conditions, and the family members who support them, to build a better quality of life through **education, support, awareness, and advocacy**. NAMI program leaders use their lived experience to increase knowledge and understanding. NAMI programs offer practical skills, caring connections, and hope. **All programs are free.**

- **Warmline** (866-960-6264; info@namisoco.org): A starting place when looking for information, support and local resources. *Se habla español*.
- **NAMI Family Support Groups / Grupo de Apoyo para Familiares:** For those supporting an adult with serious mental health challenges.
- **NAMI Connection Recovery Support Groups:** For adults in recovery, who live with mental health challenges.
- **NAMI Family-to-Family:** 8-week education program for family members of adults living with serious mental health challenges
- **NAMI Basics:** 6-week education program for those caring for a child or adolescent experiencing mental health symptoms.
- **NAMI Ending the Silence:** Presentation for youth. Shares mental health facts, myths, statistics, warning signs and steps to seeking help.
- **Family Support Referrals:** Follow-up outreach to family members referred by Sonoma County Behavioral Health Mobile Support Teams after a crisis, or the Youth & Family Services Team.

PROGRAM INFORMATION:

Program Name:
NAMI Sonoma County
Population served: Individuals and families affected by mental illness
Website: namisonomacounty.org
Phone: (866) 960-6264
Program Location:
182 Farmers Lane #202
Santa Rosa, CA 95405
Social Media:
@namisonoma
@namisoco

PROGRAM STATISTICS:

Encounters	**6,479** Total Encounters **2,601** through Outreach
Warmline	**4,491** total contacts **682** new callers **87** referred by MST or YFS
Support Groups (duplicated)	**1,014** Connection attendees **721** Family Group attendees

PROGRAM TESTIMONIALS:

"The **Family Support Group** is supportive, well run, warm, heartfelt, and informative."

"**Family-to-Family** allowed me to better understand what my loved one is experiencing and helped me feel less hopeless." "This organization is a treasure."

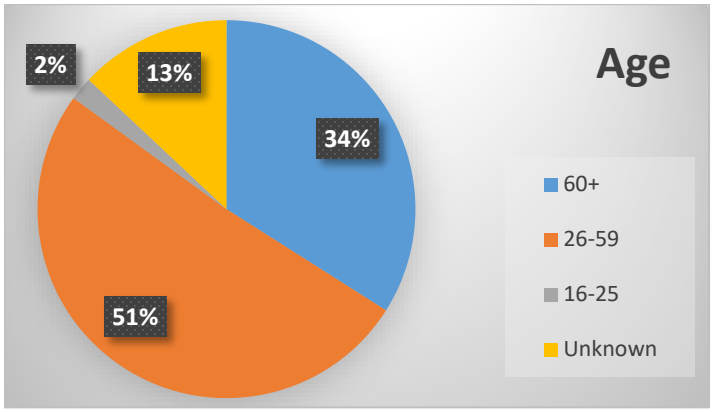
"The **Warmline** has been my saving grace. I felt stuck between my loved one and a system that fails her."

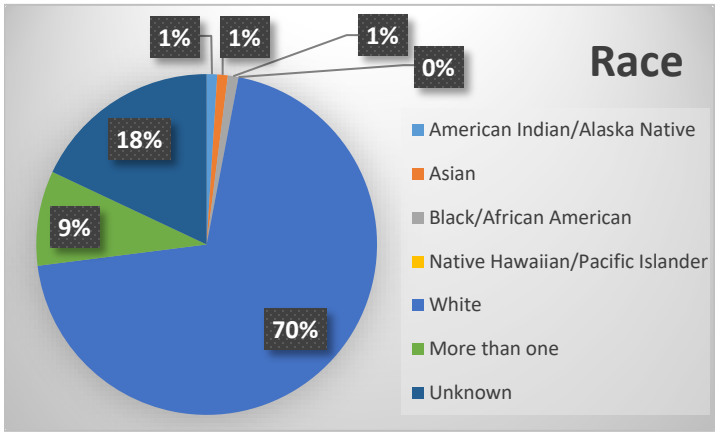
"**Ending the Silence** helped me understand how mental illness affects families. I come from a household where it's uncomfortable to talk about it."

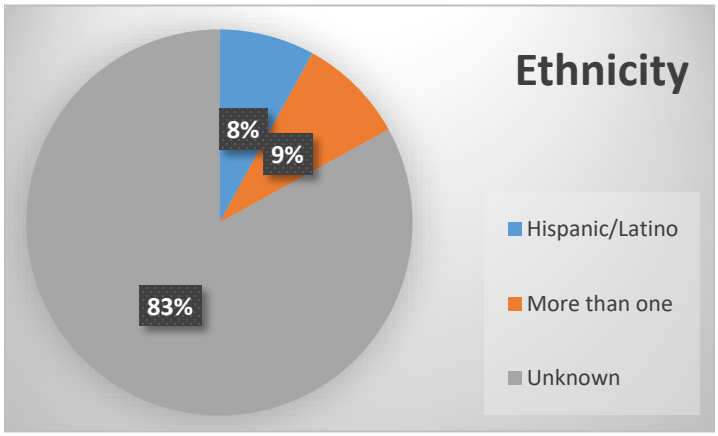
"It's so nice to be **understood and supported**, rather than isolated, by my loved one's illness."

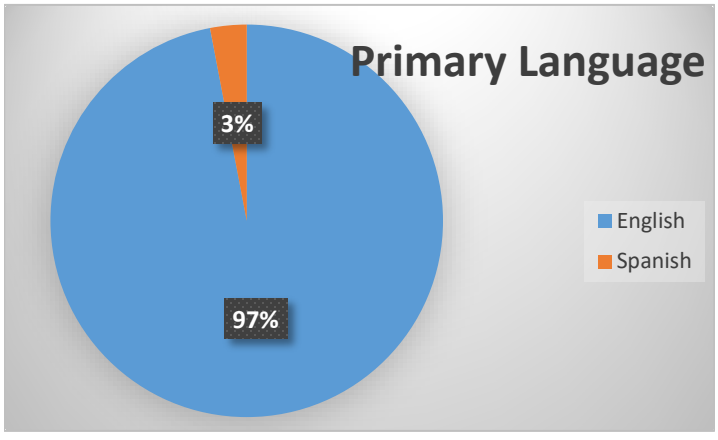
Sonoma County DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

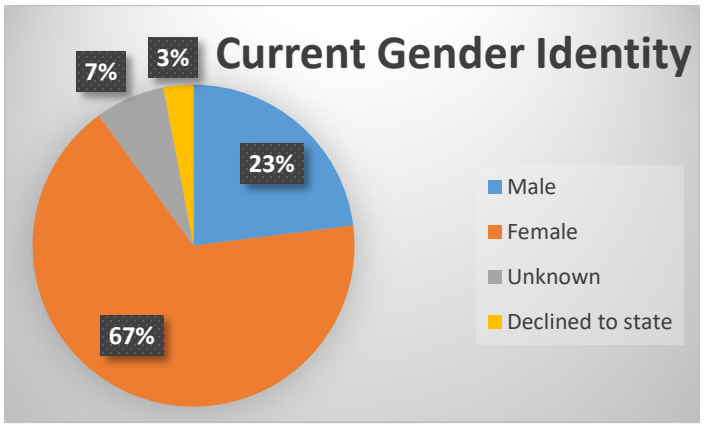
FY 2020-2021 Program Demographics:

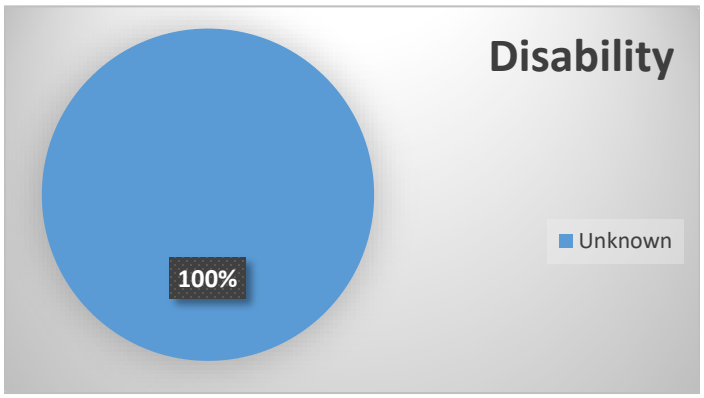


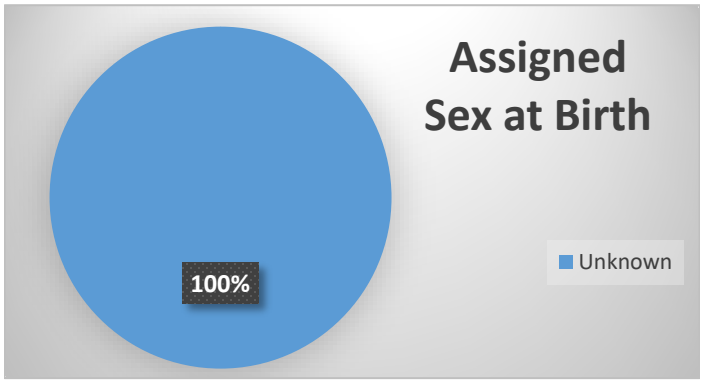


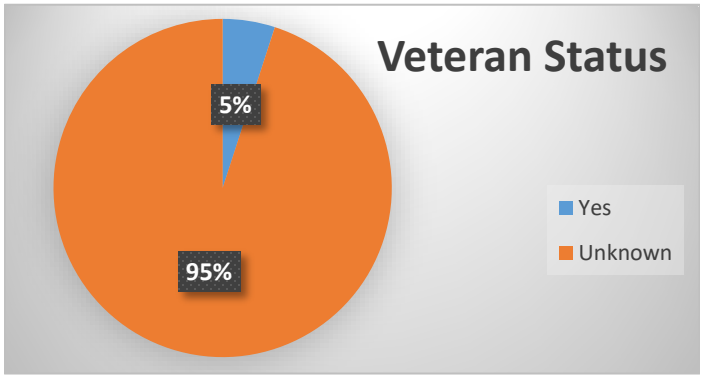


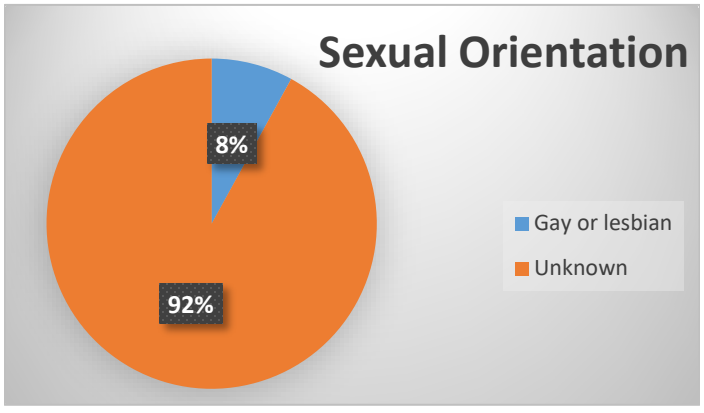












MHSA Component: Community Services & Supports (CSS)

The Empowerment Center

Takes Action for Mental Health

Wellness • Recovery • Resilience

Service Category: General System Development (GSD)

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM IMFORMATION

Program Name: Russian River Empowerment Center

Population served: Sonoma County Adults 18 years and older

Website: www.westcountyservices.org
Phone: (707)-823-1640 X 207
Program location:
9925 Main Street
Monte Rio, CA 95462
Social Media:
https://www.facebook.com/THE.RREC/

PROGRAM DESCRIPTION:

The Empowerment Center is a peer operated, self-help center sponsored by WCCS for people with chronic behavioral health challenges.

Our activities are provided by our members, peer staff members, and volunteers from the community. We share what we have learned during our own individual journeys to support each other in strengthening our mental health.

PROGRAM STATISTICS

- **Total number of clients served:** 162
- **Total number of encounters:** 2214
- **Approximate numbers reached through outreach:** 1005

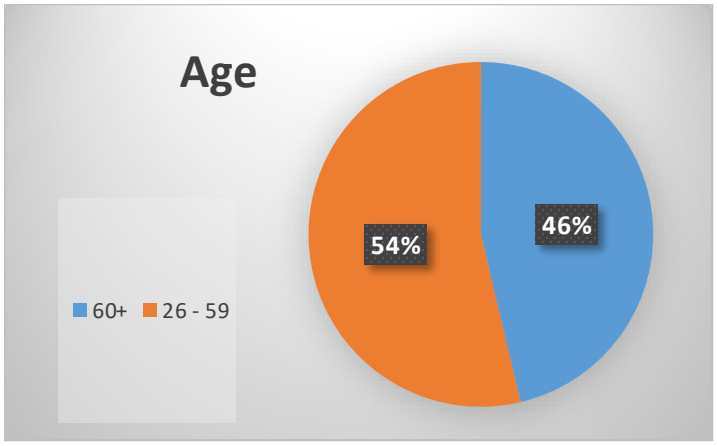
PROGRAM ACCOMPLISHMENTS:

The Empowerment Center facilitates groups, activities and workshops that provide opportunities to learn and build skills in particular areas of mental wellness. The Empowerment Center also provides a shuttle service and a warmline that offers support and resource information. It has been reported by members that participating in our offerings has assisted them with their mental health recovery and has also created an environment to interact with other members.

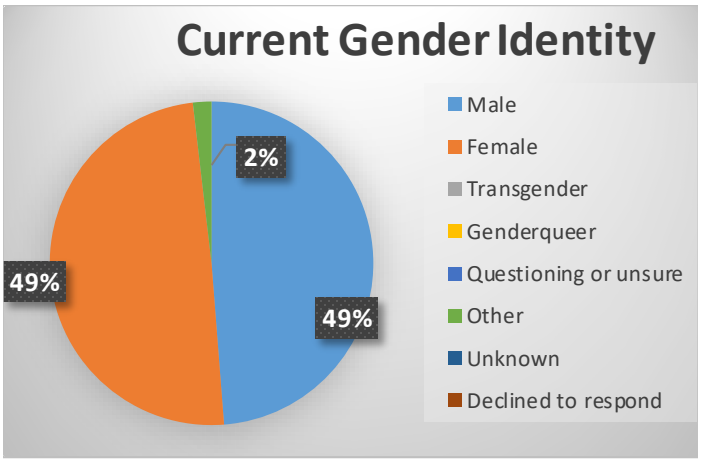
Sonoma County Department of Health Services
Behavioral Health Division

FY 2020-2021 Program Demographics:

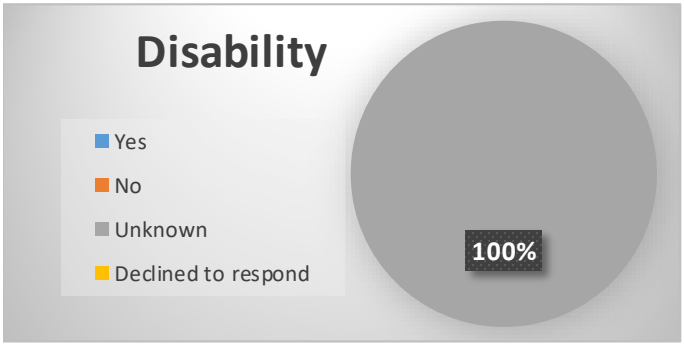
Age



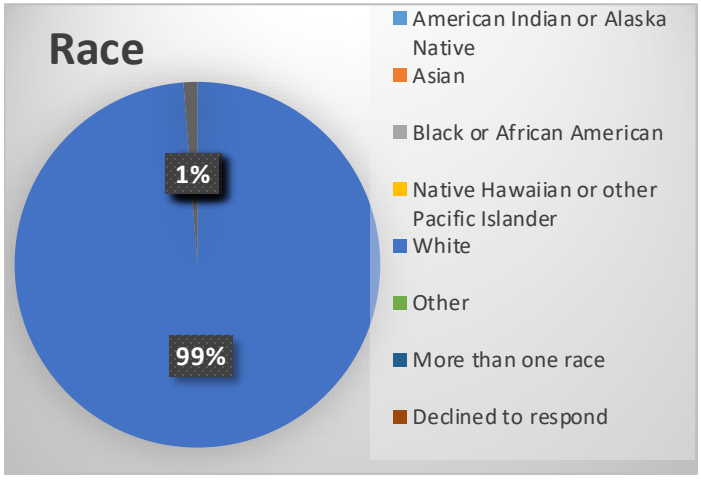
Current Gender Identity



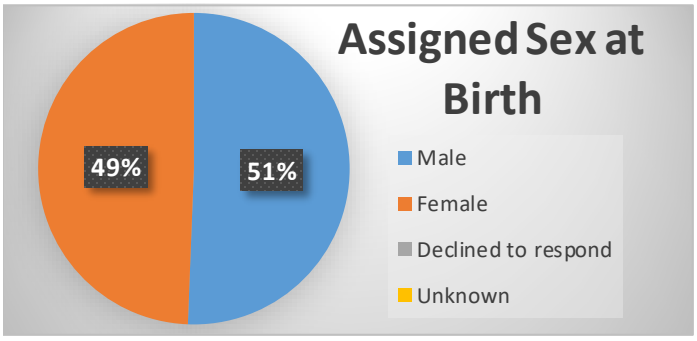
Disability



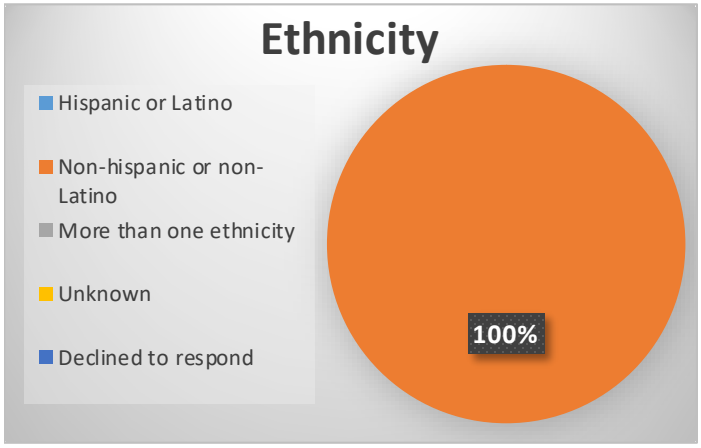
Race



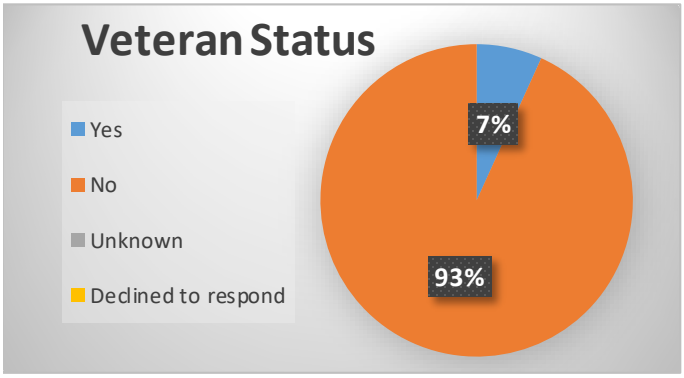
Assigned Sex at Birth



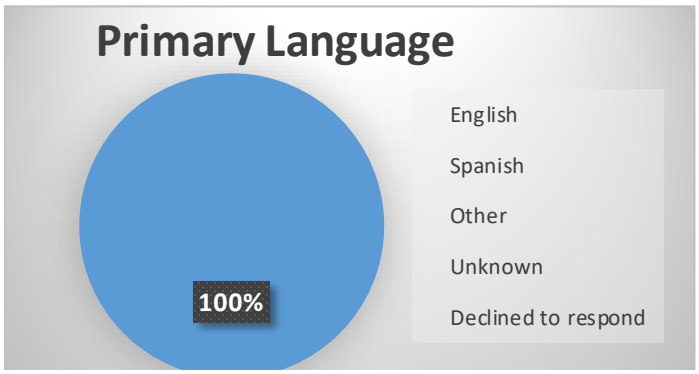
Ethnicity



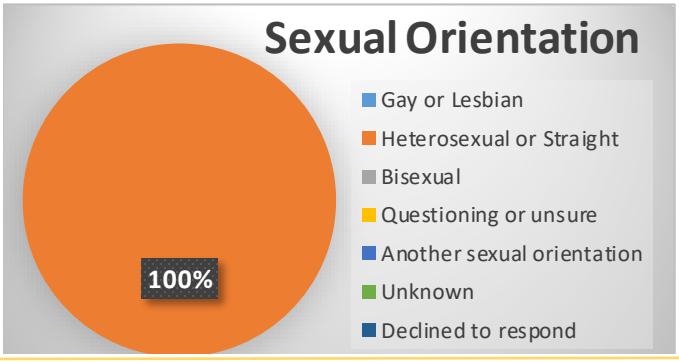
Veteran Status



Primary Language



Sexual Orientation



MHSA Component: Community Services & Supports (CSS)

WCCS Wellness & Advocacy Center

Takes Action FOR MENTAL HEALTH

WELLNESS • RECOVERY • RESILIENCE

Service Category: *General System Development*

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM IMFORMATION

Program Name: Wellness and Advocacy Center
Population served: Adults with mental health challenges
Website: www.wellnessandadvocacy.org
Phone: (707) 565-7800
Program location: 2245 Challenger Way, Ste 104 Santa Rosa, CA 95407
Social Media: https://www.facebook.com/wellnessandadvocacy.org

PROGRAM DESCRIPTION:

The Wellness and Advocacy Center provides a wellness, recovery, and support center for peers facing serious mental health challenges. The Center has a strong recovery orientation focusing on programs and services that will foster hope and empower individuals to take control of their lives, manage their most distressing difficulties, and enjoy meaningful lives as full members of their community. Services include Individual Peer Support, Self-Help Groups, Socialization Activities, Art Program, Career/Computer Lab, Resource Navigation, Showers, Laundry, and more.

PROGRAM STATISTICS

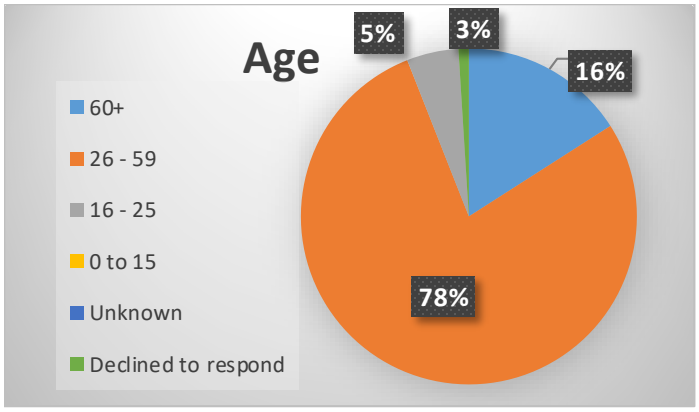
- **Total number of clients served:** 301
- **Total number of encounters:** 16336
- **Approximate numbers reached through outreach:** 288

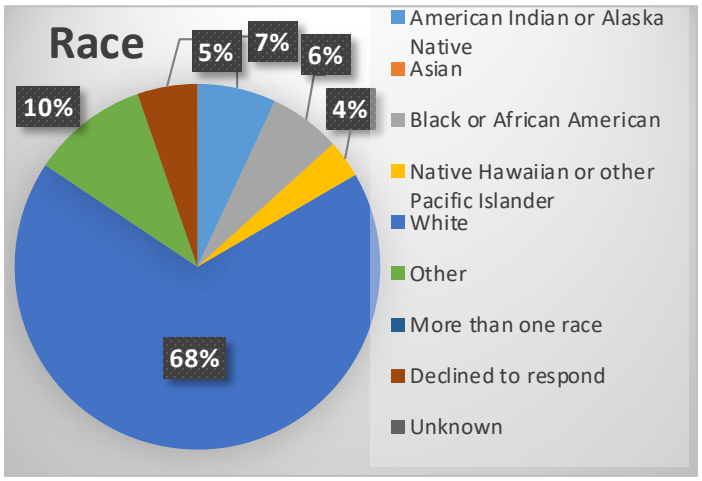
PROGRAM ACCOMPLISHMENTS:

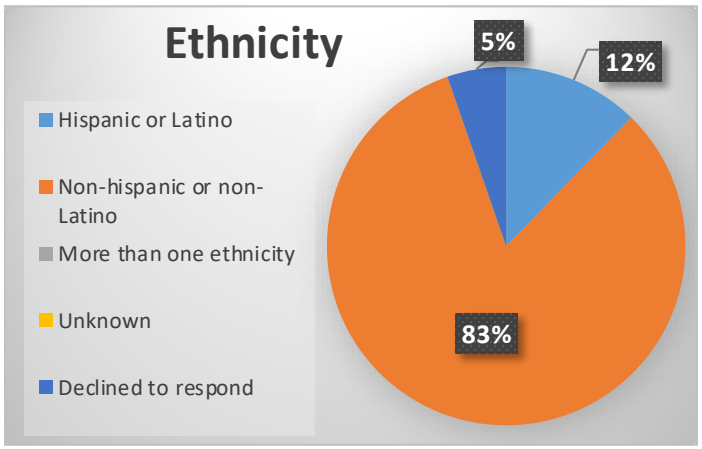
During the ongoing COVID-19 pandemic, the Wellness and Advocacy Center provided essential mental health services with limited on-site services and online support groups as well as warmline support. On-site services included peer support provided outside, showers, laundry, an electronic device charging station, access to computers, and access to a telephone. These on-site services were primarily accessed by members experiencing homelessness with 70% of the members utilizing the center in FY 2020-2021 identifying as homeless. At our peak of online services, we offered 14 support groups per week on Zoom. In June, we opened at 50% capacity for all on-site services including in person groups and one to one peer support services.

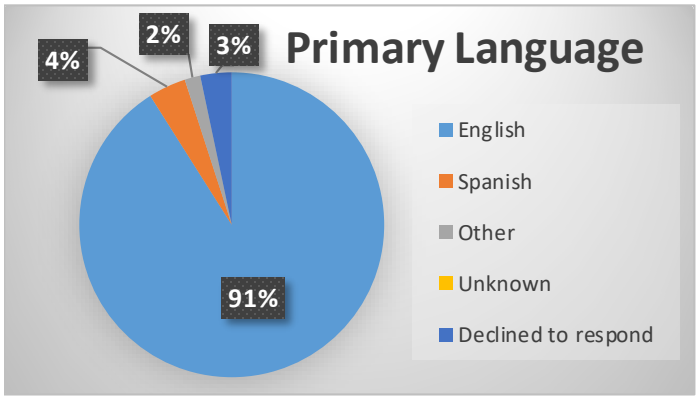
sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

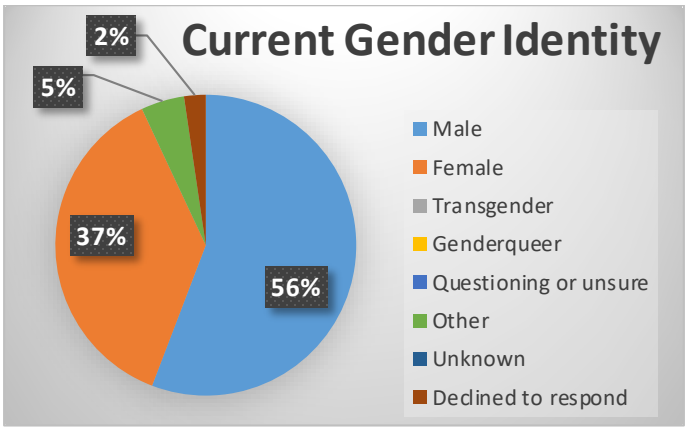
FY 2020-2021 Program Demographics:

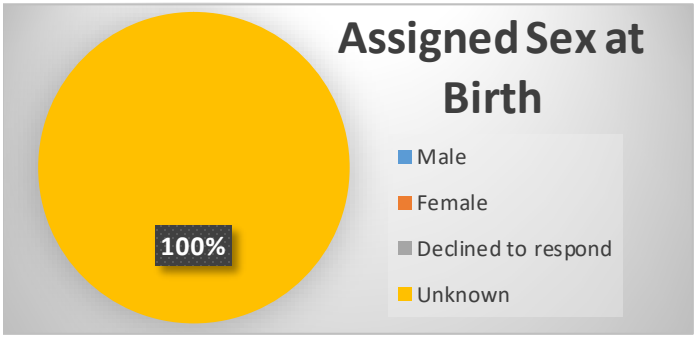


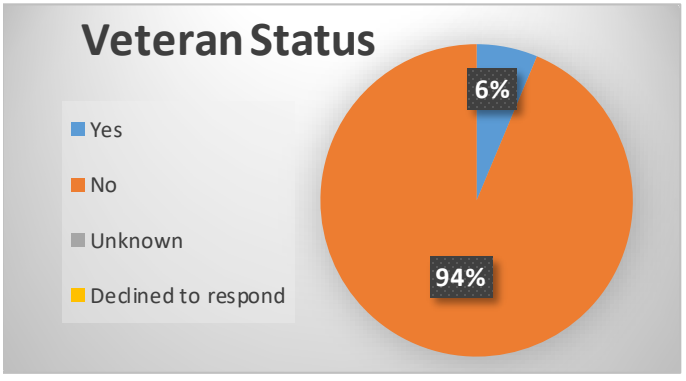


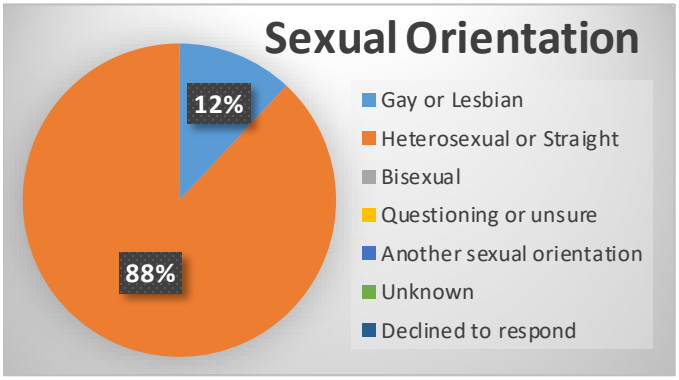












MHSA Component: Community Services & Supports (CSS)

WCCS Petaluma Peer Recovery Center

Takes Action FOR MENTAL HEALTH

WELLNESS • RECOVERY • RESILIENCE

Service Category: *General Systems Development (GSD)*

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM IMFORMATION

Program Name: Petaluma Peer Recovery Center (PPRC)

Population served: Adults facing their own mental health challenges in the Petaluma area.

Website: https://petalumaprp.wordpress.com/

Phone: (707) 565-1299

Program location: 5350 Old Redwood Highway; Suite 600, Petaluma, CA

PROGRAM DESCRIPTION: The Petaluma Peer Recovery Center (PPRC) is a peer run and managed program dedicated to empowering the local adult mental health consumer community through peer support and education. We provide a number of opportunities for connection including one-to-one and group support, monthly forums, socialization activities and help with resource navigation. We have instruments and art and craft supplies for group and individual creative pursuits. We offer in person support onsite and virtual support via Zoom as well as warmline services during our open hours on Mondays, Wednesdays and Thursdays.

PROGRAM STATISTICS

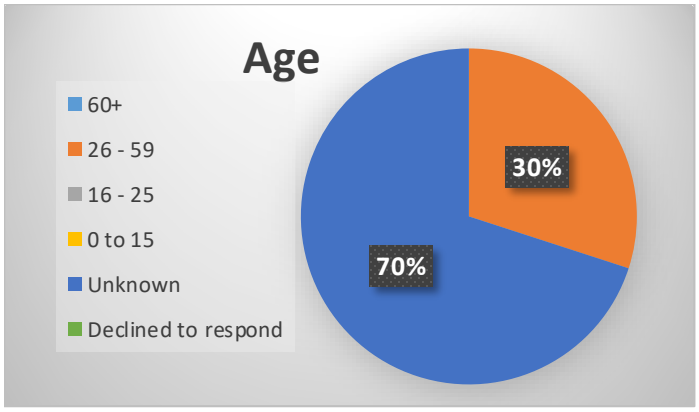
- **Total number of clients served:** 60
- **Total number of encounters:** 466
- **Approximate numbers reached through outreach:** 590

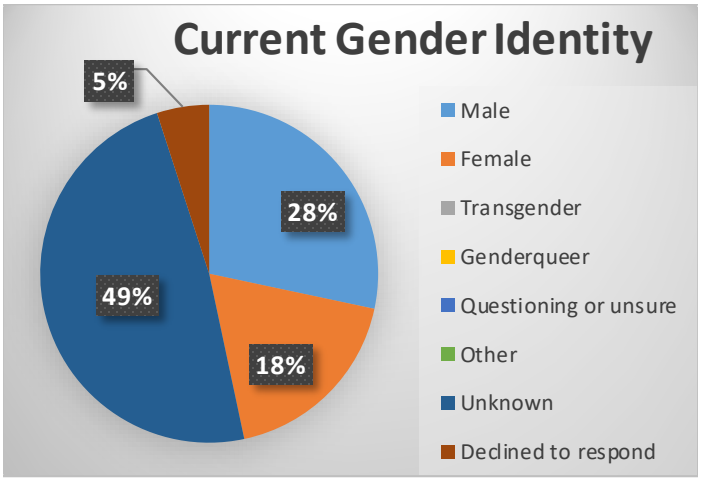
PROGRAM ACCOMPLISHMENTS: Despite COVID restrictions and realities we were able to provide services throughout the year and found some creative ways to offer support. Participants regularly shared gratitude for the ability to connect with staff via the telephone, on Zoom, socially distanced outside, and eventually inside the Center in June. We supported some members to move through technological challenges around participating in virtual support groups. As per participant request, we offered one to one support via Zoom as many found this more comfortable than being in a virtual group. At times a participant would call then go online in tandem with a staff member, navigate to the same website and then go over recovery resources. One participant called for support when trying new recipes and would call while preparing to go out in the world and shop, and again to report the results. Many Participants reported that the process of getting support including having someone to share successes with was much appreciated and meaningfully supportive, particularly during these isolating times.

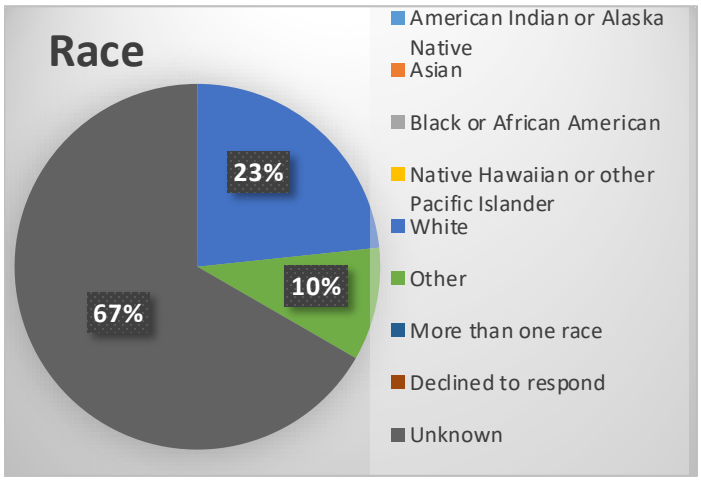
"I really appreciate our conversations." "You make me feel like I'm important." "My husband appreciates your support."

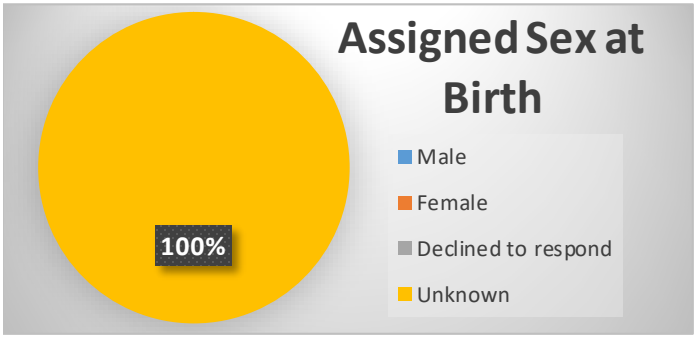
Sonoma County DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

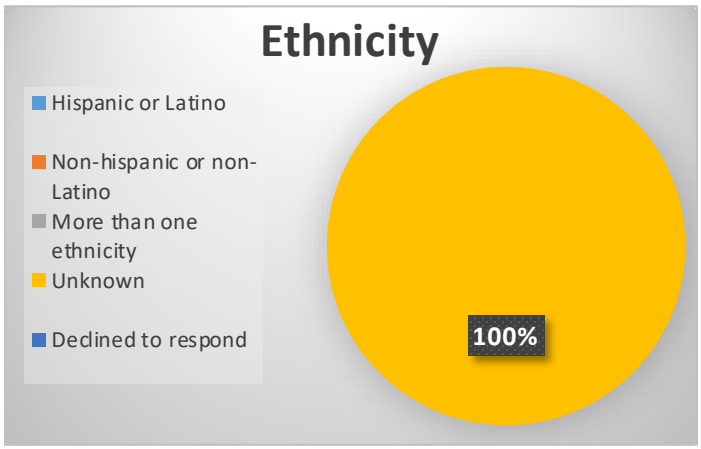
FY 2020-2021 Program Demographics:

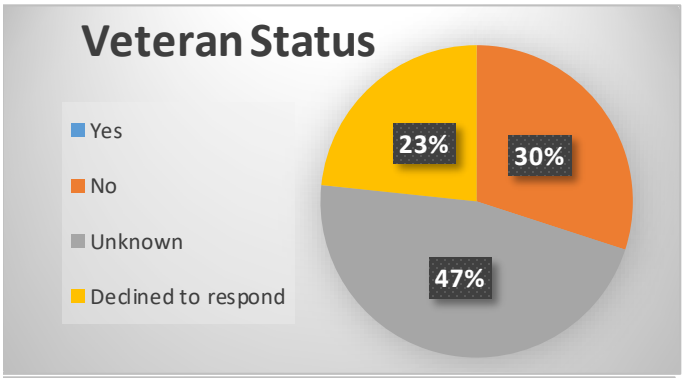


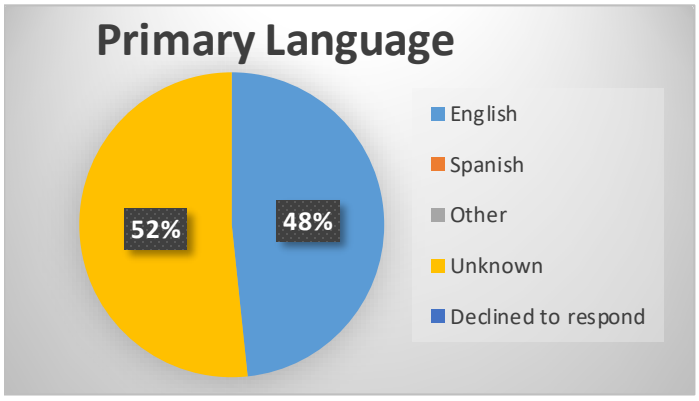


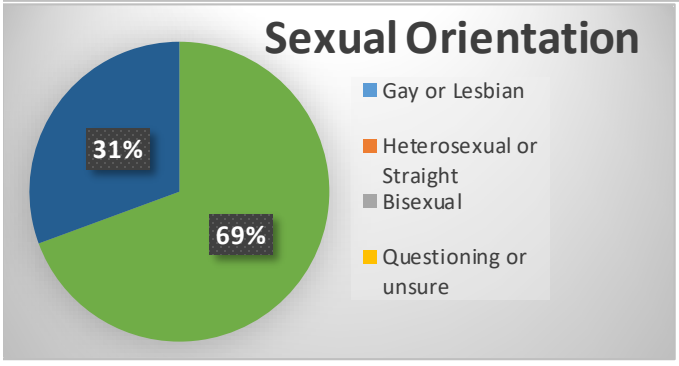












MHSA Component: Community Services & Supports (CSS)

Mobile Support Team (MST)

Takes Action FOR MENTAL HEALTH

WELLNESS • RECOVERY • RESILIENCE

Service Category: General Service Development

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM DESCRIPTION:

Sonoma County's Mobile Support Team (MST) is a partnership with the Santa Rosa Police Department, Sebastopol Police Department, Cotati Police Department, Rohnert Park Police Department, Petaluma Police Department, Santa Rosa Junior College District Police, and the Sonoma County Sheriff's Office, and Support Our Student (SOS) MST Interns. MST provides field-based support to requesting law enforcement officers responding to a behavioral health crisis.

We are staffed by licensed mental health clinicians, certified substance abuse specialists, post-graduate registered interns, mental health consumers, and family members who:

- Receive specialized field safety training by law enforcement partners.
- Are available during peak activity hours and days as informed by ongoing data review and coordination with law enforcement agencies.
- Participate in law enforcement shift briefings to maintain open communication.

When MST responds and the scene is secured, staff provides mental health and substance use disorders interventions to individuals experiencing a behavioral health crisis, including an evidence-based assessment that assists in determining if the individual should be placed on an involuntary hold.

MST provides crisis intervention, support, and referrals to medical and social services as needed.

Follow-up services are provided to help link community members to ongoing care and treatment to mitigate future crisis.

PROGRAM INFORMATION

Program Name: Mobile Support Team (MST)

Areas served: Santa Rosa, Windsor, Rohnert Park, Cotati, Petaluma, Sonoma Valley, Guerneville (Triage Grant funded service area), Forestville (Triage Grant funded service area), Sebastopol (Triage Grant funded service area)

Website: https://sonomacounty.ca.gov/Health/Behavioral-Health/Community-Response-and-Engagement/Mobile-Support-Team

Phone: (707) 565-4850
To request services: (707) 565-6900

PROGRAM STATISTICS

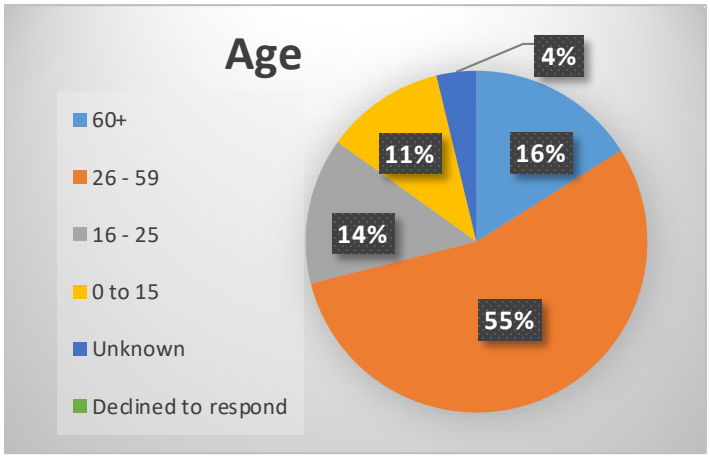
- **Total unique clients served by MST in FY 20-21: 318**
- **Total number of encounters conducted by MST in FY 20-21: 765**

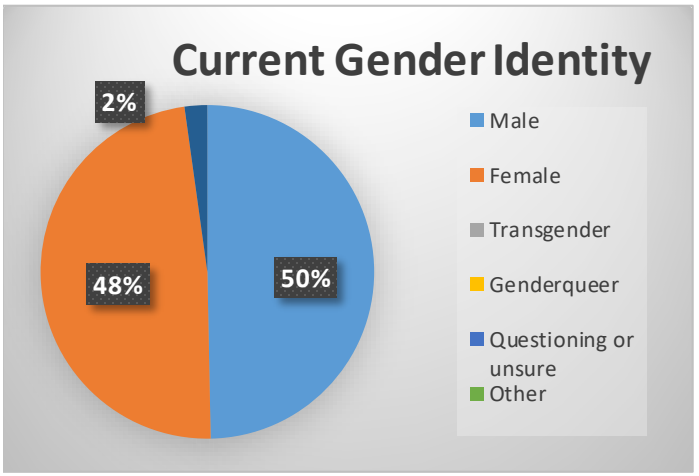
PROGRAM GOALS

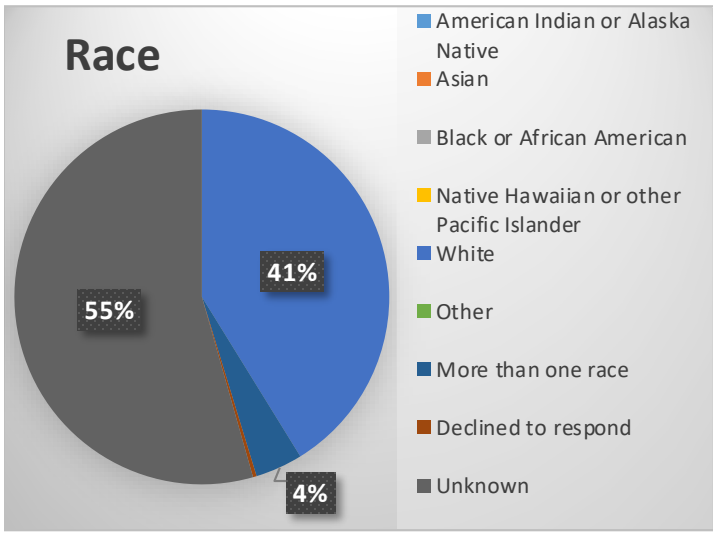
- Promote the safety and emotional stability of community members experiencing behavioral health crises.
- Minimize further deterioration of community members experiencing behavioral health crises.
- Help community members experiencing crises to obtain ongoing care and treatment.
- Prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate.

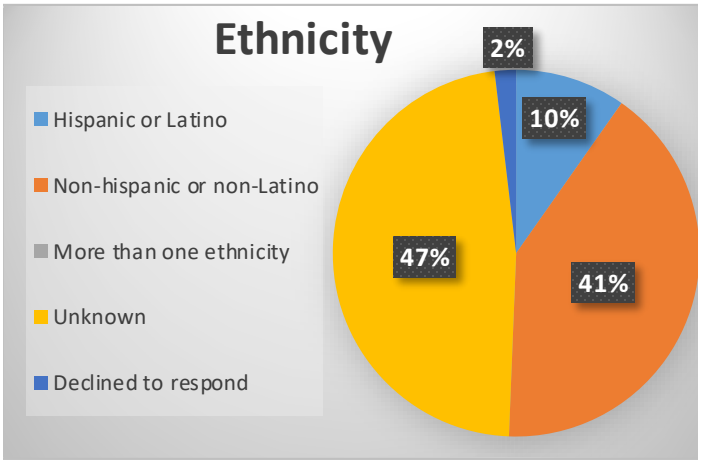
sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

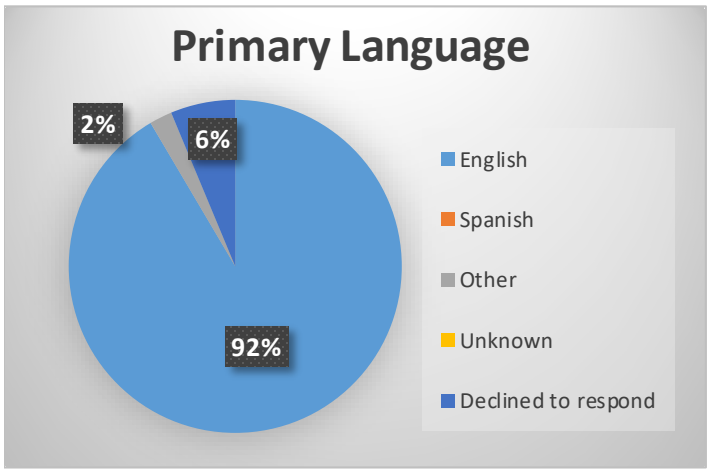
FY 2020-2021
Program Demographics:

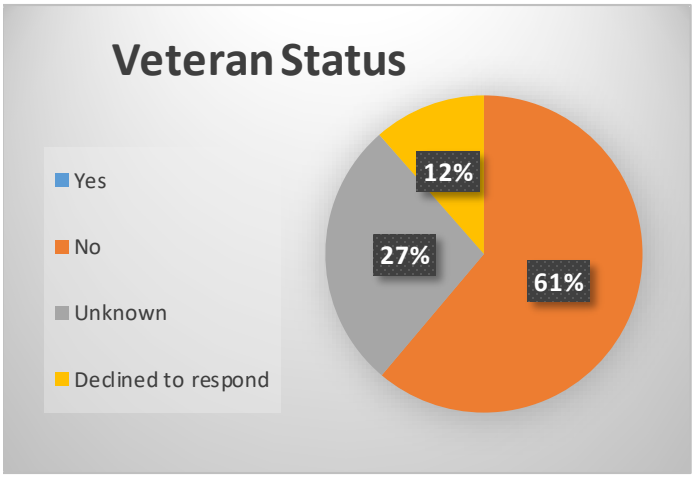












MHSA Component: Community Services & Supports (CSS)

WCCS Crisis Support

Takes Action FOR MENTAL HEALTH

WELLNESS • RECOVERY • RESILIENCE

Service Category: *General System Delivery*

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM IMFORMATION

Program Name: Crisis Support

Population served: Adult Individuals & Families in the Lower Russian River Community

Website: https://westcountyservices.org/

Phone: (707) 823-1640

Program location: Lower Russian River in Sonoma County

PROGRAM DESCRIPTION:

West County Community Services (WCCS) Crisis Support is offered through housing and resource counseling and resource referrals. Needs for individuals and families with children are assessed and prioritized. Immediate financial, food, clothing, and resource assistance are offered during meetings. Referrals for ongoing local support resources are identified and offered. The Counselor assists in filling out and submitting Season of Sharing applications.

PROGRAM STATISTICS

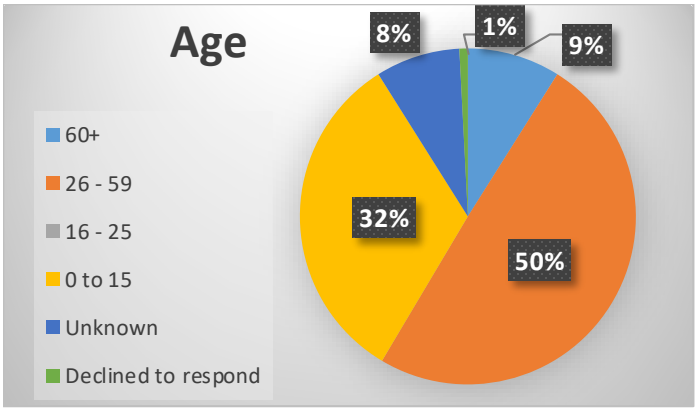
- **Total number of clients served:** 123
- **Total number of encounters:** 230
- **Approximate numbers reached through outreach:** 140

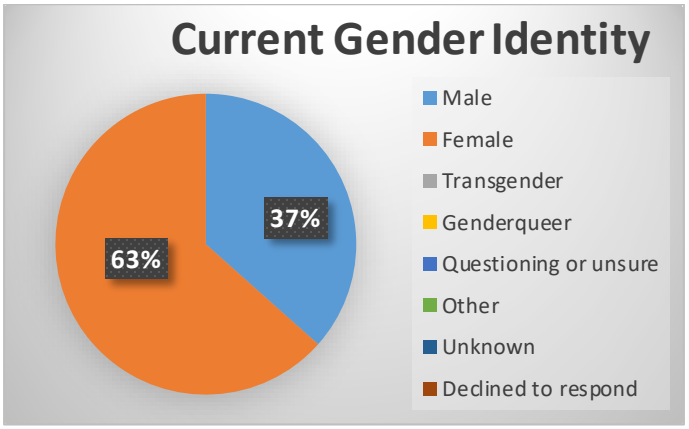
PROGRAM ACCOMPLISHMENTS:

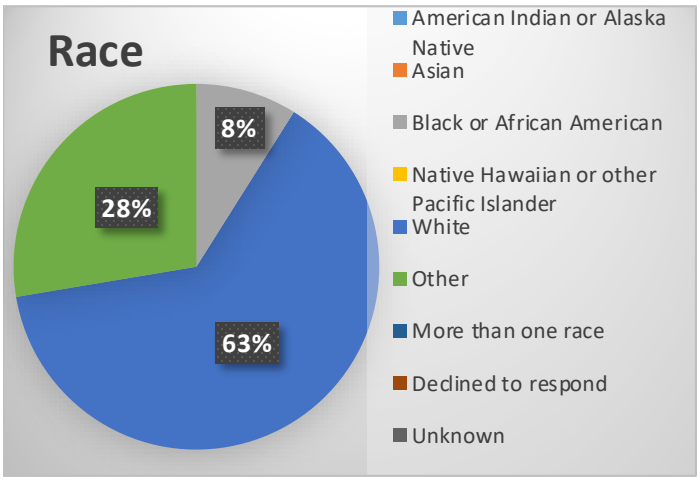
- 2 families received a gift card for their local super market.
- 1 senior was referred to our Senior Center food programs and case management.
- All clients received a list of food giveaways in their area.
- 2 families received summer clothes for their children.
- In collaboration with another program, holiday gifts were provided for 15 families with children.

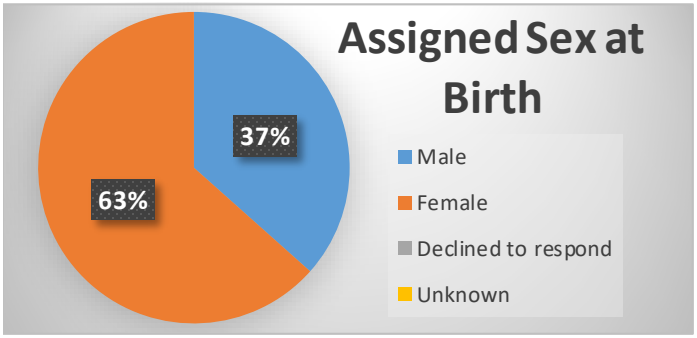
sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

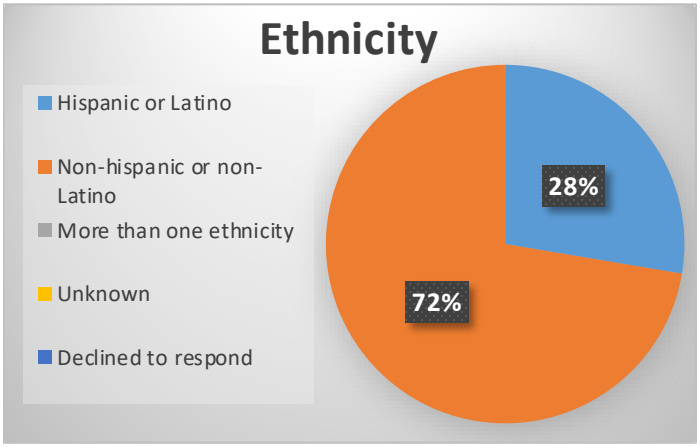
FY 2020-2021 Program Demographics:

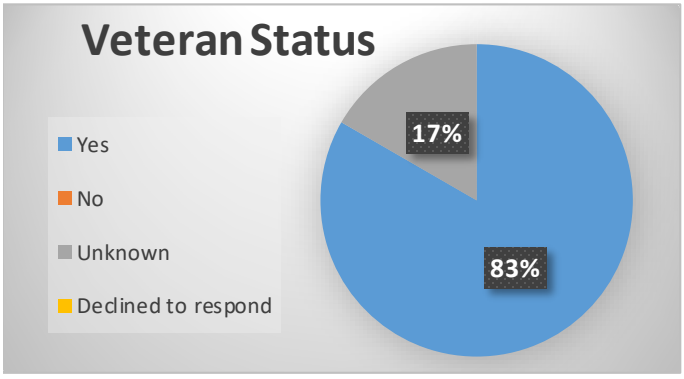


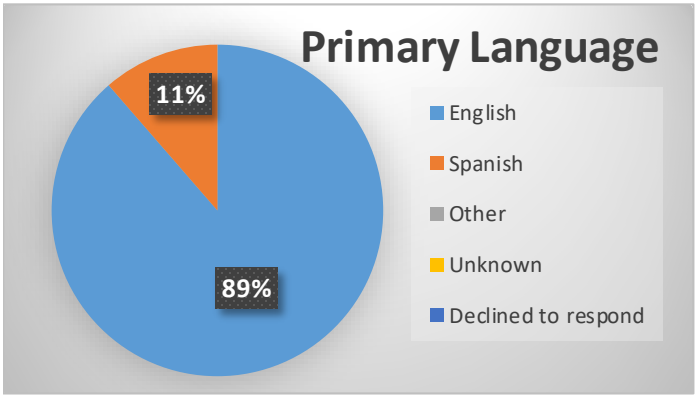


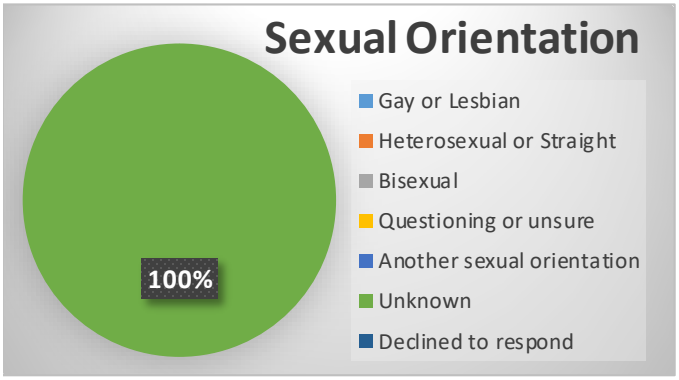












MHSA Component: Community Services & Supports (CSS)

SONOMA COUNTY JOB LINK
A proud partner of America's Job Center of California℠ network.

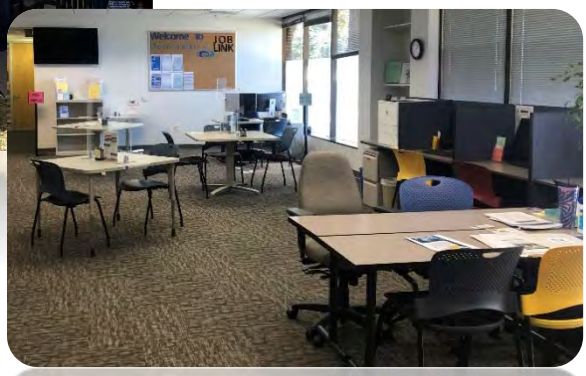
Sonoma County Job Link

Takes Action FOR MENTAL HEALTH

MENTAL HEALTH SERVICES ACT PROPOSITION 63 CALIFORNIA
WELLNESS • RECOVERY • RESILIENCE

Service Category: *General System Development*

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.



PROGRAM IMFORMATION

Program Name:
Sonoma County Job Link
Population served: Adults, Youth, and Employers in Sonoma County
Website:
www.caljobs.joblinksonoma.org
Phone: (707) 565-5550
Program location:
2227 Capricorn Way, Ste 100
Santa Rosa, CA 95407
Social Media:
@SonomaCountyJobLink
@JobLinkSonoma

PROGRAM DESCRIPTION:

Sonoma County Job Link/AJCC is a One-Stop Career Center comprised of multiple Workforce Service Providers and Partners working together connecting Job Seekers, Employers, and the Community to create a thriving Sonoma County. Job Link provides employment services including a Resource Center, Computer Lab, and Navigators and Counselors who assist with resume and interview prep, help with education and training, finding a job, or starting a career.

PROGRAM STATISTICS

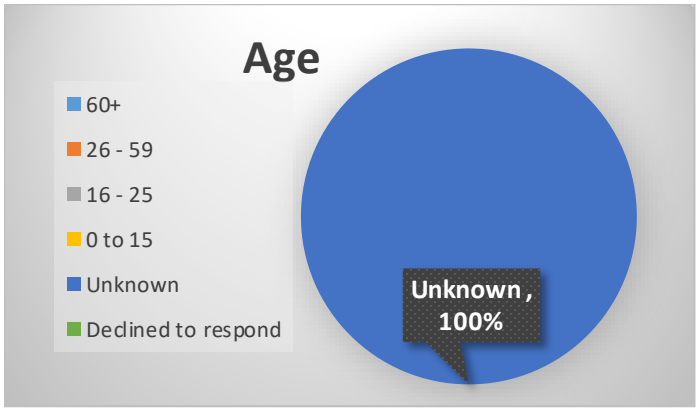
- **Total number of clients served:** 3 who were counted as individuals with serious mental illness.
- **Total number of encounters:** 17
- **Approximate numbers reached through outreach:** 150

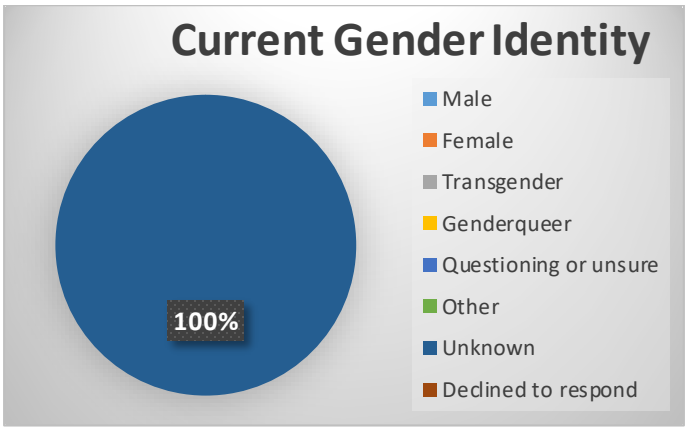
PROGRAM ACCOMPLISHMENTS:

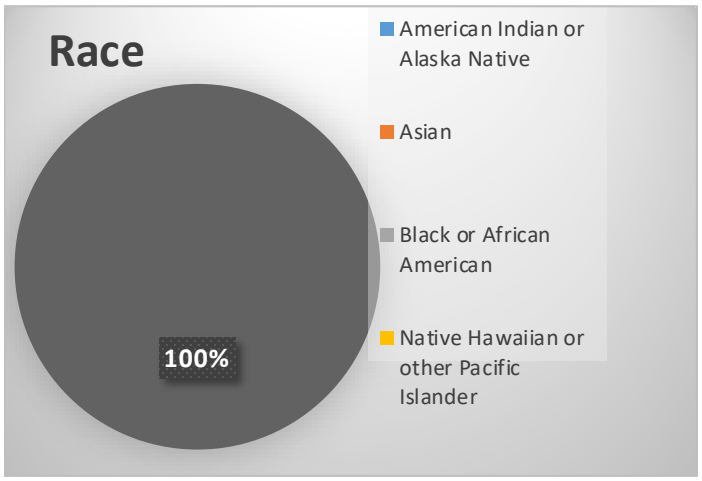
During fiscal year 2020-2021, many services were impacted due to the COVID-19 pandemic with the shutdowns and constantly changing situation. Job Link had 100+ customers who visited the One-Stop in person during that fiscal year (down from about 2,300 visitors in the prior fiscal year). Despite the impact to in-person services, these visitors were able to access job postings, workshops, use the computer lab, obtain information for resources from our navigators, and be connected to other agencies such as EDD, DOR, etc. In addition to these in-person services, over 400 participants were enrolled and received direct employment counseling and career services from Job Link counselors throughout the fiscal year. Job Link's referral process to obtain referrals from the Behavioral Health Division specifically for individuals with serious mental illness was also refreshed in May 2021 and outreach was enhanced which has resulted in increased referrals that will be visible in the next fiscal year's data.

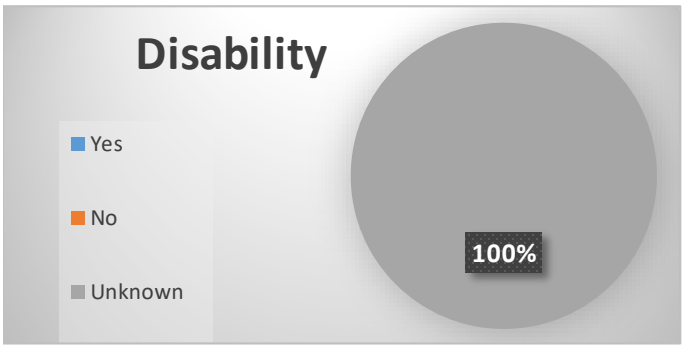
sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

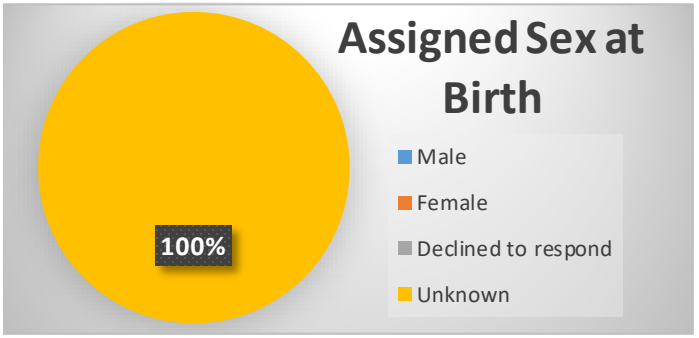
FY 2020-2021 Program Demographics:

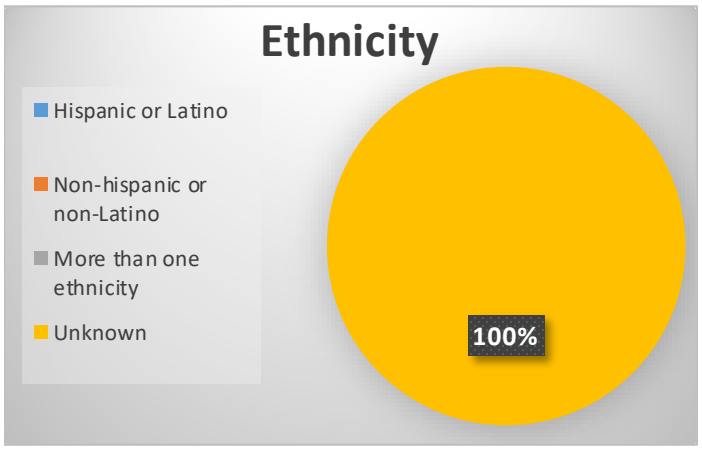


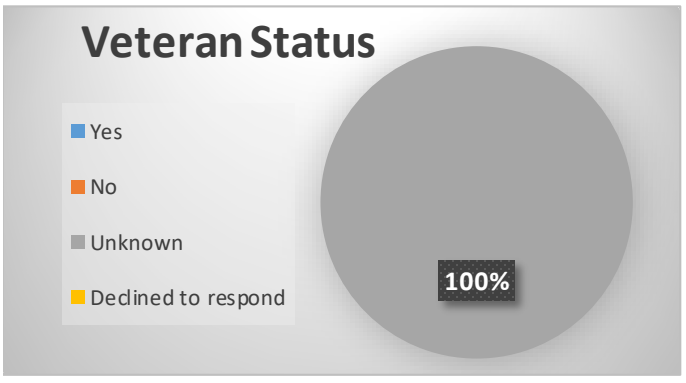


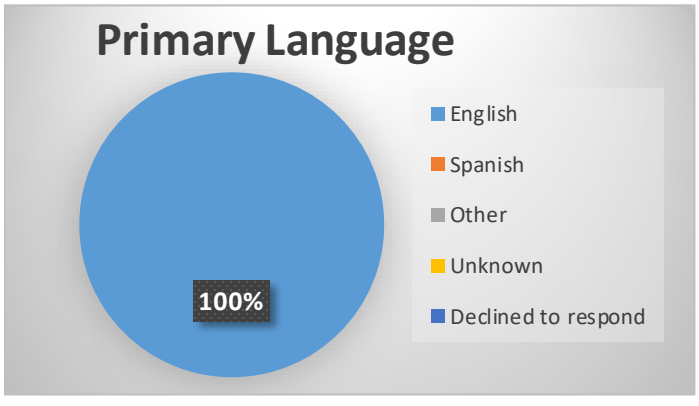


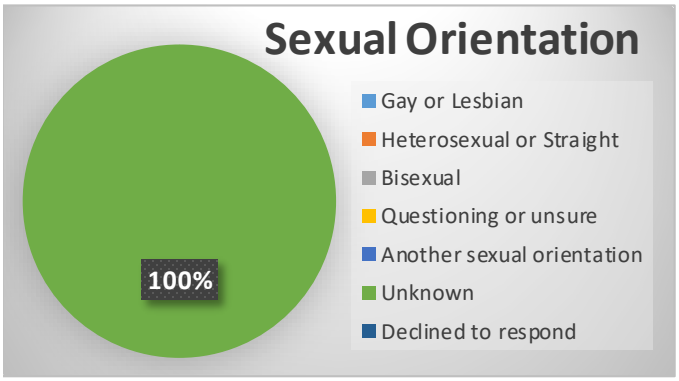












MHSA Component: Community Services & Supports (CSS)

Buckelew's Collaborative Treatment and Recovery Team

Takes Action for Mental Health

Mental Health Services Act Proposition 63 California

Wellness • Recovery • Resilience

Service Category: *General System Development*

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM IMFORMATION

Program Name: Collaborative Treatment and Recovery Team (CTRT)

Population served: Adults in Sonoma County who are new to behavioral health services

Website: www.buckelew.org
Phone: (707) 576-8181
Program location:
2300 Northpoint Parkway, Santa Rosa, CA 95407
Social Media:
https://www.facebook.com/search/top?q=buckelew%20programs

PROGRAM DESCRIPTION:

CTRT's goal is to empower adult individuals who are new to behavioral health services by assisting them to gain competencies in system navigation, access to community resources and supports and providing education about mental illness. This team works in concert with SCBH, embodying a collaborative and recovery-oriented approach.

PROGRAM STATISTICS

- **Total number of clients served:** 324
- **Approximate numbers reached through outreach:** 450

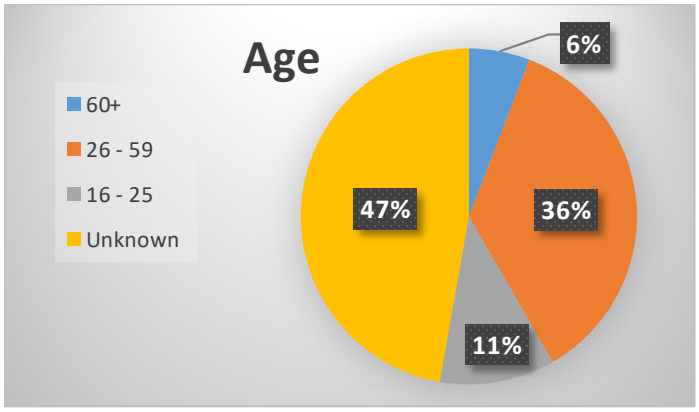
PROGRAM ACCOMPLISHMENTS:

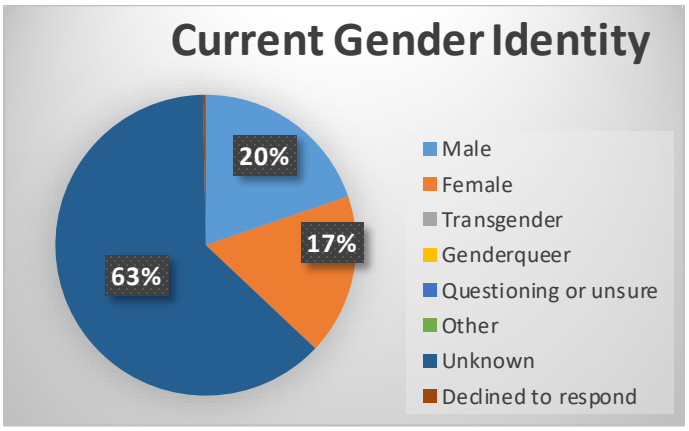
- We have been able to engage clients in obtaining independent housing from homelessness
- We have also assisted new clients created a safety plan that was sent to the Suicide hotline
- We have created a process of moving clients that are pending disenrollment off of active caseloads to a separate area on the roster so that more pending referrals can be opened more quickly.
- Assisting individuals to understand and navigate the Mental Health System on their own
- Buckelew's CTRT program supervisor and the SCBH CTRT program supervisor are meeting weekly, this has resulted in better coordination of care.
- Buckelew Programs utilizes the "Self Sufficiency" matrix assessment to assess client's overall well-being.

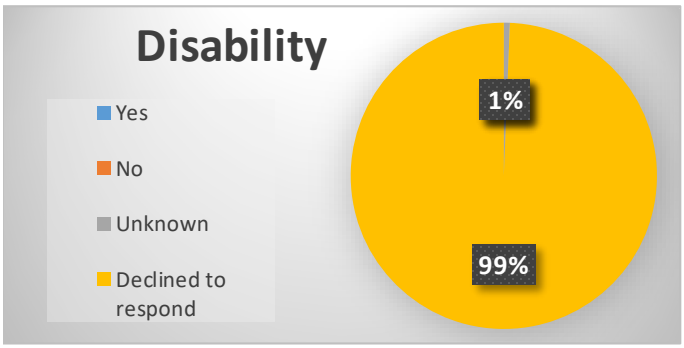
Sonoma County Department of Health Services Behavioral Health Division

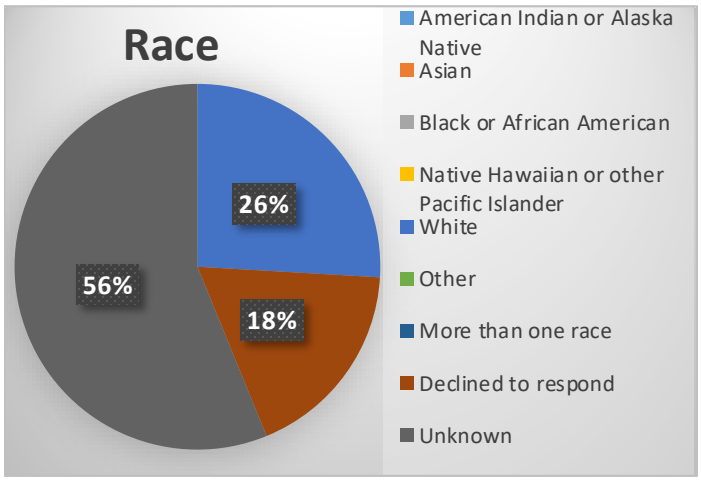
CSS Program Name:

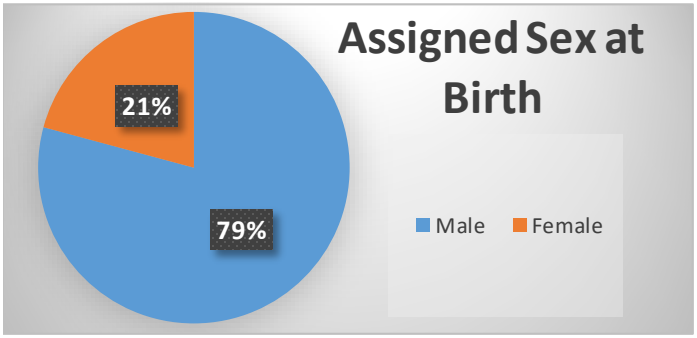
FY 2020-2021 Program Demographics:

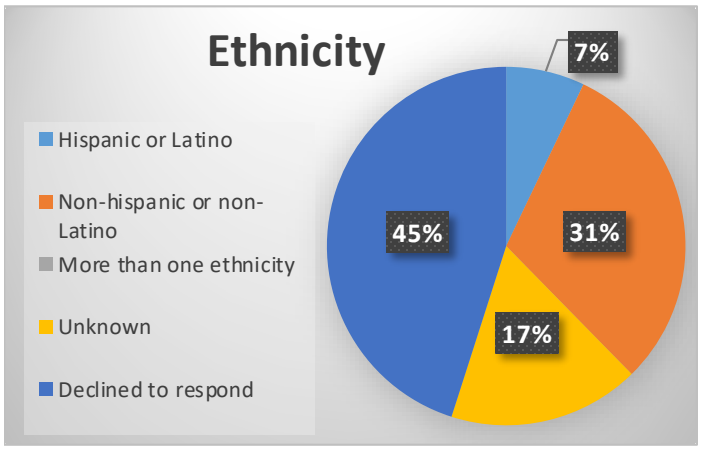


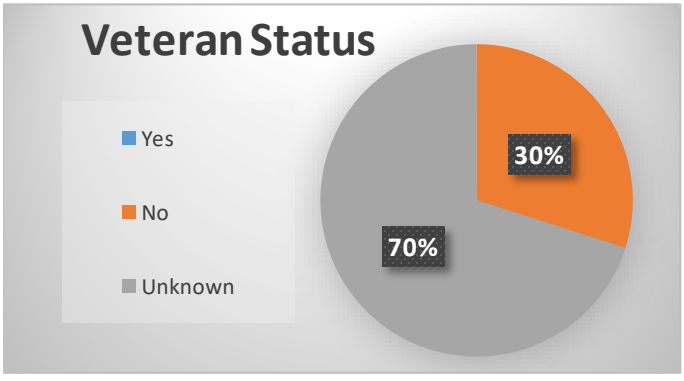


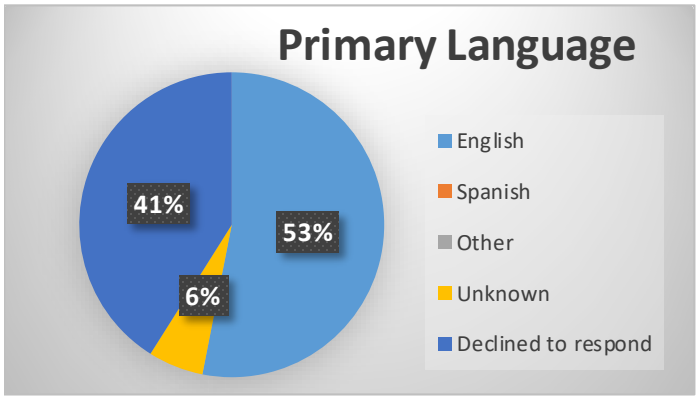


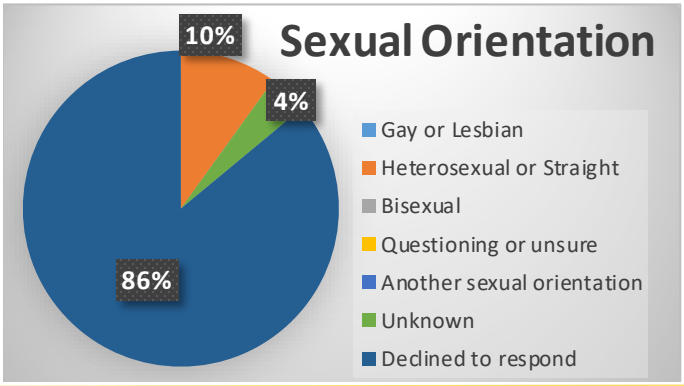












MHSA Component: Community Services & Supports (CSS)

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

DHS-BHD Collaborative Treatment and Recovery Team (CTRT)

Takes Action FOR MENTAL HEALTH

MENTAL HEALTH SERVICES ACT PROPOSITION 63 CALIFORNIA
WELLNESS • RECOVERY • RESILIENCE

Service Category: *General System Development*

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM DESCRIPTION:

DHS-BHD Collaborative Treatment and Recovery Team CTRT's goal is to empower adult individuals who are new to behavioral health services by assisting them to gain competencies in system navigation, access to community resources and supports and providing education about mental illness. This team works in concert with Buckelews's CTRT, embodying a collaborative and recovery-oriented approach.

PROGRAM IMFORMATION

Program Name: DHS-BHD Collaborative Treatment and Recovery Team (CTRT)

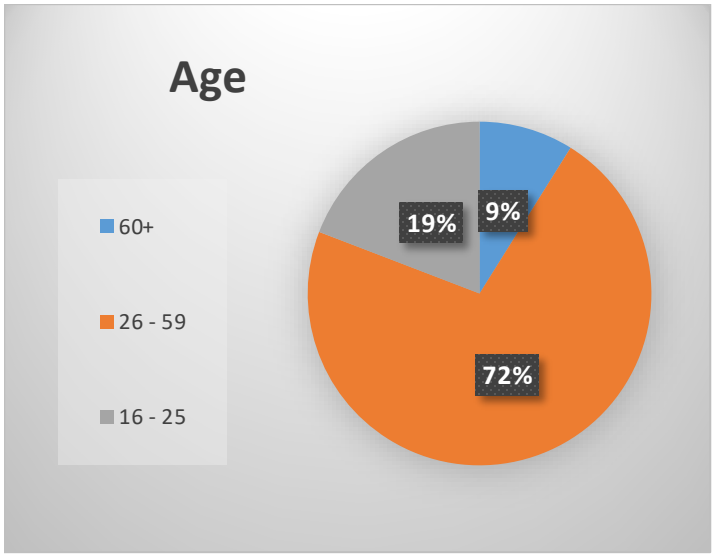
Population served: Adults Adults in Sonoma County who are new to behavioral health services.

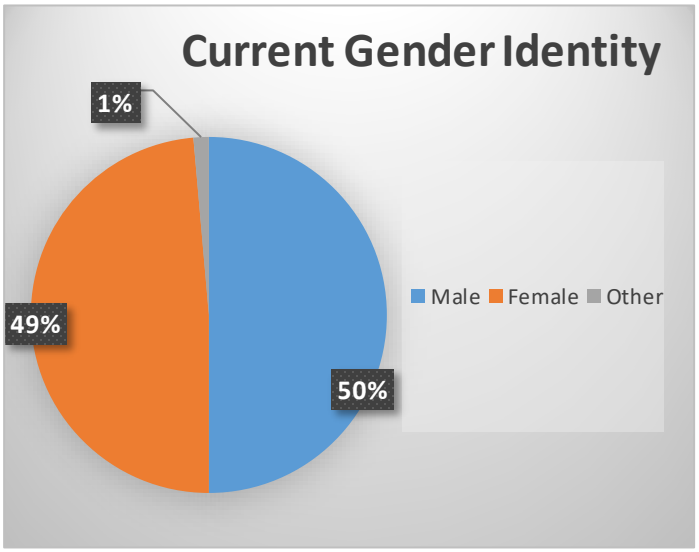
PROGRAM STATISTICS

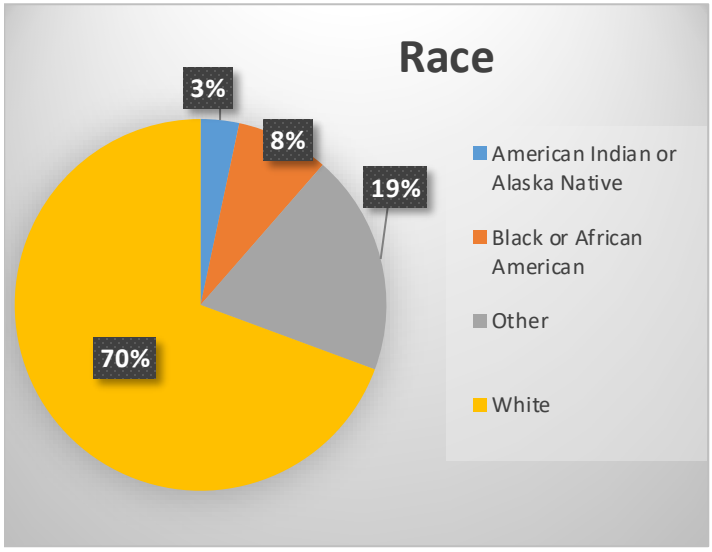
- **Total number of clients served:** 360

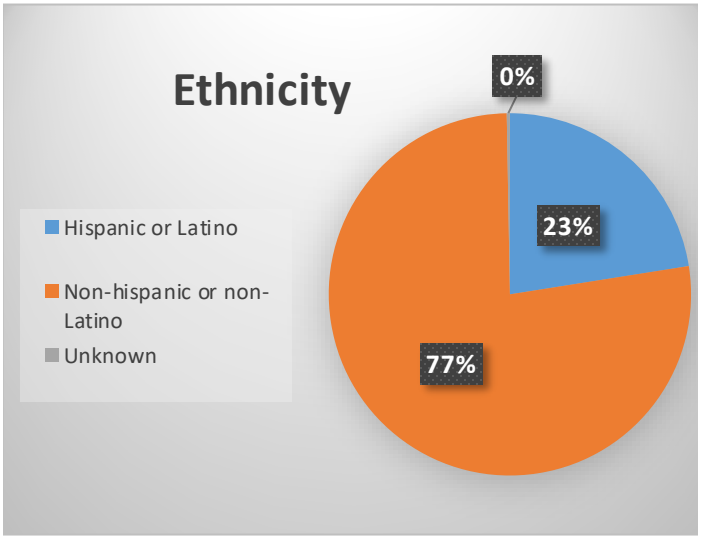
sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

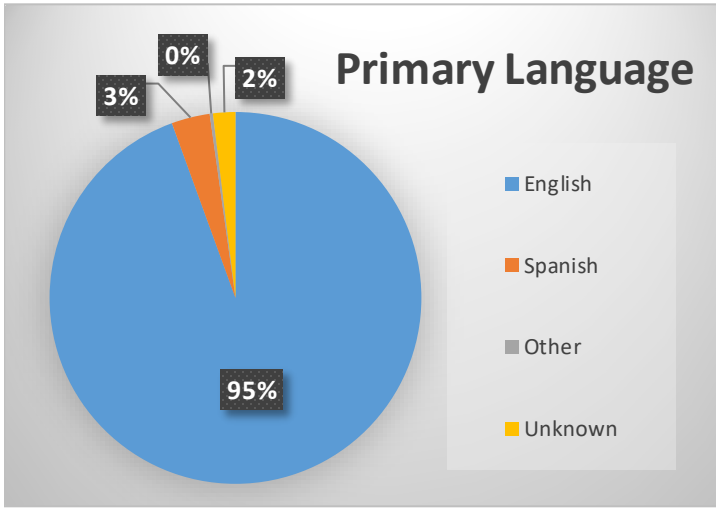
FY 2020-2021
Program Demographics:











MHSA Component: Community Services & Supports (CSS)

Telecare Corporation

Telecare ACT

Takes Action for Mental Health

Mental Health Services Act Proposition 63 California

WELLNESS • RECOVERY • RESILIENCE

Service Category: *General System Development*

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM IMFORMATION

Program Name: Sonoma ACT

Population served: Adults ages 18 and older who have been diagnosed with a serious mental illness and meet specific criteria or need for intensive level of services

Website:
https://www.telecarecorp.com/sonoma-act

Phone: (707) 568-2800
Program location:
327 College Avenue
Santa Rosa, CA 94501

PROGRAM DESCRIPTION:

At Sonoma ACT we are available to provide wrap around services 24/7 to support our members in living in the community successfully. We meet people where they are at and are here to support individuals in feeling better, stronger, and taking positive steps towards the things that matter in their lives. We believe recovery is possible with the right plan in place. Our multidisciplinary team includes licensed Clinical Director, nurse, peer support staff, substance use specialist, case managers, nurse practitioner, and psychiatrist.

PROGRAM STATISTICS

- **Total number of clients served:** 61
- **Total number of encounters:** 8046
- **Approximate numbers reached through outreach:** Full Census and COVID reduced engagement to mostly existing members.

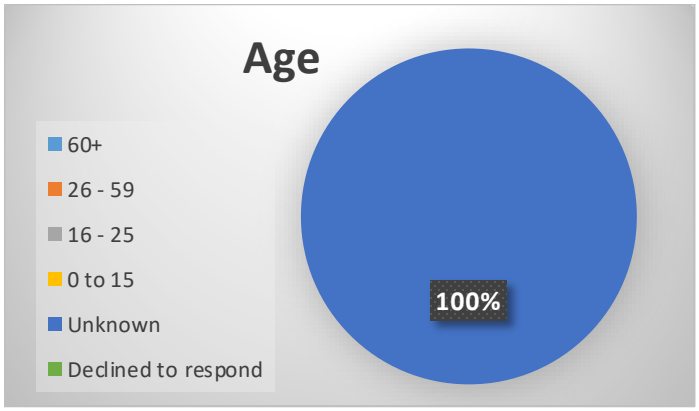
PROGRAM ACCOMPLISHMENTS:

Despite the challenging years of the pandemic, the Sonoma ACT program was able to ensure greater than 87% of our members received COVID-19 vaccinations in addition to actively engaging our unhoused partners to qualify for Housing vouchers. We are proud to report that over 93% of our members are stably housed. We also managed to continue services to our members via telehealth and social distancing and in person (when appropriate and supported with necessary PPE).

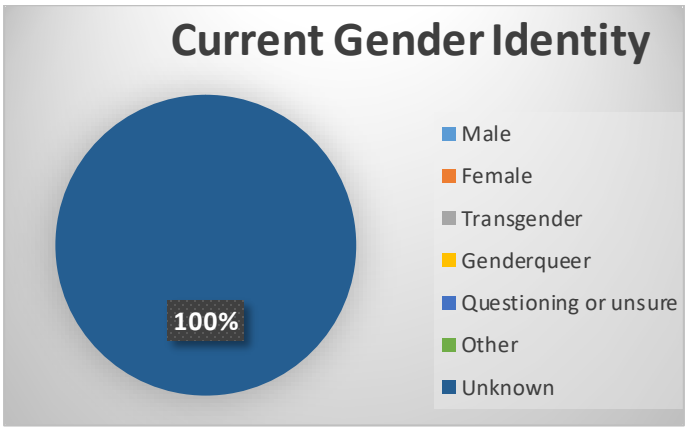
Sonoma County Department of Health Services
Behavioral Health Division

FY 2020-2021 Program Demographics:

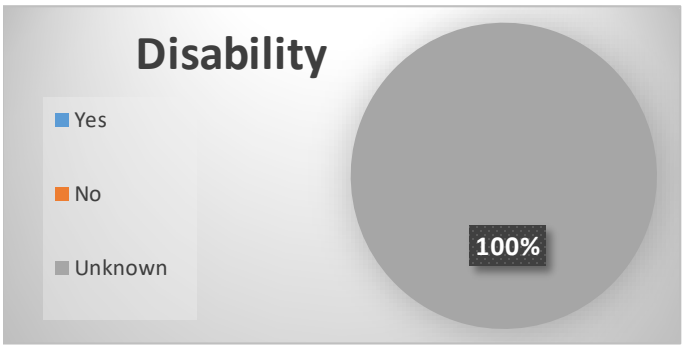
Age



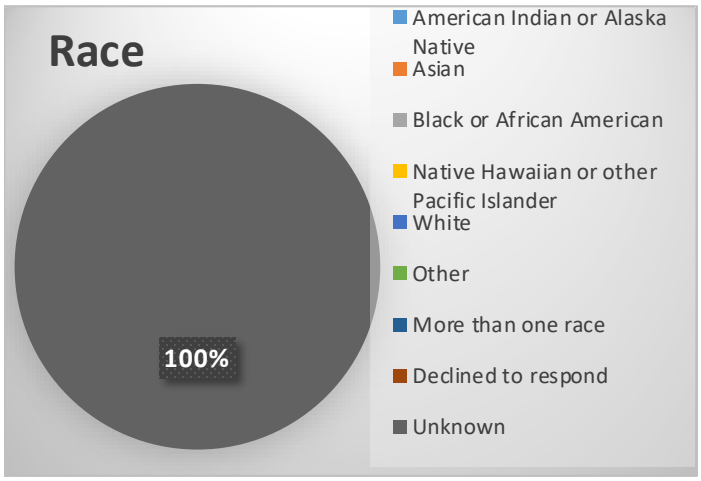
Current Gender Identity



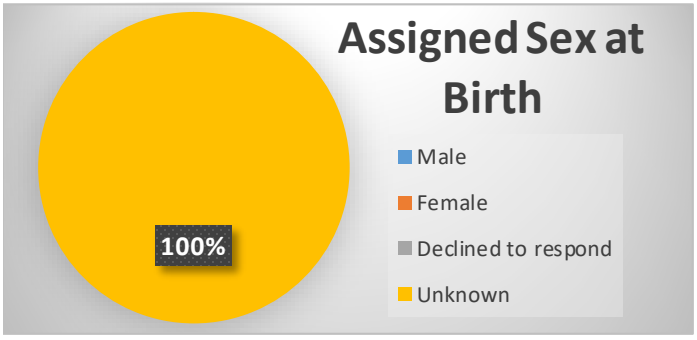
Disability



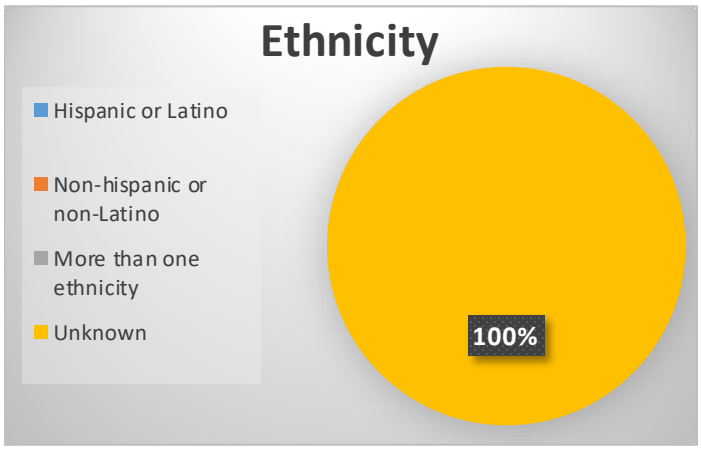
Race



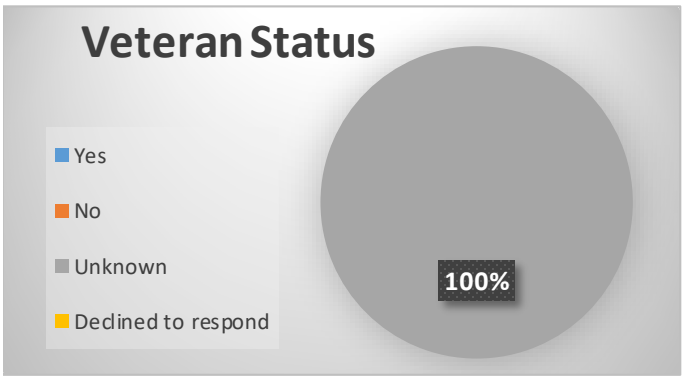
Assigned Sex at Birth



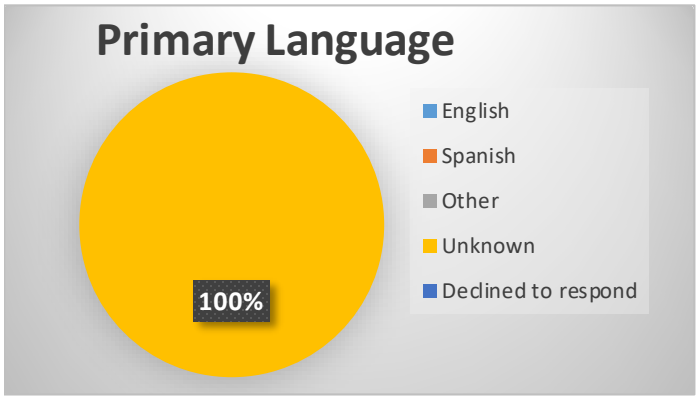
Ethnicity



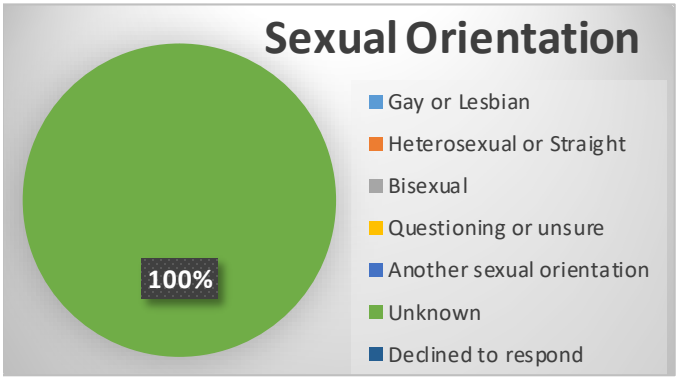
Veteran Status



Primary Language



Sexual Orientation



MHSA Component: Community Services & Supports (CSS)

Family Service Coordination at Buckelew Programs

Takes Action FOR MENTAL HEALTH

WELLNESS • RECOVERY • RESILIENCE

Service Category: *Full Service Partnership Services, Outreach and Engagement Services or General System*

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM IMFORMATION

Program Name: Buckelew Programs: Family Service Coordination
Population served: Sonoma County families and allies, supporting a loved one with a mental or behavioral health challenge.
Website: www.buckelew.org/services/sonoma-county/family-services-coordination/
Phone: 707-571-8452
E-mail: fsc@buckelew.org
Program location: 2330 Northpoint Parkway, Santa Rosa CA 95407
Social Media: www.facebook.com/FamilyServiceCoordination/ www.instagram.com/BuckelewPrograms

PROGRAM DESCRIPTION:

The Family Service Coordination program works with family members and allies of adults with mental and behavioral health challenges. FSC walks with families and allies through individualized and group support, system navigation, providing education about mental illness, reducing stigma, and connecting family and allies with community resources and supports. All Family Service Coordination services are free of charge to residents in Sonoma County.

PROGRAM STATISTICS

- **Total number of clients served:** 1524
- **Total number of encounters:** 2069
- **Approximate numbers reached through outreach:** 3008

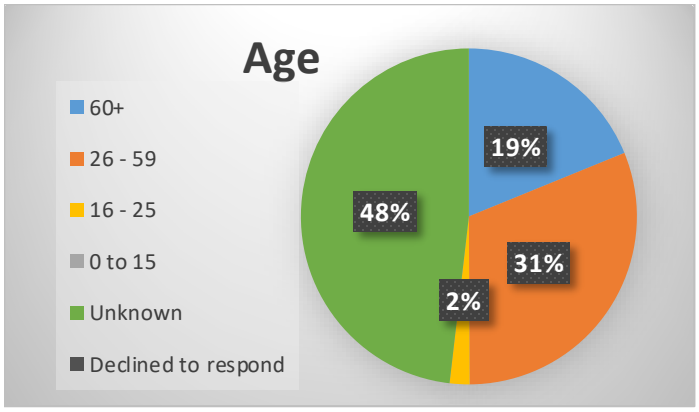
PROGRAM ACCOMPLISHMENTS:

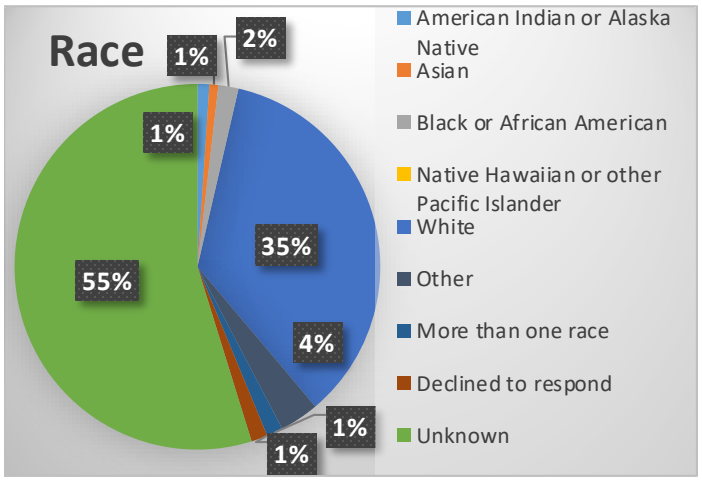
Due to the COVID-19 Pandemic, our program was able to shift to telehealth support. Families and Allies reported the following:

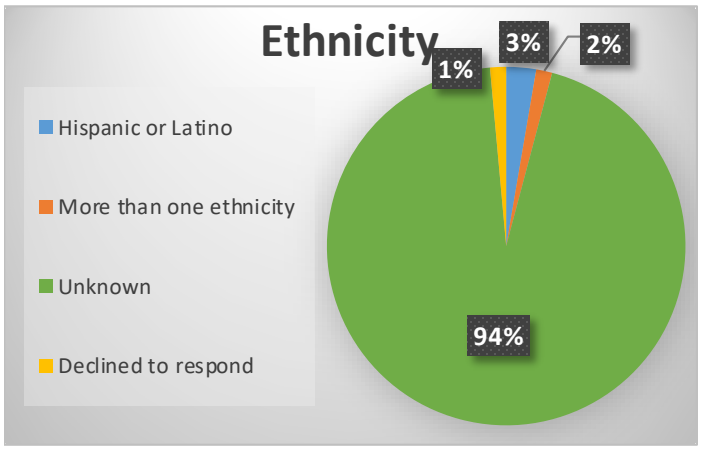
- 98% of families have reported excellent or good understanding of Sonoma County's Health System, i.e. how to access primary care, therapist, and psychiatrist.
- 100% of families reported accessing 1 or more resources for themselves.
- 100% of families reported accessing 2 or more resources for their loved one.
- 100% of families will strongly agree or agree that they have been provided with family education and community resources to help cope better with family member's mental illness.

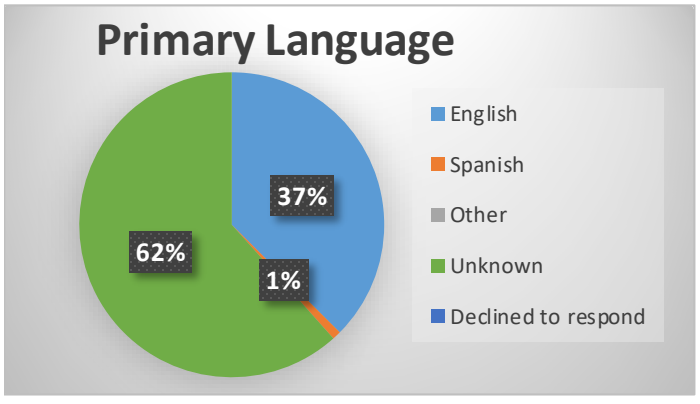
Sonoma County DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

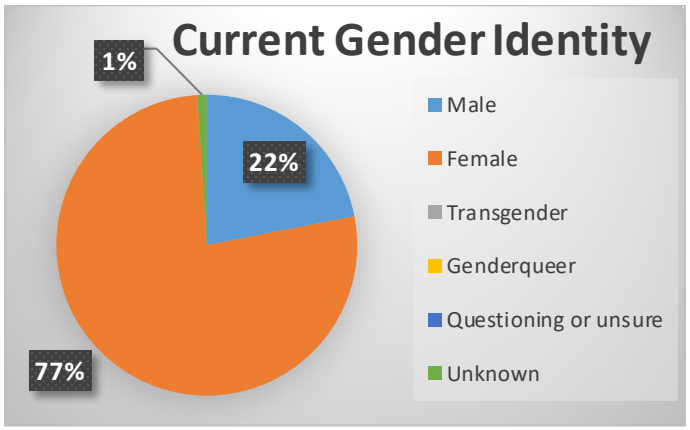
FY 2020-2021 Program Demographics:

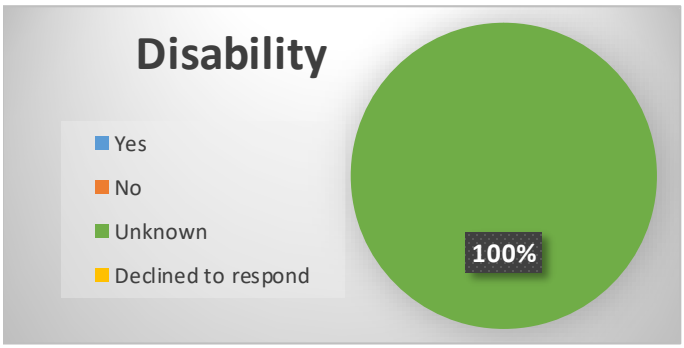


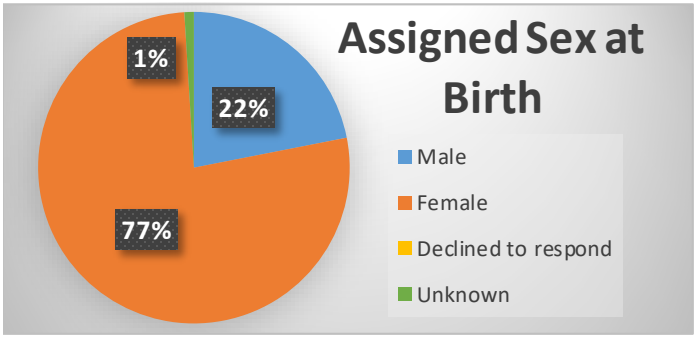


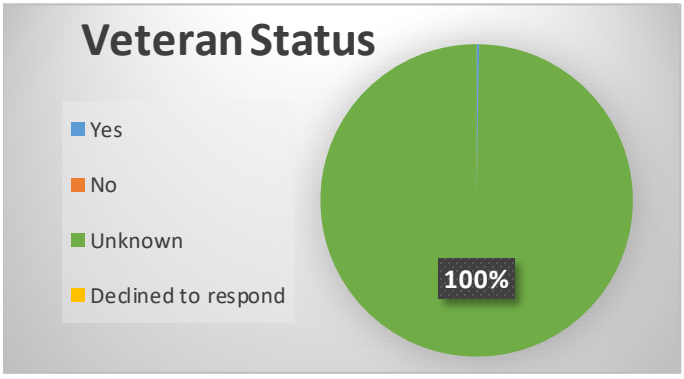


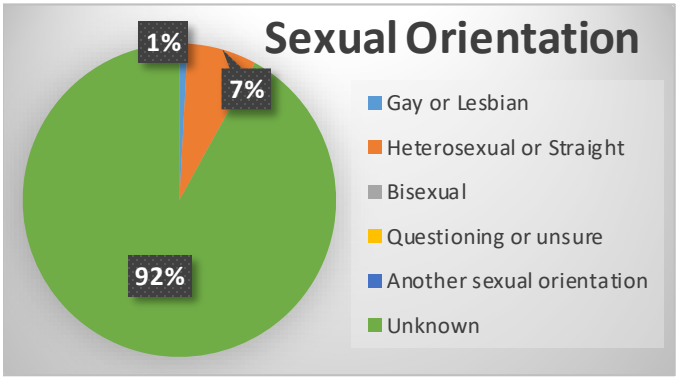












COMMUNITY SERVICES AND SUPPORTS (CSS)

Programs provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

Outreach and Engagement (OE)

A service category of the CSS component used to fund activities to reach, identify, and engage unserved individuals and communities in the mental health system and reduce disparities identified by the County.

MHSA Component: Community Services & Supports (CSS)

Whole Person Care (WPC)

Takes Action FOR MENTAL HEALTH

WELLNESS • RECOVERY • RESILIENCE

Service Category: *Outreach and Engagement (OE)*

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM DESCRIPTION:

Sonoma County's Whole Person Care (WPC) program includes outreach and engagement services, short term recuperative care services, and intensive case management services. Outreach and engagement services center around identifying clients, building trust, providing informed consent and collecting clients' data sharing permissions, completing comprehensive assessments and screenings to identify medical, behavioral health, social service, housing needs and eligibility for intensive care management services.

PROGRAM INFORMATION

Program Name: Whole Person Care (WPC)

Population served: Sonoma County residents who are experiencing homelessness or at-risk of homelessness and have a mental health condition with a chronic physical health condition.

Phone: (707) 565-4811, referral form required.

Placed-based outreach and engagement teams are strategically located throughout Sonoma County in high-density cities, as well as geographically remote, and typically underserved, areas to find and enroll participants in the field. WPC Pilot staff also actively partner with and take referrals from community partners, who typically encounter potential WPC's target population, such as:

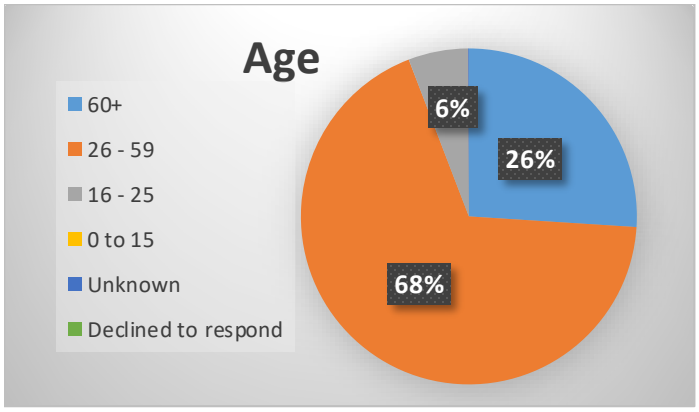
- Hospitals, community health centers, emergency departments
- Local law enforcement agencies, jail, probation
- Community-based service organizations
- Shelters, supportive low-income housing projects, medical respite programs Self-refer into the program

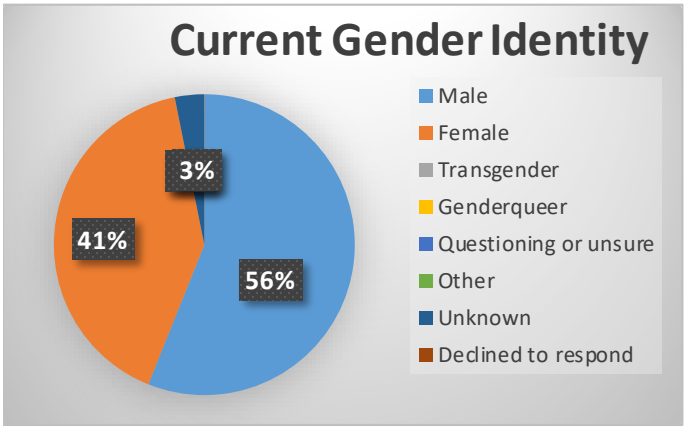
PROGRAM STATISTICS

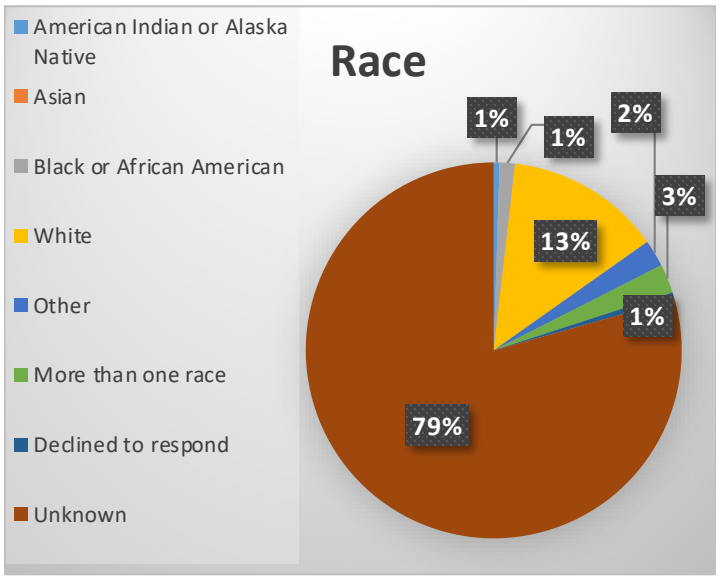
- **Total number of clients served:** 2,814
- **Total number of encounters:** 25,441

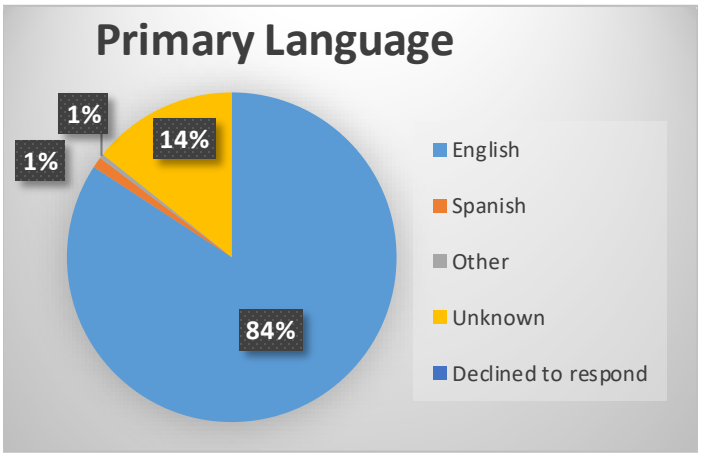
sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

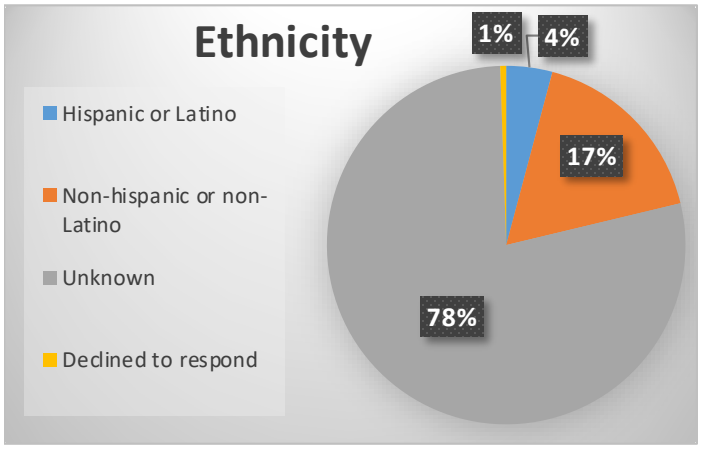
FY 2020-2021
Program Demographics:

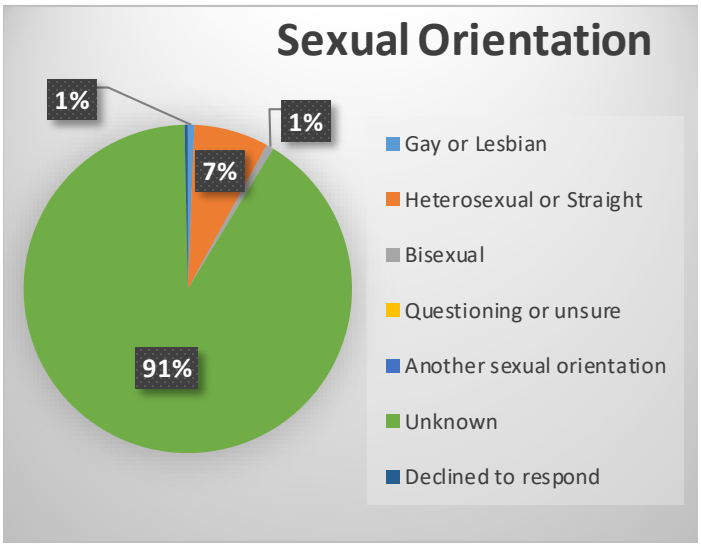












MHSA Component: Community Services & Supports (CSS)

Community Mental Health Centers (CMHCs)

Takes Action FOR MENTAL HEALTH

WELLNESS • RECOVERY • RESILIENCE

Service Category: *Outreach and Engagement (OE)*

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM INFORMATION

Program Name: Community Mental Health Centers (CMHCs)

Areas served: Sonoma County adults living in four regionally-based areas of: Guerneville, Cloverdale, Petaluma, and Sonoma

Website: https://sonomacounty.ca.gov/Health/Behavioral-Health/Community-Mental-Health-Centers

Phone: (707) 565-4850
To request services: (707) 565-6900

PROGRAM STATISTICS

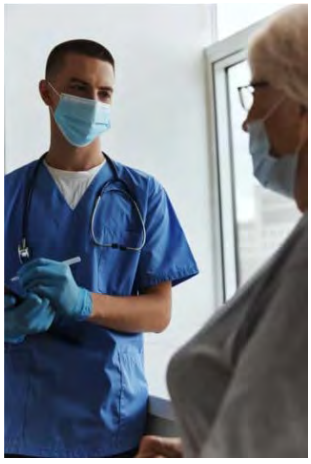
Total unique clients served by CMCH in FY 20-21: 306

PROGRAM DESCRIPTION:

The Community Mental Health Centers (CMHCs) are primarily aimed at providing access for underserved populations, including providing culturally and linguistically appropriate services to locally underserved racially and ethnically diverse communities, and homeless individuals with mental illness, in four regionally-based areas of Sonoma County:

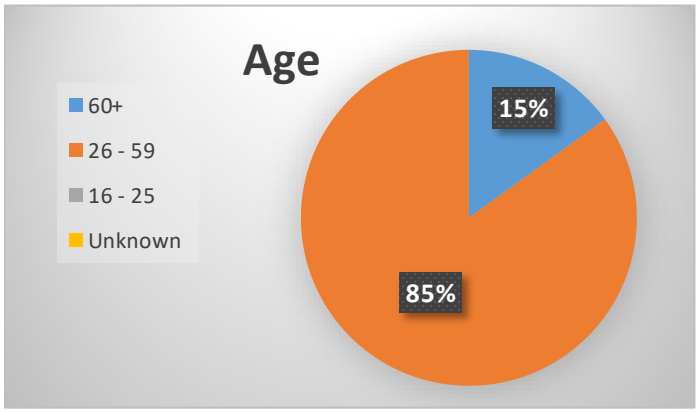
- Guerneville
- Cloverdale
- Petaluma
- Sonoma

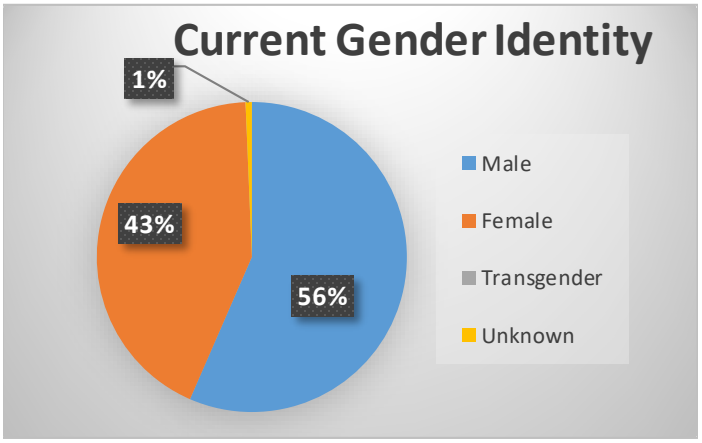
The service teams are linked to the larger adult systems of care but focus on providing services and supports in the smaller communities where they are located. Services are available through collaborations between each CMHC and community-based providers, law enforcement agencies, and local Federally Qualified Health Centers (FQHCs).

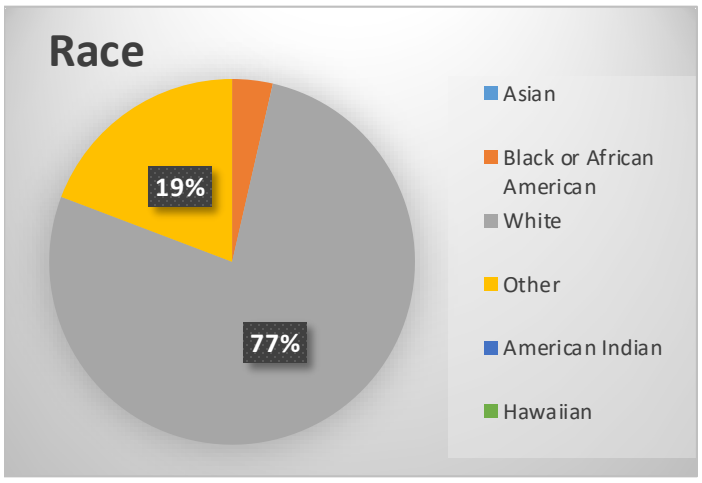


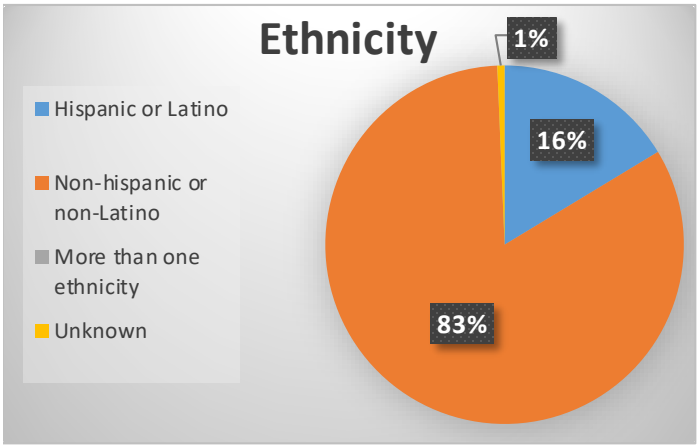
sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

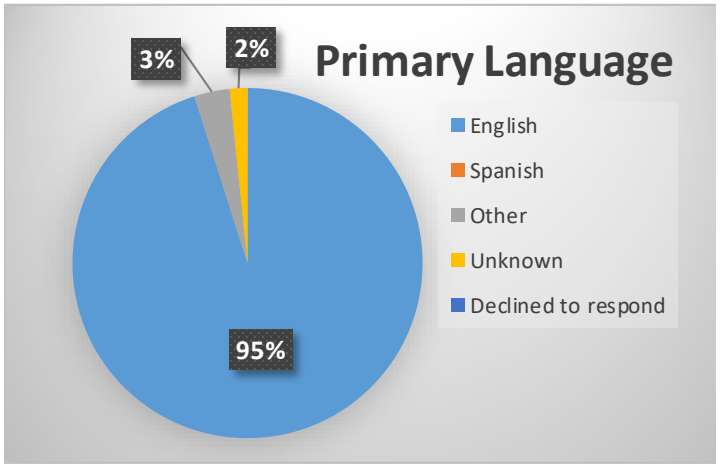
FY 2020-2021
Program Demographics:











MHSA Component: Community Services & Supports (CSS)

Sonoma County Indian Health Project, Inc.'s Community Programs

TAKES ACTION FOR MENTAL HEALTH

MENTAL HEALTH SERVICES ACT PROPOSITION 63 CALIFORNIA

WELLNESS • RECOVERY • RESILIENCE

Service Category: *Outreach and Engagement Services*

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM IMFORMATION

Program Name: Sonoma County Indian Health Project's Community Programs

Population served: Native Americans, all ages, residing in Sonoma County

Website: www.scihp.org
Phone: (707) 521-4550
Program location:
144 Stony Point Road
Santa Rosa, CA 95401
Social Media: Sonoma County Indian Health Project, Inc (Facebook)

PROGRAM DESCRIPTION:

Sonoma County Indian Health Project Inc. (SCIHP) provides psychotherapy services in an integrated system of care to Native American individuals of all ages residing in Sonoma County. SCIHP's Integrated Behavioral Health Provider is embedded in the medical department and serves as a key member of primary care team, consulting on the treatment of individuals with a behavioral health need. This provider offers clinical case management and therapy services, and referrals to additional services and resources, both onsite and elsewhere in the community.

The Integrated Behavioral Health Provider identifies, treats, triages, and manages the care of individuals identified in the primary care department with a behavioral health need. This provider is also available for warm handoffs from primary care providers, on a same day basis, for brief problem-focused interventions.

PROGRAM STATISTICS

- **Total number of clients served:** 278
- **Total number of encounters:** 720
- **Approximate numbers reached through outreach:** 278

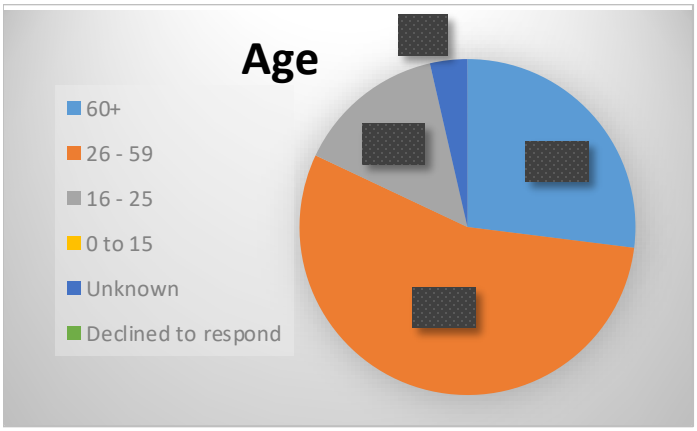
PROGRAM ACCOMPLISHMENTS:

The Integrated Behavioral Health Provider provided therapy services to 278 Native American individuals in 2020-2021. Services were further enhanced in March 2021 with the hire of our Integrated Behavioral Health Care Coordinator. These providers have made tremendous progress in increasing access to behavioral health services, improving communication and collaboration across departments and ensuring that providers and community members have access to our full continuum of culture-based behavioral health prevention and treatment programs offered at SCIHP and by partners serving our tribal community.

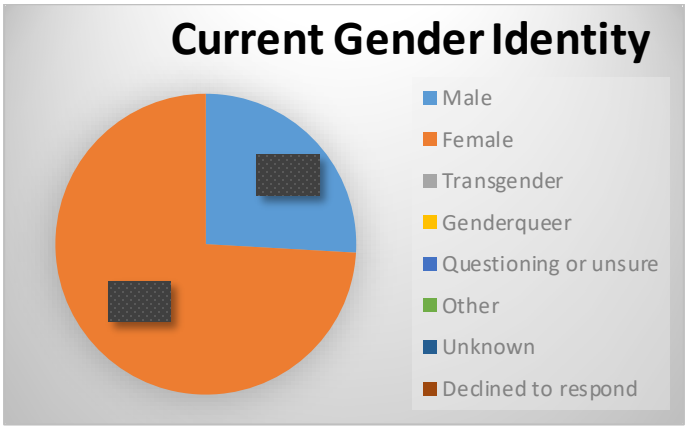
sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

FY 2020-2021 Program Demographics:

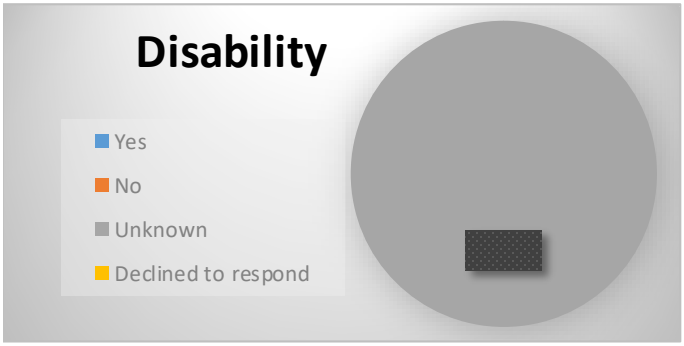
Age



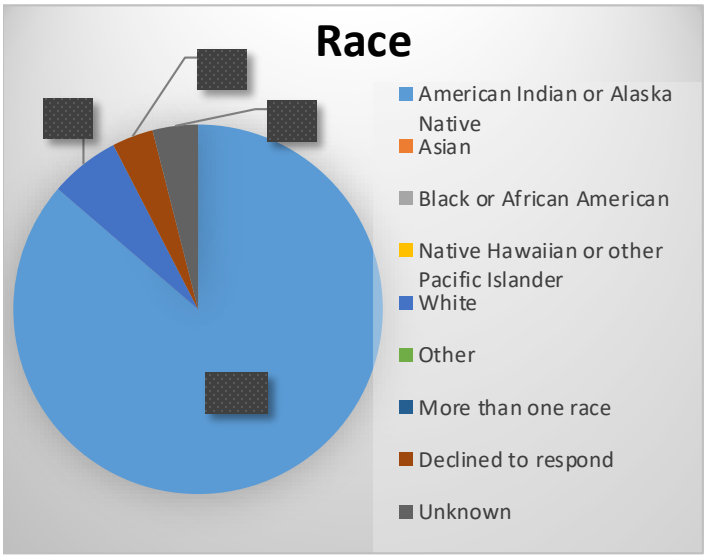
Current Gender Identity



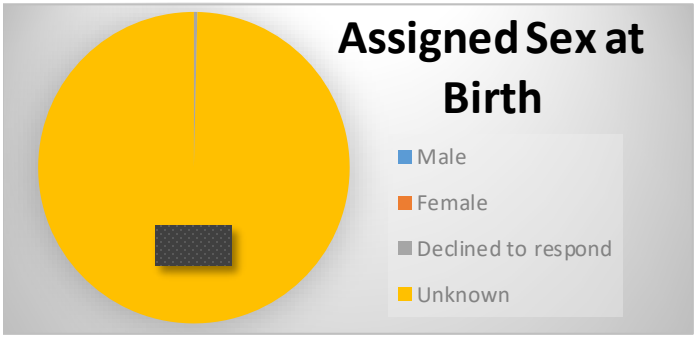
Disability



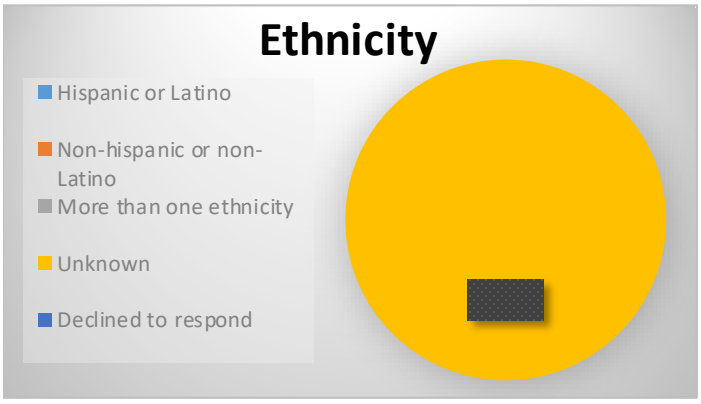
Race



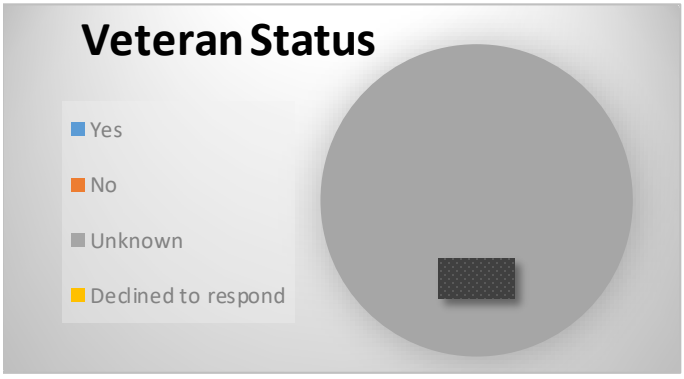
Assigned Sex at Birth



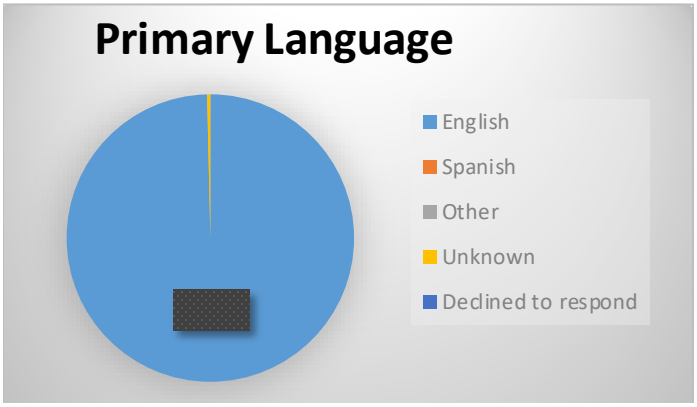
Ethnicity



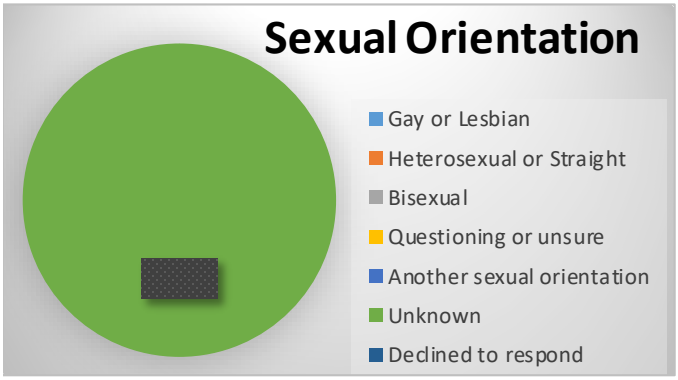
Veteran Status



Primary Language



Sexual Orientation



Prevention and Early Intervention (PEI)

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:

- Suicide
- Incarcerations
- School failure or dropout
- Unemployment
- Prolonged suffering
- Homelessness
- Removal of children from their homes

Prevention

A set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. The goal of this Program is to bring about mental health including reduction of the applicable negative outcomes listed in Welfare and Institutions Code Section 5840, subdivision (d) as a result of untreated mental illness for individuals (see page 105) and members of groups or populations whose risk of developing a serious mental illness is greater than average and, as applicable, their parents, caregivers, and other family members.

Action Network

Takes Action FOR MENTAL HEALTH

WELLNESS • RECOVERY • RESILIENCE

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, homelessness, removal of children from their homes, and prolonged suffering.

PROGRAM IMFORMATION

Program Name: Action Network
Population served: Families with children 0-5, school aged kids and teens, adults 60+ living in Sonoma County region of our service area.
Website: www.actionnetwork.net
Phone: (707) 882-1691
Program location:
Kashia Rancheria, Annapolis, School Based Services, Burbank Housing in Sea Ranch, Horicon Elementary
Social Media:
Website: www.actionnetwork.net
IG: @thecenter_actionnetwork
Facebook: @actionnetworkthecenter

PROGRAM DESCRIPTION:

Action Network aims to provide a Community Wellness approach in all support services and outreach. Youth & family services are woven together through in-home visits, distribution of resources, community events, mental health services, and in-person, phone or zoom counseling. School based and cross agency referrals help in identifying at risk individuals, and in-home or community distribution is a method of reaching those individuals and families. Building trust with consistent and reliable contact is key to continuing to serve remote communities.

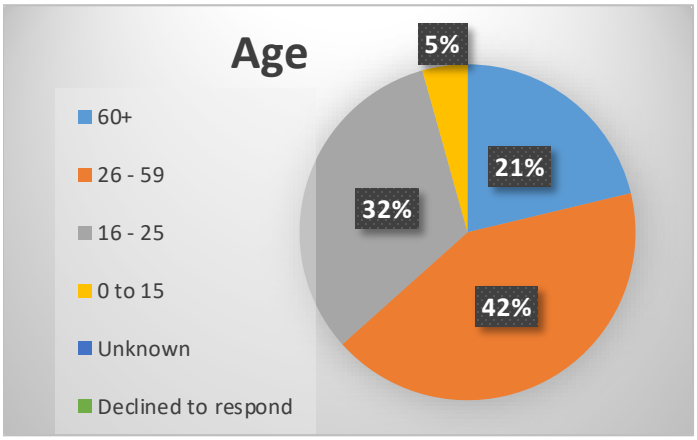
FY 2020-2021 PROGRAM STATISTICS:

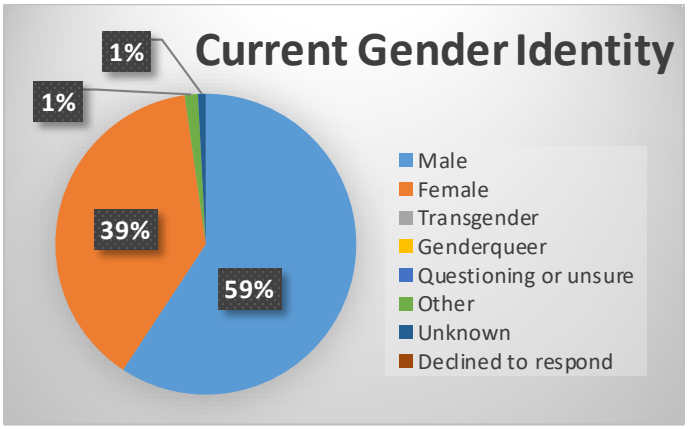
- **Total number of clients served:** 356
- **Total number of encounters:** 391
- **Approximate numbers reached through outreach:** 422

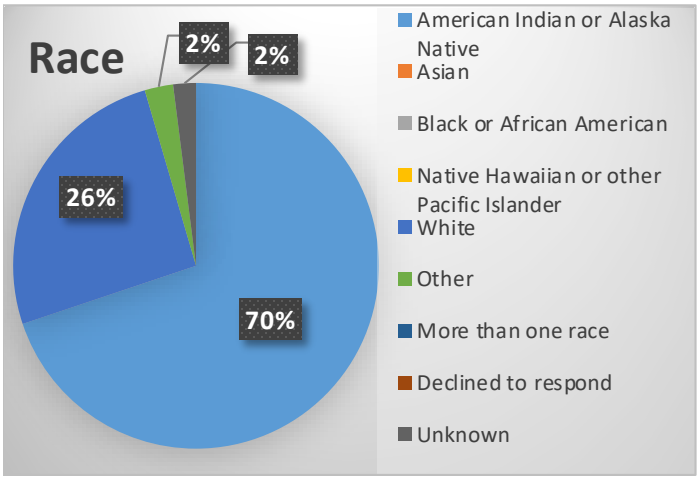
PROGRAM ACCOMPLISHMENTS:

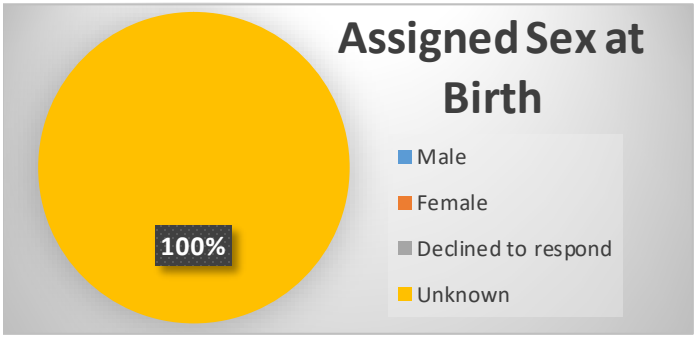
Outreach staff acted on referrals to track down hard-to-reach families. Through distribution services at Kashia, 14 household received bi-monthly resources such as diapers, food, infant formula, warm clothing, hygiene products, fresh organic produce, mental health check-ins and more. 25 households received bi-monthly services at Burbank Housing in Sea Ranch, providing outreach for youth mental and general health info. The Community Wellness Collaborative was created to assist cross agency and school-based referrals for mental and general health for youth and families. Advocate staff provided outreach via phone or zoom sessions for clients who requested support resources without in-person contact, primarily meeting families at school sites, and distribution events at Kashia Community Center, Horicon school, home visits, and agency events. Student referrals were precipitated from outreach and built on as a point of contact to serve the whole family.

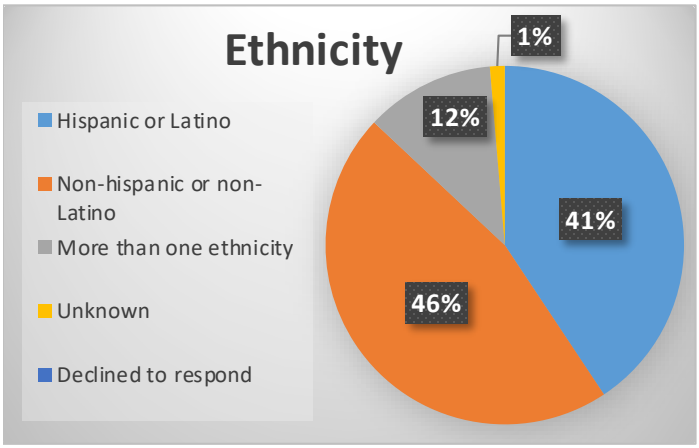
FY 2020-2021 Program Demographics:

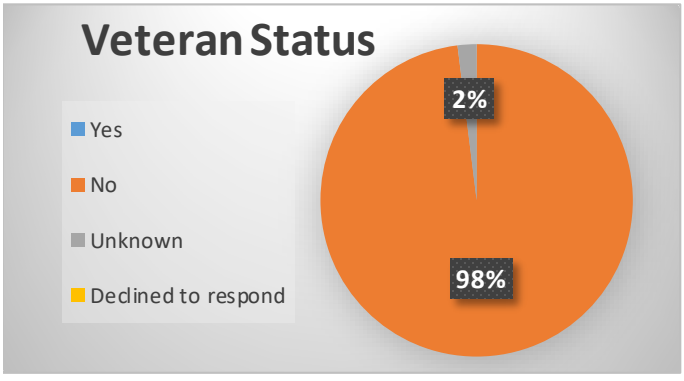


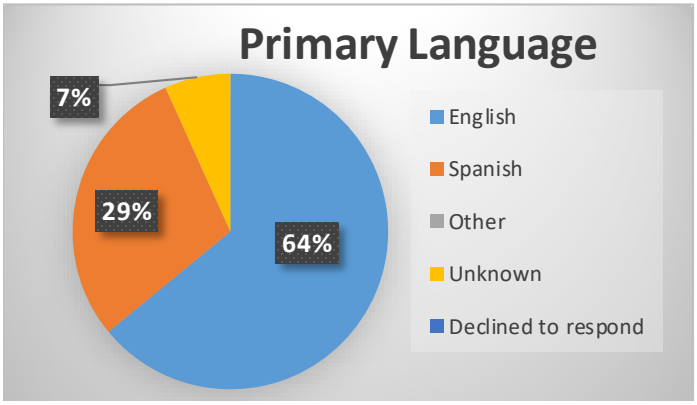


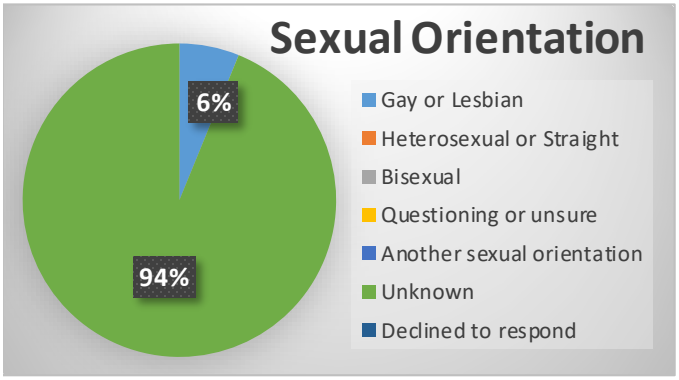












Sonoma County Indian Health Project, Inc.

Takes Action FOR MENTAL HEALTH

MENTAL HEALTH SERVICES ACT PROPOSITION 63 CALIFORNIA
WELLNESS • RECOVERY • RESILIENCE

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, homelessness, removal of children from their homes, and prolonged suffering.

PROGRAM IMFORMATION

Program Name: Gathering of Native Americans Program (GONA)

Population served: Native Americans, all ages in Sonoma County
Website: www.scihp.org
Phone: (707) 521-4550
Program location:
144 Stony Point Road
Santa Rosa, CA 95401
Social Media:
Sonoma County Indian Health Project, Inc. (Facebook)

PROGRAM DESCRIPTION:

The GONA Project offers presentations and workshops, trainings, gatherings, and cultural events that bring together our Native community with a focus on cultural strengths and behavioral health wellness. The purpose of the Gathering of Native Americans (GONA) and curriculum is to reduce mental health disparity in our local Native American communities by increasing access to mental health services by:

1) Mental health stigma reduction and decreasing suicide through community-based awareness campaigns and education (utilizing community wellness gatherings and community outreach) The GONA focuses on the following four themes: belonging, mastery, interdependence, and generosity.

2) Providing GONA events which support healing, encourages and guides community discussion about mental wellness, and helps communities build capacity for Native Americans who are at risk.

FY 2020-2021 PROGRAM STATISTICS

- **Total number of clients served:** 77
- **Total number of encounters:** 77
- **Approximate numbers reached through outreach:** 2000

PROGRAM ACCOMPLISHMENTS:

Participants communicated very positive feedback, including:

What did you enjoy most about the GONA?

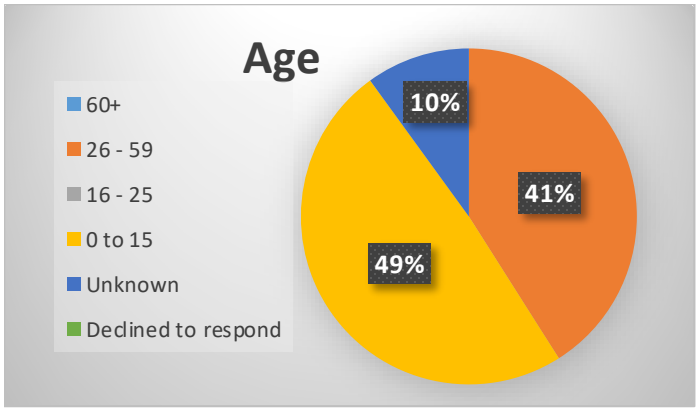
- "I love how it bring families together and you get to meet new people."
- "The humor, traditional stories, and the homework."

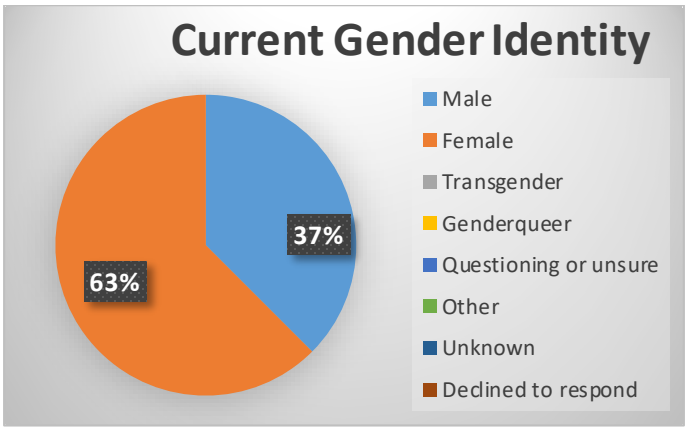
How did you and your family members feel at the end of the GONA?

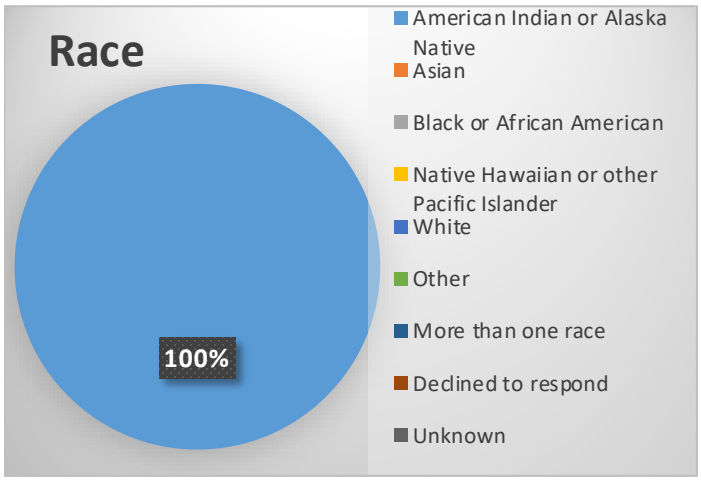
- "Affirmed, welcomed, related, confident, hopeful."
- "Generosity and keeping traditions alive."

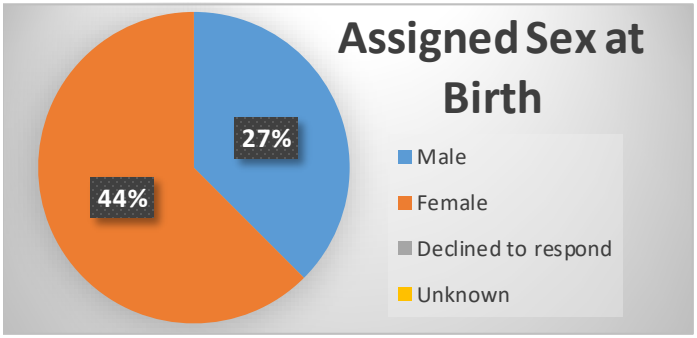
sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

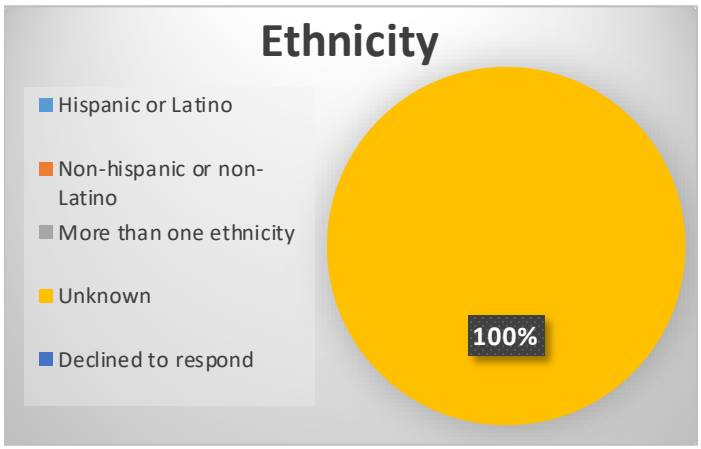
FY 2020-2021 Program Demographics:

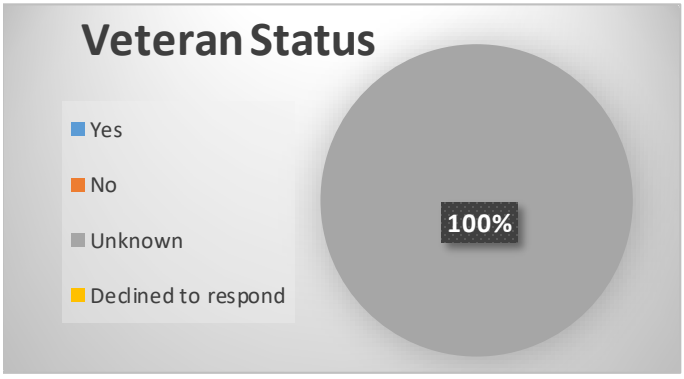


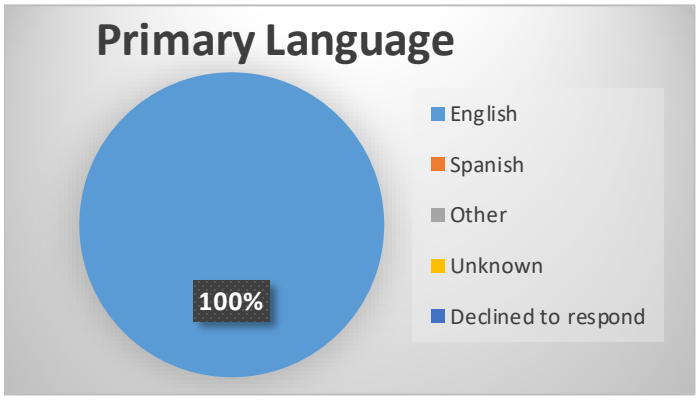


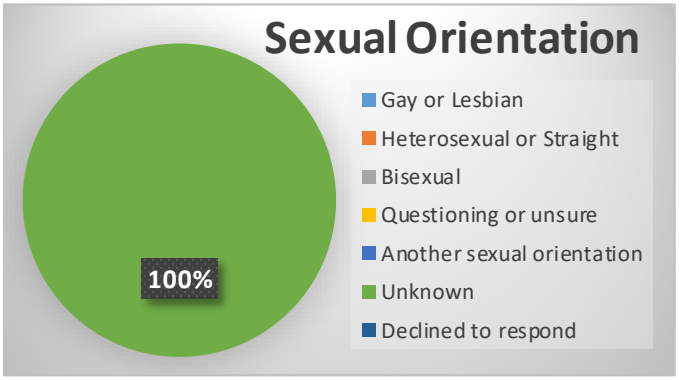












Community Baptist Church Collaborative

Takes Action FOR MENTAL HEALTH

WELLNESS • RECOVERY • RESILIENCE

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, homelessness, removal of children from their homes, and prolonged suffering.

PROGRAM DESCRIPTION:
Community Baptist Church Collaborative goals are to increase awareness of mental health issues and resources in the broader community and specifically within the African American Community. Community Baptist Church Collaborative addresses the associated risk factors of stigma, inadequate information regarding mental health issues, lack of trust for mainstream services and lack of acceptable mental health service for the African American community in Sonoma County with the following programs:

PROGRAM IMFORMATION

Program Name: CBC Collaborative
Population served: Sonoma County's broader community and specifically within the African American Community.
Phone: (707) 546-0744
Program location:
1620 Sonoma Ave, Santa Rosa, CA

FY 2020-2021 PROGRAM STATISTICS

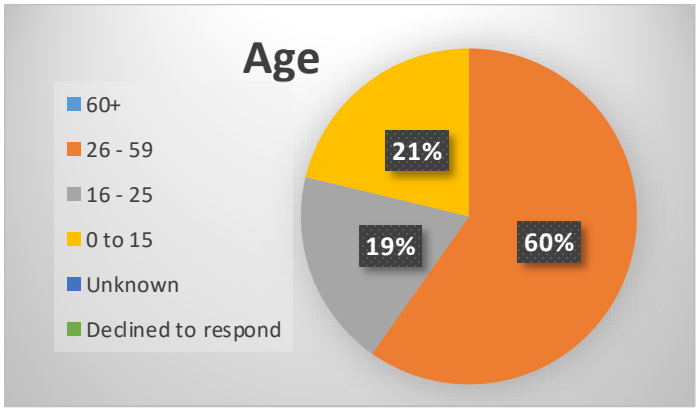
- **Total number of clients served:** 179
- **Total number of encounters:** unknown
- **Approximate numbers reached through outreach:** 4750

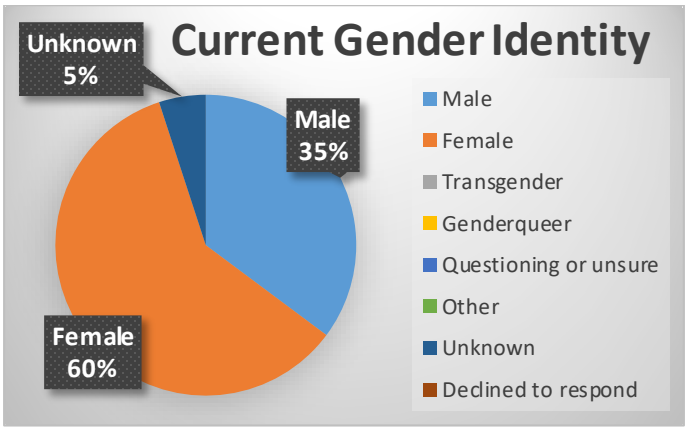
THE VILLAGE PROJECT AND SATURDAY ACADEMY are weekly programs for children ages 7-11 (Village Project) and 12-18 (Saturday Academy) using faith–based curriculum that focuses on character building and resiliency. Topics include perseverance, leadership, African American history and representation in the Bible, as well as physical and mental health topics. An additional support many of the participating youth receive is mentoring and tutoring.

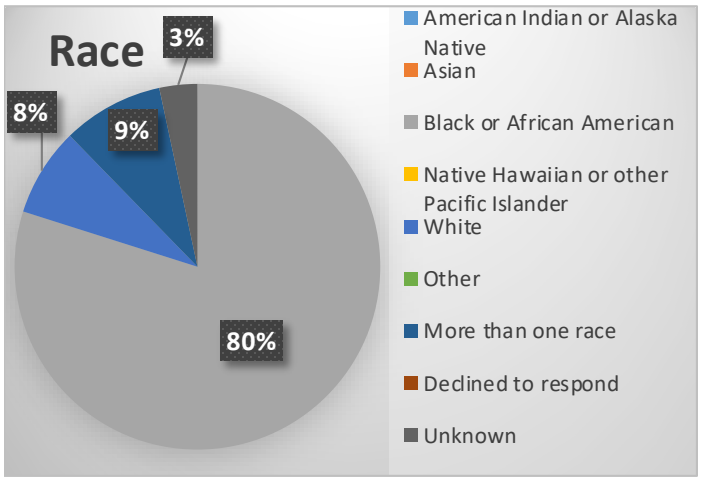
SAFE HARBOR PROJECT provides events and activities to increase well-being , reduce stress, and increase community building through the use of music, sound and vibro-acoustic techniques. In addition Safe Harbor Project provides significant outreach concerning mental health to African American and other residents. Safe Harbor Project launched a 24/7 internet radio station (KSHP Mood Music) with music intended to increase wellbeing, Public Service Announcements, interviews, speakers, and other mental health related information. Once in-person programs are viable, SHP will continue KSHP; host at least 4 large events each year at African American cultural events, health and wellness fairs, and other venues; and provide music and programing.

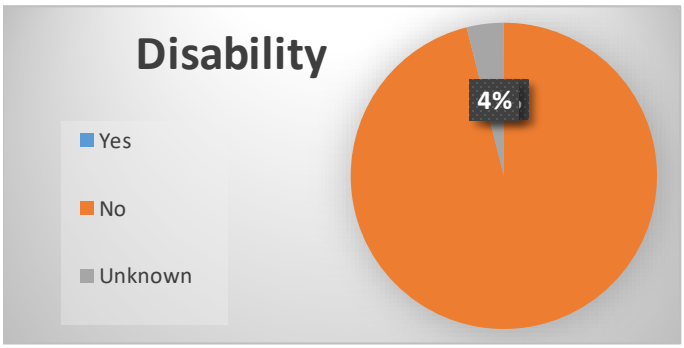
MENTAL HEALTH TRAINING AND SPEAKER SERIES hosts 4 events each year to reduce stigma, increase mental health awareness and appropriate help seeking, and increase the cultural competency of the mental health system. Our staff, leaders, mentors, and volunteers attend theses trainings, as well as others interested in the wellbeing of the African American community. Events will include QPR training regarding suicide prevention, the annual African American Mental Health Conference, annual Martin Luther King celebration and annual Juneteenth festival of which Safe Harbor Project is a sponsor.

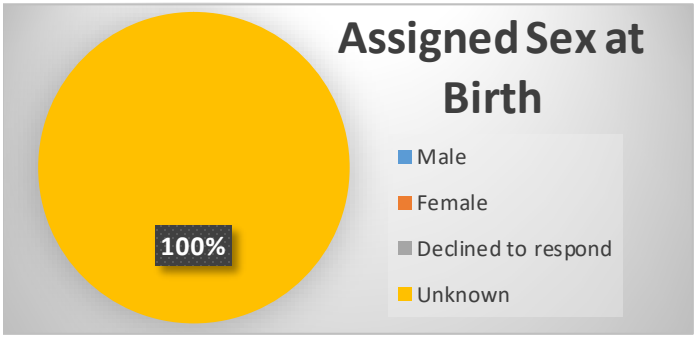
FY 2020-2021 Program Demographics:

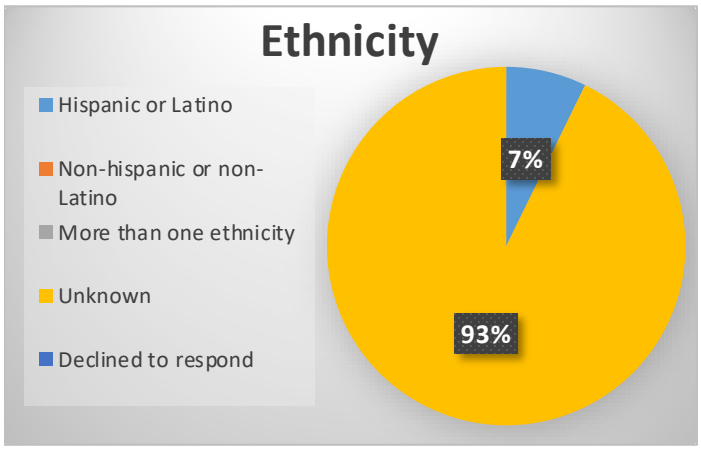


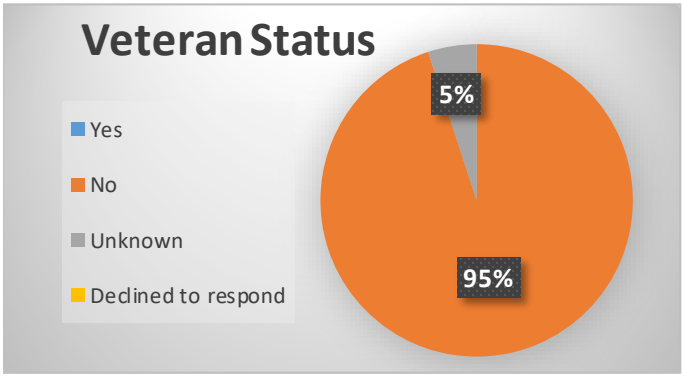


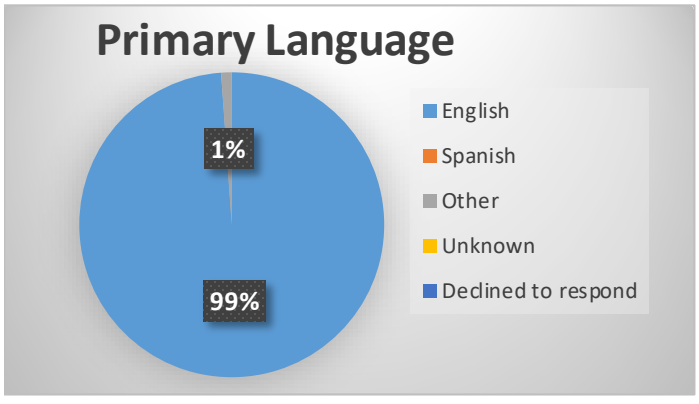


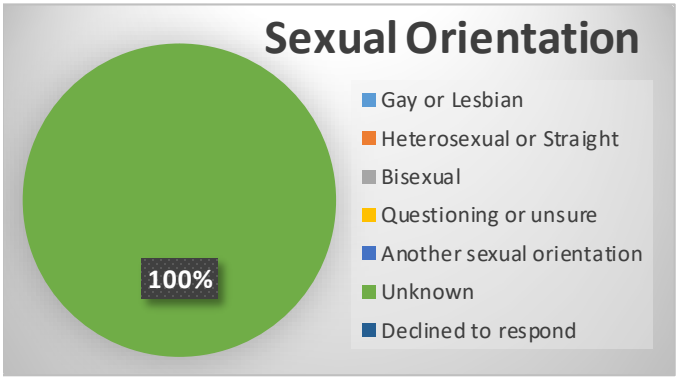












Latino Service Providers

Takes Action FOR MENTAL HEALTH

WELLNESS • RECOVERY • RESILIENCE

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, homelessness, removal of children from their homes, and prolonged suffering.

PROGRAM IMFORMATION

Program Name: Latino Service Providers
Population served: Latinx population and allies in Sonoma County.
Website: www.latinoserviceproviders.org
Phone: (707) 837-9577
Program location: 1015-A Center Drive, Santa Rosa, CA 95403
Social Media: @LatinoServiceProviders

PROGRAM DESCRIPTION:

To reduce disparities, the specific focus of a Contractor utilizes a networking model among community providers to exchange information about activities and resources that will promote economic stability, educational success, increase access to healthcare and mental health services and resources, housing, and legal services, reduce the stigma associated with behavioral/mental health issues, and address other relevant matters or areas of interest for families throughout Sonoma County.

FY 2020-2021 PROGRAM STATISTICS

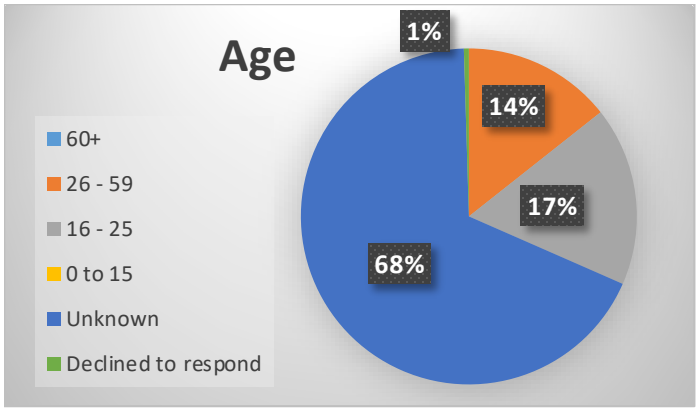
- **Total number of clients served:** 208
- **Total number of encounters:** 8,142
- **Approximate numbers reached through outreach:** 4,050

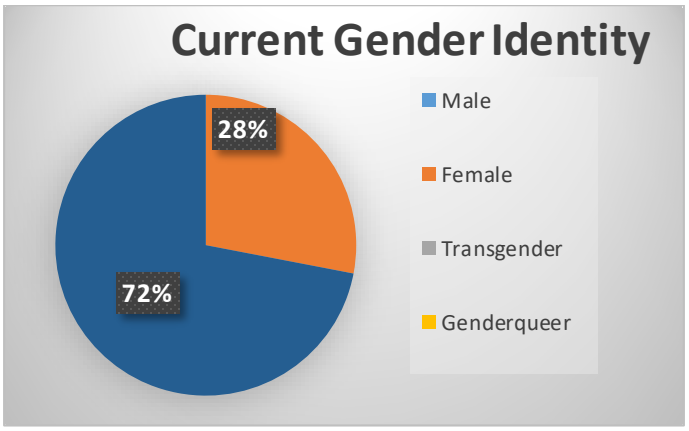
PROGRAM ACCOMPLISHMENTS:

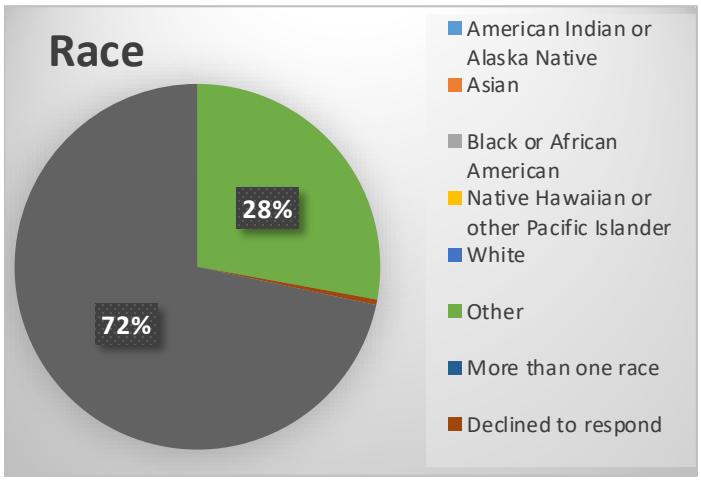
During this fiscal year July 1, 2020 to June 30, 2021, Latino Service Providers added two new members to the team, increasing our capacity and opportunity to serve our community during fires and a worldwide pandemic. COVID continues to redirect staff to operate in emergency response, however, LSP is an organization that works with community partners to increase awareness of resources, access to services, and learning opportunities. Latino Service Providers hosted 8 monthly meetings, disseminated 56 Newsletters, participated in 27 community events, and shared 451 posts via its social media platforms. Aside from LSP MHSA deliverables, LSP has expanded its Youth Promotor Program to include 47 students of Sonoma County ages 16-25 to help disseminate pertinent information and resources to our community LSP's Youth Promotores are provided with support and opportunities to present mental health education and resources through events and community conversations (pláticas). Youth Promotores engage the Latinx community, offer information in Spanish and English, and are culturally responsive. Stomp the Stigma is an annual event led by Latino Service Providers in collaboration with LSP Youth Promotores and several Sonoma County mental health service organizations. The goal of this event is to promote mental health awareness, resources, and an opportunity to practice self-care.

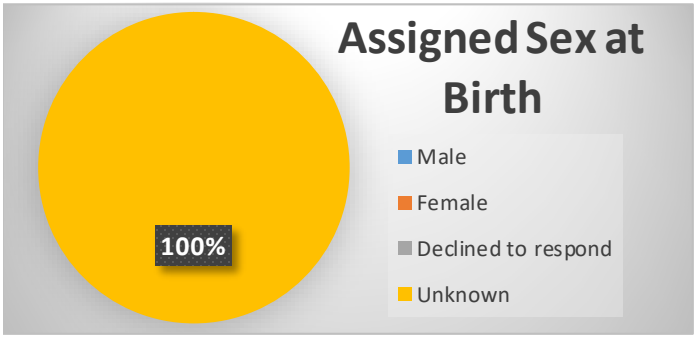
sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

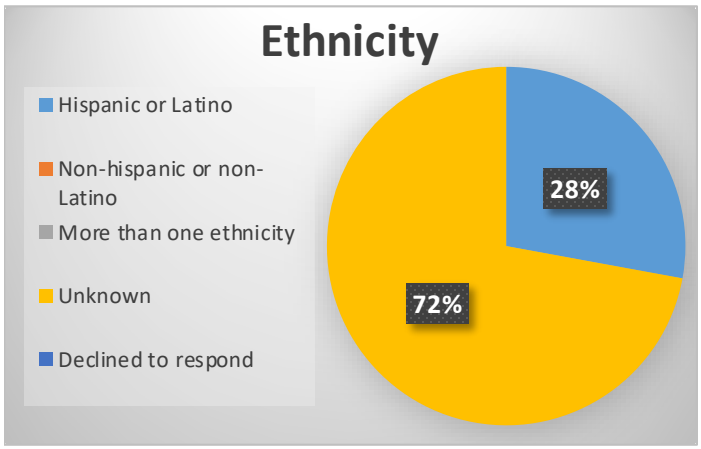
FY 2020-2021 Program Demographics:

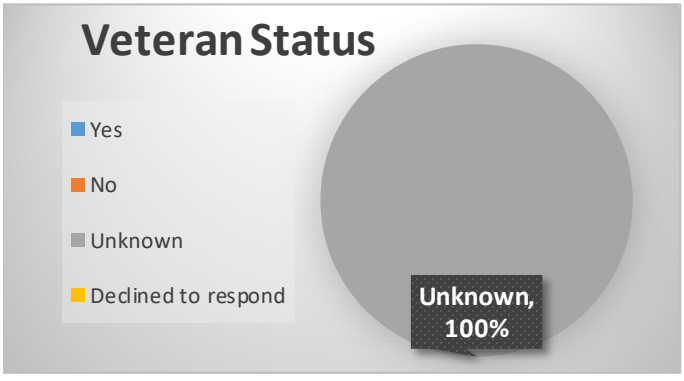


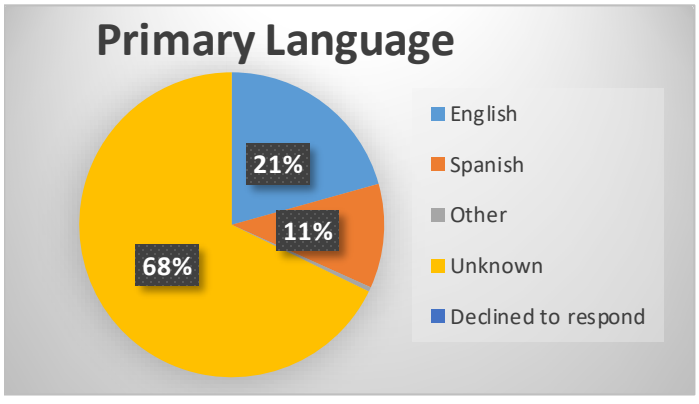


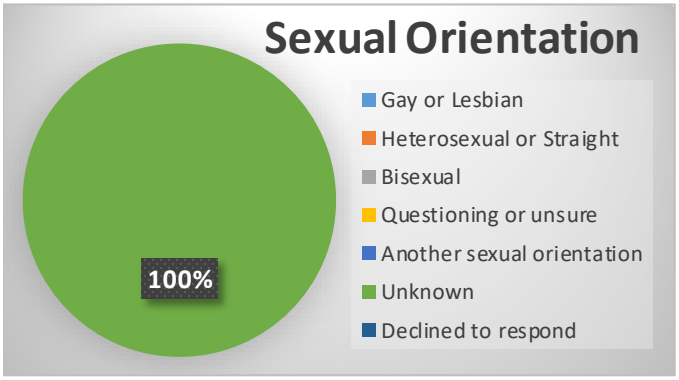












MHSA Component: Prevention and Early Intervention (PEI)

Positive Images

Takes Action FOR MENTAL HEALTH

WELLNESS • RECOVERY • RESILIENCE

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, homelessness, removal of children from their homes, and prolonged suffering.

PROGRAM IMFORMATION

Program Name: Positive Images
Population served: LGBTQIA+ Community
Website: https://www.posimages.org/
Phone: (707) 568-5830
Program location:
200 Montgomery Drive, Suite C
Santa Rosa, CA, 95404
Social Media:
Instagram: @positiveimages
Facebook: PosImages

PROGRAM DESCRIPTION:

Positive Images (PI) is a LGBTQIA+ community center which provides support to Sonoma County's LGBTQIA+ population with an emphasis on identities and individuals at the margins. We envision a Sonoma County where all LGBTQIA+ people are valued, compassionate community members building a just and equitable society. Through Peer-Run Mental Health Support Groups, a Leadership Development Program, LGBTQIA+ Cultural Competency Trainings, Resources and Referrals to affirming behavioral health resources, and Community Outreach and Engagement Activities, our programs are designed to reduce risk factors for developing a serious mental illness, build protective factors, as well as address and promote recovery.

FY 2020-2021 PROGRAM STATISTICS

- **Total number of clients served: 241**
- **Total number of encounters: 1,596**
- **Approximate numbers reached through outreach: 2,065**

PROGRAM ACCOMPLISHMENTS:

Since Positive Images was established in 1990, we have been a cornerstone in our county, providing a safe, inclusive, and welcoming space for the historically and systemically underserved and underrepresented LGBTQIA+ community. Over the last three decades, PI has served thousands of community members and been instrumental in building, developing, and nurturing a strong and resilient local LGBTQIA+ community. In the 2020-2021 Fiscal Year, our MHSA programs reached over 2000 people. We hosted 262 Peer-Run Mental Health Support Groups, 97 Leadership Development sessions, 15 community-wide Cultural Competency Trainings, and participated in 12 Outreach Events. Individuals who participate in our programs consistently report increased feelings of connectedness, life satisfaction, self-acceptance, self-esteem, and self-advocacy.

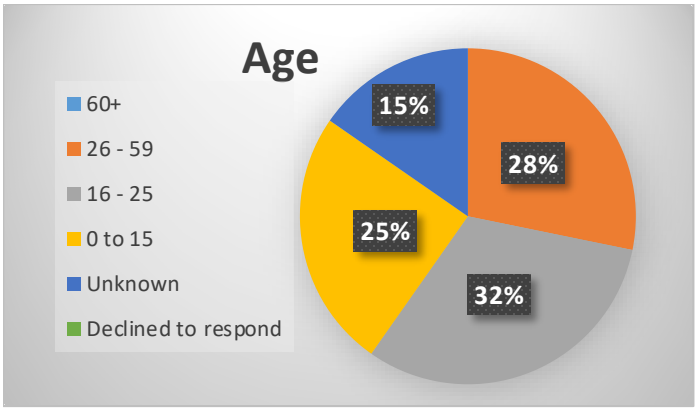
Sonoma County DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

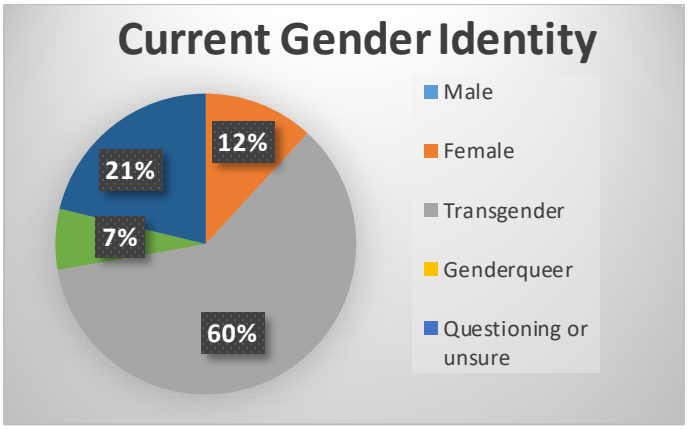
FY 2020-2021
Program Feedback:

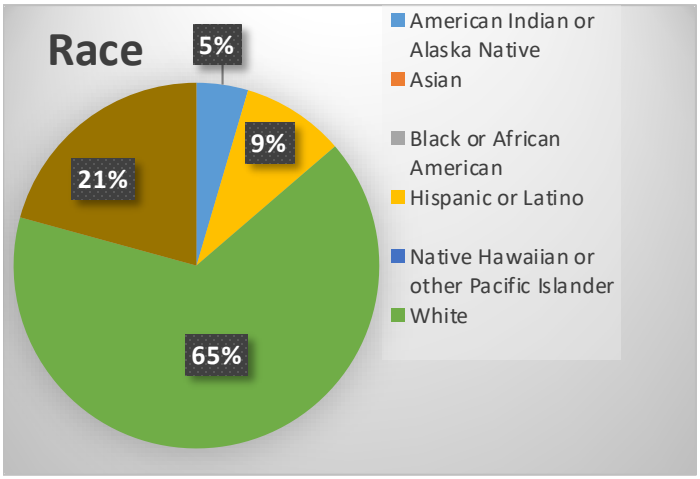
Positive Images routinely gathers participant feedback through evaluation surveys, interviews, and questionnaire forms. The following are quotes participants shared with us in 2020-2021.

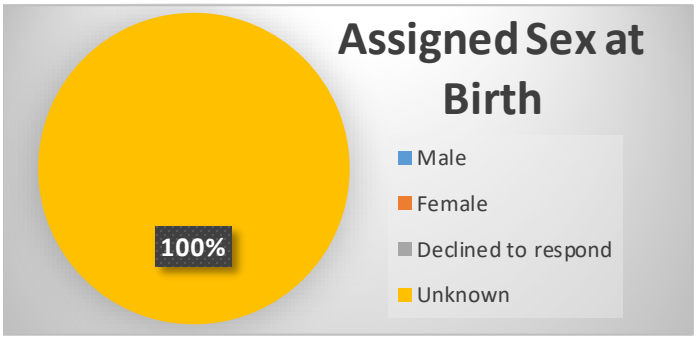
- "PI has made me feel more accepted and supported, comforting me when I am anxious and helping to alleviate my depression."
- "Not only did PI provide a weekly support group where I could be with other young people who were struggling with many of the same issues around gender and sexuality that I was, but PI also provided me with support around housing, food, clothing, work, and opportunities for leadership and service."
- "PI has changed my life, drastically brought me back from the brink of suicide, and turned me into a strong youth leader."
- "Being a part of this community and knowing these people has saved my life."
- "Positive Images provides a safe space, positive members, resources, fun activities, opportunity to connect with other LGBTQ+ folks, and so much love and support. They gave me the courage to be who I really am."
- "Pi has saved my life many times, helped me overcome self-harm, and gave the confidence I needed to come out and live as myself."
- "PI is an extremely healing place, full of supportive people and helpful resources."

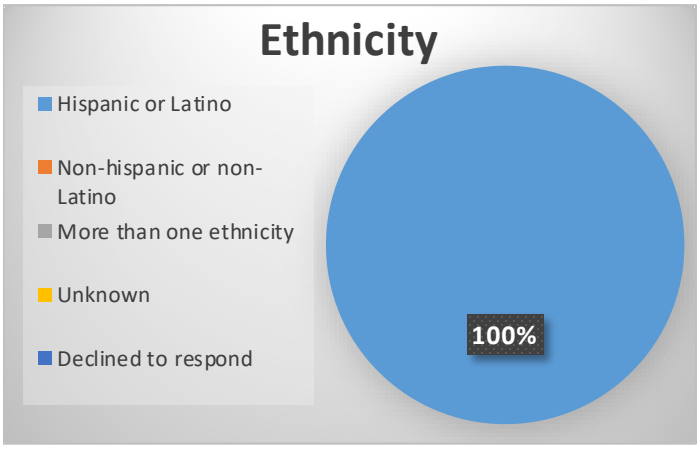
FY 2020-2021 Program Demographics:

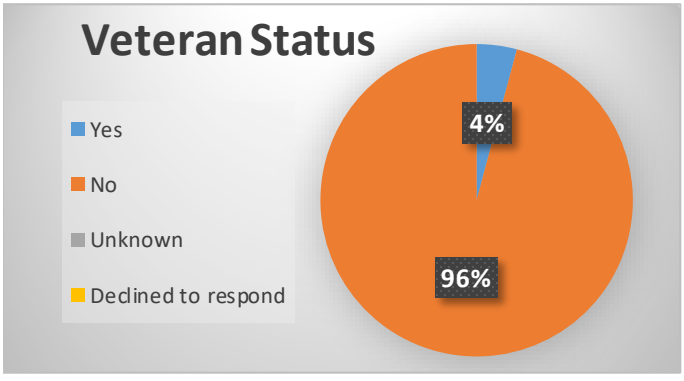


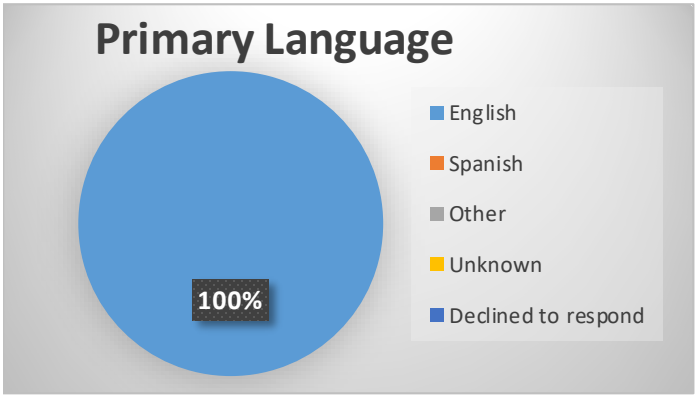


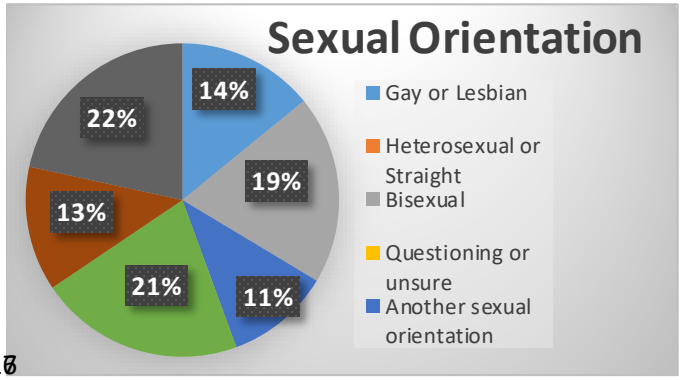












Sonoma County Human Services Older Adult Collaborative

Takes Action for Mental Health

Mental Health Services Act Proposition 63 California

Wellness • Recovery • Resilience

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, homelessness, removal of children from their homes, and prolonged suffering.

"Empower, Support, Protect"
Human Services Department
County of Sonoma

council on aging
living better, together.

Petaluma People Services Center

West County Community Services

PROGRAM INFORMATION

Sonoma County Human Services:
OLDER ADULT COLLABORATIVE
Reducing Depression in Older Adults

Population served: Older Adults (60+)
Program location: Sonoma County, CA
Contact Info: Sarah Gross
sgross@schsd.org
(707) 565-5517

PROGRAM DESCRIPTION:

The **Older Adult Collaborative (OAC)** is a four-agency collaborative between Sonoma County Human Services Department (Adult & Aging Division), Council on Aging, Petaluma People Services Center, and West County Community Services.

These member agencies are the primary providers of older adult services in Sonoma County. The OAC initiative incorporates depression screening, education, and early intervention into existing older adult programming such as case management and nutrition programs. OAC utilizes the evidence-based depression intervention Healthy IDEAS (Identifying Depression & Empowering Activities for Seniors), while also referring clients to mental health services and community resources as needed.

FY 2020-2021 PROGRAM STATISTICS

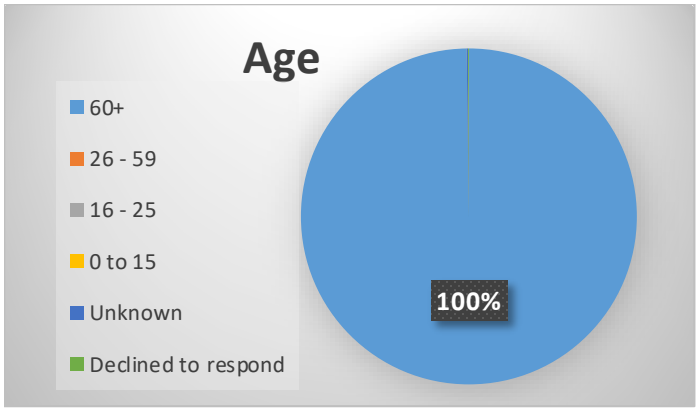
- **Total number of older adults screened for depression:** 2301
- **Total number older adults provided with depression education:** 2966
- **Total number of encounters (home visits & phone calls):** 3680

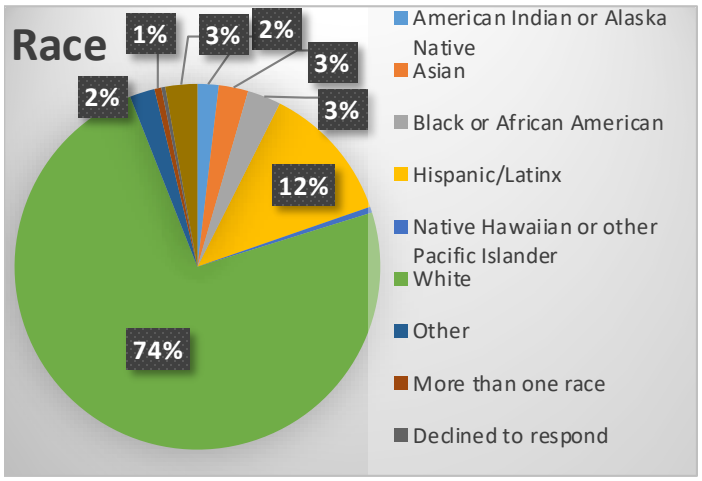
PROGRAM ACCOMPLISHMENTS:

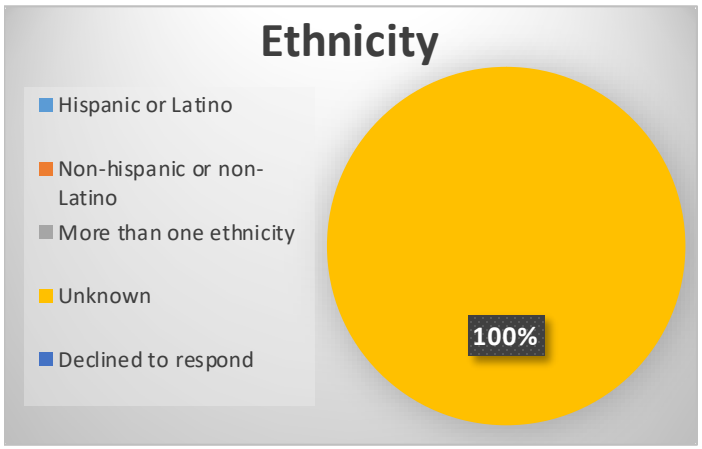
Improvement in depression symptoms:
The number of older adults who showed improvement in depression symptoms (based on PHQ-9 scores) was **250** for the 2020-21 fiscal year.

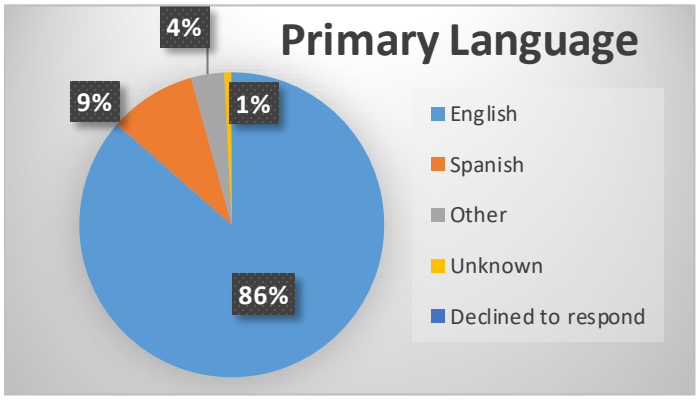
Other progam highlights: OAC partner agencies quickly pivoted during the COVID pandemic to provide virtual services that reduced isolation of older adults while providing much-needed continuation of services. Additional programs to address pandemic-related isolation and loneliness included the development of a new, widely utilized daily call program for Sonoma County's older adults, and initiatives to purchases tablets to improve communication and connection.

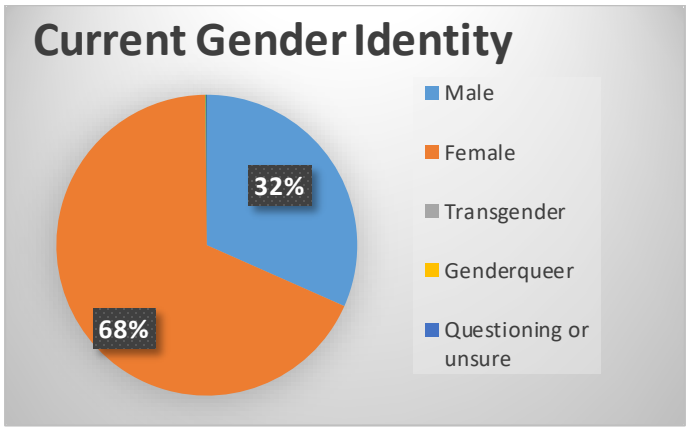
FY 2020-2021 Program Demographics:

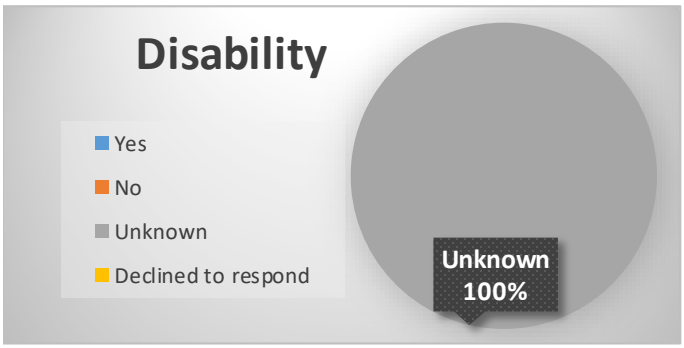


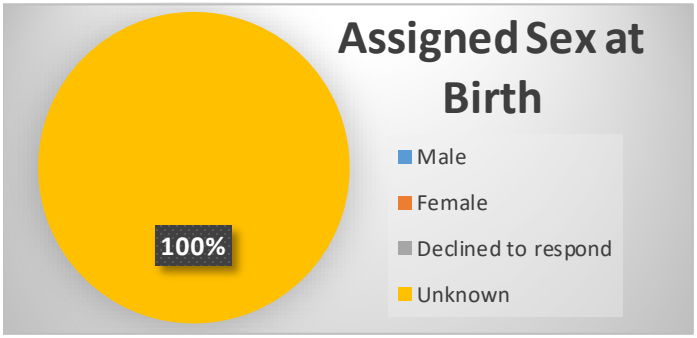


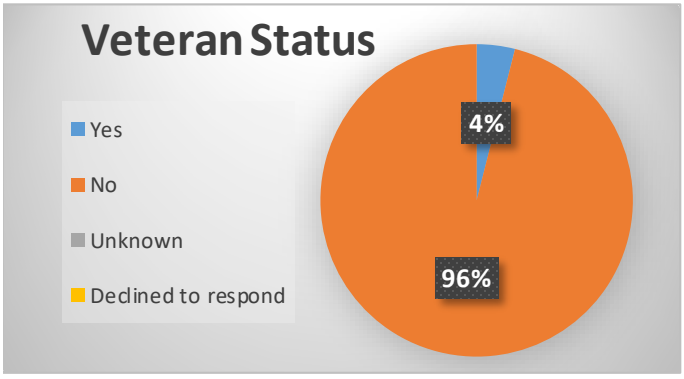


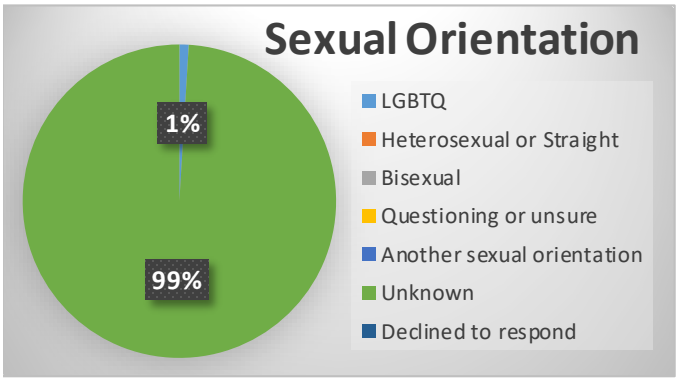












Prevention and Early Intervention (PEI)

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:

- Suicide
- Incarcerations
- School failure or dropout
- Unemployment
- Prolonged suffering
- Homelessness
- Removal of children from their homes

Early Intervention

A set Treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable negative outcomes listed in Welfare and Institutions Code Section 5840, subdivision (d) that may result from untreated mental illness.

Early Childhood Mental Health (0-5) Collaborative

Takes Action for Mental Health

WELLNESS • RECOVERY • RESILIENCE

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, homelessness, removal of children from their homes, and prolonged suffering.

PROGRAM DESCRIPTION:

Sonoma County utilizes MHSA funds for the Early Childhood Mental Health (0-5) Collaborative to support early relational health by:

- Preventing and reducing the impact of **Adverse Childhood Experiences** (ACE's);
- Identifying **developmental and social-emotional concerns and delays,** and linking families to resources;
- Strengthening **parent-child relationships** and building parent's knowledge and skills; and
- Identifying and treating women with **perinatal mood and anxiety disorders** (PMDs).

The following community partners provide contracted services under the 0-5 Collaborative:

- **Child Parent Institute (CPI)**
- **Early Learning Institute (ELI)**
- **Petaluma People Services Center (PPSC)**

PROGRAM IMFORMATION

Program Name: Early Childhood Mental Health (0-5) Collaborative
Population served: Children from prenatal stage through age 5 and their families in Sonoma County
Website: first5sonomacounty.org
Phone: (707) 522-2020
Program location: Child Parent Institute, 3642 Standish Ave, Santa Rosa, CA 95407; Early Learning Institute, 311 Professional Center Drive, #100, Rohnert Park, CA 94928; Petaluma People Services, 1500 Petaluma Blvd. Petaluma, CA 94952

FY 2020-2021 PROGRAM STATISTICS

- **Total number of clients served by the collaborative:** 3,051
- **Total served by CPI:** 296
- **Total served by ELI:** 2,674
- **Total served by PPSC:** 81

0-5 COLLABORATIVE OUTCOMES & ACCOMPLISHMENTS in FY 2020-2021

353 initial ASQ screenings for social-emotional and developmental screenings for children

765 children re-screened

187 children referred for further assessment

284 families received case management or facilitated referrals

550 parents/caregivers received support or information to access

210 parents/caregivers participated in Triple P Positive Parenting seminars (levels 2, 3, & 4) services through a navigation line or phone sessions

36 families participated in in-home and group Triple P Positive Parenting services (levels 3, 4, & 5)

56 parents/caregivers at risk of or experiencing perinatal mood disorders participated in individual counseling services

***100%** of parents/caregivers who completed services showed improvement in symptoms based on the PHQ-9 assessment

22 parents/caregivers at risk of perinatal mood-disorders participated in group counseling services

Sonoma County Department of Health Services
Behavioral Health Division

DESCRIPTION OF SERVICES PROVIDED:

MHSA agencies use a community-based approach, providing services either in the client's home or at a community-site. Agencies offer services in English and Spanish, which bolstered Hispanic/Latinx participation. The majority of those served under the Collaborative are Hispanic/Latinx, and 49% spoke Spanish as their primary home language.

CHILD PARENT INSTITUTE (CPI)

The Child Parent Institute (CPI) participates in a community continuum of care, which includes screening, intervention, and support strategies, serves children and caregivers, and establishes a framework for success beyond a single program or strategy. CPI provides:

- Triple P (Positive Parenting Program)
- Level 2 Seminars Levels 3, 4, and 5 (individual and group formats) in an in-home parent education format or at CPI or a community site.
- Enhanced services that include mental health consultations as needed

EARLY LEARNING INSTITUTE (ELI)

The Early Learning Institute's Watch Me Grow (WMG) program will serve families of children ages birth through five across Sonoma County by:

- Providing comprehensive screenings to at-risk children who would otherwise not receive them.
- Providing case management and referral assistance to families of children ages 0-5 for whom a screening identifies potential problems.

PETALUMA PEOPLE SERVICES CENTER (PPSC)

Petaluma People Services Center (PPSC), in partnership with Petaluma City School District provides developmental and social-emotional screening for children in high-risk situations with no other access to:

- Developmental and social-emotional screening
- Triple P (Positive Parenting Program) parent education
- Triple P mental health services to families of children 0-5

OTHER IMPORTANT OUTCOMES INCLUDED:

- **Parents increased their knowledge of parenting and child development** and developed their parenting skills.
- Women at risk of or experiencing perinatal mood disorder **experienced improvement in their depression and anxiety.**
- Children at risk of development **delays were identified through timely screenings and referred** to the relevant providers for ongoing evaluation and support.
- **Families received critical referrals and resources** to address their basic needs.

MHSA agencies stress the importance of meeting families' basic needs and focusing on the whole family's wellbeing in order to support parent-child relational health.

SERVICE ADAPTATIONS IN RESPONSE TO COVID-19 PANDEMIC

MHSA agencies adapted swiftly to the pandemic, rising to the challenge of meeting the emergent needs of the community in safe and creative ways. This section provides an overview of CPI, ELI, and PPSC's response.

Virtual Programming

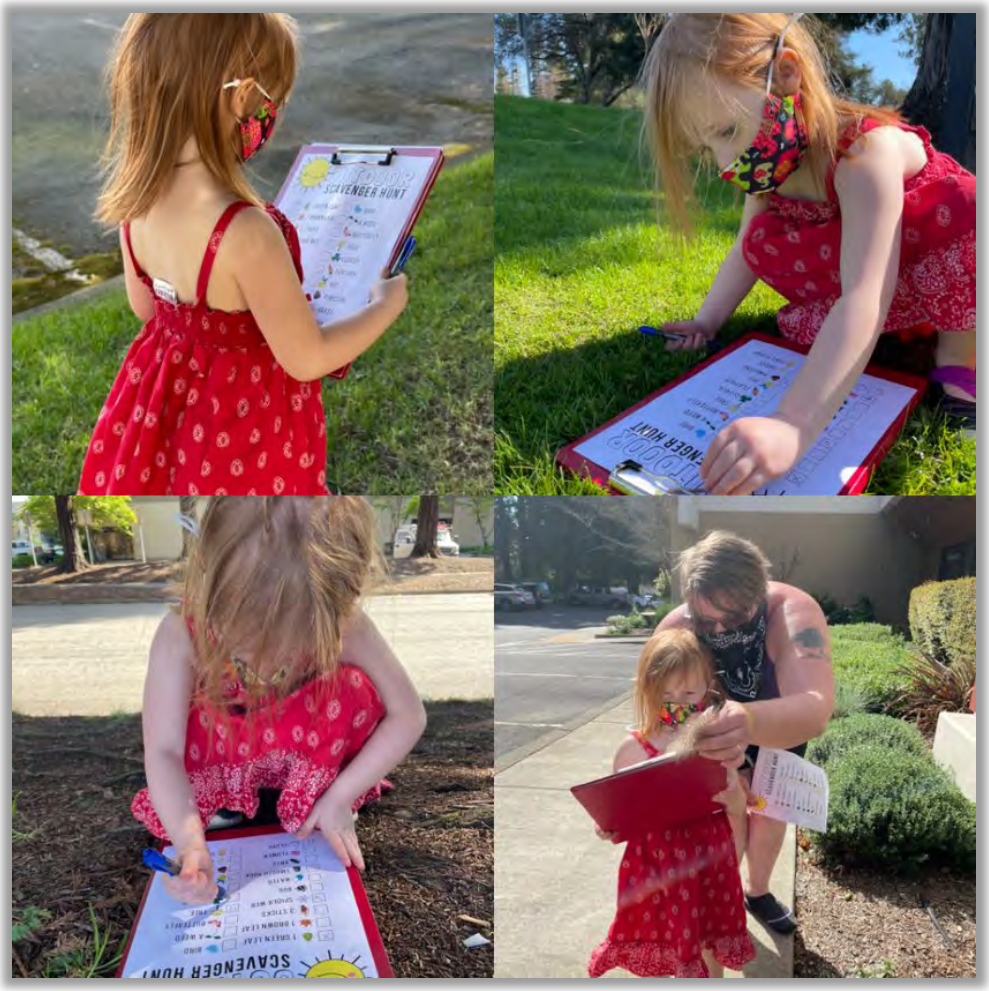
- Provided sources of support for parents and caregivers during the isolation of the pandemic.
- Removed transportation and childcare barriers, helping to increase access for Spanish-speaking families and families located in rural areas of the County.
- Allowed for greater flexibility for when providers could meet with parents, including in the evenings after children were asleep.

Modified Outreach Efforts

Increased community outreach, expanded access for parenting and child development resources, and deepened relationships with existing clients.

Provision of Basic Needs

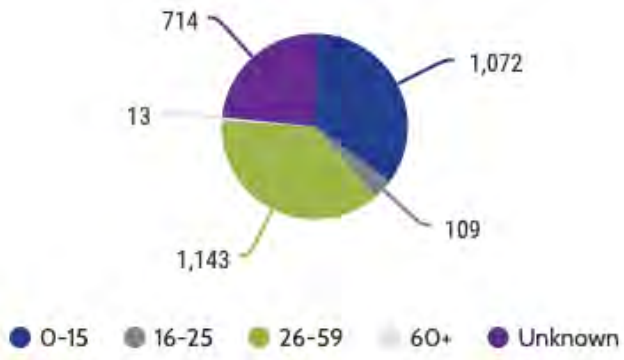
Connected clients to food, diaper banks, financial assistance, testing sites, and other resources.



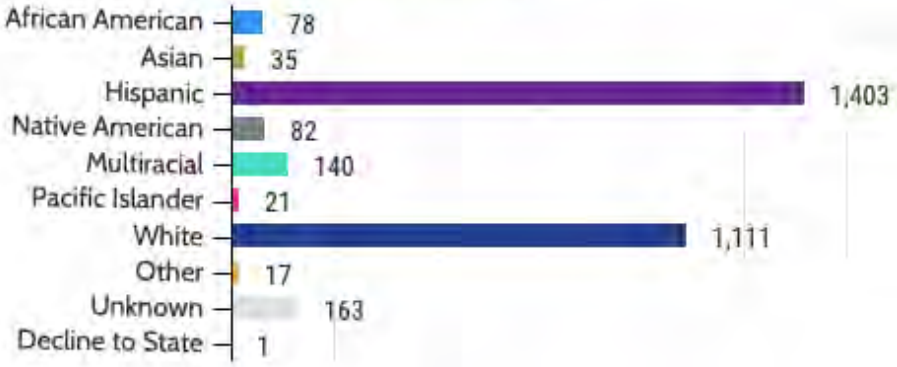
0-5 COLLABORATIVE FY 2020-2021 DEMOGRAPHICS

Current Gender Identity

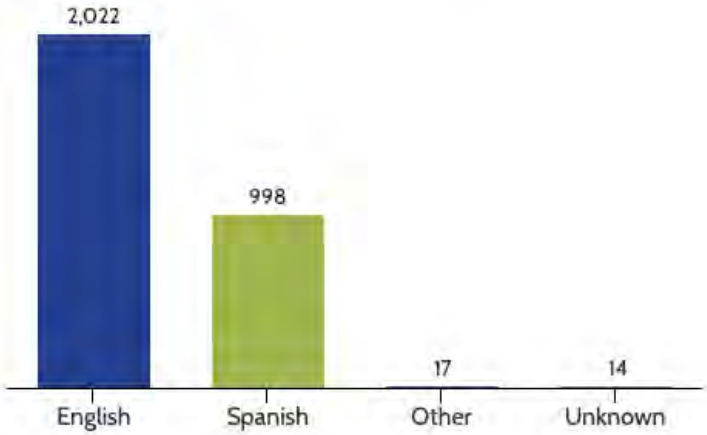
Age



Race/Ethnicity



Primary Language



Prevention and Early Intervention (PEI)

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:

- Suicide
- Incarcerations
- School failure or dropout
- Unemployment
- Prolonged suffering
- Homelessness
- Removal of children from their homes

Access and Linkage

A set of related activities to connect children with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, and adults and seniors with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, as early in the onset of these conditions as practicable, to medically necessary care and treatment, including, but not limited to, care provided by county mental health programs.

DHS-BHD's Youth Access Team

Takes Action FOR MENTAL HEALTH

WELLNESS • RECOVERY • RESILIENCE

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, homelessness, removal of children from their homes, and prolonged suffering.

PROGRAM IMFORMATION

Program Name: Behavioral Health Division's Youth Access Team

Population served: Sonoma County residents under the age of 18

Website: https://sonomacounty.ca.gov/health-and-human-services/health-services/divisions/behavioral-health/services/accessing-mental-health-services

Phone: (707) 565-6900 or
(800) 870-8786

Program location:
2227 Capricorn Way, Suite 207
Santa Rosa, CA 95407

PROGRAM DESCRIPTION:

Sonoma County - Behavioral Health Division's Youth Access Team is the first contact for requesting mental health services. They determine the level of need for mental health services, provide assessment, linkage, and information and referral for mental health services for children and youth.

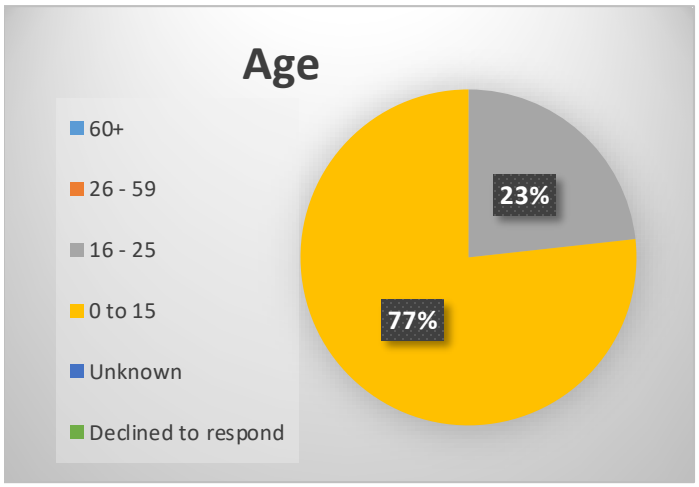
The Youth Access Team improves access to mental health services for residents of Sonoma County under the age of 18. Individuals seeking care are able to quickly receive a mental health screening and, when needed, assessment and treatment planning and/or referral for appropriate levels of care to the network of mental health services available throughout the county. While the primary purpose of the Youth Access Team is to assist the Medi-Cal beneficiary into care, the Youth Access Team also provides links to other community resources for any caller.

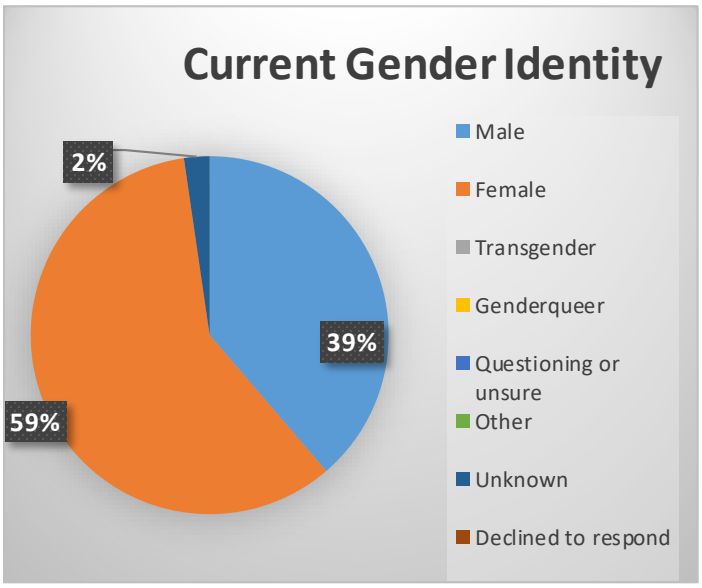
FY 2020-2021 PROGRAM STATISTICS

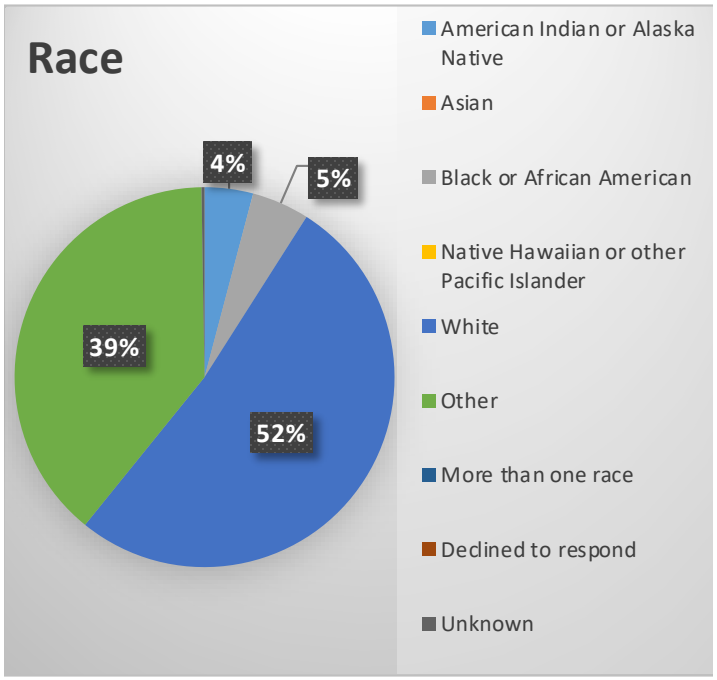
Total unique clients who assessed services through the Youth Access Team in FY 20 21: 387

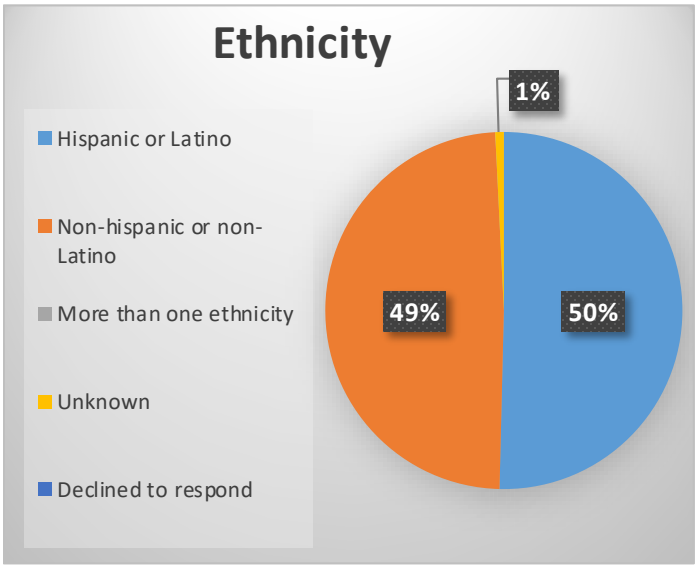
sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

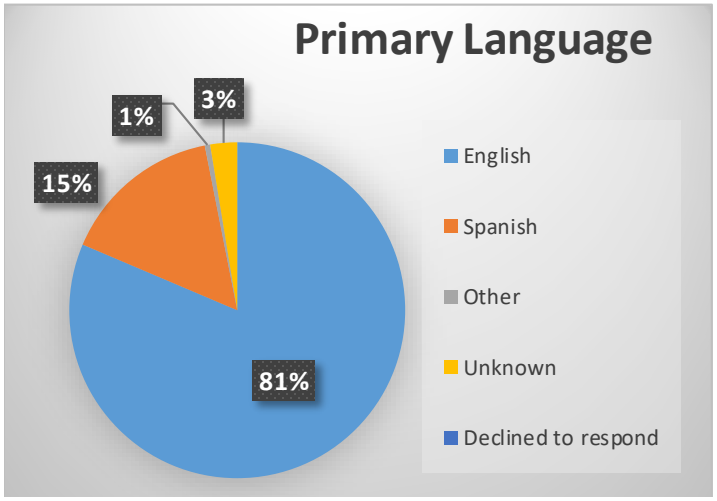
FY 2020-2021
Program Demographics:











DHS-BHD's Adult Access Team

Takes Action FOR MENTAL HEALTH

WELLNESS • RECOVERY • RESILIENCE

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, homelessness, removal of children from their homes, and prolonged suffering.

FY 2020-2021 PROGRAM STATISTICS

Total unique clients who assessed services through the Youth Access Team in FY 20 21: **497**

PROGRAM DESCRIPTION:

Sonoma County - Behavioral Health Division's Adult Access Team is the first contact for requesting mental health services. They determine the level of need for mental health services, provide assessment, linkage, and information and referral for mental health services for adults.

The Adult Access Team improves access to mental health services for adult residents of Sonoma County. Individuals seeking care are able to quickly receive a mental health screening and, when needed, assessment and treatment planning and/or referral for appropriate levels of care to the network of mental health services available throughout the county. While the primary purpose of the Adult Access Team is to assist the Medi-Cal beneficiary into care, the Adult Access Team also provides links to other community resources for any caller.

PROGRAM IMFORMATION

Program Name: Behavioral Health Division's Adult Access Team

Population served: Sonoma County residents 18 of age and over

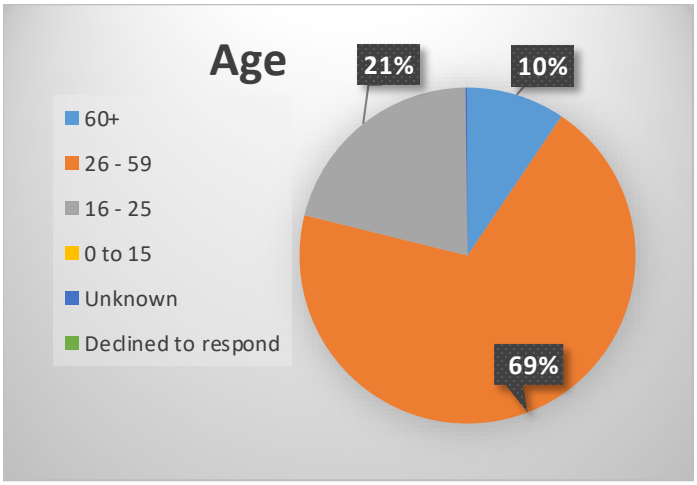
Website:
https://sonomacounty.ca.gov/health-and-human-services/health-services/divisions/behavioral-health/services/accessing-mental-health-services

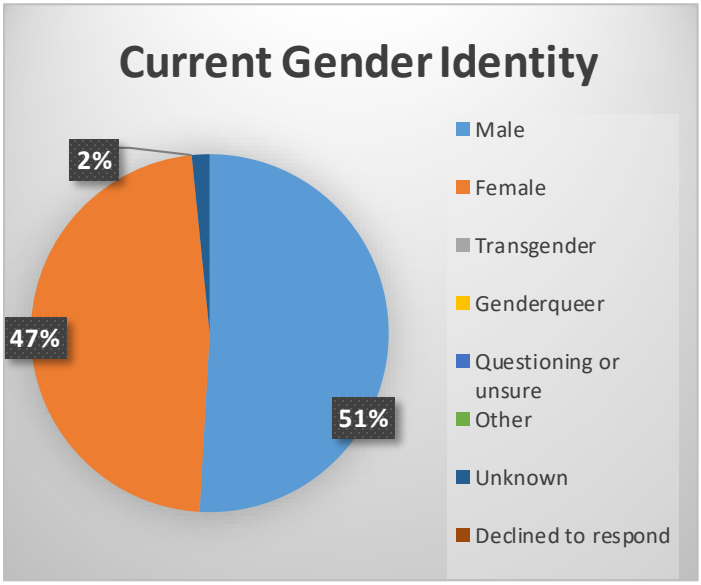
Phone: (707) 565-6900 or
(800) 870-8786

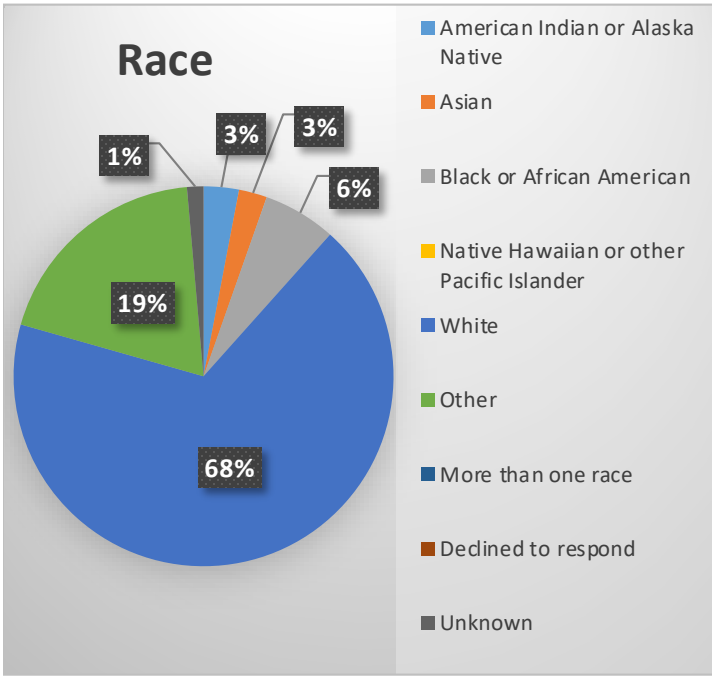
Program location:
2227 Capricorn Way, Suite 207
Santa Rosa, CA 95407

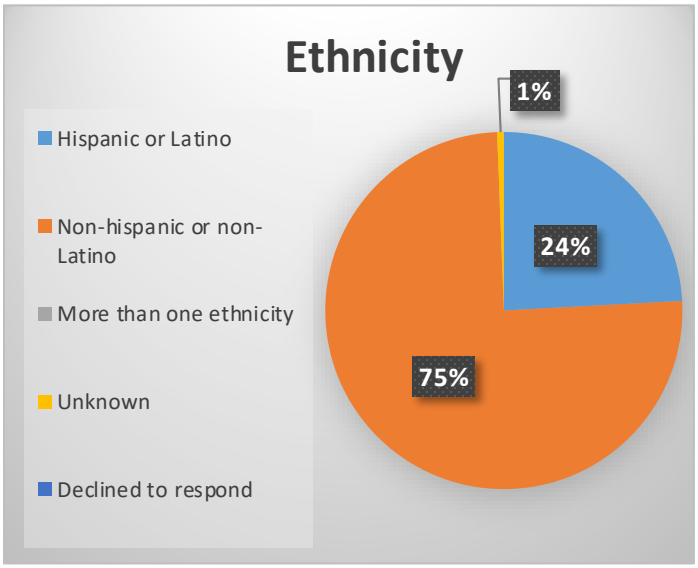
sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

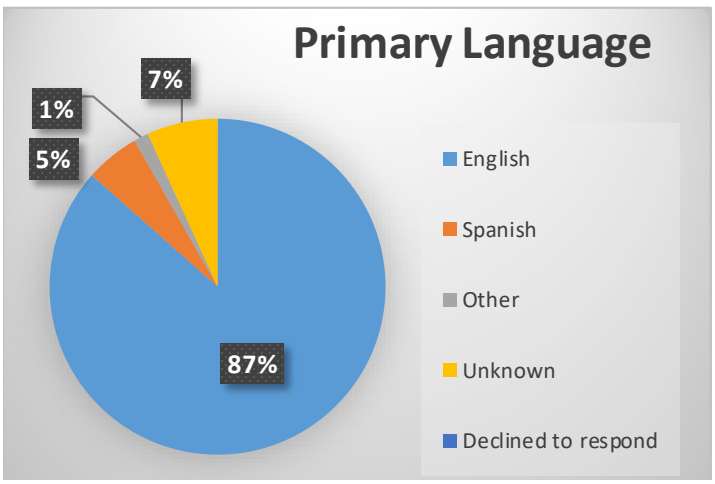
FY 2020-2021
Program Demographics:











Prevention and Early Intervention (PEI)

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:

- Suicide
- Incarcerations
- School failure or dropout
- Unemployment
- Prolonged suffering
- Homelessness
- Removal of children from their homes

Stigma & Discrimination

The County's direct activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families.

SRJC Student Health Services, PEERS Coalition

Takes Action FOR MENTAL HEALTH

WELLNESS • RECOVERY • RESILIENCE

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, homelessness, removal of children from their homes, and prolonged suffering.

PROGRAM INFORMATION

Program Name: Santa Rosa Junior College Student Health Services, PEERS Coalition
Population served: SRJC students of all ages with mental health concerns
Website: shs.santarosa.edu
Phone:

Santa Rosa	(707) 527-4445
Petaluma	(707) 778-3919

Program location:

Santa Rosa	1501 Mendocino Ave. Santa Rosa, CA 95401
Petaluma	680 Sonoma Mountain Pkwy, Petaluma, CA 94954

Social Media:
@srjcpeers
@ Student Health PEERS at SRJC
@Student Health PEERS Coalition

PROGRAM DESCRIPTION:

The PEI Program at SRJC uses a comprehensive approach to promote mental health and reduce stigma on campus. Faculty trainings on recognizing and responding to students with mental health challenges, QPR suicide prevention workshops, mental health presentations in classrooms and orientations, PEER led workshops and drop-in groups, social media, online mental health screenings and outreach events are strategies used to ensure that the SRJC community knows that Mental Health Matters.

FY 2020-2021 PROGRAM STATISTICS

Education # of students & staff	**1167** MH education in Classrooms **233** PEERS Workshops **218** Faculty Outreach **118** QPR Suicide Prevention
Outreach	**295** online mental health screenings **1151** students contacted at food distributions & vaccine clinics
Social Media # of followers	PEERS Instagram **504** PEERS Facebook

PROGRAM TESTIMONIALS:

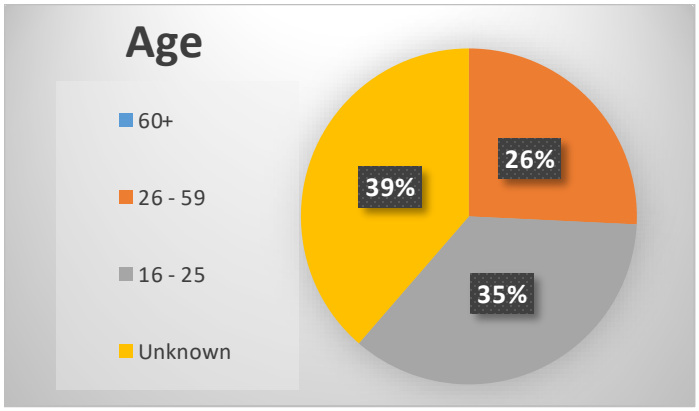
"I learned from the **PEERS Workshop** that that I am not alone in this world."

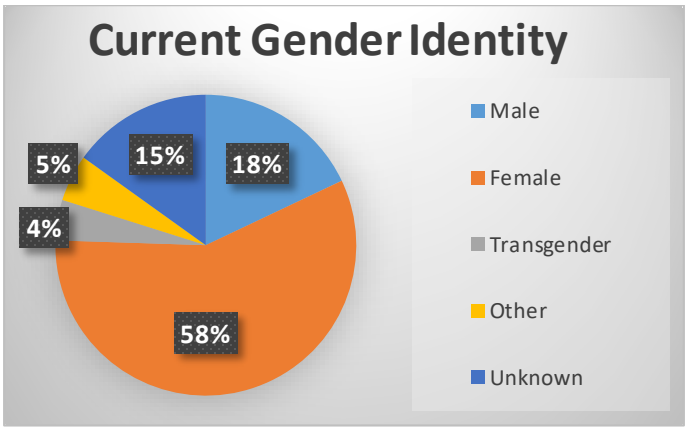
QPR Suicide Prevention: "I loved it. Everyone should complete this and understand how to talk with someone who may be suicidal. I am so happy to understand how to talk with someone. Thank you!" "I found this training to be very helpful. I am now more comfortable to ask people about suicide."

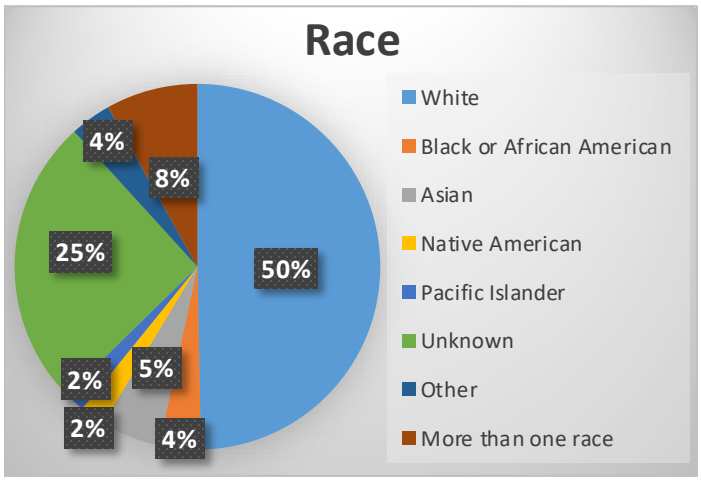
Impact of **Classroom presentation**: "I will seek help and talk more about my mental health needs." "I will focus on breathing and meditation and identify the causes of my stress." "I will be more aware of my mental state and ask for help if need be."

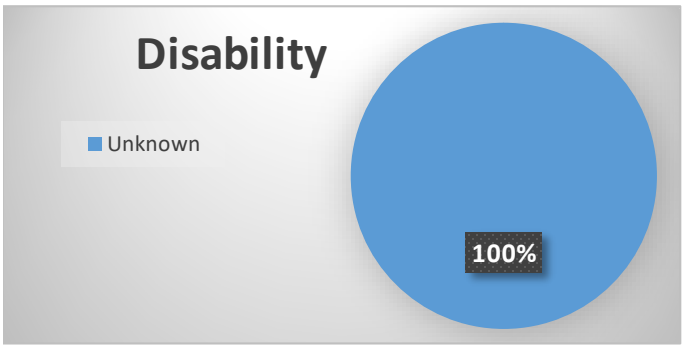
Sonoma County DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

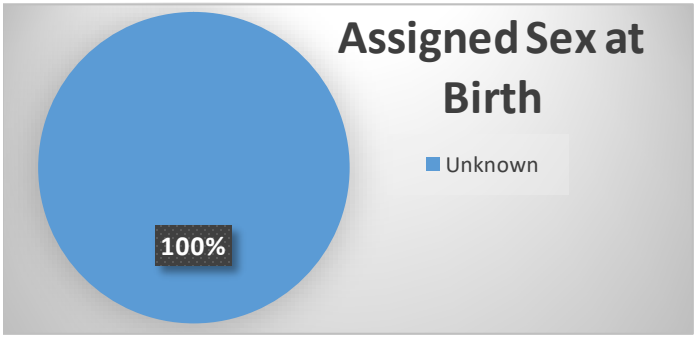
FY 2020-2021 Program Demographics:

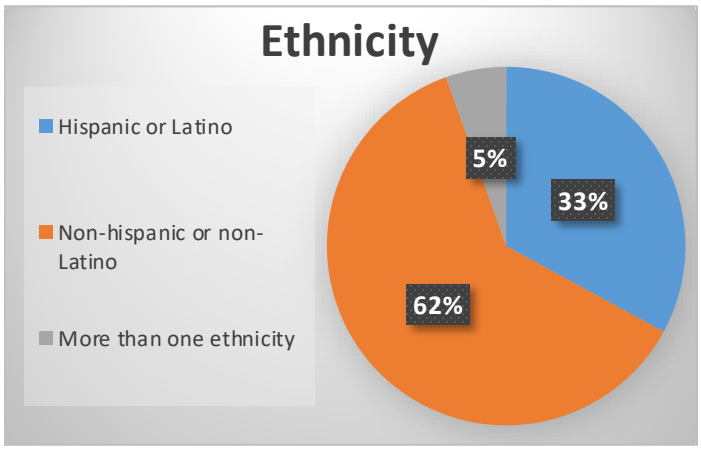


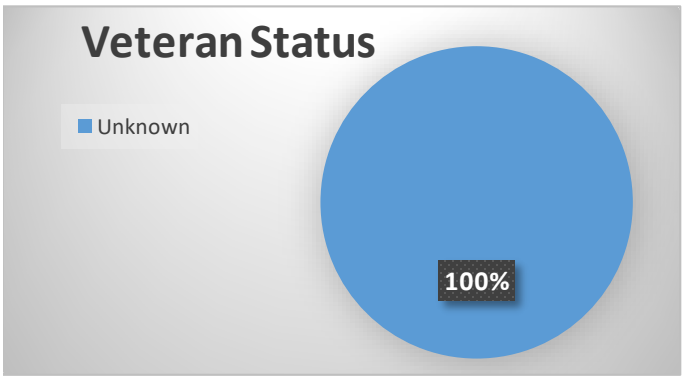


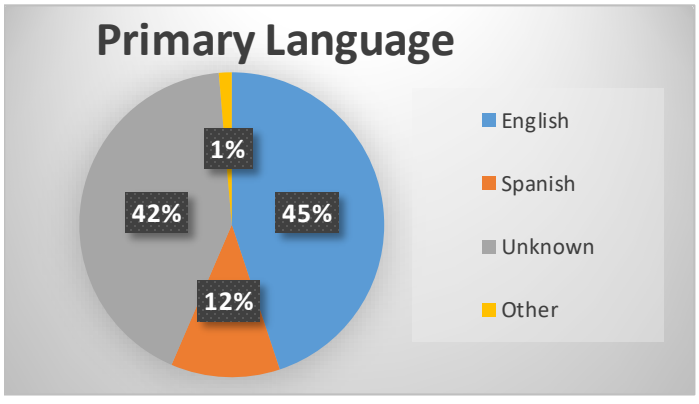


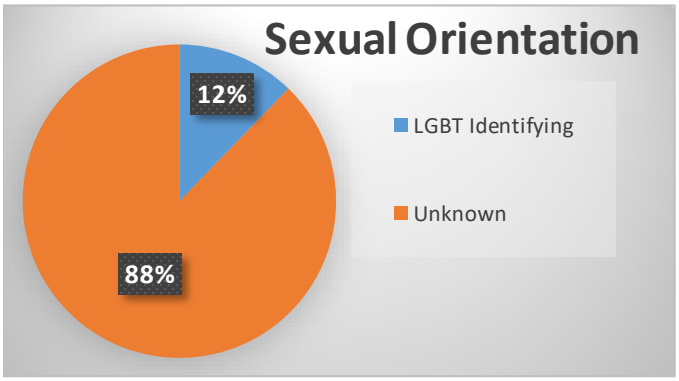












Prevention and Early Intervention (PEI)

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:

- Suicide
- Incarcerations
- School failure or dropout
- Unemployment
- Prolonged suffering
- Homelessness
- Removal of children from their homes

Outreach for Increasing Recognition of Early Signs of Mental Illness

A process of engaging, encouraging, educating, and/or training, and learning from potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness

For the PEI Outreach for Increasing Recognition of Early Signs of Mental Illness strategy the County provides the evidence based Crisis Intervention Training (CIT) for Law Enforcement personnel.

CIT was postponed for FY 20-21 due to the pandemic. The County is planning to offer training to first responders in FY 21-22.

Prevention and Early Intervention (PEI)

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:

- Suicide
- Incarcerations
- School failure or dropout
- Unemployment
- Prolonged suffering
- Homelessness
- Removal of children from their homes

Suicide Prevention

Organized activities that the County undertakes to prevent suicide as a consequence of mental illness.

MHSA Component: Prevention and Early Intervention (PEI)

Buckelew's North Bay Suicide Prevention Program

Takes Action for Mental Health

Mental Health Services Act Proposition 63 California

Wellness • Recovery • Resilience

Service Category: *Suicide Prevention*

Programs that prevent mental illnesses from becoming severe and disabling, emphasizing improvement on timely access to services for underserved populations. Programs shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, homelessness, removal of children from their homes, and prolonged suffering.

PROGRAM IMFORMATION

Program Name: Buckelew Programs Suicide Prevention Program

Population served: Callers who are experiencing suicidal ideation or who are closely connected with someone who is experiencing suicidal ideation

Website: www.buckelew.org
Phone: 415-457-6964
Program location:
201 Alameda Del Prado Suite 201, Novato, CA, 94949

PROGRAM DESCRIPTION:

Buckelew Programs Suicide Prevention Program provides support for callers who are experiencing suicidal ideation or are closely connected to individuals experiencing suicidal ideation. This support is provided through verbal de-escalation, safety planning, and/or ensuring access to resources, including emergency services or mobile crisis team intervention as needed. The program also provides community training to increase community awareness and provides a SOS (survivors of suicide) support group for community members who may need support following the loss of a loved one.

PROGRAM STATISTICS

- **Total number of clients served:** 11,552
- **Total number of encounters:** unknown
- **Approximate numbers reached through outreach:** unknown

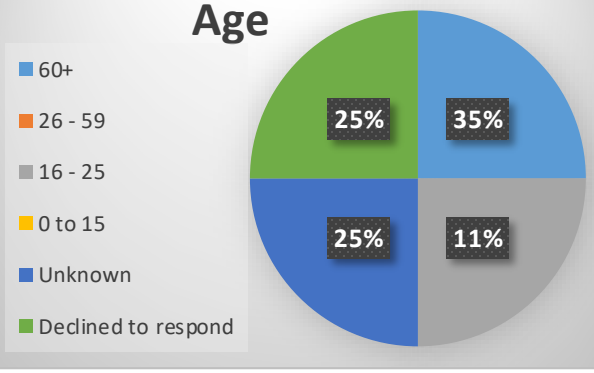
PROGRAM ACCOMPLISHMENTS:

Despite changes in the community, the impact of the Pandemic, and staffing shortages, the program has continued to serve large numbers of callers and successfully engage community partners in planning the nationwide transition to 988 hotline. Buckelew served more than 3600 callers in FY 2020-2021 and supported 99% of those callers through verbal de-escalation and/or safety plans without the need for on-site emergency intervention. One staff member stated "We can see the impact of the work we do. We know what we do saves lives and we need more programs like this in the community."

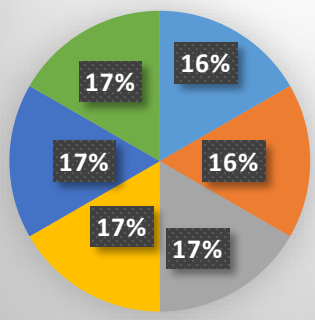
Sonoma County Department of Health Services Behavioral Health Division

FY 2020-2021 Program Demographics:

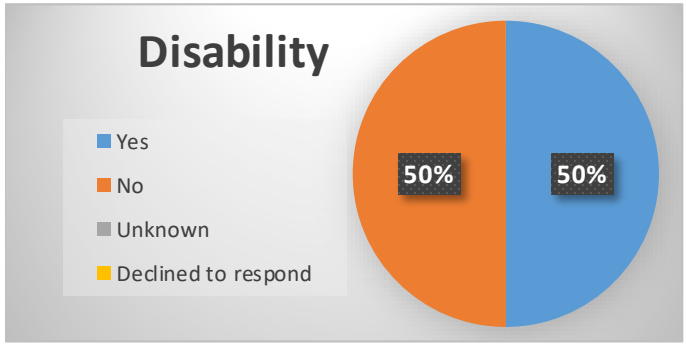
Age



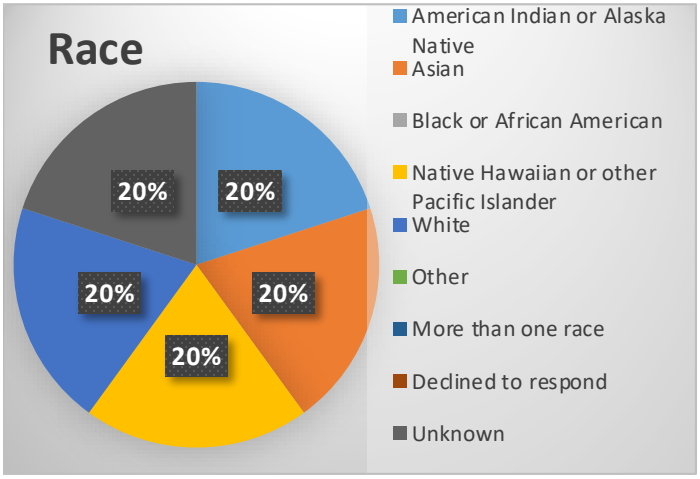
Current Gender Identity



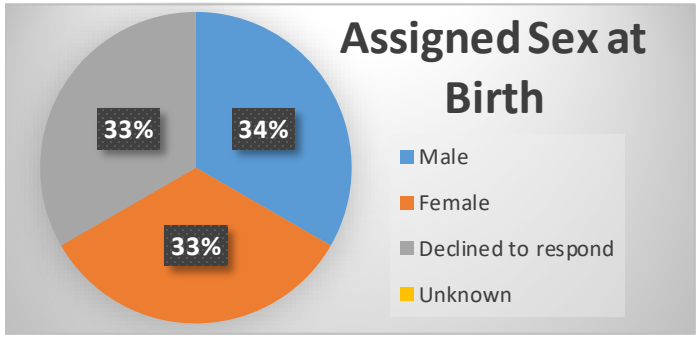
Disability



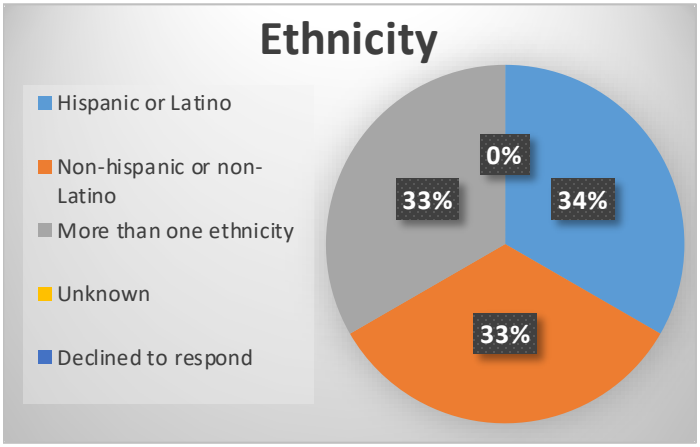
Race



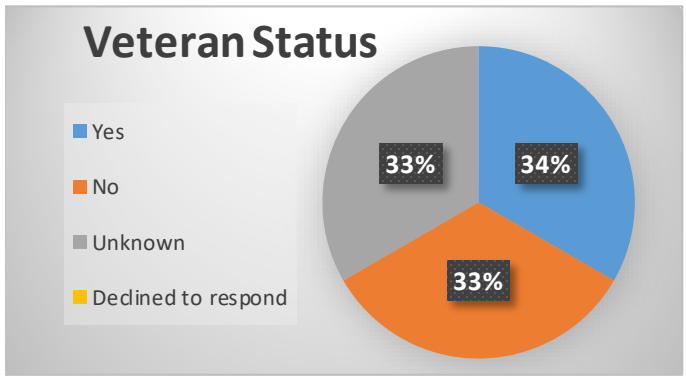
Assigned Sex at Birth



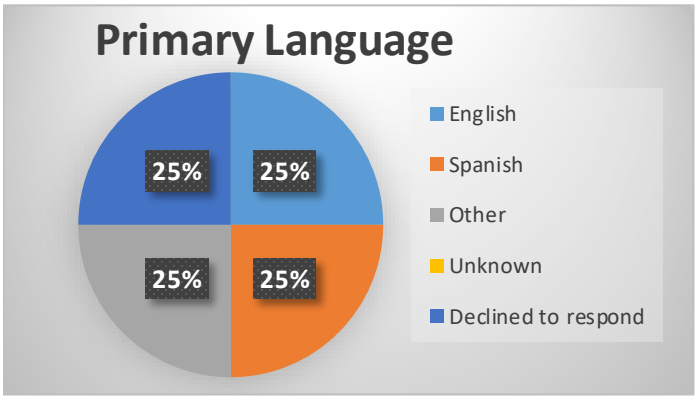
Ethnicity



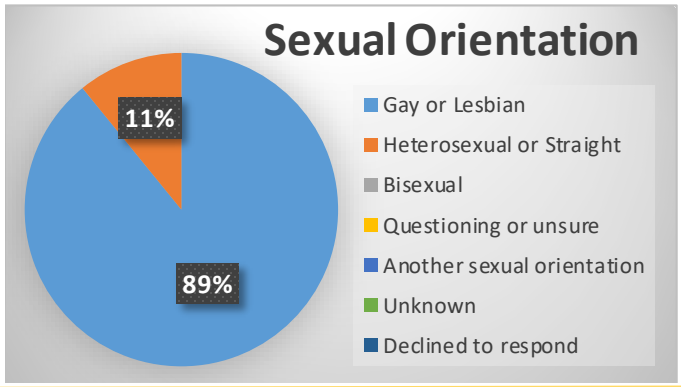
Veteran Status



Primary Language



Sexual Orientation



Innovation (INN)

Novel, creative, and/or ingenious mental health practices/approaches that are expected to contribute to learning, which are developed within communities through a process that is inclusive and representative, especially of unserved and underserved individuals.

In FY 20-21, DHS-BHD had one project funded through the Innovation component.

For a list of Innovation projects that were in development and are being implemented in FY 21-22, see pages 27 and 41-42.

MHSA Component: Innovation (INN)

Early Psychosis Learning Health Care Network

Takes Action

WELLNESS • RECOVERY • RESILIENCE

The INN component funds projects designed to test time-limited new or changing mental health practices that have not yet been demonstrated as effective. The purpose of the INN component is to infuse new, effective mental health approaches into the mental health system, both for the originating county and throughout California. These projects may focus on increasing access to underserved groups, increasing the quality of services including measurable outcomes, promoting interagency and community collaboration, or increasing access to mental health services.

DESCRIPTION OF PROJECT:

Early Psychosis Learning Health Care Network (EP LHCN) is the first treatment program specifically for youth psychosis in Sonoma County. This project will be part of the Statewide Early Psychosis Learning Collaborative (a Mental Health Services Oversight and Accountability Commission's [MHSOAC] Incubator Project) as approved by the MHSOAC. Buckelew, Aldea and the University of California at Davis are collectively leading this project.

PROJECT IMFORMATION

Project Name: Early Psychosis Learning Health Care Network

Population served: Youth and adults ages 12 – 30 who have onset of psychosis within the past two years or attenuated psychotic symptoms or recent deterioration in youth with a parent/sibling with psychotic disorder.

Website:
https://www.aldeainc.org/services/behavioral-health/the-elizabeth-morgan-brown-center

Phone Number:
(707) 224-8266

Location: 2300 Northpoint Pkwy
Santa Rosa, CA 95407

FY 2020-2021 PROJECT OUTCOMES:

Please refer to FY 2020/21 Annual Innovation Report: Early Psychosis Learning Health Care Network on page 154 for a complete list of project outcomes.

FY 2020-2021 PROJECT CHANGES:

No changes were made to the project in FY 20-21

Workforce Education and Training (WET)

The goal of the WET component is to develop a diverse workforce. Individuals with lived mental health experience and DHS BHD staff and contractors are given training to promote wellness and other positive mental health outcomes. WET funds are also used to promote and expand the cultural responsiveness of DHS BHD.

MHSA Component: Community Services & Supports (CSS)

WCCS's Peer Education & Training Program

Takes Action FOR MENTAL HEALTH

WELLNESS • RECOVERY • RESILIENCE

Service Category: *Workforce Education and Training*

The CSS component is the largest of all five MHSA components. Funding is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.

PROGRAM IMFORMATION

Program Name: Peer Education and Training Program (PET)

Population served: Adults in Sonoma County

Website: https://www.westcountyservices.org/
Phone: (707) 565-7807
Program location:
2245 Challenger Way #104
Santa Rosa, CA 95407

PROGRAM DESCRIPTION:

The Peer Education and Training Program (PET) seeks to transform the mental health system to a more recovery-oriented model based on a Peer model of support. PET provides education and training to those with lived mental health experience, or Peers who are seeking to become Peer Support Specialists.

In addition, PET provides presentations and trainings on Peer services to a variety of public and private mental health organizations to promote understanding and inclusion of Peer Support throughout continuum of care network.

PROGRAM STATISTICS

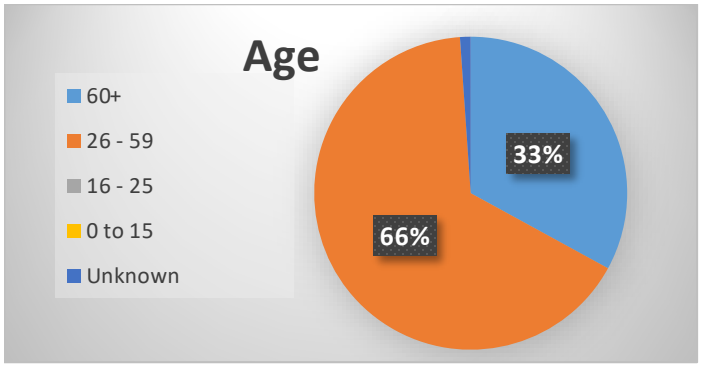
- **Total number of clients served:** 90
- **Total number of encounters:** 567
- **Approximate numbers reached through outreach:** 324

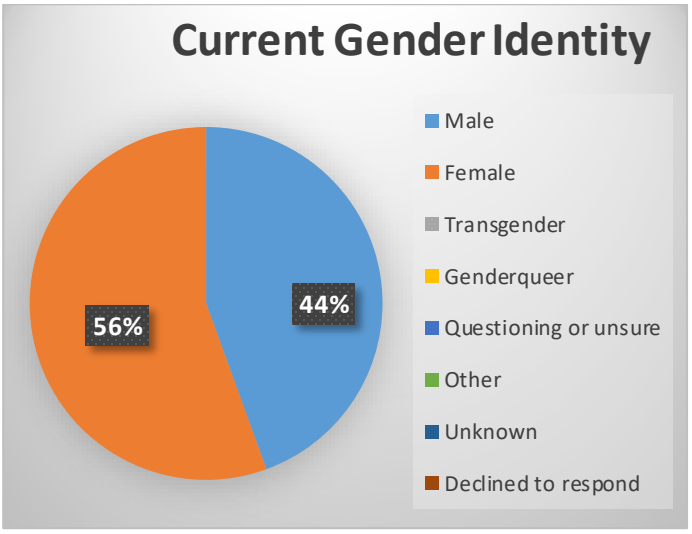
PROGRAM ACCOMPLISHMENTS:

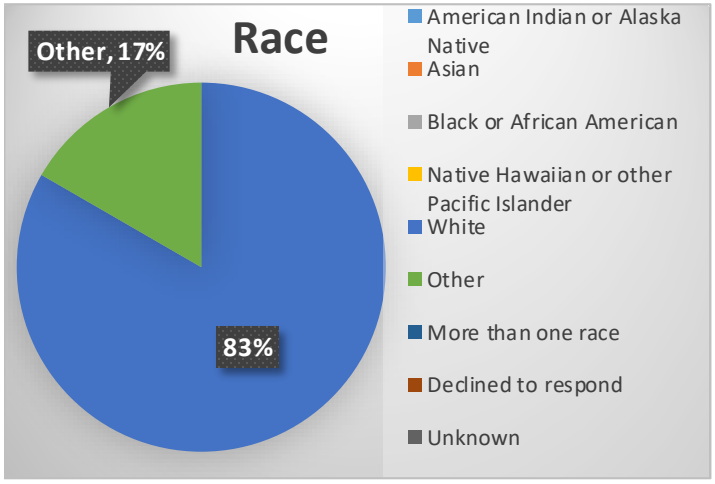
In addition to completing two additional training cohorts of Peer Support Specialists and placing several interns in programs to practice the skills and knowledge they acquired in the classroom, the Peer Education and Training program successfully navigated the numerous challenges related to the health crisis and its elimination of onsite training.

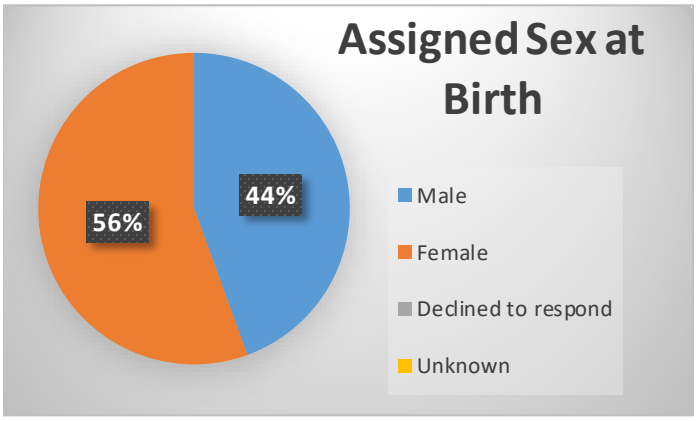
By moving to an online platform, our program adapted and moved forward in a way that allowed for the completion of the course by those who had begun prior to the stay-at-home order. This change has also allowed for participants in future classes who may have otherwise been unable to participate due to transportation challenges, thereby eliminating another barrier to equity.

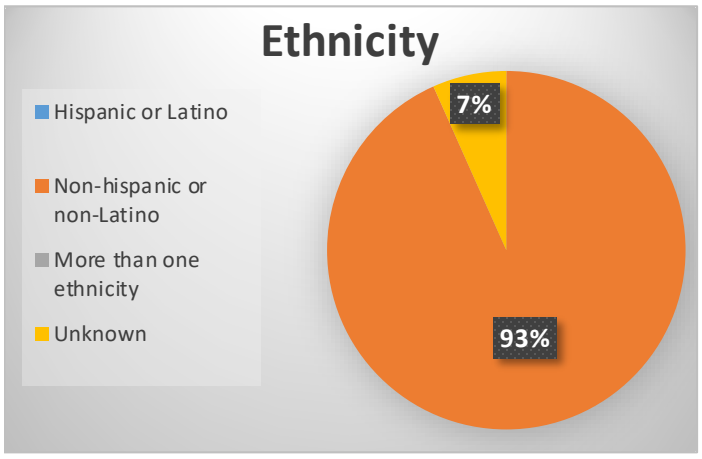
FY 2020-2021 Program Demographics:

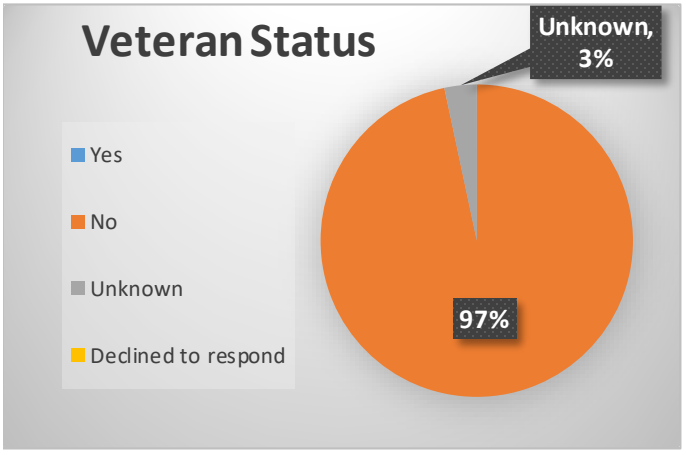


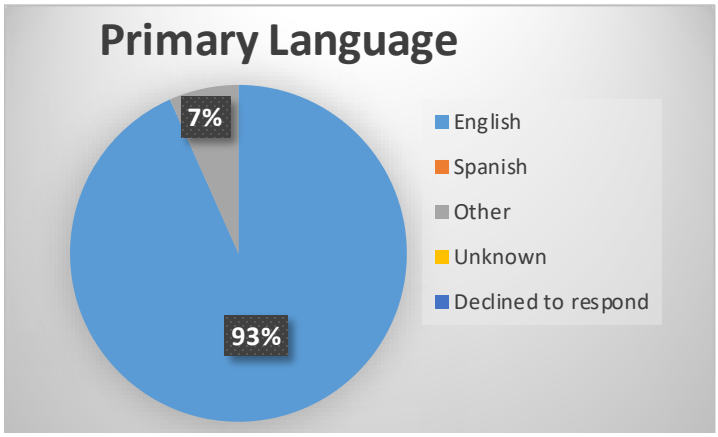












sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

DHS BHD Workforce Education and Training (WET) Activities

In FY 20-21, the WET Coordinator managed two training programs and community events to further DHS-BHD's goals in the following Domains: System Level Support and Staff Skill Development, and Workforce Diversification. Due to the pandemic the County participated in fewer community events.

Domain	Programs/events/goals
System Level Support	• Accreditation (BRN, CAMFT, CCAPP)
Staff Skill Development	• Staff Development Trainings

System Level Support

Accreditation

At the onset of FY 20-21, BHD maintained accreditation through the Board of Registered Nursing (BRN), the California Association of Marriage and Family Therapists (CAMFT) and California Consortium of Addiction Programs and Professionals (CCAPP) for the license types listed below, and provides Continuing Education Units (CEUs) for these license types:

BRN	CAMFT	CCAPP
•Licensed Vocational Nurse (LVN) •Licensed Psychiatric Technician (LPT) •Registered Nurse (RN) •Public Health Nurse (PHN) •Nurse Practitioner (NP) •Psychiatric Nurse Practitioner (PNP)	•Licensed Clinical Social Worker (LCSW) •Licensed Marriage and Family Therapist (LMFT) •Licensed Professional Clinical Counselor (LPCC) •Licensed Educational Psychologist (LEP)	•Registered Alcohol Drug Technician (RADT) •Certified Alcohol Drug Counselor I (CADC-I) •Certified Alcohol Drug Counselor II (CADC-II) •Licensed Advanced Alcohol Drug Counselor (LAADC) •Licensed Advanced Alcohol Drug Counselor Supervisor (LAADC-S)

Career Pathways and Pipeline Program

The WET Coordinator continued the Internships and Traineeship program to assist staff in obtaining clinical licensure and to develop pipeline programs with participating universities. This included a Licensure Support Program, Group Clinical Supervision, and Educational Outreach Events.

Participating Universities

Program Category	Participants
Nursing Programs	• Sonoma State University (SSU) • Santa Rosa Junior College (SRJC)
Social Work Programs	• California State Long Beach • San Francisco State University (SFSU) • Humboldt State • San Jose State University • University of Southern California • Berkeley
MFT Programs	• SSU • University of San Francisco • SFSU
Mental Health Worker Programs	• SSU • SRJC
Peer Provider Programs	• Wellness and Advocacy Center • Interlink Self-Help Center

Staff Skill Development:

The WET program offered over 20 trainings to promote professional development. The topics include: Patient Rights, Cultural Responsiveness, Substance Abuse, Law and Ethics and Suicide Risk Assessment. Staff Development Trainings: see the appendix, page 284 for a list of the trainings offered in FY 20-21.

Capital Facilities and Technological Needs (CFTN)

Works towards the creation of facilities that are used for the delivery of MHSA services to mental health clients and their families, or for administrative offices. Funds may also be used to support an increase in peer-support and consumer-run facilities, development of community-based settings, and the development of a technological infrastructure for the mental health system to facilitate the highest quality and cost-effective services and supports for clients and their families.

In FY 20-21, the following projects were funded under the CFTN component:

Provider	Project	Description
NetSmart	Avatar electronic health record (EHR)	Implementing fully integrated Electronic Health Record
FEI	Sonoma Web Infrastructure for Treatment Services (SWITS)	Database for tracking demographics and outcomes
A.J. Wong, Inc.	Data Collection Assessment and Reporting (DCAR)	Database for client CANS (Child and Adolescent Needs and Strengths) and ANSA (Adult Needs and Strengths Assessment) assessments, reassessment and closing assessments

Appendix 1 – FY 2020/21 Annual Innovation Report: Early Psychosis Learning Health Care Network

WELLNESS • RECOVERY • RESILIENCE

Mental Health Services Act: Innovations

Collaborative Statewide Early Psychosis Program Evaluation

FY 2020/21 Annual Innovation Report: Early Psychosis Learning Health Care Network

Final version submitted December 2, 2021

Prepared by:

University of California, Davis, San Francisco and San Diego

This report was supported by:

ONE MIND

National Institute of Mental Health

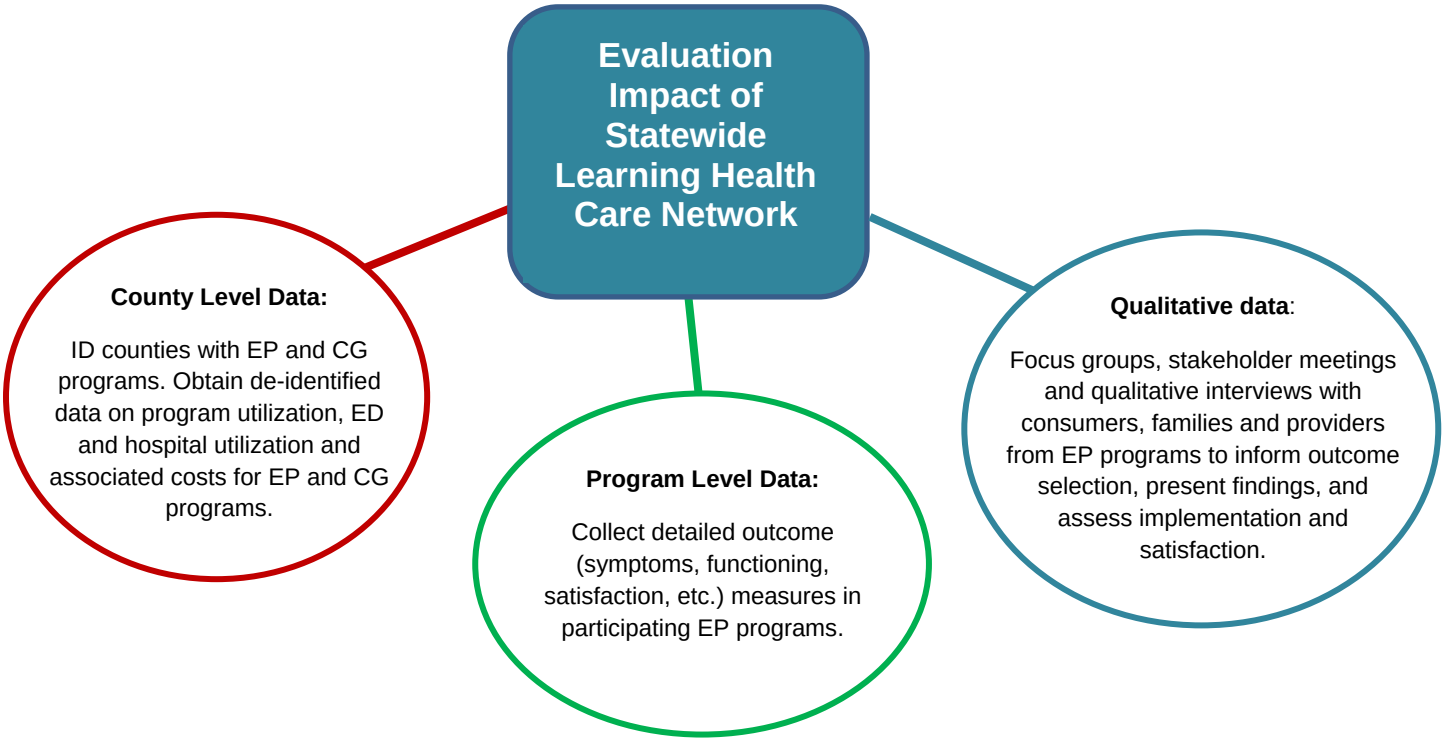
Table of Contents

Background

Multiple California counties in collaboration with the UC Davis Behavioral Health Center of Excellence, received approval to use Innovation or other Prop 63 funds to develop infrastructure for a sustainable learning health care network (LHCN) for early psychosis (EP) programs. Of those counties with approved funding, the following counties have processed and executed contracts between their behavioral health services departments and UC Davis as of June 30, 2021: San Diego, Solano, Sonoma, Los Angeles and Orange. One Mind has also contributed $1.5 million in funding to support the project. Napa and Stanislaus Counties have received approval to use Innovation funds to join the LHCN; their onboarding into the LHCN will be completed over FY 21-22. This Innovation project seeks to demonstrate the utility of the network via a collaborative statewide evaluation to assess the impact of the network and these programs on the consumers and communities that they serve. This project, led by UC Davis in partnership with UC San Francisco, UC San Diego, University of Calgary and multiple California counties, brings consumer-level data to the providers' fingertips for real-time sharing with consumers, and allows programs to learn from each other through a training and technical assistance collaborative. This Statewide EP Evaluation and LHCN propose to 1) increase the quality of mental health services, including measurable outcomes, and 2) introduce a mental health practice or approach that is new to the overall mental health system. The project must comply with the regulatory and funding guidelines for evaluation as stipulated by the applicable Mental Health Services Act (MHSA) funding regulations, contract deliverables, and best practices.

There are three components to the data collected for the LHCN: County Level, Program Level, and Qualitative data (Figure 1). The protocol for collecting each component has been reviewed by an Institutional Review Board (IRB) and approved before commencement of data collection. Further, aspects of the data design will be shaped by the input of stakeholders, including mental health consumers, family members, and providers.

Figure 1. Three Components of the Evaluation Associated with the Statewide LHCN.



This project was approved for funding using Innovation Funds by the MHSOAC in December of 2018. The California Early Psychosis Learning Health Care Network (LHCN) represents a unique partnership between the University of California, multiple California counties, and One Mind to build a network of California early

psychosis (EP) programs. Additionally, we were able to leverage this initial investment to obtain additional funding from the National Institutes of Health (NIH) in 2019, which enabled six university and two county early psychosis programs to join and also linked the California network to a national network of EP programs, including UCSF PATH, UCSD CARE, UCLA Aftercare & CAPPS, Stanford Inspire, San Mateo Felton BEAM UP/(re) MIND, UC Davis EDAPT and SacEDAPT programs. The overarching name of the project, which encompasses the LHCN and the NIH-funded components, is now “EPI-CAL.” In this and future reports, we will refer to the LHCN only when describing components of the project that are specific to the LHCN evaluation (e.g., county data analysis).

Our EPI-CAL team has made significant progress towards our goals outlined in the innovation proposal during the 20/21 fiscal year, which are summarized in the current report.

Executive Summary

The purpose of this document is to provide the EP LHCN Mental Health Services Act (MHSA) Annual Innovation Report to review EP LHCN goals accomplished during FY2020/2021. This report will include summaries and status updates on the infrastructure of the LHCN, steps taken towards implementation, and barriers that have been identified over the course of the last fiscal year. While the counties involved in the EP LHCN may be at different stages in the process, the overarching LHCN is moving forward as planned.

- Prior to beginning activities for the LHCN, UC Davis had to have an executed contract with each of the participating counties so each party could mutually agree to a scope and terms of work. As of June 2021, UC Davis had executed contracts with Solano, San Diego, Los Angeles, Orange, and Sonoma counties. The Napa County LHCN and Aldea contracts were under review. In addition to existing LHCN counties, Stanislaus County has received approval to join the LHCN. We are working together to execute their contract before officially beginning activities in their county program.
- We have held two LHCN Advisory Committee meetings in the last fiscal year, which was comprised of a county representative from each participating county, a clinical provider from each participating EP program, and consumers and family members who have been or are being served by the participating programs. We will continue to hold Advisory committee meetings on a bi-annual basis.
- In the coming year, we plan to begin fidelity assessments in EPI-CAL/LHCN clinics. We have scheduled fidelity assessments for all participating programs in the LHCN network with an executed contract.
- We have administered self-report questionnaires to providers and consumers and in the pre-implementation period of the project, as outlined in the LHCN proposal. The battery of questionnaires, including baseline and pre-implementation surveys, have been designed to assess potential factors that could influence outcomes for EP consumers that are measured in the project. By the end of the fiscal year, we have had 11 consumers and eight clinicians complete pre-implementation questionnaires across three participating clinics. While we have eight clinicians who responded, 46 clinician surveys have been completed as clinicians can complete surveys about multiple eligible consumers. We’ve had 152 providers complete the baseline surveys.
- We have continued to hold focus groups with consumers and providers to elicit feedback on the custom application (Beehive), including six focus groups to develop the End User License Agreement (EULA) and presentation of data-sharing options for Beehive users. Our team used feedback from these groups to update the EULA video and EULA screens in Beehive. We have summarized the qualitative feedback we’ve received on Beehive in a qualitative report. This includes feedback from wireframe focus groups, alpha version focus groups, and EULA/data-sharing focus groups.
- In the past year, we completed the testing and initial deployment of the Beehive application in EPI-CAL/LHCN clinics, starting with alpha testing, followed by beta testing, then full deployment across the network.
- In order to prepare for our county-level data evaluation component of the LHCN, established the data collection process for obtaining county-level utilization and cost data for a retrospective 3-year timeframe for preliminary evaluation for both EP and comparator group (CG) programs. We have also written a report on the feasibility of obtaining cost and utilization data for this retrospective period.

Current Project Goals

The current document summarizes project activities conducted for the LHCN during the 20/21 fiscal year. This includes the following project activities:

1. Establish a Stakeholder Advisory Committee that will meet at least every 6 months.

2. Schedule for EP Program Fidelity assessments.

3. Complete Pre-LHCN implementation questionnaires

4. Produce qualitative report on ongoing issues and suggestions on the app/dashboard from EP program staff and other stakeholders; including results of focus groups

5. Conduct initial site visits, detailing training of EP program staff in data collection

6. Provide feedback from beta testing of LHCN application for data collection

7. Subcontractor to make modifications to software application and dashboard to reflect findings from pilot testing and qualitative report

8. Get preliminary results on program-level data from 2 pilot EP programs, including interviews with EP programs to understand barriers and facilitators to app implementation

9. Outline plan for training EP program staff from non-pilot programs on app implementation and outcomes measurement

10. Establish data collection process for obtaining county-level utilization and cost data for prior 3-year timeframe for preliminary evaluation for both EP and comparator group (CG) programs.

11. Report on feasibility of obtaining cost and utilization data from preliminary multi-county integrated evaluation.

1. Establish a Stakeholder Advisory Committee that will meet at least every 6 months

The Advisory Committee for the LHCN is comprised of a county representative from each participating county, a representative of each participating EP program, and up to five consumers and five family members who have been, or are being served, by EP programs. This committee is co-led by Bonnie Hotz, family advocate from Sacramento County. Recruitment for the Advisory Committee is ongoing, and we have confirmed membership with multiple stakeholders. These include past consumers, family members, clinic staff and providers. Even though we have already held several Advisory Committee meetings, we continue to distribute flyers to all participating clinics, as their contracts are coming through, to make sure the Advisory Committee is open to all LHCN member clinics. In the 20/21 fiscal year, we held Advisory Committee meetings on December 8th, 2020 and June 7th, 2021.

December 8th, 2020 Meeting

During the first bi-annual meeting of the fiscal year, we gave a progress report on development of the battery, county data analysis, program-level survey data reports, and the alpha phase of the application. When reviewing the battery, family stakeholders expressed that they liked the question regarding how a consumer's role may have changed in response to mental health challenges. County and provider stakeholders appreciated the thoroughness of the battery and pointed out support for asking about involuntary hospitalizations. County stakeholders also expressed support for the level of detail collected regarding risk for

homelessness, and it was pointed out that we might want to ask whether commercial insurance is provided by one's employer due to the heavy cost burden of paying for private insurance.

During initial site visits, providers and staff at each EP program were asked to complete a battery of surveys related to factors that may impact Beehive implementation (e.g., organizational readiness for change, comfort with technology) or consumer-level outcomes (e.g., provider burnout, stigma around mental health, views on recovery). When reviewing the program-level survey data, there was general support for the way data was visualized. Various stakeholders gave helpful insight into how to interpret some of the data, especially how COVID affects the burnout and organizational challenges data. We were also provided with guidance around additional questions that should be asked to help clarify the COVID data, including whether staff may have assignments to homeless shelters or emergency services, anxiety around working with consumers with COVID, and whether staff are fully working from home or have to continue to work in the program in person. Family stakeholders also agreed that this was valuable data as those at a management level can use this data to see if providers are feeling overworked or burned out, which can affect the quality of care.

Finally, we reviewed progress on the development of the application to-date and received generally positive feedback on the alpha version of the application.

June 7th, 2021 Meeting

We held the most recent Advisory Committee meeting on June 7th, 2021. The meeting was also held remotely due to the COVID-19 pandemic. During the meeting, we gave a progress report on the county data analysis, provided a summary of findings from the EULA focus groups, shared the EULA video, discussed progress on Beehive training, and solicited feedback on the Barriers and Facilitators interview guides. When reviewing the EULA video, a consumer stakeholder expressed that the video was very clear and informative; they liked how the video explained how data would be de-identified and liked the images used to represent that. A family stakeholder commented that they appreciated that this video might help new families and consumers to feel more comfortable using the application, especially regarding the transparency and clarity of the video.

When giving an update on Beehive training progress, we had program leadership from pilot programs give their feedback on how Beehive has been integrated into their program so far. Program leadership communicated to the committee that clinicians have made some changes to their schedule and structure of sessions to introduce Beehive and that it can take some additional time when first orienting to Beehive, and that they found planning ahead has been effective. They also shared that consumers have generally had a positive reaction to this platform. Finally, they found it is important to share feedback to leadership from a clinician perspective around how this change impacts additional clinical responsibilities.

Prior to the Advisory Committee meeting, we shared our Barriers and Facilitators interview guides so attendees could review the guides ahead of time in preparation to give feedback at the meeting. The purpose of the Barriers and Facilitators interview is to explore consumer and provider experiences of integrating and utilizing the Beehive system in clinical practice. This includes understanding how intake procedures were modified to incorporate registering new consumers into the system, provider and consumer experiences of adding their data into Beehive, and their experiences of integrating measurement-based based care during the consultation. We wanted feedback at the meeting in order to know if we are asking all the right questions and asking them in the right way. Providers gave feedback that it is very important to understand how Beehive can be integrated into billable time and how long the surveys take to complete. Family stakeholders gave feedback that included clarifying the wording on some questions, including a question that asks the consumer whether the application helped them meet their treatment goals, as well as asking the consumer if the application captured the most important parts of their experience.

2. Complete Pre-LHCN implementation questionnaires

In the LHCN proposal, we proposed to ask consumers and providers to complete self-report questionnaires in the pre-implementation period of the project. Consumers are asked to complete self-report questionnaires about insight into illness, perceived utility of the application, satisfaction with treatment, treatment alliance, and comfort with technology. We also have providers at each clinic complete questionnaires on Treatment Alliance, Use of Data in Care Planning, Perceived Effect of Use for the LHCN, and Comfort with Technology. In addition to the originally planned pre-implementation surveys, we have provider surveys that assess demographics, eHealth Readiness, Organizational Readiness for Change, Attitudes Toward Evidence Based Practice, Clinician Attitudes of Recovery and Stigma, Modified Practice Pattern Questionnaire, and Professional Quality Scale. This battery of questionnaires is termed the “baseline” surveys and have been designed to assess potential factors that could influence outcomes for EP consumers that are measured in the project. Therefore, the study team felt it was important to assess these factors for inclusion in the future analysis of outcomes data.

To date, 152 EP program providers and staff completed our baseline surveys on E-Health readiness, comfort with technology, and basic demographics. We have had 121 EP program providers and staff complete the second set of surveys on organizational readiness for change, burnout and satisfaction, attitudes on evidence-based practices, clinician attitudes on recovery and stigma, and practice style. The results of the findings from the surveys are compiled into a custom report for each clinic, including suggestions for potential action items as a first step in using data to enhance care delivery in EP programs.

At the time of this report, we have had 11 consumers and eight clinicians complete pre-implementation questionnaires across three participating clinics. While we have eight clinicians who responded, 46 clinician surveys have been completed as clinicians can complete surveys about multiple eligible consumers. These survey responses include representation from the Solano Aldea SOAR and San Diego Kickstart clinics. We are currently in the process of continuing to recruit clinicians and consumers from EPI-CAL clinics who have not had Beehive implemented in their program.

3. Schedule for EP Program Fidelity assessments.

Each early psychosis clinic will undergo a fidelity assessment to determine their adherence to evidence-based practices for first-episode services using a revised version of the First Episode Psychosis Services Fidelity Scale (FEPS-FS). The FEPS-FS represents a standardized measure of fidelity to EP program best practices (Addington et al., 2016; First Episode Psychosis Services Fidelity Scale: (FEPS-FS 1.0), 2015). The FEPS-FS was developed using an international expert consensus method, focused on six domains: (1) population-level interventions and access, (2) comprehensive assessment and care plan, (3) individual-level intervention, (4) group-level interventions, (5) service system and models of intervention, and (6) evaluation and quality improvement. The FEPS-FS has been recently revised to meet the agreed upon standards of EP care in the US and allow large-scale fidelity evaluation. Additionally, most programs within EPI-CAL also provide services to individuals with the clinical high-risk syndrome (CHR), for whom evidence-based best practice differs from FEP care in a number of respects. Consequently, to provide a program assessment that most accurately represents the care delivered, alongside the FEP-FS we will be piloting a new scale under development designed to assess the components of care delivered to individuals with the diagnosis of CHR, known as the CHRP-FS.

Each EP program will participate in an assessment of EP program components using the revised FEPS-FS/CHRPS-FS, which will be completed via web-based teleconference. The fidelity assessment will be used to identify program strengths and possible areas for improvement, which can serve an important driver to improving early psychosis care delivered in EP programs in the LHCN. Additionally, the ability to evaluate the

impact of service-level factors on consumer-level outcomes collected by Beehive will provide us with important new insights into what particular components of the EP program of care are associated with improved outcomes in different domains. These findings can then be disseminated across the network (and beyond), further informing care and shaping service delivery.

Assessments will be completed in groups of 2-6 programs per quarter, starting in September 2021 until December 2022. Assessments will be completed by trained clinical staff with expertise in early psychosis care and supported by evaluation administrative and research staff. Prior to the assessment taking place, the assessors and administrative/research support staff will undergo a two-day training to go through the manual and conduct a mock site visit based on real cases. Prior to the evaluation, EP program sites will participate in an introductory meeting, in which an overview of the FEPS will be provided and the components of the evaluation will be discussed. The assessment will be conducted in consultation with Don Addington, M.D. from the University of Calgary, author of the FEPS-FS and CHRPS-FS scales. Dr. Addington will also provide the overview presentation to the participating sites.

At the time of this report, EP program fidelity assessments have been scheduled for two programs for the fall quarter of 2021: Orange County OC CREW program (November 29 - December 3, 2021) and San Diego Kickstart program (November 1-5, 2021). Aldea SOAR Solano is scheduled for the following quarter (January 17-21, 2022), Sonoma Aldea SOAR will take place in the second quarter of 2022, the five LACDMH programs are scheduled for the third quarter of 2022 (July, August, September), and Napa Aldea SOAR is schedule for the fourth quarter of 2022.

4. Produce qualitative report on ongoing issues and suggestions on the app/dashboard from EP program staff and other stakeholders, including results of focus groups.

Over the course of the past year, the EPI-CAL team has conducted extensive qualitative research in order to engage various stakeholders and utilize their valuable feedback to shape the development of the Beehive application. We received qualitative feedback throughout the development of this custom application in three different types of qualitative focus groups: wireframe focus groups, alpha testing groups, and data-sharing/end user license agreement (EULA) focus groups. We have conducted a total of 23 focus groups spanning these three focus group types in order to get detailed feedback and suggestions for the application and dashboard from EP program staff, EP program consumers, and their family members.

Wireframe focus groups

Quorum and the EPI-CAL research team have worked collaboratively to develop the wireframe for the tablet and web-based applications. The UC Davis team used these storyboards as materials for focus groups to obtain feedback on the application and dashboard’s design, flow, and functionality.

Methods
We conducted a total of 16 wireframe focus groups. Each group was 90 minutes long and categorized by the types of participants, including research staff, clinic providers, clinic administration, consumers, and their family members. Two groups were held with research staff and data experts (12 participants), six groups were held with providers at EP programs (36 participants), three groups were held with clinic administrators (20 participants), one group was held with both EP providers and clinic administrators (nine participants from Los Angeles County programs), and four groups were held with consumers and families (17 participants; see Tables 1 & 2). We did not meet separately with consumers and families for these groups, but instead held combined groups for consumers and families to attend together. Due to COVID-19, all focus groups were conducted over video conferencing (Zoom or WebEx). To maximize convenience and availability for staff

during this time of transition, multiple groups were scheduled and open to participation from staff at any EPI-CAL clinic. Many of the groups had representation from multiple clinics in the network, which allowed for the study team to better understand the differing needs and environments of programs in the network. During each group, EPI-CAL research staff presented various aspects of the application storyboard, which allows for visualization of the look, feel, and functionality of the application prior to development. Each presentation was tailored to demonstrate scenarios pertinent to how specific users (i.e., providers, clinic administration, consumers, and families) will interact with the tablet and web applications. We asked for feedback on the look and feel of the application, the functionality of the application as it relates to the current EP program workflow, and ease of use and acceptability for both consumers, support persons, and staff.

Table 1

Total Wireframe Focus Groups	**16**
Research Focus Groups	2
Provider Focus Groups	6
Clinic Admin Focus Groups	3
Provider & Clinic Admin Focus Groups	1
Consumer & Family Focus Groups	4

Table 2

Total Participants*	**94**
Research	12
Providers	36
Clinic Admin	20
Providers & Clinic Admin	9
Consumer & Family	17

**Participants could attend more than one group*

Results

Our research team discussed and synthesized the feedback for the application developers to support application development (see Appendix I). When integrating the feedback into application development, we endeavored to balance consumer and family needs with provider and staff needs. Overall, stakeholders approved of the look and feel of the application. Some stakeholders (both consumers and providers) noted that the color scheme and layout seemed overly clinical. They suggested, specifically when presenting surveys, to bring in more color, engaging imagery, and visual information. Occasionally, stakeholders disagreed on whether certain visual aspects of the application were acceptable or not. For example, several providers and family members raised the concern that the current images (drawings of individuals who do not have facial details drawn in) would be disconcerting or upsetting for consumers. However, when we asked consumers about this, they said they felt either neutrally or positively about these images. Often, stakeholders unanimously agreed on an aspect of the user interface that should change, such as changing the color of the survey progress bar in the tablet application to be more prominent.

Stakeholders provided several suggestions to improve integration of the application into their EP clinic workflow and procedures. After demonstrating the process of registering a new consumer in the tablet, clinic staff, consumers, and families alike emphasized the importance of having an option for clinic staff to pre-register consumers if they gather registration information over the phone prior to the consumer's first visit in the clinic. Stakeholders agreed this would reduce burden on the consumer and demonstrate that the clinic was

well organized and listening to the information consumers and family members had already provided.

Some stakeholders provided feedback specific to their role in the clinic. For instance, participants in a focus group with clinic administrators from various programs suggested that demographic information that clinic staff regularly report to their county, for example, be visualized on the clinic administrator dashboard. We subsequently built in data visualizations for race, ethnicity, sex, gender identity, and other metrics which clinics are commonly asked to report. On the other hand, consumers and their family members, from their unique perspective as consumers, nearly unanimously agreed that when viewing data visualizations on the web application with their provider, they would not like to see the results of the symptom survey as the default display. They instead preferred to see a more recovery-oriented measure, such as the Questionnaire about the Process of Recovery (QPR), when first looking at their survey responses. Based on this feedback, we will set the QPR to be the default data visualization presented when a provider is clicking into a consumer's data on the web application.

During focus groups with Los Angeles County stakeholders in August 2020, our team also asked for feedback about how to adapt both the data collection and data visualization components of the application for use with telehealth. Multiple EP staff participants agreed that a remote data collection option, which would allow consumers to complete surveys from home, would be ideal. Consumer and family stakeholders agreed with providers for the remote option, but and were split between their preference for a mobile application or a personalized link that could be emailed or texted from their provider. Consumer and family stakeholders said they would prefer to look at their data with their provider and would not necessarily want individual access to look at their results from home.

Alpha Version Focus Group

We held a focus group for stakeholders to review the alpha version of the Beehive application to elicit valuable feedback from our stakeholders on the development of the Beehive application. This feedback was valuable as it was the first opportunity for stakeholders to review the application in a production environment, rather than wireframes or plans.

Methods

On October 22, 2020 the EPI-CAL team conducted a focus group with four staff members from an EPI-CAL clinic (SacEDAPT) including a clinician, two peer case-managers, and a clinical supervisor. The focus group began with a demonstration of survey-completion on the tablet application and a demonstration of navigation around the web application, including registering a new consumer and viewing consumer survey data visualizations. Focus group attendees were asked for their comments and questions on the application. They were asked to think about the feasibility of the integration of the application within their current clinic workflow and ease of use. After the demonstration, the focus group attendees logged into the alpha version of the application and were able to test out functions such as consumer registration and data visualization.

Feedback

Focus group participants made suggestions to improve the application, including changes to language, look and feel, features, and information presented to consumers (Table 3). The UCD team discussed these suggestions and the action taken is described in Table 3.

Table 3: Examples of Alpha Focus Group Feedback

Suggestion /Question Content Area	**Example**	**Outcome**

Language Used in Application	It is unclear that “primary language” during tablet registration refers to the tablet display language.	UCD team discussed and decided to rename this field to “Display language” to make this clearer.
Information Presented to Consumers	During consumer follow-up visits, a reminder should be added about confidentiality and how data will be used. This information is covered in detail at the first visit but consumers may forget after 6 months.	UCD team will plan to draft a message to returning consumers at follow-up visits that will remind them of confidentiality and how data will be used.
Application Feature	Will consumers have the option to visualize any service that they deem important as part of their treatment, for example, case management, or just the four options listed (medication management, individual therapy, group therapy, education/employment support)?	UCD team to discuss this feature with developers. It is not part of alpha and is not yet functional, but there will be variation at the program-level and consumer-level services offered and received, so flexibility in this visualization will be needed.
Look and Feel of Application	The image that appears during survey completion does not represent people of color.	While there is diversity of sex/race/ethnicity in the images throughout the survey modules in the application, it is currently showing the same image repeatedly for each survey question. UCD team to ask developers whether different images can appear during each survey to avoid over-representation of one sex/race.

Data-sharing & EULA focus groups

To develop the End User License Agreement (EULA) and presentation of data-sharing options for Beehive, the EPI-CAL team conducted a series of six focus groups to gather stakeholder feedback (n=24). Two different phases of groups were conducted: (1) Data-Sharing Preferences Focus Groups, and (2) EULA Focus Groups. Each type of group was conducted three times with a different group of stakeholders in EPI-CAL EP clinics: (1) providers and clinic staff (n=14), (2) consumers (n= 6), and (3) family members and support persons of consumers (n=4). Some stakeholders attended both phase 1 and phase 2 groups.

Focus groups were conducted remotely via web conferencing (Zoom for the provider group, WebEx for the consumer and family groups), each lasting approximately 90 minutes. Informed consent was collected before the groups.

Phase 1 focus groups

These three groups were conducted in August 2020 to understand stakeholders’ views on how their personal health information is and should be used. The introduction to the discussion topics began with a brief description of the EPI-CAL study and a review of definitions of key terms (e.g., privacy, confidentiality). The first part of the discussion focused on stakeholders’ understanding of and perspective on data sharing. The second part focused on stakeholder’s understanding of and perspective of changing sharing options (i.e., “living informed consent” and “the right to be deleted”). The third part of the discussion focused on stakeholders’ understanding of and perspective on sharing different types of data (i.e., identifiable vs. de-identified) at different levels (i.e., individual- and group-levels).

Using notes and preliminary analysis of the transcripts from these focus groups as guidance, the EPI-CAL team developed the materials for the EULA focus group, described below. In general, stakeholders expressed that they were willing to share their de-identified data in order to “help others” (i.e., increase funding to their EP program or other EP programs, contribute to EP research that will improve treatment options for others, promote policy changes that increase accessibility to EP programs). They indicated that transparency of what data is collected, who has access to the data, and how it will be used is imperative for them to make informed decisions about data sharing. They also highlighted the importance of describing the data protections that are in place (i.e., laws and regulations) as well as knowing how the entity to which they are entrusting their data actually follows those laws and regulations. They expressed that giving them more control over their data (i.e., ability to access their own data, change their data sharing permissions, delete their data) would make them more comfortable sharing data.

Table 4

Total Data-Sharing Focus Groups	**3**
Provider Focus Group	1
Consumer Focus Group	1
Family Focus Group	1

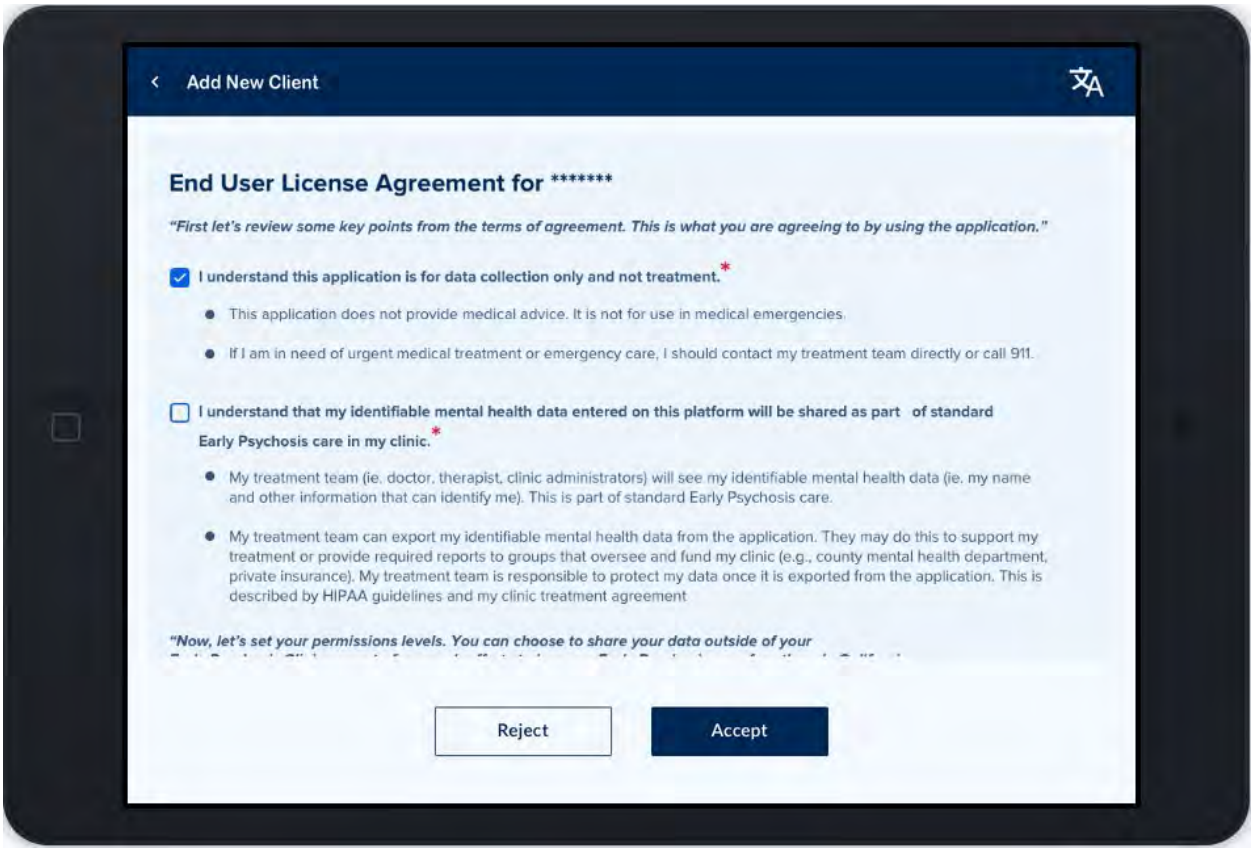
Table 5

Total Participants	**19**
Providers	9
Consumers	6
Family	4

Phase 2 Focus Groups

The three EULA focus groups were conducted in January 2021 to understand stakeholders’ response to how the End User License Agreement (EULA) in Beehive is presented. First, participants were shown an informational video (YouTube link: https://www.youtube.com/watch?v=jzrVmToiGmo&ab_channel=EPI-CAL) created by the research team presenting the key points of the Beehive EULA. After watching the video, participants were asked their opinions about how the information was presented, what questions they still had after watching the video, and how they felt about this method of presenting a EULA. Participants were then shown a demonstration of how the EULA would be presented in the application (Figure 2), with a specific emphasis on the screen on which users may opt-in to data-sharing outside of their clinic for research purposes. Participants were asked for their perspective on how the information was written and presented.

Figure 2: EULA Demonstration



In general, stakeholders thought that using a video to present the EULA was a creative approach that may help users to understand this information better than if they were simply presented this information in a written format alone. All stakeholder groups commented on how to further clarify the information provided.

Provider stakeholders made suggestions about slowing the pace of the video, simplifying visuals, and even culling information from the video to make it simpler. Consumers similarly commented that they would want the ability to pause the video and ask questions of a clinic staff member while watching the video.

In contrast to provider suggestions to remove information from the video to simplify it, consumers approved of the level of detail provided in the video. Consumers said the video helped them to understand the concepts presented. For example, one consumer indicated he had a very clear understanding of how data becomes de-identified by watching the video. Consumers even stated areas where they thought additional detail could be beneficial. For example, consumers thought the video should provide a bit more information about how Beehive would directly benefit them if they chose to use it as part of their care.

Family stakeholders likewise approved of the level of detail provided in the video. For example, they agreed it was important to include the level of detail currently present in the video to describe the relationship between National Institutes of Health (NIH) and EPI-CAL. All participants said the video helped them to have an understanding of the research scope of EPI-CAL and how the data may be used at the national-level as part of the NIH funded study.

When presented with the Beehive EULA screens, stakeholders thought that the written information on data sharing was consistent with the information presented in the video. Stakeholders provided suggestions to change text and formatting. All stakeholder groups agreed that it needed to be made clearer what was optional (e.g., sharing de-identified data with UC Davis researchers) and what was required (e.g., acknowledging that that the application is for data collection, not treatment). A suggestion on how to do this simply would be to add "(optional)" to the text on those statements, rather than relying on a lack of asterisk to indicate that it is

optional. One provider stakeholder suggested requiring a response of yes or no for the options to share data with research, rather than a checked box meaning “yes” and a blank box meaning “no.”

The research team used feedback from these groups to update the EULA video and EULA screens in Beehive. Some changes were implemented for Beta testing (e.g., providing more information about how Beehive may directly benefit users) and others will be considered for future versions of the application (e.g., re-formatting Beehive EULA screen). User feedback from Beta testing will help the team to prioritize what changes to implement moving forward.

Table 6

Total EULA Focus Groups	**3**
Provider Focus Group	1
Consumer Focus Group	1
Family Focus Group	1

Table 7

Total Participants	**14**
Providers	8
Consumers	3
Family	3

Summary

The extensive, iterative, feedback-process detailed in the qualitative section of this report has significantly informed the construction of the Beehive application. We find stakeholder feedback extremely valuable as it ensures that aspects of the application are designed and built with the end-user in mind, increasing the likelihood that other users will find the product useful and valuable. This process has significantly improved our understanding of what different groups of stakeholders consider important in a data-collection application to be used in early psychosis care. In addition, it has reinforced that a collaborative approach is foundational to the success of this project.

5. Conduct initial site visits, detailing training of EP program staff in data collection.

In our original LHCN proposal, we proposed in-person site visits to conduct the initial training for the Beehive application. However, due to the COVID-19 pandemic, we had to adjust our training plan and conduct the first training “site visits” remotely. This began with a pre-training meeting with leadership at each site to discuss which program staff members would be designated as providers, group analysts, or group and clinic admin in Beehive, as well as to cover topics around integrating Beehive into their current data collection system. Next, we conducted a three-part training series to introduce Beehive to each program (Part 1, Part 2, and Part 3). Our remote trainings began with our pilot sites on March 22, 2021 with Part 1 training for UC Davis SacEDAPT and EDAPT. These were followed with trainings for the Aldea SOAR Solano program on March 22, 2021, and the Part 1 training for San Diego Pathways Kickstart on March 31, 2021. In June, 2021, we began to onboard non-pilot sites, starting with the Los Angeles County PIER programs. All LA County PIER programs completed Part 1 trainings in June 2021, starting with The Help Group on June 14, 2021.

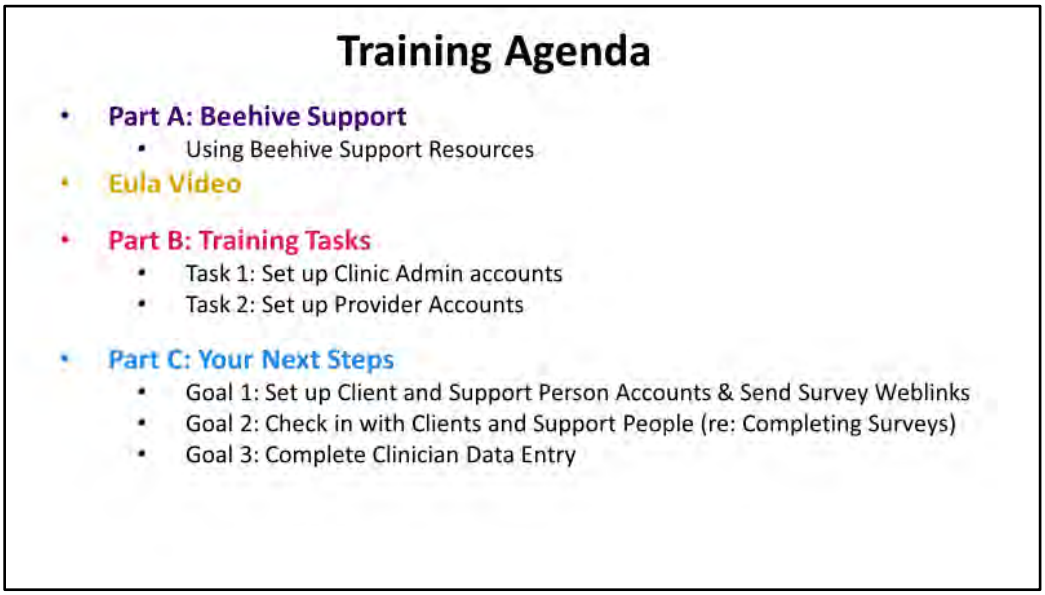
Part 1 Training

The general outline for the first training is as follows:

1. Re-introduction to the EPI-CAL project, including the overarching purpose and goals of data collection via Beehive
2. Presentation on the value of Beehive and data collection
3. Beehive Application training session (see Figure 3)

Presentation- "The Value of Beehive and Data Collection"
An EPI-CAL team member, Leigh Smith, Ph.D., gives a brief presentation that first focuses on how Beehive was developed using input from stakeholders and providers. Next, she provides a historical example of data collection that led to significant innovation in health care by giving a brief vignette of John Snow's work with the Cholera outbreak in London in 1854. She then draws parallels between Snow's work and how Beehive was designed, focusing on a meaningful connection between providers and stakeholders, a holistic approach to data collection, and prioritization of record keeping through automation and data consolidation. After, she speaks about Beehive's power to facilitate dialogue between providers and consumers, and within/between clinics, through reports provided by the Beehive team or generated within Beehive. Dr. Smith covers the purpose of participating in a Learning Health Care Network (LHCN), and how valuable information collection can be in informing treatment. Finally, she emphasizes the ability of Beehive's data collection in shaping care by illustrating how over a million points of data can be generated if each of the 18 EPI-CAL clinics enrolled 80% of their consumers and completed the baseline and two follow-up surveys in the first year.

Figure 3: Training Agenda



Part A: Using Beehive Support Resources
We provide all EP program staff with the link to our detailed resource guide, accessed here: https://sites.google.com/view/beehiveguide/home

The resource guide was created so that EP program staff may reference, in detail, how to use the Beehive application and complete the tasks reviewed during the training. This includes: Creating Clinic or Group Admin Account & Inviting them to Beehive, Accepting Beehive Invite & Completing Registration, and Adding a Provider and Inviting them to Beehive. The resource guide also provides information on how to complete the "homework" that was assigned during the first training, including Adding a Consumer & Support Person and Completing Clinician Data Entry.

End User License Agreement (EULA) Video

We show the EULA video to all EP program staff for two reasons: 1) to streamline the registration process for staff during the training (as all users watch this video as part of the registration process), and 2) to orient them to what consumers and families also see when they first access the Beehive system. The EULA video can be accessed here: https://youtu.be/3E8hiEkIvSQ. The EULA video was developed through focus groups with EPI-CAL stakeholders (consumers, family members and providers) to ensure that core aspects of Beehive (e.g., security, consent and data sharing) were clear to users. The EULA video describes what Beehive is and how it is part of the EPI-CAL project, the purpose of Beehive, how data is shared and stored, and users' options for data sharing. Every new user of Beehive will be presented with the EULA video before making their data sharing choices.

Part B: Training Tasks: Setting up Clinic Admin/Provider Accounts and Registering Consumers
There are three main types of accounts in Beehive; each account is associated with the ability to complete certain actions in the Beehive system in line with that person's job duties. The Group Admin account is for program-level staff members who provide supervision and administrative support across clinics within a particular group – for example, a Group Admin is a person whose position includes oversight of activities at more than one clinic. The Clinic Admin account is for staff members who provide supervision and administrative support within a specific clinic in a group. Finally, Provider accounts are for staff members providing direct services to consumers in a particular clinic, for example therapists, prescribers, and peer support specialists. There is a general hierarchical structure to the relationship between these account types, such as who can invite new users and who can download data from Beehive.

The first training task is to set up Clinic Admin and Provider accounts in Beehive. For the initial Part 1 trainings, EPI-CAL staff created Group and Clinic Admin accounts prior to the first training meeting and sent those specific users their invitations during the live training (for trainings of non-pilot sites, EPI-CAL staff assist all admin users to register at the pre-training meeting). Once participants with Admin-level accounts accept their invitations and completed the registration process, EPI-CAL staff guide them through creating provider-level accounts for their staff and inviting those staff to complete registration in Beehive. For sites utilizing a Single Sign-On (SSO) authentication scheme, the EPI-CAL staff also walk them through the process to log in through their institution.

Part C: Next Steps
Once all providers conclude the registration process, EPI-CAL staff demonstrate the process of registering a consumer and support persons in their support network. Next, the survey collection timeline is introduced. Baseline surveys are available for 75 days after the consumer's intake date (due date of 60 days after intake + 15-day grace period to complete surveys). After baseline, follow up surveys are opened every six months, with a ±15-day window for completion. Next, the process for consumers and primary support persons to complete/request help to complete surveys is shown, along with the steps to manually resend surveys. Participants are then given the goal to register two consumers and their support persons (if applicable) in Beehive, and have the consumers complete their surveys before the next training session (see Figure 4). A Beehive consumer introductory script is provided to support the program staff in talking about Beehive to potential participants.

The original plan for Part 1 training was to cover the process to input clinician entered data during the training session, but due to time constraints, we could not cover this section in the initial training. Instead, clinicians and administrative staff were provided with the section of the resource guide that covers the steps to complete this process, and plans were made to elaborate further on clinician-entered data during a later training once consumers have been added to Beehive.

Figure 4: Training Checklist

Part 2 Training

The second Beehive training focuses on how providers can utilize individual level data in care. The Beehive team introduces the EPI-CAL Core Assessment Battery (CAB), including its domains and how these domains were selected from stakeholder input. Next, the trainer presents two surveys from the EPI-CAL CAB: the Modified Colorado Symptom Index (MCSI) and the Questionnaire about the Process of Recovery (QPR). Then, the trainer shows participants where to find consumer data in Beehive. The trainer then demonstrates how to present the data visualizations available in Beehive and asks the group what questions or concerns the sample visualizations elicit from them. Participants then participate in small group exercises focused on example data visualizations of the MCSI with the goals of 1) exercising their data comprehension skills and 2) practicing using data to explore a consumer's story.

During small group exercises, an example consumer's MCSI scores are displayed, and participants are prompted to discuss the "story" that could be illustrated by this data set. For example, providers are presented with a graph in which MCSI scores are going up over time (indicating more frequent and/or distressing symptoms; Figure 5A) and then asked to interpret possible situations that could be leading to these data trends for this sample consumer. After providers correctly identify that the example consumer is experiencing an increase in frequency and/or number of symptoms, they are asked how they might use this information in treatment (e.g., modify the consumer's treatment plan to help reduce the frequency of these symptoms). When time allows, we cover what the visualizations would look like if there are missing data and the negative impact of gaps in data on its use in care. To this end, providers are presented with MCSI graphs to illustrate that gaps in knowledge can drastically affect data interpretation (Figure 5B). To try to help combat these issues involved with missing data, the team also explains how to increase consumer buy-in to Beehive.

Figure 5: MCSI Example Graphs from Beehive

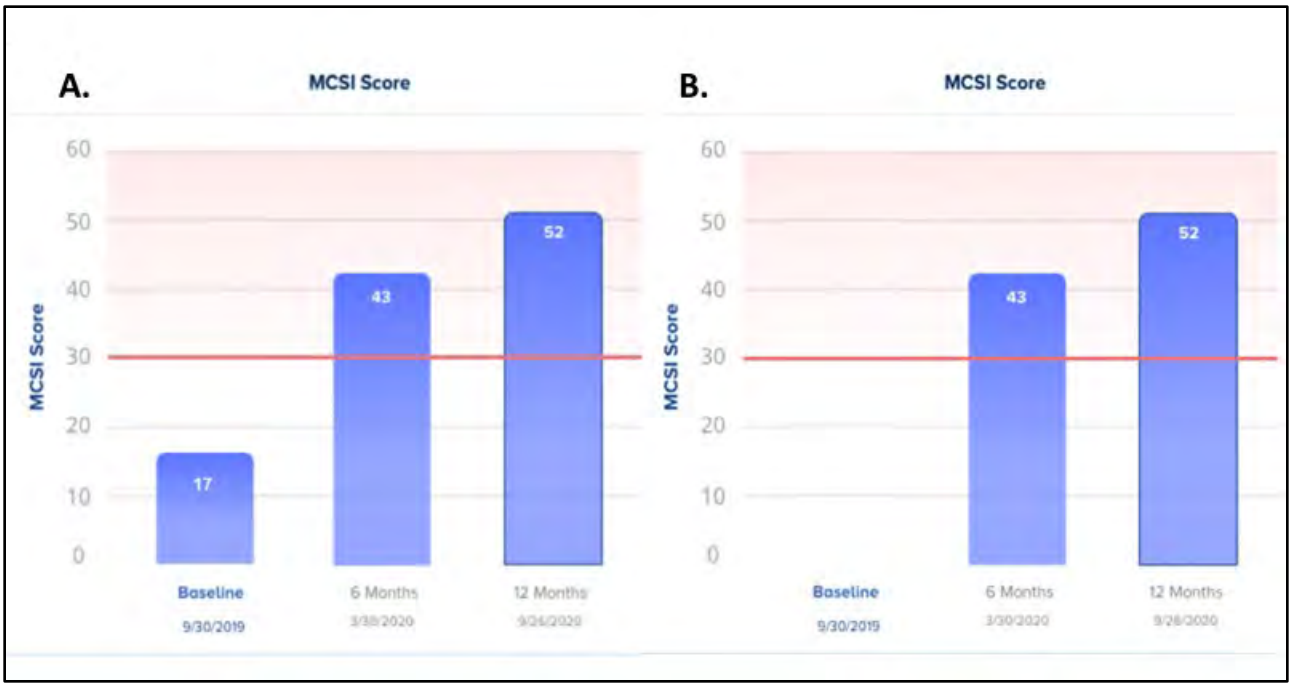


Figure legend: A. Representation of data showing increasing trend in MCSI symptom severity; B. Representation of how missing data (shown here at baseline) impacts the visualization

After these exercises conclude, small groups reconvene back into the larger group, with a member from each group presenting their group's discussion/findings to the rest of the site as a whole. As each small group has different themes and discussions that come up during the exercises, the larger group discussion is meant to help to broaden participants' understanding of data interpretation.

Next, the training details the types of urgent clinical issues that are currently tracked by Beehive, including "Risk to self", "Risk to others", "Risk of homelessness," and "Plan to stop taking medication". These issues were identified during focus groups with EP program stakeholders as critical moments for intervention during treatment. The training team also explains where each one of these alerts can be triggered within the assessment battery. Importantly, we stress that Urgent Clinical Issues in Beehive are not a replacement for each clinic's standard risk management procedures; instead, Beehive can be used as an additional tool to inform their standard risk management approaches. We also cover how to resolve urgent clinical issues using the responses programmed into Beehive (i.e., "Modified treatment plan", "Conducted risk assessment" or "Sent for emergency care") as appropriate for these alerts.

To conclude the training, the trainer introduces the "Data Use in Care" question pop up and its different response options. This pop-up appears intermittently when a user leaves a page on Beehive which displays consumer's data. It asks the user whether they reviewed the data with the consumer or family and then asks them how the data impacted treatment. These response options are the same as the response options programmed into the urgent clinical issues – the training team intentionally takes the approach of presenting these two Beehive features together to help maximize participant comprehension. These data will contribute to a data-driven understanding of Beehive's impact (e.g., whether and how staff use data as part of treatment) on the participating programs of the LHCN.

Thus far, Part 2 trainings took about two hours each and were conducted over the month of April for the pilot programs. SacEDAPT & EDAPT had their Part 2 training on Monday, April 5th, from 8am-11am. Solano's Part 2 training occurred on Monday, April 12th from 11am-1pm. The Pathways-Kickstart Part 2 training was on Wednesday, April 14th from 9am-11am.

Part 3 Training

Part 3 training revolves around applying and expanding the data interpreting skills gained in Part 2 training, with actual data from consumers that was collected after the last (Part 2) training. During Part 3 training, participants are split into small groups, and given a GUID of a consumer that receives services at their clinic. These GUIDs are identified by the site's point person before the start of each Part 3 training and consist solely of consumers that have completed their surveys and have agreed in the EULA to share their de-identified data with UC Davis. This is to ensure that each small group has real-world data to interpret, and that the data for this exercise is ethically sourced.

Before beginning to interpret real consumer data in these small groups, participants are oriented on how to input and view Clinic-entered data and how to assign additional surveys to consumers.

Part 3 training also familiarizes participants to two more measures included in the Core Assessment Battery: the SCORE-15 and the Questionnaire about the Process of Recovery (QPR). These measures were selected because they both capture quantifiable scores on domains (family impact and recovery, respectively) that were identified as high priorities by EP stakeholders during EPI-CAL outcomes focus groups. These measures were chosen for this training as, like the Modified Colorado Symptom Index covered in Part 2 Training, they are scored measures which are visualized in Beehive.

For the small group activity, each participant is assigned to a small group with at least one EPI-CAL team member to orient them to the small group worksheet which includes training activities and discussion questions about finding, interpreting, and using consumer data as part of care. As these trainings require participants to examine their consumer's data (i.e., PHI), EPI-CAL training team members are only present for the beginning of the small group exercise to introduce the activity, but they leave prior to any discussion or sharing of PHI. EPI-CAL staff encourage each participant to take an active role within the small group: note taker, screen sharer, delegate to report during large group debrief, etc. Each small group uses the small group worksheet (Appendix II) to guide their time in the small group.

After the small group exercise, participants rejoin the larger group to share their findings. After each small group has presented their findings with the rest of the groups as a whole, the EPI-CAL team facilitates a large group discussion which encourages participants to look for trends and assess what they could mean. After encouraging pattern recognition, the training team will encourage participants to view their consumer's data through this analytical lens and demonstrate how their treatment plans could benefit from this approach.

In the reporting period, we conducted our initial Part 3 trainings with two sites. Solano's Part 2 training occurred on Monday, June 7, from 11am-1pm. SacEDAPT & EDAPT had their Part 3 training on Monday, June14 , from 8am-11am.

Implementation Support After Initial Beehive Trainings

We introduce each program to their EPI-CAL staff point person who will be reaching out for regular check-ins to resolve any questions they may have as they are familiarizing themselves with the Beehive application. The point persons are introduced during pre-training and the Beehive training series. The initial check-ins are conducted weekly (or as needed by the site) where we will resolve issues as they arise and support staff with accessing resources and learning to use Beehive.

While most point person support consists of email or other electronic communications to answer questions and provide guidance, some sites require additional support. Additional "booster" trainings may be conducted over Zoom, with the potential to expand to in-person trainings as appropriate relative to the COVID-19 pandemic. Also, point person support over video calls is used to provide other forms of support or technical assistance. At one site, a point person began to provide survey completion reminders to clinicians at their weekly Zoom

clinical check-in meetings, while a different site's point person began to provide Urgent Clinical Issue resolution support via their weekly check-in emails.

6. Feedback from beta testing of LHCN application for data collection.

The first part of beta testing was internal user acceptance testing (UAT) by the EPI-CAL team. UAT began when the developers released the beta version of Beehive to the EPI-CAL team, who created test clinics and users at all levels in order to test various use-scenarios to ensure Beehive was working as expected and report any issues in cases where there were typos, bugs, etc. To do this, our team created test accounts as consumers, primary support persons, providers, group analysts, clinic admins, and group admins. These accounts also allowed us to test the sign-up process from different user perspectives. We then reviewed all the surveys in each bundle to check if they were appearing as expected against our survey codebook. We tested survey access and completion on the desktop application (including different browsers), the tablet, as well as Android and iOS mobile devices to confirm proper application formatting on the different types of devices users would access Beehive on. We also interacted with Beehive to emulate other use cases to ensure features outside of the surveys were working as expected (e.g., downloading data reports, viewing and agreeing to data sharing permissions, adding and editing users as a clinic admin). Any typo or bug that was found was reported in a shared review document and corrected internally, if possible, or sent to the developers if it was not an issue that could be resolved by our team. For example, we found that the EULA page was not displaying the video or displaying the data-sharing options correctly. Reports of issues were accompanied by screenshots or screen recordings, where possible, to aid in resolution of items.

After the initial training on Beehive in three pilot programs (see previous section on training), beta testing began in the pilot programs. We solicited feedback from providers and staff in each of the pilot programs after their initial introduction to the Beehive application via a feedback survey (see Appendix III). Thus far, feedback showed that the training was a little too fast paced, that there were plenty of opportunities to give feedback or ask questions, and that users only felt a little confident in using Beehive after the first training. We plan to re-assess users' confidence in using Beehive after the additional trainings take place, as we would expect their confidence to improve after more training and exposure to Beehive. There were mixed responses on practice time, with some individuals expressing the need to have more time to practice using Beehive during the training while others did not need to use training time to practice. There was also variability in the responses regarding the potential value of Beehive, ranging from thinking Beehive will add a little to a great deal of value to their job.

In addition to feedback surveys, we have assigned each pilot program an EPI-CAL staff point person. This point person manages any issues that arise as users implement Beehive in their assigned program. Clinic staff have been provided with their point person's contact information, as well as instructions on how to create a support request ticket in the Beehive application. The ticket system allows Beehive users to create a support request, resolve a request, and escalate a request outside of their clinic or group.

7. Subcontractor to make modifications to software application and dashboard to reflect findings from pilot testing and qualitative report

After receiving feedback from Beehive beta testing (Section "*Feedback from beta testing of LHCN application for data collection*" described above) the EPI-CAL team pushed issues to the application developers to implement in future versions of the application. The types of issues reported were bugs, cosmetic issues, fixes to already implemented features, usability problems, and requested new features.

“Bugs” are errors in the application producing unexpected results. One bug that was identified as part of internal beta testing among the research team was that the response to slider-type questions was not being saved in the database. This was resolved in the next build provided by the developers.

“Usability problems” were aspects of the beta application that did not function as desired, but that were not errors in coding (i.e., bugs). One such issue that was identified as part of internal beta testing among the research team was that character limits and permitted characters needed to be expanded in many of the text boxes throughout the application.

When features were not implemented as originally asked for, the EPI-CAL team categorized these issues as “fixes.” For example, upon receipt of the application, the dropdown menu for “race” within the registration for staff-users, consumers, and primary support persons only allowed for a single selection. The fix for this issue was to allow users to select all that apply in the “race” dropdown. This was implemented in the next release of the application.

“Cosmetic issues” include fixing typos, updating text and imagery in the application, and improving formatting. One cosmetic issue that was identified as part of internal beta testing among the research team was that the image that appeared on the survey instruction and survey question screens did not represent the diversity of the stakeholders for whom the application was developed. The EPI-CAL team had selected images to use throughout the application to represent this diversity. However, the same image appeared repeatedly on the survey screens, which is where consumers and support persons will spend the majority of their time in the application. The resolution to this issue was to change the image to a landscape image to avoid overrepresentation of any one personal identity (i.e., race, ethnicity, gender) on the application.

New features were requested when testing revealed a need for them in the application. For example, EPI-CAL staff determined that additional demographics fields needed to be added to the primary support person registration. Please see Appendix IV for a complete list of items that were identified during pilot testing.

8. Get preliminary results on program-level data from 2 pilot EP programs, including interviews with EP programs to understand barriers and facilitators to app implementation.

Preliminary results on program-level data from 2 pilot EP programs

After our initial trainings with EDAPT/SacEDAPT and Solano SOAR Aldea programs in March, programs were able to begin enrolling consumers into Beehive. Basic demographic information is collected via phone screen and entered into Beehive by clinic staff when initially registering a consumer and their support persons. All consumers had to complete the EULA before being presented with surveys. When consumers complete the EULA, they indicate whether they want to share their data with UC Davis and/or the NIH for research purposes beyond using Beehive for the purpose of their clinical care. Their choices are explained in detail in the EULA video. Our goal is to have 70% of consumers agree to share their data with UC Davis and NIH.

For the current report, we are reporting on data collected up through May 31, 2021 for those who agreed to share their data with UC Davis. Forty-one consumers were registered in Beehive across two pilot clinics, and of those, 22 completed their EULA indicating their data sharing permissions. Of those who completed their EULA, 17 consumers agreed to share their data with UC Davis (77%). Therefore, in the current report we are reporting demographic data for those 17 individuals across two clinics who have registered in Beehive, completed their EULA, and agreed to share data with UC Davis. It is important to note that clinic staff register consumers and invite them to Beehive; consumers then complete their registration and then have the ability to complete surveys. So, if someone has been registered in Beehive, it does not necessarily mean that they have completed any of the outcomes surveys available in Beehive.

Here we report demographic information that is completed at registration, which is a subset of the demographic questions that are asked in Beehive (Table 8). Complete demographic information, including all required PEI fields, are administered via a required consumer-entered Beehive survey. For any cell that has an N less than 5 individuals, this data was masked and both the N and proportion cells were updated with “<5” and “<29%”, respectively. If there were 0 individuals who endorsed a response option in the demographic surveys, the category is not represented on Table 1 (e.g., intersex under Sex at Birth); we will continue to add categories to each demographic variable if there are ≥1 individuals in each respective category.

Table 8: Preliminary Demographic Data from Beehive Pilot Testing

SacEDAPT and Solano SOAR Combined Demographics (through 5/31/21)		
Display Language	**N**	**%**
English	17	100%
Age	**N**	**%**
15-20	9	53%
21-25	<10	<58%
>25	<5	<29%
Sex at Birth	**N**	**%**
Female	8	47%
Male	9	53%
Gender	**N**	**%**
Female	7	41%
Male	<10	<58%
Unsure	<5	<29%
Pronouns	**N**	**%**
He/Him	9	53%
She/Her	<10	<58%
They/Them	<5	<29%
Race	**N**	**%**
African/African American/Black	7	41%
American Indian/Alaskan Native	<5	<29%
Hispanic/Latinx Only	5	29%
White/Caucasian	<5	<29%
Ethnicity	**N**	**%**
No - I do not identify as Hispanic/Latinx	9	53%
Yes - I identify as Hispanic/Latinx	5	29%
Prefer not to say	<5	<29%
Unsure/Don’t know	<5	<29%

Additionally, providers are able to enter a consumer’s diagnosis when they register individuals in Beehive, which is reported in Table 9. In the same manner as the table above, cells with less than 5 individuals were masked and both the N and proportion cells were updated with “<5” and “<29%”, respectively. For most diagnostic categories except Schizoaffective disorder, there were less than 5 individuals per cell. Diagnoses are grouped according to two classes of early psychosis: 1) individuals who are deemed to be at clinical high risk for psychosis (CHR), and 2) individuals who have experienced psychotic level symptoms (First Episode

Psychosis, FEP). This reflects the wide range of psychosis diagnoses that are served by the EP clinics represented in this sample.

Table 9: Consumer Diagnoses from Beehive Pilot Testing

Diagnosis	N	%
Clinical High Risk (CHR)		
Attenuated Psychosis Symptoms	<5	<29%
First Episode Psychosis		
Substance Induced Psychotic Disorder with onset during intoxication	<5	<29%
Mood disorders with psychotic features	<5	<29%
Schizoaffective Disorder (Bipolar or Depressive Type Combined)	8	47%
Schizophrenia	<5	<29%
Missing	<5	<29%

When consumers finish registration in Beehive, they then have access to Beehive surveys. After registration is complete, Beehive makes three surveys available for completion: Adverse Childhood Experiences (ACES), primary caregiver background, and questions about other lifetime experiences and static demographics information (see EPI-CAL Enrollment Life Questions, see Table 10). If a consumer is in a survey window (e.g., at intake or six months), Beehive makes available 15 additional surveys that assess various outcomes including family functioning, education, social relationships, demographics and background, medications, and symptoms (see Table 10 and Figure 6). These surveys are presented in different bundles that are grouped based on subject matter and/or timing of the surveys (i.e., whether they receive the survey just at enrollment, or at enrollment and every six months thereafter). EPI-CAL enrollment and required bundles are automatically assigned to every consumer who registers in Beehive. However, each individual clinic also has the option of assigning addition surveys if they choose to do so. The current data only include EPI-CAL enrollment and required bundles.

Table 10: EPI-CAL Enrollment and Required Survey Bundles

Bundle Name	Survey Name	Bundle Timing
EPI-CAL Enrollment Life Questions	EPI-CAL Enrollment Life Questions	Enrollment only
	Adverse Childhood Experiences (ACES)	
	Primary Caregiver Background	
EPI-CAL Experiences Bundle	Life Outlook	Every 6 months, including intake
	Questionnaire About the Process of Recovery (QPR)	
	Modified Colorado Symptom Index (MCSI)	
	Substance Use	
	Legal Involvement and Related	
EPI-CAL Treatment bundle	Intent to Attend and Complete Treatment Scale	Every 6 months, including intake
	End of Survey Questions	

	Hospitalizations	
	Shared Decision Making (SDM)	
	Medications	
EPI-CAL Life Bundle	SCORE-15	Every 6 months, including intake
	Demographics and Background	
	Social Relationships	
	Employment and Related Activities	
	Education	

When enrolled at intake, consumer and identified support persons can be registered in Beehive by clinic staff. Beehive will then prompt them to complete registration, review the EULA, and choose data sharing permissions. Beehive then shows them the surveys that are available for them to complete within each bundle (see Figure 7 below). Respondents can choose which surveys they wish to complete in the order they wish to complete them.

Figure 6: Survey Window Timing

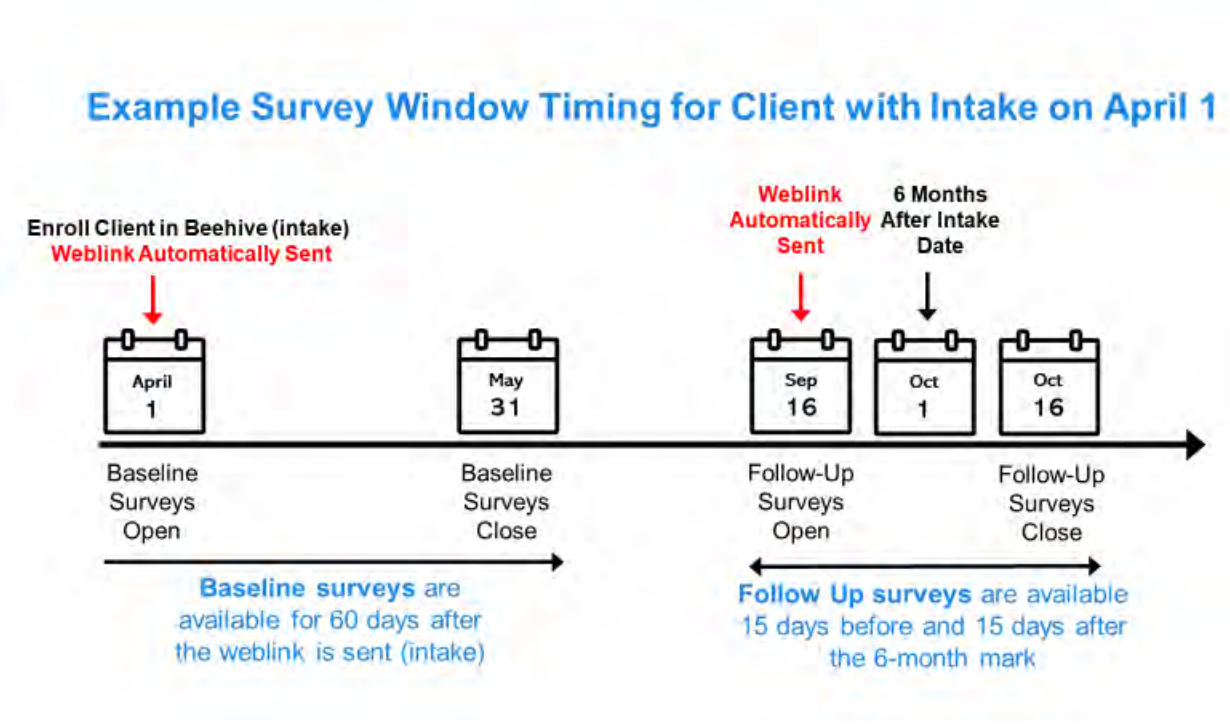
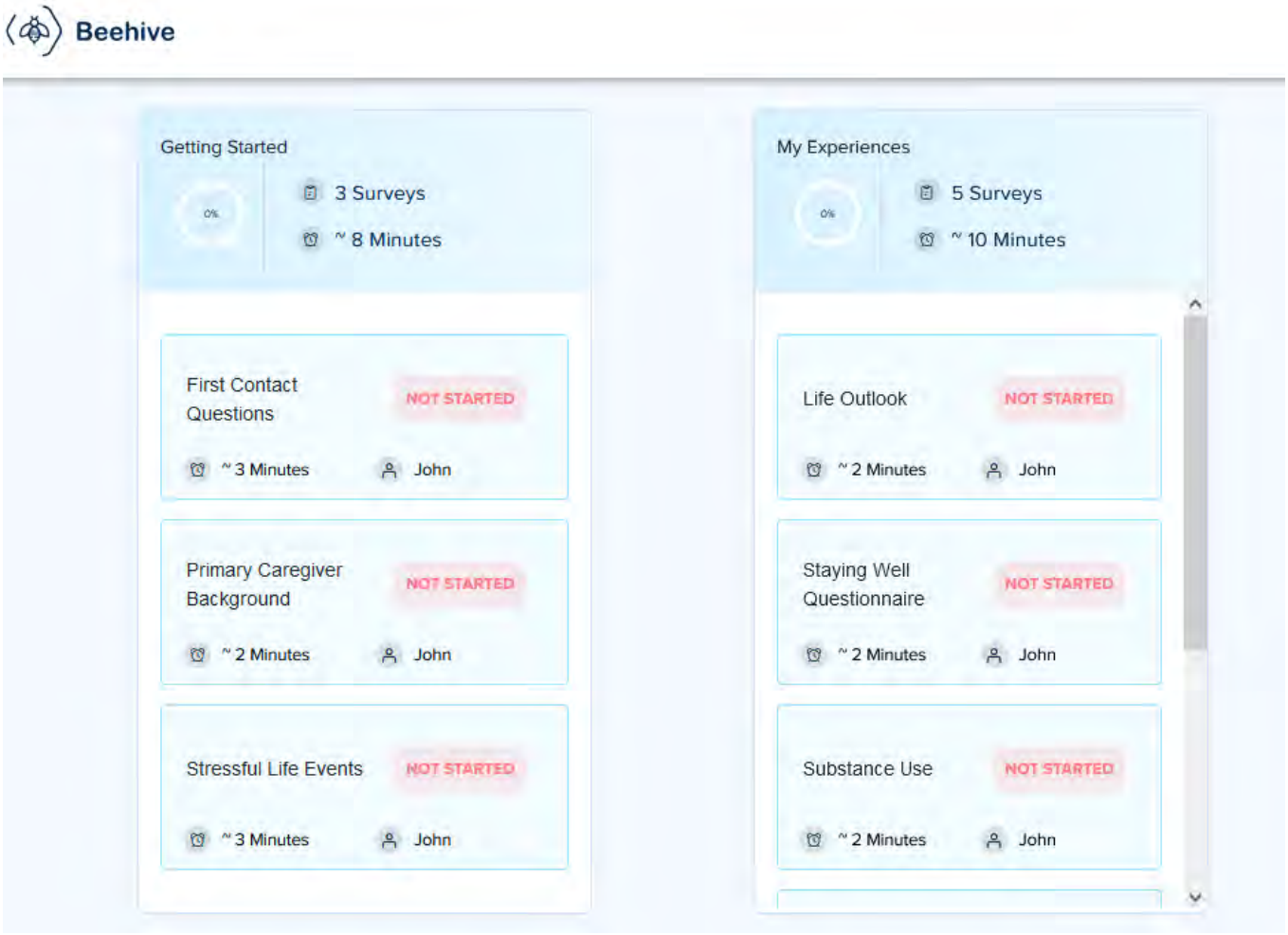


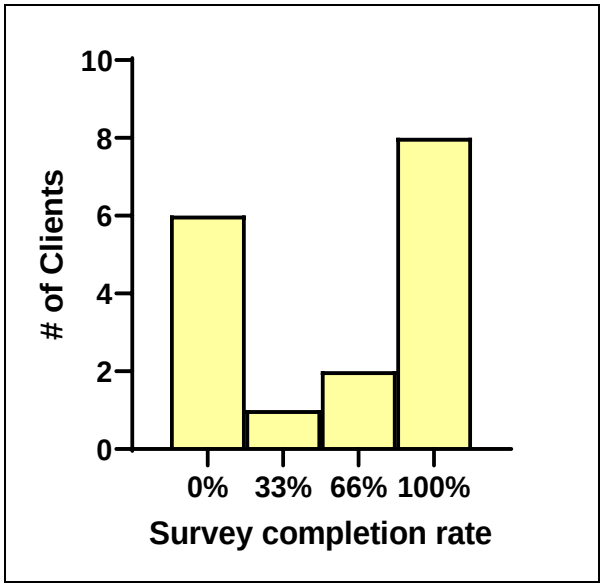
Figure 7: Surveys Available for Consumer to Complete at Baseline



During the initial phase of Beehive roll out, we asked clinics to enroll consumers and support persons who are already engaged in EP care. When these active consumers are enrolled, Beehive prompts them to complete registration, review the EULA, choose data sharing permissions, and complete enrollment surveys. If they are within the active 6-monthly survey window, they are also able to complete the EPI-CAL required bundles.

At this time, we are reporting the survey completion rate from 17 consumers on the three available enrollment surveys (EPI-CAL Enrollment Life Questions, Figure 7) because some consumers were enrolled outside of survey windows and thus were not presented with the remaining 15 surveys. The distribution of survey completion is reported in Figure 8. Survey completion rate ranges from 0-100%, with 47% of individuals completing all three enrollment surveys. The point person at each clinic site will track survey completion and inform clinic staff if there are consumers who are not completing their surveys so that the clinic staff may check in with consumers.

Figure 8: Preliminary Survey Completion Rate for Enrollment Surveys



Exploration of barriers and facilitators to implementation of the Beehive system

To support the successful integration of the data platform into clinical practice, a series of interviews will be completed with providers, consumers, and family members from participating EPI-CAL clinics. The aims for these interviews will be to determine the acceptability of the platform in this setting, identify potential barriers and solutions to implementation, and explore factors that may facilitate implementation. The interviews will focus on provider training, the data collection platform, the logistics of data collection, the data presentation platform, the feasibility and impact of integrating the data into care, and the utility of program-level metrics. To explore these topics, various stakeholders will be interviewed to share their experiences of delivering or receiving care using the application. The interviews will be audio recorded and transcribed, with the transcripts analyzed utilizing a conventional content analysis approach (Hsieh and Shannon, 2005).

Given the heterogeneity of the programs across the network, the complexity of the intake process and subsequent care composition that is the norm in early psychosis programming, and the differing needs of the different community partners involved in the process (consumers, family members, administrative staff, providers, team managers), the interview questions will be framed on a series of multiple levels. First, the interview will focus on specific barriers and facilitators that may exist within the implementation of Beehive at that specific program. Next, more generalizable factors that could potentially exist across programs will be considered. Finally, barriers and facilitators that may relate specifically to different stakeholder groups will be explored. The findings from this investigation will be used to develop a series of guidelines for successful implementation, some of which are pertinent to specific clinics, while others will be generalizable findings that will be disseminated across the whole network. The overall goal of this exercise is for the guidelines to be used by the programs to refine the implementation and integration of the Beehive platform for the benefit of all stakeholders who interact with it.

For the current report, four interviews of providers working at the EDAPT clinic were conducted. Two participants were interviewed once, while the third was interviewed twice. EDAPT is one of two pilot sites which have been charged with implementing the Beehive application into existing practice, which started on March 22, 2021. The interviews were completed by Mark Savill either alone, or with a second researcher (CH). Dr. Savill is the qualitative lead of the EPI-CAL project with expertise in early psychosis and evaluating the implementation of novel interventions in community behavioral health settings. Christopher Hakusui is a Junior Specialist who has played a significant role in the development of the Beehive application, the training, and the integration of the application into clinical services. All interviews were audio recorded, and the analysis of the transcripts will be incorporated into a broader qualitative evaluation of Beehive implementation across all EPI-

CAL clinics, to be detailed in a later report. For the current report, a brief narrative summary of the completed interviews completed is presented below.

Findings

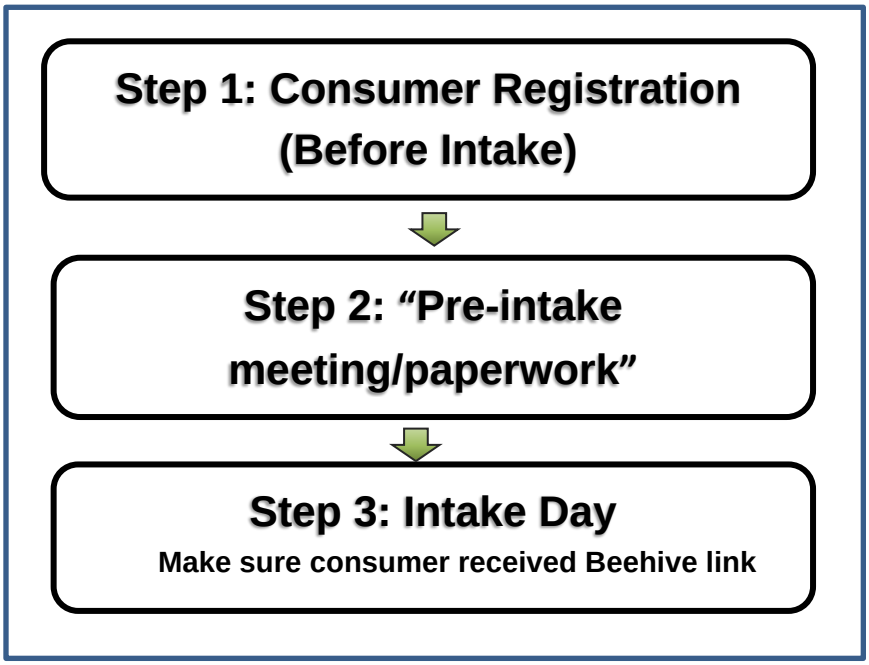
Between 4/7/2021 – 6/17/2021, four interviews were completed with three participants from the SacEDAPT program. One participant was interviewed twice, since they had not yet enrolled a consumer onto the Beehive platform at the time of the first interview and so they had additional insights to share. Two participants were clinic coordinators, and one was a peer case manager. In all cases, the participants' primary role with regards to Beehive to date was enrolling, consenting, and supporting the data collection component of the project. Therefore, the focus on the interviews centered on Beehive training, and the initial implementation of Beehive during the intake process, incorporating scheduling, consenting, enrolling, and baseline data collection both of new intakes and existing consumers. In future reports, as more consumers are enrolled into the Beehive platform and the system is fully integrated into practice, the feasibility and impact of integrating beehive data into clinical care will be explored with consumers, family members, providers, and program leadership.

Initial implementation

Prior to implementation of the Beehive application to their practice, the case managers met to develop a new intake plan that could accommodate the additional components required. During this meeting, the planning process was supported by a member of the research team (VP), which participants recognized as an important component of the process. Once the provisional plan was developed, this was then submitted to senior program management for review/approval.

The final revised intake process is presented in Figure 9. Overall, participants indicated that a significant revision to their original intake protocols was necessary. Subsequently, having the administrative team meet in collaboration with the research team to go through all intake requirements prior to implementation was considered critical. Given the additional time required to enroll consumers into the Beehive application, complete the EULA, and then complete the surveys, the team took the decision that additional steps in their intake procedure were necessary ("Step 1" and "Step 2").

Figure 9: The Revised Intake Process to Accommodate Beehive Requirements



Early Implementation of the Intake Procedure

Participants' interviews indicated that the intake process to date has been consistent with the model developed during the pre-implementation meeting. However, some additional steps have been recently proposed to help with time management when using Beehive during the intake process. This includes having the PCMs schedule an additional appointment to complete consumer and primary support person surveys that were not completed during the initial intake appointment.

Prior to implementation, participants had indicated that the ability for consumers and family members to complete data collection independently prior to the appointment would be critical to effective implementation. However, since the start of data collection, it has been evident that most consumers and family members have required additional support to complete the surveys. The support required typically focused on question comprehension and technical support. Based on current experiences, participants could not identify particular areas where support was consistently requested.

Overall, the participants suggested that the additional components added to intake process across the three stages took approximately 90 minutes, making the new intake process three hours. The main factors for the increase in time required was attributed to the additional scheduling time necessary to book an additional appointment, registering consumers into Beehive, completion of the EULA video and data permission selections, and length of the surveys consisting of Beehive required surveys and additional SacEDAPT required surveys that were integrated into Beehive. The additional procedures were noted to require additional input to the workload of the clinic coordinators, who voiced difficulty in accommodating this into their existing commitments. Additionally, some participants voiced concerns regarding the additional requirements placed on consumers and their families, particularly those who are referred directly from hospital where the intake process is required to be completed within ten days of discharge. To date, consumers and families have not been interviewed, and so their experiences will be explored and presented in later reports.

In an exploration of potential solutions to these barriers, two participants suggested that reducing the length of the intake survey at Step 3 to the just the components critical to the intake assessments, after which other elements could be completed at later appointments. One participant also suggested that they believe the process would be much more streamlined once on-site assessment resumes, given this would minimize both the technological challenges some consumers face, and would also mean that consumers and families could complete surveys in the waiting room and so would need less online support. Linked to this, another proposal was to explore options where the case managers or clinic coordinators would not be on the Zoom call during the completion of the surveys; however, there were concerns about how consumers and families would address issues without available assistance.

Participants indicated that based on previous experiences, a significant proportion of consumers typically enter data via their mobile telephones. Consequently, ongoing compatibility with mobile internet browsers was considered critical. Regarding the current incompatibility of the system with Internet Explorer, the participants were unsure if this was likely to represent a significant barrier. This issue will be explored in future interviews with consumers and family members.

Enrollment for existing consumers

Of those interviewed to date, one participant reported being involved in enrolling existing SacEDAPT consumers into the Beehive system. Overall, the procedures and challenges implementing the new protocols were considered largely consistent with new intakes, with consumers requiring the same level of support to complete the surveys. Because the surveys were being completed within their existing sessions, the participant voiced concern that this would be taking away from direct service time. To address this, the participant suggested that it would either be necessary for an additional appointment to be scheduled with the clinic

coordinator to complete the survey, or else the survey be completed outside of their treatment session without the clinic coordinator being present.

Training

Overall, participants described the training as helpful and a positive experience. While trainings have focused on the data collection component, all interview participants reported appreciating being involved in all aspects of the training. One participant suggested that being involved in all the elements meant that they would be better placed to address consumer/family member questions or queries about other aspects of the application, while others suggested that being able to see how the data can be utilized was a motivating factor in being involved in the process. Being able to see how this data could be utilized in care meant that data collection efforts were considered more important/meaningful, relative to some prior data collection efforts where neither they nor the consumer were able to access the data afterwards.

In addition to the positive experiences reported, one participant did suggest that the training was very focused on utilizing the Beehive application in care and would have appreciated more information on the enrollment and data collection process. Another participant suggested that a reference manual that details each step of the enrollment and data collection process would be very useful. In particular, a summary of what each survey question was aiming to address was considered to be helpful, given the participants reported struggling to explain how to best respond to particular questions in the survey when asked by consumers.

Importance of support

In order to support the implementation of the Beehive application, all participants suggested that having a designated point person to help address technical and logistical issues was critical. One participant suggested that having a designated person meant issues would be quicker and easier to rectify. In circumstances where that individual may not be available, the participant highlighted the importance of collaboration across provider teams to resolve issues. In addition, the current feedback system where software bugs are reported to the research team was considered effective and prompt.

Acceptability of the application

Despite challenges of data collection, most participants were positive about the possibility of utilizing the data in care. In particular, one participant identified the information collected as part of the recovery-based surveys as very useful to the services they deliver. Participants interviewed also reported being highly positive about the Beehive application, with the immediate data visualization that is available to all members of the clinic considered a significant strength. Finally, one participant indicated that the EULA was well received by consumers, containing important information that addressed multiple questions that stakeholders previously had around the data.

Discussion

Overall, the participants interviewed identified several strengths and challenges in the initial implementation of Beehive. Participants elicited some concern that the current intake process takes significantly longer relative to previous protocols. For one participant, the expectation was that some of these challenges could be alleviated by the return of in-person assessments. Other proposals included: delaying the completion of the survey to after the initial clinical intake, advocating for functionality changes to allow the Beehive system to send surveys prior to the intake date for earlier completion, and reducing the level of online support afforded to consumers during the completion of the surveys. These challenges highlight the importance of the research team providing significant support during the initial implementation process, and the necessity of the research process being as flexible as possible to help minimize stakeholder burden. In later reports, the success of implementing modifications to the intake process will be explored, with facilitators to efficient intake procedures being distributed across the network to support other programs.

More positively, participants recognized the utility of the system, and were looking forward to implementing Beehive into care. Additionally, all participants indicated that the training received was appropriate, helpful, and resulted in them feeling confident they would be able to fulfil their role. The participants indicated that the system was relatively clear and easy to use, particularly when compared to current practices that the application will replace.

Limitations

In reviewing the preliminary findings presented in this report, it is important to consider several significant limitations and caveats. Critically, these data were collected from only four interviews, all including case managers or clinic coordinators and all working at the same clinic. Consequently, a full summary of the potential benefits, challenges, and solutions have not been fully explored. In future reports, providers in other roles such as licensed clinicians, program managers, prescribers, and supported employment and education specialists will be interviewed to understand the utility and challenges of the system across different provider roles. In addition, providers from other clinics will be interviewed as the Beehive system is integrated across the network to explore the similarities and differences in implementation experiences across clinics. Importantly, consumers and family members will also be interviewed to understand the acceptability of the platform, and any barriers and facilitators to implementation from the perspective of those that receive care, in addition to those delivering care. Finally, these interviews will be conducted throughout the implementation process, from initial adoption to the end of the process where procedures and protocols are established. Once collected, these data will then be analyzed in a comprehensive and systematic manner, allowing for a deeper exploration of the implementation process relative to the findings presented in the current report.

Summary

While it is necessary to conduct a much more comprehensive assessment of the implementation of the Beehive application, multiple challenges and potential solutions and opportunities were identified. Going forward, further work to understand the experiences of providers, consumers and family members going through the data collection process and utilizing the data in care will be critical to better understand the challenges and opportunities to delivering more data-driven care in an early psychosis setting through the Beehive application. This work will take place through an extensive interview process that will be detailed in later reports.

9. Outline plan for training EP program staff from non-pilot programs on application implementation and outcomes measurement.

Our team has learned a great deal from the initial Beehive trainings regarding the most efficient way to approach training for non-pilot EP programs. One of the consistent messages was that the initial trainings were too fast paced for many users. Another major learning opportunity was that we did not have enough time to sufficiently cover all the content we had planned in each session. Therefore, instead of breaking out the initial trainings into two 2-hour sessions, we have revised our training plan to include at least three 2-hour sessions for the introduction to Beehive for non-pilot programs as well as provide a fourth training to cover additional content for the pilot programs. We will continue to incorporate any changes and feedback from additional trainings into all future trainings, as we view improvement of our training approach as an iterative process. One change we implemented to save time during Part 1 training was to register all admin users (Clinic and Group Admin) during the pre-training meetings so that we only had to register the remaining providers during the first training. This has saved a substantial amount of time in subsequent Part 1 trainings thus far. We have also broken out into small groups to register providers during Part 1 training so several people can be registered in parallel, which has also contributing to saving time.

Another important piece of information we learned from these first trainings was the need to meet with each program's IT department ahead of time to make sure that emails/server requests from Beehive are not blocked by their organization's network security protocols. For example, Solano Aldea SOAR had delays in the first training because the emails from Beehive were being quarantined. While we were able to work with IT to unblock these emails, we decided to meet with IT ahead of time and test the sign-up email process in the pre-training meeting with leadership to avoid the delays during the training moving forward. Additionally, meetings with site IT to ensure Beehive's ability to properly communicate with its servers through site networks will be conducted. Thus far, we have modified our pre-training approach with five additional programs in preparation from their training and were able to verify ahead of time that Beehive emails would not be blocked during Beehive training.

We have also identified the need to understand more about each program's intake process so that we may customize our training and support approach to each program's existing clinical workflow. We have begun collecting information and meeting with intake coordinators from each program to understand data collected during phone screen and intake, and how and where Beehive consumer registration and surveys will fit into their existing process.

Los Angeles County PIER programs were our first non-pilot sites to receive Beehive training. This process was first initiated with pre-training meetings with each program in May 2021 to set up group and clinic admin accounts, review current clinical data entry practices, and meet with each program's IT contact to ensure the Beehive email can be received by each organization's email. Then, we held Part 1 Beehive training with each program, starting with The Help Group on 6/14, followed by The Whole Child on 6/17, San Fernando Valley Community Mental Health Clinic on 6/18, and finally both Institute for Multicultural Counseling & Education Services (IMCES) programs on 6/21. We also provided tablets to each program that is was providing in-person services. In the reporting period, all clinic admin, group admin, and provider accounts were set up for those who attended the Beehive trainings. Each program was connected with their EPI-CAL point persons who assist them with any questions throughout Beehive implementation. Though each program had the ability to begin enrolling consumer and support people into Beehive by the end of this reporting period, we directed them to wait until penetration testing of the Beehive application was completed and LACDMH had reviewed the report.

During this reporting period, the OC CREW, Napa Aldea SOAR, and Sonoma Elizabeth Morgan Brown One Mind ASPIRe programs were the remaining LHCN programs that needed to receive their initial Beehive training. EPI-CAL staff had been in contact with program leadership from each of the programs to schedule the pre-training meeting, followed by the Part 1 Beehive training.

10. Establish data collection process for obtaining county-level utilization and cost data for prior 3-year timeframe for preliminary evaluation for both EP and comparator group (CG) programs.

Over the last annual period, we held a series of meetings with the EP program staff and county staff to address collection of the county-level utilization and cost data for the prior 3-year timeframe. For each county, we identified EP program information, including description of consumers served, billings codes for each service, funding sources and staffing personnel during the retrospective period. Meetings were also held with the county data analysts to discuss details about the data the county will be pulling for the LHCN team during the next annual period. The discussion included the time-period, January 1, 2017 – December 31, 2019, for which the LHCN team requested data, description of the consumers from EP programs, how similar consumers served elsewhere in the county will be identified, services provided by each program, other services provided in the county to the EP consumers (i.e., hospitalization, crisis stabilization and substance use) and data transfer methods. Follow-up meetings have been scheduled with each county to discuss issues and concerns

with the EP program data pull. Once the LHCN team has reviewed and assessed the EP program data, this data will be used to inform characteristics and availability of data elements for the CG data pull. Meetings will then be scheduled with each county to review the details of the CG retrospective data pull.

Data Collection Process

The county data analysts have identified all consumers served by the EP program between January 1, 2017 – December 31, 2019. This will include individuals who started services with the EP program between January 1, 2017 – December 31, 2019 and exclude any individuals who received services by the EP program prior to January 1, 2017. Once the county data analyst gathered all the data elements for each consumer, they sent the list of consumers to the EP program manager. The EP program manager then confirmed the list of consumers as new consumers as of January 1, 2017 – December 31, 2019, and identified whether they were: 1) clinical high risk (CHR) and enrolled in treatment; 2) first episode psychosis (FEP) and enrolled in treatment; 3) assessed and referred out during January 1, 2017 – December 31, 2019; or 4) other, with reason (e.g., incorrectly assigned to EP program in EHR). They also added any individuals missed and repeated above 1-3 categorization, if necessary. They also sent certain data elements that were not available in the county EHR to the county data analyst, who integrated them into the dataset. These data elements include information included on intake forms such as regional center involvement and referral information. The county data analysts integrated these data elements into the dataset and assigned a random ID to replace medical record numbers (MRN)s, names, and other identifying information and saved the key, in order to create a limited dataset (dates and zip code included). The county data analyst was sent a link to a secure UC Davis web portal, whereby each county can upload their county data securely and will not be able to see any other county's data.

Each county received the following data request via email:

"We are requesting a limited dataset for all individuals served in the specified *EP Program* between these dates: January 1, 2017 – December 31, 2019. Data elements requested include: 1) all diagnosis(es) (psychiatric, substance use, physical health) and dates of diagnoses; 2) year and month of birth (not date); 3) demographics, including: ethnicity (primary, secondary, Hispanic [y/n]); sex; gender; sexual orientation; Medi-Cal aid code; living arrangement (housing status); US military information; veteran status; preferred language (primary, secondary, preferred, family, English verbal proficiency); foster care/adoption; zip code; and insurance status (i.e., insurance type- find out what is available; education level; marital status; employment status); and 4) all county services utilized for the list of consumers that started services between January 1, 2017 – December 31, 2019, including: i) all outpatient mental health services for each individual including but not limited to (and as available); ii) all other mental health services including but not limited to (and as available); inpatient; crisis residential; crisis stabilization; urgent care; long-term care; forensic services and jail services; referral(s) from EP program to other services; law enforcement contacts; justice system involvement; and regional center involvement. For each service, each county will check for these data elements and include as available: service/procedure code; location code, facility code; date; EBP/supported service code; charge description; minutes; number of people in service; episode of care (EOC); encounter type; HP1 and HP2; division; building; face to face; and place of service."

Based on information received during our meetings with each county, there will be some variation in the data elements available for each county (see details in Table 11 below).

Table 11: Data elements summary for all counties retrospective data pull.

Data Type	Data Element	Source	Comments
Non-identifying ID	Identifying consumer ID removed and new ID assigned	County	Available for the following Counties: Orange, LA, San Diego, Solano

Program Name	Program Name	County	Available for the following Counties: Orange, LA, San Diego, Solano
Psychosis – category	1) Clinical High Risk (CHR) and enrolled in treatment 2) First Episode Psychosis (FEP) and enrolled in treatment 3) Assessed and referred out during Jan. 1, 2017 – Dec. 31, 2019 (add reason, if possible) 4) Other and reason (e.g., incorrectly assigned to Kickstart)	Program	Data elements # 1 and # 2 are available for the following Counties: Orange, LA, San Diego, Solano Data elements # 3 is available for the following Counties: Solano; N/A for the following Counties: Orange, LA, San Diego Data elements # 4 is available for the following Counties: Solano; N/A for the following Counties: LA; May not be available for the following Counties: Orange, San Diego
Assessed and referred out - open ended	Assessed and referred out – reason	Program	Available for the following Counties: Solano; N/A for the following Counties Orange, LA, San Diego
Other and reason - open ended	Other – reason	Program	Available for the following Counties: Solano; N/A for the following Counties Orange, LA, San Diego
Diagnoses associated with the episode of care	Diagnosis – Psychiatric	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Diagnosis – Substance use	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Diagnosis – Physical health	County	Available for the following Counties: Orange, LA, San Diego, Solano
Date of birth	Year & month of birth (not date)	County/Program	Available for the following Counties: Orange, LA, San Diego, Solano
Location (consumer zip code)	Zip code (as of first EP service)	County/Program	Available for the following Counties: Orange, LA, San Diego, Solano
Demographics (as of first EP service)	Race	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Ethnicity	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Gender	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Education level	County	Available for the following Counties: LA, San Diego, Solano; N/A for the following Counties: Orange
	Marital status	County	Available for the following Counties: LA, San Diego, Solano; N/A for the following Counties: Orange
	Preferred language	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Insurance status (i.e., insurance type)	County	Available for the following Counties: Orange, LA, San Diego, Solano

	Employment status	County	Available for the following Counties: LA, San Diego, Solano; N/A for the following Counties: Orange
	Living arrangement (housing status)	County	Available for the following Counties: Orange, San Diego, Solano; May not be available for the following Counties: LA
	Sex assigned at birth	Program	Available for the following Counties: Orange, San Diego, Solano; N/A for the following Counties: LA
	Gender identity	Program	Available for the following Counties: Orange, San Diego, Solano; N/A for the following Counties: LA
	Sexual orientation	County	Available for the following Counties: Orange, San Diego, Solano; N/A for the following Counties: LA
	Military service / Veteran status	County	Available for the following Counties: Orange, San Diego, Solano; N/A for the following Counties: LA
	Foster care / Adoption	County	Available for the following Counties: Orange; May not be available for the following Counties: LA, San Diego, Solano
Outpatient mental health services in EP program between Jan. 1, 2017 – Dec. 31, 2019	Date	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Duration	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Service / procedure code	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Funded plan (original pay sources, subunit)	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Service location code	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Facility code	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Evidence Based Practices (EBP) / supported service code	County	Available for the following Counties: Solano, LA; N/A for the following Counties: Solano, Orange, San Diego
	Medi-Cal beneficiary	County	Available for the following Counties: Orange, San Diego, Solano
All other mental health services utilized by consumers that started services between Jan. 1, 2017 – Dec. 31, 2019	Service / procedure code	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Location code	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Facility code	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Service Date	County	Available for the following Counties: Orange, LA, San Diego, Solano

	Evidence Based Practices (EBP) / supported service code	County	Available for the following Counties: LA; N/A for the following Counties: Solano, Orange, San Diego
	Service – Inpatient	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Service – Crisis residential	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Service – Crisis stabilization	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Service – Urgent care	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Service – Long-term care	County	Available for the following Counties: Orange, LA, San Diego, Solano
	Service – Forensic services and jail services	County/Program	Available for the following Counties: San Diego; May not be available for the following Counties: Orange, Solano
	Service – Referrals	Program	N/A for the following Counties: Solano, Orange, LA, San Diego
	Service – Law enforcement contacts	Program	May not be available for the following Counties: Orange, Solano, San Diego; N/A for the following Counties: LA
	Service – Justice system involvement	Program	May not be available for the following Counties: Orange, LA, Solano, San Diego
	Service – Regional center involvement (any developmental issues)	Program	Available for the following Counties: San Diego; May not be available for the following Counties: Orange, LA, Solano
	Service – Substance use services	County	May not be available for the following Counties: Orange, Solano, San Diego: N/A for the following Counties: LA
	Services – others	County	May not be available for the following Counties: Orange, LA, Solano, San Diego

Our team provided support to the county data analysts and EP program managers regarding the data extraction and integration process through a series of email and phone conversations. Los Angeles, Orange, Solano, and San Diego counties submitted their EP retrospective datasets through the secure web portal to our team. Napa County will deposit their datasets during the next project period.

11. Report on feasibility of obtaining cost and utilization data from preliminary multi-county integrated evaluation.

As part of the LHCN evaluation, service utilization and costs are compared between EP and comparator outpatient programs in that county who serve similar consumers with EP diagnoses (Niendam et al., 2016). These comparator programs are identified by input from county representatives, and an evaluation of county

level data to identify where first-episode psychosis consumers are typically treated in their county outside of the EP program. Individuals with EP diagnoses, within the same age group, who enter standard care outpatient programs during that same time period will be identified as part of the comparator group (CG). This analysis focuses on data from Los Angeles, San Diego, Orange, Napa, and Solano counties only, until other counties join the LHCN and opt in to this part of the project. For this component of the project, the evaluation has two phases: 1) the three years prior to the start of this project (e.g., January 1, 2017 – December 31, 2019) to harmonize data across counties, and 2) for the 3.5-year period contemporaneous with the prospective EP program level data collection to account for potential historical trends during the evaluation period.

Over the last annual period, through June 2021, we held a series of follow-up meetings with each EP program's staff and County staff to address data requested for the retrospective three-year period January 1, 2017 – December 31, 2019. Each county received a limited dataset request for all individuals served in the specified EP program between those dates (see details on data elements in Table 12). Our team provided support to the County data analysts and EP program managers regarding the review and extraction of data through a series of emails, phone conversations, and meetings. The counties submitted their EP retrospective datasets through a secure UC Davis web portal on the following dates: Orange County: December 7, 2020; San Diego County: December 22, 2020; Solano County: February 2, 2021; Los Angeles County: February 18, 2021. Additionally, we requested a data dictionary from each county in order to accurately identify each variable and received the data dictionaries from all counties who submitted datasets. Napa County will deposit their datasets once the county contract has been executed.

The LHCN team reviewed each EP dataset and scheduled any necessary follow-up discussions with the program and/or County staff. All counties submitted multiple data spreadsheets and we are currently working with those counties to integrate them into a multicounty dataset, as well as integrate the data dictionaries across counties to harmonize data elements. Data are currently being cleaned and standardized in order to integrate data across counties into a multi-county analysis.

Description of submitted data

The number of individual consumers in each county's EP dataset is indicated in Table 12 below. All counties serve first episode psychosis (FEP) consumers and some counties also serve consumers at clinical high risk (CHR) for psychosis. These totals represent the number of individuals enrolled and served by the EP programs for the retrospective three-year period January 1, 2017 – December 31, 2019. We also received data on consumers who were assessed for program eligibility but referred elsewhere.

Table 12: Summary of consumers for all counties retrospective data pull.

County	FEP	CHR	Number of Consumers
Orange	Y	N	87
San Diego	Y	Y	353
Solano	Y	Y	78
Los Angeles	Y	Y	91*

*Note: The number of consumers for LA County is still being finalized and may change.

Each county submitted a dataset(s) containing the data elements that were available. As anticipated, there is some variation in the data elements available for each county, which are summarized here and listed in Appendix V below.

Diagnoses. All counties submitted data on diagnosis(es) (e.g., psychiatric, substance use) and dates of diagnoses. Physical health diagnoses were not available in San Diego and Los Angeles counties.

Demographics. All counties submitted data on year and month of birth (not date). Solano County submitted data on the following demographic data elements: ethnicity (primary, secondary, Hispanic [y/n]); sex; gender; sexual orientation; Medi-Cal aid code; living arrangement; US military information; veteran status; preferred language (primary, secondary, preferred, family, English verbal proficiency); foster care/adoption; zip code; insurance status; education level; marital status; and employment status. San Diego County submitted data on all the demographics above with a few exceptions: primary language was submitted instead of preferred language, ethnicity was submitted as a single data element, sex and gender identity were submitted instead of gender. Orange County submitted data on all the demographics above except race, education level, marital status, insurance type, employment status, sex, and foster care/adoption status. Los Angeles County submitted data on all the demographics above except gender/identity, living arrangement, sexual orientation, military/veteran status, and foster care/adoption status.

Mental health services. Each county submitted data for outpatient and other mental health services utilized for the list of consumers who started services between January 1, 2017 – December 31, 2019. All counties submitted services data for date, service/procedure code, and service location. San Diego County submitted additional data for duration. Orange County submitted additional data for duration, funded plan, and Medi-Cal beneficiary. Solano County submitted additional data for Evidence Based Practices (EBP) and Medi-Cal beneficiary. Los Angeles County submitted additional data for EBP.

Other mental health services. In addition to outpatient mental health services, San Diego County submitted data for regional center and justice system involvement. Orange County submitted data for inpatient and justice system involvement. Solano County submitted data for crisis stabilization, crisis residential, and long-term care. Los Angeles County submitted data for inpatient services, Psych ER services, and some law enforcement contacts, justice system involvement, and regional center involvement.

Next steps

The LHCN team will continue to review the submitted datasets and problem-solve with counties regarding any missing data elements, particularly other mental health services received by EP program consumers, which may need to be retrieved from different sources.

The LHCN team has finalized a comparator group (CG) definition in order to identify consumers similar to those served by the EP programs who received services in other county programs. This definition will propose basic elements based on individual consumer characteristics indicating that, during the retrospective period, they experienced early psychosis, but were not served by the EP programs. We will meet with County staff to determine the feasibility of using this definition and then formally request the data. Counties will include the same elements as the data for EP program participants and they will submit the data through the same secure UC Davis web portal as the prior data sets. We will then select subsets in each county of CG individuals matched to the EP program cohort using propensity score matching or other strategies.

In addition to the services data, we will be requesting all related cost data for the services received by consumers in the EP programs and CGs. The LHCN team has met with cost data experts to determine the best course of action for obtaining cost data from the counties. Meetings will be scheduled over the next several months with each county to review the details of the CG retrospective data pull, the cost data, and to problem-solve any issues that arise, as described above. In the second half of 2021, we will conduct the statistical analyses for individual counties and across the integrated dataset.

Discussion and Next Steps

Over this last year, the team has worked to meet each of the goals that were set for this project period. It should be noted that the LHCN represents one of the first collaborative university-county partnerships between the University of California, Davis, San Diego, and San Francisco with multiple California counties to implement and expand an integrated Innovation project. Through this endeavor, all parties hope to have a larger impact on mental health services than any one county can create on their own.

We have completed beta testing of the Beehive data collection system across three pilot EP programs, which has included detailed remote site training. Beta testing officially initiated data collection on the core outcomes battery for the EPI-CAL project, and we have already collected some preliminary demographic and outcomes data from these pilot programs. Beta testing has also provided us the opportunity to obtain detailed feedback from various stakeholders on the training and data collection process via feedback surveys as well as barriers and facilitator interviews so that we may refine our approach when we transition to data collection in non-pilot EP programs. To this end, we have already made several modifications to our training approach based on constructive feedback from pilot programs and have recently implemented these changes in our first non-pilot trainings we held with the LA County PIER programs.

The extensive qualitative focus groups detailed in this report have significantly informed the construction of the Beehive application, ensuring that the product we create is built with the stakeholder in mind to increase utility for users. Throughout the implementation of the focus groups, providers, family members, and consumers were motivated to share their perspectives on the design and flow of Beehive and how data sharing should be presented and talked about. We feel confident that we have built a data collection system that EP program staff, consumers, and family members will actually use and that it will provide data visualizations that can be used to inform and improve early psychosis care.

We have also made significant progress in the county-level data component of this project by conducting the first county data pull for the retrospective period for the EP programs. We look forward to reviewing the data for the comparator groups in the coming months.

Barriers to Implementation and Changes from Initial Study Design

While the project had experienced some delays in contracting and many barriers due to the global COVID-19 pandemic, the team feels confident that we are making excellent progress at meeting our goals and catching up with the original planned timeline. For example, we had originally planned to first conduct beta testing in Fall of 2020 but did not begin until early Spring of 2021. Additionally, in our original LHCN proposal, we proposed in-person site visits to conduct the initial training for the Beehive application. However, due to the COVID-19 pandemic, we had to adjust our training plan and conduct the first “site visits” remotely. To do this, we broke down the initial trainings into a pre-implementation meeting with leadership and three separate Beehive trainings with the whole clinic team. These were all done remotely over web conference, and training materials were provided in digital format. While we hope to conduct future trainings or booster sessions in person at some point, we will continue to hold remaining trainings remotely until further notice.

Another one of the changes from the initial study design was to add the EULA focus groups described in the current report. We added these groups because the success of the learning health care network relies on EP consumers choosing to share their data with EPI-CAL researchers for the purpose of integrating outcomes data across participating clinics. We wanted each user of Beehive to understand how their data might be used, and have agency in data sharing for purposes beyond clinical care. Therefore, we sought to develop an accessible, transparent, and flexible EULA that is presented to each user prior to use of Beehive. To do this, we added multiple data-sharing and EULA focus groups to our study design so that the EULA and related materials could be shaped by the input of stakeholders as part of the Beehive design and implementation

phase of EPI-CAL.

EP LHCN Goals and Activities for FY 21/22

In the next project period, we will continue to train non-pilot EP programs from both the LHCN and larger EPI-CAL network. As implementation of Beehive continues, we will elicit feedback from EP programs how to improve both the training process and Beehive itself via feedback surveys, regular check-ins from point people, and qualitative interviews. Our goal is to continue to improve Beehive in an iterative process and to incorporate stakeholder feedback so that Beehive be a useful data collection and visualization tool for the programs using it. As more programs are integrating Beehive into their clinics, we will continue to do interim analyses of outcomes data collected via the application and plan to have another summary for the next annual report. This will include total enrollment numbers to-date, and a report on those who have completed both baseline and follow up measures.

We will continue to move forward on the county-level data analysis, with plans to provide our initial findings on cost and utilization data from the retrospective period of the multi-county integrated evaluation. Next year's annual report will also include a summary of problems that were identified during the analysis of the retrospective county-level data, so that solutions are identified for the second round of analyses. This will inform the formulation of a plan and finalized timeline for working with counties to access final round of county-level cost and utilization data for EP and CG programs.

We will also conduct our first fidelity assessments and hope to have the assessments completed for San Diego Kickstart, OC CREW, Solano Aldea SOAR, Sonoma Aldea SOAR in the next fiscal year. The fidelity assessments for Napa Aldea SOAR and the five Los Angeles County programs will be conducted in quarters three and four of 2022, so they fall into the next fiscal year. To that end, we will complete fidelity assessment training of our EPI-CAL staff, led by expert consultant Dr. Donald Addington. As part of these fidelity assessments, we will provide detailed feedback in the form of a report to all of the participating sites.

Appendix I: Wire Frame Focus Group Feedback Provided to Quorum (Software Developers)

Scenario	Participant Number/ Comment
New Consumer Registration	• Change “homeless” to “check here if do not have a permanent address” • Absolutely need to have the option to pre-enter basic consumer data prior to their first contact with the tablet. Then need to prompt consumer to review and update info as necessary • In addition to having option to take picture on iPad, we would like to have some stock icon options for consumer to select if they do not want to use their own picture. • We would like for consumer’s preferred name to autofill whenever “consumer” is used in the application. We want to also have Primary Support Person’s preferred name autofill wherever possible. • Change “primary care provider” to “primary health care provider”
Check-In	• During clinic registration, we need to have a pool of services for programs to choose from and then the option for them to use their own language for those appointments. Their language is what would display on tablet application.
Primary Support Person Module	• Add a column or icon to indicate if any PSP are the designated emergency contact
Survey List	• Comments that survey list is too word-heavy/clinical. Suggestions to add colors, to make “cards” (instead of expandable list) • Instead of “completed” on survey list, can there be something visually dynamic to show completion of survey? (want to avoid anything juvenile/frivolous, but want something reinforcing) • Some sort of overall progress indicator • Add who is completing the survey to survey list (autofill preferred name of consumer or support person) • Rename “help” to “ask for help”
Survey Flow/Completion	• Need to make progress bar more visible: move to bottom of screen – between last response option and above next/previous buttons) instead of nested at top, and possible change color to something other than blue • Also move the question progress (i.e., 1/5) down with the progress bar • Move the “prefer not to answer” option further down on the page (i.e., Separate from the other questions… more visual separation between the two so that it is clear it is not part of the scale)
Individual Consumer Profile Page	• Add Tabs to consumer page: data entry tab for each timepoint—includes area for clinician entered data and also shows consumer’s responses to surveys (Baseline, 6 Months, 12 Months, 18 Months, 24 Months) • Instead of drop-down to select survey visualization, can we have some sort of visualization (similar to consumer list) that shows all EPI-NET battery sub bundles? Would also want some sort of color coding/icon system to indicate data that should be reviewed. • Want a visualization of service utilization (include option to filter by date range). Click into cards to see history of attendance • Want a visualization of individual survey items (not just global score). Get into this data by clicking on the bar for a given timepoint? • Is it possible to set a default visualization per consumer (i.e., One consumer wants symptom data to be the default graph, and one consumer wants the recovery data to be the default graph)?
Individual level data visualization	• Change threshold line to toggle-on/off • Add info about threshold if hover over (or click on it?) • Make threshold a solid line (instead of dotted), remove the solid line for max score at the top • Remove toggle option for comparative data. We would like to have the option to add this as a drop down (to make it less visible to consumers) • Visualize incomplete/partial data as a hollow bar

Clinic Aggregate Data	• All aggregate visualizations will need to show "missing" data • Clinic Tab: Also want to see visualizations for gender identity, disability, veteran status, preferred language • Clinic Tab: Rename "diagnosis" widget to "Primary Diagnosis" • Clinic Tab: The monochromatic blue was not well received—need colors that are easier to distinguish from one another on the pie charts (also keep in mind color blind) • Clinic Tab: Visualize duration in program by consumer (based on consumer start date. Break up into 6 month buckets). Want to see this for the whole clinic but also want to see this by provider on each provider's page. • Survey Completion: Can we click into survey completion widget on dashboard and see a visualization of survey completion by different demographic factors: language, age (under 18 vs 18-25 vs. 22+), FEP vs. CHR, PSP registered vs. no PSP registered
Survey Bundles	• Need some kind of key for providers to link actual measure and any euphemistic names we create (e.g., We have renamed Modified Colorado Symptom Index to "Personal Experiences Inventory"). Click the actual title on the data visualization to see what title the consumer sees?
Clinic Admin Dashboard	• Swap out support request widget for "action items" widget—shows outstanding data to be entered (both monthly clinic data reports as well as outstanding individual level clinician entered data); shows consumers coming into survey window; shows number of open support requests. When monthly report is due, it is at the top of the action items list (in an eye catching color) and cannot be moved or dismissed until it is complete. (Pair with a pop-up when try to exit the page?) When it is submitted, reinforce (dancing unicorn, chrome dinosaur game, "thank you for contributing to science!!"). Put this widget in the current location of "survey completion" widget • On "clinic" widget, switch the icon for providers and consumers (consumers should have more figures than providers)
Consumer List/Info (web app	• Remove Sex from Consumer List • Remove picture from consumer list • Put DOB on consumer list instead of age (display age instead when click into consumer profile) Request to see insurance information on this list—or as part of consumer info page • Show Start Date in Consumer Profile Page Remove sex from consumer list • Want to show an icon for any open alerts per consumer on the consumer list • Show indication of missing data (add icon to data column, allow to sort by missing/incomplete data) on consumer list • All columns should be sortable
Provider Tab	• During provider registration, need a field to indicate whether provider has a supervisor (residents, trainees will be directly supervised by a licensed provider). When such a provider is visualized in the dashboard (i.e., As primary clinician in consumer list), their name should appear with "[supervisor name]" • Wondering about possibility to add a temporary provider to supplant a primary provider (i.e., Vacation, leave of absence). Would want the temporary/covering provider to receive any notifications about consumer and have consumer show in their consumer list. Is it possible to set an end-date for such a temporary provider or would it have to be manually removed?
Alerts	• Want to make "urgent clinical issues" widget more visually different—suggestion to outline it, bold the text. • History of resolved alerts should be displayed (in data tabs on consumer home page) • Want to be sure, when an alert is resolved, the alert history will show "resolved by [provider name]"

Appendix II: Beehive Part 3 Training Small Group Worksheet

Beehive Part 3 Training Small Group

Identify a group note-taker and a person who will report back to the larger group

Survey 1 *(Identify a member of your group to screen share survey 1)*

1. Find one of the 3 measures we have introduced to you in trainings: **Modified Colorado Symptom Index** (MCSI), **Questionnaire on the Process of Recovery** (QPR), or **SCORE Index of Family Functioning and Change** (SCORE-15). Next answer the following questions about that survey:
    a. What is the global score?
    b. Is there a clinical threshold?
    c. Is the global score above or below the threshold? What does that mean?
    d. Which is the highest rated individual item(s)? What does that mean?
    e. Which is the lowest rated individual item(s)? What does that mean?

2. Discussion Questions
    a. How might you use this information in care?
    b. Are the survey responses consistent with your knowledge of the consumer's experiences?
    c. What questions do you have after viewing these surveys?

Survey 2-3 *(Identify a new member of your group to screen share survey(s) 2-3)*

3. Reference the Table of Contents for the EPI-CAL battery (next page). Find one to two additional surveys that you are interested in or that might answer the questions you have from the first survey.
    a. Is there a global score? (i.e., is this survey visualized?). If yes,
        i. Is there a clinical threshold?
        ii. Is the global score above or below the threshold? What does that mean?
        iii. Which is the highest rated individual item(s)? What does that mean?
        iv. Which is the lowest rated individual item(s)? What does that mean?
    b. If there is no visualization, remember you can view the survey responses by clicking the "survey results" button at the top left of the page

4. Discussion Questions
    a. How might you use this information in care?
    b. Are the survey responses consistent with your knowledge of the consumer's experiences?

Additional Discussion Questions

5. Does either survey help you understand the other survey better?
6. Think about the different roles in the clinic and how they might use this data differently
    a. How might a family advocate or peer partner use this information compared to a clinician?
    b. How might a prescriber use this information compared to a case manager?

Appendix III: Beehive Application Training Feedback Survey

Please provide us with your feedback.

1. How would you describe the pace of the training?

- O It moved way too slow
- O It moved a little too slow
- O It moved at the right pace
- O It moved a little too fast
- O It moved way too fast

2. Did you have enough opportunities to give feedback or ask questions?

- O Yes, I felt like I had enough chances to give feedback or ask questions
- O No, I did not feel like I had enough chances to give feedback or ask questions
- O Kind of...I wish there had been more opportunities to give feedback or ask questions.

3. Did you have enough time to practice using Beehive during the training?

- O I would have liked a lot more time to practice
- O I would have liked a little more time to practice
- O I had the right amount of time to practice
- O I didn't need as much time as you gave to practice
- O I didn't need to practice during the training at all

4. How confident do you feel about using Beehive to complete your assigned tasks (registering consumers and support people in Beehive, and entering clinic data)?

- O Not at all confident
- O A little confident
- O Moderately confident
- O Very confident
- O Extremely confident

5. Honestly, how much value do you think Beehive will add to your job?

- O None at all
- O A little
- O A moderate amount
- O A lot
- O A great deal

If you have any suggestions for how we can improve this training, please write them below:

_____

Appendix IV: Summary of issues reported to developer during Alpha and Beta testing

Type	Issue Id	Summary	Fixed in build	Description
Bug	BEEHIVE-114	Redundant Texting messages	Next Build	1. Got a text message for the patient [removed]. The screen says 'No Records'. We should not send any erroneous and redundant text message. 2. Also, the weblink is showing 'unsecured'. Is it because it is the test
Bug	BEEHIVE-110	EULA video + data sharing screen does not display for PSP on iPad app	Next Build	See the linked screen recording for the issue: **Issue:** EULA video and data sharing language does not display for PSP, instead an error pop-up which says "please accept EULA permissions" appears **Additional Details:** This PSP was created on 4/30 on iPad app (V1.0.13). This error does not occur on the weblink solution. For this same test PSP, the EULA video displayed when accessing surveys
Bug	BEEHIVE-104	Consumer demographics form not including all active consumers	Next Build	**Issue:** Active consumer is excluded from consumer demographics report based on date range selection. **Details:** Two consumer demographics reports were pulled from the same clinic. Both reports had the same end date selected (4/8/21) but had different start dates (4/1/21 & 1/1/21). The report with the earlier start date included one additional consumer ([removed]). This demographics report is supposed to include all active consumers within the date range selected. [removed] is still active and should
Bug	BEEHIVE-99	"Question Not Found. Contact Administrator" Appearing intermittently	Next Build	
Bug	BEEHIVE-106	Level 4/5 users can resolve urgent clinical issues and PHI is displayed to them	Next Build	**Issue:** If a level 4 or 5 user clicks "unresolved" on urgent clinical issues page, a pop-up to resolve the urgent clinical issue appears AND it includes PHI (consumer name). See the linked screen recording: 1. Level 3A, 4, & 5 users should not be able to resolve urgent clinical issues (see table of permissions attached). This would prevent the pop-up from appearing in the first place and hence PHI would not be displayed to level 3A, 4, or 5 users. 2. If the above fix is not able to be implemented quickly, we need to remove the consumer's name (replace with GUID) from the pop-up for
Bug	BEEHIVE-83	Recurring Bundle not appearing as scheduled	April 15, 2021	**Issue:** The recurring bundles are not available for survey completion when scheduled. **Notes:** User created a consumer with an intake date 6 months ago (9/17/2020). When consumer went to complete weblink surveys, only Beehive Required bundles which recur every six months available to

Bug	BEEHIVE-75	Issues with Survey Version and Bundle Version in Report	Next Build	In reports we have been downloading from Beehive, we have noticed some missing or illogical data in the "Bundle Version" and "Survey Version" columns. **Sample Report 1 demonstrates issue: Survey version date is later than survey completion date.** The rule should be that the survey version must always be an earlier date than survey completion date. The survey version should record what version of the survey was completed. **Sample Report 1 demonstrates issue: Survey version is newer than bundle version.** The rule should be that the bundle version is updated every time a survey is updated. So, the bundle version should never be older than the survey version. **Sample Report 2 & 3 demonstrate issue: "N/A" in Survey version or Bundle version fields.** The rule should be that this field includes either the date of creation or the date of last update. It should never be missing.
Bug	BEEHIVE-109	Network error when logging into UAT environment	Next Build	I am getting a “network error” when trying to log into the web app (happening on both Chrome and Firefox) with both the [beehiveprodacc@gmail.com] (mailto:beehiveprodacc@gmail.com) account as well as other testing accounts I set up (e.g., level 3 user). I can, however, log into the new version of the iPad app (V1.0.13) with my level 3 username and credentials. I can log in successfully to the production environment web app, as well.
Bug	BEEHIVE-108	Disable regular login for SSO Users	Next Build	UCDavis emails are still able to log in the normal way (i.e., log in without SSO). We need to close the loop and require that UCD emails log in with SSO only.
Bug	BEEHIVE-102	Clinic admin not able to see group admin	Next Build	**Issue:** When logged in as a clinic admin account, group admin are not visible on the admin tab (even when "all clinics" is selected) **Requested fix:** Clinic admin and providers should be able to see group admin and group analysts which belong to their group on the admin tab.
Bug	BEEHIVE-101	Race variable on demographics report not showing full details as entered during registration	Next Build	**Issue:** The specific race options selected by the consumer/staff member during consumer registration on tablet or web app are not displaying in the data report. In the attached report, the consumer's race is registered in Beehive as "Cambodian" under the subheading of "Asian." However, only "Asian" shows in the data report. **Fix:** The data report should show the subheading selection(s) entered during registration.
Bug	BEEHIVE-97	Provider name showing for application admin and application owner on consumer data page	Next Build	**Issue:** While logged in as application owner or application admin, the prescriber’s name and treatment team lead name are visible on consumer data page: **Fix:** For these fields, name should be replaced by GUID. Note that this is also how this page should appear for the group analyst role as well.
Bug	BEEHIVE-107	Login _ Password Length	Next Build	For Dashboard/Clinic users, When Logging, there is a Password rule to limit the password between 6 to 12 characters. Please remove the upper restriction of 12 characters. It is very hard to limit the user from entering longer and complex passwords.
Bug	BEEHIVE-85	Survey Due Date	April 15, 2021	**Issue:** All of the consumers in the below screen shot have the same intake date, but their survey due dates are not all the same. All

		Displaying Incorrectly		of the survey due dates below **should** be May 15, 2021 (i.e., 60 days after intake). **Testing Notes:** Testing indicates that the survey due date is dependent on additional surveys being assigned to the consumer. The consumers with a due date of March 17, 2021 do not have any additional surveys assigned to them.
Bug	BEEHIVE-73	Weblink not being automatically resent	April 15, 2021	Per the weblink rules shared in chat: "The weblink should be sent to the consumer/primary support person until they complete their surveys (The email and/or SMS will be sent once in a day if consumer/PSP has not answered the surveys)." **Issue:** None of our team or testers have experienced this feature of the weblink. We have only received weblink emails/texts automatically when the consumer is first registered. After that, any other weblink emails/texts received are because a user has manually re-sent them via the button on the consumer page. If this is in fact, a rule, **we would like to change the frequency of the weblink being automatically re-sent to every 72 hours** (not every 24 hours) until the surveys are completed.
Bug	BEEHIVE-94	Repeating Bundles not available as scheduled	April 15, 2021	We have set up our Beehive Required bundles to repeat every 6 months. These bundles have been available for consumers who register within their intake window. However, for consumers who are registered in Beehive outside of their baseline window, (e.g., at 12 months after intake, 24 months after intake), the repeating bundles (for consumers, PSP, and clinicians) are not available as scheduled. (Ex. GUID: [removed]) The appropriate recurrence of bundles was tested in the staging environment in March and the bundles were available as appropriate. This seems to be a new issue.
Bug	BEEHIVE-98	Data Reports showing consumer DOB for application owner & application admin	April 15, 2021	When downloading the consumer demographics report from the application owner and application admin level, Consumer's DOB is displaying instead of just the month and year. I've attached the Report guidelines for easy reference. At Level 4/5 and this field should only display month and year of birth.
Bug	BEEHIVE-103	Group Analyst Permissions unable to be changed	Next Build	**Issue:** Once a group analyst is created, their permissions level is frozen and unable to be modified by Level 3, 4, or 5 users. **Fix:** Level 3, 4, and 5 users should be able to change the permissions of a group analyst to another admin role. This is to address issues when staff roles may change or to fix errors that may be made by users during user registration.
Bug	BEEHIVE-95	Reports are missing data	Next Build	Reports are missing data within specified time range. The first attached report ("Sample Report 4") was one that was pulled on 3/17 for the "Life Outlook" Survey. This report was previously included in sample tickets. It demonstrates the number of records that were in the report between 2/22-3/17 The second attached report was pulled today from the date range 2/22-4/1. It was pulled for the "Life Outlook" Survey. It includes no data and no variable names.
Bug	BEEHIVE-96	Bug with de-identification for Application Owner & Application Admin	Next Build	When logged in as an application admin or application owner, our team discovered that if you type a provider's name into the search bar, their de-identified (i.e., GUID only, no name) record will appear. This should not be possible since application admin and application owners should NOT see provider name anywhere in the application.

Bug	BEEHIVE-24	Repeating primary support person bug	Next Build	Primary support person was added once on web application (browser= Firefox). Now, the same PSP record shows up multiple times on iPad and web apps.
Bug	BEEHIVE-93	Urgent Clinical Issues are No Longer Populating	March 15, 2021	Urgent clinical issues are no longer populating as intended. For example, test consumer [removed] answered MCSI_13 question as follows (completed surveys on weblink) This is a response that produces an alert according to survey design: Also encountered this error for consumer [removed] (completed surveys on tablet) Alert designated in survey design: Note that this feature was previously functioning as intended. This bug is new (likely as of the last update?) No urgent clinical issues showing on group admin dashboard:
Bug	BEEHIVE-36	Checkbox to indicate PSP is same as Emergency Contact not appearing at group admin level	March 15, 2021	**Here is the view of the PSP page when logged in at group admin (there is no check box to indicate that PSP is the same as emergency contact):** **This is the view when logged in as a provider or clinic admin (iPad & web): There are check boxes to indicate that the PSP is the same as the emergency contact**
Bug	BEEHIVE-72	Weblink not being auto-sent to PSP upon registration	March 15, 2021	Per rules shared in slack: weblink should be auto-sent to PSP via both email and text upon their registration in Beehive. **Issue:** Our team is noticing a consistent bug across multiple accounts that the weblink is not automatically sent to PSP via email, but it is automatically sent via text message. **Other notes:** When the weblink is manually sent (via "re-send surveys" button on consumer page), weblink is sent via both email and text. So, this bug appears to only be related to the application automatically sending emails. The weblink is automatically sent to consumer correctly via whatever method is selected in "preferred contact."
Bug	BEEHIVE-82	Data report: Value for slider question displaying as "N/A" in data report instead of the value	March 15, 2021	**Issue with data collection on slider questions:** * Any response given in the tablet is showing as "N/A" in the data report. * Responses given on the weblink are showing up properly in data report, UNLESS zero is the response, in which case it is showing up as "N/A". * Whenever the response in the data report is "N/A", it is displaying as zero on the consumer data page. In the attached data report, you will see values of N/A. These questions were answered and should be a variety of different answers. This is the visualization of survey responses in the application. These values were answered as "3" & "7" on the iPad, but both show as zero here:
Bug	BEEHIVE-91	Survey Not Progressing as Intended on iPad App	March 15, 2021	Issue: When completing survey on the iPad, the error: "Couldn't find the next question, Please contact staff" appears. This is a new error on a survey which has otherwise been functional since the last time it was edited on Feb 25. I have recreated this issue on several different test consumers during survey completion on the iPad. Please see the screen recordings for an illustration of this: **On iPad, Survey will not progress past question 1:** On weblink, Survey progresses as intended:** **Logic was never modified for this survey in survey design. Each question simply leads to the next:**

Bug	BEEHIVE-4	Issue with User Registration	March 15, 2021	GUID: [removed] User cannot complete registration. After entering a password that matches the rules shown in the modal, user gets this screen and an OTP is never sent to him. I have re-sent the invite to Beehive to have the user try to complete registration from a new link, and the same error is seen. User has tried to register with different passwords matching the requirements and continues to get the same error.
Bug	BEEHIVE-79	Reports: Need comma separation on multiple select variables	Next Build	For data fields which may include multiple responses (i.e., multi-select questions in Beehive), we need to have comma (or some other character that is not a space) separation between response options. This is especially important once "option:" is removed from the data report. Please see the attached example, consumer demographics tab, column H for how we would prefer for this to be in the data report. Issue is demonstrated in Sample Report 2 Column T which was pulled from Beehive.
Bug	BEEHIVE-68	Age not updating	Next Build	Test consumer's birthday is today and age has not updated in the system. The age should be 18 but it is still displaying as 17.
Bug	BEEHIVE-74	Provider-entry data required icon not appearing	Next Build	Data icon which indicates provider data entry is not appearing for consumers, even when there is still data to be entered for the consumer. See screen recording linked: For reference, here is an example from a different web version which shows the icon:
Bug	BEEHIVE-78	Make "other (please specify)" response it's own column	Next Build	As demonstrated in the example reports previously provided, we would prefer for the free text data entered when "other (please specify)" is selected to be it's own column. Please see the attached document "Beehive Report Examples_2021_0201", Alerts tab, Column Q for an example of how this would be pulled into it's own column. Currently the free text is included in the same column as the multiple choice selection (see sample report 2, row 8, column T)
Bug	BEEHIVE-62	Unable to Submit Registration of New Consumer on Tablet	Next Build	User is encountering error "Looks like entered email ID already exists" with an email that has not already been used in the application. User attempted to use 3 different emails (all of which were not already used in the application) and continued to receive this error message.
Bug	BEEHIVE-48	Data-Use Pop-up Not appearing	Next Build	Our team has not been able to create the data-use pop-up that is shown in this storyboard (after leaving consumer data page): We have tried at level 1, 2, & 3 users by visiting the consumer's data page more than 20 times at each level and the pop-up has not generated.
Bug	BEEHIVE-87	Free Text for "Other (please specify)" not available in data reports	Next Build	**Issue:** If "other (please specify)" is selected during survey completion on the iPad, the text entered is not showing up in the data report or on the survey results tab. **Other testing notes:** This seems specific to data entered in the tablet. Our team has completed consumer surveys via weblink and selected "other (please specify)" then entered free text into those fields. The data entered appears in the data report and is also available when viewing survey results from consumer data page. I entered data for one consumer via weblink and it showed up on both survey results and data report.
Bug	BEEHIVE-33	Logic Resetting	March 8, 21	The logic is resetting during survey creation. Please see linked videos which capture this bug.
Bug	BEEHIVE-27	PSP weblink always directs to EULA	Next Build	PSP web link invite always goes to EULA after typing in OTP. The weblink should only direct to the EULA if it has not been completed. Otherwise, if the EULA has been completed, weblink should direct to survey bundle screen.

Bug	BEEHIVE-81	Total # of Questions shown in Survey Completion Incorrect	Next Build	This survey (PSP Demographics and Background) has 6 questions but the total questions of the survey displays as "5" Note that this survey has other reported issues with it which may be contributing towards this bug.
Bug	BEEHIVE-80	Survey Failing to load after first question in Weblink Environment; Functions Properly on iPad	Next Build	After submitting a response to the first question of this survey, instead of displaying the next question, this screen is seen on the weblink: Note that on the tablet, the next question **does** display Other notes: 1.This has been recreated on our end— multiple testers have experienced this issue. 2. The survey this is from ("PSP: Demographics and Background"), has de-activated questions in it. Unsure if that is contributing to the problems we are seeing.
Bug	BEEHIVE-84	EULA video is no longer appearing for PSP on weblink	Next Build	Please see the screen recording for a PSP who was just created and accessed surveys for the first time via weblink. EULA video does not appear as it should. This issue has been recreated by several of our team members on different browsers (chrome, firefox, edge, safari). **Other testing notes:** EULA video appears appropriately for new consumers on weblink. EULA video appears appropriately for new consumers and new PSP on tablet.
Bug	BEEHIVE-57	Beehive ipad App is crashing prior to displaying EULA video	March 15, 2021	User experienced app crashing repeatedly prior to EULA video being displayed. **Consumer registration:** The app crashed at the point of transfer of ipad from clinic staff to consumer. This happened 3 times in a row then did not happen the subsequent 3 times in a row (tested a total of six times). See the linked screen recording. Where this recording ends is the point at which the application crashed. (could not capture the actual crash as it would end the screen recording and prevent it from saving): **Adding a new PSP to an already registered consumer to complete PSP surveys:** Also experienced the app crash when adding a new primary support person to an existing consumer. User attempted again to add the PSP and the app crashed in the same place. User attempted a third time and the application displayed the EULA video without crashing. (Tested total of six times): Note that crash reports were sent in testflight for both of these events. In both scenarios of the app crashing, the data that was previously entered for the new consumer or PSP was not saved, and user would need to start over with the registration process. Since we have not noticed this happening on the web app or with the weblink, we have a few weeks to solve this issue. The first beta site we are training will exclusively use web app and weblink. However we will start introducing the tablets at our site training on **3/22/21**, so we will need a solution by that point.
Bug	BEEHIVE-51	PSP Data report is empty	March 15, 2021	There is no data available in the PSP survey report. It was pulled within a time frame when data should have been entered for multiple PSP.
Bug	BEEHIVE-41	Survey Report Not showing Survey Responses	March 8, 21	The Survey Report is not showing survey responses to each variable name. (We understand reformatting of reports is happening in the next build, but just wanted to point out this crucial information is missing from the report even before it is formatted appropriately)
Bug	BEEHIVE-52	Spanish text displaying	March 15, 2021	The Spanish survey of a title displayed for a consumer for whom Spanish was not selected as the primary language. Please also note that the survey questions and responses were still in English.

		when Spanish language not selected		Screen recording: Consumer profile which shows English as the display language:
Bug	BEEHIVE-65	Camera not functioning in Beehive	Next Build	During consumer registration or editing an existing consumer\>choose consumer profile picture\>click a picture Camera screen is black, shutter button doesn't work. This issue occurred on multiple devices where the camera is verified as working outside of Beehive application. Link to screen recording:
Bug	BEEHIVE-63	Consumer Profile cannot be updated or submitted dependent on answer to ethnicity	March 15, 2021	This issue occurs on both web app and ipad app. On the web app, we receive this error depending when attempting to update race and ethnicity for existing consumers. This appears when filling in missing data for consumers that existed prior to today's code push, but only when "no, I do not identify as hispanic/latinx" or "prefer not to say" are selected. It also occurs for consumers that were created after the code push when you attempt to change their answer to ethnicity. On the ipad app, no error message appears, but the user cannot submit the update to registration. (screen recording linked below)
Bug	BEEHIVE-54	Data-Use Pop-Up Display Logic does not reset when user selects "no"	March 15, 2021	When user selects "no" as the response to the initial pop-up, the pop-up will show at every visit to the consumer's data page until the user selects "yes." The appearance of this question should not be dependent on the user's answer to the first question. It should appear between every 5-10 visits regardless of whether they answered yes or no at the previous appearance of this pop-up. Hence, if the user selects no, they should not see this pop-up at the next visit to the data page. Please see the video linked below to for a demonstration of this problem:
Bug	BEEHIVE-64	Ward of Court Piped Text not Functional on Web App	March 15, 2021	When other text is entered during consumer registration for ward of court on ipad, the piped text is functional (note the word "test") Functional: However, it is not functional in the web app when registering a consumer. Not functional:
Bug	BEEHIVE-18	Survey names and bundle names not appearing on PSP weblink	March 8, 21	Browser: Firefox PSP for consumer GUID: [removed]
Bug	BEEHIVE-31	Users are seeing support requests they should not be able to see	March 15, 2021	A Group admin is able to see a support request submitted by a Level 4 user. As a reminder here are the rules relating to permissions levels and the ability to see support requests: * Group Analyst-- see own requests * Providers- See own requests * Clinic admin- see requests made by users within clinic * Group admin- see requests made by users within group * Application Admin— see all requests across system * Application Owner— see all requests across system
Bug	BEEHIVE-8	Issue with editing bundle prior to	March 8, 21	When editing a bundle (before it has been published), there is an error that occurs in the "participant type" drop down. Instead of showing the three categories of participants, it is repeating "60 days schedule"

		publishing it		
Bug	BEEHIVE-42	Report response options inconsistent with dropdown options	March 8, 21	Responses in the application are correct, but they are not always reflected in the data reports. See the attached xlsx file with highlighted fields. 1. Typo: "HISPANIC_LATINUX" should be "HISPANIC_LATINX" 2. "Refused" is not an option on the race drop down. It is "Prefer not to say" 3. Treat spaces consistently. Sometimes an underscore is used, sometimes the space is removed completely.
Bug	BEEHIVE-2	Other Text Box Appearing Inappropriately During Admin Registration	March 8, 21	The "Other:" Textbox is appearing when "Research staff" is selected in the primary role drop down. It does not appear when "other" is selected in the primary role drop down.
Bug	BEEHIVE-7	Date of Last Update not Updating	March 8, 21	The column "date of last update" is not updating appropriately. The following surveys were updated today (2/19/21) and the date displaying in this column is still the date of creation (2/18/21)
Bug	BEEHIVE-29	Slider Question Type Bug	March 8, 21	We have a slider question in the "Life Outlook" Survey. The response range for this question is set from 0-10. When a survey respondent selects 0, the application treats the question as unanswered.
Bug	BEEHIVE-38	Group Analyst Permission Level Seeing Identifiable Data	March 8, 21	In the current build, group analyst is seeing identifiable data (i.e. consumer names). **Permissions for Group analyst allow de-identified data only**. Consumer list and urgent clinical issues should show IDs only.
Bug	BEEHIVE-26	PSP EULA completed on weblink does not display on tablet & vice versa	March 8, 21	After PSP completes EULA on weblink, this information does not update on the tablet application. Tablet application still says EULA not completed:
Bug	BEEHIVE-45	CSV upload failing	Next Build	CSV upload fails with template provided via slack.
Cosmetics	BEEHIVE-20	EULA Text Formatting	March 8, 21	1. Our team would like to add the following key to every instance of the EULA/data sharing language: *-required The asterisk should be in red as it appears in the application. 2\. We would also like to make **bold** the phrases that refer to exporting identifiable data. Please see the attached documents for reference. ****
Cosmetics	BEEHIVE-111	Update PSP Data-Sharing Language to reflect initial request	Next Build	Now that the consumer name auto-populates in the PSP EULA, please reference the document initially shared for the text on this screen (attached again for your convenience). These changes should be made to reflect what was initially requested: * Remove the quotation marks that appear in the italicized text (stricken through in red in the attached image) * Remove the sentence "Note that the consumer refers to…" (stricken through in red in the attached image)

				These changes should also be made to the Spanish language version.
Cosmetics	BEEHIVE-53	Add text to support requests to remind users not to submit PHI	Next Build	We would like to add the following text before text fields in support requests as a reminder that users should not enter sensitive patient information: "Reminder: Do NOT submit PHI"
Cosmetics	BEEHIVE-67	Fix Typo in Emergency Contact Dropdown	Next Build	Option should be "Spouse/Partner" NOT "spouse/parent"
Cosmetics	BEEHIVE-56	Update Instructional Text in Sex Dropdown on Staff Registration Screen	March 15, 2021	The instructional text in the dropdown for sex-assigned-at-birth should say "Select Sex" not "Select Gender"
Cosmetics	BEEHIVE-3	Survey Creation: Typo in Other Option	March 15, 2021	There is a typo in the survey creation module for the "Other (please specify)" option. Please correct from "specifiy" to "specify"
Cosmetics	BEEHIVE-50	Fix typo on race visualization	March 15, 2021	This may be automatically solved when fixing the typos that show in the data reports (linked issue), but if not, wanted point out the typo of "Hispanic Latinux" (it should be "Hispanic/Latinx") here as well.
Cosmetics	BEEHIVE-58	Remove "!" from EULA error message	March 15, 2021	Please remove the exclamation point from this statement: "Please select the mandatory options to accept EULA!" The message should instead read: "Please select the mandatory options to accept EULA"
Cosmetics	BEEHIVE-25	Update Language on "Upload Picture" Button	March 8, 21	For both the **web application** and **ios application**, we would like this button to say "Choose Picture" instead of "Upload Picture"
Cosmetics	BEEHIVE-6	Update text header	March 8, 21	Per feedback in alpha, please update the identified header in consumer registration to "Display Language" and not "Preferred language"
Cosmetics	BEEHIVE-30	Make consistent the presentation of phone numbers	March 8, 21	On edit consumer info page on web application: PSP phone number should be presented with dashes, as the emergency contact phone number is presented.
Cosmetics	BEEHIVE-17	Add a space to OTP consumer email template	March 8, 21	Would like to add a space between ":" & "OTP" to make it consistent with other OTP emails and make copy & paste easier. Currently: Would like it updated to : "Your one-time password is: 960894"

Cosmetics	BEEHIVE-49	Update text on data review pop-up per September 2020 feedback	March 8, 21	Per feedback given on 9/23/20, please update the text on this pop-up to: **Did you review this data with the consumer or family?**
Cosmetics	BEEHIVE-34	Survey Instructions & Survey Completion Images	March 8, 21	The images in the survey instructions and survey completion pages do not represent the diversity of the consumers we serve, so to improve UX, we would like to change these images. **We would like this image for survey instructions:** **We would like this ribbon/badge icon for survey completion:** Ideally, we would like to add color overlays (at least to fill in the star and the question mark) in the same color scheme as previous images.
Cosmetics	BEEHIVE-28	Update icon in Action Items Widget	March 15, 2021	In the Action items widget, update the icon when there is nothing overdue. Instead of red text with a red icon when nothing is overdue (image 1), can the text be green with the green icon currently used in the alerts widget (image 2)?
Cosmetics	BEEHIVE-14	Update Languages Header in User Registration	March 8, 21	The "languages other than English in which you are fluent enough to conduct therapy/provide services" needs to be a "select multiple." (currently can only select one). Since English is a response option in this drop-down, we would also like to update this header to "**Languages in which you are fluent enough to conduct therapy/provide services"**
Cosmetics	BEEHIVE-23	Updates to Alerts	March 15, 2021	**Alerts Text updates:** * We would like to remove "resolved by N/A" from the alerts widget. * Instead of "Survey Alert" we would like for the keyword from the survey to be piped in. * The formatting of the alerts should be: **\[Consumer Name\]** endorsed **\[keyword\]** on **\[Date, MM/DD/YYYY\]** * Example: **Kathleen Nye** endorsed **Risk to Self** on **2/23/2021** **Alerts Display updates:** * When alerts are resolved, they should not display in the widget **Other Alerts Functionality** * We would like to introduce a feature whereby users can click on some portion of the alerts card to be directed to the survey question/registration item that triggered the alert. Can you let us know if this is something that can be accomplished in Beta or if our team needs to prioritize it somewhere in Phase II?
Feature	BEEHIVE-40	PSP Registration Page	Next Build	In our testing of PSP surveys, we have realized we need to add a registration page as we have for clinic users and consumers to ask demographics questions such as race, ethnicity, sex, gender, DOB. This is a new request and we do not expect it to be in the March build. However, we would like to understand how much time this will take to implement.
Feature	BEEHIVE-55	Click Alert Card to Bring User to Alert Trigger	Next Build	We would like to introduce a feature in Phase II whereby users can click on some portion of the alerts card to be directed to the survey question/registration item that triggered the alert.
Feature	BEEHIVE-88	Implement Rule that Survey version captures the version of	Next Build	From BEEHIVE-75: **Sample Report 1 demonstrates issue: Survey version date is later than survey completion date.** The rule should be that the survey version must always be an earlier date than survey completion date. The survey version should record what version of the survey was completed.

		the survey that consumer completed		
Feature	BEEHIVE-113	Adding 2 additional fields to user registration	Next Build	Due to new reporting requirements from one of our funders (NIH), we need to add 2 additional fields to user registration. 1. Start date at agency 2. Start date with CSC team Both fields should have date validation. We would like for "Start date at agency" to be required for all users. We would like for "Start date with CSC team" to be **required fields for users at level 1, 2, 3, and 3A**, but **OPTIONAL for levels 4 and 5** (level 4 and 5 users may not be part of a CSC team). We understand that these changes may not be feasible to make until the end of the sprint timeline which runs through 8/9/21. Let us know when we can expect these changes.
Feature	BEEHIVE-112	Adding Variables to Consumer Demographics Form	Next Build	Given our understanding of how the consumer demographics report has been coded, we would like to add 3 additional fields to it to facilitate it's use: * intake date * registration date * status We have also realized there is no place for the free text for "ethnicity" in the demographics report so have updated the template here as well. Please see the attached for details (changes from previous version of this document are highlighted). Is it possible to wrap these in with the remaining reports in 6/14/21 UAT?
Fix	BEEHIVE-89	Implement rule that Bundle version updates whenever a survey within it is updated	Next Build	From BEEHIVE-75: **Sample Report 1 demonstrates issue: Survey version is newer than bundle version.** The rule should be that the bundle version is updated every time a survey is updated. So the bundle version should never be older than the survey version.
Fix	BEEHIVE-77	Data Reports: Remove "Option:" from data reports	Next Build	As demonstrated in the example reports, we would prefer that the survey reports include only the text of the response and the additional text ("Option:) which is demonstrated in columns U-Z in the attached report.
Fix	BEEHIVE-39	Instructional Text Formatting	March 8, 21	For the instructional text, we want this to just be a single text box (as boxed in red below) without a header.
Fix	BEEHIVE-13	Race item needs to be "select multiple"	March 15, 2021	The race drop down in user registration and consumer registration currently only allows for selection of one race. This is a "select all that apply" question and needs to allow for user to select all. Can this race question be formatted in the same way as the "clinic" selection (After user says "yes, I work in another early psychosis program that uses Beehive"?) during user registration? We like this formatting for the following reasons: 1. You can see every answer you have selected 2. It is very clear and easy to remove options once you have selected them.
Fix	BEEHIVE-19	Web App/Weblink EULA Formatting	March 15, 2021	When the EULA is presented on the web application or weblink, our team would like the following formatting change: Instead of having the required components pre-checked, we would like for all check-boxes to be blank and require the user to actively

				select each check box. This would match how the EULA is presented on the ipad application for consumers and PSP.
Fix	BEEHIVE-5	No template CSV file for consumer import	Next Build	There is no template CSV file provided for the consumer import function. Users do not know how to format data for it to be accepted by the system. Need a downloadable template file to be available in the application. In the mean time, can your team provide us with a template so we can test this feature?
Fix	BEEHIVE-59	Inaccurate Variable Name in .CSV upload template	March 15, 2021	Column F in the template .csv provided for upload needs to match the variable name for this variable provided in reports (attached, see consumer demographics report). The variable name (or header) for column F is "Sex" not "Gender".
Fix	BEEHIVE-21	Weblink Session Expired while completing surveys	March 8, 21	One our testers experienced their weblink session ending while they were in the midst of actively completing surveys. They said they had been in the session for about 1 hour, but that the session had not gone idle. Want to problem solve around this as we do not want users to be kicked out while they are actively completing surveys, even if the session has been open for some time. Related to this: when the session end, the entire chrome browser shut down (After user selected "ok"). Is it possible for the page to reset rather than shut down the whole browser (anticipate this may be annoying to users)?
Usability Problem	BEEHIVE-32	Need a way to remove questions from surveys	March 8, 21	Once a question is created in a survey, there is no way to remove it (Even prior to publishing in a bundle). There is no delete function. Questions can be de-activated. But even questions that are de-activated are still appearing for survey respondents. Questions were deactivated prior to adding to bundles and prior to publishing bundles.
Usability Problem	BEEHIVE-115	Weblink logic	Next Build	Sandesh had previously suggested setting a maximum number of times that a weblink is pushed automatically. We have discussed and wanted to start by asking for weblinks to only be automatically sent during the survey window (i.e. 75 days after intake, 15 days +/ due date for Follow-up bundles, and 15 days after assignment of additional unscheduled survey)
Usability Problem	BEEHIVE-10	Generate random unique password for new users	March 15, 2021	Our team noticed that the same password "12345678" is always assigned as the first password for account set-up. Can we instead use a randomly generated and unique password for each person to enhance security?
Usability Problem	BEEHIVE-9	Update URL in Registration Email	March 8, 21	The url for our website has changed slightly and we need to update the hyperlink in the registration email ("What is Beehive?"):
Usability Problem	BEEHIVE-22	Remove names from urls/links	March 8, 21	Survey weblinks and user registration links currently include first and last name. These absolutely need to be removed from the weblinks. Time permitting, should also be removed from the user registration links.
Usability Problem	BEEHIVE-60	Simplify and Clarify .CSV Template	Next Build	**Current Problem/Issue:** Currently, the .csv template for adding consumers is both incomplete (it does not include all registration fields, so users will still need to go in to each consumer's profile one at a time to complete registration) AND overwhelming (despite not including all registration fields, it includes many fields). **Our solution:** Since we cannot immediately solve the first issue of completeness (per your comments in BEEHIVE-45), we would like to make this template more simple and more approachable.

				Requested fix: * Can the .csv template only include the the fields in the attached document? * We assume that the variables "Ward" and "IsSelfConsent" are required for basic registration functionality. If they ARE NOT required for this .csv upload, then we would like to remove them from the template. If they ARE required, then we would like to rename them to make it easier for users to understand what they are entering. * You have explained what the "ward" variable means. We propose changing the wording to "Consumer Is a Minor" * We do not know what "IsSelfConsent" means. Please let us know so that we can consider how to best communicate this to clinic users.
Usability Problem	BEEHIVE-35	Sizing Issues on Weblink	Next Build	During testing, our team experienced a variety of "sizing issues" when completing surveys via weblink option on a mobile device. We are linking to the following video which demonstrates some of these issues: * User must zoom out, drag on first screen in order to center * Progress bar is not visible unless user know it is there and makes an effort to drag down to see it * Issue navigation buttons not appearing or requiring scrolling past a lot of blank space in order to appear We would like to discuss this on the call on Thursday, 2/25/21. Some possible solutions we have thought of are 1. Pinning items (e.g. question & progress bar pined to top; next/previous buttons pinned to bottom) 2. No splitting of words (the problem with allowing word splitting is demonstrated in below picture on the minimum anchor. It makes it difficult to read)
Usability Problem	BEEHIVE-90	Allow hyphens and apostrophes in name fields	Next Build	The system does not currently allow for hyphens or apostrophes to be included in first or last names entered into Beehive. Users may have hyphens or apostrophes in their first name (e.g. D'Angelo, Jean-Paul) or last name (e.g. Smith-Wiggins) and users need to be able to enter the proper punctuation.
Usability Problem	BEEHIVE-46	Allow application users to return to EULA to update data permissions	Next Build	All level users in the application who complete a EULA need to be able to return to the EULA to update their data permissions. This should follow the same EULA data permissions edit flow as implemented for consumers and primary support persons.
Usability Problem	BEEHIVE-47	Add registration fields to user profile	Next Build	All registration fields should be displayed as part of user profile. Users also need the ability to edit/update these fields (for example, education or license status may change) This is okay to consider for April 15 release
Usability Problem	BEEHIVE-105	'Key Word Graph' Axis not fixed to min/max values	Next Build	**Issue:** The item visualization ('key word graph') x-axis is not locked and hence does not always show the full range of possible scores. **Fix:** As discussed on 11/05/2020, we want for the min and max scores for both graphs (global and keyword) to be fixed. This allows users to easily tell when a score is low vs. when it is high. This has already been implemented on the global graph. Below is an example of what the individual, keyword graph, should look like using the data above.
Usability Problem	BEEHIVE-92	Change time of day at which	April 15, 2021	On Friday our team started receiving weblink notifications from the staging environment for consumers who need to complete surveys. We noticed that these surveys are either being sent out at 10pm or 12am. Neither of these times is ideal to send out surveys. Can we

		weblink is auto-sent		please update the time of day at which the weblink is auto-sent to 6PM PT? Hopefully there is also an option to have this time automatically adjust to the time changes that result from moving in and out of daylight savings time.
Usability Problem	BEEHIVE -100	Reports Showing "no" for data-permissions on EULA's which are not complete	April 15, 2021	**Issue:** In data reports, the "data permissions" variables display the same for consumers who have not completed the EULA as they do for consumers who have not agreed to share data for research (i.e. "No"). See the attached data report. This consumer has not completed a EULA. **Fix:** If the EULA has not been completed, these fields should read N/A.
Usability Problem	BEEHIVE -76	Extra characters in date field in data report	March 15, 2021	In reviewing the data reports, we are unsure what all of the characters indicated in column T (variable name: Demo_PSP_1) mean. This field has date validation. We see the dates but we also see extra characters ("T….") that seem to be referring to a timestamp? Fields which have date validation do not need a timestamp in them.
Usability Problem	BEEHIVE -71	UI Update for "other" text box	March 15, 2021	When consumer selects "other (please specify)" response option, the text box does not appear in line with that particular option. This may be confusing for users. We understand that modifying the way this appears may be a substantial change, so we would like to discuss this on an upcoming call to understand on what timeline it would be reasonable to ask for this change.
Usability Problem	BEEHIVE -37	Reports variable names	Next Build	To improve end-user understanding of data fields, we would like to update the date variable names to include "(UTC)". Variable names have been updated in the attached excel document, and the changes have been highlighted.
Usability Problem	BEEHIVE -69	Vertical Scroll Bar cut off of display on mobile devices	Next Build	On multiple mobile devices, the vertical scroll bar on the right hand side is cut off of the screen and there appears to be no vertical scroll bar. Can we fix the formatting of this to ensure that the scroll bar displays on mobile devices?
Usability Problem	BEEHIVE -66	Weblink UI update: Reset to top when submitting question	Next Build	During weblink survey completion, if user has scrolled to the bottom of a list of responses, then submits the answer, the next question will not re-orient to display the question. Instead, it shows the responses lower on the list (as if the view has been saved from the previous question) We need for the page to re-set to the top of the screen and show the question when the user navigates through the survey.
Usability Problem	BEEHIVE -70	Rename error message that populates for age in consumer registration	Next Build	We would like to reword the error messages that appear during consumer registration when an age that does not match whether consumer was set up as an adult or as a minor during registration. Current error message is not clear for users. New error message when incorrect age is entered for an adult: Age\<18 check DOB New error message when incorrect age is entered for minor: Age≥18 check DOB
Usability Problem	BEEHIVE -12	Weblink Formatting Issue	March 8, 21	Some of our survey questions have response options that are multiple lines long. When this happens the formatting of the text and the check boxes becomes confusing. It is hard to tell which check box goes with which response option For example, in the image below, there should be more space between the text of different response options (currently the second line of a response option is hanging very closely to the first line of the next response…).

Usability Problem	BEEHIVE-43	Reduce frequency of requiring OTP	March 15, 2021	Currently OTP is required every time user logs in. This may be quite burdensome for clinic users at sites that do not use SSO. Can we instead require OTP once per day per device?
Usability Problem	BEEHIVE-11	Show/Reveal characters when entering OTP	March 8, 21	When entering the OTP into Beehive, we would like for those characters to be shown/revealed (rather than hidden with "******" as it is currently set up).
Usability Problem	BEEHIVE-44	Update CSV button text	March 8, 21	Please change text to "Click here to attach CSV file" In the button boxed in red above, please update the text to "Upload CSV File" since that is the button used to upload, and not attach the file.
Usability Problem	BEEHIVE-16	Allow more characters in the degree textbox during user registration	March 8, 21	During user registration, the text box to specify specialty of degree does not allow enough characters. Currently, not enough space for the most common PhD we will see, "Clinical Psychology." If there needs to be a character limit, would ask for it to allow 50 characters.

Appendix V: Data Elements Summary for all Counties Retrospective Data Pull

Data Type	Data Element	Available by County	Comments
Non-identifying ID	Identifying consumer ID removed and new ID assigned	SD - available	
		OC - available	
		Solano - available	
		LA - available	
Psychosis – category	1) Clinical High Risk (CHR) and enrolled in treatment 2) First Episode Psychosis (FEP) and enrolled in treatment 3) Assessed and referred out during Jan. 1, 2017 – Dec. 31, 2019 (add reason, if possible) 4) Other and reason (e.g., incorrectly assigned to program)	SD - available	Only 1 and 2 available
		OC - available	OC Crew serves only FEP consumers
		Solano - available	
		LA - available	
Diagnoses associated with the episode of care	Diagnosis – Psychiatric, Substance Use, Medical	SD - available	Consumer can have multiple diagnoses
		OC - available	Primary, secondary, tertiary, and quaternary diagnoses
		Solano - available	Primary, secondary, and tertiary diagnoses
		LA - available	Consumer can have multiple diagnoses
Year and Month of Birth	Year and month of birth (not date)	SD - available	
		OC - available	
		Solano - available	
		LA - available	
Location (consumer zip code)	Zip code (as of first EP service)	SD - available	
		OC - available	
		Solano - available	
		LA - available	
Demographics (as of first EP service)	Race	SD - available	
		OC - available	
		Solano - available	
		LA - available	Race and ethnicity combined into one variable

Ethnicity	SD - available	
	OC - available	2 items on ethnicity - Hispanic ethnicity and self-reported primary and secondary ethnicity
	Solano - available	
	LA - available	Race and ethnicity combined into one variable
Gender	SD - unavailable	
	OC - available	
	Solano - available	
	LA - unavailable	Variable for sex only
Education level	SD - available	
	OC - unavailable	
	Solano - available	
	LA - available	
Marital status	SD - available	
	OC - unavailable	
	Solano - available	
	LA - available	
Preferred language	SD - available	Primary language available
	OC - available	
	Solano - available	
	LA - available	
Insurance status (i.e., insurance type)	SD - available	
	OC - unavailable	
	Solano - available	
	LA - available	
Employment status	SD - available	
	OC - unavailable	
	Solano - available	
	LA - available	
Living arrangement (housing status)	SD - available	
	OC - available	
	Solano - available	

		LA - unavailable	
	Sex	SD - available	
		OC - unavailable	
		Solano - available	
		LA - available	
	Gender identity	SD - available	
		OC - available	
		Solano - available	
		LA - unavailable	
	Sexual orientation	SD - available	
		OC - available	
		Solano - available	
		LA - unavailable	
	Military service / Veteran status	SD - available	
		OC - available	
		Solano - available	
		LA - unavailable	
	Foster care / Adoption	SD - available	Indicator only, before 2017 & in 2017-2019
		OC - unavailable	
		Solano - available	
		LA - unavailable	
Outpatient mental health services in EP program between Jan. 1, 2017 – Dec. 31, 2019	Date	SD - available	
		OC - available	
		Solano - available	
		LA - available	
	Duration	SD - available	
		OC - available	
		Solano - available	
		LA - available	
	Service / procedure code	SD - available	
		OC - available	
		Solano - available	

		LA - available	
	Funded plan (original pay sources, subunit)	SD - available	
		OC - available	
		Solano - unavailable	
		LA - available	
	Service location code	SD - available	
		OC - available	
		Solano - available	
		LA - available	
	Facility code	SD - unavailable	
		OC - unavailable	
		Solano - unavailable	
		LA - unavailable	
	Evidence Based Practices (EBP) / supported service code	SD - unavailable	
		OC - unavailable	
		Solano - available	
		LA - available	
	Medi-Cal beneficiary	SD - available	Combined with original pay source
		OC - available	
		Solano - available	
		LA - available	
All other mental health services utilized by consumers that started services between Jan. 1, 2017 – Dec. 31, 2019	Service / procedure code	SD - available	
		OC - available	
		Solano - available	
		LA - available	
	Location code	SD - available	
		OC - available	
		Solano - available	
		LA - available	
	Facility code	SD - unavailable	
		OC - unavailable	
		Solano - unavailable	

		LA - unavailable	
	Service Date	SD - available	Assignment open date and assignment close date
		OC - available	
		Solano - available	
		LA - available	
	Evidence Based Practices (EBP) / supported service code	SD - unavailable	
		OC - unavailable	
		Solano - available	
		LA - available	
	Service – Inpatient	SD - available	
		OC - available	Emergency room
		Solano - unavailable	
		LA - available	
	Service – Crisis residential	SD - available	
		OC - available	
		Solano - available	
		LA - unavailable	
	Service – Crisis stabilization	SD - available	
		OC - available	
		Solano - available	
		LA - unavailable	
	Service – Urgent care	SD - available	Crisis outpatient and urgent outpatient
		OC - unavailable	
		Solano - unavailable	
		LA - unavailable	
	Service – Long-term care	SD - available	
		OC - available	
		Solano - available	Psychiatric health facility service
		LA - unavailable	
	Service – Forensic services and jail services	SD - available	
		OC - unavailable	

		Solano - unavailable	
		LA - unavailable	
	Service – Referrals	SD - unavailable	
		OC - unavailable	
		Solano - unavailable	
		LA - available	
	Service – Law enforcement contacts	SD - unavailable	PERT contacts only
		OC - unavailable	
		Solano - unavailable	
		LA - unavailable	
	Service – Justice system involvement	SD - available	
		OC - available	Juvenile court/Juvenile hall
		Solano - unavailable	
		LA - unavailable	
	Service – Regional center involvement (any developmental issues)	SD - available	
		OC - unavailable	
		Solano - unavailable	
		LA - unavailable	
	Service – Substance use services	SD - unavailable	
		OC - unavailable	
		Solano - unavailable	
		LA - unavailable	
	Services – Others	SD - unavailable	
		OC - unavailable	
		Solano - unavailable	
		LA - unavailable	

*Note: The availability of these data elements is still being finalized.

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Appendix 2 – MHSA Sonoma County FY 20-21 Newsletters

WELLNESS • RECOVERY • RESILIENCE

Sonoma County MENTAL HEALTH SERVICES ACT Newsletter

MAY 2021 | 46TH EDITION

May is MENTAL HEALTH AWARENESS MONTH

We all experience different levels of mental health throughout our lives. In fact, half of us will deal with some type of mental health challenge over the course of our lifetime. Unfortunately, sometimes these challenges can become more serious and require more attention. The good news is that recovery is also common and we are here to help!

May is Mental Health Awareness Month, a time for Sonoma County to collectively raise awareness about mental health and wellness. We've put together a calendar of events, activities and trainings to encourage people to connect virtually and support others around them especially during these times.

24 HOUR HOTLINE
NORTH BAY SUICIDE PREVENTION HOTLINE OF SONOMA COUNTY
1 855 587 6373
Suicide Prevention • Crisis Intervention • Toll free

EachMind MATTERS
California's Mental Health Movement

We hope you reach out, speak up, take part and join the movement!

Visit: www.eachmindmatters.org

Learn to recognize the warning signs of suicide.
Visit SuicideIsPreventable.org to learn more.

Welcome MHSA's New Analyst!

The Department of Health Services, Behavioral Health Division is excited to announce Fabiola Espinosa as the new MHSA Analyst! Fabiola comes from the District Attorney's Office where she served as the Coordinator at the Family Justice Center Sonoma County. She enjoys working with the community and serving as a liaison to help increase awareness of services and resources.

Fabiola is familiar with Sonoma County's MHSA programs and services as she previously worked with an MHSA-funded program, Latino Service Providers and served on the suicide prevention committee.

Fabiola will be overseeing quarterly reports, invoices, contracts, and will be assisting Melissa with MHSA newsletters, program plans and program updates.

She brings great energy to the MHSA team and is eager to help develop and enhance Sonoma County's behavioral health programs and services!

MHSA funding provides a broad continuum of prevention, early intervention and services, and the necessary infrastructure, technology and training elements to effectively support our local mental health services system.

For more information on Sonoma County's MHSA programs and services visit:
https://sonomacounty.ca.gov/Health/Behavioral Health/Mental Health Services Act/

To submit updates, events, success stories, or other content for this newsletter, please email MHSA@sonomacounty.org or call: 707 565 4909

County of Sonoma, Mental Health Services Act
2227 Capricorn Way, Suite 207
Santa Rosa, CA 95407
(707) 565-4850

sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

PEI RFP UPDATE

It had been ten years since the Sonoma County Department of Health Services, Behavioral Health Division had released a Request for Proposals (RFP) for the Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) Services. With many changes in County demographics, services and programs, an RFP was overdue!

The MHSA Capacity Assessment from 2020 and the Cultural Competency Plan 2020 made the need for an RFP even more apparent when it highlighted Sonoma County's changing demographics and barriers and identified cultural and linguistic needs. To ensure an equitable distribution of funding and to improve access and quality of care, we included Community Stakeholders in this RFP process. Community Stakeholders helped create the different types of programming in the chart below.

Population Focus	PEI Program Type	Annual Contract Maximum
African Americans	Prevention	120,000
Native Americans	Prevention	40,000
Geographically-Isolated	Prevention	60,000
LGBTQIA+	**Prevention (or Prevention and Early Intervention combined)**	102,000
Latinx	**Early Intervention (or Prevention and Early Intervention combined)**	140,000
Children Aged 0-5 (and their families)	Early Intervention	288,000
Transition Age Youth (ages 16-25)	Stigma and Discrimination Reduction	200,000
General Population	Suicide Prevention	160,000
	Total	**$1,110,000**

The RFP was released on March 9, 2021 An optional virtual Bidders' Conference was held on March 16, 2021 via Zoom. The proposals were due on April 13, 2021. 15 proposals were received by the Department. All proposals were screened to meet the minimum qualifications specified in the RFP before they were sent for evaluation by a diverse selection panel. We are excited to contract with the finalists and continue providing mental health resources to our community.

Coming Soon: Innovative Approaches to Mental Health

MHSA's Innovation component provides Sonoma County the opportunity to develop and test new, unproven mental health models with the potential to become tomorrow's best practices. Innovation projects may develop behavioral health programs for underserved communities that include services for children, transition-age youth, adults, older adults and families.

All proposed innovation projects go through a robust community program planning process and then require prior approval from the Mental Health Services Oversight and Accountability Commission (MHSOAC). Sonoma County is waiting to hear back from MHSOAC on three projects, but we are very excited to share that Nuestra Cultura Cura Social Innovations Lab, a new innovation project was recently approved!

Nuestra Cultura Cura Social Innovations Lab is a partnership of community organizations (On the Move/VOICES, La Plaza, Humanidad, Raizes Collective, Latino Service Providers, and North Bay Organizing Project) who will engage a diverse cohort (The Team) from the Latinx communities to determine root causes of mental health stigma and inaccessibility for their communities. A facilitator will support the Team in determining a strategic direction with specific actions to address defined issues. Resources will be provided for the Team members by the various CBO partners.

To learn more about other proposed innovation programs check out: www.sonomacounty.ca.gov/Health/Behavioral-Health/PDF/Sonoma-County-MHSA-Three-Year-Program-and-Expenditure-Plan-for-2020-2023/

What's Next?

The County of Sonoma Department of Health Services Behavioral Health Division (DHS-BHD) is working on MHSA's Annual Plan for FY 21-22 and Annual Program Update for FY 19-20. The publication will be released this summer on DHS-BHD's website.

Sonoma's MHSA Community Program Planning (CPP) Process Development

During the July 2020 MHSA Steering Committee, participants expressed interest in setting up a subcommittee to work on the Community Program Planning (CPP) Process. The CPP process is defined in the MHSA regulations as a process that ensures that diverse stakeholders representing the demographics of the County including individuals with serious mental health lived experience and their family members have the opportunity to participate in the MHSA planning.

The founding members of the CPP Subcommittee are Carol West, Susan Standen, Jessica Carroll, Kathy Smith, Kate Roberge and Kate Swan. The subcommittee has been meeting monthly since August 2020, and they have been exploring the topics below:

- Defining the purpose and scope of the CPP subcommittee
- How to engage more stakeholders in a meaningful way
- Increasing opportunities for stakeholder voices to be heard
- Creating stakeholder feedback loops

The next virtual MHSA Stakeholder Committee meeting will be held on May 17, 2021 from 1:30pm - 3:00pm followed by a one hour listening session from 3:00pm - 4:00pm. This meeting is open to anyone with an interest in Sonoma's Behavioral Health System of care. Please contact MHSA@sonoma-county.org for more details.

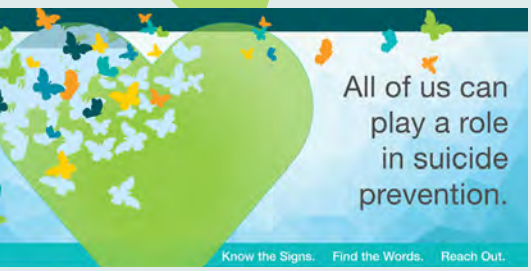
Sonoma County MENTAL HEALTH SERVICES ACT Newsletter

EachMind MATTERS
California's Mental Health Movement

AUGUST 2021 | 47TH EDITION

September is SUICIDE PREVENTION MONTH

Join the Suicide Prevention Week Activity Challenge!



Suicide Prevention Week (September 5-11, 2021) and World Suicide Prevention Day (September 10, 2021) is a time when individuals and organizations around the country and the world join their voices to broadcast the message that everyone can play a role in suicide prevention and to remember loved ones lost to suicide. We hope you will join us by participating in the Suicide Prevention Week Challenge beginning on Monday, September 6, 2021.

Visit: www.suicideispreventable.org/prevention-kit.php. to download the challenge card

This is how it works!

1. Download the challenge card and or take a picture and save it to your phone.
2. Review and complete the challenges. Check them off on the challenge card!
3. Post a picture to your social media accounts with the hashtag #Reconnect #SuicidePrevention. Not on social media? Email the card to info@suicideispreventable.org.
4. The first 25 posts or emails received before September 30, 2021 will receive a Mental Health Thrival Kit!

CHALLENGE #1: RECONNECT AND CREATE A SAFE SPACE

Feeling connected to friends, family, and our community can be a protective factor for suicide. As we reenter and rebuild the fabrics of our daily life that were disrupted, reconnecting with supportive relationships and practicing positive coping skills is essential for our emotional well being. Use this time to each out to someone in your life and let them know that you are comfortable to talk about anything they need, including suicide, and should they ever come to a point where they are questioning their reasons for living, you will be there to listen and support them. Creating this safe space at a time when there is no crisis is one way we can play a role in suicide prevention.

CHALLENGE #2: FIND THE (CROSS) WORDS

Download the Know the Signs Find the Words Reach Out Crossword Puzzle and try to solve all of the clues. Take a picture of the solved puzzle and post it to your social media with these hashtags: #SuicidePrevention #Crossword. Interested in other activities? Check out Trivia and Bingo.

CHALLENGE #3: LIKE & LEARN ABOUT A SUICIDE PREVENTION RESOURCE

Familiarize yourself with a suicide prevention resource. Visit their website or their social media page and like, share or comment to show your support for the work they do. Find a list of resources here, or visit the website or social media page of your local county behavioral health agency. Many list local resources, training opportunities and events!

CHALLENGE #4: PAUSE AND TAKE A BREATH

Schedule a 10 minute Breathe Break into your calendar and use this time to remove distractions and partake in a breathing exercise of your choice. This can be done individually, during a zoom meeting, or even as a family. Find information on different breathing techniques here.

CHALLENGE #5: LIGHT A CANDLE ON SEPTEMBER 10TH

On this special day, take some time to show your support for suicide prevention and to remember loved ones lost to suicide by lighting a candle near a window at 8 p.m. Don t forget to share on social media. To learn more about World Suicide Prevention Day, visit https://www.iasp.info/wspd2021/.

24 HOUR HOTLINE
NORTH BAY SUICIDE PREVENTION HOTLINE OF SONOMA COUNTY
1 855 587 6373

For more information visit: Suicideispreventable.org

sonoma county DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH DIVISION

County of Sonoma, Mental Health Services Act
2227 Capricorn Way, Suite 207
Santa Rosa, CA 95407
(707) 565-4850

Suicide Prevention in Sonoma County

Join Sonoma County's Suicide Prevention & Awareness Efforts!

- **September 7th** 3:00pm - 4:30pm
  - **Buckelew's Virtual Community Resource Clinic** Resource clinic via Zoom to help with understanding or assistance in accessing services for themselves or their loved one. Email MichaelE@buckelew.org to participate.
- **September 8th** 7:00 pm - 8:00 pm
  - **SOS: Allies For Hope by Buckelew** Survivors of Suicide Bereavement Support Group (Virtual) is a non-clinical peer-to-peer group to share strategies and skills for coping with loss of a loved one to suicide and transitioning to a place of greater understanding and compassion for ourselves, for those with similar experiences, and those we have lost. Email SOSinfo@Buckelew.org for more information.
- **September - 9th, 14th, 21st, 23rd & 28th** 4:00pm - 5:30pm
  - **Path to Hope Live** - Virtual educational series on suicide prevention that strengthens our community bonds and supports with the grief, loss, and mental health challenges of our times. The format of varied presenters and topics packs in heart, lived experience and personal connection. The focus for Path to Hope Live in 2021 is on our youth and their experience in this unprecedented time in our collective history. For more information, please contact Erika Klohe at Erika.klohe@stjoe.org
- **September 10th**
  - **Question, Persuade, Refer (QPR) Suicide Prevention Gatekeeper Training.** Space is limited, please email: BH-Training@sonoma-county.org for details.
  - **Candle Vigil** 8:00pm
    Light a candle to show support for suicide prevention & to remember loved ones lost to suicide on World Suicide Prevention Day. Visit https://www.iasp.info/wspd2021/ to learn more.
- **September 15th** 8:00am - 5:00pm
  - **Assessing and Managing Suicide Risk (AMSR)** for mental health professionals. Email: BH-Training@sonoma-county.org for more information.

Sonoma County MHSA's Annual Update is Posted!

Check out MHSA's Annual Plan Update for FY 21-22, Expenditure Plan for FY 21-22 and Annual Program Report for FY 19-20, now on our website!

This publication is brought to you by the County of Sonoma Department of Health Services Behavioral Health Division (DHS-BHD) and will be posted for at least 30 days prior to a public hearing at the Sonoma County Mental Health Board meeting on September 21, 2021 at 5pm. Click HERE to access the publication released on August 6th. Click HERE to learn more about the Mental Health Board Meeting.

Bringing Diversity, Equity, and Inclusion to MHSA Sonoma

Department of Health Services, Behavioral Health Division is excited to share that we are working on ways to promote more diversity, ensure equity and be more inclusive when it comes to Sonoma County's mental health care system. One recent change was the addition of the Diversity, Equity, and Inclusion (DEI) Development Manager position.

Please welcome Susan Castillo as the new DEI Development Manager! Susan has been certified since 1989 by the Equity Institute in anti-bias training and worked as a consultant for the Centers for Disease Control and Prevention, focusing on equity and social justice issues. She also served as Assistant Director for a non-profit in San Francisco and Director of Programs for an organization that was centered on social, economic, and environmental justice issues before joining the County of Sonoma.

Susan has had a number of positions with the Behavioral Health Division including Section Manager and MHSA Coordinator and she used a health equity approach of embracing whole person and person-centered care to re-design existing programs and innovate new programs.

Susan is excited to apply the collective impact framework along with other approaches to improve our mental health care system.

Some of Susan's tasks include:

- Policy Development: ensuring division policies are nondiscriminatory and inclusive;
- Workforce, Education, and Training: developing a workforce pipeline to diversify the incoming behavioral health workforce that includes participation in the development of strategies related to recruitment, hiring, on-boarding, training, support, and retention practices and ensuring the current BH workforce is appropriately attending to the needs of our diverse clientele;
- Program Design and Development: participation in program design and development to control for bias and ensure equity and cultural relevance in service provision;
- Leadership Development: Strengthening management and administrative performance

Get Involved!

Attend our next virtual MHSA Stakeholder Committee meeting! This meeting is open to anyone with an interest in Sonoma's Behavioral Health System of care. Please contact MHSA@sonoma-county.org for more details.

Attend a Sonoma County Mental Health Board meeting! The Board acts as a community focal point for mental health issues and develops a community network to promote: Coalition building that will create a unified voice to impact public policy and awareness; a wider understanding and knowledge of mental health issues; the integrity of mental health services; and involvement of clients and families in mental health planning.

The next Mental Health Board meeting is on Tuesday, September 21st at 5pm. The Board agenda and Zoom link will be posted no later than three days prior to the meeting. Click HERE for more information.

Appendix 3 – Crossroads to Hope Innovation Proposal

WELLNESS • RECOVERY • RESILIENCE

Crossroads To Hope

Sonoma County Mental Health Services Act
FY 2021 - 2027 Innovation Proposal

WELLNESS • RECOVERY • RESILIENCE

County Name: Sonoma County
Date submitted: September 17, 2021
Project Title: Crossroads to Hope
Total amount requested: $2,500,000 for FY 2021-27

Innovation Project Defined: As stated in California Code of Regulations, Title 9, Section 3200.184, an Innovation project is defined as a project that "the County designs and implements for a defined time period and evaluates to develop new best practices in mental health services and supports". As such, an Innovation project should provide new knowledge to inform current and future mental health practices and approaches, and not merely replicate the practices/approaches of another community.

SECTION 1: INNOVATION REGULATIONS REQUIREMENT CATEGORIES

GENERAL REQUIREMENT:

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

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

PRIMARY PURPOSE:

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

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

SECTION 2: PROJECT OVERVIEW

PRIMARY PROBLEM

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community. Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.

Sonoma County does not have any dedicated housing that provides supportive and recovery driven peer services for individuals with significant mental health and/or substance use disorders and criminal justice involvement. Instead, many individuals that have significant mental health and/or substance use disorders and criminal justice involvement that may be incompetent to stand trial are housed in the Sonoma County jails and do not receive supportive peer services and evidenced based treatment that will help them move towards recovery and away from criminal justice involvement.

At best, the jails can provide medications to stabilize acute mental health issues and keep the jail population safe. Recovery is difficult to achieve in such a setting. According to a report from the Bureau of Justice Statistics (BJS), more than half of those incarcerated in the United States have mental health issues. These individuals, says BJS, are more likely to have previous convictions and to serve a lengthier sentence than those who do not have mental health needs. Without treatment, mental health conditions can linger or worsen, increasing the likelihood of further involvement in the justice system.[1]

Sonoma County has seen a significant increase in the number of individuals with mental health and substance use issues entering the criminal justice system in recent years. County jail data for 2017 showed that 479 inmates (45.5% of the jail population) were receiving treatment for mental health concerns. In 2018 this number increased to 513, equal to 46.5% of the jail population. The most recent figure for April 17, 2019, indicates 520 inmates (47%) are involved with mental health services, with 246 (47.3%) of this group identified as having acute mental illness, and 117 (22.5%) determined to be seriously mentally ill.[2] In 2017, the Press Democrat published a series of investigative reports about the lack of psychiatric beds and the negative consequences for those individuals experiencing mild to severe mental illness in the local jails. Findings include:

- The number of inmates with severe mental illness diagnoses such as bipolar disorder and schizophrenia increased 60 percent to an average of 69 inmates a day in 2016, up from 43 in 2008.[3]
- Inmates found by the court to be "incompetent to stand trial" must be sent to a state psychiatric hospital to be treated until they are able to understand and face the charges

[1] "Addressing Mental Health in the Justice System", Richard Williams, National Conference of State Legislatures, Vol. 23, No. 31/August 2015.
[2] Data provided by the Sonoma County Sheriff's Department on 4/17/2019.
[3] "Jail is Largest Psychiatric Facility in Sonoma County", The Press Democrat, August 12, 2017.

against them. Because of the lack of bed space at the state's mental hospitals, inmates often wait up to three months or more for an opening.[4]

Recognizing that people with mental illness are over-represented in the local criminal justice system, Sonoma County held a two-day meeting (March 2018) of a Sequential Intercept Model planning process used by communities to assess the circumstances of people with behavioral health needs in the justice system and identify opportunities for linkages to services that can prevent deeper penetration into the criminal justice system. The County brought together over 40 stakeholders from multiple systems, including mental health consumers and professionals, substance abuse, law enforcement, pretrial services, courts, jails, community corrections, housing, health, social services, and family members to identify gaps, resources and opportunities for individuals with mental illness and co-occurring disorders in the criminal justice system. Among all of the alternative strategies, the highest number of participants named "Expand Housing with Supportive Services" as the top priority for the county.[5]

The challenges in transitioning from the jails to community is widely documented and includes finding and securing housing, re-entry into the labor market, and accessing public assistance.[6] For those who are transitioning from the criminal justice system back into the community at large, there is an overwhelming need for safe and stable housing that can enable them to begin or continue their recovery and prevent recidivism back into the criminal justice system. A two-year study conducted by Resource Development Associates states that individuals released from the criminal justice system have the highest recidivism rate in the first 90 days. The findings of this study conclude that appropriate services and supports during that critical period can reduce recidivism.[7] Even when treatment services are available, if an individual cannot identify a safe and stable residence they are significantly less likely to be successful in a jail diversion program. Securing long-term housing and/or a treatment program for individuals takes time and requires the active participation of the client. Providing access to immediate and safe transitional housing, offers a way to bridge the gap so that the client can be diverted from jail with needed supports, begin a treatment program, and have the time and assistance to locate long-term housing.

Local data highlights the difficulty of maintaining stable housing for those who have been engaged with the justice system. The 2018 Point in Time Homeless Count for Sonoma County identified a total of 2,996 homeless individuals. Of this population, 32% had spent at least one night in jail or prison in the previous 12 months, and 28% reported they were on probation or parole at the time of the survey. In addition, 35% of the total number of homeless were identified as having psychiatric or emotional conditions and 33% reported drug or alcohol abuse.[8]

Of the 1,379 individuals on probation in 2018, 180 (13%) were homeless or transient. In terms of unmet needs, a total of 153 (11%) probationers were identified as having housing, but not receiving needed mental health services. On the other hand, 46 (3%) were receiving mental health services but had unmet housing needs. Finally, 122 (9%) were lacking both housing and needed mental health services. This means that nearly a quarter of the total probation population

[4] Ibid
[5] Sequential Intercept Model Mapping Report for Sonoma County, CA; Policy Research Associates, Inc, March 20-21, 2018.
[6] "From prisons to communities: Confronting re-entry challenges and social inequality", American Psycological Association, March 2018.
[7] Sonoma County AB 109 Recidivism Analysis Report, Resource Development Associates, 2019.
[8] Sonoma County Homeless Census And Survey, 2018, p. 52.

was lacking either or both mental health and housing services.[9] As a result of changes to California sentencing policies that reduce the incentives for misdemeanants to participate in services, motivating individuals with misdemeanors to participate in treatment can be difficult. Housing is a significant incentive for this population, and the ability to offer housing to potential participants could contribute greatly to their willingness and ability to participate in treatment.

This was also a finding contained in Sonoma County's Housing Needs Assessment, April 2018. The Housing Needs Assessment report recommended the consideration of the types of supports and services needed for individuals with a history of incarceration. Given that survey respondents indicated difficulty with either securing housing upon their release or finding housing that was considered safe and secure, additional services and supports may be needed to help individuals secure housing upon their release from incarceration.[10]

Assuming transitional housing is available to those with severe mental health diagnoses and involved in the criminal justice system, appropriate and effective clinical and other support services need to be available for a successful re-entry and to establish a foundation for recovery. Interventions, such as "jail diversion" programs, have mixed results. Many incorporate legal leveraging in the form of reporting back to the courts to promote adherence to treatment and services, but this is a coercive and avoidance driven model. Instead, Sonoma County would like to address the challenge of providing a comprehensive program model for individuals who are severely mentally ill and re-entering the community from the criminal justice system.

Combining a healthy and solid transition from the criminal justice system to the community will not be solved by transitional housing alone, a supportive component staffed with peers, individuals with lived criminal justice, mental health and/or substance abuse experience can provide a trusting relationship for education, empowered recovery planning and successful connections with community resources. The Sonoma County MHSA FY 2016-19 Capacity Assessment articulates the finding that peer providers were exclusively located in discrete programs rather than integrated within DHS-BHD programs.[11] Consumers, as well as providers, participating in surveys and focus groups expressed having peer-led programs at all levels of care aligns with MHSA values and promotes a culture shift towards recovery with possible improved outcomes throughout the system of care. Research shows the effectiveness of peer support on many levels, including increasing engagement in treatment and recovery, promoting a sense of hope and self-empowerment, improving social functioning and overall quality of life, and decreasing hospitalizations.[12] Furthermore, having peer support embedded in programming is most effective if those peers have both lived experience with mental illness and criminal justice involvement. The experience with the criminal justice system impacts an individual's life in many ways and it is best understood by individuals who have experienced it.[13] Thus, the proposed Innovation Project, will establish a robust peer component in collaboration with the

[9] Data provided by the Sonoma County Department of Probation, 3/12/2019.
[10] Sonoma County Housing Needs Assessment, Harder + Company Community Research, April 2018.
[11] Sonoma County Mental Health Services Act FY 2016 – 19 Capacity Assessment, Resource Development Associates, January 2020.
[12] Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012). Peer support among persons with severe mental illnesses: A review of evidence and experience. *World Psychiatry, 11(2), 123-8.*
[13] Substance Abuse and Mental Health Services Administration, GAINS Center for Behavioral Health and Justice Transformation. (Aug 2017). Peer Support Roles in Criminal Justice Settings, A Webinar-Supporting Document.

delivery of clinical mental health services within a transitional housing environment has promising impact for an underserved population.

PROPOSED PROJECT

Describe the INN Project you are proposing. Include sufficient details that ensures the identified problem and potential solutions are clear. In this section, you may wish to identify how you plan to implement the project, the relevant participants/roles within the project, what participants will typically experience, and any other key activities associated with development and implementation.

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

The County of Sonoma (County) Innovations Project proposal is Crossroads to Hope (Crossroads). Crossroads will expand access to community-based treatment for individuals who have a severe mental health illness, with a possible substance use disorders who are eligible criminal justice diversion clients. Crossroads seeks to enhance a multi-modality approach for adult diversion clients who are determined to be at-risk for IST (Incompetent to Stand Trial) by adding intensive peer support services for up to 6 individuals at one time within a transitional housing environment. Innovation funding will add a peer support component consisting of a team of peer providers who will lead a holistic client-centered program including: recovery and wellness strategies, independent living skills, building a support network, accessing community resources, and establishing long-term stable housing. Peer providers will collaborate with clinicians to support client-driven recovery plans, facilitate educational and support groups, provide navigation for needed community services, and help support the overall well-being of the residents. Capacity will be for up to 12 - 20 clients annually. In addition, Crossroads will establish a Peer Advisory Council for the project and conduct a formative and outcome evaluation. This model is consistent with the recommendations stated in the MHSOAC's report, *Together We Can, Reducing Criminal Justice Involvement for People with Mental Illness*. Recommendation #3 contained in this report, specifically states that to reduce the backlog of individuals who are found to be or at risk of IST, state and local programs must maximize diversions from the criminal justice system.

The County recently secured funds[14] and is in contract to purchase a three-bedroom house with a second unit that will provide for six beds (transitional housing). In addition to the peer provider staffing, the residents will be supported by a clinical Assertive Community Treatment (ACT) team that will be on-site daily. The ACT team will provide intensive case management, individual, group and family/couples therapy. Education, psychiatry and medication evaluation and monitoring will be provided by a registered nurse. The ACT team will be funded through an already secured California Department of State Hospitals Felony Incompetent to Stand Trial contract.

[14] California Health Facilities Financing Authority – Community Services Infrastructure Grant Program, 2020

Crossroads is designed to provide a robust peer provider program within a short-term residential setting for diversion clients for up to six months. The transitional housing beds, the first dedicated for diversion clients in Sonoma County, will be an invaluable resource providing a safe, stable and supportive environment for clients to begin their journey of recovery. Peer providers, people with similar lived experience in mental health recovery and criminal justice involvement, will staff the residence serving a maximum of 6 individuals at one time. The peer support component will complement ACT clinical services by providing educational and emotional support, advocacy for self-determination, and connection to community-based services and other peer services.

By establishing a supportive community of peers, clinicians, and community resources, this innovative project seeks to increase the quality of mental health services for an underserved group and increase the interagency coordination with community groups and support systems. The Crossroads peer-enhanced model is designed to engage members of the target population by encouraging a high level of contact with peers who share lived experiences resulting in the development of strong, trustworthy, therapeutic relationships. Second, the model encourages clients to share their journey with their fellow peers as a basis for self-actualization and development of a meaningful recovery plan. This recovery plan will be grounded in a philosophy of self-determination and supported by the peers providing personal encouragement, relevant education and connections to community resources. Third, the model is multi-disciplinary, enabling the treatment team to draw upon multiple perspectives to support recovery. Finally, the provision of transitional housing serves as a safe and stable environment; a solid foundation to begin the recovery journey.

Peer support promotes a sense of understanding among those in recovery because they've collectively "been there," shared similar experiences and can model for each other a willingness to learn and grow. In peer support people come together with the intention of changing unhelpful patterns, getting out of "stuck" places, and building relationships that are respectful, mutually responsible, and potentially mutually transforming. Individuals may come to a peer support program because it feels safe and accepting. By sharing experiences and building trust, peers help each other move beyond their perceived limitations, old patterns and ways of thinking about mental health. This allows members of the peer community to try out new behaviors and move beyond the "illness culture" into a culture of health and ability.

Some models of therapy for mental illness focus on a series of problems or symptoms that lead the individual to feel different and alone, "othered", leaving them in relationships that are less than mutually empowering. These clients experience their illness as the driving factor to their lives and depend on professionals to interpret their everyday experiences. Peer support programs do not promote an "illness narrative" but rather look at how individuals have come to know what they know. This leads to a conversation and exploration on what else does the individual need to know and experience to move through the past and into the future. This transformative movement returns the power to the individual to open a new framework for problem solving and decision-making.

Eligible individuals will be identified through Sonoma County's Pretrial program process. The Department of Probation administers a Pretrial Risk Assessment Tool, Public Safety Assessment (PSA) to identify individuals who are appropriate for Pretrial diversion into community

placement. Additionally, the County's Department of Health Services, Behavioral Health Division (BHD) has a clinician embedded within the Pretrial process to conduct needs assessments and determine appropriate level of care for those individuals in custody who have mental health and/or substance use disorders. The clinician consults with clients about available treatment in the community and with consent, the clinician provides a warm handoff to services.

Once a client is deemed eligible for diversion, the Peer provider support team will meet with the client before he/she is scheduled for placement in the transitional housing facility. Peer providers will conduct an orientation and intake to assure the client is fully informed of the program model and evaluation and consents to participation. The ACT team will facilitate the development of personal recovery plans for each client. These plans will be a hybrid of traditional clinical approaches and a philosophy and practice of encouraging client self-determination, a pillar of the peer model. The traditional aspects of the model include the administration of the ANSA (Adult Needs and Strengths Assessment) to establish history, behavior and functionality at entry into the program (baseline). The ANSA will be re- administered between 6 – 9 months after the baseline assessment to compare any changes (outcome). Utilizing the results of ANSA, the development of the personal recovery plan will primarily be led by the client to define their desired goals and definition of success. This approach to recovery planning will be supported by the Peer Providers encouraging a practice of empowerment and self-determination. It is this blended approach to recovery that is innovative for a diversion population and will be studied in the project's process and evaluation.

Crossroads will hire up to 4.5 FTE peers who will staff the transitional housing 24 hours per day, seven days per week. Peer Providers support their peers both individually and in groups. Their responsibilities may include the following:

- Help clients create individual service plans based on recovery goals and steps to achieve those goals
- Use recovery-oriented tools to help clients address challenges
- Assist clients to build their own self-directed wellness plans
- Support clients in their decision-making
- Set up and sustain peer self-help and educational groups
- Share community resources supportive of recovery
- Advocate with clients for what they need
- Work within integrated health settings
- Support clients in crisis
- Share their personal stories of recovery with clients

Qualifications for peer providers will include lived experience (mental health challenges and/or in recovery from a substance use disorder, and prior involvement with the criminal justice system), verified peer training or two years of local peer experience, and familiarity with local resources. Sonoma County has offered peer training utilizing the Intentional Peer Support curriculum through local community-based organizations and instructors may be engaged to provide further staff support and professional development.

One standard recovery goal for all Crossroads clients will be to identify and secure long-term housing as the transitional housing is meant for up to a 6-month stay. The ACT clinical team will interface with the Sonoma County Housing Authority (SCHA), a member of the Sonoma Accessing Coordinated Care and Empowering Self Sufficiency (ACCESS) interdepartmental multidisciplinary team and other housing providers to identify long term supportive housing where Crossroads clients can be placed.

Additional recovery goals may include:

- Community connections: familial, social and recovery support
- Healthy living, including nutrition, exercise, stress reduction, spiritual development, self-care
- Engagement in workforce and/or education

Clients will receive education and support in these areas, opportunities to practice skills and establish connections that promote achievement of personal recovery plan goals. The peer support program at Crossroads will include a nutritionist to help with menu planning, shopping, and cooking demonstrations once per week, a yoga/meditation practitioner once per week, guest speakers and instructors, and opportunities for visits to the Santa Rosa Junior College, Wellness and Advocacy Center, Job Link, and recreational centers.

Peer providers will work in tandem with clinicians of the ACT team, probation officers and other providers of wrap around services. The multi-disciplinary team coordinates around a client-directed approach and actions, decisions and progress will be documented in case notes and periodic reports from the peer providers. Not to be confused with a residential therapeutic treatment center, Crossroads is transitional housing with supportive and clinical services for the residents of the house. Peers will not have the role of supervising residents nor addressing compliance issues.

To ensure that Crossroads maintains a peer recovery focus and that the program structure, policies, and procedures are supportive of the Peer Provider Team, a Peer Advisory Council will be established. This Peer Advisory Council will be comprised of peer providers from the community, family members and other stakeholders who are aligned with the intent and philosophy of the project. The role of the Peer Advisory Council is to expand the diversity of experience and views of the peer community in accordance with Community Program Planning processes. This group will meet regularly to review program and evaluation design, progress on implementation and review evaluation findings at annual benchmarks. Peer Advisory Council members will be compensated for attending meetings if not already compensated by their employer.

B) Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply an approach from outside the mental health field, briefly describe how the practice has been historically applied.

The added benefit and positive outcomes resulting from the integration of peer providers into mental health services is not a new concept. In fact, self-help groups for substance abuse and addiction have been around since the first Alcoholic Anonymous meeting started in 1935. Peer

support is instrumental in developing strong trusting relationships among those in early recovery. Sonoma County has a strong history of peer provider engagement to successfully engage consumers in community-based recovery models. In 1996, a group of individuals with lived experience established Interlink Self-Help Center, a peer managed and operated service promoting self-directed mental health recovery and wellness. This was the first formal organization funded by the County of Sonoma. Since then, Sonoma County has supported a variety of peer-led services including the Wellness Center, Petaluma Peer Recovery Center, Russian River Empowerment Center, Peer Education and Training Program, and the MST Peer Supports Project with MHSA funding.

Realizing the benefits of having peers both as advisors and providers in the mental health continuum of care, Sonoma County has continued to look for opportunities to strengthen and expand the peer role in service delivery. In June of 2016, a group of community stakeholders including consumers, peers, mental health providers and County representatives met to discuss the lack of services and supports for those who were on the precipice of a crisis. With limited beds at the Crisis Stabilization Unit (CSU), the group proposed a peer respite residential center. This proposal to provide immediate short-term housing staffed and led by peers would intervene prior to crisis and focus on wellness and recovery. Unfortunately, funding stalled and the project was not realized, but this effort set the stage for continued interest and determination for peer-led services and supports.

In the Sonoma County Capacity Assessment Report released in January 2020, community stakeholders praised peer providers and programs noting the effectiveness of engaging individuals into treatment and empowering a community of recovery that could not be achieved by clinicians alone.[15] The FY 2016-19 MHSA Capacity Assessment report continues to state that consumers, as well as providers, expressed support for peer-led programs at all levels of care. Integrating peer providers who embody recovery and what is possible for consumers is aligned with MHSA values and could create a cultural shift in the way mental health services are delivered throughout the system of care.

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

The proposed project will serve six individuals residing in Crossroad's transitional housing beds. Assuming a maximum stay of six months, with some clients that will transition to long-term housing earlier or chose to leave the program, it is anticipated that the program will be able to serve 12 to 20 clients each year. The diversion transitional housing beds will be an invaluable resource for serving the diversion population in the county, by helping clients to focus on their recovery plan, connect to treatment services, and re-engage with the community and needed resources. All alumni who complete the transitional housing phase and are still actively in recovery will be invited back to the Crossroads transitional house to participate in support groups, meetings with ACT clinicians, weekly community dinners, and select educational groups and activities.

[15] Sonoma County MHSA FY 2016-2019 Capacity Assessment, Research Associates Development, January 2020.

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

The population to be served aligns with AB1810 and the criteria for Specialty Mental Health Services for the Department of Health Services, Behavioral Health. Individuals who are eligible for local Diversion services, include the following:

- Felons or Misdemeanants
- Individuals with a serious mental illness (SMI) as identified under AB1810
- Preference will be given to clients participating in the Mental Health Diversion Court who also have a diagnosis of:
    - Schizophrenia
    - Schizo-Affective Disorder
    - Bi-Polar Disorder
- At low or no-risk to public safety and the community
- Voluntarily seeks to participate in treatment, agreement to comply/consent
- Found to be ICST (Incompetent to Stand Trial) or At risk for ICST
- Significant relationship between Mental Health condition and charged offense
- Medi-Cal eligible

Crossroads will provide services to Spanish-speakers and has contracted ASL interpreters for the hearing impaired. The transitional housing will be welcoming to all gender identities.

RESEARCH ON INN COMPONENT

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

Sonoma County does not have any dedicated housing that provides supportive and recovery driven peer services for individuals with significant mental health and/or substance use disorders and criminal justice involvement. Instead, many individuals that have significant mental health and/or substance use disorders and criminal justice involvement that may be incompetent to stand trial are housed in the Sonoma County jails and do not receive supportive peer services and evidenced based treatment that will help them move towards recovery and away from criminal justice involvement.

The proposed project, Crossroads, is based upon a combination of evidenced-based approaches, including Housing First, Assertive Community Treatment (ACT) and peer support integration into mental health treatment and recovery processes. The innovation is combining those approaches into one program model to fully engage and support individuals in their early recovery with that is client driven and addresses the barriers to successful achievement of recovery goals.

The initial research question was whether there was a successful model serving individuals with mental illness having a criminal justice background with a robust peer provider program combined with a clinical team within a supportive housing model. Research for this project discovered existing models that combined housing with ACT and/or peer-led services for the homeless, but not for adult diversion clients. The New York based homeless project, Pathways' Housing First is focused on obtaining market rate housing with minimum rules. It is almost expected that there will be challenges in maintaining housing and that the policies and procedures need to be flexible and client-driven. Pathways incorporates five principals: 1). Housing First, 2) Consumer Choice and Self-Determination, 3) Recovery Orientation, 4) Individualized and Person Driven and 5) Social and Community Integration. These five principles have transformed many staff to think differently about their approaches and understanding of recovery, and simultaneously empowered clients to be open to new ways of thinking, acting and increase ownership of their actions in the context of recovery.

The Peer Wellness Program, a service component of Pathways to Housing is exclusively run and managed by peers with lived experience. The peer run model emphasizes empowerment, social inclusion and true collaboration. Furthermore, the service delivery model focuses on the whole person, offering an array of supportive services, including housing retention, employment, pursuing their education, securing entitlements, making social connections, criminal justice issues, reuniting with children and families, living healthier lifestyles, becoming financially informed, and dealing with trauma. Pathways to Housing does use similar evidence-based and promising practices including: Housing First, Supported Employment—IPS (Intentional Peer Support) model, Integrated Dual Disorder Treatment (IDDT), the Wellness Self-Management tool, and Assertive Community Treatment Model (ACT). However, this project is not a criminal justice diversion project focusing on the severely mentally ill who are at risk of being found incompetent to stand trial.[16]

Crossroads to Hope is different from Pathways to Housing in that Crossroads will have transitional beds open and dedicated to eligible individuals leaving the criminal justice system. Pathways relies on market housing available to the broader public. In Sonoma County, housing is sparse and competition for rentals is fierce. Clients could be waiting many months for housing and thus delay access to treatment and possibly impact motivation.

Another model closer to home in California is the Amity Foundation, located in Los Angeles County. The Amity Foundation has implemented a model of short-term supportive housing coupled with case management for diversion clients but does not integrate peers into the clinical service delivery model. Furthermore, the Department of Health Services' Office of Diversion and Reentry's program offers long-term (not transitional) supportive housing with intensive case management to Probationers. Additional diversion programs have been developed by LA's Office of Diversion and Reentry for individuals found to be incompetent to stand trial, but again does not incorporate peers into the recovery model. [17]

[16] "Peer Wellness Program and Pathways to Housing", Substance Abuse and Mental Health Services Administration, https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/peer-wellness-pathways-housing

[17] Health Services, Los Angeles County, Office of Diversion and Reentry, http://dhs.lacounty.gov/wps/portal/dhs/diversionandreentry/jcbd

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

With the support of MHSOAC staff, Sonoma County reviewed three additional Innovation Projects from Marin, Sacramento, and San Joaquin counties. Although Marin and Sacramento counties address the challenges in providing effective services for those involved with the criminal justice system, Marin takes a housing and holistic therapeutic approach and Sacramento is modifying their Child and Family team model to a forensic behavioral health multi-system team approach. Marin does incorporate one staff member with lived experience (peer), but does not build a strong peer provider program component as their centerpiece. Rather, Marin focuses on holistic health to address trauma within an exclusively female population.

San Joaquin is housing first focused for individuals experiencing mental illness and homelessness. San Joaquin's project does not incorporate a peer provider component at all.

Casting a wider net of research, a review of consumer-provided services (peer provider services) combined with Assertive Community Treatment (without housing) was conducted and identified 16 published studies. Findings were mixed, with evidence supporting consumer-provided services for improving (client) engagement. However, evidence was lacking for other outcomes, such as symptom reduction or improved quality of life.[18] The gaps in research indicate a lack of documentation and evaluation on a model that combines Housing First, Assertive Community Treatment with peer-led provider support for diversion clients from the criminal justice system. This innovation proposal for Crossroads to Hope would be an excellent model to measure impact and has promising benefits for those in the criminal justice system in Sonoma County and throughout California.

LEARNING GOALS/PROJECT AIMS

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

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

The first overarching goal for the program is to learn if a combined peer-provider model that is client centered and self-directed can be blended with a clinical approach that is often compliance focused and driven by the clinician. Furthermore, the County would like to understand the challenges and successes in that development process. The second and third goal is to

[18] A review of consumer-provided services on Assertive Community Treatment and intensive case management teams: Implication for future research and practice. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3117264/

understand if the peer provider programming is a significant factor on client engagement and achievement of treatment plan goals. The lessons learned from developing this blended model and outcomes can be used for future programming that integrates **peer providers** and self-empowered, self-directed recovery philosophies.

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

A literature review finds evidence that peer-led programs have value and positive impact on mental health recovery for individuals. But there is lacking evidence on **how** peer support specifically contributes to positive outcomes. In Sonoma County, peer-led programs are usually stand-alone programs and not integrated with a clinical model. Thus, the first learning goal will contribute to an understanding of best practices for the development of future peer integrated programs. The second and third learning goals provide additional information on the impact and specifically the cause and effect of the peer support team.

EVALUATION OR LEARNING PLAN

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

Crossroads to Hope enhances a model of transitional housing and clinical support with peer provider staffing and a robust peer-recovery program for improved outcomes for diversion clients. The County of Sonoma is planning to contract with RDA Consulting, a firm that has extensive knowledge of MHSA and experience in research and evaluation, including Innovation projects. The following learning goals are proposed for the Crossroads Innovation Project:

Learning Goal 1: How do peer providers and clinicians work together to create a treatment milieu that incorporates the principles of self-determination and choice for clients?

- What were the significant barriers to overcome in developing this model?
- What were the factors that helped overcome challenges and led to success?
- Are there professional development standards for peer providers that factor into the success of a blended treatment and support team? Contributing factors may include required qualifications for the position, certification, training, team support, mentorship, and supervision.

Learning Goal 2: How do the peer providers impact the diversion clients in their early engagement in recovery?

- What is the diversion clients' perception of value/benefit in receiving peer provider support and services?
- What is the peer providers' perception of value/benefit of their support and services?
- What is the ACT teams' perception of value/benefit of having peer provider support and services?

Learning Goal 3: How do peer providers impact the accomplishment of treatment goals among the diversion clients that complete the first 6 months at Crossroads?

- Are there specific activities that peers provide that are most beneficial to diversion clients' achievement of treatment goals and what are they?
- Are there other factors that influence the success of diversion clients' to achieve treatment goals? (i.e. amount of time spent with peer providers, qualities of peer providers)

METHODOLOGY

The evaluation team will commence their planning work in tandem with the peer provider organization and the Peer Advisory Council at a session(s) designed to define the theory of change (TOC) and identify the specific ways that peers may engage clients and support the achievement of recovery goals within the six-month intervention. This TOC will be the basis for the development of the evaluation plan. It is anticipated that the evaluation will consist of a mixed-methods data collection approach including both qualitative and quantitative data. In addition, the evaluation process will employ a community-based participatory research model, engaging the Peer Advisory Council in the design and implementation of the evaluation process; collection and analysis of the data; and development/dissemination of the final report to stakeholders in the community.

Learning Goal 1 is a formative evaluation. Documentation of team meetings with peer providers and ACT team members will be maintained with a focus on discussions related to the integration of peer-model principles of self-determination and client choice. The findings in the process documentation will be validated with an annual mixed-methods (qualitative and quantitative) questionnaire to be completed by the clinical/case management team and peer providers, key informant interviews and review of program documentation.

Learning Goal 2 is an outcome evaluation question measuring the impact of peer providers on the engagement from the perspective of the clients and peer providers. The specific measures are yet to be determined, but will consist of a pre-post measure(s). For example, a tool such as the Self-Sufficiency Matrix can be completed by a peer provider as an assessment based on interactions with the client. The Self-Sufficiency Matrix consists of 20 domains examining the status/outcomes of the individual's activities of daily living. This non-clinical assessment can be completed at entry and again at the 6-month exit from transitional housing. In addition to a standardized assessment tool, interviews will be conducted with a randomized convenience sample of clients, peer providers and clinical staff to collect qualitative data to triangulate and validate findings.

Learning Goal 3 is also an outcome evaluation question focusing on the effect that peer providers have on the achievement of client treatment goals. The theory of change developed by the evaluation team and peer providers will inform the specifics of how the peer provider support may influence and ultimately impact client recovery outcomes. Appropriate tools will be identified and may include the Adult Needs and Strengths Assessment (ANSA) to benchmark client changes in clinical status and achievement of recovery goals. The ANSA is a multi-use assessment tool that can be used for treatment planning, determining levels of care, measuring outcomes and serves as a communication tool. This assessment will be administered every six months. The ANSA will be administered upon entry into the program (baseline) to help inform and support the development of treatment goals. The ANSA will be re-administered a second time at 6-months, when the client is expected to exit transitional housing. Additional administration of the ANSA at 12, 18 and 24-months will be administered by the ACT team. The local evaluation team and Peer Advisory Council will continue to review ANSA data with the participant's consent at 12, 18 and 24 months. The evaluator will conduct statistical analysis of the ANSA data to determine if there is a correlation between the Crossroads interventions and longer-term client outcomes/status. These findings will be included in the annual and final Innovation Reports.

A qualitative database will be added to examine the peer provider support intervention and whether those activities contributed to the client outcomes. An example method of data collection might be interviews conducted with all clients at 6-months to determine what factors influenced client success. Interviews could consist of open-ended questions and allow the client to respond without prompts or direction. If needed, clients may be offered suggestions such as educational groups, housing, relationships with staff/peers/peer providers/probation officers, wrap around services, community connections, etc. This will be determined by the evaluation team, peer providers and Peer Advisory Council.

SECTION 3: ADDITIONAL INFORMATION FOR REGULATORY REQUIREMENTS

CONTRACTING

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

Sonoma County Department of Health Services (DHS) will solicit up to a five-year contract with a community-based organization to provide the peer-led services for the proposed term of the Innovation funding award. DHS will need to develop a request for proposals (RFP) to select an appropriate community-based provider for the peer provider component.

In addition, the County will seek an independent evaluator from the County's qualified contractor list to oversee the evaluation. Early discussions have been held with Resource Development Associates (RDA) based in Oakland, CA as to their interest and role as the local project evaluation team. RDA has indicated that they are very interested in evaluating this project, and they have provided the County with a cost estimate. RDA has decades of experience with MHSA funded programs, including Innovation Projects, Capacity Assessments, and Community Program Planning models.

The MHSA Coordinator and the Forensic Health Program Manager of the Sonoma County DHS BHD will share responsibility to monitor the progress of **Crossroads to Hope** and assure contract compliance per County and State regulations for both the program and the evaluation contractors. The County may provide technical support in program delivery and evaluation, fiscal reporting and program reporting to these contractors. Project coordination meetings will be held quarterly to establish expectations in reporting and to assure compliance with MHSA and regulations. In addition, the selected contractor will be expected to submit quarterly reports that include client demographics (as per MHSA INN regulations), program data, program progress and challenges, and invoices for services rendered.

The selected evaluation contractor will engage with the DHS Health Prevention, Planning and Evaluation Unit to ensure alignment with the overall evaluation of the Diversion project. The evaluation contractor will also meet with the MHSA Coordinator and the Forensic Health Program Manager with regular frequency (minimum quarterly) to facilitate and assure the evaluation is on track.

COMMUNITY PROGRAM PLANNING

In June of 2016, a group of community stakeholders including consumers, peers, mental health providers and County representatives met to discuss the lack of services and supports for those who were on the precipice of a crisis. With limited beds at the Crisis Stabilization Unit (CSU), the group proposed a peer respite residential center. This proposal to provide immediate short-term housing staffed and led by peers would intervene prior to crisis and focus on wellness and

recovery. Unfortunately, funding stalled and the project was not realized, but this effort set the stage for continued interest and determination for peer-led services and supports.

In March of 2018, Sonoma County held a two-day meeting of a Sequential Intercept Model planning process used by communities to assess the circumstances of people with behavioral health needs in the justice system and identify opportunities for linkages to services that can prevent deeper penetration into the criminal justice system. The County brought together over 40 stakeholders from multiple systems, including mental health consumers and professionals, substance abuse, law enforcement, pretrial services, courts, jails, community corrections, housing, health, social services, and family members to identify gaps, resources and opportunities for individuals with mental illness and co-occurring disorders in the criminal justice system. Among all of the alternative strategies, the highest number of participants named "Expand Housing with Supportive Services" as the top priority for the county.[19]

This was also a finding contained in Sonoma County's Housing Needs Assessment, April 2018. The Housing Needs Assessment report recommended the consideration of the types of supports and services needed for individuals with a history of incarceration and/or inpatient psychiatric services. Given that survey respondents indicated difficulty with either securing housing upon their release or finding housing that was considered safe and secure, additional services and supports may be needed to help individuals secure housing upon their release from inpatient psychiatric facilities or incarceration.[20]

In the Sonoma County Capacity Assessment Report released in January 2020, community stakeholders praised peer providers and programs noting the effectiveness of engaging individuals into treatment and empowering a community of recovery that could not be achieved by clinicians alone.[21] The 2019 MHSA Capacity Assessment report continues to state that consumers, as well as providers, expressed support for peer-led programs at all levels of care. Integrating peer providers who embody recovery and what is possible for consumers is not only aligned with MHSA values, but could create a cultural shift in the way mental health services are delivered throughout the system.

Specific to this innovation project, a few members and consultants from the Sonoma County Peer Council have been participating in the development and planning of Crossroads to Hope. Interviews with three peer providers who have lived mental health and criminal justice experience and two mental health providers at local mental health agencies were conducted in April and May 2020.

The chart below lists those individuals and their affiliations.

Name	Affiliation	Organization
Sean Bolan	Peer provider	Manager, Wellness and Advocacy Center
Sean Kelson	Peer provider	Manager, Interlink and Petaluma Peer Recovery Center

[19] Sequential Intercept Model Mapping Report for Sonoma County, CA; Policy Research Associates, Inc, March 20-21, 2018.
[20] Sonoma County Housing Needs Assessment, Harder + Company Community Research, April 2018.
[21] Sonoma County MHSA FY 2016-2019 Capacity Assessment, Research Associates Development, January 2020.

Kate Roberge	Peer provider	Consumer Affairs Coordinator, Wellness and Advocacy Center
Steven Boyd, LCSW	Clinician	Clinical Director to Napa and Sonoma Programs, Progress Foundation
Sid McColley, RN, CNS	County	Section Manager, Acute and Forensic Services Sonoma County Behavioral Health Services

In addition, the Crossroad to Hope Innovation proposal and program highlights have been presented to groups of MHSA Stakeholders at the meetings listed on the table below.

Date	Stakeholder Group
May 7, 2021	MHSA Community Program Planning Workgroup
May 11, 2021	MHSA Steering Committee
May 27, 2021	MHSA Stakeholder Meeting (comprised of a broad group of stakeholders)
September 13, 2021	Innovation Contractors
September 16, 2021	Prevention and Early Intervention Contractors
October 6, 2021	Community Services and Supports Contractors
October 14, 2021	DHS-BHD Staff
November 4, 2021	Mental Health Board

Thus far all of the comments received about the proposal from the various stakeholder groups have been positive and include the following themes.

- Creates transitional housing
- Helps individuals to develop skills that will promote their ability to get and keep permeant housing
- Diverts people with mental health concerns from jail
- Integrates supportive peer services to help individuals to move towards recovery

The 30-day public review period commenced on December 1, 2021 with the publication of the Crossroads to Hope application posted on the Department of Health Services Behavioral Health website and publicized in the MHSA newsletter, emailed to list of over 2000 on the MHSA listserv, stakeholders and contractors. The Mental Health Board hosted the public hearing on Crossroads on January 18, 2022. There were 18 attendees at the public hearing, and four individuals contributed comments in support of the project. The Board of Supervisors will review the proposal for approval on February 8, 2022.

Finally, a Peer Advisory Council specific to Crossroads will be re-convened to receive updates to the project's progress and provide input to the final design and implementation of the project's evaluation and program modifications.

MHSA GENERAL STANDARDS

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

A) Community Collaboration

The discussion of increasing peer providers in the continuum of mental health services for Sonoma County has been evolving over the past 8 years or more with a stakeholder group comprised of peers, family members, clients, criminal justice personnel, behavioral health clinicians and management in that has resulted the establishment of a variety of peer-led programs in the community and an application for funding for a Peer Respite program in 2018. The dialogue between peer providers (trained and certified) and behavioral health clinicians/management has been ongoing to improve and expand peer provider services in the system of care.

Crossroads to Hope is a model that incorporates a multi-disciplinary team comprised of consumers, mental health providers, law enforcement, housing and community-based organizations. Case conferences and meetings on program operations will held with frequent regularity, especially in the first year of the project. Furthermore, a Peer Advisory Council will be established for ongoing consultation and monitoring of this project which will assure a peer perspective and support for the peer providers.

B) Cultural Competency

The diversion clients coming from the local county jails will most likely represent the diversity of ethnic and racial demographics of the jail population. The model of client-driven and self-determination will address and hopefully prevent inherent biases of a western medical model. In addition, the Behavioral Health Division has a Cultural Responsiveness Committee that will receive updates on this project and make recommendations on policy and procedures to assure the services are free from racial, economic and gender biases.

C) Client-Driven

By adopting a philosophy and practice of self-directed recovery planning supported by a peer-led support model, Crossroads will identify and provide opportunities to assure that diversion clients are empowered to define their recovery goals, actions for achievement and definitions of success.

D) Family-Driven

As noted in the earlier value of "client-driven", if diversion clients have family members (defined by the client) whom they would like to involve in their recovery, those family members will be engaged in recovery planning and actions. In addition, family member representatives will be sought to participate in the Peers Advisory Council which will guide the development, engagement and evaluation of Crossroads.

E) Wellness, Recovery, and Resilience-Focused

The premise of peer-led services integrated into a more compliance oriented, illness-focused, clinical model will necessitate a transformation of how the team looks at recovery. The journey of people in recovery does not start with a recovery plan, but of telling and understanding how they got to where they are today and where they want to go and what they want to do. Practicing self-care leading to wellness and resilience is an ongoing process. The structures that will be in place to maintain the focus on wellness, recovery and resilience include: 1). Trained and supported Peer providers; 2). Informed and engaged Peer Advisory Council; and 3) Realized opportunities for staff-development and training.

F) Integrated Service Experience for Clients and Families

The Crossroads model is inter- and multi-disciplinary. In supporting diversion clients with transitional housing, a home-base is established whereby services can come to the clients rather than asking clients to work with traditionally siloed providers. Case conferences will provide the mechanism to further identify areas of integration and coordination to support a solid start to recovery.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

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

As mentioned throughout this application, a Peer Advisory Council will be established to provide counsel and accountability to both the program and evaluation design and implementation. This Peer Advisory Council is reflected in the budget to offer stipends and cover expenses. The PAC will meet regularly with the MHSA Coordinator or designee to assure communication and continuity of policy and procedural practices. Documentation of these meetings will be maintained contributing to the formative evaluation and continuous improvement.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

A) **Briefly describe how the County will decide whether it will continue with the INN project in its entirety, or keep particular elements of the INN project without utilizing INN Funds following project completion.**

Determination of whether the program will continue after the end of the Innovation Period using other funding will be made through the Community Program Planning Process by analyzing data gathered that address the learning questions and additional outcome data including occupancy, cost-effectiveness and cost-savings to the larger community, client-feedback, and availability/prioritization of funding. Funding with MHSA Community Services and Supports (CSS) component will be considered. Also, the implementation of the California Advancing and Innovating Medi-Cal (CalAim) reforms will be continually monitored over the next five years and this is a potential be a source of funding this type of innovative whole person approach that addresses key social determinants of health. In addition, if successful outcomes are achieved through this innovative approach, the Probation department may be another potential funding source to continue this work.

B) Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals upon project completion.

Crossroads will be serving individuals with serious mental illness and if the project is to terminate at the end of the five-year Innovation funding, the ACT clinical team will continue to support diversion clients while they are in the transitional housing as well as afterwards when they are in long-term housing. There will be no break in those clinical services.

COMMUNICATION AND DISSEMINATION PLAN

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

The MHSA Coordinator will be primarily responsible for communicating the progress, results, and lessons learned to community stakeholders, including the County Mental Health Board, Board of Supervisors, MHSA Steering Committee, key Department Heads and other community leaders/stakeholders. The Peer Advisory Council and Crossroads clients will be invited to engage in the development of public materials, reports and presentations. In addition, clients may participate in testimonials at public hearings, conferences, or other key policy meetings.

In light of the MHSOAC Commission and State of California's interest in reducing the population of those with severe mental health conditions in the criminal justice system, Crossroads hold promise of an innovative, comprehensive and effective model that can be replicated in other counties throughout the state. Crossroads evaluation will document the formation and outcomes of the project for ease of replication.

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

- Mental Health Peer Providers
- Criminal Justice Diversion
- Innovative Mental Health Models

TIMELINE

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

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

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

Year 1			
April 2022	**July 2022**	**October 2022**	**January 2023**
• Contractor recruits Peer Providers, Peer Advisory Council • Convene kick-off meeting with ACT team, Peer Providers, law enforcement, evaluator • Establish policy and procedures for Crossroads • Refine roles and responsibilities of Peer Providers • Establish draft of evaluation protocols and instruments	• Enroll eligible clients for Crossroads, administer ANSA • Clients develop recovery plans • Peer providers implement educational curriculum, supportive services • Quarterly meeting with Peer Advisory Council • Establish evaluation protocols • Quarterly meetings with contractors, evaluator • Evaluator reviews evaluation protocols and data collection methods with peer providers	• Program operations refined • Quarterly meeting with Peer Advisory Council • Quarterly meetings with contractors, evaluator • Evaluator reviews data collection methods • Evaluator reviews evaluation protocols and data collection methods with Peer Advisory Council and providers	• Clients moving from transitional to long-term housing, administer ANSA • Survey administration for exiting clients and ACT team • Focus Group or key informant interviews for qualitative data collection • Quarterly meeting with Peer Advisory Council • Quarterly meetings with contractors, evaluator • Identify eligible clients for Crossroads, administer ANSA

Year 2 - 4			
April 2023 - 2025	July 2023-2025	October 2024 - 2026	January 2024 - 2026
• Clients develop recovery plans • Quarterly meeting with Peer Advisory Council • Quarterly meetings with contractors, evaluator	• Clients moving from transitional to long-term housing, administer ANSA • Survey administration for exiting clients and ACT team • Peer Advisory Council meeting • Meetings with contractors, evaluator • Identify eligible clients for vacancies in Crossroads, administer ANSA • Clients develop recovery plans	• Peer providers implement educational curriculum, supportive services • Quarterly meeting with Peer Advisory Council • Quarterly meetings with contractors, evaluator	• Clients moving from transitional to long-term housing, administer ANSA • Survey for exiting clients and ACT team • Focus Group or key informant interviews for qualitative data collection • Peer Advisory Council meeting • Meetings with contractors, evaluator • Identify eligible clients for Crossroads, administer ANSA • Clients develop recovery plans

Year 5			
April 2026	July 2026	October 2027	January 2027
• Peer providers implement educational curriculum, supportive services • Meetings with contractors, evaluator • Analyze first 2 years of evaluation, share findings with Peer Advisory Council	• Clients moving from transitional to long-term housing • Survey administration for exiting clients and ACT team • Peer Advisory Council meeting • Meetings with contractors, evaluator • Identify eligible clients for Crossroads • Begin disseminating preliminary findings from evaluation on impact, lessons learned to stakeholders, policy makers and funders	• Continued dissemination of preliminary findings from evaluation on impact, lessons learned to stakeholders, policy makers and funders • Determination of continued funding or termination of peer provider component of Crossroads • Peer Advisory Council meeting • Meetings with contractors, evaluator • On-going program implementation	• Clients moving from transitional to long-term housing, administer ANSA • Survey for exiting clients and ACT team • Focus Group or key informant interviews for qualitative data collection • Peer Advisory Council meeting • Meeting with contractors, evaluator • Identify eligible clients for Crossroads, administer ANSA • Clients develop recovery plans • Final evaluation report • Dissemination of final evaluation report to stakeholders, policy makers and interested members of the public

SECTION 4: INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

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

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

BUDGET NARRATIVE

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

Personnel Costs:

Year 1

- **1 FTE Senior Peer Provider** (2080 hours) x $25 per hour = $52,000 prorated for 3 months (.25 of year).
- **2 FTE Peer Provider** (4160 hours) x $20 per hour = $83,200 prorated for 3 months (.25 of year).
- **1 FTE Relief Peer Provider**, 2080 hours x $20 = $41,600 prorated for 3 months (.25 of year).
- **Direct Costs:** Wages of 4 FTE Peer Providers x .33 (benefits, payroll taxes, insurance) = $58,344, prorated for 3 months (.25 of year).
- **Indirect Costs** are administrative expenses related to recruitment, administrative management of Peer Providers at 10% of contract with non-profit contractor. Year 1 is prorated for 3 months (.25 of year).

Year 2 – 5

- Each year, a proposed .03 Cost of Living increase is added to salaries if personnel is stable. Direct Cost of benefits, payroll taxes and insurance of .33 is consistent, as is Indirect Cost of .10 for non-profit contractor.

Direct Operating Costs (Years 1 and 5 are prorated)

- **Peer program costs include:** Supplies (workbooks, journals, art supplies) - $4000. Educational materials - $4000. Guest speakers - $3000. Field trips - $3000. Subscriptions - $2000.
- **Food** – Year 1 = $40,000 Estimated $300 - 334/person per month @ 10 – 12 people Year 3 - 5 and 3 included $5,000 increase per year.
- **Peer Advisory Council stipends** $2400 per year for (6 meetings per year, 8 participants, $50 per meeting). $600 for snacks/meals for meetings;
- **Peer training and professional development:** 4 x $500 = $2000
- **Transportation:** County pool car fees: $1500 per year. Bus passes for clients: $62.50 per month x 6 clients x 12 months = $4,500.
- **Housewares:** dishes, silverware, glasses, mugs, serving platters at $10,000 year 1 with replacement allowance at Year 3 - $2000 and Year 5 - $1000.
- **Household Expenses:** Consumable products, including cleaning supplies, toilet paper, paper towels, and maintenance supplies = $10,000
- **Utilities:** $5,500 per month including communications for the house and cellular for peer providers, IT, PGE, water, garbage
- **Building improvements:** $5,000 for repairs, maintenance on building and grounds
- **Client Educational Funds:** $24,000 - $2,000 per client x 12 annually for GED, computer classes, books, professional development
- **Office Expense:** $2000 per year for printer paper, ink, postage, stationary, supplies
- **Peer provider education and training:** $5,500 = $1,375 annually per peer provider x 4
- **Recreation:** $7,200 per year to promote wellness and self-care - Bicycles for house (4 x $500 = $2000), yoga ($100 per week x 52 weeks = $5,200)
- **Professional & Special Services:** $23,400 for nutritionist/chef at $75 per hour x 6 hours x 52 weeks. For nutritional guidance, menu planning and meal prep education.
- **Transportation:** $4,200 lease car with insurance and registration at $350 per month for peer providers to transport clients to court, medical appointments, and other important appointments.
- **Client travel:** $4,500 for bus vouchers. $62.50 per month x 6 clients x 12 months.
- **Gas, oil, maintenance on lease vehicle:** $3,000 per year
- **Rents & Leases:** $32,000 for first, last and deposit to support clients leaving transitional housing when needed.

Indirect Operating Costs:

- 10% to non-profit contract for administration of payments, managing house inventory and utilities, lease of vehicle.

Non-Re-occurring Costs

- Computers - $4,500: Five computers for clients and peer providers at $750 each and 2 printers at $325 each.

Consultant Costs:

- Evaluation Contractor (propose RDA to evaluate the program): Year 1: $47,000; Years 2-4: $11,750; and Year 3: $25,000

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*

EXPENDITURES								
PERSONNEL COSTS		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
1	Salaries	$44,200.00	$176,800.00	$182,104.00	$187,567.00	$193,194.00	$113,020.00	$896,885.00
2	Direct Costs	$14,586.00	$58,344.00	$60,094.00	$61,897.00	$63,754.00	$37,296.00	$295,971.00
3	Indirect Costs	$5,879.00	$23,514.00	$24,220.00	$24,946.00	$25,695.00	$15,031.00	$119,285.00
4	Total Personnel Costs	$64,665.00	$258,658.00	$266,418.00	$274,410.00	$282,643.00	$165,347.00	$1,312,141.00
OPERATING COSTS		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
5	Direct Costs	$30,759.00	$181,841.00	$191,300.00	$193,900.00	$194,900.00	$174,899.00	$967,599.00
6	Indirect Costs	$3,076.00	$18,184.00	$19,130.00	$19,390.00	$19,490.00	$17,490.00	$96,760.00
7	Total Operating Costs	$33,835.00	$200,025.00	$210,430.00	$213,290.00	$214,390.00	$192,389.00	$1,064,359.00
NON RECURRING COSTS		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
8	Computers for clients and peers	$4,500.00	$0.00	$0.00	$0.00	$0.00	$0.00	$4,500.00
9	Total Non-recurring costs	$4,500.00	$0.00	$0.00	$0.00	$0.00	$0.00	$4,500.00
CONSULTANT COSTS / CONTRACTS		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
10	Direct Costs	$47,000.00	$11,750.00	$11,750.00	$11,750.00	$11,750.00	$25,000.00	$119,000.00
11	Indirect Costs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
12	Total Consultant Costs	$47,000.00	$11,750.00	$11,750.00	$11,750.00	$11,750.00	$25,000.00	$119,000.00
OTHER EXPENDITURES		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
13	Total Other Expenditures	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
BUDGET TOTALS		**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
Personnel (line 1)		$44,200.00	$176,800.00	$182,104.00	$187,567.00	$193,194.00	$113,020.00	$896,885.00
Direct Costs (add lines 2, 5 and 10 from above)		$92,345.00	$251,935.00	$263,144.00	$267,547.00	$270,404.00	$237,195.00	$1,382,570.00
Indirect Costs (add lines 3, 6 and 11 from above)		$8,955.00	$41,698.00	$43,350.00	$44,336.00	$45,185.00	$32,521.00	$216,045.00
Non-recurring costs (line 9)		$4,500.00	$0.00	$0.00	$0.00	$0.00	$0.00	$4,500.00
Other Expenditures (line 13)		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
TOTAL INNOVATION BUDGET		$150,000.00	$470,433.00	$488,598.00	$499,450.00	$508,783.00	$382,736.00	$2,500,000.00

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)								
ADMINISTRATION								
	Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**Total Budget**
1.	Innovative MHSA Funds	$103,000	$458,683	$476,848	$487,700	$497,033	$357,736	$2,381,000
2.	Federal Financial Participation							
3.	1991 Realignment							
4.	Behavioral Health Subaccount							
5.	Other funding*							
6.	**Total Proposed Administration**	$103,000	$458,683	$476,848	$487,700	$497,033	$357,736	$2,381,000
EVALUATION								
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**Total Budget**
1.	Innovative MHSA Funds	$47,000	$11,750	$11,750	$11,750	$11,750	$25,000	$119,000
2.	Federal Financial Participation							
3.	1991 Realignment							
4.	Behavioral Health Subaccount							
5.	Other funding*							
6.	**Total Proposed Evaluation**	$47,000	$11,750	$11,750	$11,750	$11,750	$25,000	$119,000
TOTAL								
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**Total Budget**
1.	Innovative MHSA Funds	$150,000	$470,433	$488,598	$499,450	$508,783	$382,736	$2,500,000
2.	Federal Financial Participation							
3.	1991 Realignment							
4.	Behavioral Health Subaccount							
5.	Other funding*							
6.	**Total Proposed Expenditures**	$150,000	$470,433	$488,598	$499,450	$508,783	$382,736	$2,500,000

Appendix 4 – CalMHSA Sonoma County Impact Statement FY 20-21

WELLNESS • RECOVERY • RESILIENCE

Fiscal Year 2020-2021 Statewide Impact Statement

The PEI Project: Achieving More Together to Support Californians

California counties collectively pool local Prevention and Early Intervention (PEI) funds through the California Mental Health Services Authority (CalMHSA) to support the ongoing implementation of the PEI Project at a Statewide level. The PEI Project is a collection of campaigns which seek to expand the awareness of mental health needs and supports, reduce stigma, prevent suicides, and teach individuals how to achieve mental wellness. These campaigns are: Know the Signs, Directing Change, and Each Mind Matters (EMM). The Each Mind Matters campaign was the original stigma reduction campaign and primarily focused on reducing stigma around mental health. The EMM campaign was an early trailblazing effort in stigma reduction. Following the direction of the CalMHSA Board of Directors, CalMHSA staff sought to reimagine the next iteration of the PEI Project towards one that is building off the work done by EMM to move California into a new phase of Taking Action. The Take Action for Mental Health campaign will help individuals learn how to Take Action for the mental health of themselves and those around them through three pillars: Check In, Learn More, and Get Support.

In FY 20/21, CalMHSA selected Civilian through a Request for Proposals (RFP) process to begin developing the social marketing campaign that would build on the legacy of the EMM campaign, with a new focus and expanded reach to traditional and non-traditional partners. In addition, the campaign will more tightly connect each of the campaigns, and the RAND evaluation efforts, to provide counties with a more interconnected suite of campaigns to support their communities.

Strategies of the PEI Project in FY 20/21

Funding to the PEI Project supported programs such as:

- Beginning the planning and formative research to launch California's next statewide mental health campaign
- Providing technical assistance and outreach to PEI contributing counties
- Providing mental health and suicide prevention trainings to diverse audiences
- Engaging youth through the Directing Change program

Statewide achievements in FY 20/21

The effects of the Statewide PEI Project go beyond county lines. Influencing all Californians in the message of Take Action for Mental Health is critical for creating a culture of mental wellness and wellbeing regardless of where individuals live, work or play. Key statewide achievements of the Statewide PEI Project in FY 2020-2021 include:

- Selection of Your Social Marketer (YSM) for Training and Technical Assistance Services, through an RFP process.
- Selection of Civilian for social marketing and campaign development, through an RFP

process.

- The YSM team conducted regular meetings with PEI contributing counties throughout the year to provide technical assistance and resource navigation.
- The Directing Change Program received 982 videos submissions from 176 schools across California, engaging over 1,800 students.
- 34,154 parents were reached through Directing Change webinars and Facebook Live events.
- More than 13,250 youth, parents, and community members reached through Directing Change awareness activities created by youth and educators through mini grant funding to 31 schools.
- 8 monthly contests through the Directing Change Hope and Justice Category
    - "What This Election Means to Me" (September 2020)
    - "Creative Ways to Measure 6 Feet Social Distancing" (October 2020)
    - "My Reasons for Wearing a Face Mask" (November 2020)
    - "My Beautiful Brain" (January 2021)
    - "The Art of Self Love" (February 2021)
    - "Hope for Change" (March-April 2021)
    - "More Than One" (May 2021)

People under the age of 25 that were served through this Program and Disclaimer

CalMHSA is unable to provide an exact number, however, based on the funded programs it is estimated that around 65% of services of this program are provided to individuals under 25 (as defined by Title 9 Regulations). For context, the program estimates are below:

- Directing Change: estimated at 95% under 25 years old
- Social Marketing: estimated at 55% under 25 years old
- Training and Technical Assistance: estimated at 55% under 25 years old
- Evaluation: 51%

Appendix 5 – Sonoma County MHSA Final Community Program Planning Strategic Action Plan

WELLNESS • RECOVERY • RESILIENCE

Sonoma County MHSA Community Program Planning Strategic Action Plan

WELLNESS • RECOVERY • RESILIENCE

Introduction

In 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA established a one percent income tax on personal income over $1 million dollars for the purpose of funding mental health systems and services in California. In an effort to effectively transform the mental health system, MHSA creates a broad continuum of prevention, early intervention, innovative programs, services, infrastructure, technology, and training elements. Community Programming Planning (CPP) is specific to Mental Health Services Act (MHSA) funding.

The MHSA was designed to transform the public mental health system, not only through the generation of new revenue to fund the expansion of services, but also by requiring unprecedented levels of ongoing stakeholder input and involvement at all levels of public mental health policy, program planning, implementation, monitoring, quality improvement, evaluation, and budget allocations. WIC § 5848(a). Furthermore, the California Code of Regulations, Title 9 states that counties are to ensure stakeholders reflect the diversity of the demographics of the county. People who have the opportunity to participate in the CPP process (CCR § 3300) include—but are not limited to—geographic location, age, gender, race/ethnicity, individuals with lived experience, and family members.

The benefits of having a structured Community Program Planning (CPP) model cannot be overstated. Public programs designed with and for the members of the community are more relevant, culturally-appropriate, and are oriented to cost-effectiveness. The benefits of stakeholder engagement can include:

- Better decision making
- More effective service delivery
- Greater community support
- Community development
- Increased engagement with services

- Increased cultural competence

Incorporating Community-Based Participatory Research (CBPR) practices into a local community program planning process strengthens and assures that the voices of consumers, family members, and stakeholders are represented in decisions, actions, and results of the planning process. CBPR involves a partnership between researchers and community members in all aspects of the process: defining the research questions, deciding who participates, how the data is collected and analyzed, and determining how to share the findings. CBPR has been shown to provide an opportunity to build greater trust between institutions and the community, explore the depth of local knowledge and perceptions, empower community members toward self-determination, and improve health equity within a system of care.

Diversity, Equity, and Inclusion (DEI)

In August 2020, the Sonoma Board of Supervisors established the Office of Equity to focus on the immediate spike in COVID-19 cases within the Latinx community. However, this health indicator was just a tipping point within a series of apparent inequities experienced during the recent wildfires, floods, power-grid shut offs, and Stay-at-Home orders by communities of color, poverty, and others who are often on the margins of mainstream society. The Office of Equity states that "Equity is an outcome whereby you can't tell the difference in critical markers of health, well-being, and wealth by race or ethnicity, and a process whereby we explicitly value the voices of people of color, low income, and other underrepresented and underserved communities who identify solutions to achieve that outcome."

In alignment, the Department of Health Services, Behavioral Health Division appointed a new DEI Development Manager to ensure division policies and practices are non-discriminatory and inclusive, promote the diversification of a behavioral health workforce, and ensure equity and cultural relevance in program services.

Stakeholder Bill of Rights

Access California, a statewide consumer-led public mental health advocacy program, has adopted and published a Stakeholder Bill of Rights to further their mission of advancing client and community empowerment through sustainable solutions. The Sonoma County Community Program Planning workgroup, comprised of stakeholders, adopted the following statements as foundational guiding principles in developing a sustainable, inclusive community engagement plan responsive to MHSA Stakeholders.

1. **Transformation:** We have the right to an MHSA funded system which embraces the Recovery Model of Care and is fully committed to all General Standards for programs and services set forth by the MHSA.
2. **Information:** We have the right to transparency in our MHSA funded programs.

3. **Education:** We have the right to understand the meaning and implications of facts and data relevant to our MHSA funded programs.
4. **Participation:** We have the right to provide feedback on policy and in all important programming and funding decisions in our MHSA funded programs.
5. **Consideration:** We have the right to submit grievances[1] to our public mental health system, to have our grievances acknowledged, and to receive thorough and timely responses to our grievances.

Current opportunities for community participation:

Sonoma County currently has a structure in place which meets the requirement for a Community Program Planning process. The table below lists the MHSA committees and mental health governing boards with a brief description of the member composition.

Committee/Board	Open, appointed or elected	Composition of members	Number of seats	Meeting Frequency
MHSA Stakeholders	Open to the public	Consumers and family members nonprofit providers of health, social services, criminal justice, education; Contractors and providers of the health department and behavioral health division; interested members of the public.	Undefined	Bi-annually
MHSA Steering Committee	Application and selection process managed by the MHSA Coordinator and Department of Health Services, Behavioral	Members must represent the following: · Clients and consumers · Families of clients/consumers · Providers of mental health, substance use, and social services · Persons with disabilities · Education field · Health care · Law enforcement	20-25 seats	Quarterly

[1] Sonoma County Behavioral Health Division has a Client Rights policy with a stated grievance procedure. https://sonomacounty.ca.gov/Health/Behavioral-Health/Medi-Cal-Informing-Materials/

	Health Division administration	· Veterans and/or representatives from veterans' groups · College-age youth · Other interests (faith-based, aging and adult services, youth advocates) · Individuals from diverse cultural and ethnic groups		
MHSA Workgroups: Innovation, PEI, CSS, CPP, RFP	Combination of voluntary and appointed	MHSA Steering Committee members, Stakeholders	4 – 8 members	As needed workgroups
Mental Health Board	Appointed by Board of Supervisors	Member of the public vested in mental health services. Fifty percent of the Board membership shall be consumers or the family members of consumers who are receiving or have received mental health services. At least 20% of the total membership shall be consumers and at least 20% shall be family members of consumers.	16 members: 3 representatives for each of the 5 county districts and one Supervisor	Monthly, third Tuesday at 5:00 p.m. Check calendar.
Board of Supervisors	Elected		5 district representatives	Weekly on Tuesday at 8:30 a.m. check calendar

County Capacity Assessment

In addition to these regular meetings, the Sonoma County Behavioral Health Division conducts a Mental Health System Capacity Assessment every three years to prepare for the development of the Three-Year Program and Expenditure Plan. Counties have flexibility to conduct their capacity assessments to include specific elements of inquiry, and MHSA regulations (WIC § 330) require the identification of the number of consumers across age groups by gender, race/ethnicity, and other demographics compared against projected need and utilization to analyze population disparities.

The most recent MHSA 2016-2019 Sonoma County Capacity Assessment, provided the community with many opportunities to share their experiences with the Sonoma County mental health system in order to ensure that any recommendations made in this assessment were community-driven and responsive to their needs. Stakeholders in the county had opportunities to express their opinion of the current Sonoma County mental health system and their suggestions for future improvements through surveys, focus groups, and key informant interviews.

The capacity assessment process included a variety of stakeholders reflective of the geographic and cultural diversity of Sonoma County—including groups listed in MHSA regulations and the Welfare and Institution Code.[2] This included representatives from the following groups:

- Adults and Seniors with Lived Experience
- Family Members
- DHS-BHD Staff, Managers, and Senior Leadership
- Community Mental Health Service Providers
- Law Enforcement Agencies
- Education Agencies
- Social Service Agencies
- Veterans and Veterans Organizations
- Providers of Alcohol and Drug Services
- Health Care Organizations

The next County capacity assessment is projected to occur in the summer/fall of 2022 which will present a significant opportunity for the CPP workgroup to engage a broader representation of the community and assure a process which is diverse, equitable, and inclusive. The County will continue to conduct capacity assessments every three years as outlined in regulations.

[2] Per the MHSOAC, WIC § 5848 states that each Annual Update shall be developed with local stakeholders, including: Adults and seniors with severe mental illness; Families of children, adults, and seniors with severe mental illness; Providers of services; Law enforcement agencies; Education; Social services agencies; Veterans; Representatives from veterans organizations; Providers of alcohol and drug services; Health care organizations; Other important interests (e.g., individuals served or targeted by Prevention and Early Intervention (PEI) services and individuals expected to benefit from INN projects). CCR § 3300 further includes: Representatives of unserved and/or underserved populations and family members of unserved/underserved populations, as defined in CCR § 3200.300 and CCR § 3200.310; Stakeholders that reflect the diversity of the demographics of the county, including but not limited to, geographic location, age, gender, and race/ethnicity; Clients with serious mental illness and/or serious emotional disturbance, and their family members.

Expanding the Scope of Sonoma County's Community Program Planning (CPP)

The purpose of the Sonoma County CCP workgroup is to establish a process whereby community voices are elevated and incorporated into MHSA program planning for the behavioral health system. This workgroup is comprised of a diverse group of individuals interested in developing strategies and actions to engage a broader group of stakeholders.

Our Vision: All people from various cultural backgrounds and languages have accessible opportunities to provide feedback into how MHSA funding supports behavioral health programs and services in a system of care which is people centered and community driven. Community members in Sonoma County are acknowledged as critical partners in creating an equitable community practice which inspires a cultural shift[3] in which the voices of people in Sonoma County from all backgrounds are heard, acknowledged, and utilized in the ongoing evolution of the MHSA funded programs.

Our Mission: Increase community input into program planning by establishing regular, timely, meaningful, safe, and culturally appropriate opportunities for (1) deep listening, (2) free exchange of ideas, and (3) consideration of actions based on those ideas.

Our Values:

- Practice **deep listening**: Listen to learn, listen to understand, and listen without judgement.
- Be **strategic**: Leveraging community and financial resources, respond to opportunities expediently, plan for long-term impact.
- Recognize and support community resilience: Encourage healthy communities to work collectively for greater impact, acknowledge historical trauma, **self-determination.**
- Promote community voice in all decision making: **Respect**/ honor individual expertise about their needs and solutions; focus on strengths and aspirations.
- Act with transparency: Make the purpose, expectations, and impacts of stakeholder participation explicit.
- Be **inclusive**: Commit to diverse multicultural and unserved, underserved, and inappropriately served populations, Share responsibility and accountability.
- Utilize the MHSA principles as foundational guidance.

[3] CPP Workgroup definition: accumulation of listening to marginalized voices, developing increased awareness, creating new beliefs, and demonstrating new behaviors over a period of time.

- Build capacity of community members: advocate for meaningful stakeholder participation, promote public education and training in CPP activities.
- Conduct multiple methods of outreach: Dedicate efforts to increase accessibility.

Goals

1) Expand and strengthen the community's knowledge of the public mental health system—specifically MHSA scope, funded programs, and services.
2) Expand and strengthen community partnerships and relationships with diverse representation.
3) Expand and strengthen partnership and relationships with consumers and family members.
4) Increase the engagement of community representatives in existing and emerging CPP opportunities.

Key Actions for FY 2022-2023

- Refine objectives and messaging of CPP.
- Expand the list of stakeholders to increase diversity.
- Support and improve existing opportunities for community engagement.
- Identify and define additional opportunities for community engagement and input.
- Develop community relationships, build, and expand network.
- Develop outreach toolkit (skills, resources, and workbook: Include Dialogue and Appreciative Inquiry, TING) (See Appendix).
- Host outreach and education events.
- Conduct a series of community focus groups with trained co-facilitators from the communities we seek to engage.

CPP Strategic Action Plan

Objective	Action	Partners	Resources	Timeline
Prepare for Outreach and Education campaign to inform the community about MHSA and opportunities for community participation to promote system transformation and value the expertise of community members	● Develop outreach materials (English/Spanish) ● Develop educational materials (English/Spanish) ● Refine and expand stakeholder list ● Develop outreach plan to include social media, radio/TV, print and public presentations	MHSA PEI contractors, MHSA Steering Committee, media partners	Consultant team to support development and implementation of outreach and engagement plan	June 2022 – August 2022
Identify organizations for new partnerships, community participation and outreach	● Develop list of organizations to explore partnerships: NAMI, Health Action leadership and all local chapters, Sonoma Connect, CHW CARES Act funding, IOLERO, NBOP, Graton Day Labor Center, Homeless Action, SAVS, Housing is Healthcare Collaborative, School and Church-based events, Peer programs, Disability Service and Legal Center	Recruit additional champions for workgroup that represent diversity in community, bi-lingual Spanish, other languages?	Workgroup brainstorming session	July-August 2022

Objective	Action	Partners	Resources	Timeline
Conduct Outreach and Education Campaign	● Host a minimum of five events in accessible virtual or geographic locations. ● Explore public radio, TV, and newsprint interviews in collaboration with County PIO.	County PIO, media outlets, diverse Community Based Organizations (CBO) to host outreach and education events	Consultant team and County PIO to secure locations, set up interviews. Coordinate with CPP workgroup members.	October-November 2022
Prepare for community listening sessions (Collecting data/input)	● Define objectives: o Data that contributes to the needed changes for system of care. ● Recruit community members to help develop listening session protocols and questions. ● Train community members on facilitation and reflective listening. ● Draft questions and review with community. ● Establish locations/virtual platforms. ● Advertise for community participation.	MHSA PEI contractors, Community Partners	Stipend for training community co-facilitators. Cost of materials. Paid advertising. Consultant team to provide support and guidance.	November-December 2022

Objective	Action	Partners	Resources	Timeline
Conduct community listening sessions	● Conduct up to 12 community listening sessions.	Community partners, community co-facilitators	Stipend for co-facilitators and recorders. Rental of space, food, stipends for attendees.	November 2022-January 2023
Publish results from Community Listening Sessions	● Draft findings. ● Review findings with co-facilitators and other stakeholders. ● Finalize report. ● Distribute report and present at various meetings	MHSA contractors, stakeholder groups, Mental Health Board, Board of Supervisors, public forums	Paid consultant to draft findings from focus groups. Review findings with CPP workgroup.	February-March 2023

Appendix of Supporting Materials for CPP Workplan

Community Outreach Toolkit/Workbook

Community Engagement Spectrum

INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
Provide residents with info and assist in understanding problems, alternatives, and solutions.	Obtain public feedback on analysis, alternatives, and decisions.	Work directly with residents and consistently consider their concerns and aspirations.	Partner with residents in decision-making, including in identification of solutions.	Residents are making decisions and leading solution-based efforts.

Deep Listening

Deep Listening, what is it: levels of listening (Video)

We have many opportunities to listen to people on a daily basis but to what degree are we truly listening? What opportunities can present themselves when we do?

Inspired by the thinking of Otto Scharmer, we can break listening down into **four levels:** inner chatter, factual, empathic, and generative. The further down we go, the more powerful our conversations become and the more impact we can have.

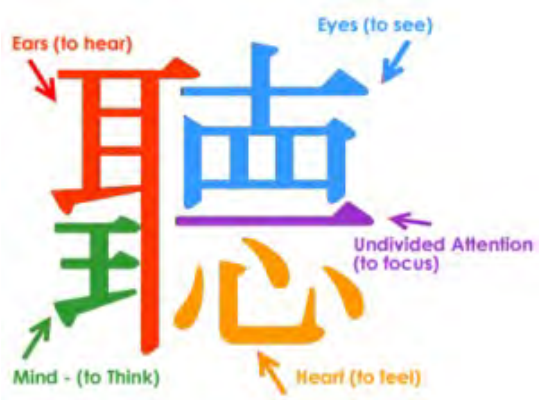
1. **Level 1** – *Inner chatter* - At this level we're more focused on listening to ourselves; our monkey brain takes over and we're really thinking about other things than the conversation. At best, we are only picking up information which confirms what we know already.

2. **Level 2** – *Factual Listening* - Here we find the factual level of listening where we focus on the facts being stated in the conversation. It allows us to listen to new information with an open mind and change our opinions and views about a subject.
3. **Level 3** – *Empathic Listening* - We have the emotional story. This is where we go beyond ourselves and see the world through the eyes of the other which opens up more perspectives. To be at this level, it helps if we pay attention to congruence between the words and the way they are said.
4. **Level 4** - *Generative Listening* - This is the deepest level of listening where we are able to connect with the narrator in a safe, optimistic, forward-looking manner—thereby opening up a wider field of possibilities.

Improving your listening is possible. Try these tips:

- Use mindfulness to calm the inner chatter in level 1.
- Letting go of your agenda will help you move to Level 2 and 3.
- Asking "what if" questions will help you get to Level 4.

So, on what level of listening do you find yourself most often? Where do you aspire to be? And what steps will you take to get there?



"TING"

- Listening with **ears** - two ears, one mouth listen twice as much as talking.
- Listen with **eyes**—take note of body language and context: nonverbal communication is 70%.
- Undivided **attention**—focus on the person you are listening to; quiet any internal and external distractions.
- Listen with your **mind**—be engaged.
- Listen with your **heart**—feel the emotion of the person you are listening to. Be aware of the emotional reaction in yourself in response to what they are saying.

The seven skills of dialogue are

1. Deep listening
2. Respecting others
3. Inquiry
4. Voicing openly
5. Balancing advocacy and inquiry
6. Suspending assumptions & judgements
7. Reflecting

Appreciative Inquiry

Introduction to Appreciative Inquiry

Ap-pre'ci-ate, v. 1. valuing; the act of recognizing the best in people or the world around us; affirming past and present strengths, successes, and potentials; to perceive those things that give life (health, vitality, excellence) to living systems 2. to increase in value, e.g., the economy has appreciated in value. Synonyms: VALUING, PRIZING, ESTEEMING, and HONORING.

In-quire' (kwir), v., 1. the act of exploration and discovery. 2. To ask questions; to be open to seeing new potentials and possibilities. Synonyms: DISCOVERY, SEARCH, and SYSTEMATIC EXPLORATION, STUDY.

Appreciative Inquiry

The Core Principles of Appreciative Inquiry, which describe the basic tenets of the underlying AI philosophy, were developed in the early 1990's by David Cooperrider and Suresh Srivastva (Cooperrider's advisor at Case Western Reserve University) and serve as the building blocks for all AI work. The five original principles are: Constructionist, Simultaneity, Anticipatory, Poetic, and Positive.

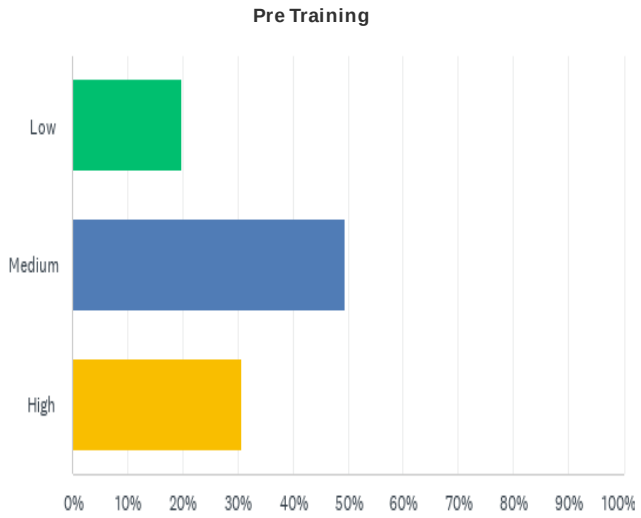
Appendix 6 – SRJC QPR Outcomes Report FY 20-21

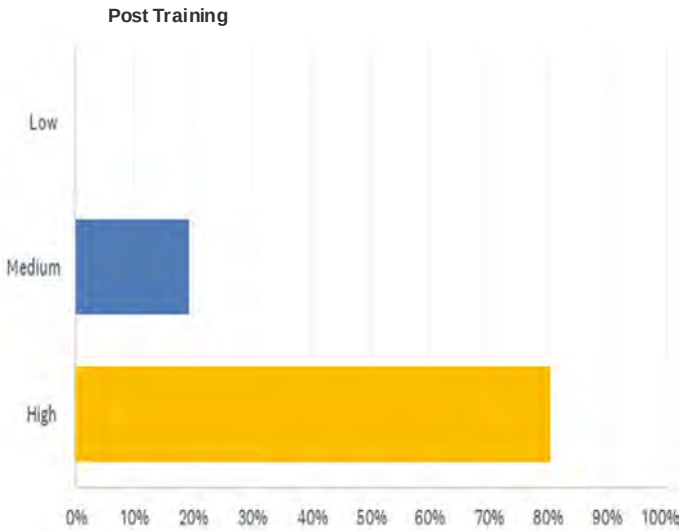
WELLNESS • RECOVERY • RESILIENCE

SRJC QPR Outcome Data 2020-2021

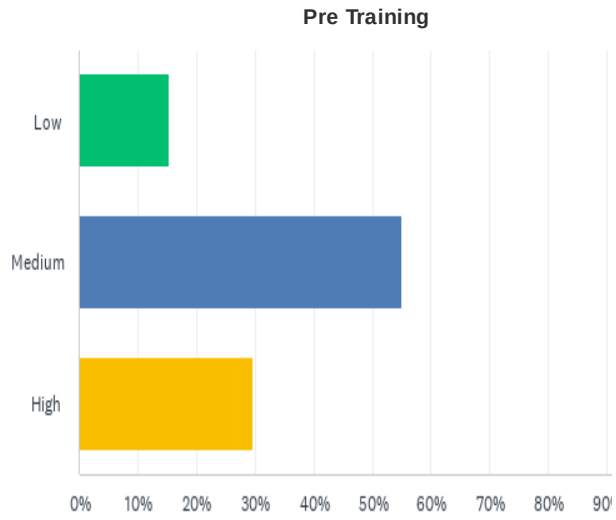
Powered by

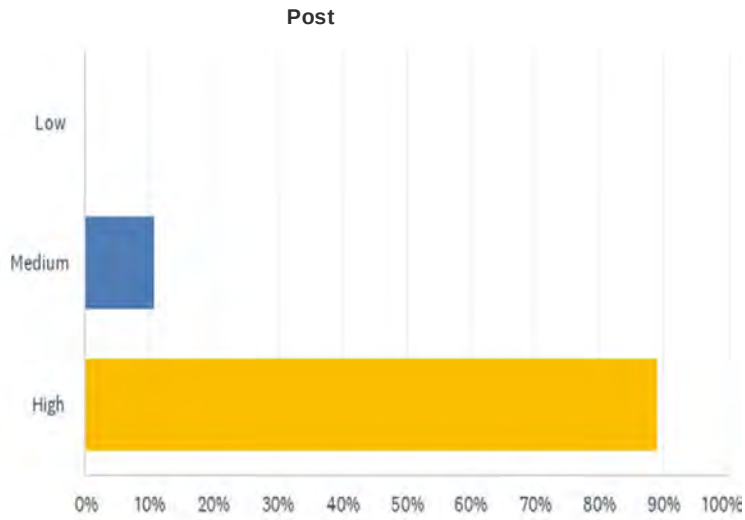
How would you rate your knowledge of suicide in the following area?
Facts concerning suicide prevention:





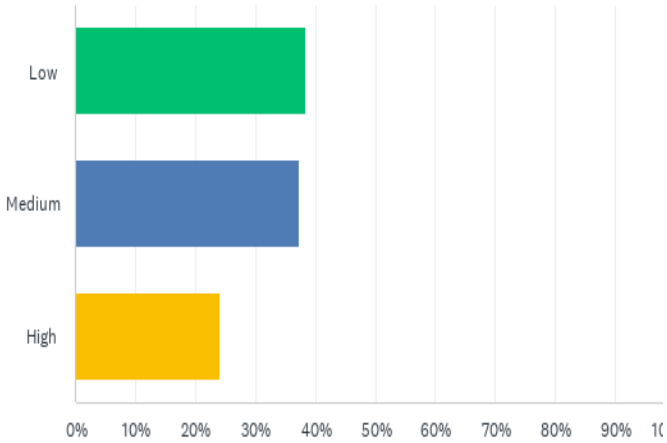
How would you rate your knowledge of suicide in the following area? Warning signs of suicide:



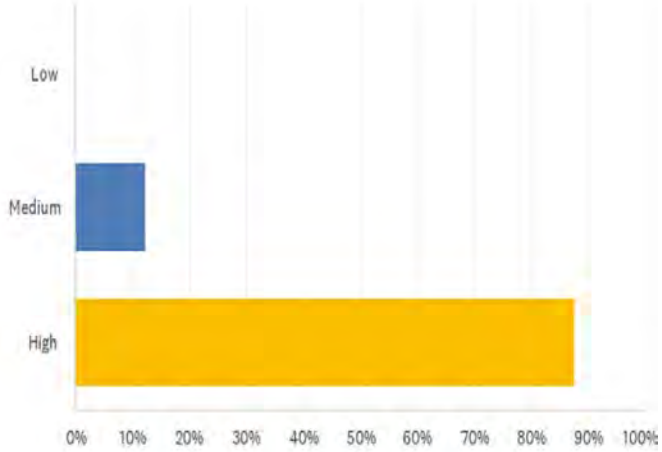


How would you rate your knowledge of suicide in the following area? How to ask someone about suicide:

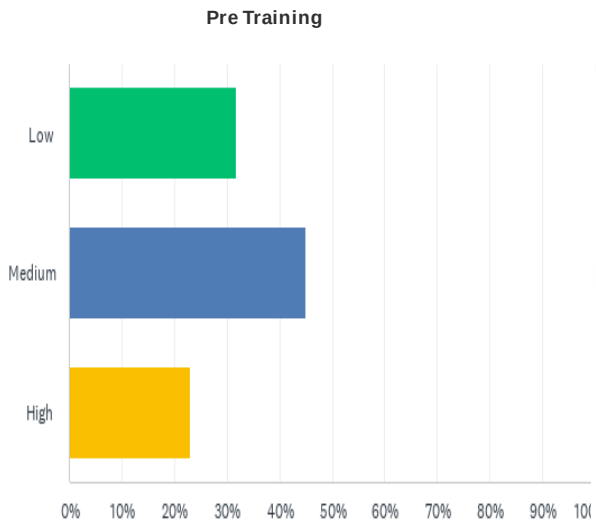
Pre Training

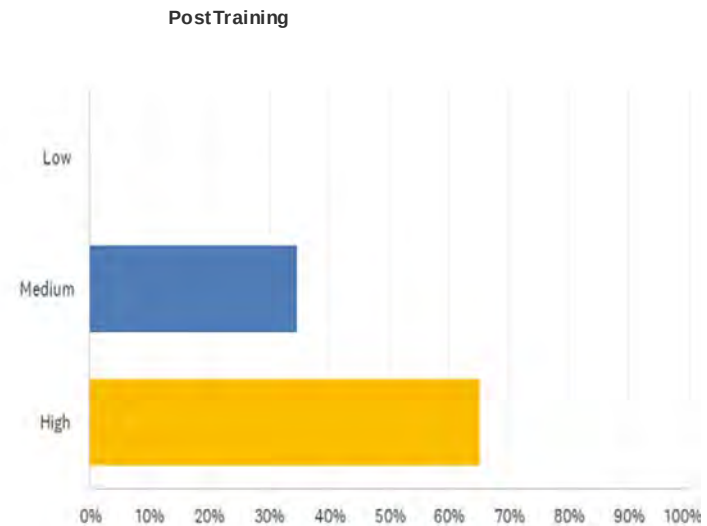


Post Training

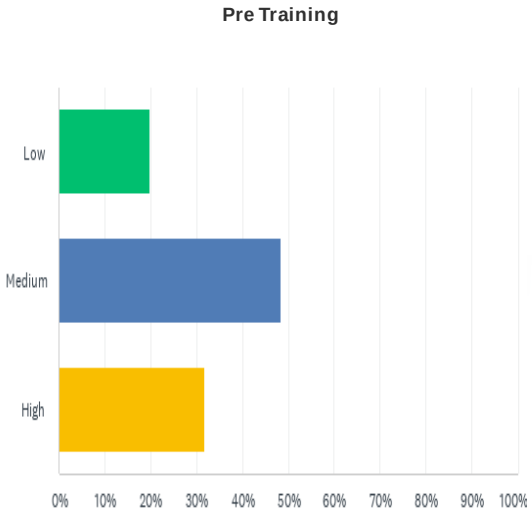


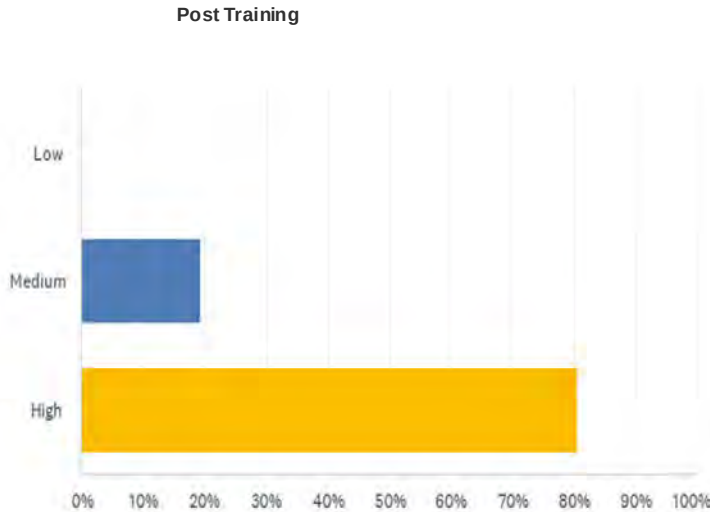
How would you rate your knowledge of suicide in the following area? Persuading someone to get help:



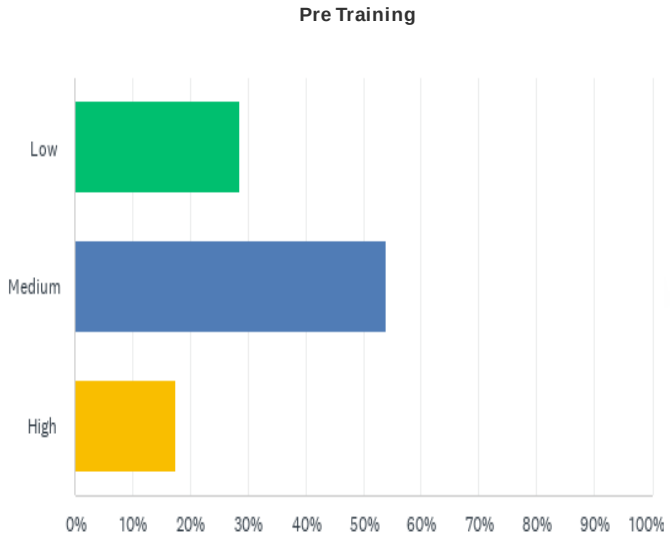


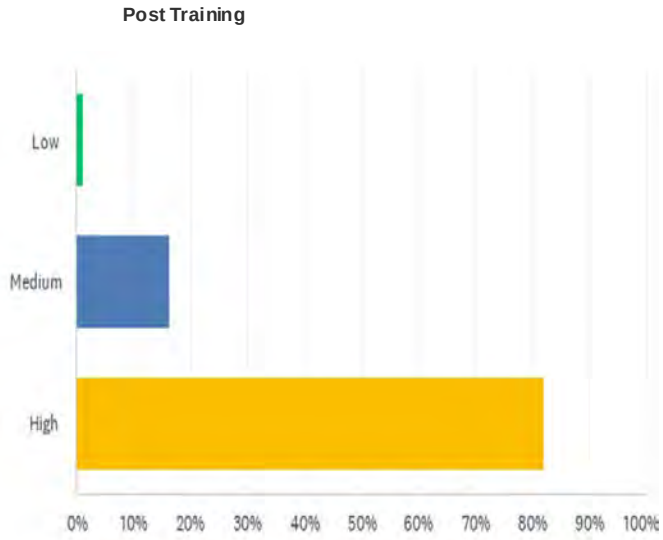
How would you rate your knowledge of suicide in the following area? How to get help for someone:



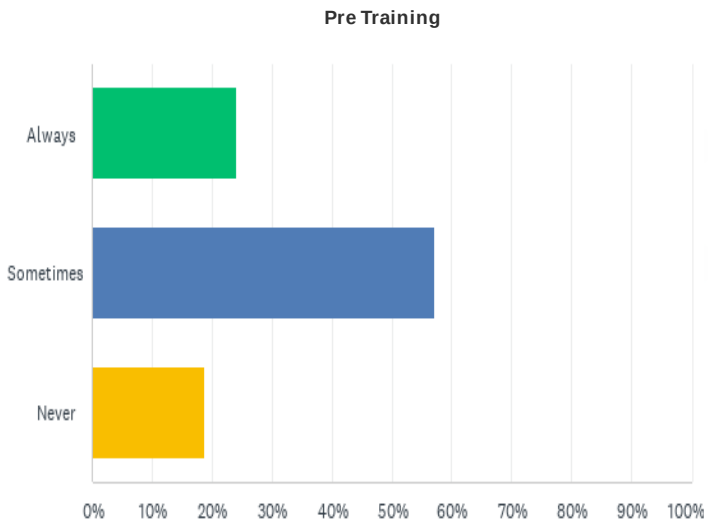


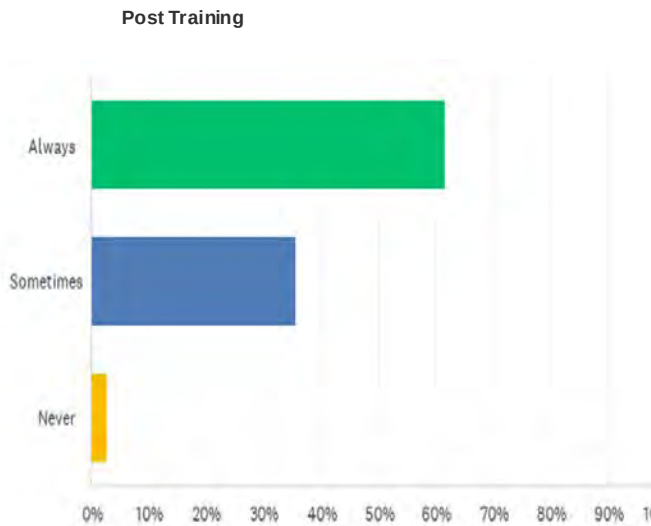
How would you rate your knowledge of suicide in the following area? Information about local resources for help with suicide:



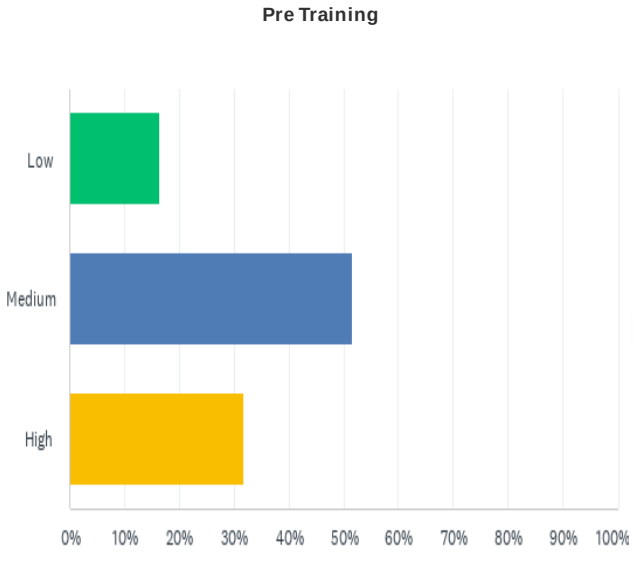


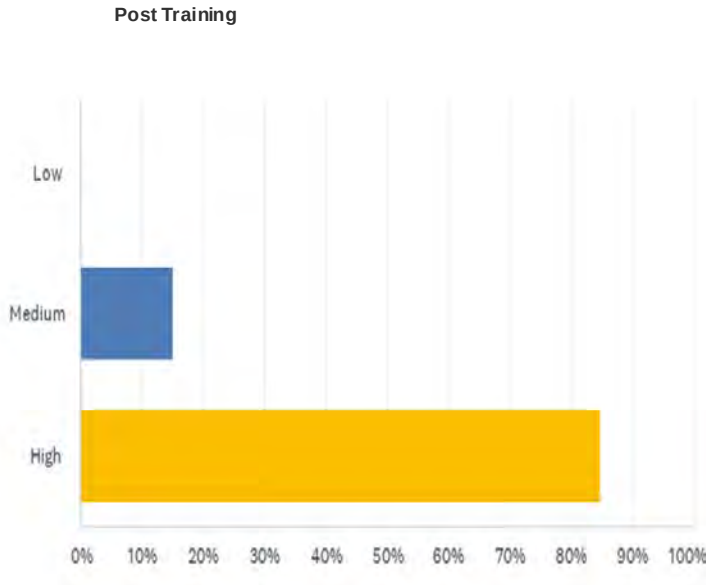
Do you feel likely to ask someone if they are thinking of suicide?



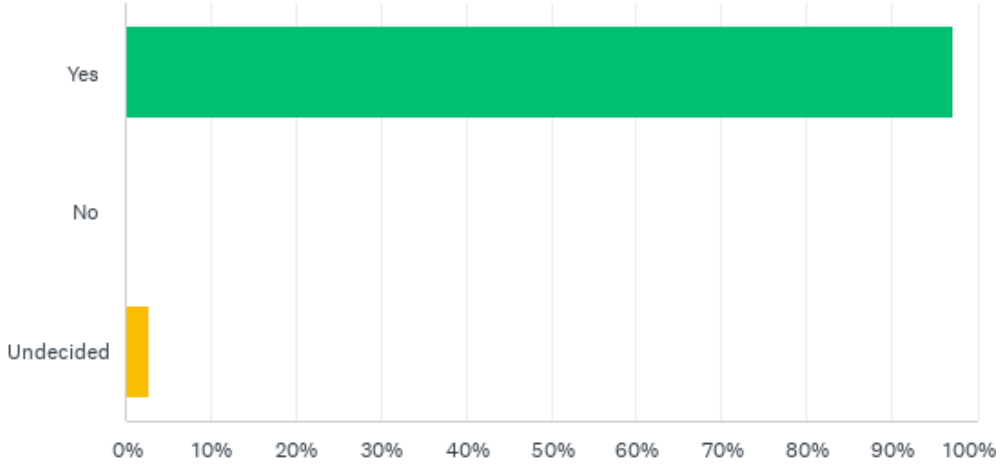


Please rate your level of understanding about suicide and suicide prevention:





Would you recommend QPR training to other?



Appendix 7 – SRJC Event Flyers

WELLNESS • RECOVERY • RESILIENCE


The PEERS Coalition presents
The Many Faces of Mental Health
INTRODUCING THE PANELISTS:
TAMMY SAKANASHI
SRJC
DEAN, HEALTH SCIENCES
APASS CO-COORDINATOR
BRIJIDA ALEMÁN
SRJC SPS
PSYCHOTHERAPIST
DEAN HOAGLIN
SONOMA COUNTY INDIAN HEALTH PROJECT, COMMUNITY OUTREACH SPECIALIST
COREY TIMBERLAKE
SRJC SPS
PSYCHOTHERAPIST
JESSIE HANKINS
LGBTQ CONNECTIONS, PROGRAM AND EVALUATION MANAGER
SRJC STUDENT HEALTH SERVICES
PEERS COALITION

PEERS Coalition invites you

Mental Health: Motivation and success

Panel discussion with teachers, students, therapists talking about tips and tricks about how to keep your motivation up and the effects of loss of motivation on your mental health

Are you feeling stress/anxious due to (but not limited to):

- [x] Covid
- [x] Virtual classes
- [x] post-fires
- [x] work

When: Wednesday December 2nd

Time: 5-7pm

Zoom ID: 995 4597 5676

SRJC STUDENT HEALTH SERVICES
PEERS COALITION

Mental Health through a Cultural Lens

BLACK HISTORY MONTH

P.E.E.R.S Invites You:

Discussion on Stigma and Obstacles in the Black community

THURSDAY FEBRUARY 25TH
TIME 4PM TO 6PM

Panelists :

New SRJC therapists:

Nadine Henley, LCSW

Dr.Corey Timberlake PhD

BSU student members

ZOOM ID: 961 2274 7330
Q&A, PRIZES, AND MORE!

SRJC Black Student Union

SRJC STUDENT HEALTH SERVICES
PEERS COALITION

STUDENT HEALTH PEERS PRESENTS:

THE "S" WORD

FILM SCREENING AND DISCUSSION

A suicide attempt survivor is on a mission to find fellow survivors and document their stories of unguarded courage, insight, pain, and humor.

Suicide

Suicide alone is not the problem, it is the deafening silence that surrounds it.

Date / Time

Date: Wednesday, October 28
Time: 5:00pm - 7:00pm

Prevention

By helping to reduce pain and increase hope we can help prevent suicide.

Disclaimer:

This film mentions topics that can be triggering. We will have Mental Health Professional and resources available for any questions.

Zoom ID: 919 7958 7046

(closed captioning will be available)

SRJC STUDENT HEALTH SERVICES
PEERS COALITION

Appendix 8 – FY 20-21 DHS-BHD Trainings

WELLNESS • RECOVERY • RESILIENCE

FY 20-21 Behavioral Health Trainings

DATE	*TITLE*	*TIME*	*PRESENTER(S)*	*AUDIENCE*
Aug 12, 2020	Professional Resiliency	2.0	Meghan Murphy, ASW	*Recommended for all SCBH Staff*
Aug 18, 2020	5150 – Review of 5150's and Other Legal Holds in Mental Health	2.0	Bill SmithWaters & Frank SmithWaters; SmithWaters Group	*SCBH Clinical Staff*
Sep 2, 2020	5150 – Review of 5150's and Other Legal Holds in Mental Health	2.0	Bill SmithWaters & Frank SmithWaters; SmithWaters Group	*SCBH Clinical Staff*
Sep 4, 2020	5150 – Review of 5150's and Other Legal Holds in Mental Health	2.0	Bill SmithWaters & Frank SmithWaters; SmithWaters Group	*Staff at Auroro*
Sep 9, 2020	MHSA Issue Resolution	1.0	Melissa Ladrech, LMFT	*SCBH Staff and Contractors in MHSA funded programs*
Sep 10. 2020	MHSA Issue Resolution	1.0	Melissa Ladrech, LMFT	*SCBH Staff and Contractors in MHSA funded programs*
Sep 24, 2020	5150 – Review of 5150's and Other Legal Holds in Mental Health	2.0	Bill SmithWaters & Frank SmithWaters; SmithWaters Group	*Staff at Kaiser, Sutter, Seneca, SCBH*
Dec 3, 2020	5150 – Review of 5150's and Other Legal Holds in Mental Health	2.0	Bill SmithWaters & Frank SmithWaters; SmithWaters Group	*Staff at SCBH, Kaiser, Telecare/ACT, Wellpath*
Jan 7, 2021	5150 – Review of 5150's and Other Legal Holds in Mental Health	2.0	Bill SmithWaters & Frank SmithWaters; SmithWaters Group	*Staff at SCHC, Wellpath, Sutter, Buckelew*
Jan 13, 2021	We Are Resilient™ by Dovetail Learning (part 1)	1.5	Bryan Clement, MEd, Dovetail Learning	*SCBH Staff*
Jan 20, 2021	We Are Resilient™ by Dovetail Learning (part 2)	1.5	Bryan Clement, MEd, Dovetail Learning	*SCBH Staff*
Jan 28, 2021	5150 – Review of 5150's and Other Legal Holds in Mental Health	2.0	Bill SmithWaters & Frank SmithWaters; SmithWaters Group	*Sonoma Valley Hospital ER Doctors*
Feb 10, 2021	Law & Ethics	3.0	Linda Garrett	*SCBH Staff*
Mar 10, 2021	Topic – LGBTQ+ Cultural Competency	2.0	Jessica Carroll, Maxwell Anderson, Mell Browning	*SCBH Staff*
Apr 14, 2021	Panaptic- Cannabis Use & Mental Health: A Review of Current Research and Strategies for Brief Intervention	2.0	Sarah Ferrano Cunningham, PsyD; Richard Von Feldt, PsyD	*SCBH Staff*
Apr 15, 2021	5150 – Review of 5150's and Other Legal Holds in Mental Health	2.5	Bill SmithWaters & Frank SmithWaters; SmithWaters Group	*Aurora*
April 27/29, 2021	AMSR: Assessing & Managing Suicide Risk	6.5	Melissa Ladrech, LMFT: Serina Sanchez LMFT	*SCBH Staff*
Apr 28, 2021	5150 – Review of 5150's and Other Legal Holds in Mental Health	2.0	Bill SmithWaters & Frank SmithWaters; SmithWaters Group	*SCBH, Healdsburg District Hospital*

May 5/7, 2021	AMSR: Assessing & Managing Suicide Risk	6.5	Melissa Ladrech, LMFT: Serina Sanchez LMFT	*SCBH Staff*
May 6, 2021	5150 – Review of 5150's and Other Legal Holds in Mental Health	2.5	Bill SmithWaters & Frank SmithWaters; SmithWaters Group	*Aurora*
May 19, 2021	5150 – Review of 5150's and Other Legal Holds in Mental Health	2.0	Bill SmithWaters & Frank SmithWaters; SmithWaters Group	*SCBH, Wellpath, Sutter. Kaiser*
May 19, 2021	AMSR: Assessing & Managing Suicide Risk	6.5	Melissa Ladrech, LMFT	*SCBH Staff*