CONNECTION IS PREVENTION

SONOMA COUNTY MENTAL HEALTH SERVICES ACT (MHSA) DRAFT FY 2024-2025 ANNUAL PLAN UPDATE WITH FY 2022-2023 PROGRAM REPORT

MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA

WELLNESS · RECOVERY · RESILIENCE

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

TABLE OF CONTENTS

County Compliance Certification **4**

County Fiscal Accountability Certification **5**

Message from the Behavioral Health Director **6**

Meet Our MHSA Team **7**

Executive Summary **8**

Purpose of this Document 8

History of MHSA 8

The Five Components of MHSA 10

FY 24-25 MHSA Changes and Impacts 11

Introduction 13

Description of Sonoma County 13

Medi-Cal Beneficiaries and Threshold Languages 15

Community Program Planning Process (CPPP) **16**

Community Program Planning 16

MHSA Steering Committee 17

Community Program Planning Workgroup 18

CPP Listening Sessions 20

Stakeholder Participation 25

Life Worth Living: Suicide Prevention Alliance 30

Additional Stakeholder Outreach 34

The Public Review and Public Hearing Process 35

Sonoma County's FY 2024 – 2025 Three Year Program Plan Update **37**

MHSA and Prop 1: Behavioral Health Services Act 37

Expanded Medi-Cal Mobile Crisis 39

Significant Changes for FY 24-25 40

The Community Services and Support (CSS) Plan for FY 24-25 40

Prevention and Early Intervention (PEI) Plan for FY 24-25 44

Innovation (INN) Plan for FY 24-25 46

Workforce, Education and Training (WET) Plan for FY 24-25 54

TABLE OF CONTENTS

Capital Facilities and Technological Needs (CFTN) Plan for FY 24-25 58

No Place Like Home 59

No Place Like Home (NPLH) Background 59

Population to be Served 60

NPLH in Sonoma County 60

MHSA Expenditure Plan 63

Sonoma County's FY 2024 – 2025 MHSA Expenditure Plan 63

Sonoma County's FY 2021-2022 MHSA Program Report 64

FY 2022-2023 Community Services and Support (CSS) Programs Report 73

Full Service Partnership Programs (FSPs) 103

General Systems Development (GSD) Programs 115

Outreach and Engagement (OE) Programs 140

Sonoma County Annual PEI Report FY 2022-2023 145

Prevention Programs 146

Early Intervention Programs 155

Prevention & Early Intervention Programs 160

Stigma and Discrimination Reduction 165

Access and Linkage to Treatment Programs 170

Suicide Prevention Programs 175

Outreach for Increasing Recognition of Early Signs of Mental Illness 178

FY 2022-2023 Innovation (INN) Project Report 179

FY 2022-2023 Workforce, Education and Training (WET) Program Report 188

FY 2022-2023 Capital Facilities and Technological Needs (CFTN) Report 197

Appendices 199

FY 22-23 Annual MHSA Innovation Reports 200

TABLE OF CONTENTS

FY 22-23 Annual Innovation Report: Instructions Not Included: Dads Matter 318

FY 22-23 Annual Innovation Report: Nuestra Cultura Cura 318

FY 22-23 Annual Innovation Report: Unidos Por Nuestro Bienestar 424

FY 22-23 Annual Innovation Report: New Parent TLC 401

FY 22-23 Annual Innovation Report: Early Psychosis Learning Health Care Network 407

FY 22-23 Annual Innovation Report: Sonoma County Electronic Health Record 424

Santa Rosa Junior College QPR Report 444

FY 22-23 Sonoma MHSA Community Program Planning Listening Sessions Report.....523

FY 22-23 MHSA Sonoma Newsletters.....529

May is Mental Health Month 2023 Events Calendar.....539

May is Mental Health Month 2023 Event Flyers.....539

Suicide Prevention Month 2023 Events Calendar.....539

Suicide Prevention Month 2023 Event Flyers 539

Remembrance Day Event Flyers.....539

Sonoma County CalMHSA's Impact Statement for FY 22-23 539

Remembrance Day Event Flyers.....539

2023 Sonoma County Cultural Competency Plan 539

Draft Sonoma County Suicide Prevention Strategic Plan 539

Intentionally left blank

County Fiscal Accountability Certification

Intentionally left blank

MESSAGE FROM THE BEHAVIORAL HEALTH DIRECTOR

Dear MHSA Community Members and Supporters,

I would like to welcome you to Sonoma County Behavioral Health Services Division's Mental Health Services Act (MHSA) Annual Program and Expenditure Plan update for FY 2024—2025. Fiscal year 2024-2025 will mark the second year of our current MHSA Three-Year Plan, FY 2023 to 2026. This annual update embodies the vision, promotes the activities, and shares the outcomes of programs initiated in the Three-Year Plan as well as introduces several new projects we plan to provide to the community.

My heartfelt thanks to all who have contributed to and participated in our Community Planning Process and numerous stakeholder group meetings. Working together we will build healthy, resilient, and responsive systems of care that support our clients, families, and our staff.

Sonoma County is recovering from a series of traumas experienced over the past several years, including devastating fires and floods as well as a global COVID pandemic. Our workforce and the community we serve have been impacted. As we work to rebuild and heal our communities, the need for Behavioral Health (BH) services has increased in parallel and, in spite of our workforce challenges, BH staff have continued to provide outstanding service and supports to our clients and their families. Embodying the transformational recovery philosophy of MHSA, our programs continue to provide accessible, community-based mental health services to all our clients.

There is still plenty of work to do. We need to continue to strengthen and expand our networks of care to continue to serve our most vulnerable clients, repair our traumatized system, and build a community of practice and healing. Our commitment to trauma informed care threads through this annual update as we prioritize system transformation with initiatives begun in the first year of the Three Year Plan:

- We are increasing staffing at critical access and entry points in our system of care.
- We are implementing the building blocks of a comprehensive training program for staff and contractors which will improve our skills and the services we provide our clients.
- We continue to build out a continuum of housing supports for our most vulnerable clients.

Some new initiatives you will find in this annual update:

- We are planning to add a Homeless Services FSP with Housing Supports in an effort to expand our supports for unhoused BH clients.
- Our Life Worth Living Suicide Prevention Coalition has been working diligently to develop a Suicide Prevention Strategic Plan. We are proud to share this with the community and we hope you find it a helpful, meaningful, healing map for the community to implement to help build connections and lives worth living.
- Including the wisdom of lived experience in the services we provide, we plan to develop Peer and Family Support Services who will work with the new Behavioral Health School Partnership Program.

This plan embodies the spirit of BHSA: wellness, collaboration, recovery, and healing practices. I am deeply grateful for the supports that BHSA provides our communities and for all the work that all of you do. Together we can build healthy resilient caring, and safe communities and restore wellness to our system.

Warm regards,

Jan Cobaleda-Kegler
BH Division Director

Melissa Ladrech
MHSA Coordinator

Fabiola Espinosa
MHSA Analyst

Meet Our Team
MHSA SONOMA

Lisa Nosal
Cultural Responsiveness,
Inclusion & Training Coordinator

Iridian Onofre
Senior Office Assistant

EXECUTIVE SUMMARY

PURPOSE OF THIS DOCUMENT

As per the California Welfare and Institutions Code (WIC) Title 9, Section 3310 the Sonoma County 2024-2025 Mental Health Services Act (MHSA) Annual Update Plan provides stakeholders with:

- The Annual Update and Expenditure Plan for Fiscal Year (FY) 2024-2025.
- The Annual Program Report for FY 22-23 includes the activities, services, program descriptions and outcomes of the programs funded through MHSA for FY 22-23.

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 24-25, it is estimated that over $3 billion in MHSA funds will be collected statewide, and it is estimated that Sonoma County will receive over $30 million. MHSA funds are not guaranteed, and the amount of MHSA funds that the County of Sonoma Department of Health Services Behavioral Health Division (DHS-BHD) receives varies each year.

WELLNESS • RECOVERY • RESILIENCE

In 2024 Governor Newsome spear headed efforts to modernize MHSA. California voters passed Proposition 1: Behavioral Health Services Act (BHSA), in March 2024. Sonoma County is working in partnership with the state to implement BHSA. The law dictates that major changes will be phased in over several years, and the County has started to work with stakeholders to ensure that the changes will successfully serve our clients.

Proposition 1 has two major components:

1. Changes the Mental Health Services Act (MHSA) that was passed by voters in 2004, with a focus on how the money from the Act can be used. The new funding allocations become effective July 1, 2026.

    - Prop 1 makes no changes to the amount of money collected through the MHSA (now BHSA) tax, but the money would be used differently.

- Prop 1 will change how counties can use BHSA dollars to allow counties to use the funds to treat substance use disorders.

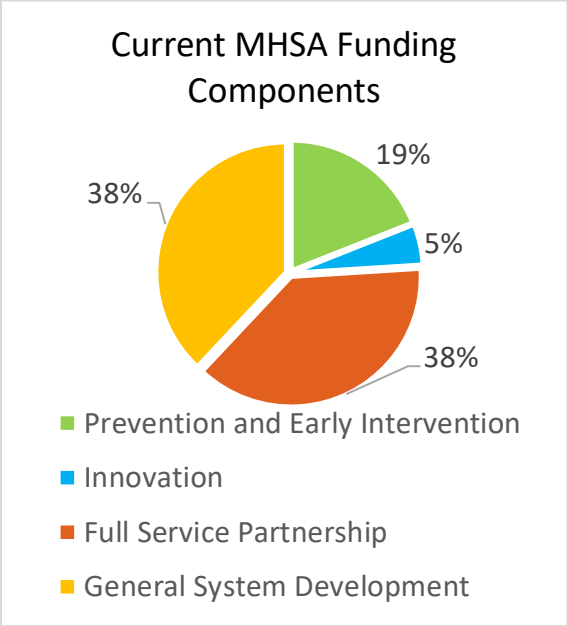
- BHSA creates a new requirement that 30% of funds allocated Sonoma County must be spent on housing interventions for people with behavioral health challenges.

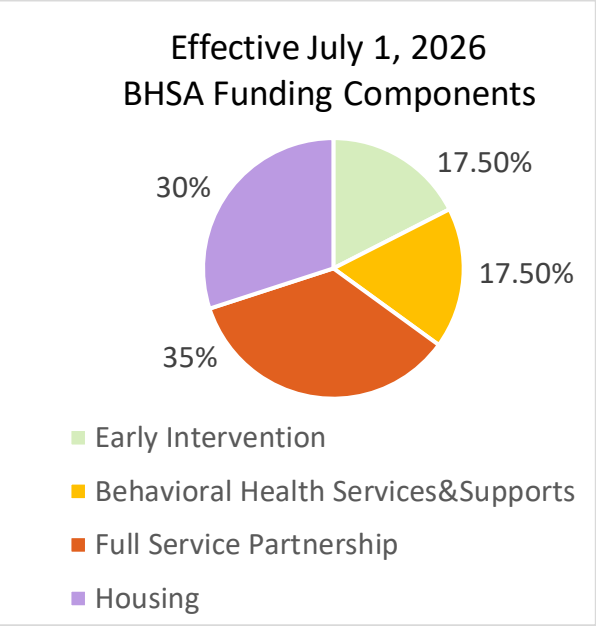
- Counties will not receive additional funding under Prop 1 for services previously funded by MHSA; therefore, less money will be available for non-housing services under BHSA. There will be fewer resources for prevention programs, outpatient mental health treatment, and outreach efforts.

2. Approves a $6.4 billion bond to build more places for mental health care and drug or alcohol treatment and more housing for people with mental health, drug, or alcohol challenges.

Bond funding will finance the building of new bricks and mortar infrastructure to house and treat county behavioral health clients. Many of Sonoma County's behavioral health clients are receiving treatment despite not having permanent housing or shelter, and being able to provide more of our clients a safe space to live while they receive treatment is a welcome opportunity to build on the many paths to recovery.

The charts below illustrate the funding components of MHSA and BHSA:





For FY 2024-2025 the county will continue to implement the current MHSA regulations. 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 that 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 clients with the most serious mental health impairments. *(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.

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.

[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.

Capital Facilities and Technological Needs (CFTN)[2]
Provides funding for building projects and increasing technological capacity to improve mental health service delivery.

DRAFT FY 24-25 MHSA CHANGES & IMPACTS

The following table highlights additions and substantial changes to MHSA funded programs from the FY 23-26 Three-Year Program Plan and Expenditure Plan (FY 23-26 Three-Year Plan) to the FY 24-25 Plan Update and Expenditure Plan (FY 24-25 Plan Update).

Draft FY 24-25 MHSA Changes and Impacts

Changes	Impacts
Community Services and Supports	
Full Service Partnership (FSP)teams: The FSP teams provide wrap-around services to clients in our system of care with the most serious mental health impairments and the majority of the Community Services and Supports funds must be allocated to the FSP teams.	
Full Service Partnership (FSP) Team for Unhoused Adults: This FSP will serve adults who are homeless or at risk of being homeless with serious mental health challenges. This program is budgeted at $1,700,000 annually.	The addition of this FSP team will provide wrap around, intensive recovery oriented behavioral health services and housing support for 75 individuals. The FSP team will collaborate with clients to attain the client's goals.
General System Development	
Project-Based Housing: The Behavioral Health Division will transfer General System Development funds to the Department of Health Services, Homelessness Services Division which is Sonoma County's local government housing entity. The funds will be used to renovate an unused dormitory at Los Guilicos. This renovation is a onetime expense that is budgeted at $2,300,000.	This renovated dormitory will provide permanent supported housing for a total of 40-65 Transition Age Youth (18-25 year olds) and adult Full Service Partnership clients.
Prevention and Early Intervention (PEI)	
Peer and Family Support Services will work in conjunction with the new Behavioral Health School Partnership program. Funding the Peer and Family Support Services of this program is budgeted at $200,000 annually.	The Peer and Family Support Services is an Early Intervention program that will support 50-100 young people in accessing peer support from available community organizations, provide a safe space to talk about mental health symptoms in a non-judgmental setting, assist youth in learning about available options for treatment, if desired, and assist youth in navigating mental health treatment systems.

Seneca WRAP Program: Seneca WRAP Program: This Early Intervention program will provide services for children and youth who are involved in foster care, the juvenile justice system, and/or who are at risk of out of home placement or psychiatric hospitalization. MHSA will provide $500,000 annually for this program.	The addition of this Seneca WRAP program will serve 73 children (0-15 years old) and 32 youth (16-25 year olds). The program encourages coordination among agencies, disciplines, and communities to enhance outcomes for youth and families. WRAP services aim to prevent children and youth from going to higher levels of care by increasing resilience and recovery, teaching positive coping skills to youth, and improving caregiver ability to successfully support the youth in their care. WRAP services are designed to be short term, intensive interventions lasting 6 – 12 months.

Photo above: from May 2024's May is Mental Health Matters Month Healing Circle event in Healdsburg, CA

INTRODUCTION

DESCRIPTION OF SONOMA COUNTY

Sonoma County which is located in the San Francisco Bay Area, approximately 50 miles north of San Francisco The estimated population is 481,812[3]. This is a decrease of 1.4% since the confirmed census count of 2020. A medium, urban-rural county of 1,576 square miles with 76 miles of Pacific Ocean coastline, Sonoma County is known for its Mediterranean climate that supports an agricultural industry including vineyards producing world class wine. The County's

major industries listed by highest number of civilians employed are: healthcare and social assistance, retail trade, and manufacturing.[4] The top employers are Kaiser Permanente, Sutter Medical Center of Santa Rosa, St. Joseph Health System, and Graton Resort & Casino.

---

[3] US Census, Sonoma County, California. https://www.census.gov/quickfacts/fact/table/sonomacountycalifornia/PST045222

[4] Data USA: Sonoma County, CA. https://datausa.io/profile/geo/sonoma-county-ca#:~:text=In%202021%2C%20Sonoma%20County%2C%20CA,%2491%2C607%2C%20a%206.31%25%20increase.

Santa Rosa is the county's most populous city with 177,181 people (U.S. Census Bureau, 2022 estimate) , and it is home to over one-third of county residents. Santa Rosa is also the County seat, including the offices of the Department of Health Services, Behavioral Health Division's (DHS-BHD) main campus. Beyond Santa Rosa, the major population centers are Petaluma (pop. 58,652) and Rohnert Park (pop. 44,326) to the south, and Windsor to the north (pop. 25,789). (U.S. Census Bureau, 2022 estimates) 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, along the coast and for those without a personal vehicle to access other areas in the county.

In 2022, 60.6% of residents identified as White, non-Hispanic with 28.9% identifying as Hispanic or Latinx, the County's largest and fastest growing minority population.[5] The County's poverty rates vary significantly by ethnicity with disparities affecting the Latinx community in particular. While Hispanic or Latinx residents represented almost 30% of the population, this group accounted for 40% of Sonoma County's Medi-Cal beneficiaries in 2021.[6] Additionally, there are an estimated 27,000 undocumented residents in the County. Of those, 12,000 or 44% are estimated to speak English less than "very well," suggesting possible linguistic isolation for this population.[7] Individuals who are undocumented and/or linguistically isolated experience unique challenges accessing medical, transportation, and social services.

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 only 2.3% of the County's total population and about 1% of Medi-Cal beneficiaries. According to US Census, in 2022 the Asian/Native Hawaiian/Pacific Islander population represented 5.4% of the total population and African American/Blacks represented 2.2%. Although these percentages are relatively small, the diverse culture and language differences can reduce access as well as the quality of services available—particularly for individuals with lower levels of income.

Finally, Sonoma County is aging. The 65+ age group was the fastest growing between 2010 and 2021 with its population increasing from 14% to 21.9% (rate of 55.5% growth). The share of population that is 0-4 years old decreased from 5.8% in 2010 to 4.65 in 2022 as did the 5 – 9 year -old population, from 19% to 16.5% for the same years.[8] This data trend has serious

---

[5] USA Facts, Our Changing Population: Sonoma County, California. https://usafacts.org/data/topics/people-society/population-and-demographics/our-changing-population/state/california/county/sonoma-county/

[6] 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

[7] Profile of the Unauthorized Population, Sonoma County, CA. Migration Policy Institute. https://www.migrationpolicy.org/data/unauthorized-immigrant-population/county/6097

[8] USA Facts, Our Changing Population: Sonoma County, California. https://usafacts.org/data/topics/people-society/population-and-demographics/our-changing-population/state/california/county/sonoma-county/

implications for service delivery needs for the elderly and economic impacts for school districts. The intersectionality of race, age, economics, language spoken, and gender have deep implications on access to housing, services, and healthcare.

Sonoma County's median household income has increased to $99,266 (U.S. Census Bureau, est. 2022), and the percentage of County residents living in poverty has decrease slightly from 9.1% to 8.9% in the past year. The unemployment rate has ticked up a bit in the past year, reported at 4.2% in March 2024 by the Labor Market Information Division, California Employment Development Department.

In 2021, 61.4% of the housing units in Sonoma County were occupied by their owner.[9] The remaining 38.6% of the population has encountered increasing rents over the past five years. Overall, median asking rents in Sonoma County have increased by 20% between 2021 and 2023.[10] This rent burden disproportionately impacts Black and Latino residents.

MEDI-CAL BENEFICIARIES AND THRESHOLD LANGUAGES

In calendar year 2021, the number of people eligible for Medi-Cal in Sonoma County was reported at 129,764 according to the most recent External Quality Report released on FY 2022-23.[11] The report states that 3,227 beneficiaries were served by the Mental Health Plan. However, the overall penetration rate is low, at 2.49% as compared to the statewide average of 4.34%. Examining the penetration rate of those eligible as compared to those served by race/ethnicity are illustrated in the following table:

Race/Ethnicity	Annual Eligible	Beneficiaries Served	PR MHP	PR State
African-American	2,058	108	5.25%	7.64%
Asian/Pacific Islander	4,038	56	1.39%	2.08%
Hispanic/Latino	51,799	665	1.28%	3.74%
Native American	1,260	34	2.70%	6.33%
Other	34,294	1,037	3.02%	4.25%
White	36,315	1,327	3.65%	5.96%
Total	129,764	3,227	2.49%	4.34%

The penetration rate is lower than statewide in every race/ethnicity category. However, there has been a positive upward trend in penetration rate for African-American, Native Americans and Asian/Pacific Islanders since 2020.

The threshold language continues to be Spanish with 33.3% of unduplicated Medi-Cal enrollees in Sonoma County declaring Spanish as their primary language. California's Department of Health Care Services (DHCS) defines "Threshold Language" as a language identified as the primary language, as

[9] ibid
[10] State of Housing in Sonoma County, Generation Housing, 2023.
[11] FY 2022-23 Medi-Cal Specialty Behavioral Health External Quality Review, Sonoma Final Report. Behavioral Health Concepts, Inc. February 2023.

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%
Spanish	43,478	33.3%
Other/Unknown	2,633	2%
Total	130,665	100%

COMMUNITY PROGRAM PLANNING PROCESS

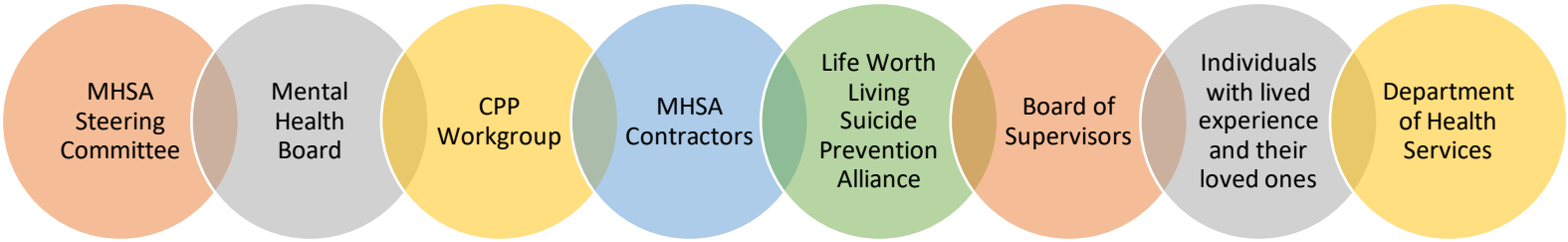
COMMUNITY PROGRAM PLANNING WORKGROUP

Over the years, Sonoma County has refined the system and structure for the Mental Health Services Act (MHSA) Community Program Planning Process (CPPP) as a basis for developing the Three-Year Program and Expenditure Plans, Annual Plan Updates and other MHSA initiatives including Innovation proposals.

This structure is anchored by the MHSA Steering Committee and adheres to the California Code of Regulations (CCR) § 3200.270 and CCR § 3200.300 to ensure that stakeholders reflect the diversity of the county's demographics, including, but not limited to geographic location, age, gender, and race/ethnicity. The CPPP also utilizes the Community Program Planning (CPP) 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.

The chart below illustrates the Stakeholder groups.



MHSA STEERING COMMITTEE

The current composition of the MHSA Steering Committee includes representation from individuals with lived experience, family members, the Mental Health Board, education, health, law enforcement, housing, veterans, 0-5 year olds and their caregivers, transitional age youth, and LGBTQ+.

The Steering Committee has a total of 29 members after conducting a recruitment in 2023. New members are provided in-depth training covering MHSA history and regulations, Sonoma's CPPP, current expenditure plan, MHSA funded programs, and expectations for participation. Sonoma County offers stipends to participants that are not attending meetings as part of their job to encourage full participation.

In FY 2023-2024 the Steering Committee engaged in timely discussions about mental health in the county, assessed the FY 22-23 Listening Session Report, reviewed the Life Worth Living Suicide Prevention Alliance activities, and learned about SB 326: Behavioral Health Services Act.

The MHSA Steering Committee meeting minutes can be found on the Sonoma County Department of Health Services, Behavioral Health Division MHSA website at: https://sonomacounty.ca.gov/health-and-human-services/health-services/divisions/behavioral-health/about-us/mental-health-services-act

MHSA Steering Committee members for 2023-2024 are listed in the table below:

Name	Representation
Allison Murphy	0-5 year olds, mothers and caregivers
Amanda Lopez	Veterans Affairs
Amy Ramirez	Healthcare
Angie Dillon-Shore	First Five (0-5 year olds)
Becky Ennis	Mental Health provider, family member

Christy Davila	Mental Health Provider
Dory Escobar	Community Health Consultant, DEI Expert
Ellisa Reiff	Disabilities
Erika Klohe	Provider, lived mental health experience, family member
Fabiola Espinosa	MHSA Analyst, Family member, Latina
Fletcher Skerrett	Law Enforcement
Jan Cobaleda-Kegler	Behavioral Health Director
Jeane Erlenborn	Education, transition age youth
Julie Kawahara	MHSA Consultant and DEI Expert
Katie Bivin	Youth and Behavioral Health School Partnership
Kathy Smith	Family member
Kimi Barbosa	Positive Images, LGBTQI+
Lisa Nosal	Cultural Responsiveness, Inclusion & Training Coordinator
Mandy Corbin	Education
Maricarmen Reyes	Family member, Latina
Mary-Frances Walsh	Family member, NAMI
Matt Perry	Law Enforcement
Melissa Ladrech	MHSA Coordinator, Family Member
Michael Gause	Ending Homelessness
Michael Johnson	Mental Health Board, lived mental health experience
Michael Schemmel	Law Enforcement, Coroner's Office
Paula Glodowski Valla	Human Services Department
Renee Alger	0–5-year-olds and caregivers, Family member
Robin Phoenix	Lived mental health experience, Homeless Services
Saskia Garcia	Provider, family member, lived mental health experience
Wardell Anderson	Probation, African American

The Steering Committee convened four times in FY 2023-2024. The dates and topics of the meetings are in the chart with all the stakeholder meetings on page XX.

COMMUNITY PROGRAM PLANNING WORKGROUP

A powerful force leading CPPP is the Community Program Planning (CPP) Workgroup, a subcommittee of the MHSA Steering Committee. The CPP Workgroup is comprised of MHSA Steering Committee members and other stakeholders from the community at-large.

When the CPP Workgroup was established in 2020, it was determined that the purpose of the Workgroup is to support community engagement of local stakeholders to obtain input on the development of the county's MHSA Three-year plans and Annual Updates. More specifically, the CPP Workgroup established the following goals:

CPP Workgroup members:

Name	Representation/Organization
Barbosa, Kimi	Positive Images LQBTQI +
Escobar, Dory	Community Health Consultant, DEI Expert
Espinosa, Fabiola	MHSA Analyst, Family Member
Erlenborn, Jeane	Education, transition age youth
Garcia, Saskia	Sonoma Connect
Gutierrez, Angelina	Sonoma County Indian Health Project
Johnson, Michael	Mental Health Board, lived experience
Kawahara, Julie	MHSA Consultant, DEI Expert, family member
Klohe, Erika	Provider, lived mental health experience, family member
Ladrech, Melissa	MHSA Coordinator, family member
Manieri, Stephanie	Latino Service Providers
Murphy, Meghan	Provider
Onofre, Iridian	MHSA Senior Office Assistant
Reynolds, Michael	Mental Health Board, lived experience
Rogers, Michele	0–5-year-olds and caregivers
Rogers, Tina	CPP Listening Session co-facilitator
Swan, KT	Mobile Crisis Response, lived experience, family member
Turner, Lee	Community Baptist Collaborative

The CPP Workgroup was aware that most of the stakeholder input was from current clients, individuals, and organizations involved that were already involved with the Behavioral Health Division. The Workgroup wanted to expand the stakeholders to include voices that MHSA

hadn't heard from in the past.

In 2022, the CPP Workgroup decided to conduct Listening Sessions with diverse populations that have been historically unserved and underserved.

CPP Listening Sessions Project Phases:

The workgroup selected 16 populations to find out more about their perceptions of local mental health support and services, what services are available, and what is still needed.

FY 2022-2023	FY 2023-2024
African American/Black	African American/Black Youth
Asian American/Pacific Islander	Agricultural Workers
Latinx Youth (immigrant & US-born)	Asian American/Pacific Islander Youth
Latinx Adults (immigrant) – Sonoma Valley	Indigenous (central County)
Latinx Adults (immigrant) – Cloverdale	Indigenous (coastal)
Latinx Adults (low-wage earners) – Guerneville	People with Physical Disabilities
LGBTQIA	Transitional Age Youth
Older Adults	Unhoused Adults

Within these populations, individuals and organizations were identified by Dory Escobar, the Listening Session consultant. The consultant and CPP Workgroup members identified co-facilitators for the selected populations. Once the seventeen co-facilitators were identified, they participated in an orientation and a comprehensive training. The co-facilitators are compensated with a stipend for attending trainings, outreach, and conducting the listening sessions. An outline of this training is illustrated in the following table:

Orientation	Facilitation Training
○ Project Overview & Context ○ MHSA 101 ○ Listening Session Groups ○ Health & Safety ○ Role of Co-facilitators ○ Administrative Tasks/Forms ○ Team Meetings ○ Zoom Tips	○ Guiding Principles ○ Listening Session Questions ○ Participant Recruitment ○ Facilitation Skills ○ Sessions Planning & Prep ○ Interpretation of Results ○ Developing Recommendations

Photo above: Healing circle in Healdsburg for May is Mental Health Matters month in 2024.

The listening session questions used were adapted from the California Mental Health Services Oversight & Accountability Commission for Transitional Age Youth listening sessions that were conducted in 2022. The co-facilitators found that the questions were very relevant to each one of the populations being engaged. The Sonoma County MHSA listening sessions co-facilitators used the following questions for this project:

Qualitative data was captured through transcripts of the audio recordings of the listening sessions, along with co-facilitator notes. A review of the transcripts revealed emerging themes in each listen session, as well as themes that were common to several or all the groups. A simple thematic table was composed for each listening session, followed by a identification of common themes. As a community-based participatory project, the engagement of community representatives to serve as listening session co-facilitators was key.

Key Takeaways:

Themes found across culturally specific listening sessions include:

- Culturally aware and relevant services
- Cultural norms and stigma
- Increased mental health concerns including isolation, depression and stress
- Intergenerational trauma
- Racism and discrimination
- Formal and informal peer support

Facilitators who are representative of the listening session participants are at increased risk of experiencing and conflating primary and secondary trauma and need ongoing support.

Social isolation, stress, anxiety, and depression increased in recent years in all populations represented in the project. Participants identified the pandemic, fires, interpersonal violence, racism, and recent political divisiveness as contributing factors.

There is a need for greater access to services before the mental health concerns becomes a crisis, not only prevention, but widely available early intervention services for all income levels.

Intergenerational trauma is experienced in diverse populations in Sonoma County and is discussed or addressed to varying degrees and in different ways.

Culturally relevant peer support is critical, in some cases increased since the start of the pandemic and needs to be supported and expanded.

Decentralized (beyond Santa Rosa) and more culturally aware and relevant services and providers are needed to increase access and utilization by diverse populations.

Regardless of population, services need to be provided by organizations and individuals who are welcoming; authentically interested in and respectful of people's concerns, experiences, and perspectives; nonjudgmental; empathic; compassionate; and trustworthy.

In some cases, participants stated there are no services available in their community or in their preferred language when, in fact, there are. Regardless of that fact, their perception is of great importance and indicates a need for improved culturally aware and relevant outreach, education, and information about services and how to access them.

Recommendations for Further Actions:

Provide support to trusted community-based organizations to sustain safe spaces like these listening sessions in the community.

Support cultural groups/organizations to build upon existin gresources.

Organize some listening sessions with even more focused, specific cultural groups to promote greater affinity to build emotional and social safety and encourage participation.

Continue to support capacity building within Sonoma County's diverse cultural populations to facilitate dialogue about mental health and institutionalize their voice and influence within the MSHA system, structures, and processes.

Provide community education about intergenerational trauma and engage community representatives to providemore information.

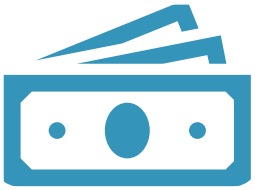
Improve and increase culturally aware and relevant outreach, education, and information about services and how to access them.

Ensure that mental health services are not only linguistically appropriate, but culturally appropriate for the diversity within populations served.

Expand facilitator's training on understanding the difference and interaction between primary and secondary traumatization.

Progress on Recommendations:
Based on the recommendations of the listening sessions, the Division is working on two initiatives:

1. **Mini Grants:** The division planning on investing $325,000 in mini grants with technical and administrative support from California Mental Health Authority (CalMHSA). CalMHSA assists county behavioral health departments in administering grants to local organizations for providing mental health early intervention services to their communities. These Time-Limited Community Driven Early Intervention grants can help to improve access to early intervention programs, linkages mental health resources, and culturally relevant healing and wellness activities to unserved and underserved groups.



$250,000 can provide community-based organizations (CBOs) with technical assistance to develop Early Intervention Programs for historically unserved/ underserved/BIPOC/ LGBTQI+ communities. CBOs will need to apply for these funds, and it will be a competitve process.

$75,000 is for inclusive culturally relevant supportive and healing community events for unserved/ underserved/BIPOC/ LGBTQI+ communities (i.e. healing circles, community wellness gatherings)

2. **Interactive digital Resource Map**: The Division is developing an interactive and bilingual behavioral health and basic needs resource map. The map will be posted on the division's website, and the map can also be printed out with a QR code that connects to the online map.

The dates and topics of the CPP meetings are in the chart with all the stakeholder meetings on page XX.

STAKEHOLDER PARTICIPATION

The MHSA Stakeholder Meetings are developed with and co-facilitated by the members of the CPP Workgroup. One goal for stakeholder engagement is to build the capacity for community members to have a foundation of knowledge about Sonoma's MHSA planning and actively participate in promoting wellness and shaping access to quality services for a diverse population seeking mental health services.

These meetings are well attended, and the standard agenda includes a 30 minute briefing on

MHSA history and regulations, updates on programs, funding, and dedicated time for break-out sessions with discussions on current topics of interest, stakeholder feedback is documented and considered in future decision-making. Discussion questions have included:

- How do we get more engagement and diversity in our stakeholder group?
- How do we create a safe space for diversity in this stakeholder group?
- What is working well in the Sonoma County Behavioral Health System?
  - What would you like to see more of?
- What is not working well in the Sonoma County BHS?
  - What are the top three changes you would like to see?
- What is the most effective or best way to get input from the group you represent?

The dates and topics of the meetings are in the chart below with all the stakeholder meetings.

Overall Community Program Planning Process for Sonoma County's MHSA Calendar: July 1, 2023 – June 30, 2024

Date	Location	Stakeholder Group	Topics Discussed
Jul 6	Santa Rosa & Zoom	Life Worth Living: Suicide Prevention Alliance	• Mission & Guiding Principles • Suicide Prevention Month Activities • Means Safety – Resources
Jul 26	Zoom	MHSA Contractors: Results Based Accountability – Turn the Curve	• Coming Soon: Anti-Racist Results-Based Accountability • Turn the Curve example • Turn the Curve on your organization's data
Aug 1	Zoom	MHSA Innovation Contractors check-in	• MHSA Updates • Innovation Project Updates • Annual Innovation Report Outline & Timeline
Aug 3	Santa Rosa & Zoom	Life Worth Living: Suicide Prevention Alliance	• Charter • High Level Goals & Next Steps • Strategic Planning • Suicide Prevention Month Activities
Aug 9	Santa Rosa & Zoom	MHSA Steering Committee	• FY 23-26 Three-Year Plan • Modernization of MHSA • Life Worth Living: So Co Suicide Prevention Alliance: • CPP Strategic Plan: Listening Sessions Update
Sep 7	Zoom	Life Worth Living: Suicide Prevention Alliance	• High Level Goals & Strategic Planning • NAMI Suicide Prevention Efforts

			• Suicide Prevention Month

Sep 10	Santa Rosa	All stakeholders and community members	• Connection is Prevention: Suicide Prevention Event
			  ○ Engaging workshops
			  ○ Interactive Activities

Sep 12	Santa Rosa & Zoom	CPP Workgroup	• Review Listening sessions Report • Crossroads to Hope Peer Advisory Council • Suicide Prevention Month Events
Oct 5	Zoom	Life Worth Living: Suicide Prevention Alliance	• Supporting and Integrating with NAMI • Logo Development • Recap of Suicide Prevention Month Activities
Nov 2	Zoom	Life Worth Living (LWL): Suicide Prevention Alliance	• Review Spanish name for LWL • Suicide Remembrance Day events • Updates on Strategic Plan

Nov 7	Santa Rosa	MHSA Annual Innovation Reports for Stakeholders	• MHSA Updates
			• Annual Innovation Project Reports:
			  ○ Early Psychosis - Learning Health Care Network
			  ○ Instructions Not Included: Dads Matter
			  ○ Nuestra Cultura Cura Social Innovations Lab
			  ○ New Parent TLC
			  ○ Unidos por Nuestro Bienestar
			  ○ Crossroads to Hope

Nov 8	Santa Rosa & Zoom	MHSA Steering Committee	• Discussion Question • SB 326: Modernization of MHSA • Life Worth Living: So Co Suicide Prevention Alliance Update
Nov 14	Sonoma Valley	Survivors of Suicide Remembrance Day	• Viewing of Life Journeys Reclaiming Life After discussion • Update on Survivors of Suicide Group • 988 Information • Self-care ideas
Nov 16	Santa Rosa	Survivors of Suicide Remembrance Day	• Panelists • Update on Survivors of Suicide Group • 988 Information • Self-care ideas
Nov 21	Santa Rosa & Zoom	Mental Health Board	• Modernization of Mental Health Services Act
Dec 7	Santa Rosa & Zoom	Life Worth Living: Suicide Prevention	• LWL Logo Selection • 2023 Accomplishments

		Alliance	• Priorities for 2024
Jan 4	Zoom	Life Worth Living: Suicide Prevention Alliance	• Review December meeting minutes and plans for 2024 • Review LWL Suicide Prevention Strategic Plan
Feb 1	Santa Rosa & Zoom	Life Worth Living: Suicide Prevention Alliance	• Review LWL Suicide Prevention Strategic Plan • 2024 Overnight Walk • Connection is Prevention Planning Group
Feb 20	Santa Rosa & Zoom	Mental Health Board	• Potential Impacts of Behavioral Health Services Act with Panel Discussion
Mar 6	Santa Rosa & Zoom	MHSA Steering Committee	• Discussion Question • May is Mental Health Matters Events • Connection is Prevention Suicide Prevention Month Event • Behavioral Health Services Act (BHSA) Timeline
Mar 7	Zoom	Life Worth Living: Suicide Prevention Alliance	• Sonoma County Annual Suicide Data Review • Annual Data Report for Strategic Plan • Behavioral Health School Based Program • Striving for Zero Conference Report
Apr 10	Zoom	CPP Workgroup Planning	• Reviewing Purpose of CPP • BHSA information • Recruiting more members • Stakeholder Committee meeting
Apr 23	Santa Rosa & Zoom	CPP Workgroup	• Behavioral Health Services Act (BHSA) • Listening sessions FY 23-24 Update • Planning Stakeholder Committee meeting
May 1	Healdsburg	All stakeholders and community members	• May is Mental Health Month Matters Community Event with Corazon ○ Community Healing Circle
May 2	Santa Rosa & Zoom	Life Worth Living: Suicide Prevention Alliance	• Sonoma County Suicide Data Update • Strategic Plan Update • May is Mental Health Matters Month
May 8	Santa Rosa & Zoom	MHSA Steering Committee	• Discussion Question • FY 24-25 MHSA Plan Update • Behavioral Health Services Act (BHSA) Implementation Planning

May 14	Petaluma	All stakeholders and community members May is Mental Health Month Matters	• May is Mental Health Month Matters Community Event with Santa Rosa Junior College ○ Mindful Movement
May 15	Sonoma Valley	All stakeholders and community members May is Mental Health Month Matters	• Community Event with La Luz ○ Mindful Guided Art Session
May 17	Guerneville	All stakeholders and community members	• May is Mental Health Month Matters Community Event with West County Community Services ○ Mindful Guided Nature Walk
May 28	Santa Rosa	All stakeholders and community members	• May is Mental Health Month Matters Community Event ○ Mindful Guided Art Session
May 29	Santa Rosa	MHSA Contractors	• Anti-Racist Results Based Accountability Training for MHSA contractors
Jun 6	Santa Rosa & Zoom	Life Worth Living: Suicide Prevention Alliance	• Final Suicide Prevention Strategic Plan • Develop workgroups to implement plan
Jun 18	Santa Rosa & Zoom	Stakeholder Committee	• MHSA 101 • Discussion Question • Behavioral Health Services Act (BHSA) • FY 24-25 MHSA Plan Update • Listening Session Update
Jun 18	Santa Rosa & Zoom	Sonoma County Mental Health Board	• Public Hearing on FY 24-25 MHSA Plan Update
Aug 13	Santa Rosa & Zoom	Sonoma County Board of Supervisors	• Review and approval of FY 24-25 MHSA Plan Update and Expenditure plan

LIFE WORTH LIVING: SONOMA COUNTY SUICIDE PREVENTION ALLIANCE

LIFE WORTH LIVING
VIVA LA VIDA
Alianza para la Prevencion del Suicidio del Condado de Sonoma
Sonoma County Suicide Prevention Alliance

In 2022 Jan Cobaleda-Kegler, Behavioral Health Director, convened a time limited Suicide Prevention Alliance to develop a Sonoma County Suicide Prevention Strategic Plan. Because Sonoma County has a suicide rate that is significantly higher than the state average, Sonoma is being provided technical assistance from Striving for Zero Suicide Prevention Learning Collaborative Technical Assistance Team.

The coalition recruited members from a broad spectrum of community and government organizations that are concerned about suicide prevention. Members have participated in collaborative meetings, reviewing suicide related data, information gathering activities, and prioritization of activities.

The Alliance has accomplished the following in FY 2023-2024:

- Developed the Alliance name: **Life Worth Living and logo.** Alliance name and logo were developed by Alliance members with lived mental health experience and enthusiastically adopted by the Alliance.
- Hosted inaugural annual suicide prevention month event: **Connection is Prevention**
- Hosted two **Survivors of Suicide Remembrance Events**
- Developed draft **Sonoma County Suicide Prevention Strategic Plan**

Pictured above: Aztec dancers from Connection is Prevention, a suicide prevention event in 2023.

The table below lists the Life Worth Living Alliance members:

NAME	Organization/Representation
Alethea Larson	The Living Room, unhoused
Ali Soto	Sonoma County Office of Education, Transition Age Youth
Amanda Lopez	Veterans Affairs
April Reza	Sonoma County Office of Education, Transition Age Youth
Carly Memoli	Consultant
Christina Nihil	Buckelew, Suicide Prevention
Citlaly Martinez	Humanidad, Latinx
Cristian Gutierrez	Latino Service Providers, Latinx
Deepali Sansi	Buckelew, Suicide Prevention
Erika Klohe	Buckelew, lived experience, family member
Fabiola Espinosa	MHSA Analyst, family member
Fletcher Skerrett	Law Enforcement
Gabriel Kaplan	Public Health
Imelda Vera	Humanidad, Latinx
Jan Cobaleda-Kegler	Behavioral Health Division Director
Jeane Erlenborn	Santa Rosa Junior College, Transition Age Youth
Jenny Mercado	Department of Health Services, Epidemiology
Juan Torres	Humanidad, Latinx
Justin Haugen	Law Enforcement, Coroner's Office
Katie Bivin	Behavioral Health School Based Program and Medication Support Manager, youth
Leslie Petersen	Hanna Center, Sonoma Valley

Lisa Nosal	Cultural Responsiveness, Inclusion & Training Coordinator
Marikarmen Reyes	Family member, Sonoma Valley
Mary Champion	Sonoma County Office of Education
Mary-Francis Walsh	NAMI, family member
Meghan Murphy	Buckelew, Family Services Coordination
Melissa Ladrech	MHSA Coordinator, family member
Michael Johnson	Mental Health Board, lived experience
Michael Reynolds	Mental Health Board, lived experience
Michael Schemmel	Law Enforcement, Coroner's Office
Rebekah Pope	Sonoma County Office of Education
Sandra Black	Consultant
Sarahi Hernandez	Latino Service Providers, Latinx
Shelly Niesen-Jones	Kaiser, healthcare
Shriya Ambre	Buckelew, Suicide Prevention
Steve Diamond	Buckelew, Suicide Prevention
Susan Standen	Peer at large, lived experience

Special thank you to the Alliance's Strategic Plan Workgroup that drafted the Strategic Plan with input and feedback from the Alliance. The workgroup is listed below:

The Sonoma County Suicide Prevention Strategic Plan Workgroup

Name	Organization
Carly Memoli	Striving for Zero Learning Collaborative
Fabiola Espinosa	MHSA Analyst, family member
Mary Champion	Sonoma County Office Of Education

Mary-Francis Walsh	NAMI
Melissa Ladrech	MHSA Coordinator, family member
Michael Reynolds	Mental Health Board, West County Community Services, Lived experience
Rebekah Pope	Sonoma County Office of Education
Shelly Niesen-Jones	Kaiser

ADDITIONAL STAKEHOLDER OUTREACH

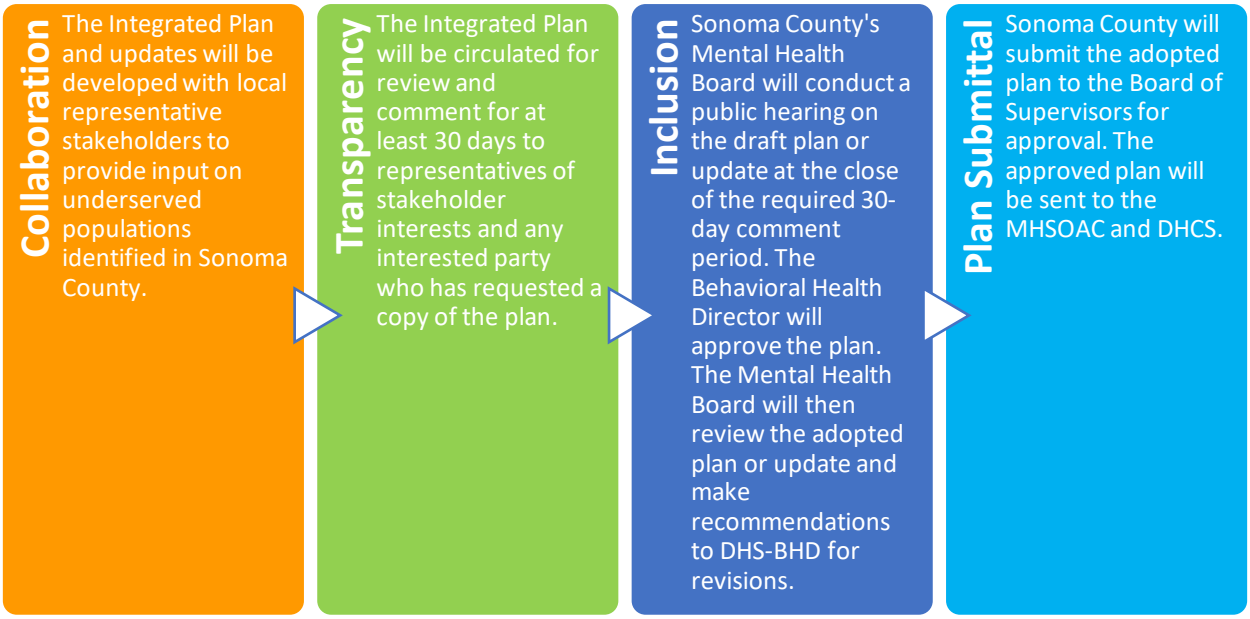
DHS-BHD also publishes an MHSA Newsletter, featuring relevant MHSA news, information, and events. The newsletter is produced every 3-4 months and is shared with a variety of community groups and stakeholders, including the Mental Health Board, Sonoma County Board of Supervisors, DHS-BHD program managers, and contractors. An archive of the newsletter PDFs is available on the MHSA website. People can subscribe to the email newsletter via the MHSA website at: http://service.govdelivery.com/service/subscribe.html?code=CASONOMA_181

See Appendix 1 on Page XX for the MHSA newsletters distributed during FY 2023-2024.

THE PUBLIC REVIEW AND PUBLIC HEARING PROCESS

Per Title 9, CCR Section 3315, Sonoma County has conducted a local review process for the community to review and comment on the FY 2024-2025 MHSA Annual Plan Update and Expenditure Plan.

Graphic: The Public Hearing Process



Sonoma County's Draft FY 2024-2025 MHSA Annual Plan Update and Expenditure Plan was posted and emailed for public review on May 17, 2024. DHS-BHD requested that stakeholders review the draft Three-Year Plan and submit comments and questions before June 18, 2024 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

The 30-day comment period culminated in a final public hearing for the FY 2024-2025 MHSA Annual Plan Update on June 18, 2024 hosted by the Sonoma County Mental Health Board.

MHSA Annual Plan Update Distribution and/or Public Hearing Outreach to Stakeholders for 2024-2025

Date	Action
5/17	Post draft MHSA Plan on DHS, BHD, MHSA, and Mental Health Board web pages
5/17	Email Mental Health Board, MHSA Steering Committee, MHSA Stakeholder Committee, MHSA Contractors, and Staff Contact List with link to draft Plan
5/17	Send notice via email to 2000+ MHSA Update subscribers
*7/18	Public Hearing with Mental Health Board and Stakeholders
*8/13	Board of Supervisors reviews and finalizes MHSA Annual Plan Update

*This has not occurred: The FY 2024-2025 MHSA Annual Plan Update and Expenditure Plan was adopted by the Sonoma County Board of Supervisors **XX, 2024.** DHS-BHD sent the approved plan to DHCS and the MHSOAC to remain on file for review and evaluation purposes **on September XX, 2024.**

MENTAL HEALTH SERVICES ACT (MHSA) FY 24-25 ANNUAL PLAN UPDATE

Sonoma County Department of Health Services, Behavioral Health Division (DHS-BHD) is pleased to present this Mental Health Services Act (MHSA) Annual Program Plan Update for Fiscal Year (FY) 2024-2025 (24-25) and this FY 24-25 Annual Plan is an update to the FY 2023-2026 Three Year Plan. The MHSA Annual Plan for FY 24-25 has been developed in collaboration with MHSA stakeholders as detailed in the Community Program Planning section on pages XX. This Annual Plan Update ("The Plan") describes MHSA funded programs including: the program purpose and the monies allocated to fund these programs. The program outcomes for FY 22-23 can be found in the FY 22-23 Program Report that follows the FY 24-25 Expenditure Plan. The content of this Program Plan includes:

- MHSA and Proposition 1: Behavioral Health Services Act
- Changes to The Plan from FY 23-26
- Expanded Medi-Cal Mobile Crisis Service
- Detailed description of MHSA programs and services planned for FY 23-24 by component:
    - Community Services and Supports (CSS) modifications
    - Prevention and Early Intervention (PEI) modifications
    - Innovation project updates
    - Workforce Education and Training (WET) Plan Update
    - Capital Facilities and Technology Needs (CFTN) Plan Update
- Update on No Place Like Home

MHSA and Proposition 1: Behavioral Health Services Act

California's Mental Health Services Act is funded by a one percent tax on personal annual incomes exceeding one million dollars. Also known as Proposition 63, this act, passed by California voters in 2004, provides mental health funding that is allocated into the following five components:

Community Services and Supports provides services for individuals with serious mental health challenges

Prevention and Early Intervention services for those at higher risk of developing a mental health challenge, unserved and underserved populations

Innovative programs to develop new approaches that increase access to unserved and/or underserved communities and improves the quality of services

Workforce, Education and Training (WET) 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 Technology Needs provides funding for building projects and increasing technological capacity to improve mental health service delivery

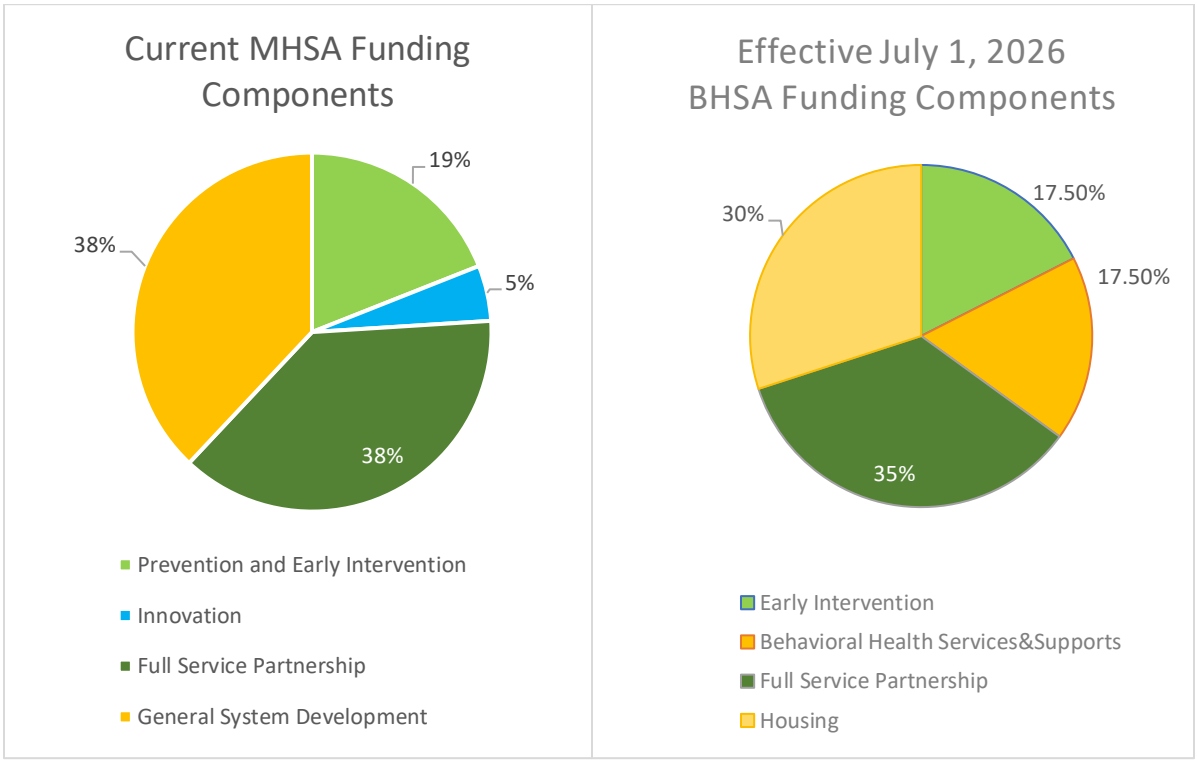
Proposition 1: This Proposition was on the California ballot in March 2024. The passage of Prop 1 has set into motion a significant level of change for the MHSA funding stream and for County Behavioral Health Departments. Counties will have until July 1, 2026 to fully implement all of the changes that Proposition will create. Proposition 1 has two major components related to providing mental health care and drug and/or alcohol treatment to people, as well as addressing homelessness issues.

This proposition will:

- Change the MHSA, with a focus on how the money from the act can be used. Under Prop 1 there is a wider service focus, that includes dedicated funding for housing and expanding the target population to include individuals with substance use only disorder diagnoses. The name of the act will be changed to the Behavioral Health Services Act (BHSA), because behavioral health is a term that is inclusive of individuals with both mental health challenges and/or substance use challenges. There are no additional funds available to fund the housing component or the additional target population. The County alongside our stakeholders will need to develop plans for enhancing some service areas such as Full Service Partnerships, and the County may also need to reevaluate services in other areas such as prevention, workforce, and outpatient treatment. Initial analysis and discussions for service changes have begun internally, and no dicisions have been made at this time. Planning for BHSA implementation will take place with the subsequent FY 2026-2029 Three-Year Plan.

- Approves a $6.4 billion bond to build more places for mental health care and drug or alcohol treatment.

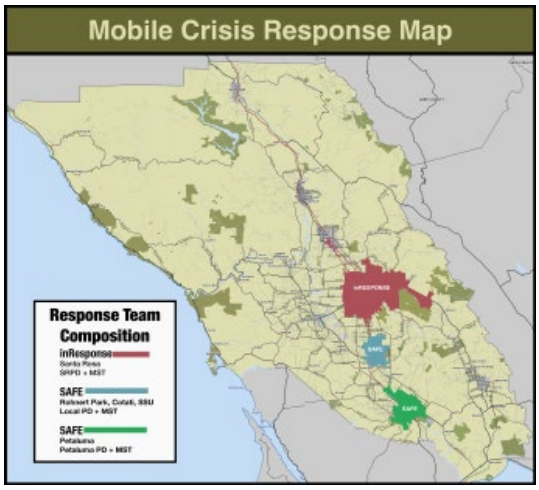
The charts below illustrate the funding components of MHSA and BHSA:



Expanded Medi-Cal Mobile Crisis Service:

The Medi-Cal Mobile Crisis Service Benefit was developed by new California Department of Health Care Services requirements for counties to provide community-based mobile services to Medi-Cal beneficiaries experiencing a behavioral health crisis. This expanded MST aims to provides rapid response, individual assessment, and community-based stabilization to reduce the immediate risk of danger and subsequent harm and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement. The Counties Mobile Support Team (MST), which originated from an MHSA Innovation project in 2008, has expanded services to dispatch the mobile crisis team 24 hours a day and seven days a week. MST is collaborating with the other local mobile crisis teams to provide complete coverage 24/7 through the county. Call 1-800-746-8181 to reach the mobile crisis hotline.

Existing Mobile Crisis Teams



- inRESPONSE (Santa Rosa)
- SAFE (Petaluma)
- SAFE (Rohnert Park)
- SAFE (Cotati)
- SAFE (SSU)
- Mobile Support Team (County)

SIGNIFICANT CHANGES TO THE FY 24-25 PLAN

As detailed in the FY 24-25 Expenditure Plan, the County estimates a fund balance of $31 million. The fund balance accumulated due to the unpredictability of MHSA funds that are based on the behaviors of about 76,000 individuals making over one million dollars a year. In addition to the fund balance the County is also estimating receiving $30.5 million in FY 24-25. The Expenditure Plan details a total budget of $47.7 million for FY 24-25, and this is the largest MHSA budget the County has ever developed.

It is paramount to spend MHSA funds within three years because MHSA regulations (WIC Title 9 Section 5847) state that any funds allocated to a county that have not been spent within three

years shall revert to the state. The County has not reverted any MHSA funds since the Act's inception. However, BHSA does not state what will happen to County MHSA fund balances when BHSA is implemented. As the County anticipates the implementation of BHSA, and the lack of clarity in BHSA about the disposition of existing fund balance at the time of BHSA implementation, the County has decided to spend down fund balance. The additional funding is going towards contract increases with prescribers, Mobile Support Team expansion, new housing project and a new Full Service Partnership for unhoused individuals with serious mental health challenges.

THE COMMUNITY SERVICES AND SUPPORT (CSS) PLAN FOR FY 24-25

Here are the significant changes and impacts to Community Services and Supports Programs for FY 24-25:

Changes	Impacts
Community Services and Supports	
Full Service Partnership (FSP)teams: The FSP teams provide wrap-around services to clients in our system of care with the most serious mental health impairments and the majority of the Community Services and Supports funds must be allocated to the FSP teams.	
Full Service Partnership (FSP) Team for Unhoused Adults: This FSP will serve adults who are homeless or at risk of being homeless with serious mental health challenges. This program is budgeted at $1,700,000 annually.	The addition of this FSP team will provide wrap around, intensive recovery oriented behavioral health services and housing support for 75 individuals. The FSP team will collaborate with clients to attain the client's goals.
General System Development	
Project-Based Housing: The Behavioral Health Division will transfer General System Development funds to the Department of Health Services, Homelessness Services Division which is Sonoma County's local government housing entity. The funds will be used to renovate an unused dormitory at Los Guilicos. This renovation is a **onetime expense** that is budgeted at $2,300,000.	This renovated dormitory will provide permanent supported housing for a total of 40-65 Transition Age Youth (18-25 year olds) and adult Full Service Partnership clients.

Sonoma County's FY 2024 – 2025 Three Annual Program Plan Update

The following table provides the estimated cost per client for FY 24-25 CSS Programs:

Provider/Program	Estimated # to be served in FY 24-25	Children and Youth (0-15)	Transition Age Youth (16 - 25)	Adults (25-59)	Older Adults (60+)	Estimated MHSA cost per person in FY 24-25
Forensic Assertive Community Treatment (FACT) Team	70	0	3	64	3	$14,268
Includes the following programs: • County of Sonoma Department of Health Services Behavioral Health Division (DHS-BHD) • Buckelew Programs - FACT - Independent Living Skills (ILS) [contractor] • Buckelew Programs - FACT - Supplemental Patch for Unlicensed Supportive Housing Units [contractor						
Family Advocacy, Stabilization & Support Team (FASST)	200	105	95	0	0	$20,039
Includes the following programs: • DHS-BHD • Seneca [contractor] • Lifeworks [contractor] • AFS Outpatient Services for FASST Clients • TBD - RFP [contractor]						
Integrated Recovery Team (IRT) DHS-BHD	150	0	0	135	5	$13,415
Older Adult Intensive Team (OAIT) DHS-BHD	70	0	0	0	70	$14,918
Transition Age Youth (TAY) Team DHS-BHD	70	0	70	0	0	$20,679
Includes the following programs: • Buckelew Programs - TAY - Sonoma County Independent Living (SCIL) [contractor]						

- TBD Housing [contractor]
- On The Move - VOICES [contractor]

Adult Full Service Partnership (AFSP)						
DHS-BHD	100	0	0	100	0	$11,882
Telecare ACT [contractor]	60	0	1	39	20	$12,446
National Alliance on Mental Illness (NAMI) Sonoma County - Family-based Education, Advocacy and Support (FEAS) [contractor]	5529	20	2000	2514	995	$39
WCCS - Interlink [contractor]	680	0	50	500	130	$202
WCCS - Wellness & Advocacy Center [contractor]	100	0	5	65	30	$1,043
WCCS - Russian River Empowerment Center [contractor]	40	0	5	25	10	$1,761
WCCS - Petaluma Peer Recovery Center [contractor]	65	5	10	35	15	$1,982
Housing FSP Program						
DHS- Homelessness Division [contractor]	75	0	15	50	10	$22,667
General Systems Development (GSD)						
DHS-BHD Mobile Support Team (MST)	200	20	35	65	40	$8,788
DHS-BHD Collaborative Treatment and Recovery Team (CTRT)	400	0	100	230	70	$2,434
Buckelew Programs - CTRT System Navigation [contractor]	400	0	100	230	70	$526

DHS-BHD Community Mental Health Centers	60	0	0	0	60	$6,965
Council on Aging - Senior Peer Support [contractor]	80	0	0	0	80	$1,485
WCCS - Senior Peer Counseling [contractor]	1300	0	150	800	350	$957
Buckelew Programs - Family Service Coordination [contractor]	15	0	2	12	1	$177
Sonoma County Human Services Department (HSD) - Job Link [contractor]	240	0	20	170	50	$2,250
WCCS - Crisis Support [contractor]	1565	0	266	1001	298	$163
DHS-BHD Medication Support Services for Adult Programs	578	405	173	0	0	$3,724
DHS-BHD Medication Support Services for Youth Programs	30	25	5	0	0	$4,205
Alternative Family Services [contractor]	100	0	0	100	0	$3333
Siyan Clinical Research [contractor]	100					$6250
DHS - Homelessness Division [contractor]	50	0	10	35	5	$46,000
Outreach and Engagement (OE)						
DHS-BHD Whole Person Care (WPC)	1406	0	56	984	366	$844
Sonoma County Indian Health Project - Community Programs [contractor]	162	37	32	66	27	$531

PREVENTION AND EARLY INTERVENTION (PEI) PLAN FOR FY 24-25

Here are the significant changes and impacts to Community Services and Supports Programs for FY 24-25:

Changes	Impacts
Prevention and Early Intervention (PEI)	
Peer and Family Support Services will work in conjunction with the new Behavioral Health School Partnership program. Funding the Peer and Family Support Services of this program is budgeted at $200,000 annually.	The Peer and Family Support Services is an Early Intervention program that will support 50-100 young people in accessing peer support from available community organizations, provide a safe space to talk about mental health symptoms in a non-judgmental setting, assist youth in learning about available options for treatment, if desired, and assist youth in navigating mental health treatment systems.
Seneca WRAP Program: This Early Intervention program will provide services for children and youth who are involved in foster care, the juvenile justice system, and/or who are at risk of out of home placement or psychiatric hospitalization. MHSA will provide $500,000 annually for this program.	The addition of this Seneca WRAP program will serve 73 children (0-15 years old) and 32 youth (16-25 year olds). The program encourages coordination among agencies, disciplines, and communities to enhance outcomes for youth and families. WRAP services aim to prevent children and youth from going to higher levels of care by increasing resilience and recovery, teaching positive coping skills to youth, and improving caregiver ability to successfully support the youth in their care. WRAP services are designed to be short term, intensive interventions lasting 6 – 12 months.

Sonoma County's FY 2024 – 2025 Three Annual Program Plan Update

The following table provides the estimated cost per client for FY 24-25 PEI Programs:

Provider/Program	Estimated # to be served in FY 24-25	Children and Youth (0-15)	Transition Age Youth (16 - 25)	Adults (25-59)	Older Adults (60+)	Estimated MHSA cost per person in FY 24-25
PEI Programs - Prevention						
Action Network [contractor]	264	124	55	53	32	$241
Community Baptist Church Collaborative [contractor]	179	30	26	94	30	$711
Sonoma County HSD-Older Adult Collaborative [contractor]	2926	0	0	0	2926	$79
Sonoma County Indian Health Project [contractor]	28	9	6	10	3	$1,516
PEI Programs - Prevention & Early Intervention						
La Luz [contractor]	460	60	40	307	53	$77
Latino Service Providers of Sonoma County [contractor]	268	0	65	143	60	$424
Positive Images [contractor]	196	37	60	62	37	$552
PEI Programs - Early Intervention						
BH Schools Partnership RFP [contractor]	65	30	35	0	0	$3,077
Seneca WRAP [contractor]	105	73	32	0	0	$4,762
Child Parent Institute (CPI) [contractor]	311	130	30	130	21	$676
La Luz [contractor]	460	60	40	307	53	$106
Early Learning Institute (ELI) [contractor]	1646	662	65	900	19	$28
PEI Programs - Stigma & Discrimination Reduction						

Santa Rosa Junior College [contractor]	468	0	378	80	10	$453
PEI Programs - Suicide Prevention						
Buckelew Programs - North Bay Suicide Prevention Program [contractor]	2321	46	375	1600	300	$73
PEI Programs - Access and Linkage to Treatment						
DHS-BHD Youth Access Team	434	338	96	0	0	$3,350
DHS-BHD Adult Access Team	496	0	114	347	35	$5,019
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
Crisis Intervention Training (CIT) with Law Enforcement	30	0	2	26	2	$1,008

INNOVATION (INN) PLAN FOR FY 24-25

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.

Brief descriptions of current Innovation projects can be found in the following pages:

Category	Project Information
Organization	**Early Learning Institute**
Project	**Instructions Not Included (INI) - Dads Matter**
Total Project Budget	$689,360
Brief Description	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.
Innovation	Makes a change to an existing practice in the field of mental health, including but not limited to application to a different population.
Primary Purpose	• Increase access to unserved or underserved group.

Category	Project Information
	• Promote interagency collaboration related to Mental Health Services or supports.
Population to be served	• 450 first time Dads, likely working so weekend and evening hours will be offered. • Possible low-income, home renters, mid-20s to mid-30s in age • 54% estimated to be Spanish speaking in the home. • County-wide
Learning Goals	1. What 3-5 key strategies are most effective in the engagement of fathers to participate in and complete visits 1-5 of the INI home visitation program. 2. What key community resources (or lack thereof) are utilized by fathers based on results of their Edinburgh Postnatal Depression Scale (EPDS) screening? 3. What key resources (or lack thereof) are utilized by father based on the results of their ACES screening? 4. How can we best serve 1st time fathers, especially those who score low-average, or below-average on the Nurturing Skills Competency Scale (NSCS)?
Need in Sonoma	No programs address or support the screening for mental health of first-time fathers. Addresses 0-5 year old prevention (intergenerational ACEs), and suicide prevention.

Category	Project Information
Organization	**First 5 Sonoma County**

Category	Project Information
Project	**New Parent TLC**
Total Project Budget	$418,185
Brief Description	"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.
Innovation	Makes a change to an existing practice in the field of mental health, including by not limited to, application to a different population.
Primary Purpose	• Increase access to unserved or underserved groups • Promote interagency collaboration related to Mental Health Services or supports *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. In addition, the project will promote community collaboration among nontraditional points of entry for individuals needing mental health support, developing a public health education movement encouraging possible policy change.
Population to be served	• Up to 100 childcare sites, seven faith communities, 3-5 large employers, and seven cosmetology providers to be trained • Reaching up to 500-2000 mothers and 250 fathers who are not engaged in any other parental/newborn home visiting program • Spanish-speaking, lower-income population, county-wide
Learning Goals	1. Does training nontraditional gatekeepers in Question Persuade Refer (QPR) model result in appropriate referrals for parental depression? 2. Does training nontraditional gatekeepers in QPR model prevent parental suicide? 3. Does training nontraditional gatekeepers in QPR model prevent infant exposure to ACEs as a result of untreated parental depression?
Need in Sonoma	0-5 prevention and early intervention, unserved/underserved group (new fathers/mothers), suicide prevention

Category	Project Information
Organization	**Sonoma County Human Services Department, Adult and Aging Division in partnership with Santa Rosa Community Health Clinics**
Project	**Collaborative Care Enhanced Recovery Project (CCERP)**
Total Project Budget	$999,558
Brief Description	Combines an established short-term intervention with 9-months of in-home case management, resulting in positive impacts for adults from 50 - 64 years old with depression.
Innovation	Makes a change to an existing practice in the field of mental health, including but not limited to application to a different population.
Primary Purpose	• Increase access to unserved or underserved groups • Increase quality of mental health services, including better outcomes • Promote interagency collaboration related to Mental Health Services or supports • Increase access to mental health services
Population to be served	• Up to 225 clients, ages 50 - 64 years over three years • Focus on Latinx/Spanish speaking adults • Central Santa Rosa as in partnership with SRCH Lombardi, Vista and Brookwood campuses
Learning Goals	1. For adults 50 – 64 years old, whose depression symptoms improve with the existing 12-week Collaborative Care Model (CoCM) intervention, are these improvements sustained over the course of an additional nine-month case management period? 2. For adults 50 – 64 years old, whose depression symptoms improve with the existing CoCM 12-week intervention plus 9-months of case management, is there an improvement in appropriate health care utilization? 3. For Latinx/Spanish Speaking adults 50 – 64 years old who receive the CCERP intervention, are there sustained depression symptom improvements and improvements in appropriate health care utilization?
Need in Sonoma	Addresses a population age group 50-64 years olds that is in the gap years (older than TAY, younger than elders) and at higher risk for suicide than the general population, and Latinx/Spanish Speaking (underserved group) with integrated health model combined with in-home case management. Suicide prevention for mature adults. (Note: 4 out of the 5 SMART Train suicide deaths in 2019 involved adults between the ages of 50-64)

Category	Project Information
Organization	**On the Move/VOICES in partnership with La Plaza, Humanidad, Raizes Collective, Latino Service Providers, and North Bay Organizing Project**
Project	Nuestra Cultura Cura Social Innovations Lab
Total Project Budget	$736,585
Brief Description	A partnership of community organizations 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.
Innovation	Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
Primary Purpose	• Increase access to unserved or underserved groups • Increase quality of mental health services, including better outcomes • Promote interagency collaboration related to Mental Health Services or supports • Increase access to mental health services The Social Innovations Lab will create more culturally relevant mental health strategies that will reduce depression and anxiety and promote cultural protective factors.
Population to be served	• The Team is composed of 20 diverse individuals from four communities: West County, Sonoma Valley, Healdsburg and Southwest Santa Rosa • Community engagement from a variety of sectors: Intergenerational, faith-based, artists, cultural practitioners, academics and research, public and nonprofit sectors • Reach up to 500 Spanish-speaking community members in four communities
Learning Goals	1. What are the root cause of the unique mental health challenges faced by the Latinx community in Sonoma County? 2. What culturally-specific interventions and language will reduce stigma around mental health among Latinos and increase cultural protective factors that lead to mental health? 3. Can the current clinically-driven mental health system be influenced to adopt and fund culturally-specific experimental interventions deemed successful or promising?
Need in Sonoma	Lack of culturally responsive mental health services for Latinx/Spanish speakers; geographically based w/ localized services and improve low Latinx Mental Health Penetration Rate 

Category	Project Information
Organization	DHS-BHD, Felton, and Behavioral Health Outcomes Data Services (BHODS)
Project	Crossroads to Hope
Total Project Budget	$2,500,000
Brief Description	Crossroads to Hope will provide 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.
Innovation	Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite
Primary Purpose	• Increase access to unserved or underserved groups • Increase quality of mental health services, including better outcomes
Population to be served	• 12-20 adults annually • Serves individuals with serious mental health concerns referred by probation and the courts
Learning Goals	1. Does providing peer supervised transitional housing with ACT reduce recidivism? 2. Does supervised transitional housing with ACT reduce recidivism for diverted?
Need in Sonoma	The 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 mental health involved. In 2018, this number increased to 513, (46.5%). The most recent figure for April 17, 2019, indicates 520 inmates (47%) are involved with mental needs.

Category	Project Information
Organization	DHS-BHD & California Mental Health Services Authority (CalMHSA)
Project	Semi-Statewide Enterprise Health Record
Total Project Budget	$5,526,045
Brief Description	CalMHSA is currently partnering with 20+ California Counties – collectively responsible for over half of the state's Medi-Cal beneficiaries – to enter into a Semi-Statewide Enterprise Health Record project. This project is unique in that it engages counties to collaboratively design a lean and modern EHR to meet the needs of counties and the communities they serve both now and into the intermediate future. Optimizing EHR platforms used by providers to meet their daily workflow needs can enhance their working conditions, increase efficiencies, and reduce burnout. This increased efficiency translates into more time to meet the needs of Californians with serious behavioral health challenges, while improving overall client care and increasing provider retention.
Innovation	Introduces a new practice or approach to the overall mental health system, including prevention and early intervention
Primary Purpose	• Promotes interagency and community collaboration related to mental health services or supports or outcomes. • Increase quality of mental health services, including better outcomes.
Population to be served	• Serves Behavioral Health Care System clients and their families.
Learning Goals	1. Using a Human Centered Design approach, identify the design elements of a new Enterprise Health Record to improve California's public mental health workforce's job effectiveness, satisfaction, and retention. 2. Implement a new EHR that is more efficient to use, resulting in a projected 30% reduction in time spent documenting services, thereby increasing the time spent providing direct client care. 3. Implement a new EHR that facilitates a client-centered approach to service delivery, founded upon creating and supporting a positive therapeutic alliance between the service provider and the client.
Need in Sonoma	Sonoma County, like many California Counties, has struggled with implementing Federal and State requirements, with our current EHR vendors and systems. The Division has minimal resources to administer our systems, and lack technical expertise in modification, enhancement, implementation and maintenance of our EHR systems.

Sonoma County's FY 2024 – 2025 Three Annual Program Plan Update

The following table provides the estimated cost per client for FY 24-25 INN Projects:

Provider/Project	Estimated # to be served in FY 24-25	Children and Youth (0-15)	Transition Age Youth (16 - 25)	Adults (25-59)	Older Adults (60+)	Estimated MHSA cost per person in FY 24-25
Innovation Projects						
Collaborative Care Enhanced Recovery Project (CCERP)aka Unidos Por Nuestro Bienestar - [Sonoma County Human Services Department]	10	0	0	0	10	$7,156
Crossroads to Hope (Peer Program Provider) - Felton Institute	12	0	1	10	1	$51,176
Instructions Not Included (INI) - Dads Matter [Early Learning Institute - contractor]	20	0	5	15	0	$11,652
New Parent TLC - [First 5 Sonoma County - contractor]	40	0	5	30	5	$4,234
Nuestra Cultura Cura Social Innovations Lab - [On The Move - contractor]	N/A	N/A	N/A	N/A	N/A	N/A
Crossroads to Hope (Evaluation Consultant) - Behavioral Health Outcomes Data Services	N/A	N/A	N/A	N/A	N/A	N/A
CalMHSA Electronic Health Record	N/A	N/A	N/A	N/A	N/A	N/A

WORKFORCE, EDUCATION AND TRAINING (WET) PLAN FOR FY 24-25

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."

Cultural Responsiveness, Inclusion and Training Coordinator

The Sonoma County Behavioral Health Cultural Responsiveness, Inclusion & Training Coordinator (CRIT) position is responsible for ensuring behavioral health services are provided in a culturally responsive manner to the diversity of our clientele, and that our diverse staff are supported and respected in their work. This oversight involves participation in several cross-cutting areas in the division including:

- Policy Development: ensuring division policies are nondiscriminatory and inclusive.
- Workforce, Education, and Training: diversifying the incoming behavioral health workforce and supporting its ability to care for diverse clients, including developing strategies for 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.

Workforce, Education and Training Activities

- The goal of our Workforce, Education, and Training (WET) Activities is to create and maintain a robust comprehensive training program, including evidence-based clinical practices and culturally responsive frameworks, to make Sonoma County Behavioral Health an attractive place to work and to promote wellness and meaning for our diverse clients. To better support these goals, WET hopes to add a full-time clinical specialist role to support this program in the future.

The Cultural Responsiveness, Inclusion & 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	• Strength 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.

System Level Support

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 Cultural Responsiveness, Inclusion & 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

As part of the Pipeline Program, the Cultural Responsiveness, Inclusion & Training Coordinator will participate in several community career events at both the high school and college level. Focus will be given to encouraging Latinx/Latine 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
Peer Provider Programs	• Wellness and Advocacy Center • Interlink Self-Help Center

Workforce, Education, and Training Activities

The goal of our Workforce, Education, and Training (WET) Activities is to create and maintain a robust comprehensive training program, including evidence-based clinical practices and culturally responsive frameworks, to make Sonoma County Behavioral Health an attractive place to work and to promote wellness and meaning for our diverse clients. To better support these goals, Sonoma County hopes to add a full-time clinical specialist role to support this program in the future.

WET Activities	Trainings
Staff Skill Development	• Staff Development Trainings
Comprehensive training Program	Evidence-Based Practices: • Strengths Model Care Management • Family Systems • EMDR • CBT for Psychosis • Cognitive Behavioral Social Skills Training • DBT • Trauma-Focused CBT • Assertive Community Treatment • Harm Reduction • Trauma Informed Systems • CBT for Depression • Seeking Safety • Peer-Based Supports (WRAP, Transformative Mutual Aid Practices) • Psychopharmacology for Non-Medical Staff • Motivational Interviewing
Culturally Responsive Practices	• Incorporating and working with peers in the workforce • Cultural humility • Special concerns for LGBTQIA+ clients • Adapting Evidence-Based Systems to Community Need, "Fidelity vs Fit"

Sonoma County's FY 2024 – 2025 Three Annual Program Plan Update

The following table provides the estimated cost per client for FY 24-25 WET funded programs:

Program/Project	Estimated # to be served in FY 24-25	Children and Youth (0-15)	Transition Age Youth (16 - 25)	Adults (25-59)	Older Adults (60+)	Estimated MHSA cost per person in FY 24-25
Ethnic Services, Inclusion and Training Coordinator	N/A	N/A	N/A	N/A	N/A	N/A
DHS-BHD WET Activities	N/A	N/A	N/A	N/A	N/A	N/A
0.5 FTE Senior Office Assistant (SOA)	N/A	N/A	N/A	N/A	N/A	N/A

West County Community Services - Peer Education and Training [contractor]	79	0	0	49	30	$1,872

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.

In 22-23 DHS-BHD implemented the SmartCare Innovation project. Eventually SmartCare will be the only electronic health record for the division. During the next 5-7 years as each phase of SmartCare is implemented, the division will be reducing the use of Avatar, SWITS and DCAR. It is estimated that the division will need to maintain Avatar through 2029 to ensure a seamless transition. The following projects will be funded through CFTN in FY 23-26:

Provider	Project	Description
NetSmart	Avatar Electronic Health Record (EHR)	Implementing fully integrated Electronic Health Record
SacValley MedShare [contractor]	Protected data exchange	Operates an electronic health information exchange.
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

Sonoma County's FY 2024 – 2025 Three Annual Program Plan Update

The following table provides the estimated cost per client for FY 24-25 CFTN funded programs:

Program/Project	Estimated # to be served in FY 24-25	Children and Youth (0-15)	Transition Age Youth (16 - 25)	Adults (25-59)	Older Adults (60+)	Estimated MHSA cost per person in FY 24-25
Avatar Electronic Health Record (EHR) - Netsmart	N/A	N/A	N/A	N/A	N/A	N/A
Avatar Electronic Health Record (EHR) - DHS staff	N/A	N/A	N/A	N/A	N/A	N/A
SacValley MedShare[contract]	N/A	N/A	N/A	N/A	N/A	N/A
Sonoma Web Infrastructure for Treatment Services (SWITS) - FEI	N/A	N/A	N/A	N/A	N/A	N/A
Data Collection and Reporting (DCAR) - AJW	N/A	N/A	N/A	N/A	N/A	N/A

NO PLACE LIKE HOME

NO PLACE LIKE HOME (NPLH) BACKGROUND

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

Playground at Orchard Commons

The picture above, of Caritas Homes, is the most recently completed NPLH funded project in Sonoma County to open and provide supportive housing for the population to be served. The table below, provided by Sonoma's Community Development Commission, lists the NPLH projects in Sonoma County. Sage Commons opened in 2022, and Orchard Commons, which is for families, opened in 2023.

The table below provides additional information on the NPLH projects including the sponsor, name of the project, total units, designated NPLH units, the target population for the units, and current status.

Project Sponsor	Project Name	Project City	Total Project Units	NPLH Units	Population	Current Status
Danco Communities	**Sage Commons**	Santa Rosa	54	29	Single adults	Opened April 2022
Danco Communities	**Orchard Commons**	Santa Rosa	45	15	Families	Opened February 2023
Burbank Housing Development Corp.	**Caritas Homes** Phase 1 64 total units 22 NPLH with project based vouchers	Santa Rosa	128	30	Single adults, seniors, veterans, and families	Opened August 2023
Mid-Pen Housing	Petaluma Blvd. North	Petaluma	40	13	Single adults and small families	Opening in Fall 2024

Supportive Housing Services for NPLH Residents:

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

DHS-BHD in partnership with Danco, Burbank Housing and Catholic Charities is providing supportive services to individuals who have been certified as eligible prospective tenants in NPLH-funded units. These services focus on three areas:

1. Move-In Process
2. Ongoing Tenancy and Lease Violation Intervention
3. 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.

EXPENDITURE PLAN

FY 2024-2025

A summary of Sonoma County's MHSA estimated funding and expenditures for FY 2024 - 2025.

MHSA Expenditure Plan for FY 24-25

FY 24-25 Estimated Funding and Expenditures Summary

Category/Program	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs
Estimated FY 2024/25 Funding					
Estimated Unspent Funds from Prior Fiscal Years	19,609,937	9,507,709	2,139,410	0	0
Estimated New FY 2024/25 Funding	23,194,606	5,798,651	1,528,970		
Transfer in FY 2024/25a/	(2,871,037)			1,899,680	971,357
Access Local Prudent Reserve in FY 2024/25					
Estimated Available Funding for FY 2024/25	39,933,506	15,306,360	3,668,380	1,899,680	971,357
Estimated FY 2024/25 Expenditures	35,544,151	7,063,269	2,092,162	1,069,624	926,188

Estimated Local Prudent Reserve Balance	
Estimated Local Prudent Reserve Balance on June 30, 2024	944,981
Contributions to the Local Prudent Reserve in FY 2023/24	0
Distributions from the Local Prudent Reserve in FY 2023/24	0
Estimated Local Prudent Reserve Balance on June 30, 2025	944,981

FY 24-25 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)	1,404,314	884,874	450,000			69,440
Buckelew Programs - FACT - Independent Living Skills (ILS) [contractor]	135,881	83,881	52,000			
Buckelew Programs - FACT - Supplemental Patch for Unlicensed Supportive Housing Units	30,003	30,003				
Family Advocacy, Stabilization & Support Team (FASST)						
DHS-BHD	4,958,373	3,847,741	981,000			129,632
Seneca (SMHS for FASST Clients)[contractor]	200,000	53,781	146,219			
Lifeworks (SMHS for FASST Clients)[contractor]	100,000	26,891	73,109			
TBD - RFP [contractor] (SMHS for FASST Clients)	245,000	65,882	179,118			
TBD – AFS Outpatient Services for FASST clients	50,000	13,446	36,554			
Integrated Recovery Team (IRT)						
DHS-BHD	1,402,844	1,199,183	170,000			33,661
Older Adult Intensive Team (OAIT)						
DHS-BHD	1,191,712	1,044,228	110,000			37,484

Category/Program	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Transition Age Youth (TAY) Team						
DHS-BHD	1,091,229	960,659	117,000			13,570
Buckelew Programs - TAY - Sonoma County Independent Living (SCIL) [contractor]	145,576	110,576	35,000			
TBD Housing [contractor]	164,500	123,130	41,370			
On The Move - VOICES [contractor]	253,154	253,154				
Adult Full Service Partnership (AFSP)						
DHS-BHD	1,253,396	1,188,153	9,000			56,243
Telecare ACT [contractor]	1,493,488	746,744	746,744			
National Alliance on Mental Illness (NAMI) Sonoma County - Family-based Education, Advocacy and Support (FEAS) [contractor]	215,817	215,817				
WCCS - Interlink [contractor]	423,311	48,545				374,766
WCCS - Wellness & Advocacy Center [contractor]	726,822	709,143				17,679
WCCS - Russian River Empowerment Center [contractor]	176,135	176,135				
WCCS - Petaluma Peer Recovery Center [contractor]	79,268	79,268				
Unhoused Program FSP						
DHS- Homelessness Division [contractor]	1,700,000	1,700,000				
Non-FSP Programs						
General Systems Development (GSD)						
DHS-BHD Mobile Support Team (MST)	8,974,800	1,757,651	2,040,854			5,176,295
DHS-BHD Collaborative Treatment and Recovery Team (CTRT)	1,333,028	973,796	340,000			19,232
Buckelew Programs - CTRT System Navigation [contractor]	445,534	210,534	235,000			

DHS-BHD Community Mental Health Centers	2,756,307	2,089,420	640,000			26,887
Senior Peer Support [contractor TBD] -RFP	89,077	89,077				
Senior Peer Counseling [contractor TBD] - RFP	76,554	76,554				
Buckelew Programs Family Service Coordination [contractor TBD] - RFP	229,965	229,965				
Sonoma County Human Services Department (HSD) - Job Link [contractor]	33,750	33,750				
WCCS - Crisis Support [contractor]	10,611	10,611				
DHS-BHD Medication Support Services for Adult Programs	6,193,966	5,828,786	345,000			20,180
DHS-BHD Medication Support Services for Youth Programs	2,944,573	2,430,343	473,990			40,240
Alternative Family Services [contractor]	200,000	100,000	100,000			
Siyan Clinical Research [contractor]	1,250,000	625,000	625,000			
DHS- Homelessness Division	2,300,000	2,300,000				
Outreach and Engagement (OE)						
DHS-BHD Whole Person Care (WPC)	1,703,179	1,186,790	451,000			65,389
Sonoma County Indian Health Project - Community Programs [contractor]	85,988	85,988				
CSS Annual Planning	640,158	605,765				34,393
CSS Administration	3,362,935	3,348,887				14,048
CSS MHSA Housing Program Assigned Funds	0	0				
Total CSS Program Estimated Expenditures	**50,071,248**	**35,544,151**	**8,397,958**	**0**	**0**	**6,129,139**

FY 24-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]	63,664	63,664				
Community Baptist Church Collaborative [contractor]	127,327	127,327				
Sonoma County Human Services Department - Older Adult Collaborative [contractor]	233,432	233,432				
Sonoma County Indian Health Project [contractor]	42,443	42,443				
PEI Programs - Prevention & Early Intervention						
La Luz [contractor]	35,206	35,206				
Latino Service Providers of Sonoma County [contractor]	113,533	113,533				
Positive Images [contractor]	108,228	108,228				
PEI Programs - Early Intervention						
BH Schools Partnership RFP [contractor]	200,000	200,000				
Child Parent Institute (CPI) [contractor]	210,089	210,089				
La Luz [contractor]	48,618	48,618				
Early Learning Institute (ELI) [contractor]	46,687	46,687				
Seneca WRAP [contractor]	2,050,000	500,000	1,025,000	525,000		
PEI Programs - Stigma & Discrimination Reduction						
Santa Rosa Junior College [contractor]	212,211	212,211				
PEI Programs - Suicide Prevention						

Buckelew Programs - North Bay Suicide Prevention Program [contractor]	169,769	169,769				
PEI Programs - Access and Linkage to Treatment						
DHS-BHD Youth Access Team	1,896,322	1,454,026	190,000			252,296
DHS-BHD Adult Access Team	3,181,964	2,489,298	462,000			230,666
OPTUM - MOU County of Contra Costa, Marin, San Mateo	150,000	150,000				
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
Crisis Intervention Training (CIT) with Law Enforcement Personnel	30,250	30,250				
PEI Annual Planning	100,266	94,879				5,387
PEI Administration	563,136	560,936				2,200
PEI Assigned Funds (CalMHSA Statewide PEI Project)	172,673	172,673				
Total PEI Program Estimated Expenditures	9,755,818	7,063,269	1,677,000	525,000		490,549

FY 24-25 Estimated Innovation (INN) Funding and Expenditures

INN Programs	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Collaborative Care Enhanced Recovery Project (CCERP)aka Unidos Por Nuestro Bienestar - [Sonoma County Human Services Department]	71,558	71,558				
Crossroads to Hope (Peer Program Provider) - Felton Institute	614,108	614,108				
Instructions Not Included (INI) - Dads Matter [Early Learning Institute - contractor]	233,043	233,043				
New Parent TLC - [First 5 Sonoma County - contractor]	169,377	169,377				
Nuestra Cultura Cura Social Innovations Lab - [On The Move - contractor]	348,146	348,146				
Crossroads to Hope (Evaluation Consultant) - Behavioral Health Outcomes Data Services	13,830	13,830				
CalMHSA Electronic Health Record	642,100	642,100				
INN Annual Planning						
INN Administration						
Total INN Program Estimated Expenditures	2,092,162	2,092,162				

FY 24-25 Estimated Workforce, Education and Training (WET) Funding and Expenditures

WET Programs	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Cultural Responsiveness, Inclusion & Training Coordinator (CRITC)	251,500	251,500				
DHS-BHD WET Activities	500,000	500,000				
0.5 FTE Senior Office Assistant (SOA)	79,825	77,167				2,658
West County Community Services - Peer Education and Training [contractor]	147,926	147,926				
WET Annual Planning	15,426	14,597				829
WET Administration	78,773	78,434				339
Total WET Program Estimated Expenditures	1,073,450	1,069,624	0	0	0	3,826

FY 24-25 Estimated Capital Facilities and Technological Needs (CFTN) Funding and Expenditures

CFTN Programs/Projects	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Avatar Electronic Health Record (EHR) - Netsmart	777,000	777,000				
Avatar Electronic Health Record (EHR) - DHS staff	647	647				
SacValley MedShare [contractor]	23,000	23,000				
Sonoma Web Infrastructure for Treatment Services (SWITS) - FEI	2,200	2,200				
Data Collection and Reporting (DCAR) - AJW	38,875	38,875				
CFTN Annual Planning	15,426	14,597				829
CFTN Administration	70,208	69,869				339
Total CFTN Program Estimated Expenditures	927,356	926,188				1,168

APPENDICES

FY 22-23 MHSA Innovation Annual Report

Instructions Not Included

Brief description of Project
ELI's Instructions Not Included, (INI) is the first home visiting program in Sonoma County to target new fathers in a mental health focused fashion. INI is unique in that it includes the use of the Edinburgh Postnatal Depression Scale (EPDS with modified scoring for males) screening and ACE screening for dads. Referrals to INI come from Community Partners, Medical Professionals, and self-enrollment. Outreach is done at birthing classes, Obstetricians, MH partners and other places likely to be seen by new parents. INI home visitors conduct 5 home visits with fathers with 4 open to both parents, strategically placed to coincide with known vulnerable periods during an infant's first year of life:

- VISIT 1: 4-6 weeks after birth; sooner if requested. (Surveillance for PPD happens at this visit.)
- VISIT 2: 3-4 months after birth; (PPD screening tools are administered.)
- VISIT 3: 9 months after birth; (ACEs screening is given to both Caregivers)
- VISIT 4: 12 months after birth (ASQ is used to screen baby)
- Father Only Visit – 6 months after birth or earlier if requested by father.

Problem Statement
The primary problem this project wants to solve is the lack of screening and early identification of perinatal mood disorders in new fathers and a resulting lack of understanding of the magnitude of the problem in Sonoma County. Without this data, existing home visiting programs will continue to ignore the needs of new fathers and fail to engage them in the care of their child and partner from the very beginning.

Learning Goals
The Following learning goals have been defined for Instructions Not Included:

1) What percentage of new fathers are engaged in the INI home visiting program and complete both the PPD and ACEs screenings offered?
2) Identify the rate of paternal PPD in Sonoma County.
3) Identify availability of appropriate paternal PPD support, education and counseling resources in Sonoma County
4) Identify the rate of high ACE scores in new fathers in Sonoma County.
5) Identify availability of appropriate paternal ACE support, education and counseling resources in Sonoma County.
6) Identify the co-occurrence of paternal PPD and high ACE scores.

We will use what we find out to inform community partners as to how to increase support for partners, should that be needed. Data from this project may also inform child abuse prevention strategies as high ACE scores have been shown to correlate to more frequent use of corporal punishment from fathers.

Findings to date (preliminary)

Since Instructions Not Included is ending its first year, and enrollment in the program was slow, there are not yet significant findings. However, preliminary data shows that most fathers/partners are attending all of the visits and they do want their separate visits – and most want it with our male counselor/home visitor when offered a choice. There has not been a high correlation of high ACE scores to high PMD scores – but the PMD scores have been in the moderate to concerning range. Referrals for PMD support for both moms, dads and other caregivers are well received but resources in Sonoma County are scarce and there are often wait lists or high copays, which is a burden on young families.

Additional findings indicate that INI home visitors need further and frequent training on mental health resources in Sonoma County as capacity, staffing and funding impact availability of services.

Evaluation data (if available), including outcomes and information about elements that are contributing to these outcomes.

* 100% of INI workforce ready to provide service by September 30, 2022 – Done and completed on time.

*50% of participants in INI will have been referred by a community partner or medical provider. 70% of participants were referred by a community partner or medical provider.

•70% of families enrolled in INI will complete, or be on track to complete, all home visits in the series. 85% of families have completed or are on track to complete all their visits.

•50% of fathers enrolled in INI program will participate in all INI visits, including the PPD and ACEs screenings. – *statistics currently not available. Should have these in a couple of weeks.*

*Identify the rate of paternal PPD in INI Participants. 28.5% of fathers screened had a high PPD score. Almost half of the father's are reporting high stress levels to the home visitors during the father's visits. The most common issue was feeling like they had to be strong when the mother or baby were crying, stressed or emotional. They said they felt like they had to hold it all together and take care of everyone. This came up even for those whose PMD score was low. The fathers reported relief in having another man that they could talk to about these feelings, without being judged. This common theme has the INI team thinking if we want to offer a father's group every quarter, where the dad's could make a toy for their child, or play a game of basketball, etc. and talk about "life as fathers."

*Identify availability of appropriate paternal PPD support, education and counseling resources in Sonoma County, for INI participants - This is a work in progress across the three years of this program. However, antidotal reports from the fathers seeking MH support for PPD is that it is typically treated like generalized anxiety. One stated he felt patronized by his MD who said “all new fathers feel this way. It means you are normal.”

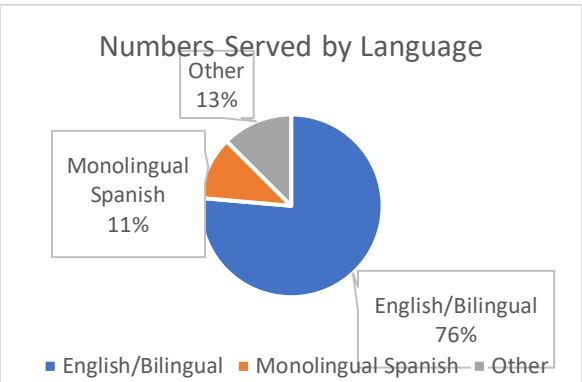
*Identify the rate of high ACE scores in new fathers participating in INI. Surprisingly, none of the fathers have reported high ACE scores. 15% of their partners had high ACE scores.

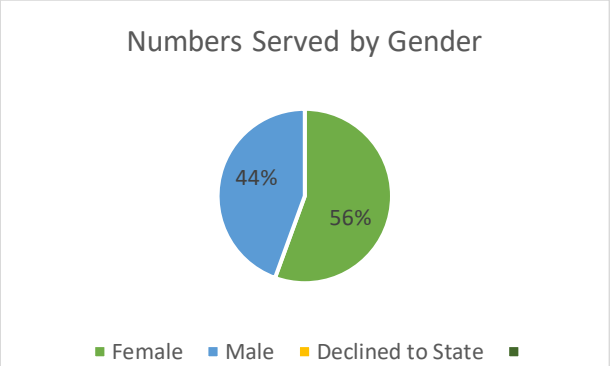
*Identify the co-occurrence of paternal PPD and high ACE scores. 0 co-occurrence as there are no high ACE scores. Very early in the program and numbers are small.

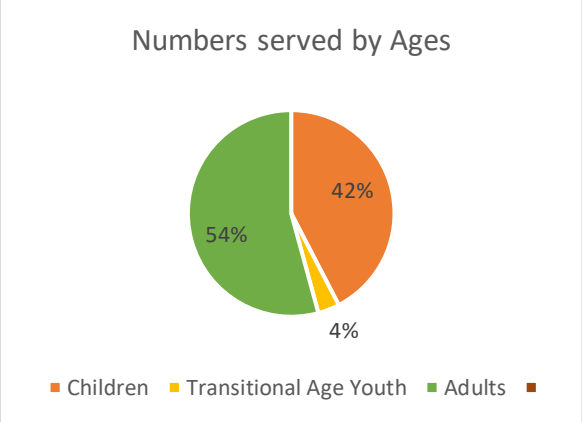
Any changes that were made to the project during the reporting period and the reasons for the changes, including any changes in the timeline.

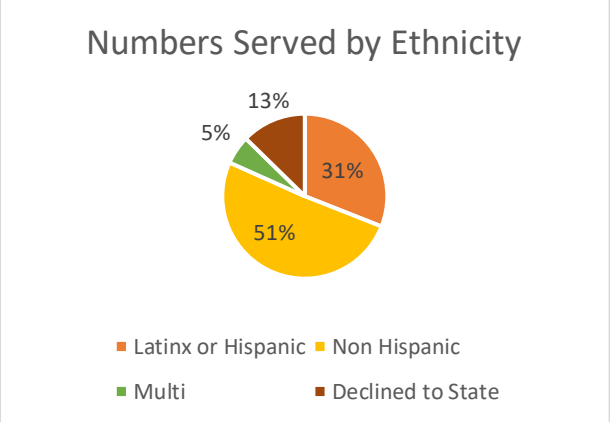
1) Expanded the program eligibility criteria too all families in Sonoma County with a young infant, not just first time Caregivers. We did this to increase program access based on the referrals we were receiving. We also wanted to strategically increase number of families utilizing INI as a resource.
2) Extended the timeframe for enrollment in INI to increase access to the program. Referrals are now accepted for families with an infant up to 6 months of age, instead of 2 months of age.
3) Adapted timeframe for visits for late referrals to allow Caregivers to access all 5 visits if the family desires. We did this to increase the available screening data from later visits.
4) Allow the father screenings to be done when it is most comfortable for the fathers. One lesson we have learned during the first year of the program is that many fathers prefer to wait for the father visit to take the PPD and ACE's screenings. Reporting they want to stay and look strong so their spouse doesn't worry, while at the same time wanting help around areas they feel insecure about.

Demographics from the reporting period:





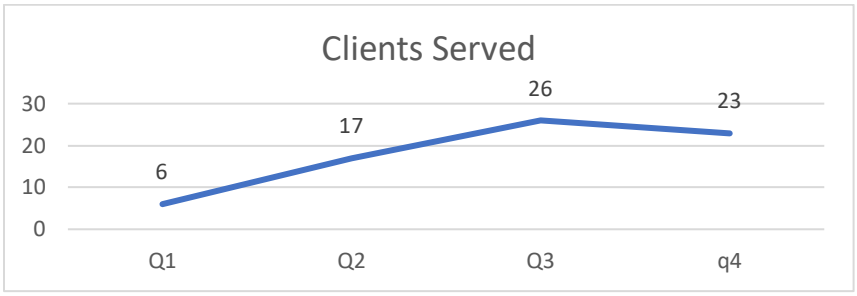




Instructions Not Included also served 4 individuals who identified as LGBTQ and 3 who identified as having disabilities in one or more categories, including deaf/hard of hearing.

Successes

- <u>INI seems to be finally taking off!</u>



There has been a steady increase in referrals since January.

- Outreach for INI is also taking off! Efforts have included targeted social media posts (on Facebook and on Twitter) as well as email reminders to community partners through the "mail chimp" system. In the last quarter there have been 8 separate boosted posts, resulting in ***over 200 views and/or "likes***." 12 community partners have "shared" the information through their own social media outlets. Additionally, ELI has finalized a set of tools on our website that allows full language and disability access. All information can be automatically translated into the family's home language. In the past few months, we've been invited to present the program at different organizations staff meetings, tabled, or passed out information at a variety of community events, done public service announcements, and posted on a variety of social media platforms over the last year. In the final quarter of fiscal year 22/23 we have done direct outreach at:
  * Mitote Food Park in Santa Rosa on four separate occasions
  * LGBTQ events and meetings throughout the county
  * Nurse Family Partnership staff meeting on 4/4/23
  * Sonoma County Children's Museum, 4/13/23
  * Sonoma State Children's Fair on 4/15/23
  * Community Resource Fair for Victims of Crime on 4/29/23
  * Teen Parent Connection staff meeting on 5/9/23
  * Reminder outreach to NICU nurse at Sutter Santa Rosa on 5/16/23

* Shared INI information at the opening of Rohnert Park FRC on 6/8/23
* Meeting with UCSF NICU nurse to discuss INI for clients they have from Sonoma County

- Important referrals have been made for Families. One referral was made for a baby based on the Newborn Behavioral Observation screening and that child received Early Start services. Two other children were referred for other children's programs and received the services. Five families were referred to WIC, Sonoma County 4C's program or for financial support services.
- ELI strives to keep our staff up to date on issues affecting our clients. The entire INI staff attend the Brazelton Touchpoints Center National Forum: All About Fathers and the Men in Children's Lives conference, May 2-5, 2023.

Brief Story

Though it has taken INI longer than anticipated to gain traction, the families we have served have expressed extreme appreciation for the service, support, and referrals they received. Having these home visits helps families get the help they need, when and if they need it. One family in particular needed an extreme amount of help. When the mom made the appointment, she expressed a need for breastfeeding support and stated she felt her partner needed help understanding how hard the past few months had been on her since the baby's birth. The INI home visitor, Rosa, went out to see the family almost immediately, given the mother's level of distress. The initial visit ended up being over three hours as Rosa grew more and more concerned about the mother's emotional health. Mom said she was struggling to feed the baby and believed in her heart that this was not her baby – that this little boy was not the baby she gave birth to. No amount of reassurance from dad was helping. It was no surprise that mom tested high on the Edinburgh, showing high levels of postpartum depression. Rosa believed that mom was bordering on psychosis and urged both caregivers to seek immediate medical treatment. The mother was resistant but eventually put in a call to her physician who gave her an immediate appointment and started treatment for PPD. The family has since had two more appointments and though mom still has a lot of anxiety about her baby, she is doing better. Dad is participating in all the visits and is committed to learning as much as he can about helping the mom.

Challenges in implementation

- Referrals to Instructions Not Included were very slow between July and January. We have been devoting a lot of staff time to increasing these numbers. You can see the increase in Q3 and Q4 and we are still seeing it in Q1 of 2023/2024.

- ELI's reputation in the community seems to be one challenge to implementation. A couple of referrals we had difficulty connecting with. When we finally reached them, they said they weren't sure they needed Instructions Not Included. The home visitor asked more questions and learned that both families knew of the Early Learning Institute and loved our reputation. They went on to state that they did not have developmental or social-emotional concerns about their baby, so they didn't want to take services from those that need them. Upon explaining the differences in the programs, the families were then eager to accept INI services.

ON THE MARGINS

NUESTRA CULTURA CURA LA PLAZA

LATINO Service Providers

Botanical Bus
Bilingual mobile herb clinic

HUMANIDAD
Therapy & Education Services

NOVEMBER 2, 2023

MHSA INNOVATIONS ANNUAL REPORT: FY 2022-2023

Artwork Created by NCC SIL Members During a Monthly Gathering

NCC SIL Altar (present at every gathering)

Table of Contents

1. Introduction
2. Name of Project
3. Project Overview and Description
4. NCC SIL Collaborating Partners
5. Problem Statement
6. Learning Goals
7. Findings to Date
8. Evaluation Data & Outcomes
9. Project Updates
10. Challenges in Implementation
11. Success
12. The Road Ahead
13. Appendices

A Shared Vision with Intentionality

"Being in community, with like minded people and people experiencing similar challenges as leaders, has provided me the **opportunity to feel supported, reduced my concerns/anxiety and gave me the sense of belonging,** which is very important for my mental health which translates to my physical health. As with any process, **it took some time for me to find a tune. Once I discovered how powerful** this experience is, it was just a matter of **being present and to have an open mind to see and listen.**"

NCC SIL Participant Feedback

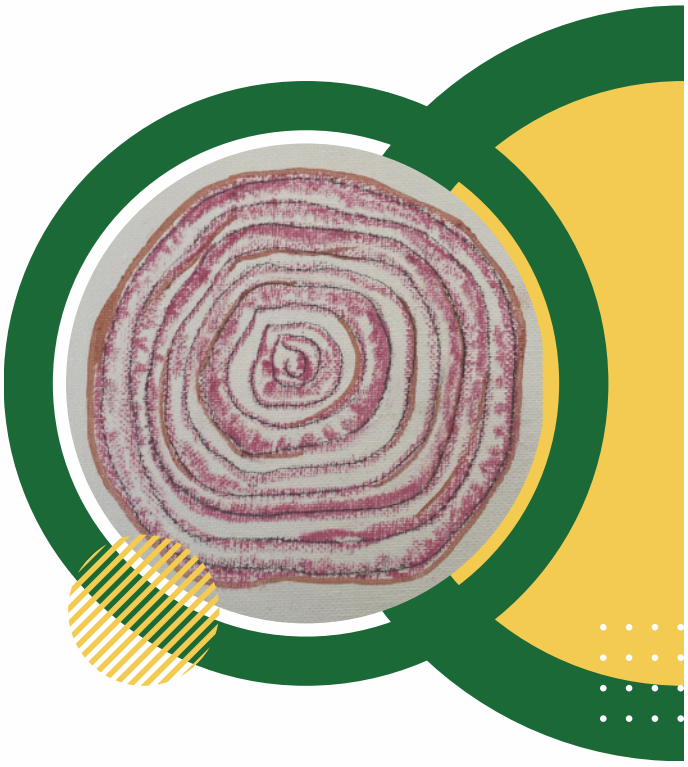
Collaborating Partners

The Nuestra Cultura Cura Social Innovations Lab is made possible through collaboration with the five organizations.

In addition, to these partners, NCC SIL will invite cultural healers, individuals providing healing resources and services as defined by those they serve, to join the NCC SIL.

NUESTRA CULTURA CURA

Social Innovations Lab



MHSA ANNUAL REPORT: YEAR TWO

1. INTRODUCTION

The converging pandemic of COVID-19 and racial injustice have increased our collective sense of urgency to more actively participate in systemic changes that address inequities and social determinants of health. In Sonoma County, the disproportionate toll this pandemic has had on individuals from disadvantaged communities serves as a clear indicator of the needed shifts in existing paradigms, including the ways in which organizations and individuals engage with, and provide services to and alongside, our community.

Drawing from the framework developed by Social Lab expert and author Zaid Hassan, the *Nuestra Cultura Cura Social Innovations Lab* (NCC SIL) launched on October 1, 2021 and seeks to implement a culturally responsive approach to mental health services delivery in Sonoma County through a three year, multi-phase process, with a projected completion year of 2025. The following report presents data regarding Year Two of the project.

ABOUT THIS REPORT

In 2022, Nuestra Cultura Cura Social Innovations Lab (NCC SIL) commissioned On the Margins, a collective of educators, mental health practitioners, health practitioners, artists and researchers who practice at the intersection of anti-racism, feminist theory and trauma responsive practices, to support the project by providing program evaluation and facilitation. This report was written for the Nuestra Cultura Cura Social Innovations Lab by On the Margins. The author is Cindy Berríos. Questions about this report can be directed to cindy@onthemargins.us.

RECOMMENDED CITATION

Berríos, C. (2023). MHSA Innovations Report 2023.

2. NAME OF INNOVATION PROJECT

The name chosen for this project is Nuestra Cultura Cura Social Innovations Lab (NCC SIL).

3. PROJECT OVERVIEW AND DESCRIPTION

The Nuestra Cultura Cura Social Innovations Lab (NCC SIL) was created to support a unique collaboration of Latinx-led community-based mental health and cultural arts organizations. These organizations are a combination of formal and informal groups consisting of nonprofits, churches, civic organizations and clubs. Early discussions in the pre-planning phase were held with Latino Service Providers, Humanidad Therapy & Education Services, The North Bay Organizing Project and The Botanical Bus. In addition to these partners, NCC SIL invited cultural healers, individuals providing healing resources and services, as defined by those they serve, to join the NCC SIL. At the end of year two, five community organizations and five cultural healers comprised the NCC SIL partnership coordinated by On The Move.

4. NCC SIL COLLABORATING PARTNERS

The Nuestra Cultura Cura Social Innovations Lab is made possible through collaboration with the following project partners:

The Botanical Bus - The Botanical Bus is a bilingual mobile herb clinic that takes community-based action for health equity. They are driven by the proven success of the self-healing community model in which holistic health is empowered by the people and for the people. They meet their Latinx and Indigenous clients were they are - at vineyard worksites and family service center hubs - to provide upstream, culturally centered health services including massage, acupuncture, somatic therapy, diabetes prevention and care, clinical nutrition and herbalism. Their programs, led by Promotora Community Health Advocates, include farmworker clinics and wellness workshops.

Latino Service Providers - Latino Service Providers (LSP) was founded in 1989, in response to helping the Latinx community in Sonoma County obtain knowledge and access to resources to enrich lives and help improve our communities. LSP works with community partners to engage, collaborate, and exchange valuable information; to increase awareness of available resources, access to programs and services; to influence public policy, delivery of services, enhance inter-agency communication; and to promote professional development within the Latinx community. The organization currently comprises over 1,400 members from a broad spectrum of the community, including a diverse group of individuals, community-based organizations and local businesses. Members come together to educate and network in support of the Latinx community, to improve access to healthcare, mental health services, education, legal support and other social services available in the area.

Humanidad Therapy & Education Services - Humanidad Therapy & Education Services' mission is to strengthen the lives of the Latinx community by increasing access and utilization of community mental health resources. They transcend barriers and reduce stigma by providing culturally proficient therapist training, inclusive community education, and bilingual therapy services. Humanidad envisions healthy and thriving communities where the stigma associated with mental health does not exist and all have access to quality and compassionate culturally sensitive therapy services.

North Bay Organizing Project - The North Bay Organizing Project (NBOP) is a grassroots, multiracial, and multi-issue organization comprised of over twenty-two faith, environmental, labor, student and community-based organizations in Sonoma County. NBOP seeks to build a regional power organization rooted in working class and minority communities in the North Bay: Uniting people to build leadership and grassroots power for social, economic, racial and environmental justice.

5. PROBLEM STATEMENT

Current services to address health, healing and wellness in the Latinx community are limited and those that are available are not rooted in cultural humility, awareness, or responsiveness. This service gap has led to a lack of access to historically marginalized and oppressed groups, which has impacted population health. In 2012, the UC Davis Center for Reducing Health Disparities, in collaboration with the California Department of Mental Health, led an extensive process for identifying community-defined needs and strengths-based practices to reduce disparities in mental health as part of the California Reducing Disparities Project (CRDP). Their research confirms that current disparities in mental health care for Latinos are severe, persistent, and well documented. The Latinx community has less access to mental health services, are less likely to receive needed care, and are more likely to receive poor quality care when treated. The reasons range from poor access and poor quality of care, limited insurance coverage, ineffective communication between provider and patient, patients' lack of trust, doctors' assumptions about the distribution of disease and their inability to perceive severity among minorities, and low minority representation in the workforce with implications for health insurance coverage.

6. LEARNING GOALS

NCC SIL's learning goals are two-fold. First the project seeks to learn what additional knowledge can be gleaned about the unique challenges that inhibit Latino/x/e community members from accessing mental health services in Sonoma County. Second, it seeks to understand how culturally-specific interventions and language might improve the quality of mental health services for the Latino/x/e community.

The NCC SIL partners have created a variety of culturally-rich, non-clinical prevention and early intervention services designed for the Latinx population of Sonoma County. By engaging in community based participatory research, the partners have worked to develop and implement a minimum of three intervention strategies aimed at decreasing stigma, increasing cultural protective factors, and promoting access to appropriate mental health services. This research has been led by Sonoma County Latinx community members with lived mental health experiences. In an effort to learn about the communities' desires and aspirations, the Lab has authentically engaged the community

to collect information and analyze self-identified needs data in order to design and implement culturally relevant solutions. The Nuestra Cultura Cura project has relied on community defined evidence practices, which are innovative and culturally-rooted traditions designed by the communities they serve, and will ensure mental health equity by providing culturally and linguistically responsive prevention and early intervention services.

The learning goals outlined in the NCCSIL project are as follow:

- To understand what healing looks like for individual and the community as a whole
- To tap into cultural wealth and learn about existing healing practices
- To understand and deepen collective and individual healing practices

Additionally, NCC SIL is seeking to access culturally relevant prevention and early intervention mental health services for Latine community members who are underserved, unserved or inappropriately served. Innovations will continue to seek, recognize and understand strengths and skills of each person and acknowledge that when these strengths are brought together, communities can form a powerful collective.

7. FINDINGS TO DATE (PRELIMINARY)

NCC SIL found that in order to engage meaningfully, ensure successful implementation of the project, and achieve its learning goals, it is essential to continue to respond to the learning and relational needs of the collaborative. This commitment to centering relationships is an important component of ensuring the success and sustainability of the project. An additional and, quite significant finding, is that given the low numbers of members of the LGBTQIA2+ Community who attended NCC SIL's first community offering, it is clear that more targeted outreach is needed with and within that community in order for NCC SIL to truly create spaces of belonging rooted in cultural humility. While members of the Innovations Team understood that during the second year it would be important to start traveling, visiting, engaging, and connecting "out in the community," it is clear that a more target approach is necessary in order to meet NCC

SIL's goal for these "culturally-rooted spaces of belonging" to become a model that can be replicated across the county and beyond.

8. EVALUATION DATA & OUTCOMES

Q1 FINDINGS

This quarter's sessions served as an opportunity to acknowledge the deep-rooted challenges that various communities face when it comes to accessing mental health services in Sonoma County. There was an overwhelming list of systemic and structural challenges that were named that have historically created many barriers. For example, language and culture continues to be a challenge, as well as not having sufficient and appropriate services offered to community members. This acknowledgment was integral in helping the collective to strategize and identify concrete tactics that would be utilized to address these barriers and increase access to services.

Q2 FINDINGS

NCC SIL witnessed the challenges of the winter season, which was unexpected. Many participants found it difficult to attend scheduled monthly gatherings due to illness and holiday travel. There were a couple of sessions that were missing two to three members of the collective, which created a challenge in moving the project forward. However, the collective adapted and reached out directly to those who were unable to join to ensure that they were up to date with the information discussed in the larger group. This level of relational accountability and engagement with each other is deeply rooted in the core values of NCC SIL.

Q3 FINDINGS

During this quarter, project facilitators and organizations realized the need to have an important conversation about commitment to the project and to the process of our work. The collective had to slow down and have deeper conversations and gain understanding about trauma informed care and healing-center care best practices, as it became clear that the individual toll of working both within traumatized organizations and with clients that have experienced multiple traumas (racialized trauma, immigration trauma, trauma of poverty, etc.) was impacting the ability of providers to participate fully in NCC SIL. Additionally, the collective explored different forms of power and how power can impact NCC SIL's work as a collaborative community and in the larger Sonoma

County community. These were essential pieces for NCC SIL to discuss in order to be able to continue the work ahead. Again, it became necessary to slow down and focus on the relationship before proceeding with the work. In other words, NCC SIL decided to pause in order to focus on connection before content. During this quarter, the collective also identified geographic locations that were in need of services and committed to moving away from being, "Santa Rosa Centric." For this reason, it was decided that the first NCC SIL offering, a Caminata led by Humanidad, would be held in Jack London State Park in Glen Ellen. Both the venue and geographic location were strategically selected in order to deliver programming in a historically underserved community and at a site that has not previously hosted the Latine community or many other communities of color.

Q4 FINDINGS

This quarter saw the successful execution of NCC SIL's first community offering, a Caminata. The majority of community members who attended expressed an immense amount of gratitude for holding this gathering and expressed the need for more community gatherings, of this type, on a more consistent basis. The success of the Caminata solidified NCC SIL's commitment to continuing to provide culturally-rooted spaces of belonging.

DEMOGRAPHIC INFORMATION

TABLE 1. Numbers Served

NUMBERS SERVED	FISCAL YEAR JULY 2022- JUNE 2023
Unduplicated or Unique	124
Total Numbers Served	124

TABLE 2. Age Group

TOTAL NUMBERS SERVED BY AGE	FISCAL YEAR JULY 2022- JUNE 2023
Children/Youth (0-15)	0
Transition Age Youth (16-25)	10
Adult (26-59)	26
Older Adult (60+)	7
Missing/Unknown	79
Declined to State	2
TOTAL	124

TABLE 3. Sex & Gender

ASSIGNED SEX AT BIRTH	FISCAL YEAR JULY 2022- JUNE 2023
Female	37
Male	7
Missing/Unknown	1
Declined to State	79
TOTAL	124

CURRENT GENDER IDENTITY	FISCAL YEAR JULY 2022- JUNE 2023
Female	37
Male	7
Transgender	0
Genderqueer	1
Questioning/Unsure	0
Other	0
Missing/Unknown	79
Declined to State	0
TOTAL	124

TABLE 4. Race

TOTAL NUMBERS SERVED BY RACE	FISCAL YEAR JULY 2022- JUNE 2023
American Indian or Alaska Native	3
Asian	0
Black or African American	0
Native Hawaiian or other Pacific Islander	0
White	10
Other	17
Multi	6
Missing/Unknown	79
Declined to State	9
TOTAL	124

TABLE 5. Ethnicity

5A. TOTAL NUMBERS SERVED BY ETHNICITY (LATINO/X/E OR HISPANIC)	FISCAL YEAR JULY 2022- JUNE 2023
Caribbean	1
Central American	0
Mexican/Mexican-American	37

Puerto Rican	0
South American	1
Other	2
Multi	4
TOTAL	45

5B. TOTAL NUMBERS SERVED BY ETHNICITY (NON-HISPANIC/NON-LATINO/X/E)	FISCAL YEAR JULY 2022- JUNE 2023
African	0
Asian Indian/South Asian	0
Cambodian	0
Chinese	0
Eastern European	0
European	0
Filipino	0
Japanese	0
Middle Eastern	0
Vietnamese	0
Other	0

Multi	3
TOTAL	3

5C. TOTAL NUMBERS SERVED BY ETHNICITY (MORE THAN ONE ETHNICITY, DECLINED TO STATE, OR UNKNOWN)	FISCAL YEAR JULY 2022- JUNE 2023
More than one ethnicity	3
Missing/Unknown	0
Declined to State	79
TOTAL	82

TABLE 6. Primary Language

TOTAL NUMBERS SERVED BY PRIMARY LANGUAGE	FISCAL YEAR JULY 2022- JUNE 2023
English	11
Spanish	26
Other	3
Missing/Unknown	79
Declined to State	5
TOTAL	124

TABLE 7. Culture

TOTAL NUMBERS SERVED BY CULTURE	FISCAL YEAR JULY 2022- JUNE 2023
LGBTQ	5
Veteran	0
Experiencing Homelessness	0
Individuals in Foster Care	0
Other	0
Missing/Unknown	0
Declined to State	0
TOTAL	5

TABLE 8. Medi-Cal Beneficiaries

TOTAL NUMBERS SERVED BY MEDICAL	FISCAL YEAR JULY 2022- JUNE 2023
Medi-Cal Beneficiaries	N/A
Missing/Unknown	N/A
Declined to State	N/A
TOTAL	N/A

TABLE 9. Sessions Offered by Program

TOTAL NUMBERS OF SESSION OFFERED BY PROGRAM	FISCAL YEAR JULY 2022- JUNE 2023
TOTAL	17

TABLE 6. Sexual Orientation

TOTAL NUMBERS SERVED BY SEXUAL ORIENTATION	FISCAL YEAR JULY 2022- JUNE 2023
Gay or Lesbian	0
Heterosexual or Straight	28
Bisexual	0
Questioning or Unsure	1
Queer	2
Other	0
Missing/Unknown	79
Declined to State	14
TOTAL	124

TABLE 10. Disability

TOTAL NUMBERS SERVED BY DISABILITY	FISCAL YEAR JULY 2022- JUNE 2023

No Disability	29
Communication Disability: Difficulty Seeing	1
Communication Disability: Difficulty hearing or speech	0
Communication Disability: Other	0
Intellectual or Mental Disability	0
Physical/Mobility	1
Chronic Health Condition	5
Other Disability	3
Declined to State	1
Missing/Unknown	0
TOTAL	40

9. PROJECT UPDATES

The biggest change made to the project was in the timeline of delivering the offerings. Given the challenges in coming together, the schedule to deliver community offerings was extended until the end of the calendar year (December 2023).

10. CHALLENGES IN IMPLEMENTATION

The biggest challenges to implementation have been scheduling and consistency. These two items have, and will continue to be, challenges due to organizing such a large group of individuals. In addition, operational challenges such as planning and preparation, communication between all partners and healers, and consistent messaging among all NCC SIL members were also experienced during this reporting period. Lastly, there were challenges in data collection after the first offering/community event. It was observed that close to eighty (80) people who attended NCC SIL's Caminata either left earlier than expected and/or decided not to fill out the evaluation survey. However, they did partake in many of the feedback art activities, which provided rich qualitative data. It should be noted that NCC SIL is actively working on addressing the items which posed challenges to improve for future gatherings.

11. SUCCESSES

The biggest success experienced during this reporting period was the launch of NCC SIL's offerings by holding a Caminata in Glen Ellen at Jack London State Park. This event provided an opportunity for the collective to come together to nurture well-being in Sonoma County. It provided an opportunity to co-create a space where community members felt connected, valued, and supported on their wellness journey. Through collaboration with communities and like-minded organizations, NCC SIL was able to build a culturally-rooted environment that celebrated diversity and honored the traditions, practices, and healing wisdom of different cultures. Through the Caminata, NCC SIL was able to: 1.) co-create inclusive spaces that honored and respected diverse cultural backgrounds; (2) promoted wellness practices rooted in the rich traditions of the Latine and Indigenous communities; (3) provided resources and support for individuals and their families on their journey to well-being; (4) and engaged in meaningful partnerships to strengthen community impact.

12. THE ROAD AHEAD

NCC SIL will continue to center relationships as the timeline for delivering community offerings progresses. Additionally, the collective will hold itself accountable for ensuring that it is being inclusive and intentional in its outreach to communities on the margins of society.

APPENDICES

Caminata con Humanidad

En el parque de Jack London

Escanea el código QR para registrarte

https://tinyurl.com/Caminata-Junio

Sabado, 24 de Junio

10:00am a 2:00 pm

2400 London Ranch Rd,

Glen Ellen, CA 95442

Estacionamiento gratuito para las personas que se registren

HUMANIDAD
Therapy & Education Services

LA LUZ

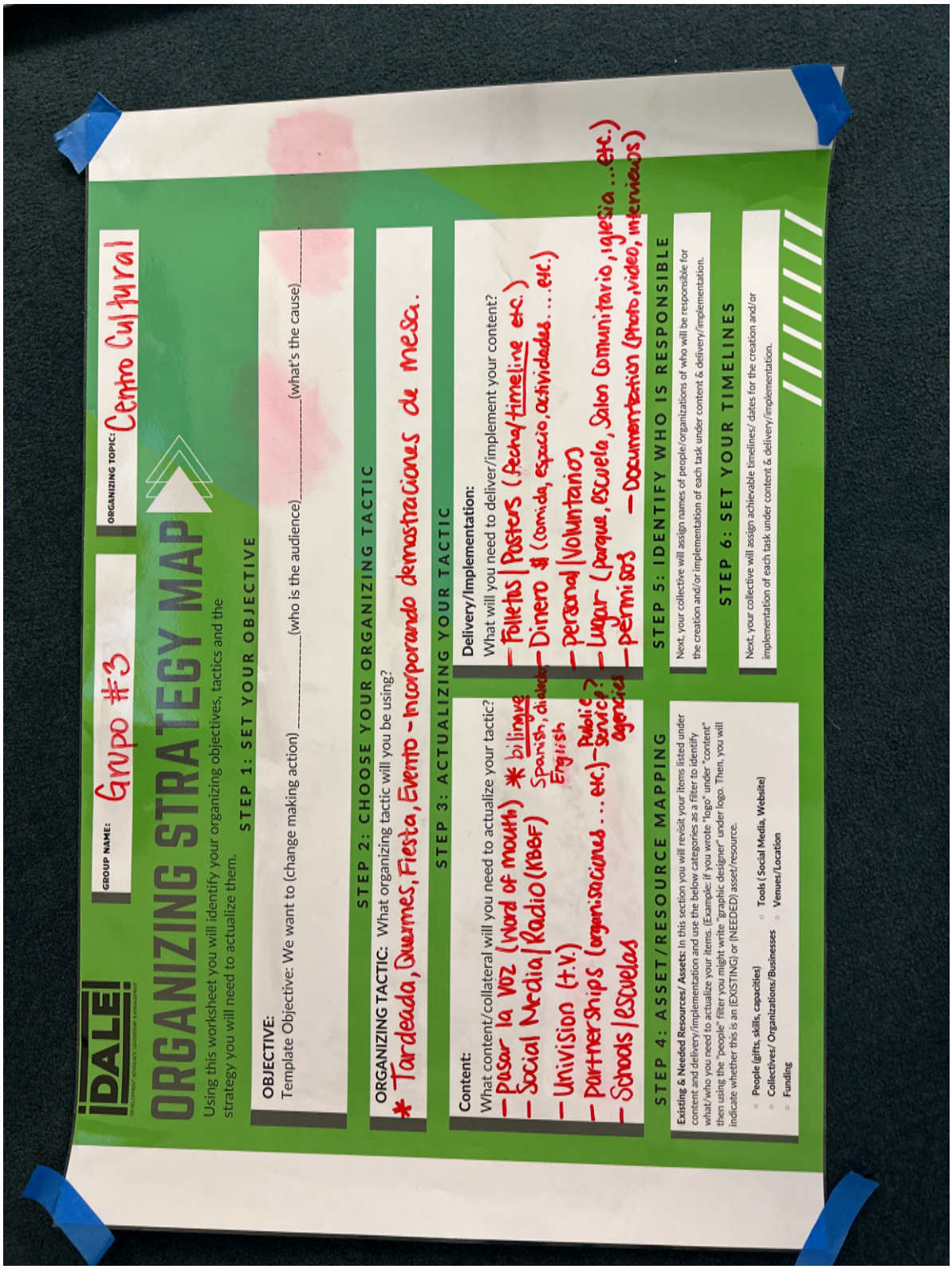
LATINO Service Providers

NUESTRA CULTURA CURA LA PLAZA

NORTH BAY ORGANIZING PROJECT
PROYECTO ORGANIZATIVO DEL NORTE DE LA BAHIA

Botanical Bus
Bilingual mobile herb clinic

Marketing Flyer for First NCC SIL Event - Caminata con Humanidad



NCC SIL Community Offering Strategy Session

MHSA Innovation Annual Report (FY22-23) – Sonoma County Human Services Department

Name of Innovative Project

Current Name: Unidos por Nuestro Bienestar – United for Our Wellness (aka 'Unidos')
Former Name: Collaborative Care Enhanced Recovery Project (CCERP)
Start Date: 9/1/2021

Brief Description of Project

In 2019, Sonoma County Human Services Department, Adult & Aging Division (A&A) and Santa Rosa Community Health (SRCH)-Lombardi Campus embarked on a partnership to deliver behavioral health care in a primary care setting (in coordination with social services delivered in the patient's home) to Latinx patients with symptoms of depression ages 50+. The original project—conceived prior to the pandemic—entailed testing an innovative modification to an evidence-based depression intervention known as the Collaborative Care Model.

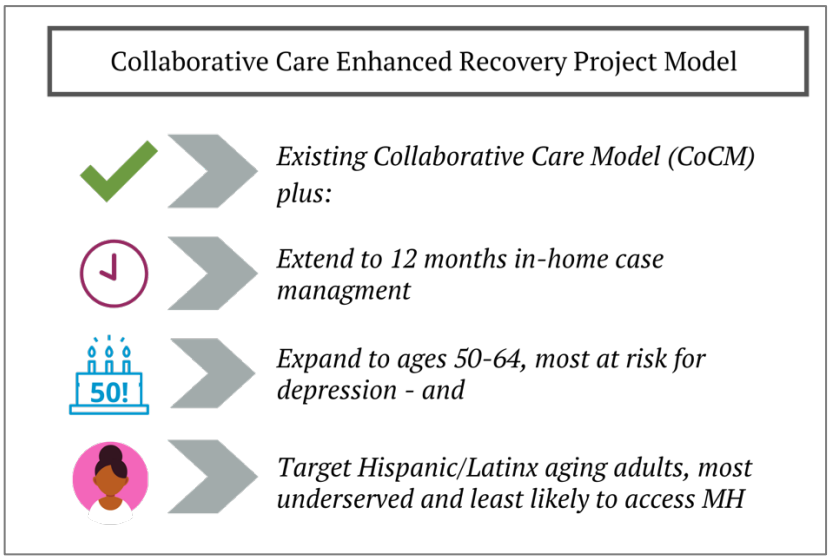
The Collaborative Care Model (aka CoCM) integrates physical and behavioral health services with the following key components: 1) brief care coordination between primary care and behavioral health care providers over a 12-week period that includes weekly multidisciplinary team meetings; 2) regular monitoring, treatment and case management (using validated clinical rating scales) that entail home visits at initiation and weeks 6 and 12 and phone check-ins at weeks 3 and 9; and 3) systematic psychiatric caseload reviews and consultation, as indicated, for clients who do now show clinical improvement.

This innovation builds on A&A's local experience since 2015 in delivering this model-of-care to low-income older adults ages 65 and over. A&A continues to collaborate with Petaluma Health Center in implementing CoCM with fidelity and recently completed a project to support its implementation at West County Health Centers in partnership with West County Community Services. A&A learned from these experiences not only that younger "senior" populations could benefit from this program, but also that 3 months is insufficient duration for the intervention to yield enduring benefits. In addition, A&A recognized that the efforts-to-date have not adequately supported the needs of the Latinx community.

The project, now known as Unidos Por Nuestro Beinestar—United for our Wellness—or Unidos, for short, intentionally engages Latinx patients ages 50+ served @ SRCH and extends the case management period from 3 months to a full year. We changed our project name in 2022 from Collaborative Care Enhanced Recovery Project (CCERP) to Unidos in the spirit of engaging the population-of-focus for this initiative. Coordinated care is provided by a bilingual/bicultural team comprised of primary and behavioral healthcare providers at the FQHC and a Sonoma County Adult & Aging social worker who is embedded at the health center and also conducts home and telephonic visits. Unlike the CoCM intervention, we also extended eligibility to those who screen positive for mild depression (vs. moderate depression) on the PHQ-9, as we have found that:

1) Clients often report their mental health status more favorably than it actually is until they develop trust with their provider, as stigma, taboo and shame about mental health deters disclosure (as observed in many cultures, including the Latinx community [https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/Hispanic-Latinx]); and

2) Even those with mild depression benefit from the intervention.
Those diagnosed with severe persistent mental illnesses are referred to appropriate care.



Our goals were to reach 215 unduplicated individuals during the project period and demonstrate that:

- 50% of clients who show improved depression symptoms during the first 12-weeks will sustain these improvements over the following 9-month extended intervention period; and
- one-quarter of clients will increase their appropriate utilization of primary healthcare services.

Problem Statement

Sonoma County as a whole is experiencing a profound demographic shift, mirroring that which is underway throughout the state and the nation, as the population ages and demand for behavioral health services grows among older adults. The percentage of Sonoma County's aging adults continues to grow faster than the US average and makes up a significantly larger share of the total population than the state average: 39.1% of the County's approximately 504,000 residents are over the age of 50, compared to 31.6% for the state. Further, the number of residents aged 60 and older is projected to increase by nearly 38% between 2015 and 2025.

Hispanic/Latino individuals also make up a growing proportion of Sonoma County's population: 27% of the County's population is Hispanic and 62.1% is white. Correspondingly, more than a quarter of County residents speak a primary language other than English, 77% of which is Spanish. Further, as the largest city in Sonoma County and the biggest urban center between San Francisco and Portland, Santa Rosa is home to a disproportionate share of low-income Sonoma County residents struggling with unaddressed mental health disorders, chronic disease, and contributing social determinants of health.

As the County faces an increasingly senior and Hispanic/Latino population; increases in depression, suicide and chronic health problems; disparities in culturally responsive treatment and access to care among low-income and Hispanic residents it concurrently poses significant challenges to the local mental health care system.

In response, the County of Sonoma Human Services Department (HSD) Adult and Aging Division (A&A) and Santa Rosa Community Health (SRCH) proposed a pilot project to improve treatment for older adults struggling with depression. Unidos por Nuestro Bienestar is designed to augment an established short-term intervention model with longer-term, in-home case management and target it to the underserved Hispanic/Latinx population, resulting in positive and more equitable impacts on mental health, physical health, and quality-of-life for older adults with depression.

Learning Goals

Unidos' original learning goals entailed assessment of the following:

Learning Goal #1: The project's population impact via sustained patient outcomes by establishing whether extending the duration of home-based care management from 12 weeks to 12 months results in sustained improvement of depression symptoms over the course of the intervention period.

Learning Goal #2: The project's system impact via appropriate healthcare utilization, as indicators that clients are accessing optimal medical care that is preventive in nature and supports their overall physical and mental health.

Learning Goal #3: The effectiveness of this intervention for the Hispanic/Latinx population. SRCH serves a large population of Hispanic/Latinx adults. The goal of serving this population is to address the cultural barriers to serving Hispanic/Latinx adults with symptoms of depression.

Findings to Date
(preliminary)

Year 2 Performance

The objectives for Project Year 2 and our progress toward achieving them are described below:

1) Deliver Unidos services to at least 105 unduplicated clients with a focus on Latinx clients

   We continued to deliver services to 3 clients enrolled in Unidos in FY21-22, received 41 client referrals resulting in 13 new enrollments, closed 5 cases due to client health or other issues precluding their continued participation

2) Conduct project evaluation activities

   Our formal project evaluation plan to inform program improvement activities included the following tools and administration protocol:

   - Intake/Tracking Forms – Includes Care Plan and encounter/unable to reach/lost to follow-up/program exit records to support output and process measurements;

- PHQ9 – Administered at screening and at each client visit, and regularly tracked and plotted by the case manager to support sharing with client;
- Social Needs Screening Tool (adapted from the CMS Accountable Health Communities Health-Related Social Needs Screening Tool) – Administered at intake, 6 and 12 months to support client establishment/modification of goals and their achievement (Appendix A);
- Katz Index of Independence in Activities of Daily Living – Administered at intake, 6 and 12 months (Appendix B);
- Client Satisfaction Survey – Administered at 12 months (or at patient exit from program if served for ≥ 6 months with notation) (Appendix C); and
- Results-Based Accountability Measures – Measured by PHQ9, Client Satisfaction and Goal Achievement (Appendix D)

3) Implement quality improvements based on project evaluation results

   Please refer to the "Changes" section for details on quality improvements instituted this project year to address challenges encountered in implementing the project as originally planned.

4) Develop first annual performance report and disseminate to key stakeholders

   - We submitted our final Year 1 report in December 2022 and shared with our community internal and external partners.

Evaluation Data
(including outcomes and information about elements that are contributing to these outcomes)

We served 14 unduplicated clients this project year, four completed the full 12-month Unidos program. Among these four clients:

- All of them (100%) met the goals they established at enrollment to address their needs and improve their mental health status;
- Three of them (75%) demonstrated improvements in their depression symptoms as reflected in a 9- to 15-point decrease in PHQ9 score from program entry to exit; and
- The 2 client satisfaction surveys received from program completers revealed strong satisfaction with services and their case manager (a score of 25/25--see attached sample satisfaction survey).

Changes
(specifically during the reporting period and the reasons for the changes, including any changes in the timeline)

We submitted the following proposed project modification to the Sonoma County Department of Health Services/Behavioral Health Program in March/April 2023 to address the implementation barriers detailed in the "Challenges" session. Our workplan change is driven by our commitment to:

1) Preserve the original intent of our approved MHSA Innovations project—to test an innovation to an evidence-based depression intervention—with primary care as the entry-point to the program;

2) Build on Sonoma County A&A and SRCH's solid foundation of partnering to improve patients' mental and overall health status; and

3) Demonstrate that integrating mental/behavioral healthcare in a primary care setting, augmented by coordinated and ongoing social services case management delivered in the clinic and in the patient's home over a 12-month period, will yield sustained mental health improvements.

Our proposed solution entails the following:

Program Components:

Integrated Mental/Behavioral Healthcare in Primary Care: Preserve and build upon SRCH's existing model of integrating mental and behavioral health within its primary care clinics.

- Embed the A&A social worker into the SRCH Lombardi clinic a minimum of 2 days per week to engage with primary care and/or behavioral health staff on potential referrals. Ideally, warm hand-offs of referred patients would occur during this on-site presence.

Multi-Disciplinary Team (MDT): Convene MDT meetings every 2 weeks that include SRCH primary care providers, behavioral health staff, other members of the SRCH team, the A&A social worker and A&A supervisor. SRCH primary care providers have regular and direct access to psychiatry consultation when needed for complex patients.

- SRCH will refer patients to the Unidos program during the MDT meeting. The A&A supervisor and A&A social worker will review new referrals and provide updates of existing patients during this MDT meeting. Case consultations will address how to proceed in a patient's treatment and include any care-planning needs in the home that relate to the patient's healthcare.

Use of Patient Health Questionnaire 9 (PHQ-9): Continue to administer the PHQ-9 to older adult patients (50+) and navigate those patients with a score of 5-18 to the A&A social worker (see below for range of individuals that benefit from the Healthy IDEAS intervention).

Interventions Used:

The A&A social worker utilizes two interventions with patients served by SRCH in the community (home).

1) The Linkages Case Management Intervention—a person-centered model that implements evidence-based motivational interviewing strategies and techniques. Through motivational interviewing, the A&A social worker engages the patient in their own care-planning needs by exploring readiness for change, identifying existing barriers to overcoming their goals, and developing potential solutions to meet those goals.

- SRCH patients who have been screened for depression (using the PHQ-9), referred to the Unidos program, AND indicate an interest to participate in a case management program to address needs in other areas of their lives, are appropriate for Linkages.

- The A&A social worker will conduct a full needs assessment with patients in their home and engage them in a care-plan development conversation that includes goal-setting and breaking those goals down into smaller objectives that can reasonably be achieved within the 1-year program-enrollment period.

2) The Healthy IDEAS (Identifying Depression and Empowering Activities for Seniors) Intervention—an evidenced-based depression intervention embedded in an older adult case management program. Healthy IDEAS builds on the established client relationship to empower at-risk older adults to address depression and other basic care concerns so they can remain at home.

    - The PHQ-9 depression score guideline for Healthy IDEAS enrollment is 5-14. We recommend the range of scores acceptable for enrollment be adjusted to 5-18 in order to reach a greater population who may benefit from this intervention.

    - The A&A social worker will implement this intervention within the Linkages Case Management intervention through regularly administering the PHQ-9 to the patient, delivering education on depression, making community referrals where possible to address symptoms of depression and by setting behavioral activation goals within the Linkages care plan.

    - The A&A social worker will share patient progress or significant decline on the Healthy IDEAS intervention at the bi-weekly MDT meetings to promote collaboration/care coordination.

Demographics

(from the reporting period)

Number of Unduplicated Clients Served:	14
Age:	
26-59:	6
60+:	8
Gender Assigned at Birth:	
Female:	13
Male:	1
Race:	
American Indian/Alaska Native:	0
Asian:	0
Black/African American:	0
Native Hawaiian/Pacific Islander:	0

White:	12
Other:	2
Multi:	0

Ethnicity (Latinx/Hispanic):

Caribbean:	0
Central American:	0
Mexican/Mexican American:	11
Puerto Rican:	0
South American:	2
Other:	1
Multi:	0

Ethnicity (Non-Hispanic/Non-Latinx)

African:	0
Asian Indian/South Asian:	0
Cambodian:	0
Chinese:	0
Eastern European:	0
European:	0
Filipino:	0
Japanese:	0
Korean:	0
Middle Eastern:	0
Vietnamese:	0
Other:	0
Multi:	0

Primary Language:

English:	1
Spanish:	13
Other:	0

Culture:

LGBTQ:	0
Veteran:	0
Homeless:	0
Individuals in Foster Care:	0
Other (Not Applicable):	0

Medi-Cal Beneficiaries: 9

Successes

(include pictures, quotes, stories, and other graphics)

Exponential Benefits

A Unidos client diagnosed with depression reported feelings of isolation that likely contributed to her mental health status. Although she lives with family, she expressed a deep desire for connecting with other Spanish-speaking women familiar with her culture. Together, the client and the Unidos social worker developed a case plan that included a goal of socialization. The Unidos case manager provided a list of local resources to the client, who used it to guide her finding social activities that would surround her with women of the same cultural background. She contacted these resources and began attending local events. Ultimately, the client found a community group where she has increased her socialization, connection and engagement in meaningful activities. Through monthly contacts, the client has worked on her own personal growth and continues to work on her case plan with support of her Unidos social worker. This experience not only provided tangible benefits to the client, but also opened this resource and opportunity to other Unidos clients with similar needs and goals.

Challenges in Implementation

The pandemic significantly altered the environment in which we initiated our MHSA Innovations project (September 2021). Both SRCH and the Sonoma County A&A grappled with delivering services during the start-up period and into early 2023. Fluctuating conditions not only challenged our respective abilities to conduct 'business-as-usual,' they also demanded that we modify staffing patterns and responsibilities (while concurrently trying to fill project positions), adjust workflows, and essentially do more with reduced resources.

We served our first clients in Q4 of FY21-22, having filled the A&A Case Manager and several other SRCH Project Team positions (e.g., Lombardi Site Director). However, the service delivery model (including the client identification and referral process) was not launched according to our original plan due to the above-cited challenges. By the end of Q2 of FY22-23, we served 12 unduplicated clients, closed 3 of the cases, and received 32 referrals for individuals whose cases we closed primarily due to our inability to reach them to schedule an appointment. (Note that some of the referred patients were inappropriate for Unidos and were referred to other services while other patients moved or expressed disinterest in enrolling). This prompted us to consider how we may adjust our approach to gain traction with all of the key project personnel, the broader clinical healthcare provider team at SRCH and their eligible patients.

In January 2023, we invited the co-director of the University of Washington Advancing Integrated Mental Health Solutions (AIMS) Center (the CoCM developer) to address our Unidos team regarding the key model components and essential next steps for rebooting project implementation and optimizing its success. This meeting precipitated a deliberative process that yielded the project workplan changed described in the "Changes" section above.

Appendix A

Social Needs Screening Tool

Living Situation		
Question		
1. What is your living situation today?	☐ I have a steady place to live	☐ I am worried about losing it in the future ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park) (+2)
2. Think about the place you live. Do you have problems with any of the following?	☐ (n/a)	☐ Pests such as bugs, ants, or mice ☐ Mold ☐ Lead paint or pipes ☐ Lack of heat ☐ Oven or stove not working ☐ Smoke detectors missing or not working ☐ Water leaks
Food		
3. Within the past 6 months, you worried that your food would run out before you got money to buy more.	☐ Never	☐ Sometimes ☐ Often(+2)
Transportation		
4. Do you have reliable transportation to get to medical appointments, meetings, work or for getting things needed for daily living?	☐ Always	☐ Sometimes ☐ Never(+2)
Utilities		
5. In the past 6 months have any of the following services threatened to shut off services or have shut off services in your home?	☐ (n/a)	☐ electric ☐ gas ☐ oil ☐ water ☐ phone ☐ internet
Safety		
6. Do you feel physically safe in your home?	☐ Always	☐ Sometimes ☐ Never(+2)
7. Do you feel emotionally safe in your home?	☐ Always	☐ Sometimes ☐ Never(+2)
Financial Strain		
8. How hard is it for you to pay for the very basics like food, housing, medical care, and heating?	☐ Not hard at all	☐ Very hard(+2) ☐ Somewhat hard

Adapted from: The Accountable Health Communities Health-Related Social Needs Screening Tool, Center for Medicare & Medicaid https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

Employment		
9. Do you need help finding or keeping a job?	☐ No	☐ Yes
Family and Community Support		
10. If for any reason you need help with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc., do you get the help you need?	☐ I don't need any help ☐ I get all the help I need	☐ I could use a little more help ☐ I need a lot more help (+2)
		Total= /35

Adapted from: The Accountable Health Communities Health-Related Social Needs Screening Tool, Center for Medicare & Medicaid https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

Patient Name:_____ Date:_____
Patient ID #_____

Katz Index of Independence in Activities of Daily Living

Activities Points (1 or 0)	**Independence** (1 Point) **NO** supervision, direction or personal assistance.	**Dependence** (0 Points) **WITH** supervision, direction, personal assistance or total care.
BATHING Points: _____	**(1 POINT)** Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	**(0 POINTS)** Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing
DRESSING Points: _____	**(1 POINT)** Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	**(0 POINTS)** Needs help with dressing self or needs to be completely dressed.
TOILETING Points: _____	**(1 POINT)** Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	**(0 POINTS)** Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
TRANSFERRING Points: _____	**(1 POINT)** Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable	**(0 POINTS)** Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE Points: _____	**(1 POINT)** Exercises complete self control over urination and defecation.	**(0 POINTS)** Is partially or totally incontinent of bowel or bladder
FEEDING Points: _____	**(1 POINT)** Gets food from plate into mouth without help. Preparation of food may be done by another person.	**(0 POINTS)** Needs partial or total help with feeding or requires parenteral feeding.

TOTAL POINTS: _____ **SCORING:** 6 = High (*patient independent*) 0 = Low (*patient very dependent*

Source:
try this: Best Practices in Nursing Care to Older Adults, The Hartford Institute for Geriatric Nursing, New York University, College of Nursing, www.hartfordign.org.

general assessment series

try this:®

Best Practices in Nursing Care to Older Adults

From The Hartford Institute for Geriatric Nursing, New York University, College of Nursing

Issue Number 2, Revised 2007

Series Editor: Marie Boltz, PhD, GNP-BC
Series Co-Editor: Sherry A. Greenberg, MSN, GNP-BC
New York University College of Nursing

Katz Index of Independence in Activities of Daily Living (ADL)

By: Meredith Wallace, PhD, APRN, BC, Fairfield University School of Nursing, and Mary Shelkey, PhD, ARNP, Virginia Mason Medical Center

WHY: Normal aging changes and health problems frequently show themselves as declines in the functional status of older adults. Decline may place the older adult on a spiral of iatrogenesis leading to further health problems. One of the best ways to evaluate the health status of older adults is through functional assessment which provides objective data that may indicate future decline or improvement in health status, allowing the nurse to intervene appropriately.

BEST TOOL: The Katz Index of Independence in Activities of Daily Living, commonly referred to as the Katz ADL, is the most appropriate instrument to assess functional status as a measurement of the client's ability to perform activities of daily living independently. Clinicians typically use the tool to detect problems in performing activities of daily living and to plan care accordingly. The Index ranks adequacy of performance in the six functions of *bathing, dressing, toileting, transferring, continence, and feeding*. Clients are scored yes/no for independence in each of the six functions. A score of 6 indicates full function, 4 indicates moderate impairment, and 2 or less indicates severe functional impairment.

TARGET POPULATION: The instrument is most effectively used among older adults in a variety of care settings, when baseline measurements, taken when the client is well, are compared to periodic or subsequent measures.

VALIDITY AND RELIABILITY: In the thirty-five years since the instrument has been developed, it has been modified and simplified and different approaches to scoring have been used. However, it has consistently demonstrated its utility in evaluating functional status in the elderly population. Although no formal reliability and validity reports could be found in the literature, the tool is used extensively as a flag signaling functional capabilities of older adults in clinical and home environments.

STRENGTHS AND LIMITATIONS: The Katz ADL Index assesses basic activities of daily living. It does not assess more advanced activities of daily living. Katz developed another scale for instrumental activities of daily living such as heavy housework, shopping, managing finances and telephoning. Although the Katz ADL Index is sensitive to changes in declining health status, it is limited in its ability to measure small increments of change seen in the rehabilitation of older adults. A full comprehensive geriatric assessment should follow when appropriate. The Katz ADL Index is very useful in creating a common language about patient function for all practitioners involved in overall care planning and discharge planning.

MORE ON THE TOPIC:

Best practice information on care of older adults: www.ConsultGeriRN.org.

Graf, C. (2006). Functional decline in hospitalized older adults. *AJN*, *106*(1), 58-67.

Katz, S., Down, T.D., Cash, H.R., & Grotz, R.C. (1970) Progress in the development of the index of ADL. *The Gerontologist*, *10*(1), 20-30.

Katz, S. (1983). Assessing self-maintenance: Activities of daily living, mobility and instrumental activities of daily living. *JAGS*, *31*(12), 721-726.

Kresevic, D.M., & Mezey, M. (2003). Assessment of function. In M. Mezey, T. Fulmer, I. Abraham (Eds.), D. Zwicker (Managing Ed.), *Geriatric nursing protocols for best practice* (2nd ed., pp 31-46). NY: Springer Publishing Co., Inc.

Mick, D.J., & Ackerman, M.H. (2004, Sept). Critical care nursing for older adults: Pathophysiological and functional considerations. *Nursing Clinics of North America*, *39*(3), 473-93.

Appendix C

Unidos Por Nuestro Bienestar – United for Our Health

Client Survey

Score

1. Meetings with my Unidos social worker helped me feel better. (circle one)

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

2. My Unidos social worker helped me identify my needs. (circle one)

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

3. My Unidos social worker helped me set goals to address my needs. (circle one)

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

4. My Unidos social worker connected me to resources that I used. (circle one)

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

5. I would recommend this program to family and friends. (circle one)

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

Total:

6. Any other comments? _____

_____

For office use only: Code - _____

Survey Period (check one) - ☐ 6 mo. ☐ 12 mo. ☐ Other: _____

Unidos Por Nuestro Bienestar – United for Our Health

Client Survey

1. **Las juntas con mi Trabajdor/a Social Unidos me ayudaron a sentirme mejor. (seleccione uno)** Puntaje





Totalmente de acuerdo	De acuerdo	Neutral	En desacuerdo	Totalmente en desacuerdo
5	4	3	2	1

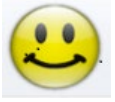
2. **Mi Trabajador/a Social Unidos me ayudó a identificar mis necesidades. (seleccione uno)**





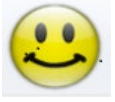
Totalmente de acuerdo	De acuerdo	Neutral	En desacuerdo	Totalmente en desacuerdo
5	4	3	2	1

3. **Mi Trabajador/a Social Unidos me ayudó a establecer metas para atender mis necesidades. (seleccione uno)**

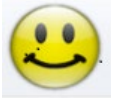

Totalmente de acuerdo	De acuerdo	Neutral	En desacuerdo	Totalmente en desacuerdo
5	4	3	2	1

4. **Mi Trabajador/a Social Unidos me conectó con recursos que utilicé. (seleccione uno)**


Totalmente de acuerdo	De acuerdo	Neutral	En desacuerdo	Totalmente en desacuerdo
5	4	3	2	1

5. **Yo recomendaría este programa a familiares y amigos.(seleccione uno)**


Totalmente de acuerdo	De acuerdo	Neutral	En desacuerdo	Totalmente en desacuerdo
5	4	3	2	1

Total:

6. **Algun otro comentario?** _____

_____

Para uso de la Oficina: Codigo - _____

Perido de Encuesta(seleccione uno) - ☐ 6 ms. ☐ 12 ms. ☐ Other: _____

Unidos Por Nuestro Bienestar – United for Our Health

Client Survey

Addendum 1: Results-Based Accountability Plan

The Results-Based Accountability (RBA) Plan may be periodically amended, as evidenced in writing and signed by all Parties. A written, signed RBA Plan, outlining specific performance measures, will constitute an addendum to this Scope of Work.

1. Program Information:

Organization: County of Sonoma's HSD & Santa Rosa Community Health Centers
Program Name: Collaborative Care Enhanced Recovery Project (CCERP)

1.1. Location and region where services are to be provided (location of where clients served live):

North county: ☒ South county: ☒ East county: ☒ West county: ☒
Central county: ☒

1.2 Language services will be provided in: English: ☒ Spanish: ☒ Other:

1.3 Client demographics for program, if available, check all that apply:

Race/Ethnicity: Hispanic/Latino ☒ White ☒ African American ☒ Asian/Pacific Islander ☒ Native American ☒

Other

Gender: Male ☒ Female ☒ Transgender Female to Male ☒ Transgender Male to Female ☒

Genderqueer/Gender non-binary ☒ Not Listed, please specify:

Age: 0-5 (children) ☐ 6-15 (youth) ☐ 16-25 (transition age youth) ☐
26-59 (adults) ☒ 60 and over (older adults) ☒

Other:

** For reporting purposes only*

2. Result Area:
Result (population accountability)
What population result does your program contribute to? The County has identified a list of results and population indicators for each Department. Add result(s) relevant to this procurement from the list.

2.1 Result: *All Sonoma County Residents Live a Long and Healthy Life*

3. Performance Measures for Program Year 2 –

List proposed activities that you plan to monitor with performance measures	***Program Performance Measures***	***Performance Measure Target***	***Data Collection Method***	***Data Reporting Cycle***	***Turn the Curve Frequency – (data review & action plan)***
Provide longer-term (12 months), in-home case management to adults aged 50+ who have two or more impairments with a goal of reducing depression, increasing targeted outreach to and engagement of Latinx and Spanish-speaking individuals, with an enhanced focus on culturally and linguistically appropriate care.	**How much do we do? (# of participants served, # of activities)** • # of unduplicated clients	• 105 unduplicated clients per year	• EHR patient registry	• July 1-September 30 • October 1-December 31 • January 1-March 31 • April 1-June 30	• October • January • April • July
	How well do we implement the service? (Participant satisfaction, retention rates, cost) • % of unduplicated clients who meet their goals and exit the program in a quarter (meet goals or exit the program at end of 12-month program)	• 50 % of unduplicated clients will meet their goals or exit the program at end of 12-month program)	• EHR patient registry	• July 1-September 30 • October 1-December 31 • January 1-March 31 • April 1-June 30	• October • January • April • July
	Are people better off? (#/% skill or knowledge, #/% attitude or opinion, #/% behavior, #/% circumstance/condition) • % of unduplicated clients who exit the program and self-report mental health improvements	• 50% of unduplicated clients who exit the program will self-report improvements with their mental health	• Client survey or questionnaire	• July 1-September 30 • October 1-December 31 • January 1-March 31 • April 1-June 30	• October • January • April • July

4. Reporting Requirements:

Contractor shall apply, document and report on performance measures and activities detailed in the RBA Plan. These documents may be modified at any time as agreed to in writing by both parties. Contractor shall report these data based on the timeline determined in the RBA Plan, and participate in Turn the Curve monitoring as defined in the RBA Plan. Contractor shall disaggregate the performance measures by demographics and geographic area for reporting when possible. Upon contract closeout, contractor shall report client demographics for program if available.

Contractor	Contract Manager or Designee	Department RBA Lead

New Parent TLC

Talk. Link. Confirm.

Habla. Conecta. Confirma

FIRST 5 sonoma county

sonoma county DEPARTMENT OF HEALTH SERVICES Behavioral Health Division

I. Brief description of Project

Sonoma County-wide MHSA Innovation project, New Parent TLC (Talk, Link, Confirm) employs a gatekeeper training model similar to the evidence-based model QPR (Question, Persuade, Refer) to identify signs, and intervene early with new parent mental health issues that may otherwise go unaddressed, ultimately preventing suicide. As a secondary outcome, New Parent TLC also aims to prevent the exposure of infant Adverse Childhood Experiences (ACEs) resulting from parental depression and the associated disruption of optimal infant/toddler brain development. The model increases access to mental health services to underserved groups including new parents of all types: biological, non-biological, adoptive, gay, or straight (Beck, 2014). New Parent TLC promotes interagency and community collaboration related to mental health services with the innovative model that engages childcare providers, cosmetology service providers, and employees of medium to large places of employment as peers, as "Connectors," (formally known as "gatekeepers") with a robust outreach method to raise awareness of new parental depressive symptoms, and helps get parents linked to mental health services by initiating the conversation (Talk), providing culturally appropriate referrals to parental mental health services (Link), and following-up with the parent to confirm they have accessed services (Confirm).

The project includes a culturally responsive curriculum development process with a community advisory group, training for a core team of trainers to implement the project, and community-wide training for groups of childcare providers, cosmetology service providers, and employees of medium to large places of employment. The community groups will be trained in the New Parent TLC (Talk, Link, Confirm) model, and become a "Connector" who will work in the community to identify parental mental health concerns, link the identified new parents with culturally appropriate resources, and follow-up to confirm the new parents have accessed services.

II. Demographics

The primary population to serve with this project are "Connectors," which will include groups of child care providers, cosmetology service providers, and employees of medium to large places of employment as peers. When training begins, approximately 30% of the training groups will be facilitated in Spanish to match the demographics of Sonoma County. At the end of the second year of the project, the curriculum is being finalized, and outreach and training materials are being created and translated. The first set of training events is currently being scheduled for November 2023.

In the curriculum development phase, a culturally responsive community group was established to inform the curriculum development process and ensure the curriculum and training implementation for the community is inclusive, and representative of Sonoma County parents. The culturally responsive community advisory group includes birthing parents, non-birthing parents, heterosexual parents and parents who are part of the LGBTQIA2s+ community. In

addition, the curriculum is culturally responsive for English speaking parents and Spanish speaking parents in Sonoma County. The culturally responsive community advisory group includes members of organizations to represent the Latinx and LGBTQIA2s+ parental communities, with organizations represented including Positive Images, Latino Service Providers, Postpartum Support Center, North Bay LGBTQI Families, and participants with lived experience.
The First 5 program staff have all been trained in the New Parent TLC model. Of the trainers, four are bilingual Spanish speaking, and three trainers are monolingual English speaking trainers. The ratio of Spanish speaking trainers will allow for meeting the needs of the community and sufficient to hold at least 30% of the trainings in Spanish as planned.

III. Problem Statement

The primary problem that this project intends to address is 3-fold:

1. The high prevalence of postnatal mental health issues for new parents;
2. Postnatal mental health issues very often go unidentified, untreated and unmitigated;
3. Untreated parental mental health issues pose a significant risk of exposure to ACEs to thousands of Sonoma County children in the first year of life when the brain is most vulnerable to such exposure.

IV. Learning Goals

Learning Goal 1: What is the difference, if any, of the number of referrals for parents for services for parental depressive symptoms by trained connectors?

Sub-goal 1a: Is there a statistically significant difference in the rate of referrals between the three groups of childcare providers, cosmetology services providers, and coworkers/employees?

Learning Goal 2: What is the experience of parents experiencing depressive symptoms, trained connectors, and postpartum service providers who have participated in the New Parent TLC pilot project?

Sub-goal 2a: What factors contribute to completed linkages to services and a positive experience for parents, and trained connectors?

Sub-group 2b: What factors were identified as barriers for referrals made that were not successfully completed?

V. Findings to date (preliminary)

In the first year of the project, First 5 Sonoma County contracted with consultants to develop culturally responsive curriculum that was first used to train the primary trainers of the project, and then for the primary trainers to train the connectors in the community. The curriculum

development consultants were mental health professionals who specialize in maternal mental health.
Also in the first year, a culturally responsive community advisory group was developed to provide feedback during the curriculum development. The group was strategically developed to represent underrepresented demographics of parents in Sonoma County, to ensure inclusivity and belonging in the framework of the curriculum. There were seven participants in the culturally responsive community advisory group, from four different organizations including participants with lived experience, with the intention of inclusiveness for LGBTQIA2s+ and Latinx parents. The group met monthly to review curriculum, with six monthly hour and a half meetings completed by the end of the reporting period, and additional meetings that continued into year two of the project. Feedback from each session was implemented to update the train-the-trainer and connector training curriculum.

***Participants of the Culturally Responsive Curriculum Advisory Group provided the following statements about their participation in the group*:**

"Participating in the Culturally Responsive Curriculum Group was a very positive experience. Each time I joined this group, I felt empowered to share my perspective and my ideas with the group. The facilitators did an amazing job inviting each of our voices into the conversation and Jenni and Allison showed us respect each time by showing us how they implemented our opinions and feedback. This group was truly special because it finally felt like we weren't just another equity group to check off a box, our voices mattered. I am excited to see this program reach our communities."

-Alayza Cervantes, Community Engagement Manager at Latino Service Providers

"I'm heartened by the innovative NPTLC program. I've known new parents and care providers who faced serious mental health struggles but did not feel safe opening up to their partner or family. Training hair stylists— and other people to whom a new parent might open up—on how to recognize signs of these challenges and connect people to support is an excellent idea. I'm grateful that First5 engaged me and other LGBTQIA+ community members to guide the curriculum toward being culturally relevant to- and acknowledging of queer and trans parents. Mainstream society's approach to parenthood is rooted in cisheteronormativity; for queer and trans parents, this can create and exacerbate feelings of isolation and other new parent mental health challenges."

-Chelsea Kurnick, Member of the Board of Directors for Positive Images

"This is a quick thank you to let you know of my appreciation for the opportunity to influence a program directed at postpartum mental health. The opportunity to have my experience heard and my ideas validated is important to me. I am pleasantly surprised and amazed to see an entire program grow from my thoughts. It is a life lesson in using my energy to speak up, and engage, in a process to try and make positive change.

My experience with postpartum depression left me aware there is a gap between the technical competence of the medical world and its ability to engage with patients. That lack of engagement can come from the formality of the system, the lack of awareness of desperate patients, or from feeling the system isn't there to support your specific needs. I am hoping this new program will help alleviate the gap in the first two. And in another good life lesson, I see, through the great effort to build inclusiveness that this program is addressing the last as well."
-Greg Ludlam, Parent with lived experience

Some of the major findings to date throughout the curriculum development phase included a focus on inclusive language that is not gender specific. As an example, instead of referring to either a mother or a father, our curriculum refers to the birthing parent, or a non-birthing parent. Within the curriculum there is also intention in the area of calling out that when the gender specific terms are used, that it is only because there are direct quotes from a study. There was significant exploration about addressing parental stress that is related to traditional cultural norms, with a conscious decision to remove as many examples with stereotypes as possible. In addition, the curriculum initially included significant background information specific to maternal mental health, but was eventually adapted to include parental mental health, with less gender specific examples, as they were irrelevant to identifying the signs, and providing a referral, which is the goal of the project.

In the second year of the project, the curriculum development continued. There were multiple key informant interviews with potential connectors who represent each of the groups to inform the implementation of the training curriculum. The key information interviews were with one person per Connector group, so one child care provider, one employer with Amy's Kitchen, and one hair dresser. Once the curriculum was thought to be finalized,
First 5 Sonoma County started their training components of the grant. The first part of the training was to train the trainers which included First 5 Staff Members: two Program Coordinators, three Program Managers, and the Program Director. First 5 Staff participated in a four hour training facilitated by the consultants who created the curriculum. Some of the major findings that came out of the training was that there was more curriculum development that needed to take place and that some of the curriculum needed to be made into more interactive materials for the Connector training to be effective and utilize adult learning theories.

Another finding that came out of this year was the importance of including lived experiences in the curriculum and delivery of materials. It just so happened that two First 5 staff members had babies within the last year. Including the perspective of those staff members and having their fresh parenting perspective reshaped the curriculum to be more accessible and realistic.

Lastly, another finding from this year (although it was present in previous years) was that to do something right takes time and patience. With new parents involved in the process this year, the preciousness and delicate nature of this program was highlighted.

VI. Changes to Program

One of the biggest changes to the program was the timeline of the curriculum development (as noted in the challenges section below). Since this is an innovative program, we worked with consultants to develop the Curriculum from scratch. The development of the curriculum with the consultants took longer than expected because of the convening of the Culturally Responsive Curriculum group which shaped and changed the content of the originally planned curriculum. Also, meetings with the three individuals from the child care, esthetician, and employer sectors make it clear that each curriculum would need to be curated to meet the needs of each population more than expected. With these realizations, First 5 Staff chose to focus on one sector curriculum at a time (first sector was child care). The creation of the Connector training binders, role play scripts, and outreach materials (including translation) also changed the timeline and will need to be specially curated for each sector. With all that being said, the curriculum/material development took twice as long as anticipated on the original Scope of Work.

VII. Challenges in implementation

In the first year of the contract some of the notable challenges include the timeline. The contract execution was later than expected, which pushed back the timeline for the entire project. The contract delay also came after an extremely long proposal approval delay, through the pandemic and negotiations of details of the project. The combination of delays resulted in the need to reconfigure portions of the project to meet current needs before the project could fully launch. including uncertainty about in-person training, which was the original plan.

Once the subcontract with the consultants was in place, the curriculum development phase got off to a solid start with strong participation from the culturally responsive community advisory group. Through this process, the process for the curriculum development took much longer than originally anticipated, as fully embracing the community voice was often time consuming, as the feedback came with rich conversations and deep discussions to ensure inclusive language was being utilized consistently, and that the true vision of the project was moving forward.

In the second year, the current reporting period, the timeline is still a notable challenge. The development of curriculum for a pilot program is a living document that evolves as more trainings are conducted and more feedback is given on the materials and process. The curriculum has to be curated for three different populations and settings, which involved more specialized sections than originally anticipated. For example, an interaction between a child care provider and a parent may be brief (at a drop off or pick up) whereas an interaction with a hairdresser and their client may last for hours. This discrepancy in interactions changes how each sector might

approach the Talk, Link or Confirm aspect of the program, thus requiring extensive differences in approach for each sector.

Another challenge has been how to make sure harm is not created through secondary trauma for Connectors. The First 5 team recognized that not having concrete supports for Connectors could lead to trauma thus counteracting the positive work of New Parent TLC. Resources and a solid system for support and feedback has been under development to ensure Connectors are supported.

Lastly, with a pilot program, it can be hard to conceptualize the delivery of the materials to the target audience. The First 5 team has held several internal meetings to create and practice role plays and certain parts of the curriculum to ensure that the material is not only accessible, but that it upholds the spirit and feedback of the culturally responsive group. With all that being said, the depth of curriculum development and service delivery were underestimated in the original Scope of Work.

VIII. Successes

In the first year, some success was that the curriculum was fully inclusive, and grounded in community voice and lived experience. Throughout the process, there were additions to the original plan to include more community voice wherever possible. In addition to the originally planned culturally responsive community group for curriculum feedback, there were one-on-one key informant interviews added to provide specific feedback within each connector group of childcare providers, cosmetology service providers, and employees at medium to large places of employment.

A humanistic approach to the curriculum development resulted in multiple positive outcomes. Not only does the curriculum framework completely embrace and represent the parental communities of Sonoma County, but the culturally responsive group also shared many positive impacts based on their participation in the group. The participants felt their voices were heard and clearly represented throughout the curriculum, and the participants expressed interest in being a part of the process moving forward, as demonstrated in a quote above.

There has been time in this first phase for the primary trainers to prepare for their training within the next few months by having the time to proactively prepare their workloads to accommodate the time responsibility to participate in the initial training, learn the material, and fully prepare for implementation in the community. Within the early learning sector there has been opportunities for cross collaboration with partners in the childcare sector. Some of the other projects First 5 facilitates and funds have been great places to engage professionals in the childcare sector when information or feedback is needed, and it has helped that the relationship is already established as we prepare for large scale trainings in the near future.

Successes in the second year include a fully developed curriculum translated to Spanish. Along with the Curriculum, First 5 Managers developed a comprehensive Child Care Connector training binder. The binder for the Child Care Connectors includes the slides with a notes section, a self-care guide, a page for them to plan how they will Confirm, flyers for doors and community boards, magnets, resource cards, and various other helpful handouts. All of the materials will be in English and Spanish. Throughout the curriculum "finalization" and materials development First 5 Staff met multiple times to discuss next steps but also to start practicing role plays and talking points.

Using the childcare connections mentioned in the first year successes, Staff has begun outreach for our first training which is scheduled for November 4th, and the second training (in Spanish) tentatively scheduled for November 18th.
As stated in the "Findings to Date" section, First 5 also had two Managers who had babies through this year of the project, and were vital in fully embracing the lived experience in real-time as the curriculum was being updated and revised. The depth of lived experience voice in this project has added significant value to the project. With all that being said, the quality of the product that was created exceeded anything that was envisioned in the beginning of the pilot program. The next steps will be to conduct the first two cohorts of child care provider Connector trainings, receive feedback via a survey, and then potentially adjust the curriculum again depending on feedback. We will also be shifting focus to the other two Connector sectors: Medium/large employers, and cosmetologists.

Mental Health Services Act

Collaborative Statewide Early Psychosis Program Evaluation

Annual Innovation Report:

Summary Report of the Activities of the LHCN

Fiscal Year 2022-2023

Draft submitted November 13th, 2023

Prepared by:

University of California, Davis, San Francisco and San Diego

This report was supported by:

Table of Contents

Background **5**

Figure 1. Three Components of the Evaluation Associated with the Statewide LHCN. 5

Executive Summary **6**

Current Project Goals **8**

1. Recruit EP community partners for external Advisory Committee meeting **8**

2. Establish a community partner advisory committee that will meet at least every 6 months **9**

November 29th, 2022 9
June 6th, 2023 10

3. Complete baseline and pre-LHCN implementation questionnaires for new LHCN Counties **10**

4. Report on post-LHCN implementation questionnaires administered to program and county staff. **11**

5. Schedule EP program for fidelity assessment. **12**

6. Present results from fidelity assessments of EP programs **13**

Table I: FEPS-FS 1.1 Components 14

Assessment Summary *15*

Table II: Fidelity Assessment Characteristics 15
Figure 2: Proportion of programs meeting good to high fidelity on FEPS-FS Items 16

7. Provide training and implementation of outcomes measurement on app in non-pilot EP programs and progress of data collection in all EP programs **16**

Figure 3: Beehive Training Schedule 17
Table III: EPI-CAL Site Training Completion 17

Pre-Training Meeting *18*

Part 1 Training *18*

Presentation- “The Value of Beehive and Data Collection” 18
Figure 4: Training Agenda 19
Part A: Using Beehive Support Resources 19
End User License Agreement (EULA) Video 19
Part B: Training Tasks: Setting up Clinic Admin/Provider Accounts and Registering Consumers 19
Part C: Next Steps 20
Figure 5: Training Checklist 21

Intake Workflow Meeting *21*

Part 2 Training *21*

Figure 6: MCSI Example Graphs from Beehive 22

Data-Entry Workflow Meeting *22*

Implementation Support After Initial Beehive Trainings *23*

Tablet Training *24*

Figure 7: Diagram showing workflow differences in client registration based on environment 24

8. Submit report on LHCN enrollment and follow up completion rates for LHCN app in all EP programs 25

LHCN Overview *25*

Figure 8: LHCN Progress Towards EPI-CAL Enrollment Targets 25
Figure 9: Proportion of Data Sharing with UCD for Research by Site 26
Figure 10: Proportion of Data Sharing with UCD for Research among Completed EULAs 27

Progress of data collection in all EP programs *27*

Figure 11: Survey Completion Rates Across EPI-CAL Network 28
Table IV: Demographic Data from all Participating EPI-CAL Clinics 28
Table V: Client Diagnoses from all Participating EPI-CAL Clinics 30

9. Submit final data analysis plan for all data 31

Table VI: Beehive Surveys by Timepoint and Respondent Type 32

10. Draft preliminary data on feasibility and acceptability of LHCN app in all EP programs 35

Table VII: Preliminary client and PSP Beehive enrollment 36

11. Subcontractor to make additional revisions to dashboard to include feedback from programs and community partners. 37

Table VIII: Changes to Beehive Implemented over the Fiscal Year 22/23 37

12. 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 39

Data Collection Process *39*

Retrospective 40
Prospective 40

13. Identification of county-level available data and data transfer methods, and statistical analysis methods selected for integrated county-level data evaluation 41

Table IX. Multicounty Program Services and Billing Information 42

14. Deliver a plan and timeline for working with counties to support infrastructure to access final round of county-level cost and utilization data for EP and CG programs 44

Overview of Deliverable for Annual Report *44*

Prospective Data Analysis 44

Retrospective Data Request for Napa County *45*

Follow-up to Preliminary Retrospective Data Analysis *46*

Follow-up of preliminary analysis of service utilization data *46*

Cost Analysis *47*

Sample and Methods 47
Results 48

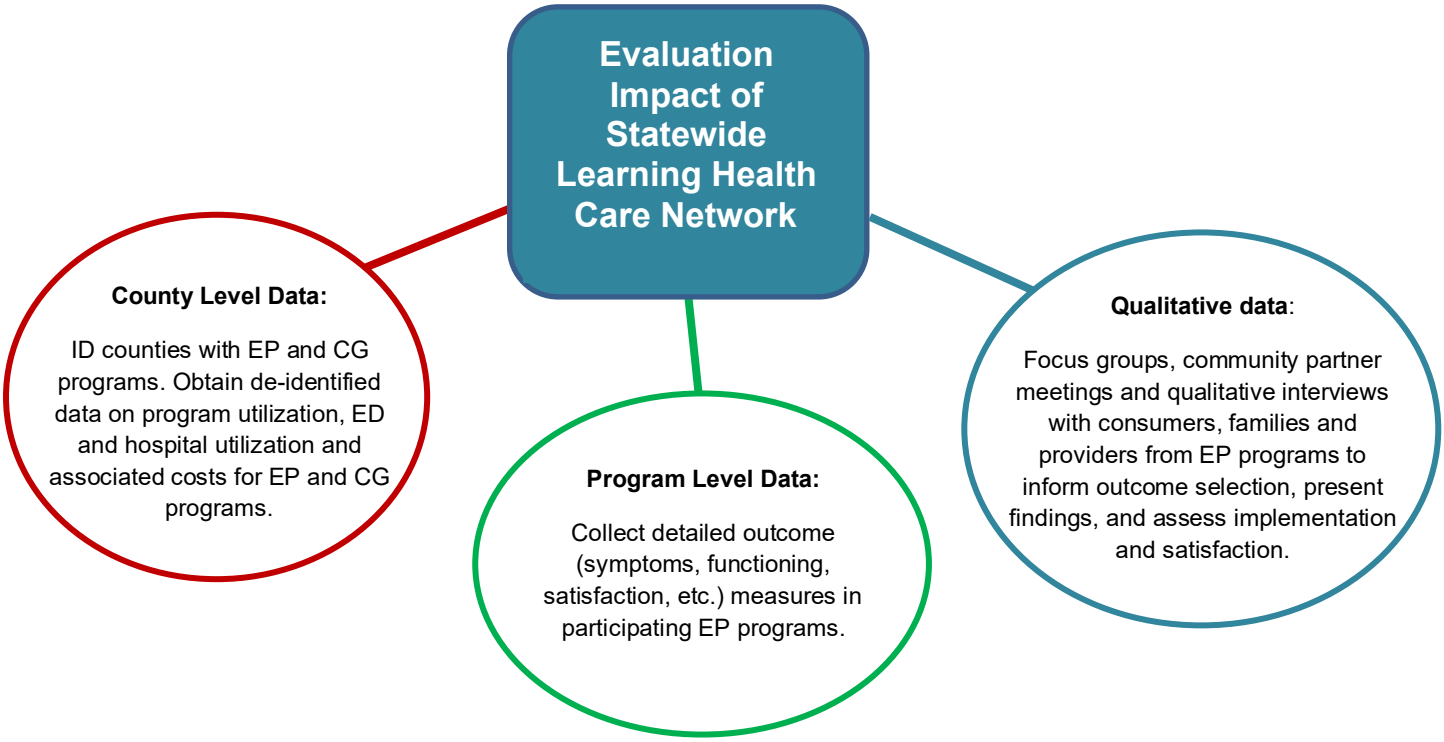
Summary....49
Table XI: Demographic Characteristics of Youth Clients of Kickstart and a Comparison Group....49
Table XII: Mean Annual Services Use, Standardized by Demographic Characteristics, in the Year Prior and Year Post Enrollment....50
Table XIII: Mean Annual Visits, Standardized by Demographic Characteristics, in the Year Prior and Year Post Enrollment....50
Table XIV: Mean Annual Probability of Psychiatric Inpatient Admission, Standardized by Demographic Characteristics, in the Year Prior and Year Post Enrollment....51
Table XV: Mean Annual Probability of Use of Psychiatric Emergency Services, Standardized by Demographic Characteristics, in the Year Prior and Year Post Enrollment....51
Table XVI: Mean Annual Costs of Outpatient Services, Standardized by Demographic Characteristics, in the Year Prior and Year Post Enrollment....51
Future Analyses....*52*
Discussion and Next Steps....**52**
Discussion....*52*
Next Steps....*53*
Appendix I: Intake Workflow Meeting Template....**55**
Appendix II: Data-Entry Workflow Meeting....**56**
Appendix III: Beehive Part 3 Training Small-Group Worksheet....**57**
References....**60**

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: San Diego, Solano, Sonoma, Los Angeles, Orange, Stanislaus, Napa, Lake, and the Multi-County Collaborative (MCC) which includes Nevada, Mono, and Colusa Counties. One Mind has also contributed $1.5 million in funding to support the project. 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, will bring consumer-level data to the providers' fingertips for real-time sharing with consumers, and allow 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 have been and continue to be shaped by the input of community partners, 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 and

included Los Angeles, Solano, Orange, and San Diego counties. 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. 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. Since then, we have also had additional counties join EPI-CAL, including Napa, Stanislaus, Sonoma, Lake, Nevada, Mono, and Colusa. The overarching name of the project, which encompasses the LHCN and the NIH-funded components, is now "EPI-CAL." In this report, 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).

The EPI-CAL team has made significant progress towards our goals outlined in the innovation proposal during the 22/23 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 FY2022/2023. 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.

- As soon as a contract is executed between UC Davis and a county to join the LHCN, our team initiates recruitment activities so that the counties' community partners can participate in our biannual Advisory Committee Meeting. In the past fiscal year, the Multi-County Collaborative (Colusa, Mono, Nevada) and Lake County LHCN contracts were executed, and their respective EP programs joined EPI-CAL's LHCN. Our team introduced the meeting to the EP program team and distributed flyers so that their community partners could be appraised of the upcoming LHCN meetings.
- 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 and summarize meetings activities in our deliverables and annual reports.
- As each new program joins the Learning Health Care Network, our team holds a synchronous EPI-CAL introductory meeting with all team members at participating programs to introduce the project in detail. This past fiscal year, we had two new programs join and the LHCN and attend the introductory meeting. At this introductory meeting, providers and staff are invited to complete baseline questionnaires that assess provider and program variables as these variables are hypothesized to have an effect on the observed outcomes of clients in EP programs. We administer 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.
- In the LHCN proposal, we proposed to ask clients and providers to complete self-report questionnaires in the pre-implementation period of the project. To examine adoption of a new technology in the EP program, we proposed to compare providers with respect to their reporting use of data to determine treatment choices at two timepoints, prior to Beehive implementation and after training in and using Beehive. Prior to Beehive implementation in each EP program, providers completed "pre-

implementation" surveys. We are now currently at the stage of the project where we want to evaluate change in these same variables after Beehive implementation. To do this, the same set of surveys are administered to EP programs who have sufficiently implemented Beehive in their program. During the past fiscal year, we have administered post-implementation surveys to three programs' staff that meet the criteria for post-implementation.

- In the last year, we continued fidelity assessments in EPI-CAL LHCN clinics and by the end of the 22/23 FY we had completed a total of 17 fidelity assessments of programs in the LHCN. This included EPI-CAL LHCN county programs (San Diego, Solano, Orange, Sonoma, Los Angeles, Stanislaus, Sacramento, San Mateo, and Napa) as well as university programs (UCLA CAPPS, UCLA Aftercare, UCSD CARE, UCD EDAPT). We have submitted fidelity assessment reports to each program and met with individual program leadership to discuss their fidelity assessment results. We have scheduled fidelity assessments for all remaining participating programs in the LHCN network with an executed contract, including new programs who have recently joined the LHCN, with a goal of completing them in the current 23/24 fiscal year.
- Since the EPI-CAL project began, our team has conducted a total of 20 fidelity assessments (this includes non-LHCN programs as well that are part of EPI-CAL through the training and technical assistance program). In the current report, we present aggregate results from fidelity assessments of EP programs in EPI-CAL, including data from both the CHRPS and FEPS. Amongst those where a full or formative assessment could be conducted, the mean FEPS-FS score was 3.86 out of 5. With the CHRPS, mean scores were slightly higher at 3.96 out of 5.
- In the past year, we continued implementation of the Beehive application in EPI-CAL/LHCN clinics, which has included extensive training and site-specific support. We have refined our training approach and have completed Beehive training in several participating EPI-CAL programs.
- We conducted an interim analysis of Beehive enrollment, consumer demographics, data sharing preferences, and survey completion. The observed rate of enrollment across the LHCN is 412 clients across all diagnoses or 255 clients with a diagnosis that indicates FEP. There are an additional 258 clients who have been registered by the clinic in Beehive, but who have not engaged with Beehive by completing the EULA or starting their surveys. We found that a large majority of consumers (86%) opted in to sharing data for research purposes with UC Davis, and high completion rates of enrollment surveys (83%). We will shift our focus in the future to higher survey completion rates, as we know that while the vast majority of consumers have completed some self-report surveys, not many have completed the full EPI-CAL bundle of surveys for each time point.
- In the current report, we describe a detailed statistical analysis plan for outcomes data collected via Beehive.
- As a first step to assessing the successful implementation of the LHCN in EP programs across California, we assess preliminary data on feasibility and acceptability of LHCN app in all EP programs. To do this, we used a previously defined benchmark of enrollment of at least 70% of eligible participants and 50% of their available family members across the network as enrolled to meet our criteria as feasible and acceptable. We compare actual enrollment against this benchmark and summarize the results in this report.
- Over the last fiscal year, we have made a number of changes and improvements to Beehive based on feedback from programs and community partners. We summarize these changes in the current report.
- In order to finalize the data collection process for our county-level data evaluation component of the LHCN, we met with new LHCN counties to introduce our 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 continued to meet with all participating counties to refine the process as we receive data from each county.
- During the last fiscal year, our team continued to hold meetings with the EP program managers and the county data analysts for each participating LHCN county to identify county-level available data and data transfer methods. We discussed services provided by the EP program, description of consumers served, staffing specifics and billings codes for each service. We also reviewed details of funding sources, staffing levels during certain time-periods and other types of services provided for specific types of consumers (i.e., foster care). We have discussed time-periods for which the LHCN team will

request data, description of the consumers from EP programs and 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 treatment), and data transfer methods. Our research team has gathered all the information from each program/county, including each new LHCN county, and summarized it in a multicounty data table included in this report.

- During the last fiscal year, our team finalized our plan and timeline for working with counties to support infrastructure to access final round of county-level cost and utilization data for EP and CG programs. One goal of this analysis was to provide a preliminary demonstration of the proposed method for accessing data regarding EP programs and CG groups across California. The secondary goal was to analyze service utilization and costs associated with those services across counties.

Current Project Goals

The current document summarizes project activities for the LHCN for fiscal year 2022/2023. This includes the following project activities:

1. Recruit EP community partners for external Advisory Committee meeting

2. Establish a stakeholder (community partner) advisory committee that will meet at least every 6 months.

3. Complete baseline and pre-LHCN implementation questionnaires for new LHCN counties.

4. Report on post-LHCN implementation questionnaires administered to program and county staff.

5. Schedule EP program for fidelity assessment.

6. Present results from fidelity assessments of EP programs.

7. Provide training and implementation of outcomes measurement on app in non-pilot EP programs and progress of data collection in all EP programs.

8. Submit report on LHCN enrollment and follow up completion rates for LHCN software application and dashboard in all EP Programs.

9. Submit final data analysis plan for all data.

10. Draft preliminary data on feasibility and acceptability of LHCN app in all EP programs.

11. Subcontractor to make additional revisions to dashboard to include feedback from programs and community partners.

12. 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.

13. Identification of county-level available data and data transfer methods, and statistical analysis methods selected for integrated county-level data evaluation.

14. Deliver a plan and timeline for working with counties to support infrastructure to access final round of county-level cost and utilization data for EP and CG programs.

1. Recruit EP community partners for external Advisory Committee meeting

Once the contract for the LHCN between new counties and UC Davis was executed, the UC Davis team could start recruiting from each new county and program for the Advisory Committee. Our team sends program

leadership our LHCN Advisory Committee recruitment flyer for distribution within the program to recruit clients and family members who wished to participate in the Advisory Committee. During the past fiscal year, Lake County and the Multi-County Collaborative (MCC) of Nevada, Colusa, and Mono counties joined the LHCN. We had representation from both the MCC and Lake County at our most recent Advisory Committee meeting, including EP program leadership. We will continue to work with the program to include other stakeholders from Nevada, Mono, Colusa, and Lake Counties, such as a client or other family member.

2. Establish a community partner 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 community partners. 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.

November 29th, 2022
We held our first Advisory Committee meeting of the fiscal year on November 29th, 2022. The meeting was held remotely due to the continuing COVID-19 pandemic. During the meeting, we discussed recruitment and enrollment progress and challenges. Valerie Tryon gave a general overview of enrollment across the LHCN. While many programs are making progress using Beehive (i.e., enrolling clients and supporting completion of surveys), multiple programs have not integrated Beehive into their program to the degree necessary to achieve project aims. We discussed in the meeting that there are many reasons for this and considered ways in which programs could address these issues. Over the past six months, the rate of enrollment has improved significantly. The EPI-CAL team encouraged sites to keep up their pace of enrollment and make sure that surveys are also being completed. Sabrina Ereshefsky then gave a presentation summarizing how urgent clinical issue alerts are being addressed by clinic staff within Beehive. Her preliminary findings supported that the vast majority of urgent clinical issues are resolved within a few days. We received feedback from attendees at the meeting that they appreciated the integration of both client and support persons in risk assessment. Then, Mark Savill gave a presentation on the general analysis plan for the data collected via the LHCN project, with a particular focus on Beehive data. Variables of interest were prioritized during the extensive qualitative work done by our team in the first phase of the project. Functioning was a key area focus groups really cared about when discussing what outcomes to measure, whereas distal outcomes (homelessness, incarceration, mortality) may occur later than what is captured in many clinics' clientele. He elicited feedback from attendees to examine if we were considering the most important outcomes for our analysis. One attendee expressed interest in seeing a summary of the carceral data that is being collected via Beehive and said that this data may help us lobby the state for more urgent crisis response options.

Lindsay Banks then gave a brief presentation on fidelity assessment progress thus far, followed by a description of the duration of untreated psychosis (DUP) study by Rachel Loewy. Adrian Asbun reminded programs about an upcoming research opportunity for Spanish-speaking providers, family members, and clients. We then closed out the meeting by talking about how best to connect with programs for additional research opportunities as part of the larger EPINET and then proposed submitting a new innovation project to possibly examined long-term outcomes of clients in EP programs.

We recognize that we summarized a lot of information during this most recent Advisory Committee meeting and thus we sent a follow-up survey out after the meeting to give attendees an opportunity to provide additional feedback on the topics covered if they were not able to during the meeting.

June 6th, 2023

We held the second Advisory Committee meeting of the fiscal year on June 6th, 2023. The meeting was held remotely. During the meeting, we discussed recruitment and enrollment progress and challenges. Kathleen Nye gave a general overview of enrollment across the LHCN, including comparing enrollment today to the last progress report at the last Advisory Committee Meeting in November 2022. While there was a promising trajectory of enrollments in the second half of last year after having several meetings with individual programs, multiple programs' enrollment has now plateaued and several still have not integrated Beehive into their program to the degree necessary to achieve project aims. The EPI-CAL team encouraged sites increase the pace of enrollment and make sure that surveys are also being completed. Misha Carlson then gave a brief presentation on the DUP portion of the study, which is also contending with enrollment challenges. We discussed in the meeting that FEP enrollments seem to be particularly affected and asked programs to share their thoughts and experiences.

The next section of the meeting consisted of data presentations. Valerie Tryon presented preliminary data from Beehive, including data summarizing symptoms, quality of life, and functioning; these domains were selected for preliminary descriptive analysis because they were prioritized during the outcomes focus groups. Tara Niendam then gave a presentation on the how experiences of several adverse childhood experiences (ACEs) in individuals with early psychosis is associated with housing instability and suicidal ideation in our preliminary data collected in Beehive. This was particularly important to present to our committee because while we found that our EP teams noted the importance of trauma in contributing to outcomes during qualitative data collection, they did not see justice involvement or homelessness as key issues early in care but our data show that their clients do face these challenges both in their lifetime history and in the present to a lesser degree. ACEs and other social determinants are likely drivers of poor outcome in early psychosis and should be addressed in treatment. Then, Sabrina Ereshefsky gave a presentation on the importance of lived and living experience integration in early psychosis coordinated specialty care. Her data evaluated whether the presence of peers, individuals with lived and living experience with psychosis, and/or family advocates affected attitudes towards recovery and stigma. She found that there were generally high rates of recovery-oriented attitudes and low variability across programs, despite team composition, but that the CSC teams with persons with lived or living experience could reduce stigma and bias.

We had a guest speaker at this Advisory Committee Meeting. Christina McCarthy provided a presentation on One Mind at Work, an organization that seeks to have mental health workers improve the design of their workplaces to benefit individuals and teams and grow access to mental health services and support. Participants were invited to have people from each organization nominate a colleague to participate in One Mind at Work and the application was distributed after the meeting. Lastly, we ended the meeting by discussing preliminary renewal plans for the EPI-CAL R01 and proposed submitting a new innovation project to possibly examine outreach to improve enrollment in EP programs or examine long-term outcomes of clients in EP programs.

3. Complete baseline and pre-LHCN implementation questionnaires for new LHCN Counties

We have a standardized process for every county that joins the Learning Health Care Network which starts with the EPI-CAL team meeting with EP program staff to introduce the EPI-CAL project and administer pre-

implementation surveys to program staff. As each new program joins the Learning Health Care Network, our team holds a synchronous EPI-CAL introductory meeting with all team members at participating programs to introduce the project in detail. At this introductory meeting, providers and staff are invited to complete baseline questionnaires that assess provider and program variables as these variables are hypothesized to have an effect on the observed outcomes of clients in EP programs. At the introductory meeting, we administer 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.

This past fiscal year, we had two new programs join the LHCN, including Lake County Early Intervention Services (EIS) program and the multi-county collaborative hub and spoke EP program of Nevada, Mono, and Colusa counties (MCC). MCC staff and providers who attended our EPI-CAL Introductory meeting on December 9th, 2022 and Lake County Behavioral Health Services (LCBHS) staff and providers attended our EPI-CAL Introductory meeting on February 23rd, 2023. The EP program staff were approached to participate in research as part of the LHCN EPI-CAL project. During the meeting, staff signed consents to participate in research to complete our baseline questionnaires. Staff completed measures assessing their comfort with technology and readiness to implement eHealth. Additional questionnaires on organizational readiness for change, level of burnout and compassion satisfaction in their work as a helper, their attitudes about evidence-based practice, stigma related views toward psychosis and help-seeking, and their recovery-orientation were sent to EP program staff following that initial meeting, due a couple of weeks after the initial meeting. Their results will be incorporated into the statewide data on these measures.

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. Clinicians with eligible clients were approached about completing these additional pre-implementation surveys described above. At this time, one clinician from LCBHS has completed surveys about their clients. This clinician is working with our team to recruit clients from their program to participate as well, but no client has expressed interest at the time of this report. Our team is working closely with LCBHS staff to address concerns clients may have with participating in research activities.

4. Report on post-LHCN implementation questionnaires administered to program and county staff.

In the LHCN proposal, we proposed to ask clients and providers to complete self-report questionnaires in the pre-implementation period of the project. To examine adoption of a new technology in the EP program, we proposed to compare providers with respect to their reporting use of data to determine treatment choices at

two timepoints, prior to Beehive implementation and after training in and using Beehive. Prior to Beehive implementation in each EP program, providers completed “pre-implementation” surveys about their demographic information (age, sex, race, ethnicity) and professional characteristics (years of education, degree type) and completed questionnaires on their Treatment Alliance, Use of Data in Care Planning, Perceived Effect of Use for the LHCN, and Comfort with Technology. Clients are also asked to complete self-report questionnaires about insight into illness, perceived utility of the application, satisfaction with treatment, treatment alliance, and comfort with technology. Beehive training materials were implemented consistently across participating EP program, highlighting the utility of data to identify treatment goals and metrics of improvement during treatment planning, and provided guidance on client-centered ways to review data to monitor progress during treatment.

We are now currently at the stage of the project where we want to evaluate change in these same variables after Beehive implementation. To do this, the same set of surveys are administered to EP programs who have sufficiently implemented Beehive in their program. At this time, we have 11 provider-completed post-implementation survey packets completed across three participating EP programs (OC CREW, Kickstart, and Aldea Solano SOAR). These three programs were amongst the earlier programs to be trained to use Beehive in their program in the LHCN. We are continuing to recruit providers and clients from EP programs to complete these surveys once sufficient time has passed from initial Beehive implementation. These data will be used in analyses to assess changes in these variables prior to implementation of Beehive compared to after use of Beehive with clients in EP programs.

Additionally, our post-implementation analysis will include provider-rated “use of data in care” questions, which are intermittently presented to providers while they are reviewing a client’s data page in Beehive so that they may indicate 1) if the data was reviewed during a session with the client or family and, if yes, 2) how the data was used as part of care, such as “followed up by phone” or “scheduled follow up appointment,” or “no action taken.” These data use metrics allow analysis on rates of adoption and level of implementation of Beehive. Exploratory analysis will examine clinician expertise and training needed to effectively implement clinician review of client outcome data using Beehive at 80% of available time points.

5. Schedule EP program for fidelity assessment

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 are 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 are completed in groups of 2-6 programs per quarter, which started in November 2021. Assessments are 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 undergo a two-day training to go through the manual and conduct a mock site visit based on real cases. Prior to the evaluation, each EP program site participates in an introductory meeting, in which an overview of the FEPS will be provided and the components of the evaluation will be discussed. The assessments are conducted in consultation with Don Addington, M.D. from the University of Calgary, author of the FEPS-FS and CHRPS-FS scales.

At the end of the 2/23 FY, EP program fidelity assessments had been conducted for 17 programs in the LHCN. There are five remaining programs in the LHCN that need to complete their fidelity assessment. Of those, three are currently in progress, including the MCC multicounty collaborative, Stanford INSPIRE program, and UCSF Path program. Lake County Behavioral Health Services assessment is scheduled for Fall 2023. Kern County is the last remaining program, and finalizing their assessment is pending an executed LHCN contract with UC Davis.

6. Present results from fidelity assessments of EP programs

This section includes preliminary findings from the fidelity assessments that have been conducted with EPI-CAL EP programs, including programs that are not currently in the LHCN but have a received a fidelity assessment from our team through their participation in the EPI-CAL's training and technical assistance program. The majority of participating programs serve clients with both clinical high-risk syndrome (CHR) in addition to first episode psychosis (FEP). Therefore, most fidelity assessments were conducted using the First Episode Psychosis Services – Fidelity Scale (FEPS-FS) version 1.1 and a pilot version of the Clinical High Risk for Psychosis Services – Fidelity Scale (CHRPS-FS) (Addington, 2021). In this assessment Version FEPS-FS 1.1 was used, which includes additional items from the published 1.0 version related to discharge planning and the delivery of peer services. Additionally, given the widespread treatment of CHR clients within California CSC programs, and the inherent differences in the treatment approach between FEP and CHR, we have collaborated with the FEPS-FS 1.1 author to pilot a complimentary assessment tool that adapts some items of the FEPS-FS 1.1 to be appropriate for CHR care (i.e., the CHRPS-FS). These tools were developed to rate the degree to which the care mental health teams deliver adheres to the Coordinated Specialty Care Model (CSC; Heinssen et al., 2014) for clients with a first episode of Schizophrenia Spectrum Disorder and Clinical High Risk for Psychosis. The purpose of this fidelity assessment is to better understand the range and nature of services delivered by coordinated specialty care programs across the EPI-CAL network. Please see Table I for a detailed summary of the components that are assessed on the FEPS-FS 1.1 Scale. This differs slightly from the currently published scale with the inclusion of two additional items (items 36 and 37); one which focuses on the peer specialist role, and the second which focuses on transitions in care. These were added due to meet our state level clinical, policy and research priorities.

It is important to note that the findings come with multiple caveats:

- The field of early psychosis is a rapidly developing one, with evidence-base practices and recommendations evolving over time.

- While there is good evidence for coordinated specialty care leading to improved outcomes in early psychosis (i.e., Guo et al., 2010; Kane et al., 2016; Secher et al., 2015), understanding what the necessary specific components of coordinated specialty care are that leads to these improved outcomes, and how they should be optimally delivered, is in many cases still a matter of debate.
- The measure selected for use across the EPI-CAL network (the FEPS-FS v1.1), is one of multiple that exist. The FEPS-FS was selected due to the fact the tool is currently one of the most extensively used and validated in the field (Addington et al., 2020; Durbin et al., 2019)
- The FEPS-FS has been developed as an international standard, and so the tool has been designed to work across different systems of care. This may make high scores on some items much harder to achieve in the US due to the current structure of behavioral health service provision across the country.
- The ratings and the feasibility of meeting high-fidelity scores may vary widely depending upon the context in which the program is delivered. The FEPS-FS may include items where a high-fidelity score may be constrained by state, local, or insurance coverage decisions outside of the control of the specific program.

Table I: FEPS-FS 1.1 Components

	FEPS-FS 1.1		
1	Practicing team leader	20	Antipsychotic dosing within recommendations
2	Participant/provider ratio	21	Clozapine for medication-resistant symptoms
3	Services delivered by team	22	Patient psychoeducation
4	Assignment of case manager/ care coordinator	23	Family education and support
5	Psychiatrist caseload	24	Cognitive behavior therapy (CBT)
6	Psychiatrist role on team	25	Supporting Health
7	Weekly multi-disciplinary team meetings	26	Annual formal comprehensive assessment
8	Explicit diagnostic admission criteria	27	Services for patients with Substance Use Disorders
9	Population served	28	Supported employment (SE)
10	Age range served	29	Supported education (SEd)
11	Duration of FEP program	30	Active engagement and retention
12	Targeted Education to community groups	31	Patient Retention
13	Early Intervention	32	Crisis intervention services
14	Timely contact with referred individual	33	Communication between FEP and inpatient services
15	Family involvement in assessments	34	Timely contact after discharge from hospital
16	Comprehensive clinical assessment	35	Assuring Fidelity
17	Comprehensive psychosocial needs assessment	36	Peer support specialist role on team
18	Treatment / care plan after initial assessment	37	Transition in Care
19	Antipsychotic medication prescription		

The results of this assessment can be used in multiple ways. First, when combined with systematic data collection of client outcomes across multiple programs, fidelity assessments can be used to assess how variation in service delivery may impact client outcomes. Available data on which service components lead to specific outcomes could be used to advance the field of early psychosis care, and to advocate for potential changes in program funding and structure. Second, fidelity assessment can inform quality improvement efforts, highlighting individual areas of strengths and areas for improvement. Furthermore, it can enable individual clinics to review how their program compares to validated international standards and other programs in the state. Third, this information can be vital for county leadership and other key community partners to understand exactly what is being delivered by programs in a concrete, standardized format.

Assessment Summary

To date, we have completed assessments in 20 programs. Thirteen provide services for both FEP and CHR clients, four serve FEP only, and three serve clinical high risk only. Some of the assessed programs are well-established programs, but others are new and haven't even seen their first client yet. As a result, they do not have the sufficient service data to complete the health record abstraction necessary for the full fidelity assessment. To address this, in collaboration with the author of the FEPS-FS, Dr. Don Addington, we developed different levels of assessments, and operationalized rules around how to implement them. These included full assessments, formative assessments, and quality improvement (QI) assessments in cases where there were insufficient health record data to do a formal assessment. To meet criteria for a full fidelity assessment, the program must be delivering CSC services to EP clients two or more years and have five or more clients enrolled for at least one year and the time of the assessment. If those criteria are not met, the program may have a formative fidelity assessment if they have served ten or more clients ever, have at least five clients who have been enrolled for six months or more, and have supervision and defined admission criteria, assessment, and treatment approach. If the above criteria are not met, the program may have a simply quality improvement assessment in which their plan for program implementation in assessed by our team for consultation and feedback purposes.

Table II: Fidelity Assessment Characteristics

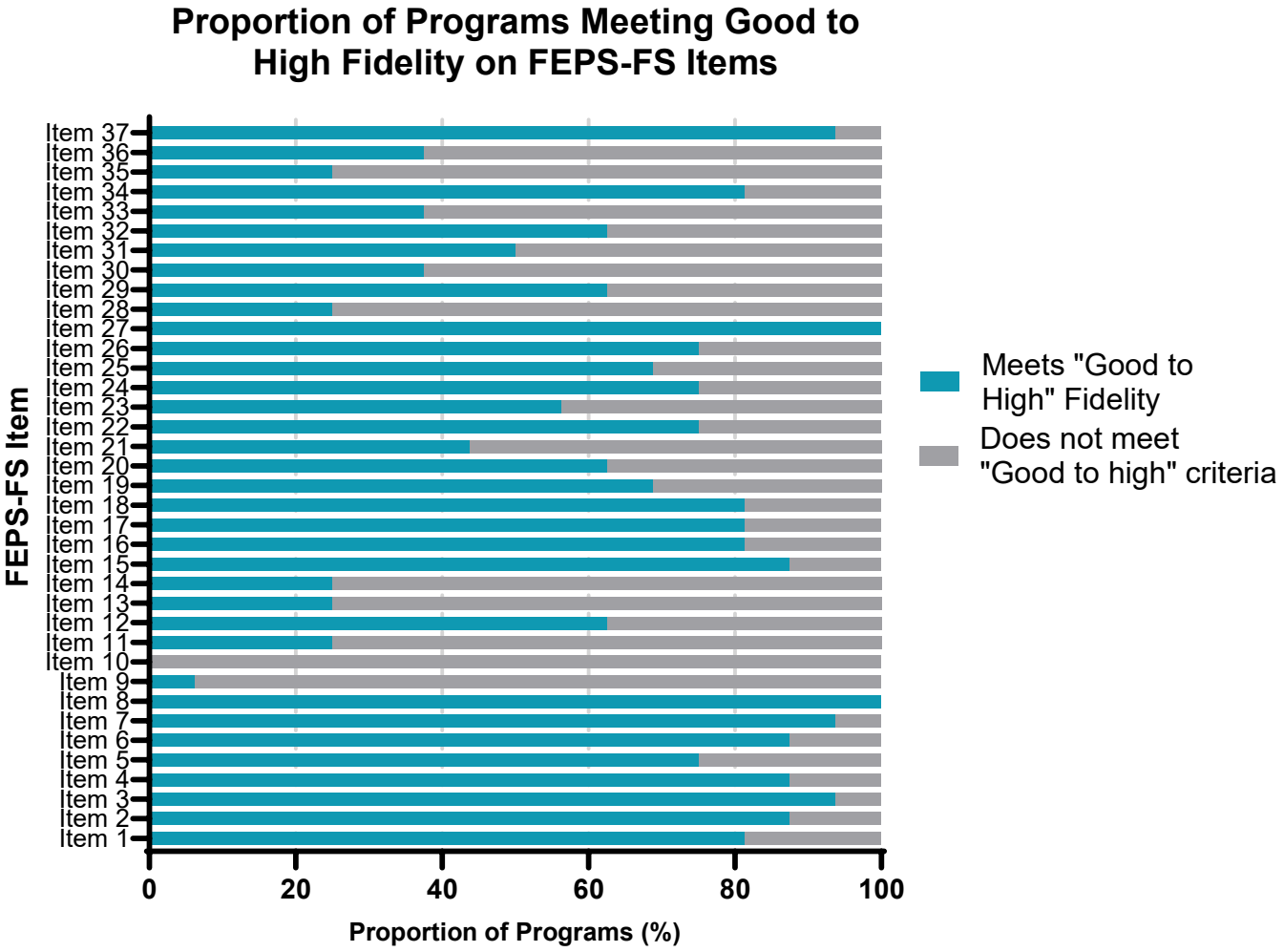
FEPS-FS n =17			
Assessment Types			
	Full	14	82.4%
	Formative	0	0.0%
	QI	3	17.7%
Program Type			
	Community	14	82.4%
	University	3	17.7%
Mean FEPS-FS Score*		3.86	0.25
% Items good to high fidelity*		66.6%	9.09

CHRPS-FS n=16			
Assessment Types			
	Full	11	68.8%
	Formative	1	6.3%
	QI	4	25.0%
Program Type			
	Community	14	87.5%
	University	2	12.5%
Mean CHRPS-FS Score*		3.96	0.32
% Items good to high fidelity*		71.2%	8.15

For both FEPS and CHRPS, the full assessment was possible in the majority of programs. Amongst those

where a full or formative assessment could be conducted, the mean FEPS-FS score was 3.86 out of 5. Figure 2 shows a breakdown of the proportion of programs meeting good to high fidelity by each FEPS-FS item. With the CHRPS, mean scores were slightly higher at 3.96 out of 5.

Figure 2: Proportion of programs meeting good to high fidelity on FEPS-FS Items

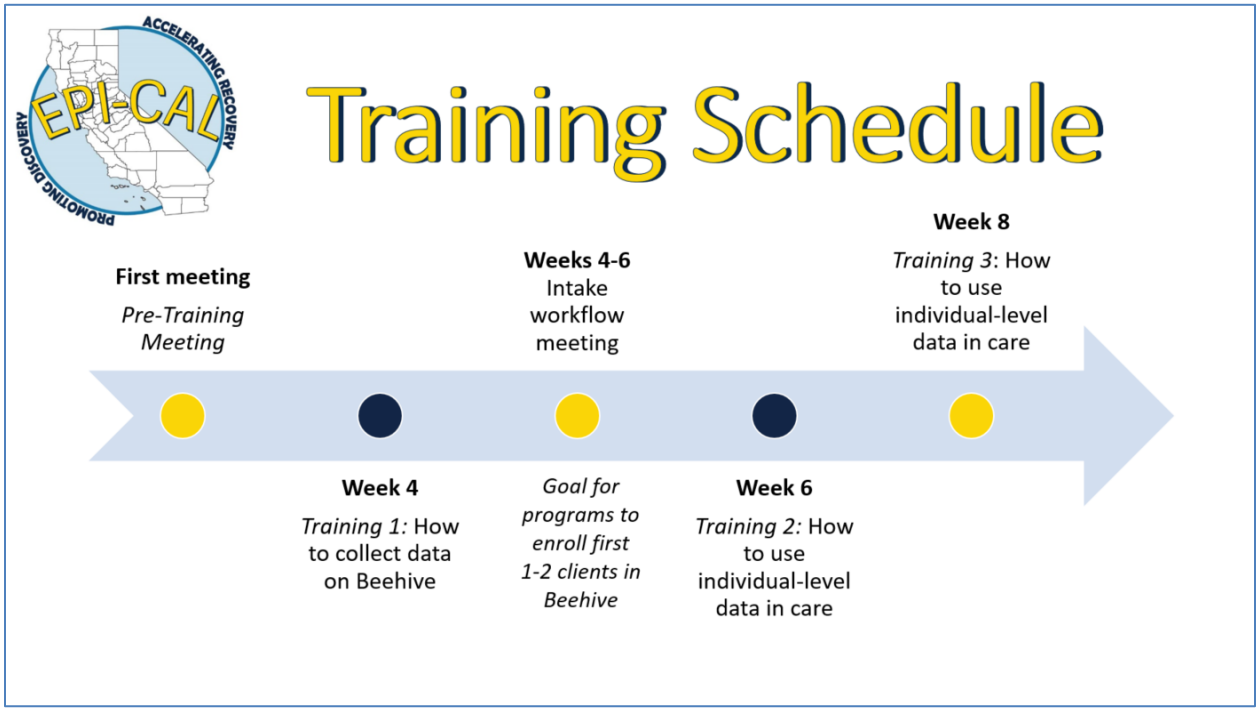


7. Provide training and implementation of outcomes measurement on app in non-pilot EP programs and progress of data collection in all EP programs

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.

The core trainings begin with a pre-training meeting with leadership at the program to discuss which program staff members would be designated as providers, group analysts, or group and clinic admin in Beehive (roles described below), as well as to cover topics around integrating Beehive into their current data collection system. Next, we conducted a training series consisting of a pre-training meeting with program leadership to introduce the training plan, three training sessions to introduce Beehive to each program (Part 1, Part 2, and Part 3), and an intake-workflow meeting with key clinic staff to understand clinic workflow and brainstorm how to best implement Beehive within their program context.

Figure 3: Beehive Training Schedule



Our remote trainings began with our pilot programs in March 2021. In June 2021, we began to onboard non-pilot programs, starting with the Los Angeles County PIER programs. See table below for all core trainings conducted through June 2023. Note that booster trainings (for entire program or for individuals at the program) have also been conducted in addition to the core trainings and are not included on the table below. We are also in the process of adding all of the training modules for Beehive trainings part 1 through 3 to a learning management system, Cornerstone, we all staff and providers from participating programs will be able to access asynchronous training materials. The planned release date for LHCN Cornerstone materials in at the end of June or early July.

Table III: EPI-CAL Site Training Completion

Site	Pre-Training	Training 1	Intake Workflow	Training 2	Training 3
UCD SacEDAPT	3/10/2021	3/22/2021	3/10/2021	4/5/2021	6/14/2021
UCD EDAPT	3/10/2021	3/22/2021	3/10/2021	4/5/2021	6/14/2021
Solano SOAR	3/18/2021	3/22/2021	3/29/2021	4/12/2021	6/7/2021
Napa SOAR	7/23/2021	8/19/2021	10/21/2021	10/14/2021	12/2/2021
Sonoma SOAR	8/24/2021	9/29/2021	10/21/2021	10/14/2021	12/2/2021
Kickstart Pathways	3/24/2021	3/31/2021	6/8/2021	4/14/2021	7/28/2021
LAC- IMCES 3	5/10/2021	6/21/2021	8/11/2021	11/10/2021	12/8/2021
LAC - IMCES 4	5/10/2021	6/21/2021	8/11/2021	11/10/2021	12/8/2021
LAC - SFVCMHC	5/11/2021	6/18/2021	7/19/2021	11/18/2021	12/9/2021
LAC- The Whole Child	5/13/2021	6/17/2021	7/21/2021	11/23/2021	1/25/2022
LAC- The Help Group	5/14/2021	6/14/2021	8/10/2021	11/29/2021	1/5/2022

OC CREW	7/13/2021	8/12/2021	8/23/2021	10/13/2021	12/8/2021
San Mateo Felton	7/14/2021	10/20/2021	12/9/2021	7/13/2022	12/6/2022 & 6/13/2023
UCLA - Aftercare	7/29/21	9/1/2021	2/9/2022	5/20/2022	6/8/2023
UCLA - CAPPS	9/23/2021	11/22/2021	2/1/2022	5/3/2022	TBD
UCSF PATH	9/21/2021	5/6/2022	5/25/2022	10/28/2022	TBD
UCSD CARE	4/7/2022	5/23/2022	7/15/2022	9/30/2022	11/7/2022
Stanislaus LIFE PATH	2/23/2022	4/8/2022	5/10/2022	5/31/2022	9/22/2022
Stanford INSPIRE	3/21/2023	4/26/2023	5/23/2023	TBD	TBD
MCC	2/8/2023	3/9/2023 & 3/28/2023	4/7/2023	5/1/2023	6/9/2023
Lake County	4/21/2023	6/23/2023	TBD	TBD	TBD
Totals	**21**	**20**	**20**	**19**	**17**

Pre-Training Meeting

The pre-training meeting is conducted between EPI-CAL staff, including the site's assigned point person, site leadership, and a site IT representative. The purpose of this meeting is to introduce the training schedule and gather information to facilitate the first Beehive training. For example, the site leadership are invited to Beehive to create their accounts and test network compatibility (e.g., ensure that invite emails are not blocked by institution, ensure that program staff can access web application). The IT representative is engaged as needed to resolve technical issues (e.g., add beehive email address to approved senders list). Site leadership complete their account registration ahead of the Part 1 training as they will be inviting all other program staff from their clinic to Beehive.

Part 1 Training

The general outline for the first training is as follows:

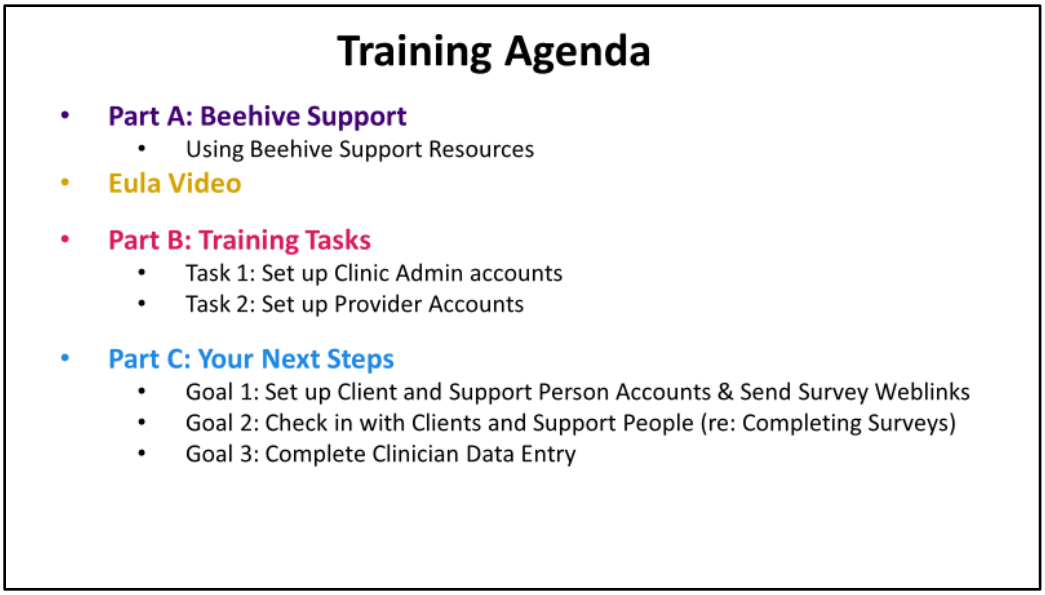
1. Re-introduction to the EPI-CAL project, including the overarching purpose and goals of data collection via Beehive
2. Presentation on the value of Beehive and data collection
3. Beehive Application training session (see Figure 3)

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 4: 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. (Spanish: https://youtu.be/UgY7ZUhe-Fk Vietnamese: https://youtu.be/NqdC51TqGc0). We developed the EULA video through focus groups with EPI-CAL community partners (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:

- Group Admin account: 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.
- Clinic Admin account: For staff members who provide supervision and administrative support within a specific clinic in a group.
- Provider account: For staff members providing direct services to consumers in a particular clinic, for example therapists, prescribers, and peer support specialists.

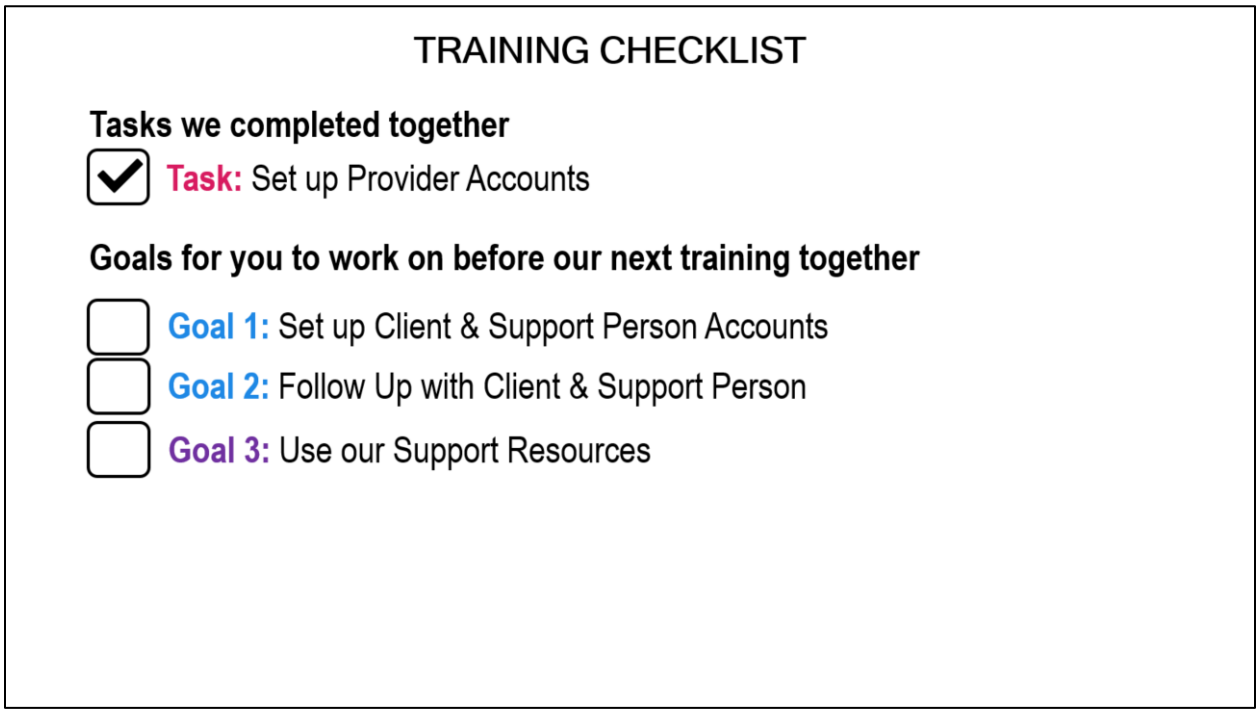
There is a general hierarchical structure to the relationship between these account types, such as who can invite new users and who can download data from Beehive.

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 programs, EPI-CAL staff assist all admin users to register at the pre-training meeting). Once participants with Clinic 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 programs 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 their support persons. Next, the survey collection timeline is introduced. Baseline surveys are available for four months after the consumer's intake date. After baseline, follow up surveys are sent, which are due every 6 months from baseline will open two months prior to the due date and close four months after the due date. 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 5). These consumers can be at any point in treatment when they are enrolled in Beehive. A Beehive consumer introductory script is provided to support the program staff in talking about Beehive to potential participants.

Figure 5: Training Checklist



Intake Workflow Meeting

After the Part 1 Training, EPI-CAL staff, including the program's point person, meet with the program's key staff involved in intakes. The purpose of this meeting is to understand the program's current workflow to facilitate a smooth transition to implementing Beehive. Once EPI-CAL team have a basic understanding of the program's intake process, they ask questions to operationalize how Beehive will be integrated into this process (e.g., "Who will be responsible for registering clients in Beehive?"). They may offer suggestions or ideas based on what has worked at other programs. The goal of this meeting is to create an initial plan for the program to introduce Beehive into their current workflow. Please see Appendix I for a template of the questions asked at the intake workflow meeting.

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 6A) 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).

Figure 6: MCSI Example Graphs from Beehive

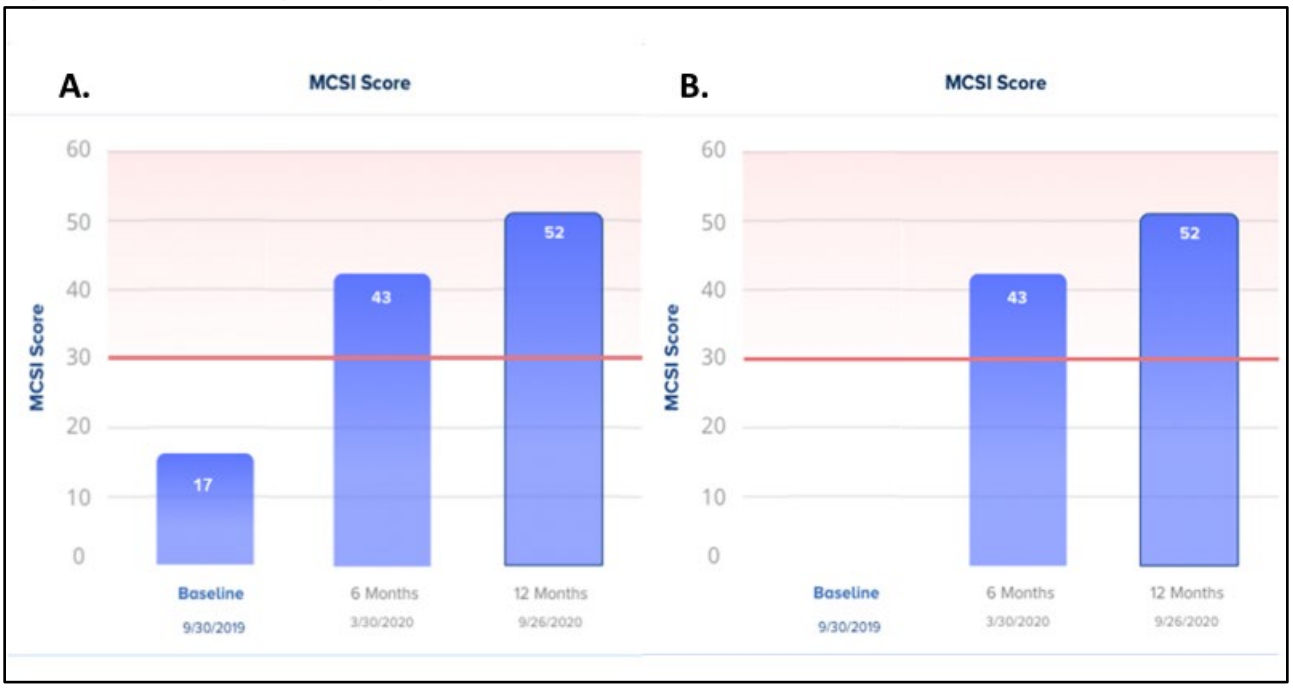


Figure legend: A. Representation of data showing increasing trend in MCSI symptom severity; B. Representation of how missing data (shown here at baseline) impacts the visualization

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.

Data-Entry Workflow Meeting

After the Part 2 Training, EPI-CAL staff, including the program's point person, meet with the program leadership. The purpose of this meeting is to help the program create a reasonably sustainable plan for completing clinic-entered data about each client's clinical outcomes in Beehive. EPI-CAL team will ask question to understand whether there is an existing data-entry workflow in place as well as which roles on the teams are involved in the process. Once EPI-CAL team have an understanding of the program's existing data-entry workflow, they ask questions to operationalize how Beehive will be integrated into this process (e.g., "Who will be responsible for entering clinic-entered data for clients?"). They may offer suggestions or ideas based on what has worked at other programs. The goal of this meeting is to support the program to create an initial plan to complete clinic-entered surveys about key client outcomes. This should include a plan for which team members will monitor and track completion and which team members will enter the data. Please see Appendix II for a template of the questions that will be asked as part of the data-entry workflow meeting.

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 oriented on how to input and view Clinic-entered data and how to assign additional surveys to consumers, and how to close and re-open client episodes in Beehive.

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

Next, participants are split into small groups, and given a GUID of a consumer that receives services at their clinic and has completed surveys in Beehive. This is to ensure that each small group has real-world data to interpret. At the beginning of the small group, an EPI-CAL team member orients the group to a 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 III) 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 of common patterns in the data, the training team encourage participants to view their consumer's data through this analytical lens and demonstrate how their treatment plans could benefit from this approach.

Implementation Support After Initial Beehive Trainings

Each program has an EPI-CAL staff point person to provide regular check-ins to provide training and implementation support. The point persons are introduced during pre-training and the Beehive training series. Initially, we request weekly meetings or calls with key program staff (as determined by the program). At these meetings, point persons can help programs troubleshoot issues and support staff with accessing resources and learning to use Beehive.

In addition to regular check-ins with key program staff, point persons may also provide booster trainings to individuals at the program or to groups of program staff. These may be conducted remotely via web conferencing or in-person for sites that have resumed in-office operations.

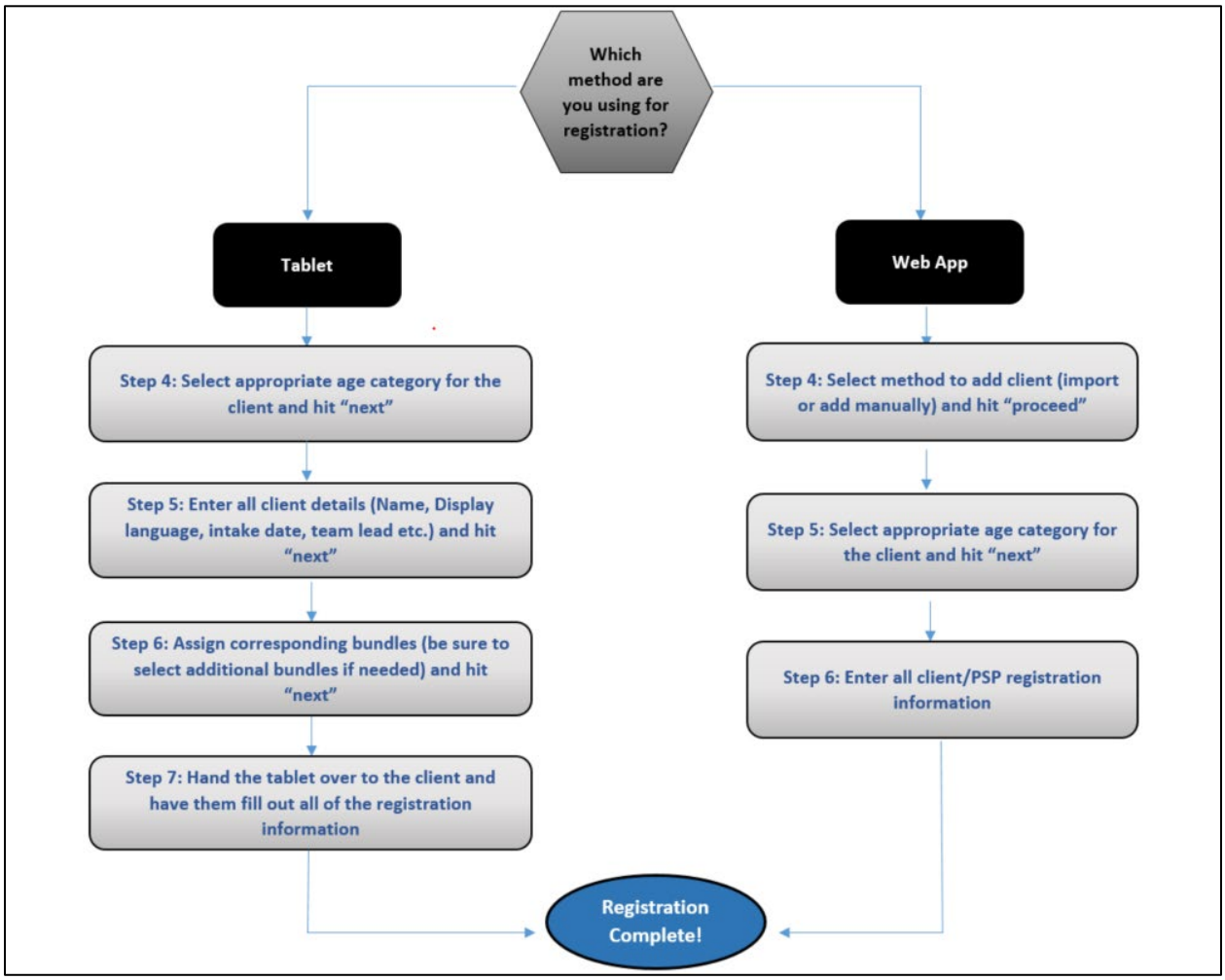
Point persons will also respond to ad hoc requests from the program for technical support and troubleshooting. For example, if a program experiences a bug or glitch while using Beehive, they are told to contact their point person who can help to troubleshoot or escalate this report.

Tablet Training

The Beehive application is available as both a web application and on tablets (i.e. iOS application). The tablet application is intended for clients who are receiving in-person services in the clinic or in the community. Due to the prevalence of telehealth and low incidence of in-person appointments, most sites did not plan to use the tablet application at the time of their initial core trainings. The EPI-CAL team developed a standalone tablet training to offer to sites on-demand whenever needed.

The tablet training covers the differences between registering clients and administering surveys on the iOS app as compared to the web application. It also covers several iOS app specific features such as the client individual check-in and group check-in features.

Figure 7: Diagram showing workflow differences in client registration based on environment



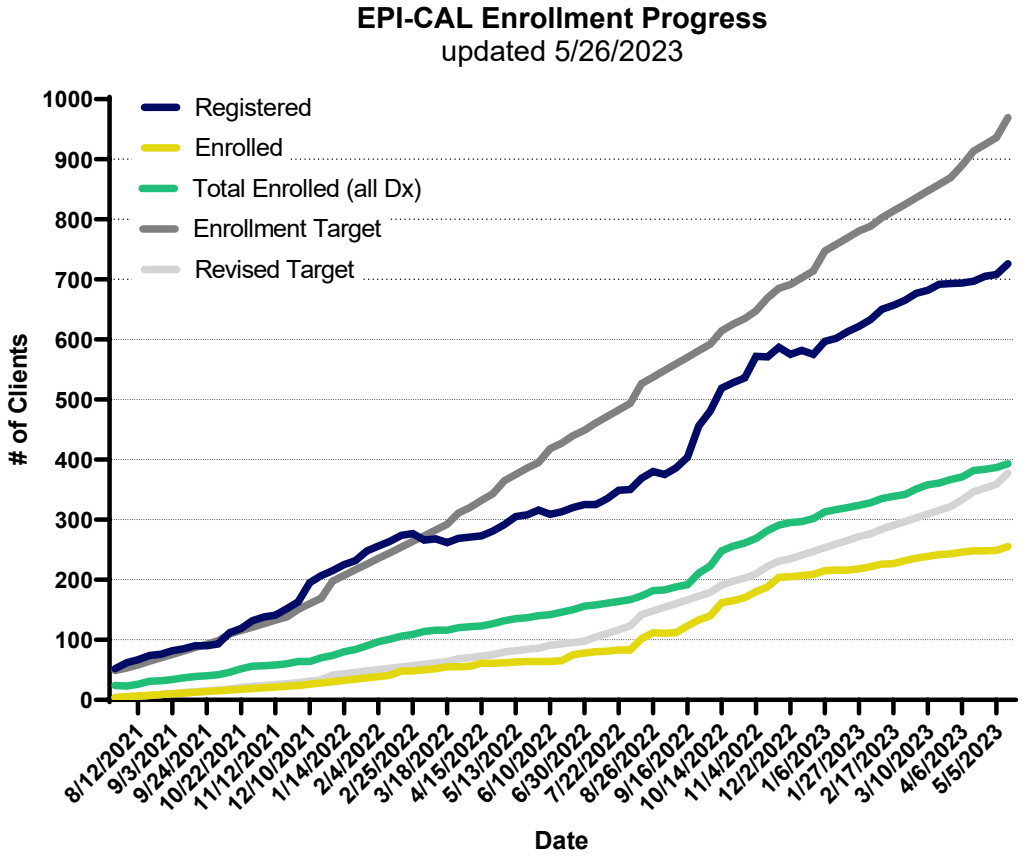
In the past year, only three programs have asked for this tablet training (OC CREW, San Mateo Felton, and Stanislaus LIFE Path). Other sites chose not to schedule a synchronous training, but rather have relied on the training materials and resource guide as they have begun to use the iOS application. We will continue to offer the live tablet training as needed, or refer staff to our asynchronous training materials.

8. Submit report on LHCN enrollment and follow up completion rates for LHCN app in all EP programs

LHCN Overview

Figure 8 shows the LHCN Progress towards EPI-CAL Enrollment targets through May 26, 2023. Clients are considered enrolled if they have completed the Beehive EULA and agreed to share their data with UC Davis for use in research. If clients do not allow their data for use in research but agree to use Beehive as part of clinical care, their data may be used for quality management or quality assurance purposes only. The goal at this point in the project was to have 969 individuals enrolled (solid dark gray line in figure below). In summer of 2022 we worked with sites to create a revised enrollment target (light gray line) based on observed rates of enrollment up to that point. The observed rate of enrollment across the LHCN is 412 clients across all diagnoses (green line in figure below) or 255 clients with a diagnosis that indicates FEP, (the yellow line in figure below)). There are an additional 258 clients who have been registered by the clinic in Beehive (dark blue line in figure below), but who have not engaged with Beehive by completing the EULA or starting their surveys. We monitor the number of registered individuals because it serves as a proxy for program census (however we know that clinics may not yet have all active clients registered) and allows us to see what possible enrollment across the network could be.

Figure 8: LHCN Progress Towards EPI-CAL Enrollment Targets



Figures 9-10 show a site-by-site breakdown of the proportion of individuals who agreed to data sharing with UC Davis for research purposes as of May 26, 2023. Figure 9 shows all registered clients, regardless of EULA completion status. Hence this figure shows the room for growth if sites support clients to complete their EULA in Beehive if those clients agree to data sharing.

Figure 9: Proportion of Data Sharing with UCD for Research by Site

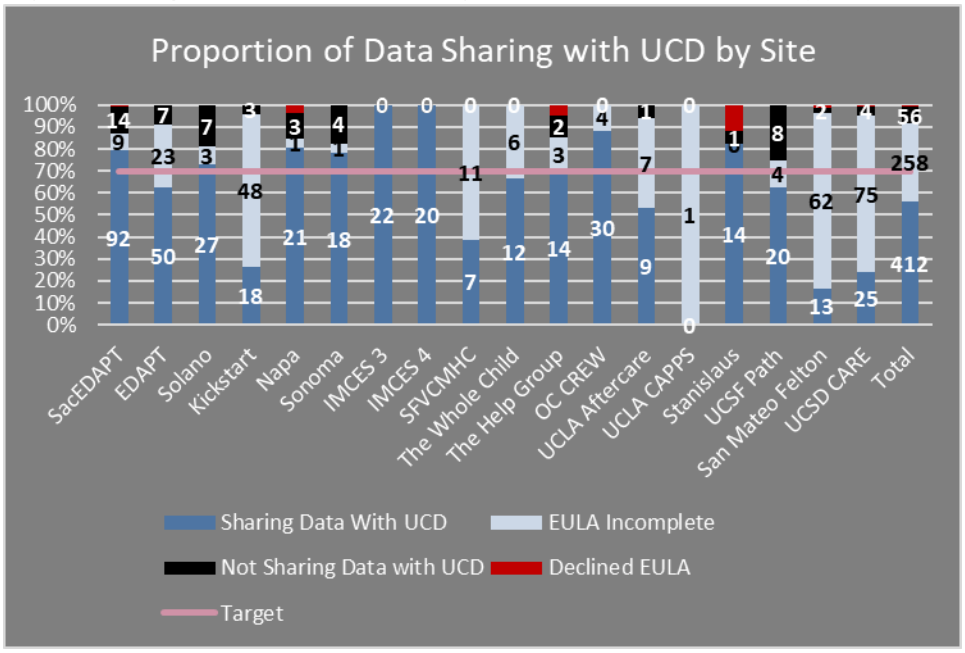
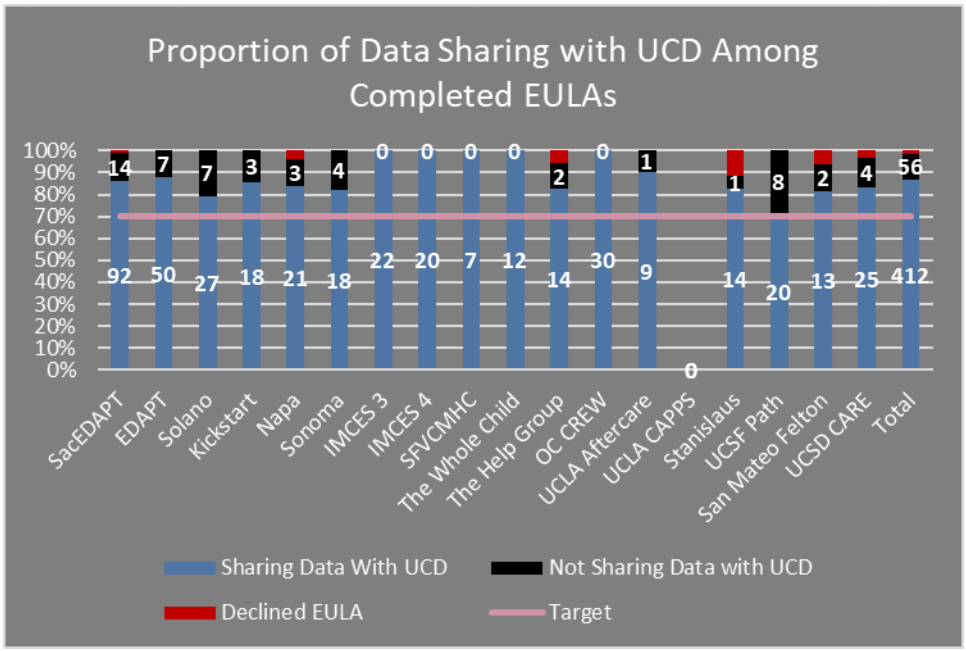


Figure 10 shows the proportion of data sharing choices made by those clients who have completed their EULA in Beehive. We can see that some sites on this graph do not have a bar at all because they do not have any clients who have been registered in Beehive.

Our goal is that 70% of active clients at each site agree to use Beehive and share their data for research purposes. When considering all clients known to EPI-CAL (i.e., all those registered in Beehive), we can see that only a few sites are meeting this metric. However, among those individuals who have actually engaged with Beehive and completed the EULA, we are exceeding our target across the network, and at most sites individually as well. When considering all enrolled clients across the LHCN, 86% of clients have agreed to share their data with UC Davis and 83% of clients agreed to share their data with NIH for research purposes.

Figure 10: Proportion of Data Sharing with UCD for Research among Completed EULAs

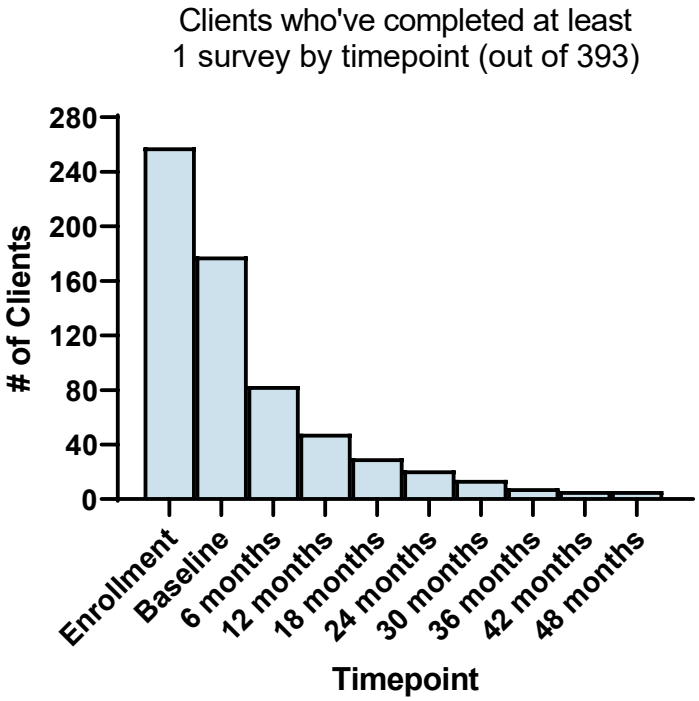


Progress of data collection in all EP programs

As of May 26, 2023, 18 EPI-CAL clinics have registered 733 clients in Beehive. Of those 733 clients who have been registered, 63% (n=468) have completed their Beehive EULA and are considered to be enrolled in Beehive. Of those who have completed their EULA, 83% (n=393) have agreed to share their de-identified data with NIH and 86% percent (n=412) have agreed to share their de-identified data with UCD.

Figure 11 shows network-level survey completion rates by time point as of May 26, 2023. Note that all clients are able to complete enrollment surveys regardless of when in their treatment they are enrolled. Clients are not able to complete some survey windows (e.g., baseline) if they are enrolled later in treatment. Some clients have completed surveys at more than one time point. Of the 468 clients who have been enrolled in Beehive, 88% (n=413) have completed at least one survey in Beehive.

Figure 11: Survey Completion Rates Across EPI-CAL Network



Here we report demographic information that is completed at registration, which is a subset of the demographic questions that are asked in Beehive (Table IV). Complete demographic information, including all required PEI fields, are administered via a required client-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 "<2%", respectively. If there were 0 individuals who endorsed a response option in the demographic surveys, the category is not represented on Table IV (e.g., Genderqueer/gender non-conforming in the gender category); we will continue to add categories to each demographic variable if there are ≥1 individuals in each respective category.

Table IV: Demographic Data from all Participating EPI-CAL Clinics

EPI-CAL Combined Demographics, n =413 (through 5/26/2023)		
Display Language	**N**	**%**
English	402	97%
Spanish	9	2%
Missing	<5	<2%
Age	**N**	**%**
<12	<5	<2%
12-17	157	38%
18-23	182	44%
≥24	72	17%

Sex at Birth	**N**	**%**
Female	202	49%
Male	206	50%
Intersex	<5	<2%
None of these describe me	<5	<2%
Prefer not to respond	<5	<2%
Gender	**N**	**%**
Female	176	43%
Male	192	46%
Non-binary	16	4%
Transgender	6	1%
Questioning or unsure of gender identity	<5	<2%
Other	5	1%
Prefer not to say	14	3%
Missing	<5	<2%
Pronouns	**N**	**%**
He/Him	173	42%
She/Her	149	36%
They/Them	19	5%
Other	<5	<2%
Missing	68	16%
Race	**N**	**%**
African/African American/Black	49	12%
Asian	44	11%
American Indian/Alaskan Native	<5	<2%
Hispanic/Latinx Only	139	34%
White/Caucasian	10	2%
More than one race	149	36%
Unsure/Don’t Know	9	2%
Prefer not to say	<5	<2%
Missing	<5	<2%
Ethnicity	**N**	**%**
No - I do not identify as Hispanic/Latinx	208	50%
Yes - I identify as Hispanic/Latinx	153	37%

Unsure/Don't know	48	12%
Missing	<5	<2%

Additionally, providers are asked to enter a client's diagnosis when they register individuals in Beehive, which is reported in Table V. 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 "<2%", respectively. 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). There is also a section for those individuals for which their FEP or CHR status is not yet confirmed. This reflects the wide range of psychosis diagnoses that are served by the EP clinics represented in this sample.

Table V: Client Diagnoses from all Participating EPI-CAL Clinics

EPI-CAL Combined Diagnoses, n = 413 (through 11/28/22)	**N**	**%**
Clinical High Risk (CHR)		
Attenuated Psychosis Symptoms	26	6%
Genetic Risk and Deterioration Syndrome (GRDS)	<5	<2%
Other	52	13%
First Episode Psychosis (FEP)		
Substance Induced Psychotic Disorder with onset during intoxication	<5	<2%
Mood disorders with psychotic features	47	11%
Schizoaffective Disorder (Bipolar or Depressive Type Combined)	29	7%
Schizophrenia	50	12%
Schizophreniform Disorder	6	1%
Delusional Disorder	<5	<2%
Brief Psychotic Disorder	<5	<2%
Other Specified Schizophrenia Spectrum Disorder	14	3%
Unspecified Psychosis	48	12%
Other FEP	58	14%
CHR or FEP Status Not Confirmed		
Anxiety Disorders*	23	6%
Mood Disorders*	30	7%
Other Diagnoses*	11	3%
Not enough Information	<5	<2%
Missing	35	8%

**Individuals may be counted more than once for these diagnoses*

9. Submit final data analysis plan for all data

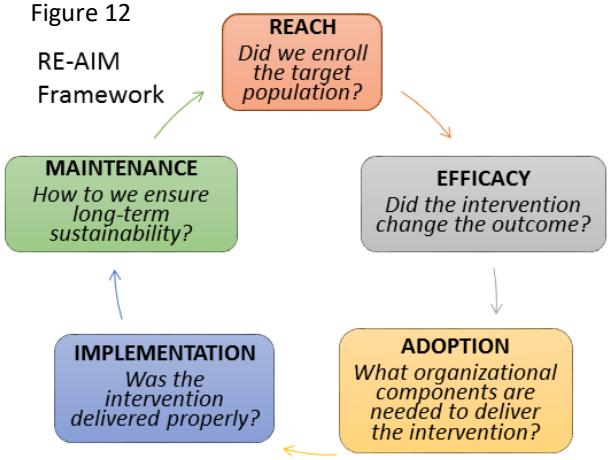
As a reminder, this project contains data collected via three components: program-level data, county-level data, and qualitative data (Figure 1). The county data analysis plan was described in prior deliverables. While we describe some qualitative analysis here, much of the qualitative data analysis was described in prior deliverables, including "Provide qualitative report on ongoing issues and suggestions on the app/dashboard from EP program staff and other community partners; including results of focus groups."

Therefore, this analysis plan will focus on client data collected via Beehive, including client self-report data, data from the primary support person for the client, and clinician rated data. The majority of the data is designed to be collected longitudinally, i.e., at baseline and then every six months of treatment thereafter. For our purposes, baseline is associated with a client's intake date, not when they are enrolled in Beehive. Therefore, any reference to "baseline" is referring to the client's intake date or start in their program regardless of their interaction with Beehive, and "enrollment" is referring to when the client was enrolled in Beehive, which occurs after intake. There are several variables that are only assessed at enrollment in Beehive, including multiple items that are assessed if they occurred over the client's lifetime. For example, clients are asked in the "EPI-CAL Baseline Only Questions" survey if they have ever, in their lifetime, experienced any legal interaction. Then, on follow-up surveys, clients are asked every 6 months thereafter if they have had legal involvement in the past 6 months. Therefore, the legal experiences variables represent variables that is assessed initially as a single lifetime variable and then longitudinally for more recent involvement. All clients are able to complete enrollment surveys regardless of when in their treatment they are enrolled. Clients are not able to complete some survey windows if they are enrolled later in their treatment (e.g., client enrolled at 6 months would complete the enrollment and 6-month bundle but would not be able to complete the baseline bundle). Please see Table VI for a list of all data domains collected in Beehive. This table outlines whether a domain is rated only at enrollment or longitudinally, and also indicates who completes the survey. Who rates the data will also be included as a variable in the analysis as we want to differentiate between information that is client self-report or clinician rated.

RE-AIM provides a conceptual framework to facilitate the translation of research to clinical practice. We will use this framework to examine the real-world impact of the proposed core battery and Beehive based on five dimensions (Figure 12): 1) Reach – the number and representativeness of the participants who use Beehive; 2) Efficacy – the impact of the intervention on specific outcomes; 3) Adoption – proportion and representativeness of people and places that adopt the intervention; 4) Implementation – quality and consistency of intervention delivery in real-world settings; and 5) Maintenance – long term outcomes of the intervention and its sustainability over time. This implementation research framework provides structure to examine initial impact of the project.

Figure 12

RE-AIM Framework



Prior to analysis, we will complete descriptive summaries for all data collected in Beehive, including client and clinician demographics, survey completion for each survey at each timepoint, and survey scores for quantitative measures. The distribution and completeness of each analysis variable will be examined to

determine appropriateness of different statistical methods. Availability of within-person longitudinal data will be reviewed to determine whether longitudinal or cross-sectional approaches are most appropriate. Descriptive summaries will be generated for each clinic individually as well as network wide.

Table VI: Beehive Surveys by Timepoint and Respondent Type

Respondent	**Measure**	**Timepoint**	
		Enrollment	Every 6 months (including Baseline)
Client	Registration Demographics	1*	0*
Client	EPI-CAL Baseline Only Questions	1	0
Client	Primary Caregiver background	1	0
Client	Adverse Childhood Experiences (ACES)	1	0
Client	Demographics & Background	0	1
Client	Education	0	1
Client	Employment and Related Activities	0	1
Client	Social Relationships	0	1
Client	SCORE-15	0	1
Client	Legal Involvement and Related	0	1
Client	Substance Use	0	1
Client	Medications	0	1
Client	Intent to Attend and Complete Treatment Scale	0	1
Client	Modified Colorado Symptom Index	0	1
Client	Questionnaire about the Process of Recovery (QPR)	0	1
Client	Life Outlook	0	1
Client	Hospitalizations	0	1
Client	Life Events Checklist (LEC-5) & PTSD Checklist for DSM-5 (PCL-5)	0	1
Client	Child and Adolescent Trauma Screen (CATS)	0	1
Clinician	Pathways to Care	1	0
Clinician	Diagnosis and DUP	0	1
Clinician	Family Involvement	0	1
Clinician	Risk to Self/Others	0	1
Clinician	Health	0	1
Clinician	Medications	0	1
Clinician	Service Use	0	1
Clinician	Functioning	0	1
Clinician	Symptoms	0	1
PSP *	Baseline Only Questions	1	0
PSP	Demographics & Background	0	1
PSP	Legal Interactions & Related	0	1
PSP	SCORE-15	0	1
PSP	Burden Assessment Scale	0	1
PSP	Modified Colorado Symptom Index	0	1

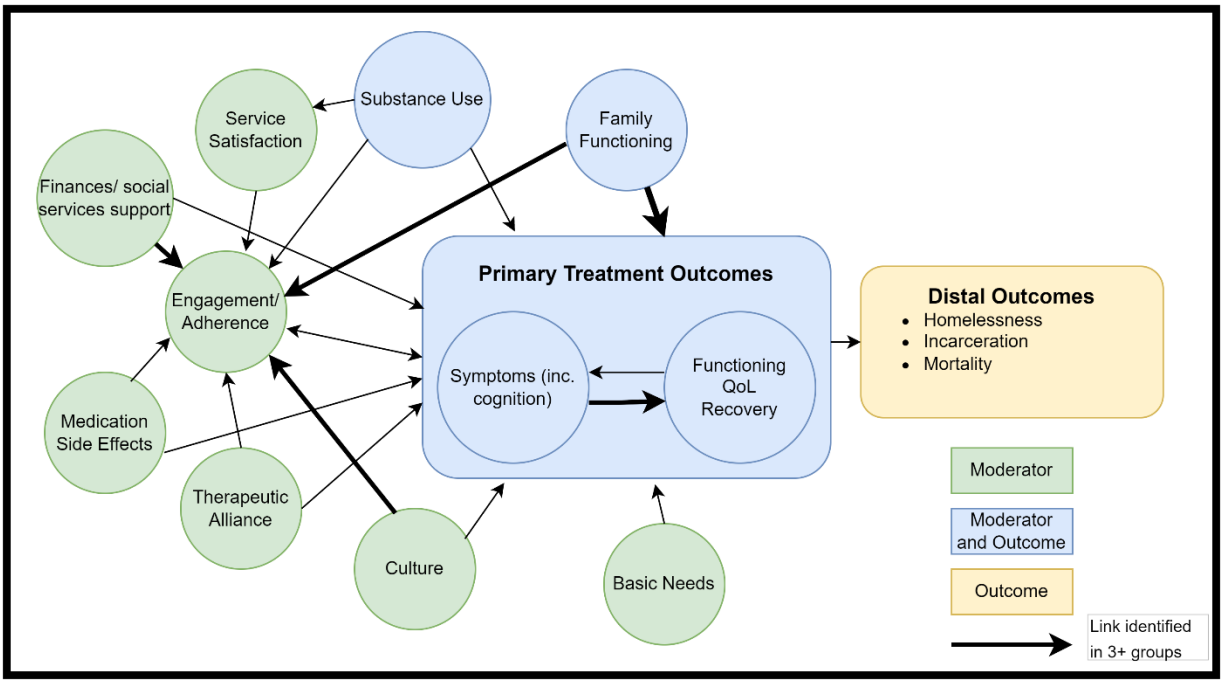
PSP	Medications	0	1

* PSP = Primary support person; 0 = not available; 1 = available

First, we will examine is whether we achieved adequate enrollment in Beehive (*Reach)*. We will examine this using descriptive statistics to see if at least 70% of eligible participants, who are representative of the target population based on current program demographics, and 50% of their available family members, across the network were enrolled and completed at least one survey timepoint. To approximate the number of total clients eligible for enrollment, we will pull the total census number from each programs' completed fidelity assessment and program-level core assessment battery (PL-CAB). Data on of the number of available family members is available in Beehive and we are able to assess whether a primary support person (PSP) has completed enrollment and any additional surveys. Survey data analysis procedures for clustered data (treating early psychosis programs as clusters) will summarize characteristics of enrolled clients who complete enrollment and at least one longitudinal assessment. Enrollment rates (with 95% confidence interval) will be computed for 1) all eligible clients and 2) potentially available family members. For the latter, we will report, for the denominator of eligible clients with available family members, what proportion of those clients had at least one family member complete a baseline or 6-month assessment.

Through the extensive qualitative work that was completed in the first phase of this project (Figure 13), a variety of key outcomes were identified by our program, client and family workgroups. As described in the qualitative results from the Outcomes Focus groups, psychiatric symptoms, quality of life, and functioning were prioritized as key outcomes by all types of respondents and our analysis will center on these domains. Initially, as we continue to enroll and gather longitudinal data, our analyses will provide repeated cross-sectional assessment of these outcomes, with preliminary analyses of client's longitudinal trajectories when possible. As the longitudinal dataset grows, to account for the hierarchical structure of the data (nesting of measurements from clients, who are nested within clinicians within EP programs) and for continuous, binary, and count outcomes, generalized linear mixed models will be used to estimate the adjusted effects of exposures of interest on the key outcomes of interest, including quality of life, functioning, and recovery. Regression models will include independent variables (specified as fixed-effect terms) that operationalize relevant clinician metrics

Figure 13: Moderators and Outcomes of Interest



along with a parsimonious set of other clinician- and client-level covariates, in order to statistically adjust for confounders. Relevant clinician metrics may include clinician demographic information collected at registration, such as degree level, years working with this specific population, and other demographic variables. Random effects will be specified for sites, with additional effects specified for clinician and clients' effects if either/both improve model fit, according to Schwarz Information Criterion.

Next, we will examine *efficacy* of measurement-based care, comparing adjusted mean differences in baseline to 12-month change in psychotic symptom severity between groups defined by clinician metrics available from Beehive. When examining group-level differences, it is important to note that there is not a "Beehive" and "not Beehive" group of clients; all clients are assigned to the Beehive group and thus any analysis cannot examine the effect of Beehive use in treatment compared to a typical control group. Instead, clients will be classified according to the timeliness of clinician assessment of the client's Beehive data; the primary clinician metric will be a binary indicator for whether clinician accessed the patient's data within two weeks of surveys being completed. Exploratory metrics will include time spent reviewing Beehive data and whether the clinician reported that Beehive data impacted treatment plan. Our primary analysis will estimate impacts on mean baseline to 12-month changes in psychotic symptom severity, with separate regression models built for each of the primary and exploratory operationalizations of the Beehive clinician-usage metrics described above. Estimations of timepoint-specific changes (e.g. from baseline to 12-months) could either be done by computing the specific change score and using it as a dependent variable in a regression or, when data from other timepoints is also available, by analyzing the available data from each patient at each of multiple timepoints and including in the regression models terms for time, comparison group, and the interaction, to enable estimating timepoint-specific effects. When baseline data are available for a given outcome, we have opted to use regression approaches that pertain to estimating mean changes from baseline (e.g., a difference in differences type approach) instead of with baseline-adjusted mean differences at follow-up (e.g. an ANCOVA-type strategy) because our study is nonrandomized (Van Breukelen, 2006). Psychotic symptom severity data is available from both the client self-report Modified Colorado Symptom Index and a clinician-rated symptom measure, either the Brief Psychotic Rating Scale (BPRS) or the COMPASS-10. To address attrition, we will use multiple imputation to impute follow-up assessment scores and change scores based on them.

To assess the *maintenance* of measurement-based care via Beehive, we will assess timepoint-specific changes in psychotic symptom severity for each of the half-yearly assessment timepoints during the first 24 months, with the primary analysis based on a time-varying indicator for any endorsement of "impact on treatment plan" as a time-varying independent variable. We will also use data from the barriers and facilitator interviews to examine client-, provider- and program-level barriers to enrollment and completion. Separate models will be fit for each of the primary and alternative operationalization of Beehive clinician-usage metrics as the exposure variable of interest.

To examine *Adoption*, we will compare providers with respect to their reporting use of data to determine treatment choices at two timepoints, prior to Beehive implementation and after training in and using Beehive. To assess *Implementation*, we will examine if EP providers use Beehive in direct care with clients for at least 50% of completed assessments. Prior to Beehive implementation in each EP program, providers completed "pre-implementation" surveys about their demographic information (age, sex, race, ethnicity) and professional characteristics (years of education, degree type) and completed questionnaires on their 1) beliefs about the utility of data in care planning and 2) skills in discussing data with clients. Beehive training materials were implemented consistently across participating EP program, highlighting the utility of data to identify treatment goals and metrics of improvement during treatment planning, and provided guidance on client-centered ways to review data to monitor progress during treatment. For post-implementation analysis of use of data in care,

we will use provider-rated “use of data in care” questions, which are intermittently presented to providers while they are reviewing a client’s data page in Beehive so that they may indicate 1) if the data was reviewed during a session with the client or family and, if yes, 2) how the data was used as part of care, such as “followed up by phone” or “scheduled follow up appointment,” or “no action taken.” These data use metrics allow analysis on rates of adoption and level of implementation of Beehive. We will use a mixed effects regression model with robust standard errors to estimate site- and provider-adjusted pre-to-post differences in the proportion of client sessions where client-level data was used. The regression model will include fixed effects for site and a binary indicator for post-implementation and random effects for providers. If convergence can be obtained, we will use a linear link with a binomial variance. Otherwise, we will use a linear-normal model, relying on the robust variance estimator to correct for heteroscedasticity. Exploratory analysis will examine clinician expertise and training needed to effectively implement clinician review of FEP participant outcome data using Beehive at 80% of available time points.

To identify barriers and facilitators to Beehive implementation, our team is in the process of completing semi-structured qualitative interviews with clients and providers. Client-, provider- and program-level implementation barriers will be identified through analyses of qualitative data. Stratified purposeful sampling was and will continue to be used to recruit participants across clinics where Beehive adoption and implementation has been both high and low, and with clients who have and have not received data-integrated care. The data will be analyzed using an inductive approach to thematic analysis to identify data-driven themes to explain aspects of a phenomenon. Multiple coding will be adopted, and where possible, service users and providers will be involved in developing the topic guide and reviewing the data analysis and interpretation. Our goal is to have a total of 30 interviews completed by the Spring of 2023.

In addition to the program-level data described here, we also collected project data via fidelity assessments, program surveys, and the PL-CAB. Each program has completed a fidelity assessment to determine the components of coordinated specialty care (CSC) provided using the First Episode Psychosis Services Fidelity Scale (FEPS-FS), a standardized measure of fidelity to EP program best practices. Similar to the fidelity assessments, program surveys and the PL-CAB assess various components offered through the CSC program, program census, and staffing. The data from these other sources may also be used to inform the analysis of the program-level data described above.

Future analyses seek to examine the other relevant outcomes and moderators identified in Figure 13. Specifically, outcomes like homelessness, incarceration, and mortality are critically important for individuals with psychosis, but were not prioritized during the qualitative work given that these outcomes are not frequently observed in during the early course of illness. Therefore, these outcomes will be described for each of the programs, but not incorporated into statistical analyses for the purposes of the current report. Instead, we may need longer-term follow up data of those that transition out of the clinic and these domains have been identified as a priority for future work.

10. Draft preliminary data on feasibility and acceptability of LHCN app in all EP programs

One of our primary metrics to evaluate the feasibility and acceptability of the Beehive application in EP programs it to examine is whether we achieved adequate enrollment in Beehive. We examined this using a previously defined benchmark of enrollment of at least 70% of eligible participants, who are representative of the target population based on current program demographics, and 50% of their available family members, across the network were enrolled. To approximate the number of total clients eligible for enrollment, we have

asked the programs to provide us with their current total census number. This was compared to clients currently enrolled in Beehive, and not including clients who have been discharged from Beehive. Clients must have completed their EULA to be considered enrolled. For the purposes of the preliminary analysis, we are only considering individuals who have agreed to share data with UCD as "enrolled", but clients can decline this option and still use their data within their program for clinical purposes. Data on of the number of available family members is available in Beehive and we are able to assess whether a primary support person (PSP) has completed enrollment. Just like clients, primary support persons are not considered enrolled unless they have agreed to share data with UCD. Clients and support persons can make different choices regarding their data sharing permissions, i.e., a client can decline to share their data for research purposes while a support person can opt in. For the purpose of the preliminary feasibility analysis, we are only examining what proportion of enrolled clients also have an enrolled PSP, acknowledging that there may be more enrolled PSPs whose corresponding client opted out of data sharing. Programs who have not begun enrollment are not included in this analysis (Lake County, MCC, and Stanford INSPIRE).

Table VII: Preliminary client and PSP Beehive enrollment

Program Name	Current Census	Currently Enrolled	% Enrolled	Clients with an enrolled PSP	% with a Primary Support Person
UCD SacEDAPT	25	29	116%	17	59%
UCD EDAPT	61	35	59%	20	57%
Solano SOAR	11	8	73%	4	50%
Napa SOAR	17	14	82%	9	64%
Sonoma SOAR	18	15	83%	5	33%
Kickstart Pathways	95	4	4%	3	75%
LAC- IMCES 3	11	17	154%	3	18%
LAC - IMCES 4	28	17	61%	4	24%
LAC - SFVCMHC	18	6	33%	1	17%
LAC- The Whole Child	34	12	35%	3	25%
LAC- The Help Group	19	13	68%	9	69%
OC CREW	42	16	38%	3	19%
San Mateo Felton	70	13	19%	3	23%
UCLA - Aftercare	21	9	43%	5	56%
UCLA - CAPPS	45	0	0%	0	0%
UCSF PATH	100[1]	20	20%	4	20%
UCSD CARE	244	23	9%	2	9%
Stanislaus LIFE PATH	8	7	86%	3	43%

[1] Updated census not provided; estimate from program-level survey used.

As described in Table VII, there is quite a bit of variability across programs in the proportion of the program's census that are enrolled in Beehive (mean = 55%, range = 0-154%). Two programs have more clients enrolled in Beehive than currently in their program, indicating they have clients who have been discharged from the program but not Beehive. EPI-CAL point persons are working with the sites to make sure they discharge clients from Beehive in a timely manner moving forward. Five of the participating programs meet or exceed the previously defined benchmark of 70% of eligible clients are enrolled. There was also extensive variability in the number of PSPs enrolled in Beehive across the programs as well (mean = 37%, range = 0-75%). Seven of the participating programs meet or exceed the previously defined benchmark of 50% of PSPs enrolled in Beehive.

The heterogeneity of enrollment across sites supports the need for the qualitative barriers and facilitators interviews to understand the issues that sites are facing. Future analyses will examine survey data from clients in more detail, and survey data analysis procedures for clustered data (treating early psychosis programs as clusters) will summarize characteristics of enrolled clients who complete enrollment and at least one longitudinal assessment.

11. Subcontractor to make additional revisions to dashboard to include feedback from programs and community partners.

Over the last fiscal year, we have made a number of changes and improvements to Beehive based on feedback from programs and community partners. Annual penetration testing ("pentesting") was conducted in June of 2022 and May 2023. Results from the first annual testing of the fiscal year changes to Beehive (release date of 8/25/2022) in order to maintain compliance with increasing security standards. Results of the pentesting from May 2023 resulted in changes to Beehive in our current fiscal year and are not summarized in the current report. Table VIII summarized changes made to Beehive over the last fiscal year. Please see the table below for more detail.

Table VIII: Changes to Beehive Implemented over the Fiscal Year 22/23

Date	Changes to Beehive
7/8/2022	• Performance updates (e.g., increased efficiency in application to reduce loading times) at login • Allow user to be logged into web browser and iOS app at the same time to prevent disruption in client survey completion • Added a link from Beehive dashboard to Beehive resource guide • Added a modal which shows survey expiration date when user hovers over survey due date • Added email notifications for urgent clinical issues Alphabetized user dropdowns by first name
7/22/2022	• Added in-App notifications for urgent clinical issues Added ability for users to manage their email notifications (e.g. users can turn off email notifications if desired)
8/25/2022	• Group Admin (i.e. program leadership) are notified of screen-shots taken on the iOS app • Users see a reminder not to share PHI without client's written permission when taking screenshots on the iOS app • Updated password policy (does not apply to SSO-users) • Added "change password" functionality

	Added One-Time Password timeouts (e.g., user can request OTP for a maximum of 3 times before they are locked out for 15 minutes, user can enter an invalid OTP a maximum of 5 times before they are locked out for 15 minutes).
9/14/2022	• Improved workflow for editing client data (e.g. summary page shows all registration information, user can jump to sections for editing purposes, user may save and close at any screen of client's profile when editing registration information) Updates to weblink distribution frequency (reduction in frequency in response to longer survey windows)
10/03/2022	• Performance updates (e.g. increased efficiency in application to reduce loading times) during survey completion • Added email notification when clients use "ask for help" feature Updated survey reports so that free text responses to "other (please specify)", for example, are treated as a separate variable
10/14/2022	• Performance updates (e.g. increased efficiency in application to reduce loading times) throughout application Added an OTP cool down to prevent users from requesting a new OTP before the first OTP has had time to arrive
11/21/2022	• Performance updates (e.g. increased efficiency in application to reduce loading times) on survey results and client data view page • Update to client registration feature: allowing users to save registration before it is completed to finish later Added two additional response options to question asked when resolving urgent clinical issues based on user free-text responses from the past year
12/23/2022	• Weblink & OTP emails and text will be delivered to clients and support persons in their chosen display language (e.g., Spanish, Vietnamese) • Added an option for "no weblink" to "Weblink Delivery Method" in response to request from LHCN programs • Added an option to indicate when support persons decline to provide DOB in response to request from LHCN programs • Report file names generated by Beehive will include more detail, including survey name and relevant clinics in the report, in response to request from LHCN programs • To address request from LHCN programs, added in notifications relevant to track outstanding surveys: in-app survey notifications and weekly digest email
01/23/2023	• Launch of Vietnamese (CA threshold language) translations for Beehive interface (e.g., EULA video, all navigation text) & client & support person surveys
02/13/2023	• Added mobile phone validation and verification for client and support person weblinks
03/13/2023	• In response to feedback from LHCN programs, gave provider-level users permission to close client episodes. Prior to this update, this permission was restricted to admin users only • To support LHCN programs administer surveys to clients remotely, added an indication of the phone or email that OTP has been sent to • In response to request from LHCN programs, added in a "download as PDF" option on client surveys so that surveys may be easily included in medical record or for other reporting purposes

03/31/2023	• Performance updates (i.e., increased efficiency in application to reduce loading times) while loading data (e.g., client data view, survey results, clinic aggregate data)
6/15/2023	• Arabic is available as a display language for Beehive interface (e.g., EULA video, navigation buttons). Survey translations not yet available because EPI-CAL team needs time after this language becomes available in production to enter them. • Lengthened time before OTP expires from 5 minutes to 15 minutes to respond to institutional email screening procedures at sites which were slowing down email receipt and not delivering OTP before it would expire

12. 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

We have previously reported on our data collection process in past annual reports. However, we continue to work on the data collection process as new counties join the LHCN. During the last annual year, we continued to have follow-up meetings with the counties that are involved in retrospective data collection (Los Angeles, San Diego, Orange, Solano, Stanislaus, and Napa). We held a series of initial meetings with the EP program staff and county staff to address the collection of the county-level utilization and cost data for the prospective evaluation for both EP and comparator group (CG) programs (Los Angeles, San Diego, Orange, Solano, Stanislaus, Napa, and Lake). We identified EP program information, including a description of clients served, billing 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 extraction. We reviewed all data elements that will be needed to define the EP and CG sample, including historical diagnostic and utilization data for both groups (January 1st, 2013- December 31st, 2016). We reviewed data categories, elements, and sources for utilization and cost to determine a) which services are provided in the county, and b) which data elements are available to be shared for the analysis. Any follow-up meetings with county data analysts are scheduled on an ongoing basis.

Lake and Kern counties will only be participating in the second phase of the evaluation, the prospective period, because their EP programs were not established until after the date range of the first evaluation phase concluded. In addition, Lake County will have a phase two timeframe that begins later due to the establishment of their EP program in 2022. Their prospective period will be January 1st, 2022- June 30th, 2024. This will allow for their EP program to have served more clients and collected service data for two and a half years for the prospective analysis.

Data Collection Process

The retrospective data extraction procedures have been completed for Los Angeles, Orange, and San Diego, and are in progress for Solano, Stanislaus, and Napa counties. The prospective data extraction procedures are in progress for San Diego, Los Angeles, Orange, Solano, Stanislaus, Napa, and Lake counties. The county data analysts have been asked to identify all clients served by the EP program for the retrospective period dates between January 1st, 2017 – December 31st, 2019, and the prospective period dates between January 1st, 2020 – June 30th, 2022, with an exception for Lake County. For the retrospective period, this includes individuals who started services with the EP program between January 1st, 2017 – December 31st, 2019 and excludes any individuals who received services from the EP program prior to January 1st, 2017. For prospective period this includes individuals who started services with the EP program between January 1st,

2020-June 30th, 2022 and excludes any individuals who received services from the EP program prior to January 1st, 2020. The county data analyst will send the list of clients to the EP program manager, who will then confirm the list of clients as new clients as of January 1st, 2017 – December 31st, 2019 (for retrospective period, if applicable) and January 1st, 2020-June 30th, 2022 (for prospective period) and identify 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 1st, 2017 – December 31st, 2019 (retrospective) or January 1st, 2020-June 30th, 2022 (prospective); or 4) other, with reason (e.g., incorrectly assigned to EP program in EHR or claims data). They will also add any individuals missed and repeat above 1-3 categorization, if necessary. They will also send any available data elements that are not available in the county EHR and claims data to the county data analyst, who will integrate them into the dataset. These data elements may include information on intake forms, such as regional center involvement and referral information, or other data elements. The county data analyst will integrate these data elements into the dataset and assign an ID to replace medical record numbers (MRN), names, and other identifying information, then save the key in order to create a limited dataset (dates and zip code included). The county data analyst will be sent a username and password to login to a secure UC Davis GoAnywhere portal, whereby each county can upload their county data securely and will not be able to access any other county's data.

We formally requested this information when we met with each county. A summary of what we asked for is described below for the retrospective and prospective periods, respectively.

Retrospective
We are requesting a limited dataset for all individuals served in the specified EP Program between these dates: January 1st, 2017 – December 31st, 2019. Data elements requested include: 1) all diagnoses (psychiatric, substance use, physical health) and dates of diagnoses; 2) year and month of birth (not date); 3) demographics, including: race; ethnicity; sex; gender; gender identity; sexual orientation; living arrangement (housing status); US military information/ veteran status; primary language; foster care/adoption; zip code; insurance status (i.e., insurance type); education level; marital status; and employment status; and 4) all county behavioral health services utilized, including: i) all outpatient mental health services; 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; and service duration/minutes. We also requested a data dictionary from each county.

Based on our preliminary analysis of the data from Los Angeles, Orange, San Diego, and Solano counties, we determined that we also need historical diagnostic and service utilization data going back to January 1st, 2013 for both EP and CG clients. This will allow us to improve the comparability of individuals in the CG group with those in the EP group by either, a) appropriately matching individuals from the CG group to individuals in the EP group or b) weighting clients by their predicted pre-period probability of being observed in the EP program during the study period. Therefore, all counties also received this additional request:

We are now requesting to extend our service utilization data request for the EP group to the four years prior to our active period (January 1st, 2017 – December 31st, 2019), going back to January 1st, 2013.

Prospective
We are requesting a limited dataset for all individuals served in the specified EP Program between these dates: January 1st, 2020 – June 30th, 2022. Data elements requested include: 1) all diagnoses (psychiatric,

substance use, physical health) and dates of diagnoses; 2) year and month of birth (not date); 3) demographics, including: race; ethnicity; sex; gender; gender identity; sexual orientation; living arrangement (housing status); US military information/ veteran status; primary language; foster care/adoption; zip code; insurance status (i.e., insurance type); education level; marital status; and employment status; and 4) all county behavioral health services utilized, including: i) all outpatient mental health services; 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; and service duration/minutes. We also requested a data dictionary from each county.

Based on our preliminary analysis of the data from Los Angeles, Orange, San Diego and Solano counties, we determined that we also need historical diagnostic and service utilization data going back to January 1st, 2016 for both EP and CG clients. This will allow us to improve the comparability of individuals in the CG group with those in the EP group by either, a) appropriately matching individuals from the CG group to individuals in the EP group or b) weighting clients by their predicted pre-period probability of being observed in the EP program during the study period. Therefore, all counties also received this additional request:

We are now requesting to extend our service utilization data request for the EP group to the four years prior to our active period (January 1st, 2020 – June 30th, 2022), going back to January 1st, 2016.

13. Identification of county-level available data and data transfer methods, and statistical analysis methods selected for integrated county-level data evaluation

One component of the LHCN project is to identify and describe the services and related costs for individuals served by the EP programs in each county. We also examine services and costs associated with similar individuals served elsewhere in each county. We continue to work on harmonizing and integrating data across all LHCN counties in order to perform these analyses.

Specifically, in each county we identified an early psychosis (EP) group consisting of individuals served by the early psychosis program. We also identified a comparator group (CG), consisting of individuals with EP diagnoses, within the same age group, who entered standard care outpatient programs during that same time period. This analysis focuses on data from Los Angeles, San Diego, Orange, Napa, Stanislaus, Lake, and Solano counties. Inclusion of Kern County is pending an executed contract. 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 1st, 2017 – December 31st, 2019) to harmonize data across counties and to account for potential historical trends and 2) for the 2.5-year period contemporaneous with the prospective EP program level data collection (January 1st, 2020 – June 30th, 2022).

Lake and Kern counties will only be participating in the second phase of the evaluation, the prospective period, because their EP programs were not established until after the date range of the first evaluation phase concluded. In addition, Lake County will have a phase two timeframe that begins later due to the establishment of their EP program in 2022. Their prospective period will be January 1st, 2022-June 30th, 2024. This will allow for their EP program to have served more clients and collected service data for two and a half years for the prospective analysis.

For each county, our team held meetings with the EP program managers and the county data analysts. The meetings with the program managers discussed services provided by the EP program, description of clients

served, staffing specifics and billing codes for each service. A follow-up meeting was held with each county to review details of funding sources, staffing levels during certain time-periods and other types of services provided for specific types of clients (i.e., foster care). Meetings were held with the county data analysts to discuss details about the data the county will be pulling for the LHCN team. The discussion included time-periods for which the LHCN team will request data, description of the clients from EP programs and how similar clients served elsewhere in the county will be identified, services provided by each program, other services provided in the county to the EP clients (i.e., hospitalization, crisis stabilization, substance use treatment), and data transfer methods. We have met with the program managers and data analysts from all LHCN counties with active contracts and have scheduled follow-up meetings with the data analysts as necessary. Each meeting has been described in detail in the call log provided in the deliverables. Our research team has gathered all of the information from each program/county and summarized it in meeting notes and a multicounty data table. For the purposes of this report, we have provided a sample of the data collected from each county (see Table IX).

Table IX. Multicounty Program Services and Billing Information

County	San Diego	Orange	Solano	Napa	Stanislaus	Los Angeles	Lake
Program Name	Kickstart	OC CREW	Aldea SOAR	Aldea SOAR	LIFE Path	CAPPS	Early Intervention Services (EIS)
Clients Served	FEP, CHR	FEP	FEP, CHR	FEP, CHR	FEP, CHR	CHR+	FEP and CHR
Census	140-160	42	26	15-Oct	Current 10-15, cap 40	60	30
Length of Services	(+/-) 2 yrs	2 - 4 yrs	(+/-) 2 yrs	(+/-) 2 yrs	2 yrs	2 years (case by case)	2-4 years
Inclusion - Ages	Ages 10-25	Ages 12-25	Ages 12-30	Ages 8-30	Ages 14 - 25	Ages 12-25	15-25 y/o
Inclusion - Diagnoses	Any type of psychoses (NOS) but not required, SIPs score of 6	FEP	CHR diagnosis or FEP within 2 yrs	All Psychotic D/Os (within 2 yrs of meeting dx criteria) & CHR diagnosis	Psychotic d/os within 1 year of meeting dx criteria including affective, & CHR diagnosis	CHR - based on SIPS, must have at least positive symptom score of 3-6.	Any type of psychoses, but not required.
Inclusion - Insurance	Medi-Cal, Uninsured	None	Medi-Cal, Uninsured	Medi-Cal, Private, Uninsured	Medi-Cal, Private, Uninsured	Medi-Cal only	Medi-Cal, uninsured, Medicare. We are only contracted with Medi-Cal and Medicare. We bill all other insurances,

County	San Diego	Orange	Solano	Napa	Stanislaus	Los Angeles	Lake
							but we are out-of-network.
Inclusion - Duration of Psychosis	First psychotic symptoms within 2 yrs	First psychosis within 2 yrs	First psychosis within 2 yrs	First psychotic episode within 2 years; Attenuated psychosis of any duration	First episode within 2 years;	No longer than 30 days since onset	First break within last 2 years.
Exclusion - Cognition	IQ < 70 - Case by case discretion	IQ < 70	IQ < 70	IQ < 70	IQ < 70, Substance induced psychosis, psychosis due to medical conditions including TBI	IQ below 70	IQ <70
Exclusion - Diagnoses	Case by case discretion: Medical diagnosis that better explains symptoms; substance use	No substance use or medical condition that better explains symptoms	Substance dependence would not allow to participate in treatment – refer to substance abuse treatment, Head injury or medical condition	Substance dependence would not allow to participate in treatment – refer to substance abuse treatment, Head injury or medical condition		Primary diagnosis of substance abuse	Primary substance use disorder
Exclusion - Other	Qualitative Judgement call: Physically aggressive, sexually inappropriate, safety issues	Not received counseling prior for psychotic disorder in the last 24 months	Qualitative Judgement call: Physically aggressive, sexually inappropriate, safety issues	Qualitative Judgement call: Physically aggressive, sexually inappropriate, safety issues	Qualitative: requires 24 hour care/higher level; staff/peer safety issues	Nothing beyond Specialty Health Services exclusions	We exclude when they are non-Specialty Mental Health Services.
Assessments - Billing Codes	10	90899-6 (H2015)	90791	10	10	90791	H2015 HE(SmartCar

County	San Diego	Orange	Solano	Napa	Stanislaus	Los Angeles	Lake
							e), 100 (Anasazi).
Assessments - Provider type	Clinicians	Clinician: master's level BHCI, BHCII, psychiatrist	Therapist; clinical supervisor	Therapist	LPHA	MD/DO, PA, PhD/PsyD (Licensed or Waivered), SW (Licensed, Registered or Waivered), MFT (Licensed, Registered or Waivered), NP or CNS (Certified), PCC (Licensed or Registered), Student professionals in these disciplines with co-signature*	Waivered Clinicians, LPHA, physician, nurse, case manager (other qualified provider).
Assessments - Notes	Behavioral Health assessment and HRA (high risk assessment)	Code 90899-6 for each of multiple sessions leading up to intake completion;Same code for psychiatrist completing conservatorship evaluation, disability assessment, or eval for med services by telephone		Initial, Annual/ Periodic	Initial, periodic	n/a	Case managers provide screenings. Anasazi is the old electronic healthcare record. SmartCare has been utilized since 3/1/2023.

14. Deliver a plan and timeline for working with counties to support infrastructure to access final round of county-level cost and utilization data for EP and CG programs

Overview of Deliverable for Annual Report

Prospective Data Analysis

Over the last fiscal year, we continued to meet with each county that has already submitted data from the retrospective period (Los Angeles, Orange, San Diego, and Solano) to review and finalize the prospective data request. In these meetings, we discussed when claims data would become available for service utilization and estimating costs, as well as time needed for data extraction. Data availability ranged from 4-11 months after the service was billed. We also conferred with other LHCN team members about the timelines for program fidelity assessments to be completed and Beehive implementation to obtain client-level outcomes. Based on these pieces of information, we determined that the 2.5 year period of January 1, 2020 – June 30th, 2022 would be best aligned with the goals of this analysis. This period will allow us to obtain service and cost data for all counties Jan 2020 - June 2022, then finish cleaning, harmonizing and integrating data for a preliminary analysis to be completed by December 2023. That would allow for stakeholder feedback and a final analysis completed by June 2024 (see Table X). The process of harmonizing and integrating data for the initial retrospective period has been incredibly useful and will allow us to do the same for the new service period much more quickly. This prospective period would include almost all program fidelity assessments, with the last assessment scheduled for December 2022.

Table X. *Proposed Timeline for Prospective Data Pull*

County	**Preliminary analysis due date**	**Length of time required for County to receive data**	**Data available by this date**
Solano	June 2023	3 months	**Sept 2022**
Orange	September 2023	10 – 11 months for charge data	**May 2023**
LA	June 2024	3 months for charge data DHS Hospital data - 6 months other hospitals - 30 days	**Jan 2023**
San Diego	June 2023	3 months - for annual report, so that there will be enough time for clinic to input all data	CCBH data available end of **Oct 2022**, Optum data available December 2023

Due to Covid-related delays in Beehive implementation (e.g., staffing shortages in county programs, reduced program censuses across the network), we do not expect to complete integrated analyses with sufficient statistical power by the end of the award period, but we do expect to conduct pilot analyses integrating client-level data from Beehive with county data.

Further, in our meetings with program and county staff, we discussed any changes to the county EHR or billing and claims systems, changes in data elements collected during the new time period, or any other relevant changes to data availability. We met with Solano County on June 2, 2022; Los Angeles County on May 23, 2022; Orange County on May 19, 2022; and held conversations with San Diego County on May 23, 2022. We will confirm this timeline with Napa and Stanislaus counties after we complete the retrospective data analysis with them.

Retrospective Data Request for Napa County

During the last project 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 Napa County.

We identified EP program information, including description of clients served, billing 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 extraction. The discussion included the time-period, January 1, 2017 – December 31, 2019, for which the LHCN team will formally request data. We reviewed all data elements that will be needed to define the EP and Comparator Group (CG) sample, including historical diagnostic and utilization data for both groups (Jan 2013-Dec 2016). We reviewed data categories, elements and sources for utilization and cost to determine a) which services are provided in the county and b) which are available to be shared for the analysis. Follow-up meetings with county data analysts have been scheduled.

Follow-up to Preliminary Retrospective Data Analysis

The County Data evaluation of the LHCN project examines the services and costs associated with individuals treated in Early Psychosis (EP) programs across several California counties in comparison to the services and associated costs for a comparator group (CG) of similar individuals treated in other outpatient clinics representing "standard care," during a concurrent time frame in the same community. The primary goal of this component, submitted December 2021, was to provide a preliminary demonstration of the proposed method for accessing data regarding EP programs and CG groups across California. The secondary goal was to analyze service utilization and costs associated with those services across counties.

In the prior report, we were able to successfully complete our primary goal and the first part of our secondary goal (service utilization comparison). We were unable to complete the cost comparison analysis due to the complexity of the data required to be harmonized across counties and the variety of data sources. Nearly all programs and counties have been impacted by staff shortages due to unfilled positions and redeployment of staff during the COVID-19 pandemic, as well as our central team, which has delayed project coordination and data extraction.

Over the last fiscal year, we have continued to meet with counties with clarifying questions about received cost and utilization data, and to troubleshoot issues related to incomplete or unclear data elements. In these meetings, we requested that each county provide us with contracts and budgets for their EP programs to account for non-billable activities and other unaccounted-for costs of running the program. Further, we worked with counties to obtain actual costs per service, per client, rather than reimbursement amounts or fixed costs per unit of service, as these have differed.

In our efforts to thoroughly balance EP and CG groups, we decided to request historical data for the EP group from each county and have worked to modify data use agreements as necessary. For Napa County, they observed that the existing agreement between the county and UC Davis only covered de-identified data when it should have a described a limited dataset for the county data analysis. To make sure data sharing was covered appropriately, UC Davis drafted a data use agreement (DUA) covering all data elements to be shared between the county and the university as part of the EPI-CAL project. The draft DUA is currently under review by Napa County's compliance department. Finally, we asked each county to provide us with clients' episode of care end dates for those clients who may have ended their services since the data was originally extracted.

Follow-up of preliminary analysis of service utilization data

After completion of the last report, the County Data evaluation team focused on addressing the limitations of the preliminary analysis of service utilization data. This effort is composed of three main activities: 1) improving the harmonization of variables across counties and the detection of episodes of care, 2) addressing missingness in county data, and 3) addressing selection bias into EP programs.

The County Data evaluation team is reviewing CG and EP group data to identify ways to improve the harmonization of data across the counties in the evaluation. This exercise will allow us to fully leverage the

diversity of our service-level data. Additionally, we are working closely with county staff to improve how we detect client episodes of care in the data. Accurate identification of episodes of care are crucial to accurately measuring service utilization in both the CG and EP groups, improving the credibility and rigor of our estimates of the effects of EP programs.

Subsequent descriptive analyses of county-level service data after prior Deliverables revealed substantial variation in the number of variables with missing values across counties, as well as the degree to which data is missing within each county's data. The county data evaluation team is exploring the extent of missingness in the data from each group in each county, as well as the extent to which missingness is correlated with a client belonging to the CG group. Once the team has a clear understanding of missing data in our sample, we will explore solutions and determine the extent to which missingness is a limitation of the evaluation.

The preliminary analysis of service utilization data provided comparisons between the CG and EP group adjusted for a small initial set of observable client-level characteristics. However, we know clients are not randomly assigned to the EP group, so even adjusted analyses still suffer from selection bias. This selection bias arises from the likelihood that clients in the EP group differ systematically from those in the CG group such that they were a priori more likely to have been members of the EP group. Hence, a rigorous comparison of the EP and CG groups should correct for this selection bias. To address selection bias, the county data evaluation team is implementing a generalized version of propensity score weighting, using augmented inverse probability weighting (AIPW) with Lasso covariate selection. The principal idea behind this method is to leverage historical data from each client to predict the probability we later observe them in the EP group during the study period by modeling selection into the EP group. Each client is then "weighted" by the inverse of this predicted probability, which statistically approximates random assignment of EP care. While powerful, the propensity score weighting method is dependent on the evaluation team's ability to accurately predict the "true" probability a person is observed in the EP group. Lasso, a machine learning technique, allows us to find the best selection model within the available data. The combination of these methods will allow the evaluation team to correct for selection bias to the best of the data's ability. Correcting for selection bias makes the comparison of the EP and CG groups as close to "apples-to-apples" as possible.

In addition to methodological improvements, the county data evaluation team is working with county staff to extract additional data required for the analytic methods. We requested historical data for clients in our county EP groups to be used in the weighting methodology described above. LA county staff were able to identify previously unavailable service data for 24-hour service categories for all clients. We are also working closely with Solano County to obtain inpatient service utilization data for the specific CG clients selected for our comparison. We are also working with two new counties that will contribute data to these combined utilization analyses, Napa and Stanislaus. We have met with both county and program staff to discuss the process for this element of the project and submitted the formal data requests on June 13th, 2022 for Stanislaus and May 26th, 2022 for Napa.

Cost Analysis

We presented a preliminary analysis comparing the EP and CG groups in San Diego County on service utilization and related costs data as an example of the cost comparisons in the last annual report. Due to the challenges outlined above, we were not yet able to integrate or analyze cost data from Solano, Orange, and Los Angeles County. We have not yet received cost data from Napa or Stanislaus Counties. We are confident that the cost comparison analysis, along with a finalized comparison analysis of service utilization, will be completed for the deliverable due December 2023.

Sample and Methods

We identified clients who initiated services in the San Diego EP program, “Kickstart,” from January 1, 2017 to December 31, 2019, and a comparison group of clients who were using outpatient services during the same time period. We identified Kickstart clients who first enrolled in the programs between January 1, 2017 and December 31, 2019. We limited the sample to clients ages 12-25 who did not have a diagnosis of psychosis (ICD-10 codes F20, F22, F23, F25, F28, F29, F31.2, F31.5, F31.64, F32.3 F33.3) greater than two years before enrollment (through October, 2008). We excluded clients with private insurance, due to an inability to capture all of their services in the public claims system, and clients who received a diagnosis of intellectual disability (ICD-10 codes F70-F79, ICD-9 codes 317-319), to harmonize the sample with our other counties’ exclusion criteria.

We shared a list of Kickstart clients with program staff who confirmed that these were past or current clients who had enrolled in services, and were identified as either First Episode Psychosis (FEP) or Clinical High Risk (CHR). FEP clients have threshold psychosis symptoms defined as having a Psychosis Syndrome on the Structured Interview for Prodromal Syndromes (SIPS), roughly corresponding to a score of 6 for Positive Symptoms on the Scale of Prodromal Symptoms (SOPS). CHR clients have subthreshold symptoms, defined roughly as having a SOPS score of 3-5.

We identified a comparison group (CG) of clients with likely FEP ages 12-25 who received an outpatient mental health service in San Diego County between January 1, 2017 and December 31, 2019, and who had a first diagnosis of psychosis (same diagnoses as above) within two years prior to their first service during this time period. We defined the first outpatient service during January 1, 2017 to December 31, 2019 as the index outpatient visit. We similarly excluded clients with private insurance, clients who received a diagnosis of intellectual disability, and clients with a diagnosis of psychosis greater than two years before the index outpatient visit.

We summarized service use over 365 days prior and 365 days following enrollment in Kickstart or the index outpatient visit. Outpatient services included case management, crisis intervention, medication management, and mental health services including rehabilitation and therapy. We defined a visit as a unique day receiving services. We summarized psychiatric admissions including admissions to psychiatric hospitals, admissions to psychiatric units of acute care hospitals, and admissions to crisis residential facilities; and psychiatric emergency services including the emergency psychiatric unit and mobile psychiatric emergency response teams. We also summarized costs of outpatient mental health services covered by Medi-Cal, California’s Medicaid program.

We estimated the numbers of services and visits during the year using negative binomial regression models. We estimated the probabilities of having a psychiatric inpatient admission and of using psychiatric emergency services using logistic regression models. We estimated costs using a generalized linear model with a gamma distribution and a log link function. In each model, we included covariates for age, gender, and race/ethnicity (included as indicator variables for Black and Latino), along with indicator variables for FEP and CHR. We calculated standardized estimates for each outcome using the estimated coefficients to generate predicted values for each client in the sample as if they were alternately assigned to each group: FEP, CHR, and CG. The standardized mean is the mean of the predicted values across the sample. We calculated standard errors using the non-parametric bootstrap, and significance values using non-parametric permutation.

Results

We identified 301 clients in the Kickstart program, of whom 104 were FEP and 197 were CHR, and 687 likely FEP clients in the CG (Table XI). Mean age in the FEP group was 18.3 years (SD=2.8) and the largest percentage of clients was 15-17 years (N=51, 49%). Mean age was lower among the CHR group (16.5 years, SD=2.8), due to a large percentage of clients under age 15 (N=63, 32%). Mean age was highest among the

CG (19.5 years, SD=4.0), due to a large percentage of clients ages 21 and over (N=294, 43%). The FEP group had the largest percentage of clients who were male (N=73, 70%). The distribution of race/ethnicity was similar across the groups.

Table XII shows the mean number of services in the year prior and year post enrollment for Kickstart clients and in the year prior and year post the index outpatient visits for CG clients, as well as the difference in services from pre to post. Service use was highest for the FEP group in both the pre and post periods, followed by CHR and CG. The FEP group also had the greatest increase in services from pre to post (45.7, SE=6.6), followed by CHR (24.0, SE=3.1) and CG (12.3, SE=1.8).

Table XIII shows the mean number of visits in the year prior and year post enrollment or index outpatient visit and the difference between years. Visits were highest for the FEP group in both the pre and post periods, followed by CHR and CG. The FEP group also had the greatest increase in visits from pre to post (32.5 SE=4.2), followed by CHR (17.5, SE=1.9) and CG (8.9, SE=1.1).

Table XIV shows probabilities of psychiatric admission in the pre and post periods and the change in probability of admission from the pre to post period. The CG had the highest probability of admission in the pre period, when 14.4% (SE=1.3) of clients had admissions. The rate of psychiatric admission was similar among FEP and CG, but slightly lower among the CHR group in the post period. As a result, the FEP group had the greatest increase in probability of admission with an 18.1 (SE=4.7) percentage point increase from pre to post.

Table XV shows the probabilities of using psychiatric emergency services. The CG had the highest probability of emergency service use in the pre period, when 12.4% (SE=1.5) of clients used services. The rate of emergency service use was similar among FEP and CG, but slightly lower among the CHR groups in the post period. As a result, the FEP group had the greatest increase in emergency service use with a 25.3 (SE=4.5) percentage point increase from pre to post.

Table XVI shows Medi-Cal reimbursed outpatient mental health services. Outpatient costs were similar in the year prior to enrollment or index outpatient visit. In the post period, costs were greatest among FEP ($9,711, SE=$910) followed by CHR ($6,334, SE=$451) and CG ($4,620, SE=$272). As a result, outpatient costs increased the most among FEP, followed by CHR and CG.

Summary

Youth clients enrolled in Kickstart had higher outpatient service use, visits, and costs than a comparable group of adolescent and young adult clients who were receiving services in standard outpatient programs. Services, visits, and costs were greater for clients with FEP than clients who were CHR. We did not find significant differences in psychiatric inpatient or emergency services use in the year following enrollment. However, since Kickstart clients had lower use of these services in the pre period, they appear to have greater increases in use from the pre to post period.

Table XI: Demographic Characteristics of Youth Clients of Kickstart and a Comparison Group

	First Episode Psychosis	Clinical High Risk	Comparison Group	P-value for difference across groups
N	104	197	687	
Age N (%)				P<.001
Age <15	9 (9%)	63 (32%)	113 (16%)	

Age 15-17	51 (49%)	88 (45%)	161 (23%)	
Age 18-20	25 (24%)	30 (15%)	119 (17%)	
Age 21+	19 (18%)	16 (8%)	294 (43%)	
Gender N (%)				P=.006
Male	73 (70%)	108 (55%)	368 (54%)	
Female	31 (30%)	89 (45%)	319 (46%)	
Race/Ethnicity N (%)				P=.002
Non-Latino White	23 (22%)	39 (20%)	158 (23%)	
Black	14 (13%)	19 (10%)	66 (10%)	
Latino	57 (55%)	118 (60%)	325 (47%)	
Other	4 (4%)	16 (8%)	60 (9%)	
Unknown	6 (6%)	5 (3%)	78 (11%)	

Table XII: Mean Annual Services Use, Standardized by Demographic Characteristics, in the Year Prior and Year Post Enrollment

	First Episode Psychosis	Clinical High Risk	Comparison Group	P-value for difference across groups
Pre	19.4 (3.9)	17.8 (2.5)	15.3 (1.4)	<.0001
Post	65.1 (5.5)	41.8 (2.7)	27.6 (1.5)	<.0001
Difference	45.7 (6.6)	24.0 (3.1)	12.3 (1.8)	<.0001

Table XIII: Mean Annual Visits, Standardized by Demographic Characteristics, in the Year Prior and Year Post Enrollment

	First Episode Psychosis	Clinical High Risk	Comparison Group	P-value for difference across groups
Pre	12.4 (2.2)	11.5 (1.4)	10.6 (.9)	<.0001
Post	44.9 (3.5)	29.0 (1.7)	19.5 (.9)	<.0001

Difference	32.5 (4.2)	17.5 (1.9)	8.9 (1.1)	<.0001

Table XIV: Mean Annual Probability of Psychiatric Inpatient Admission, Standardized by Demographic Characteristics, in the Year Prior and Year Post Enrollment

	First Episode Psychosis	Clinical High Risk	Comparison Group	P-value for difference across groups
Pre	5.4 (2.2)	3.8 (1.4)	14.4 (1.3)	.0002
Post	23.4 (4.3)	17.1 (2.8)	24.8 (1.6)	.095
Difference	18.1 (4.7)	13.3 (3.1)	10.3 (2.1)	<.001

Table XV: Mean Annual Probability of Use of Psychiatric Emergency Services, Standardized by Demographic Characteristics, in the Year Prior and Year Post Enrollment

	First Episode Psychosis	Clinical High Risk	Comparison Group	P-value for difference across groups
Pre	4.4 (1.9)	6.6 (1.8)	12.4 (1.5)	.011
Post	29.7 (4.3)	18.3 (2.7)	23.1 (1.6)	.075
Difference	25.3 (4.5)	11.7 (3.1)	10.8 (2.0)	.010

Table XVI: Mean Annual Costs of Outpatient Services, Standardized by Demographic Characteristics, in the Year Prior and Year Post Enrollment

	First Episode Psychosis	Clinical High Risk	Comparison Group	P-value for difference across groups
Pre	3606 (785)	3264 (484)	2915 (316)	.490

Post	9711 (910)	6334 (451)	4620 (272)	.001
Difference	6105 (1186)	3070 (640)	1704 (420)	.041

Future Analyses

During the next fiscal year, we will finalize our analysis of service utilization across the entire retrospective period (January 1, 2017 – December 31, 2019) rather than comparing services received during the year prior and the year post program enrollment. In addition, outcomes will be calculated as unique outpatient services accounting for varying durations of active treatment. We will also expand the scope of the cost analysis. Currently, costs are limited to the amounts paid for Medi-Cal reimbursable mental health outpatient services. In the next period, we will consider the costs incurred to the County for all outpatient services, including those services that are not reimbursable by Medi-Cal. We will also consider additional service types including inpatient and crisis residential, and the emergency psychiatric unit and the psychiatric emergency response team.

Although CHR clients enrolled in the EP program were included as a comparison group in the current analysis, these clients will be excluded from future planned analyses as they cannot be reliably identified for the comparator group using standard diagnostic codes. We will also refine the exclusion criteria for the CG group based on diagnostic and service utilization history of the EP group as well as utilizing a weighting strategy for included clients in both groups, as described previously. This will ensure that the CG group only contains clients most likely to have a first episode of psychosis, allowing for a more accurate comparison between FEP clients in the EP and CG groups on service utilization and related costs data.

Discussion and Next Steps

Discussion

Over this last fiscal year, the team has continued to meet each of the goals that were set to out for this project period. In addition to completing Deliverables laid out in our original Innovation plan timeline, the EPI-CAL team has also continued to bring in new counties to the multi-county collaborative to expand our Learning Health Care Network of EP programs. Through creating a Learning Health Care Network, all parties hope to have a larger impact on mental health services than any one county or program can create on their own. While the project has experienced some delays and challenges during the initial COVID-19 pandemic, the team works closely with counties and programs to adapt and adjust to the post-pandemic mental health landscape. We are confident that we are making excellent progress at meeting our goals and catching up with the original planned timeline.

We have completed Beehive training with all the original LHCN counties and are in the process of completing the Beehive training series for our newest LHCN county programs, including Lake County and the multi-county collaborative (MCC) programs. We are continuing to collect data on the core outcomes battery for the EPI-CAL project with 19 programs. Based on feedback from users in these programs, we have continued to work with Beehive developers to make modifications to the application, such as extending survey windows, printing survey results to PDF, accessing the Beehive resource guide in the application, as well as modify our training approach based on constructive feedback from programs, including creating a testimonials slide from users of Beehive that describe the benefits of using Beehive thus far from real clinic users. We are in the process of

workshopping additional changes to the application, including the ability for clinics to edit data after survey completion as well as creating additional visualizations for more surveys for both client and clinic entered data.

We have also begun some of our planned feasibility analyses for the LHCN. While we have been monitoring LHCN enrollment and survey completion since EP programs began implementation of Beehive in their programs, we have just begun to assess whether current enrollment is meeting our pre-defined enrollment goals (70% of eligible clients enrolled in Beehive). Our preliminary analyses shows that a subset of programs are meeting this goal, and we are using our ongoing barriers and facilitators interviews to examine factors that are influencing enrollment across programs differently and contributing to the heterogeneity of enrollment that we observe in the LHCN.

As noted previously, we were able to successfully complete our primary goal for the retrospective county data analysis, to provide a preliminary demonstration of the proposed method for accessing data regarding EP programs and CG groups across California, and the first part of our secondary goal, to analyze service utilization and costs associated with those services across counties. However, we are still gathering additional data to inform a final analysis of the 2017-2019 period, which we expect to complete by Spring 2023.

We are in the process of procuring the final datasets in order to complete the integrated cost and utilization data for all counties. This has taken longer than originally expected given staffing shortages and problem solving needed to harmonize variables across counties. Over the next project period, we hope to gather the final datasets from all counties.

Next Steps

In the next fiscal year, we will conclude fidelity assessments with EPI-CAL programs and meet with county and program leadership to provide detailed feedback on fidelity results. At the end of FY 22/23, 17 LHCN EP programs (20 total programs as part of EPI-CAL) have completed a fidelity assessment and there are only five remaining fidelity assessments to complete, three of which were in progress. We will also continue and complete training new 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 community partner feedback so that Beehive be a useful data collection and visualization tool for the programs using it. We are also working with sites to understand why enrollments are not matching the original projections and to support them to increase the degree to which they are integrating Beehive into their standard practice. We are collecting informal data on these factors via regular check-in meetings with programs, as well as through a qualitative research approach by examining barriers and facilitators to Beehive implementation through interviews with EP program participants. While we first focused on interviewing providers and staff over the last fiscal year, our efforts will shift to recruiting clients to elicit their feedback about using Beehive in the current fiscal year.

Over the next fiscal year, the LHCN team expects to receive and review data for both EP program and CG clients and their service utilization data from Napa and Stanislaus counties for the retrospective data period January 1st, 2017 – December 31st, 2019. Upon receiving the data, we will review the submitted datasets and problem-solve with counties regarding any missing data elements, particularly other mental health services received by EP program clients, which may need to be retrieved from different sources. We will harmonize these data with the prior counties' and integrate them into the final dataset. We will also be requesting all related cost data for the services received by clients in the EP programs and CG groups from Napa and Stanislaus counties.

This 23/24 fiscal year is the last project year for many of the counties and programs that were part of the

original multi-county collaborative innovation plan and therefore our team in working to prepare a report that summarizes the overall progress of the LHCN to date. This report will include a summary of qualitative data that has been collected over the course of the project, outcomes data collected via Beehive, and a multi-county integrated analysis of cost and utilization data. The report will be prepared for review by our county and program partners, and we hope to have other community partners provide feedback on the overall success and challenges of implementing a Learning Health Care Network of EP Programs in California.

Appendix I: Intake Workflow Meeting Template

Our goal for this meeting: understand your intake workflow to help make transition to using Beehive at intakes smoother. Today we are focusing on how to integrate Beehive into your workflow, but remember (once Beehive is approved for use), you can also register existing clients.

Questions

a. Current Intake process
    i. What is program's general intake workflow?
        1. Do you do phone screenings before scheduling an intake? (review template of phone screen to compare with Beehive registration fields)
        2. Do you currently have clients complete surveys/paperwork with the intake appointment?
            i. Treatment consent, research consent, ROIs?
            ii. How are surveys administered?
            iii. When surveys they sent (e.g., prior to intake date, morning of intake date)?
        3. At what stage in the process do you register clients into the Electronic Health Record
        4. How do you complete assessments or other paperwork for people who are in need of interpretive services?
b. Integration of Beehive
    i. At what stage in the workflow would Beehive registration fit best?/When would you register clients into Beehive (takes about 15 minutes)
        1. In advance (Web app)? Is all of the information in registration already gathered? (see phone screen)
        2. Day of (tablet)?
    ii. Which staff member(s) will complete registration?
    iii. When would client complete the intake surveys (EPI-CAL battery takes about 45 minutes)?
        1. Do clinicians plan to use survey data as part of their intake assessment?
        2. Consider prioritization of surveys required for intake assessment
    iv. Which staff member(s) will orient client to EULA/surveys on intake day?

(As needed) demonstration of registration process

Appendix II: Data-Entry Workflow Meeting

1. **Questions to Understand Current Clinic Data** *(can skip if already asked at Intake Workflow meeting)*

    2. Is clinic already using a data-entry platform?
        i. If so what? (excel, EMR, redcap, in-house platform (ex. MHOMS)
        ii. Who designs the surveys on that platform?
        iii. Do you first enter data on a CRF prior to entry in this system?
    3. What roles on team currently complete data-entry? (QM, Clinic Coordinator, Clinicians)
    4. How do you access/view data after it is entered?
    5. Does your program have dedicated staff to analyze data?

2. **Questions about Integration of Beehive for Survey Completion**

    a. Who will be responsible for each of these items (one person? Each clinician for their caseload? Leadership?):
        i. Following up with clients about completing their surveys?
        ii. Entering clinician-entered data for each client?
        iii. Monitoring urgent clinical issues? (our recommendation is that each clinician monitors their caseload)
    b. What level of support do you want with tracking survey completion (clients & clinicians) and urgent clinical issues?
    c. Are there other surveys that your clinic wants to collect through Beehive?
        i. Standardized measures that are already built in: PSC-35, CATS-Guardian report
        ii. Other measures can also be entered-- our team needs to review first to ensure that we can design the surveys in Beehive
    d. Who is assessing COMPASS & GFS/GFR? Who is monitoring ACES to determine if additional survey should be assigned?
        i. We will want to make sure that they have completed the trainings for these trainings

Demonstration on how to access clinician-entered data, view survey status page (for client & PSP) as necessary

Appendix III: 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 there score severity shading? In which direction? What does that mean?
    d. Is the global score above or below the threshold? What does that mean?
    e. Which is the highest rated individual item(s)? What does that mean?
    f. 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 client'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 there score severity shading? In which direction? What does that mean?
        iii. Is the global score above or below the threshold? What does that mean?
        iv. Which is the highest rated individual item(s)? What does that mean?
        v. 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 client'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?

Table of Contents

CLIENT Surveys

EPI-CAL ENROLLMENT LIFE QUESTIONS ("GETTING STARTED")

EPI-CAL Baseline Questions ("First Contact Questions")

Primary Caregiver Background

Adverse Childhood Experiences – ACES ("Stressful Life Events")

EPI-CAL LIFE BUNDLE ("MY LIFE")

Demographics And Background

Education

Employment And Related Activities

Social Relationships

SCORE-15 ("Family")

EPI-CAL EXPERIENCES BUNDLE ("MY EXPERIENCES")

Legal Involvement And Related

Substance Use

Modified Colorado Symptom Index ("Personal Experiences Inventory")

Questionnaire About The Process Of Recovery ("Staying Well Questionnaire")

Life Outlook

EPI-CAL TREATMENT BUNDLE ("MY TREATMENT")

Medications

Intent To Attend And Complete Treatment Scale ("Treatment")

Hospitalizations

Shared Decision Making Questionnaire (Sdm-Q-9) ("Shared Decision Making")

EPI-CAL TRAUMA ADULT ("STRESSFUL LIFE EXPERIENCES")

Life Events Checklist (LEC-5) & PTSD Checklist for DSM-5 (PCL-5) ("Stressful Life Experiences")

EPI-CAL TRAUMA CHILD ("STRESSFUL LIFE EXPERIENCES")

Child and Adolescent Trauma Screen (CATS) – Youth Report (Age 7-17) ("Stressful Life Events")

Primary Support Person Surveys

EPI-CAL PSP ENROLLMENT QUESTIONS ("GETTING STARTED")

PSP: Baseline Questions ("Demographics And Lifetime Questions")

EPI-CAL PSP LIFE QUESTIONS ("MY LIFE") .....

PSP: Demographics And Background ("Demographics And Background").....

PSP: Score 15 ("Family").....

Burden Assessment Scale ("Family Impact") .....

EPI-CAL PSP EXPERIENCES QUESTIONS ("THEIR EXPERIENCES") .....

PSP: Legal Involvement And Related ("Legal Involvement And Related")

PSP: Modified Colorado Symptom Index (Mcsi) ("Personal Experiences Inventory") .....

PSP: Medications ("Medications").....

References

Addington, D. E. (2021). First Episode Psychosis Services Fidelity Scale (FEPS-FS 1.0) and Manual. University of Calgary Press.

Addington, D., Noel, V., Landers, M. and Bond, G.R., 2020. Reliability and feasibility of the first-episode psychosis services fidelity scale–revised for remote assessment. Psychiatric Services, 71(12), pp.1245-1251.

Durbin, J., Selick, A., Langill, G., Cheng, C., Archie, S., Butt, S. and Addington, D.E., (2019). Using fidelity measurement to assess quality of early psychosis intervention services in Ontario. Psychiatric Services, 70(9), pp.840-844.

Guo, X., Zhai, J., Liu, Z., Fang, M., Wang, B., Wang, C., Hu, B., Sun, X., Lv, L., Lu, Z. and Ma, C., (2010). Effect of antipsychotic medication alone vs combined with psychosocial intervention on outcomes of early-stage schizophrenia: a randomized, 1-year study. Archives of general psychiatry, 67(9), pp.895-904.

Heinssen, R. K., A. B. Goldstein, and S. T. Azrin. "Evidence-based treatments for first episode psychosis: components of coordinated specialty care." National Institute of Mental Health (2014).

Kane, J.M., Robinson, D.G., Schooler, N.R., Mueser, K.T., Penn, D.L., Rosenheck, R.A., Addington, J., Brunette, M.F., Correll, C.U., Estroff, S.E. and Marcy, P., (2016). Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program. American Journal of Psychiatry, 173(4), pp.362-372.

Secher, R. G., Hjorthøj, C. R., Austin, S. F., Thorup, A., Jeppesen, P., Mors, O., & Nordentoft, M. (2015). Ten-year follow-up of the OPUS specialized early intervention trial for patients with a first episode of psychosis. Schizophrenia Bulletin, 41(3), 617-626.

Niendam, T. A., Sardo, A., Trujillo, A., Xing, G., Dewa, C., Soulsby, M., . . . Melnikow, J. (2016). *Deliverable 3: Report of Research Findings for SacEDAPT/Sacramento County Pilot: Implementation of Proposed Analysis of Program Costs, Outcomes, and Costs Associated with those Outcomes*. (12MHSOAC010).

County of Sonoma

Semi-Statewide Enterprise Health Record

Multi-County Collaborative INN Project

Annual Innovative Project Report

Reporting Period: July 1, 2022 – June 30, 2023

Project Period: November 17, 2022 - November 16, 2027

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

In partnership with

CalMHSA
California Mental Health Services Authority

Table of Contents

Project Overview and Local Need....3

Progress Update and Identified Changes....4

CalMHSA's Internal Evaluation and Qualitative Analysis of the State of Electronic Health Records Across California Counties....4

Evaluation Data/Learning Goals/Project Aims....5

Program Information for Individuals Served....7

Budget and Annual Expenditures....7

Exhibit 1 – Pre-Survey User Data....7

Exhibit 2 – Pre-Survey Questions....9

Project Overview and Local Need

1. Please describe this Innovation project and its purpose.

This is a multi-county, scalable INN project that stems from a larger Semi-Statewide Enterprise Health Record (EHR) project CalMHSA is concurrently leading (the EHR Project). CalMHSA is partnering with 23 California counties – collectively responsible for 27% of the state's Medi-Cal beneficiaries – on the Semi-Statewide Enterprise Health Record project.

This project is unique in that it engages counties to collaboratively design a lean and modern EHR to meet the needs of counties and the communities they serve both now and in the future.

The key principles of the EHR project include:

- **Enterprise Solution:** Acquisition of an EHR that supports the entirety of the complex business needs (the entire "enterprise") of county behavioral health plans. This approach also facilitates data sharing between counties for patient treatment and payment purposes as patients move from one county to another.
- **Collective Learning and Scalable Solutions:** Moving from solutions developed within individual counties to a semi-statewide cohort allows counties to achieve alignment, pool resources and bring forward scaled solutions to current problems, thus reducing waste, mitigating risk and improving quality.
- **Leveraging CalAIM:** CalAIM implementation represents a transformative moment when primary components within the EHR are being re-designed (e.g., clinical documentation and Medi-Cal claiming), while data exchange and interoperability with physical health care — toward improving care coordination and client outcomes — are being both required and supported by the State.
- **Lean and Human-Centered**: Engaging with experts in human-centered design to reimagine the clinical workflow in a way that reduces "clicks" (the documentation burden), increases client safety and natively collects outcomes.
- **Interoperable**: Typically, county behavioral health has, in response to state regulations, developed documentation that is out of alignment with data exchange standards. We are reimagining the clinical workflow so critical information about the people we serve is formatted in a way that will be interoperable (standardized and ready to participate in key initiatives like health information exchanges).

2. Please describe how this project makes a change to an existing practice in the field of mental health, including but not limited to application to a different population.

This project will meet the general requirements by making a change to an existing practice in the field of mental health, specifically, the practice of documentation of care provision in an EHR that meets the needs of the county's workforce and the clients they serve.

3. Please describe how this project impacts your County's local need(s):

Progress Update and Identified Changes

1. Please describe your project progress from the date of approval by the Mental Health Services Oversight and Accountability Commission (MHSOAC) through June 30, 2023.

Sonoma County completed primary data conversion and migration for go-live date of 7/1/23. End-user staff training was completed between 6/5/23 and 6/15/23. Trista Carr, Behavioral Health Informatics Analyst, was hired to support the implementation of this project as a primary system admin for the new system, and primary training coordinator for on-boarding new staff. Sonoma has participated in multiple weekly collaboration and planning meetings with CalMHSA and other counties. Additionally, CalMHSA has provided ongoing TA pertaining to clinical needs, prescriber needs, billing set-up, reporting, and inpatient/residential functionality.

2. Has your county experienced any changes in project implementation and/or local need since the submission of your Appendix for MHSOAC approval? What is/are the reason(s) for this/these change(s)?

Sonoma County has requested changes to the participation agreement, these additions include one additional lab (LabCorp) and text reminders for appointments. The additional of the secondary lab options will facilitate improved care coordination by allowing for all lab interfaces within the same system. The text reminder feature will help reduce the incidence of no-shows for psychiatry and clinical appointments.

3. How does this change/these changes noted in #2 above impact or modify your project plan and/or timeline?

N/A

CalMHSA's Internal Evaluation and Qualitative Analysis of the State of Electronic Health Records Across California Counties

During this project period, CalMHSA partnered with IDEO, a global design and research company with over 40 years of consulting experience working in social and government sectors. IDEO was uniquely positioned to assist CalMHSA based on their strong focus on capacity building and creating new, strategized approaches to previously unsolved problems. CalMHSA, at the request of participating counties, sought to create a semi-statewide EHR system, built according to the needs of the user, that not only meets documentation and regulatory requirements, but also integrates provider needs for transparent communication, augments support for decision-making and best practices and, through increased efficiency, reduces staff burnout and improves workforce retention.

IDEO conducted interviews with over 50 county staff from participating county agencies, primarily focused on outpatient psychiatry services, to better understand different users' interactions and needs within an EHR. The staff interviewed included doctors, nurses, social workers, and peer counselors. Sonoma County had 101 users participate in these interviews. IDEO also met with EHR experts and analogous experts, such as digital storytellers, data visualization scientists, and behavioral scientists to draw inspiration for what was possible for this future EHR vision. They also conducted an in-depth

analysis of the transitional EHR, SmartCare, to better understand what could be leveraged versus what would need to be customized to achieve the goals as stated above.

Some key needs identified from these interviews included:

- An improved EHR design that allows for a holistic view of patient data rather than siloed across different areas of the software
- Better facilitation of record keeping and sharing across the platform
- Improved utilization of automaticity and intentional pauses as moments to accurately capture structured data to reduce redundancy, disseminate key information and promote best practices while maintaining flexibility and trust amongst users
- Transparent dialogue and a disruption of bias patterns in the software so the data entered can promote equitable outcomes and care

Evaluation Data/Learning Goals/Project Aims

CalMHSA contracted with the RAND Corporation during this project period to conduct a comprehensive evaluation of the project. To ensure a systematic evaluation of the migration to the new EHR platform, RAND is employing two measurement approaches: 1) a pre-post user survey, 2) pre-post task-based usability testing. RAND selected evidence based EHR metrics grounded in measurement science that are precise, reliable and valid.

The goal of the pre-post user survey is to measure user experience and satisfaction of existing EHRs and the new EHR across all participating counties. This pre-phase of the survey was administered during this project period and prior to the "go-live" implementation of the new EHR system. It was sent to all EHR users in participating counties (see Exhibit 1 for Pre-Survey User Data). The survey (see Exhibit 2) included outcome measures such as the Post-Study System Usability Questionnaire (PSSUQ), satisfaction with EHR attributes, satisfaction with specific tasks in the EHR, and likelihood of recommending the EHR. The PSSUQ is a 16-item standardized questionnaire that originated from the IBM project called System Usability Metrics in 1988. This standardized tool allows for a single metric to be calculated as an average of the 16 items, which provides a reliable measure that can be compared to other studies that have used the tool. The tasks included in the survey were also based on the most common use cases across different role types (e.g., prescribers, medical staff, licensed clinicians, non-licensed providers and administrators).

The goal of the pre-post task-based usability testing is to obtain objective measures of EHR usage and burden (as measured by the length of time required to complete specific, common tasks in the EHR) before and after the migration to the new EHR. The pre-phase of this usability testing was conducted from May 30, 2023, to June 30, 2023, and included 30 prescribers and licensed clinicians in the select counties who opted to participate. The usability tests asked each participant to complete three tasks in a simulated EHR environment with simulated client scenarios. Tasks included creating an assessment/evaluation and progress note for a new client visit, reviewing a chart for an existing client and creating a progress note for a return client visit. The outcome metrics included task completion rate,

time on task, errors and post-task satisfaction. These usability tests complement the user survey to provide objective measures of the EHRs in a controlled environment.

The post-phase of the survey and task-based usability testing will likely occur in approximately January/February 2024 to allow users to become accustomed to the new EHR platform. The optimal time to conduct a post-migration assessment is when users have established stable and sustainable behaviors, which has typically been three to six months after implementation. The post-survey will also address the original learning goals and project aims regarding quality, safety/privacy, satisfaction and outcomes.

Overall, the evaluation will eventually allow for an assessment of how the transition to the new EHR resulted in changes to usability and user satisfaction.

Learning Goals/Project Aims
Quality ▪ Comprehensiveness of client care ▪ Efficiency of clinical practice ▪ Interactions within the health care team ▪ Clinician access to up-to-date knowledge
Safety/Privacy ▪ Avoiding errors (i.e., drug interaction) ▪ Ability to use clinical data for safety ▪ Personal and professional privacy
Satisfaction ▪ Ease of use ▪ Clinician's stress level ▪ Rapport between clinicians and clients ▪ Client's satisfaction with the quality of care they receive ▪ Interface quality
Outcomes ▪ Communication between clinicians and staff ▪ Analyzing outcomes of care ▪ System usefulness

- Information quality

Future annual reports will include status updates on the above learning goals and project aims.

Program Information for Individuals Served

This project focuses on transforming current EHR systems and processes counties use for the provision of behavioral health services. Accordingly, we have not estimated the number of individuals expected to be served annually. As noted previously, the participating counties in the Semi-Statewide Enterprise Health Record project are collectively responsible for serving the population of Medi-Cal beneficiaries who need specialty mental health and/or substance use disorder treatment services among approximately 27% California's Medi-Cal beneficiaries, or among approximately 4,000,000 people.

Regarding specific project information on individuals to served, this project focuses on transforming the current EHR system and the processes California counties use for the provision of behavioral health services rather than directly testing an innovative approach to service delivery.

Budget and Annual Expenditures

Total dollar amount expended during the reporting period on this Innovative Project:

Total Annual Budget Amount from Proposal (2022)*	Actual FY 22-23 INN Expenditures	Actual FY 22-23 Medi-Cal Expenditures	Actual FY 22-23 Realignment Expenditures	Actual FY 22-23 Other Expenditures
$1,038,189.84	$1,691,333.19	$0	$0	$0

*Proposal listed budget in calendar year versus fiscal year.

Total dollar amount expended during the reporting period for administration of this project:

Total Annual Budget Amount from Proposal (2022)	Actual FY 22-23 INN Expenditures	Actual FY 22-23 Medi-Cal Expenditures	Actual FY 22-23 Realignment Expenditures	Actual FY 22-23 Other Expenditures
$0	$0	$0	$0	$0

Total dollar amount expended during the reporting period for the evaluation of this project:

Total Annual Budget Amount from Proposal (2022)	Actual FY 22-23 INN Expenditures	Actual FY 22-23 Medi-Cal Expenditures	Actual FY 22-23 Realignment Expenditures	Actual FY 22-23 Other Expenditures
$250,000	$250,000	$0	$0	$0

FY 22-23 total Expenditures compared to Estimates from Proposal:

Description	FY 22-23 Total	7 Year Estimates (includes Innovation & CFTN funding) from Proposal
Participant Instance Installation	$250,000	$250,000.00
System Acquisition Fee	$95,484.83	$115,353.02
Initial Development Fee (Customization and Security)	$95,484.83	$115,353.02
Discretionary Development Budget	$95,484.83	$115,353.02
Professional Services Implementation	$738,461.52	$8,000,000.00
SmartCare Patient Portal Implementation	$2,400.00	$2,400.00
SmartCare IP/Residential Implementation	$7,500.00	$7,500.00
SmartCare OE/EMAR Implementation	$18,000.00	$18,000.00
SmartCare Pharmacy Interface Implementation	$15,000.00	$15,000.00
SmartCare Pyxis Interface Implementation	$0.00	$0.00
SmartCare Lab Interface Implementation	$15,000.00	$0.00
SmartCare HIE / MCO Interface via FHIR Implementation	$12,000.00	$12,000.00
High Availability Cloud Infrastructure Implementation	$0.00	$12,000.00
Disaster Recovery Implementation	$6,000.00	$6,000.00
SmartCare CalMHSA Package	$63,475.20	$2,997,440.00
SmartCare Rx Prescribers Subscription	$13,395.20	$487,968.00
SmartCare Patient Portal Subscription	$165.60	$25,024.00
SmartCare IP/Residential Subscription	$2,875.00	$97,750.00
SmartCare OE/EMAR Subscription	$2,875.00	$97,750.00
SmartCare Pharmacy Interface Subscription	$575.00	$19,550.00
SmartCare Pyxis Interface Subscription	$0.00	$0.00
SmartCare HIE / MCO Interface via FHIR	$575.00	$19,550.00
SmartCare Add-On Hosting Storage Subscription	$0.00	$68,000.00
High Availability Cloud Infrastructure Subscription	$0.00	$380,800.00

Disaster Recovery Subscription	$3,456.00	$163,200.00
SmartCare Lab Interface Subscription	$488.76	$0.00
Annual %3 Fee Increase - Subscription	$2,636.42	$0.00

Exhibit 1 – Pre-Survey User Data

1. **User Roles**
    a. 96 prescribers
    b. 121 prescriber med staff
    c. 730 clinician LPHA
    d. 723 non-LPHA
    e. 1081 admin
    f. 17 other
    g. 157 no response

2. **Users by County (Please note: Counties participating in the Multi-County INN project are noted with an "*" below)**
    a. Colusa - 5
    b. Contra Costa - 6
    c. Fresno - 290
    d. Glenn - 29
    e. Humbolt* - 67
    f. Imperial* - 189
    g. Kern - 585
    h. Kings* - 44
    i. Lake - 74
    j. Marin - 29
    k. Mono* - 16
    l. Placer* - 103
    m. Sacramento - 303
    n. San Benito* - 20
    o. San Joaquin* - 165
    p. San Luis Obispo - 119
    q. Siskiyou* - 27
    r. Sonoma* - 101
    s. Stanislaus - 104
    t. Tulare* - 232
    u. Ventura* - 299
    v. Other - 9
    w. Did not respond - 89

Exhibit 2 – Pre-Survey Questions

Usability and Satisfaction Metrics

A. PSSUQ: On a scale between "Strongly Disagree" and "Strongly Agree," please rate the following statements (1 - Strongly Disagree to 7 - Strongly Agree).

1. Overall, I am satisfied with how easy it is to use this system.
2. It was simple to use this system.
3. I was able to complete the tasks and scenarios quickly using this system.
4. I felt comfortable using this system.
5. It was easy to learn to use this system.
6. I believe I could become productive quickly using this system.
7. The system gave error messages that clearly told me how to fix the problems.
8. Whenever I made a mistake using the system, I could recover easily and quickly.
9. The information provided with this system was clear.
10. It was easy to find the information I needed.
11. The information was effective in helping me complete the tasks and scenarios.
12. The organization of information on the system screens was clear.
13. The interface of this system was pleasant.
14. I liked using the interface of this system.
15. The system has all the functions and capabilities I expect it to have.
16. Overall, I am satisfied with this system.

B. Based on your experience, please indicate how satisfied you are with the way your EHR performs on the following items (1 - Very Dissatisfied to 5 - Very Satisfied, NA).

1. Ability to use the EHR without needing IT or additional support
2. Supports delivery of quality healthcare
3. Interactions within the care team
4. Amount of time spent in the EHR
5. Your stress level
6. Rapport between providers and clients
7. Data privacy and security
8. Access to up-to-date information
9. Usefulness of alerts
10. Comprehensiveness of client care
11. Efficiency of clinical practice
12. Avoiding errors (such as overlooking a drug interaction, selecting the wrong intervention or scheduling the wrong service time)
13. Amount of information presented on each screen
14. Amount of data entry required
15. Response time (i.e., speed of system response or loading time)
16. Reliability (i.e., system performs correctly every time)
17. Costs of providing care
18. Inclusivity or adequacy of demographic data fields

C. Based on your experience, how satisfied are you with the way your EHR allows you to perform the following tasks? (1 - Very Dissatisfied to 5 - Very Satisfied, NA)

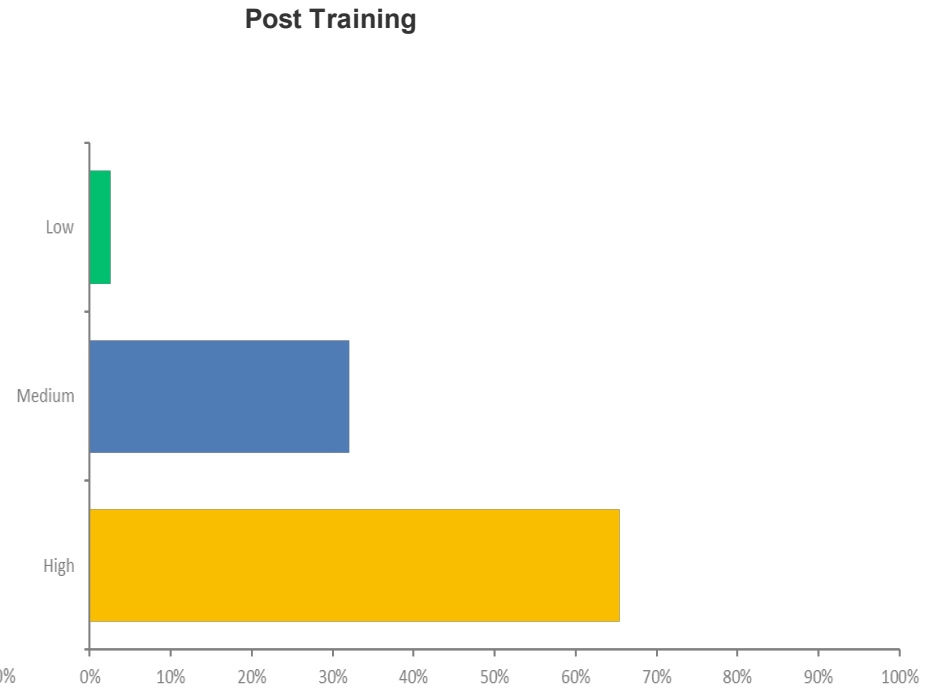
1. Review progress notes
2. Obtain and review lab results
3. Obtain and review imaging or test results

4. Review past and current medications or prescriptions
5. Identify allergies
6. Update medication lists
7. Enter a progress note with all relevant service indicators (e.g., person contacted, contact type, place of service, service intensity, etc.)
8. Create and maintain problem lists
9. Customize templates
10. Prevent providers from signing a document if required fields are not complete
11. Link a new episode or admission record to previous care coordination activities
12. Enable documentation of social determinants of health (SDOH) or Z-codes
13. Bill for services in a timely manner
14. Complete a psychosocial assessment or screening
15. Enter new outpatient lab orders
16. Enter orders for other tests
17. Add/renew/discontinue prescriptions
18. Receive drug interaction or dosage error alerts when writing prescriptions
19. Receive drug allergy alerts when writing prescriptions
20. Prevent other adverse events
21. Schedule appointments
22. Manage a closed-loop referral process (i.e., make a referral to an outside entity and track if the referral was completed)
23. Manage client caseload (e.g., identify people at risk or those who have not engaged in services in the last 60 days)
24. Run reports on metrics across your client network (e.g., number of clients dealing with homelessness, timeliness to treatment, number of referrals, etc.)
25. Analyze outcomes of care
26. Send quality measures to other entities (e.g., preventive screening rates)
27. Facilitate continuity of care and follow-up across organizations or providers
28. Communicate with clients electronically
29. Generate documents in my client's preferred language

D. How likely are you to recommend this EHR to a colleague? (0-to-10-point scale)

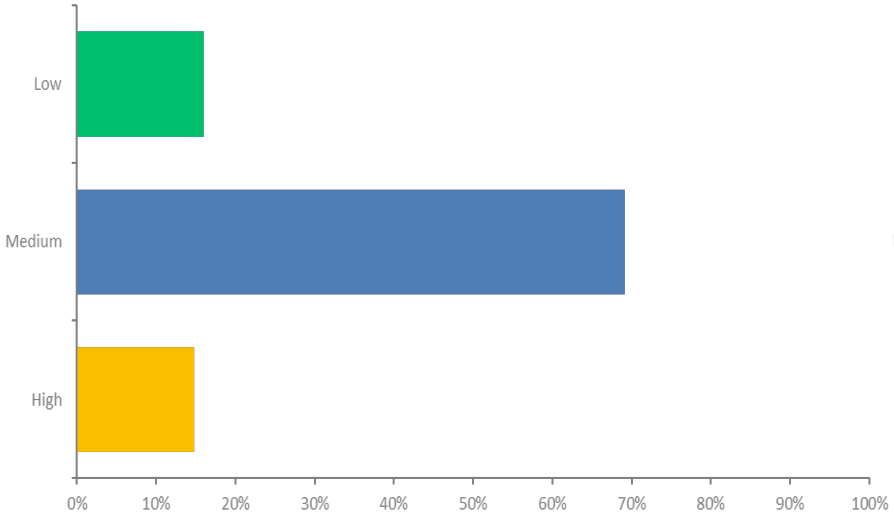
SRJC QPR Outcome Data 2022-2023

How would you rate your knowledge of suicide in the following area?
Facts concerning suicide prevention:

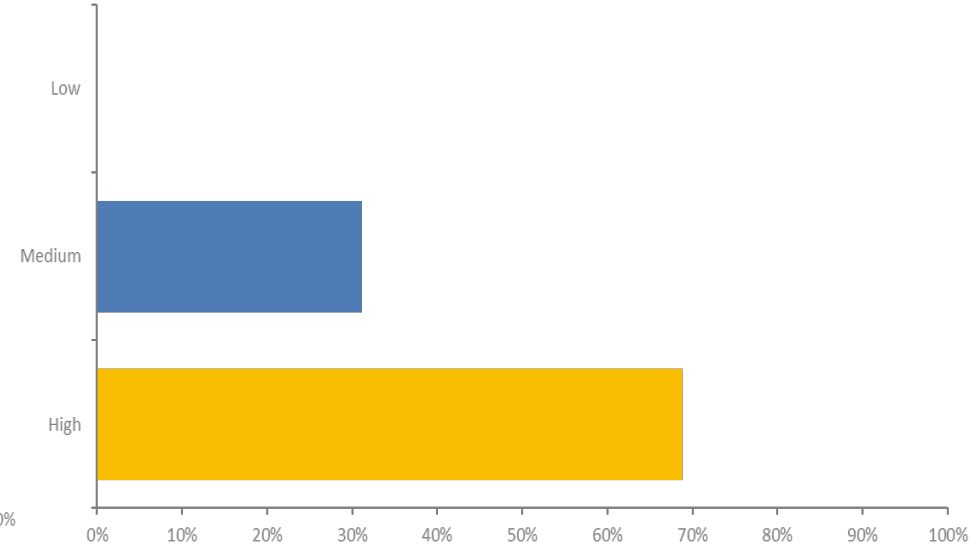


How would you rate your knowledge of suicide in the following area? Warning signs of suicide:

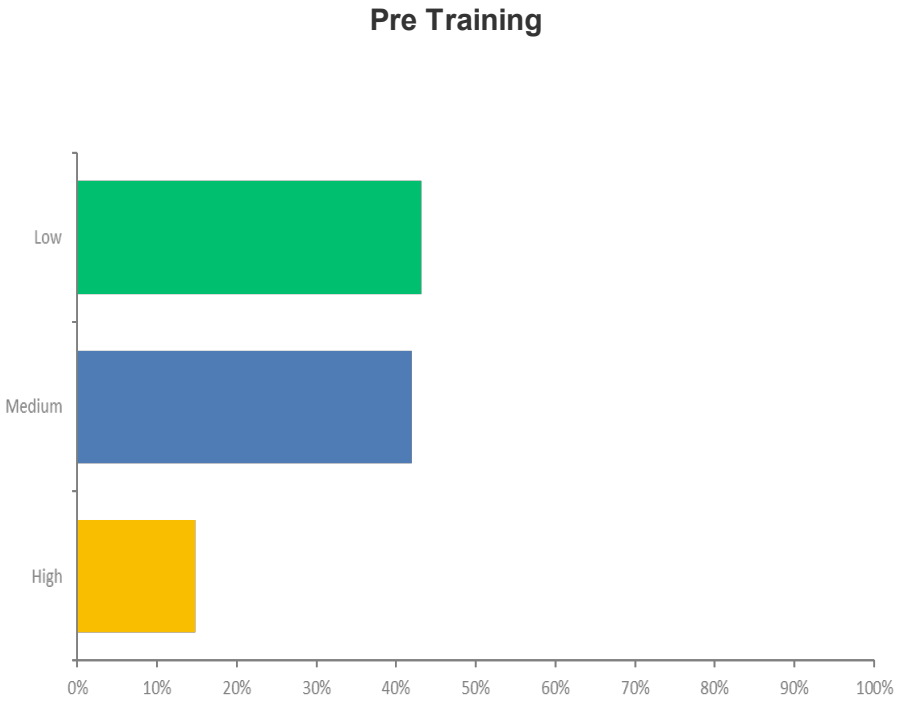
Pre Training

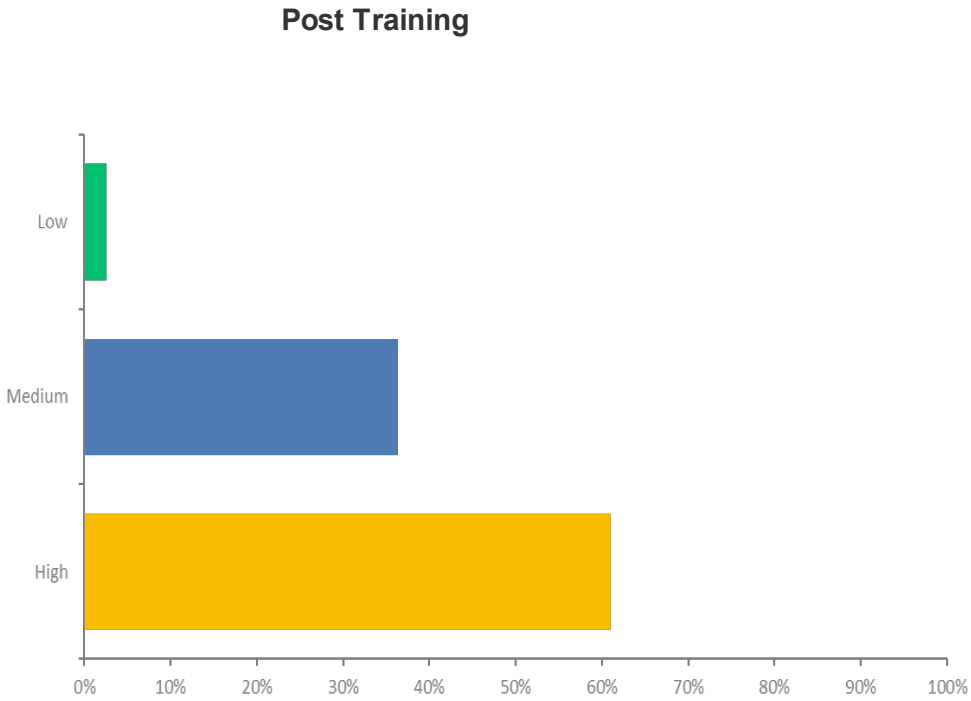


Post Training

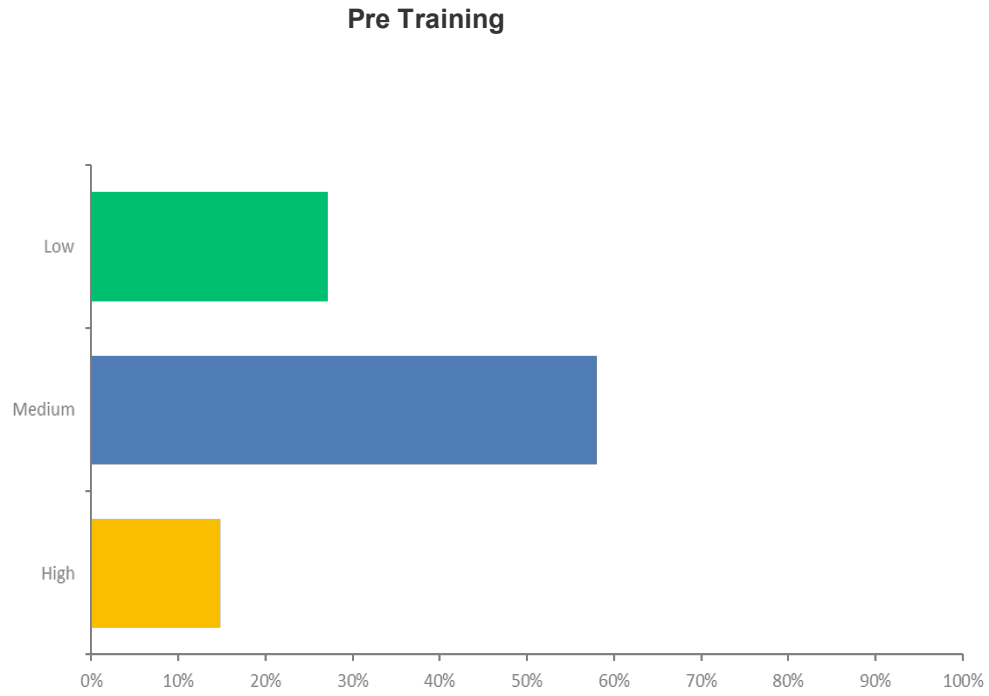


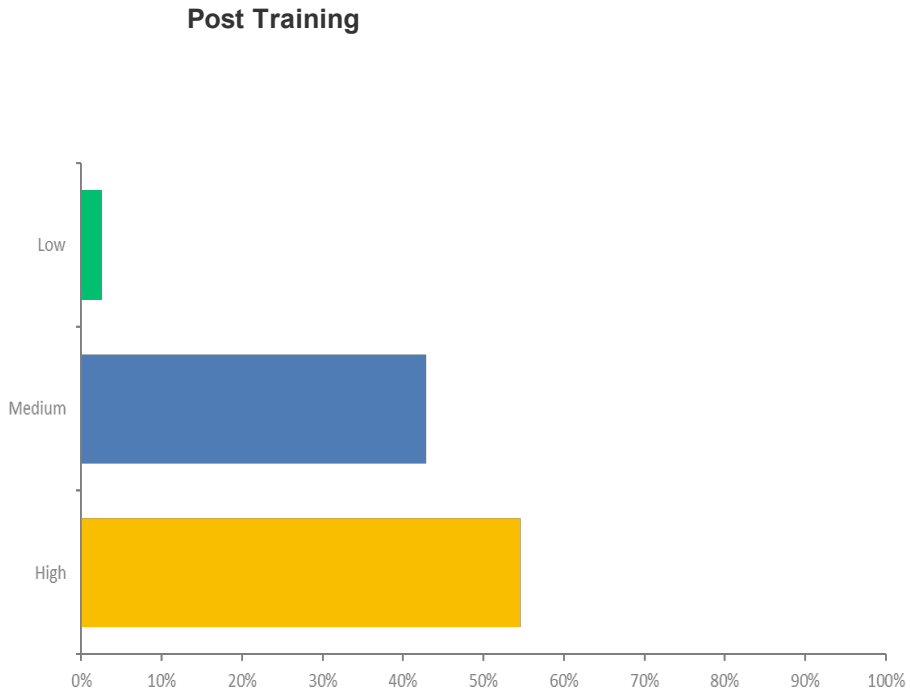
How would you rate your knowledge of suicide in the following area?
How to ask someone about suicide:



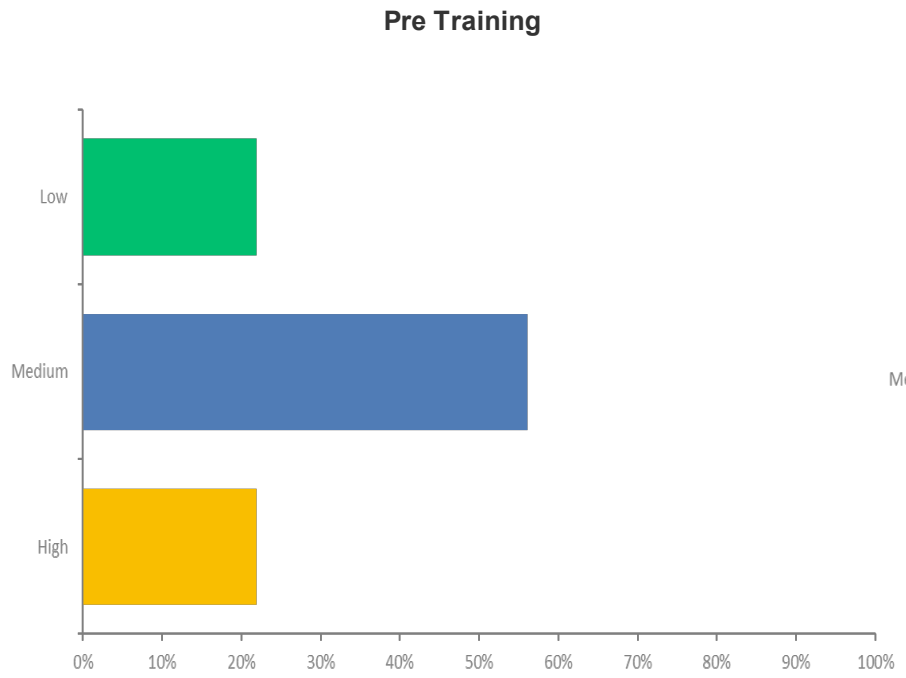


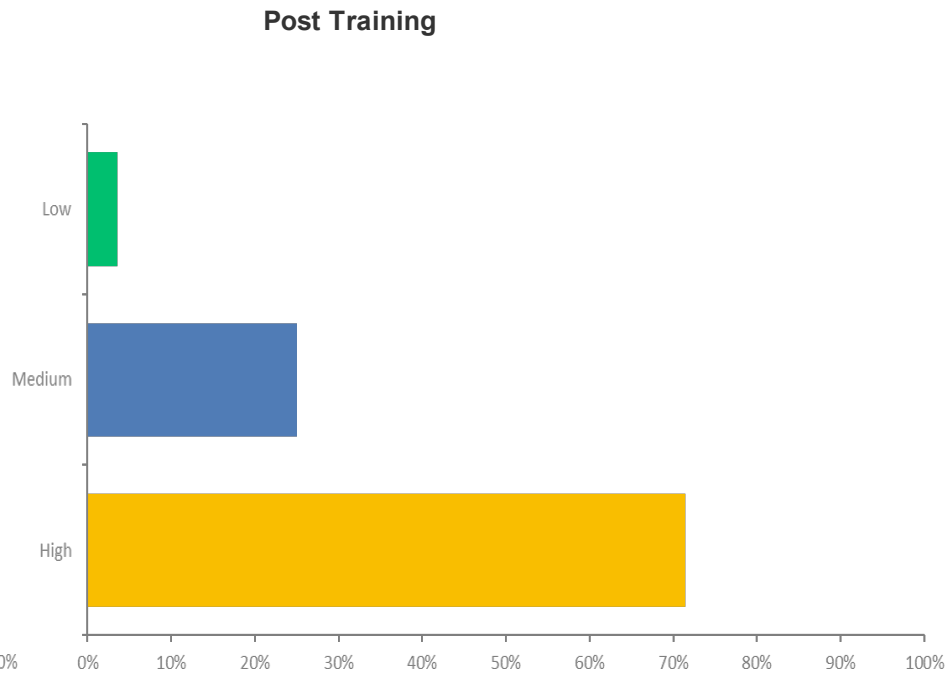
How would you rate your knowledge of suicide in the following area? Persuading someone to get help:



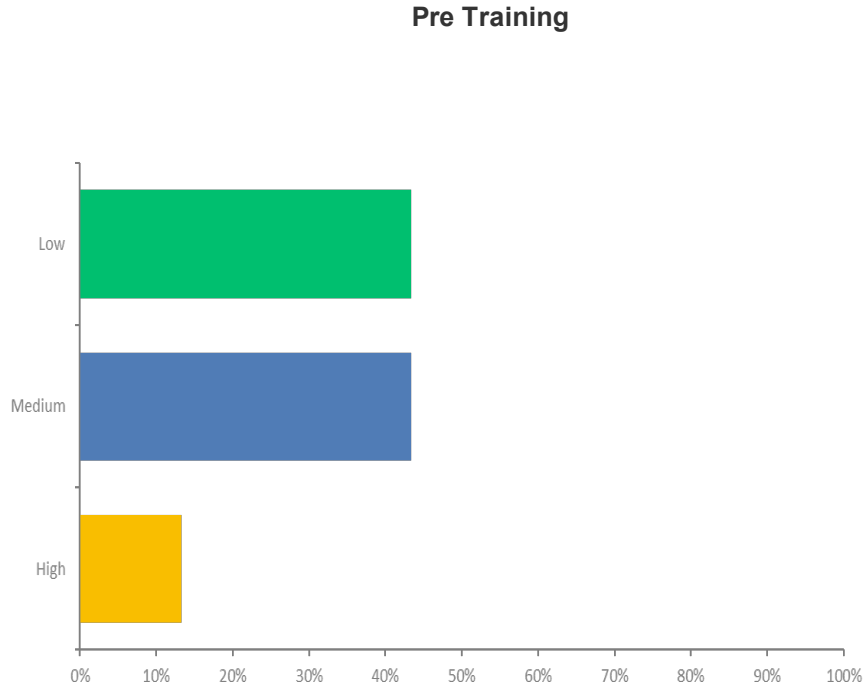


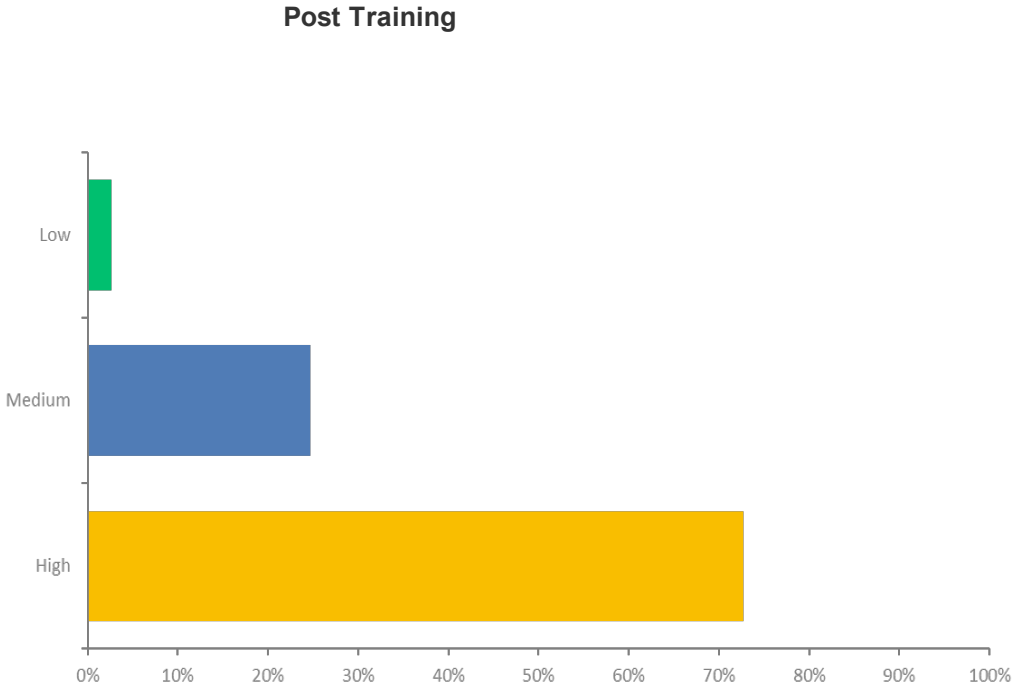
How would you rate your knowledge of suicide in the following area? How to get help for someone:



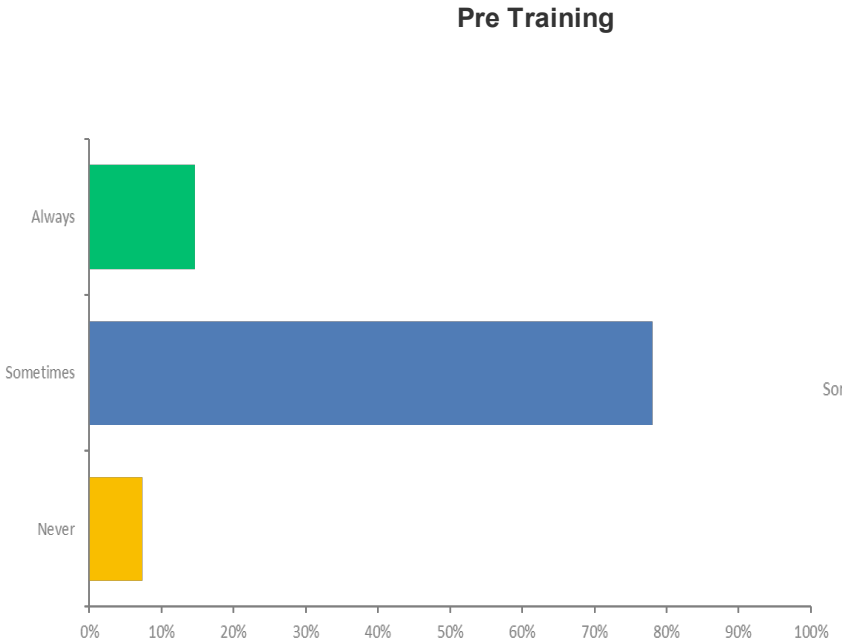


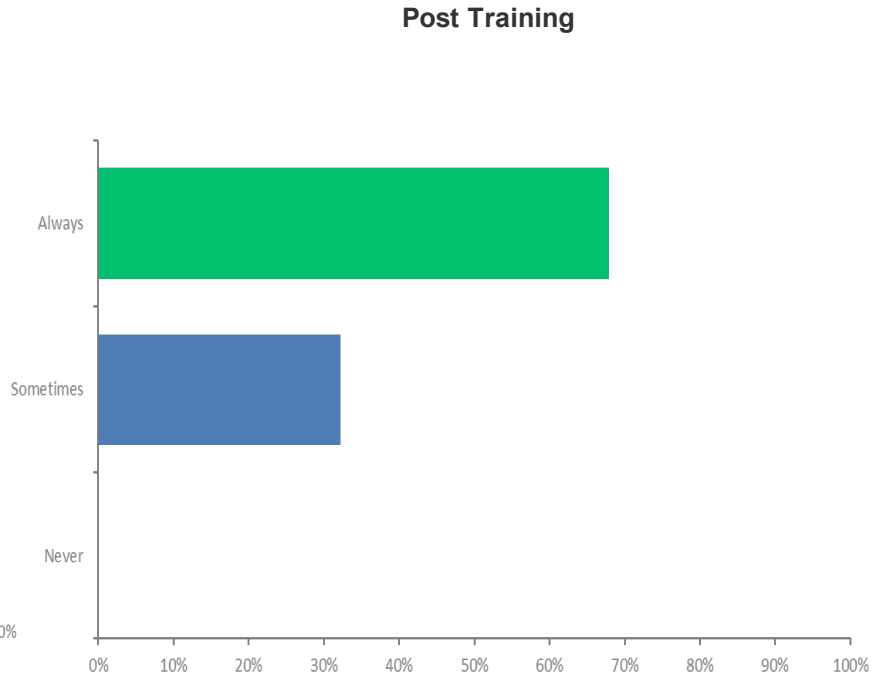
How would you rate your knowledge of suicide in the following area? Information about local resources for help with suicide:



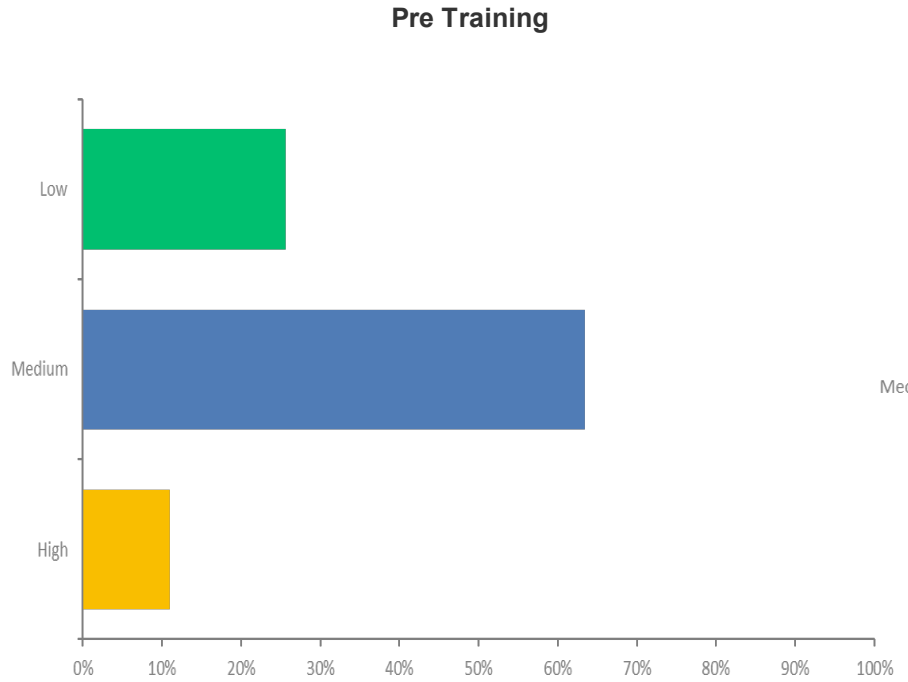


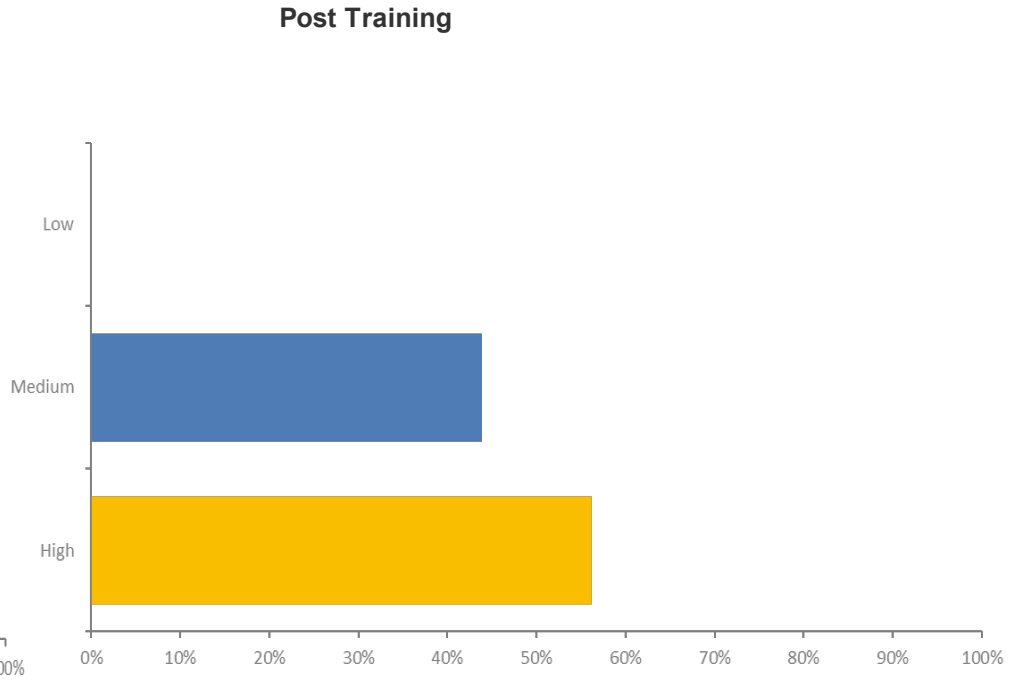
Do you feel likely to ask someone if they are thinking of suicide?



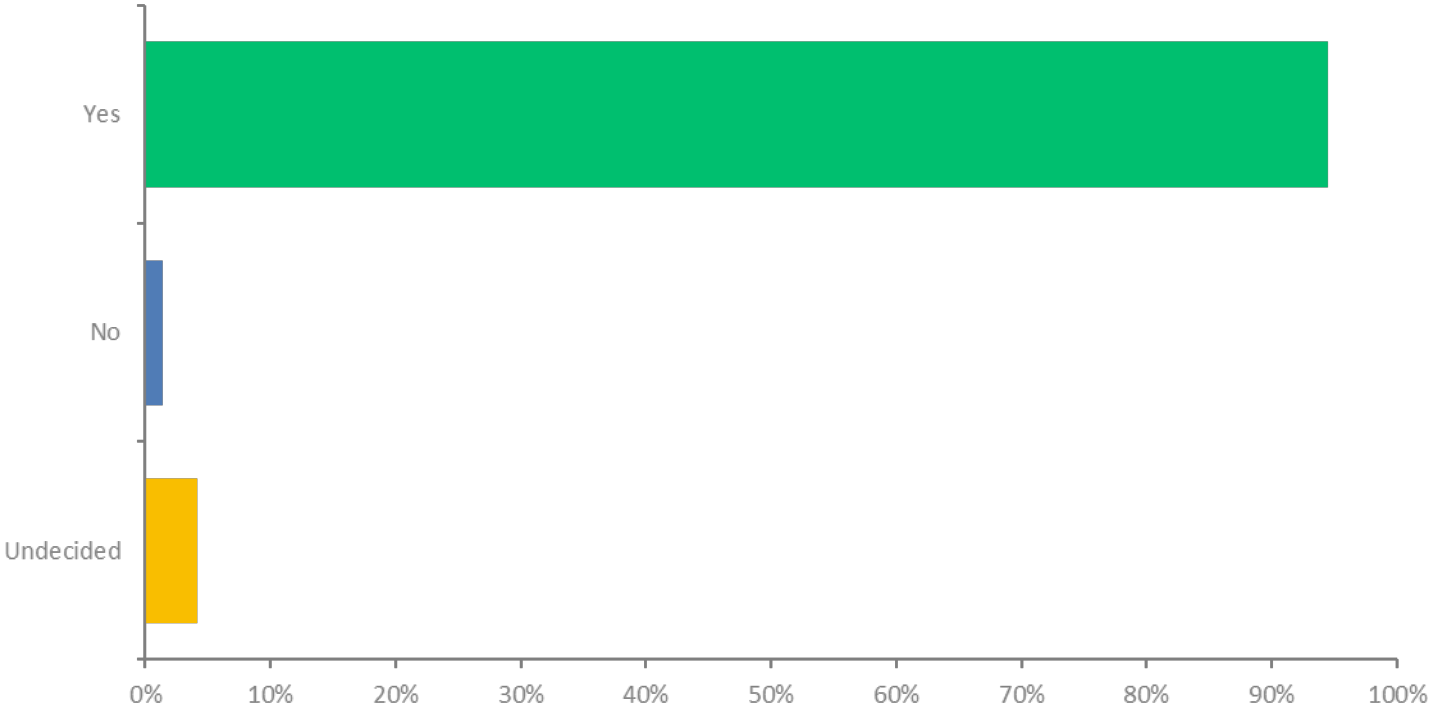


Please rate your level of understanding about suicide and suicide prevention:





Would you recommend QPR training to other?



Sonoma County MHSA Listening Sessions

FY 2022-2023 Annual Report

Prepared for Sonoma County Department of Health Services, Behavioral Health Division

by Coaction Institute

July 2023

Acknowledgements

This project is the result of the innovative efforts of Sonoma County's Mental Health Services Act Community Program Planning Workgroup, who went above and beyond in the development of a strategic plan to deepen engagement with the County's diverse communities experiencing mental health inequities. In bringing that plan to life, the heart and soul of the project lies with the community leaders and activists who stepped forward as co-facilitators to engage their communities in these important conversations. We would like to recognize their hard work and thank them for their contributions to the effort:

- For African American/Black residents: Mina Newman, Tina Rogers,
- For Asian American/Pacific Islanders: Grace Villafuerte, Jerry Thao
- For immigrant and US-born Latinx youth and adults: Isabel Lopez, Renee Saucedo, Maricarmen Reyes, Dalya Amador, Mar Rivas, Victoria Amador, Oscar Lopez, Chelene Lopez
- For LGBTQIA residents: Chelsea Kurnick, Celeste Austin
- For Older Adults: Mina Newman
- Contributing to facilitator conversations and planning: Madonna Feather Cruz

We would also like to thank the community partners who supported the co-facilitators in their outreach and provided logistical support, including Hanna Center, La Familia Sana, Latino Service Providers, Positive Images, Providence-Santa Rosa Memorial Hospital, Santa Rosa Junior College, and West County Community Services' Senior Center.

Sonoma County's MHSA Listening Sessions coordinating team includes Melissa Ladrech, MHSA Coordinator, Fabiola Espinosa, MHSA Analyst, Julie Kawahara, MHSA Consultant, and Dory Escobar, Executive Director of Coaction Institute. The project also had the support of Saoirse McCormack, MPH Candidate at the University of San Francisco.

Table of Contents

Background 2
Project Process 4
Findings 6
Key Takeaways 11
Recommendations for Further Action 12
APPENDIX 1 13

Background

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 for the purpose of funding mental health systems and services in California. To effectively transform the mental health system, MHSA creates a broad continuum of prevention, early intervention, innovative programs, services, and infrastructure, technology, and training elements. State legislation requires that each County establish Community Programming Planning (CPP) specific to Mental Health Services Act (MHSA) funding. The CPP recognizes that community members are critical partners in creating an equitable community practice that inspires a cultural shift in which the voices of people in Sonoma County from all backgrounds are heard, acknowledged, and utilized in creating a system of mental health care funded by MHSA. Sonoma County's CPP Workgroup's 2022 Strategic Plan expanded upon its original mandate to establish a process whereby these community voices are elevated and incorporated into MHSA program planning.

The [Sonoma County] 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, ensure equity and cultural relevance in program services, and strengthen management and administrative performance relative to DEI.

The Sonoma County Community Program Planning workgroup, comprised of stakeholders, has adopted the following statements as foundational guiding principles in developing a sustainable, inclusive community engagement plan responsive to MHSA and the broader public mental health system:

Transformation:	**Information:**	**Education:**	**Representation:**	**Participation:**	**Consideration:**
We have the right to a public mental health system that embraces the Recovery Model of Care and is fully committed to all General Standards for programs and services set forth by the MHSA.	We have the right to full transparency in our public mental health system.	We have the right to fully understand the meaning and implications of facts and data relevant to our public mental health system.	We have the right to competent and adequate representation when important decisions are made in our public mental health system.	We have the right to shape policy and meaningfully participate in all important programming and funding decisions in our public mental health system.	We have the right to submit grievances1 to our public mental health system, to have our grievances acknowledged, and to receive thorough and timely responses to our grievances.

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

taking action to engage a broader community than themselves. The CPP's vision is that all people from various cultural backgrounds and languages have accessible opportunities to influence how MHSA funding support behavioral health programs and services in a system of care that is people centered and community driven. Community members in Sonoma County are acknowledged as critical partners in creating an equitable community practice that inspires a cultural shift in which the voices of people in Sonoma County from all backgrounds are heard, acknowledged, and utilized in creating a system of mental health care funded by MHSA.

The Sonoma County CPP's mission is to increase community input into program planning decision making by establishing regular, timely, meaningful, safe, culturally appropriate opportunities for (1) deep listening, (2) free exchange of ideas, and (3) determining action based on those ideas. Results should be demonstrated by policies, procedures and program outcomes of the community service programs funded by the MHSA plan. The following values guide the CPP's efforts:

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.

Promote community voice in all decision making: Respect and 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.

Build capacity of community members: advocate for meaningful stakeholder participation, promote public education and training in CPP activities.

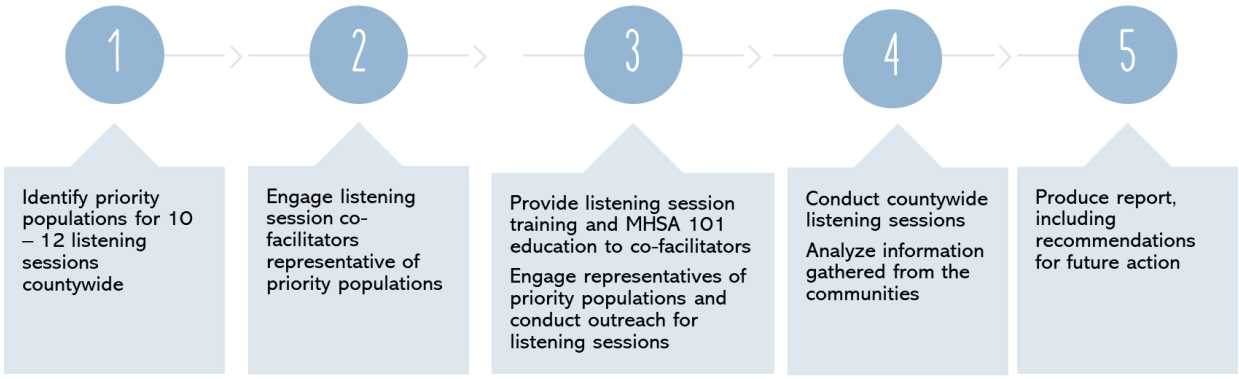
Conduct multiple methods of outreach: Dedicate efforts to increase accessibility.

The CPP established the following goals in January 2022:

Project Process

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.

This project took place in five phases:



Phase I focused on identifying the populations most likely to experience inequities in mental health status and access to and utilization of mental health services and programs. It became clear that it would be impossible to engage in one year with all the people whose voices needed to be heard, and so a two-year plan was developed. Some of the population groups were still quite diverse and the team recognizes the benefits of both targeted groups with strong affinity and more diverse groups that still share some identity. Multiple listen sessions with Latinx residents were planned for FY 2022-2023 given the size of and diversity within that population in Sonoma County and the unmet needs and mental health inequities identified in recent local assessments. During Phase I of the project the following population groups were prioritized for engagement over two years:

FY 2022-2023	FY 2023-2024 (provisionally planned)
African American/Black	African American/Black Youth
Asian American/Pacific Islander	Agricultural Workers
Latinx Youth (immigrant & US-born)	Asian American/Pacific Islander Youth
Latinx Adults (immigrant) – Sonoma Valley	Indigenous (central County)
Latinx Adults (immigrant) – Cloverdale	Indigenous (coastal)
Latinx Adults (low-wage earners) – Guerneville	People with Physical Disabilities
LGBTQIA	Transitional Age Youth
Older Adults	Unhoused Adults

During Phase II of the project, with recommendations from the CPP members and support from community-based organizations, fifteen residents representing the priority populations for FY22-23

were recruited to work in pairs as co-facilitators. During Phase III the co-facilitators received orientation about MHSA, including its history, purpose and structures on state and County levels. This was followed by training for the listening sessions, which included the following topics:

Project Orientation

- Project Overview & Team Building
- FY22-23 Listening Session Groups
- Health & Safety for In-Person Activities
- Co-Facilitator Expectations
- Review of Administrative Forms
- Team Meetings Overview and Scheduling
- Zoom Tips

Facilitator Training

- Introduction
- Guiding Principles
- Listening Session Questions
- Participant Recruitment
- Facilitation Skills
- Planning and Preparation of Listening Sessions
- Interpretation of Input & Recommendations
- Understanding Secondary Traumatization

The listening session questions used were an adaptation of those developed by the California Mental Health Services Oversight & Accountability Commission for Transitional Age Youth listening sessions conducted in 2022. Upon review, the co-facilitators found that they were relevant to each one of the populations to be engaged. The only modifications made to the question was to translate them for the Spanish-speaking groups. The Sonoma County MHSA listening sessions co-facilitators used the following questions for this project:

After completing the training, the co-facilitators planned their listening sessions and worked with community partners to conduct targeted outreach to potential participants. Each listening session was limited to a maximum of fifteen participants, to ensure that the listening sessions would be comfortable and safe spaces, and that every voice in the room could be heard. In addition to recruitment, co-facilitators addressed all the logistical issues for their sessions. Groups were conducted fully in English or in Spanish, and though initially considered in the project, language interpretation was unnecessary. Food and stipends were provided to the participants to thank them and recognize the value of their contributions and this, too, was planned during Phase III. Monthly facilitation team meetings began during Phase III and continued through Phase IV to monitor progress, celebrate successes, troubleshoot challenges, and process what the co-facilitators were hearing from the communities.

The listening sessions were conducted during Phase IV. The sessions were audio-recorded to ensure that the participants' input was not lost. Before launching into the dialogue, participants in each session were presented with the purpose and process of the listening session and asked for their verbal consent for participation in the session and for the audio recording. One hundred percent of the participants gave their consent to participate and to be recorded. In the case of the Latinx Youth listening session, a written consent form for parents of minors was explained and obtained by the facilitators.

The final phase of the project for FY 2022-2023, Phase V, was the analysis and interpretation of the data collected in Phase IV, as well as formulation of recommendations made by the facilitation team to the Sonoma County MHSA CPP and MHSA Coordinator for future project implementation. Periodic updates were provided throughout the project to Sonoma County's MHSA Steering Committee and the CPP.

Qualitative data was captured through transcripts of the audio recordings of the listening sessions, along with facilitator notes taken during their sessions. A review of the transcripts revealed emerging themes in each listen session, as well as themes that were common to several or all the groups. A simple thematic table was composed for each listening session, followed by a identification of common themes. As a community-based participatory project, the engagement of community representatives to serve as listening session facilitators was key and they were trained and supported to lead their own groups. In some cases, technical issues, and lack of experience in documenting listening sessions led to incomplete or missing transcripts. So, some data has been supplemented with notes of listening session facilitators and observers and is included as a paraphrase of what was said by participants.

Findings

The facilitation team reviewed and discussed the results of the data analysis, using the following questions to guide their discussion:

Triggering Issues

- What issues seemed to be particularly triggering for participants or generated strong feelings or opinions?
- What ideas do you have about why this might be?

Frequent Themes

- Why do you think that one theme may appear more often than another?

- How does that compare with what you might expect?

Related Themes

- In what ways are themes related, influence each other, or interact?

Unique Concerns

- What issues seemed to be of great importance to some participants, even if they were not mentioned by many others?
- How might these still be addressed?

Summary of Findings

Tables with the raw data from each listening session can be found in the appendix of this report. A summary of findings heard across listening sessions is presented below.

Increase in mental health concerns

Increasing social isolation and loneliness were mentioned as a priority concern throughout the listening sessions. This is congruent with national trends and the recent declaration of loneliness as a public health crisis in the United States. Isolation is associated with increased stress, anxiety, and depression. While social isolation became a greater problem during the COVID-19 pandemic, it did not begin with it. Intimate partner or family violence, loss of loved ones, sustained unemployment, political divisiveness and other issues can also lead to isolation and increase a person's risk for the mental health issues associated with it. Listening session participants expressed concern in particular for the increased isolation of children, youth, and older adults during the pandemic.

"The need increased quite a bit due to all the social issues not only historically that we've endured, but [also] the most recent four to five years."

"Everything's happening at the same time. Social isolation, stress, and depression have increased a lot."

"When the world stopped people had time to look at themselves and become aware of their depression."

"Social isolation leads to loneliness and are triggers for mental health crises."

Participants in all the listening sessions noted an increase in stress and depression among their community members. Speakers associated the increase with natural disasters and the pandemic, which exacerbated and made more visible existing issues.

Age-specific mental health needs

"Youth are having emotional crises and there aren't enough therapists in schools. Teachers should have QPR training to understand what's behind behavior problems to support and not label students."

"[There's a] constant overload and misinformation that hits older adults harder and causes secondary trauma and stress."

Listening session participants identified children and youth and older adults as being particularly vulnerable to mental health issues and in need of specialized attention. Concerns raised included the heightened risk for isolation among these age groups that increased during the COVID-19 pandemic.

Impact of racism and discrimination on mental health

Racism and other forms of discrimination occur on systemic, institutional, and interpersonal levels; and each one negatively impacts mental health. It communicates to certain populations that their lives and concerns are of lesser value than those of the majority. Experiencing discrimination directly and indirectly is traumatizing, increases isolation, and can lead to mental health concerns. Every population group engaged in this project identified discrimination as a significant threat to mental health and wellbeing.

"Mostly white dominated spaces people of color can be very intimidating and entering spaces can feel really uncomfortable."

"Asian Americans don't necessarily show up as any significant demographic on any reports regarding mental health or health services, etc., so it plays into that myth of the model minority where we don't need mental health services."

Influence of cultural and familiar norms on mental health

"Some people don't know how to say I have an issue. Being an African American male, asking for help [isn't] something that comes easily for me to ask for help. Because that would mean something's wrong."

"[There are] cultural taboos against talking about mental health. We weren't raised to communicate, and that's the basis of everything."

"I grew up in a family system where no one talked about how they felt or knew how to manage their emotions and feelings. We don't talk about it. You just buckle up and you move forward."

Mental health concerns are not openly discussed in many cultures, with the implication being that the individual is "crazy," or in some way defective. Asking for help is seen as a sign of weakness for not only the person in need, but by extension for the entire family or cultural group as well. Cultural and familiar norms that impede acknowledging and addressing mental health concerns were mentioned in nearly all the listening sessions.

Relationship between housing status and mental health

Listening session participants pointed to the lack of access to stable and affordable housing as a significant risk factor for mental health in Sonoma County. Unhoused residents were identified as some of the most vulnerable to mental health disturbances and whose mental health concerns are often not considered or sufficiently addressed by the system. It was noted that there can be a cyclical relationship between housing instability and mental health problems, each one potentially exacerbating the other.

"Housing and just basic survival is a constant mental health stressor, especially in Sonoma County."

Need for sensitive and culturally aware and relevant services

"We want people that we can trust… the most important characteristic for me when it comes to care is being culturally responsive, having people that look like us, that understand us."

"Some providers or organization staff don't seem sincerely interested, like they're just doing their jobs. Can feel intimidating, dismissive, or condescending. Makes it hard for people already having a hard time asking for help. Need providers to be nonjudgmental, authentically interested in me and my story."

Participants shared concerns about deficiencies in culturally aware and relevant mental health services and agency staff. Barriers cited included lack of Spanish-speaking providers and support staff, culturally relevant outreach materials and information about how to maneuver the system, as well as education about mental health-related topics. Likewise, many participants reported a lack of sensitivity to the needs of those seeking services, regardless of their cultural identity.

Need for improved access to services

In addition to the cultural or linguistic barriers noted above, the following barriers to access to mental health services that were also noted in the listening sessions: affordability, long waiting lists, lack of transportation to services, inconvenient hours, and lack of easily accessible information about services available.

Participants in all the listening sessions conducted outside of Santa Rosa addressed the need for decentralized services to help overcome these obstacles.

"I have healthcare, cannot get into a mental health professional, have been on a waiting list for like eight months. So even individuals that have health care or benefits not able to utilize them."

"I think it's very important that our county have resources go to people. And this is something that has been a little bit of a shift. We can no longer keep having people go to the services. The services have to go to the people."

Intergenerational Trauma

"We have that generational trauma. It's in our DNA and comes out in adaptive behaviors that we learn and get passed on from generation to generation without you even knowing that you're passing on that trauma, because it's something that we use to protect ourselves."

"Parents have trauma, war, trauma, evacuation trauma, whatever trauma it is. That plays out in families, and nobody says anything."

Participants spoke about the experience of intergenerational trauma in their families and communities and about its influence on their mental health. Unresolved trauma experienced by previous generations can repeat and be expressed in generations that follow. Traumas associated with racism or other forms of discrimination, interpersonal or socio-political violence, migration experiences, natural disasters, or other causes can be internalized and expressed as anger, irritability, anxiety, sleep disturbances, and mistrust and inability to bond with others.

Value of formal and informal peer support

Participants noted that a person's mental health status does not depend exclusively on access to professional service providers. Throughout the listening sessions, they spoke of the importance of formal and informal peer support to promote and restore mental health. Each group highlighted the importance of emotionally safe spaces such as the listening sessions as a way to support each other and, in that way, also themselves. They frequently asked how these spaces could be sustained and in two communities, Cloverdale and the Sonoma Valley, community partners have already stepped up to help make that happen.

"Peer support groups get together and they're not in denial about their situation or their condition. They're just saying this is how we cope; how we can live the best life we can live. how to become more selfless to one another and carry this conversation that we're having here outside in everyday life to other people and help other people just talking."

"I'm not a trained therapist, but I'm able to reach out to people who tend to reach out to me because I'm around their age and they are more comfortable with me talking about their problems…there's not always a format where we can talk about this openly in a safe space with other folks. How do you create more spaces for these conversations to occur?"

"We need more spaces like this. Can we meet again?

Key Takeaways

Themes found across culturally specific listening sessions include:

- Culturally aware and relevant services
- Cultural norms and stigma
- Increased mental health concerns including isolation, depression and stress
- Intergenerational trauma
- Racism and discrimination
- Formal and informal peer support
- Access to services
- Decentralized services

Facilitators who are representative of the listening session participants are at increased risk of experiencing and conflating primary and secondary trauma and need ongoing support.

Social isolation, stress, anxiety, and depression increased in recent years in all populations represented in the project. Participants identified the pandemic, fires, interpersonal violence, racism, and recent political divisiveness as contributing factors.

Stigma and cultural or familial traditions can impede accessing help when needed. This is common to different cultural groups. Each one identifies it as an issue unique to them, suggesting that along with cultural-specific spaces for dialogue and mutual support on mental health, intergroup dialogue would also be supportive of building connectedness and mutual support.

More culturally aware and age-specific outreach and community education about available services is needed.

There is a need for greater access to services before the mental health concerns becomes a crisis, not only prevention, but widely available early intervention services for all income levels.

Intergenerational trauma is experienced in diverse populations in Sonoma County and is discussed or addressed to varying degrees and in different ways.

Culturally relevant peer support is critical, in some cases increased since the start of the pandemic and needs to be supported and expanded.

Decentralized (beyond Santa Rosa) and more culturally aware and relevant services and providers are needed to increase access and utilization by diverse populations.

Regardless of population, services need to be provided by organizations and individuals who are welcoming; authentically interested in and respectful of people's concerns, experiences, and perspectives; nonjudgmental; empathic; compassionate; and trustworthy.

In some cases, participants stated there are no services available in their community or in their preferred language when, in fact, there are. Regardless of that fact, their perception is of great importance and indicates a need for improved culturally aware and relevant outreach, education, and information about services and how to access them.

Recommendations for Further Action

Provide support to trusted community-based organizations to sustain safe spaces like these listening sessions in the community.

Support cultural groups/organizations to build upon existing or create welcoming and safe culturally aware and representative centers to foster connectedness and provide information about resources.

Organize some listening sessions with even more focused, specific cultural groups to promote greater affinity to build emotional and social safety and encourage participation.

Continue to support capacity building within Sonoma County's diverse cultural populations to facilitate dialogue about mental health and institutionalize their voice and influence within the MSHA system, structures, and processes.

Provide community education about intergenerational trauma and engage community representatives to provide information about culturally aware and relevant ways to dialogue about and address it.

Improve and increase culturally aware and relevant outreach, education, and information about services and how to access them.

Ensure that mental health services are not only linguistically appropriate, but culturally appropriate for the diversity within populations that speak the same language.

Expand facilitator's training on understanding the difference and interaction between primary and secondary traumatization, protective factors, and when to reach out for support to address secondary trauma when facilitating listening session.

Ensure 1:1 support as needed to listening session facilitators from someone trained and experienced in secondary trauma.

APPENDIX 1

FY22-23 MHSA Listening Sessions Themes

African Americans/Blacks

Themes	Illustrative Quotes
Person-centered care	we need to be more what I want to say more directive to the person is specific basically. And so that means you're going to have to get to know that person to develop a plan that's going to work for them and is what I might need is different than what somebody else would need. And so I think that's something that should be highlighted moving forward when we're thinking about mental health. That is not a cookie cutter situation. It has to be specific.
Culturally aware and responsive services	more cultural culturally responsive therapists… we want people that we can trust and understand our stuff… we have to actually love the people that we're interacting with. the most important characteristic for me when it comes to care, not just mental health care, all care because we also have issues with our medical system is being culturally responsive...don't put us in a bucket and say, Oh, you're just like everybody else, because they have been very detrimental to our population. When we go in for medical care…they just ignore us and they just brush us off. So being culturally responsive, having people that look like us that understand us, that is one of the main characteristics that needs to go into mental health and whatever other services need to be compassionate .,,have grace and mercy… we need an African American Resource Center… We need to be at these meetings when all of this stuff and I'm no, I'm not allowed. But a lot of times I've had meetings. I'm the only one black there. But this is what I'm making those decisions. And so and I mentioned it to him, we have to be at these meetings and we know that these meetings by the time we hear about it's already made… we need more black people's on these committees.
Respectful culturally aware treatment of unhoused people with untreated mental illness	…my uncle died on the streets with schizophrenia….they kicked him out of the shelters… the police the way they address them that needs to be they need to be trained on how to address African Americans who have mental health issues or conditions.
Physical health, spirituality, and the arts as mental health	Those also have to be talked about because you just can't talk about mental health without also talking about what you're putting inside your body… your spirit, and your soul. All of those things go into mental health…research has been done to show the positive effects of music and dance and just being physical overall, as a part of that their counseling.
Increased and improved outreach to increase use of services	You see, people have a hard time with the stigma with mental health, or how it's looked at or how you look at it. How can we make it more accessible and engaging in and more informing for our people to go in and get some help? before it becomes a crisis?... we have to really be able to encourage our folks to take that step. So, we do have a lot of things here in Sonoma County. But a lot of times I hear people complain or talk about something, they don't know where to go. And so usually for mostly bills and nonprofits and so forth, they'll tell you go sign up online. And so that's just one mode of signing up. And that's not the only way people should be able to sign up. So, we have to really look at meeting people where they are in order for them. To get the service that they need. ...in the hospitals they used to have a someone who was a, like if you had cancer they would would meet with the counselor. And then they would tell you these are your this is what you can do. This is where and then that would be a they will give you this little book here. This is everything you

Themes	Illustrative Quotes
	need to know about how you can get treatment for cancer. And that's something that I think we should also have as well are like a little magnet that you can put on your frigerator these are all the numbers that you can call that they can, you know send out for that kind of thing, but definitely older people need.
Normalizing looking for help, challenge cultural norms, reduce stigma	being an African American man, that was one of my biggest issues, someone trying to diagnose me, you know, I may be just, you know, rambunctious, and all of a sudden it's got a name, you give it a name. So now I'm pigeonhole. So mental health isn't always pigeon. Is it always mental health? You know, so what do we have available? That could not diagnose them but a person can go first of all feel comfortable with saying I had an issue? Maybe I'm the only one that has a problem with their I have an issue. Maybe some people don't know how to say I have an issue, because asking for help. Being an African American man. I could say that that's not something that comes easily for me to ask for help. Because that would mean something's wrong.
Mental health promoting youth activities	I think a lot of kids nowadays, well, for the younger people, they got ADHD, so that they need something for themselves to do and if they like they, they might run around and get in trouble and then they're further, like, ostracized from the community. And that can lead to like going into other activities more and then further deteriorating their mental health. So if we just have something for people to do, like the young people do get into that's positive. I think that it'll be a great positive effect on the community.
Intergenerational trauma	We have that generational trauma. And it's in our DNA. And that comes out in certain ways of adaptive behaviors. That we learn and get passed on from generation to generation without you even knowing that you're passing on that trauma, because it's something that we use to protect ourselves. But that could also be your kryptonite. You know, something that was useful at one time is not any cannot be useful now, in this day and age. So really being able to have conversations where people can look at these ideas.
Trauma-informed care	I think that a lot of times when you grow up with trauma that like anxiety stress, just negative self-talk and stuff can feel so normal that you're not even aware that you maybe are depressed because it has been around in your family or it's just normal to be in that environment. And I think that it's important that everybody who's going to receive help have an advocate there that is separate that because if you're in a state of trauma and you whether it be up elder or dealing with law enforcement or needing to talk about something that is very personal and you don't feel necessarily you can trust somebody that you're going to be in sort of a state of shock, so you might not be able to clearly express what you need. And I think that it's important for any organization or for anybody who's working in, in like social services to be mindful of that. And gentle and compassionate like if we're saying so yeah, be mindful about like lifetime trauma.
Connectedness	We need to have more discussion and more talking more communicating, more connectedness as a people… We need to talk to each other. And we have to have compassion… We just got to do it. We just got to come together. Because look at the ancestors. Look what they did.
Perinatal mental health support	I think that every woman who's going to have a baby should have there should be a proactive outreach to offer her mental health services.
Improved access to needed services	I have healthcare, cannot get into a mental health professional, have been on a waiting list for like eight months, right? So even individuals that have health care or benefits not able to utilize them… access for seniors who are at a certain age and a certain mindset is that also prevents them from accessing care if they don't have somebody who's an advocate.

Themes	Illustrative Quotes
Need to increase prevention activities	So how do we help people who are going over the edge? How do we make it more attractive to not do certain things and have alternatives? You know, how is social media driving this ship? You know, and how social media seems to be perpetuating and disconnecting us from each other. So we have to start, continue to do stuff like this.
Increased mental health concerns	The need is increased by quite a bit, just due to all the social issues not only historically that we've endured, but the most recent four to five years has caused a significant increase in everyone's mental health. ..It is increased across the country since the isolation caused by the pandemic. And a lot of it is not recognized because people are suffering and there's not they're not categorized as suffering. A lot of people suffer in silence
Peer support (formal and informal)	peer support groups. They get together and they're not in denial about their situation or their condition. They're just saying we this is how we cope with. This is how we can live the best life we can live and then like you said, Those who support people, they need support to that. Yeah, this is this is new territory. So I was just saying support for each other, peer support for each other for those who don't think Yeah, and so so that they can go to a place and feel like that I'm being heard or being seen This is great. And we're here to talk and we're here to come together and talk right so how do we come my two biggest thing is how to become more selfless to one another and carry this conversation right that we're having here. How do we carry outside in this everyday life in normal life?... how do we carry a conversation outside of here to chat to other people and help our other people just talking and saying hey, like, you know, this is what I know or this is why, what I can do or you're dealing with this problem.
Foster system support	I want to say that my mother and I have both been in the foster system. And as black youth in Sonoma County. I feel like some of some of my success has been due to being in foster care because they have looked at me like, oh, you're a black man. So you might need more help than what this white boy might meet? Because they can see my skin color. I might get downplayed a little bit so they might actually try and help me and I feel like I don't know what it's like for other people in foster systems like, for being white. However, I know for being black in Sonoma County. They somewhat do try and help you. So yeah, and the transitional housing program I'm in it has helped me a lot very much.
Racism and discrimination	But I think that you could work differently with black males because we may come up in different upbringings. And it may look at certain things that you do may be looked at as different from your elders in the black community, as opposed to like the white community…what I've seen is when we take young black men to like Aurora mental hospital, or the hospital, especially if they're like large bodied, you know, darker complected especially if they got like dreads or tattoos. They're definitely like stigmatized at the door. And there's racist intake workers. You got racist like security guards. They just messed up the whole vibe, trying to bring someone in and there's like no oversight on that, so that's been a big barrier
Decentralized services	I think it's very important that our county put resources to go to people. And this is something that has been a little bit of a shift. We can no longer keep having people go to the services. The services have to go to the people. We have a lot of black population that live out in Floresville in Guerneville. And the access to internet and those areas are is very limiting. So it has to be having some satellite buildings throughout our county and say we will be in your area on this day go to the people so we have to push our government to go to the people we can no longer keep having everybody come to Santa Rosa to get the care because last we heard the waiting list is long. So they need to start pushing it out to the outer areas of Sonoma

Themes	Illustrative Quotes
	County and getting to where the people are. That's just not for our population. That's for every population because everyone is having the same issue where they say come to Santa Rosa. This is the hub of where our services are. Our services need to go to our public in our community,

Asian American / Pacific Islanders (Hawaiian, Hmong, Filipino, Chinese, Japanese)

Themes	Illustrative Quotes
Culture clash as mental health issue	Coming from Asian communities, we tend to immerse ourselves in family and culture, and think of us as part of a community instead of somebody who could go out there and make your individual mark in the world. So, I think those create mental health conflict right there, for a lot of us since a lot of us are trapped in low paying jobs, no advancement, because you're busy just trying to get ahead. So that would be one of the issues I would pinpoint is the family culture, the culture clash, basically.
Substance use	There's so much oppression, there's substance abuse, there's a lot of people who are coping through alcoholism and things like that, but we don't go back to why people are using it. And so, it's more accepted, unintentionally, that will people use to cope.
Cultural norms, stigma	I grew up in a family system where no one talked about how they felt or knew how to manage their emotions and feelings. Their only goal was to learn how to speak English, learn how to communicate with people, and put food on the table. We don't talk about it. You just buckle up and you move forward in my family. I'm aggressive. I'm expressive. I'm a hugger. I wear my emotions on my sleeve as y'all can see. But the majority of my family is like, Oh, we don't talk about it. We just move forward like this is life and you move forward…I knew I had numerous health issues, depression, and everything, but I didn't really know about it until I was in college. There was the encouragement to go talk to a therapist. That's where I really started to learn about mental health wellbeing.
Intergenerational trauma	I think about my parents, survivors of war. They had to bring all that trauma here and continue culture and country. How do you deal with all of that? Parents have trauma, war, trauma, evacuation trauma, whatever trauma it is. That plays out in families, and nobody says anything. When I talk about them being born in internment camps and intergenerational trauma, they disassociate like they're gone. Like, they cannot hold that conversation. So I have to be very gentle in how I talk about things and not make it about them, but about the larger community. I grew up with a lot of racism in the area, and they just can't go there. Like you weren't to do your post World War II children, like you had to be facing racism, like constantly on a day-to-day basis, and they just don't talk about it.
Culturally aware and relevant care	What does mental health mean for our AAPI community? Bringing awareness and having folks who understand our community, someone who can connect with our elders and talk about mental health; being able to connect and translate because we have our communities who are still suffering to this day. You don't see a lot of people who look like you, that you can relate to. And so, within the mental health community and even thinking about getting the services, I would say that it can be intimidating. You don't know if people are going to judge you. Because of the culture here. It's very different. Change needs to happen. We need to direct this funding in ways where's it going to make that difference. Having hotlines absolutely helped you in that moment, knowing that the person on the other line is going to be someone who is of same culture to you.

Themes	Illustrative Quotes
	if someone asked me, where can you go and get mental health services for the AAPI community, I'm like, Where would I direct them? I couldn't answer that question. There needs to be a network where you just tap it wherever point to have full access to services, no matter what type of services they are, that are generated for API. So that when somebody does ask, they can get culturally relevant care. Developing a whole generation that ties back into self-efficacy and mental health and confidence and building a healthier community. And then you're empowering others to do the same thing, when they may have come with their trauma, and they're bringing everything that they come with. empowering others to be able to take that leap and maybe do something and fill in their career path thinking, Oh, I never thought I would do this or be here or you know what I mean, but then it gives them that, that avenue. Sometimes I don't want to just be the Asian American worker, you know, the only one. At the same time, I do want to make a difference, and it's going to help the other people that come behind me, but it's just costing, it's tiring sometimes. It is exhausting.
Housing and homelessness	Housing and just basic survival even if they're working full time, in college, just trying to find affordable housing and pay all their bills is a constant mental health stressor, especially in Sonoma County. Where I live, I see a lot of homeless people. And yeah, there's their mental state. It goes beyond that--it's not being addressed that they're a human being. That's really overlooked. And yeah, we need good doctors and so forth, but it's beyond that also because a person doesn't always just need to be medicated, they need to find the root of the problem.
Connectedness	[We need] but more places to connect with other people in this group. How do you create more spaces for these conversations to occur? The first and most significant step for me is having the space to talk with other Asian Americans. Because being in Sonoma County versus maybe being somewhere like San Francisco, I'm hardly in a room with that many more Asian Americans, much less have the space to talk about this safely and openly, without like worrying about offending somebody. We have such overlapping experiences even though we might come from so many different backgrounds. Like exactly what we're doing now. It's just being in a circle and just talking about stuff, a private and safe space. this would be awesome with all because you're Asian American, and we were just talking about, like, our mental health and things that we go through day to day. So like, that would be my ideal. So safety, and, you know, have these resources be more obvious
Informal and formal peer support	Family really ties into the health of Asian Americans. I know that a lot from experience and also talking to other people. I'm not a trained therapist, but I'm able to reach out to people who tend to reach out to me because I'm around their age and they are more comfortable with me talking about their problems. As Asian American Pacific Islanders growing up, you just inherently know this stuff, a there's not always a format where we can talk about this openly in a safe space with other folks. How do you create more spaces for these conversations to occur? And for support groups? In some ways? Maybe that's a service that could be available? If we had more representation for our community, that would help normalize the conversation. Because there really isn't just a space for us to be able to have that.
Youth services needs	I feel like there should be like, I don't know, some sort of like center or like shelter, where there is access to in person therapy, and some sort of protection. Where parents aren't allowed to step in or intervene. We have

Themes	Illustrative Quotes
	very good counseling at school right now. There's a lot more money that's gone into mental health and emotional wellbeing; but there's not connection with county services or city services, and everyone's trying to do the same thing somehow. Schools really need to be transformed into community schools, that's where the kids are. We're doing things in silos and we have to combine and do it together.
Racism and discrimination	My parents might be [assume] that if a white person is serving this service, or whatever it is, they might think it's higher quality. Asian Americans don't necessarily show up as any significant demographic on any reports regarding mental health or health services, etc., so it plays into that myth of the model minority where we don't need mental health services. It's invisibility. Some folks think we're doing so well, and they're like, Oh, y'all are having all the privileges of white folks. And so, we you don't really need this and you and you're not accessing these services, so you must not need them. There's racism within the Asian American community, for sure. we internalize those frameworks and so It doesn't escape us. Some of the immigrant mentality too, is internalized racism.

Latinx Adults (Immigrant and US-born – multiple sessions and communities)

Themes	Illustrative Quotes
Culturally aware and relevant services	Need more Spanish-speaking providers and staff and Spanish-speaking therapists in schools. Having services in Spanish isn't enough, we come from different places and different cultures (Mexico, Central American, urban, rural, etc.). There are cultural differences, regional linguistic differences that can still get in the way of understanding even if someone technically speaks Spanish. Even if you speak English, you don't necessarily want to talk about your experience in English. It may not help in the same way. Need people who understand me. Not enough services for the indigenous people from Oaxacan, Spanish is their second language.
Access to services	There are very limited mental health services in Spanish in the Guerneville area. In all communities, there are wait lists and it can be hard to get an urgent appointment, especially for services in Spanish. Sometimes can't get help until it's a crisis. Necessary paperwork can be intimidating and there isn't always staff to help fill it out. Like to enroll in Medi-Cal. Some people can't read or write and sometimes the staff is rude to them. There's a lot of paperwork to fill out and costs can be high, especially for medications. If someone asks for something they don't provide, organizations should give out information about other places they can go to get the help they need. These days you need access to technology and the internet to get services, not everyone does or knows how to use them.
Increased mental health concerns	Needs have increased and intensified since COVID and natural disasters. Everything's happening at the same time. Social isolation and depression have increased a lot.
Increased bullying of children and youth	Those being bullied skip or refuse to go to school, experience social isolation, stress, and depression. Parents aren't always informed about it by the schools. Sometimes bullying is based on gender, language, or race.
Multi-generational families	Families caring for older adults in the house need mental health support.
Youth service needs	School counselors focus on academics and not mental health. Youth are having emotional crises and there aren't enough therapists in schools. Need programs about body image and to build self-esteem. Need parenting and parent-support programs. Kids are over-stimulated from too much screentime and electronics.

Themes	Illustrative Quotes
Need for more sensitive providers	Sometimes providers don't listen, minimize problems. Providers and staff need to have empathy and truly care about the people who come to them for help. Need to make sure that their words and their body language is respectful.
Racism and discrimination	The system discriminates against the homeless and against Latinx.
Formal and informal peer support	By listening to others, we also learn about ourselves. We need to show empathy for others. Need to build trust through solidarity. Social support is important, so we don't get sick from stress. I find support opening up to friends.
Housing and homelessness	Housing is not affordable, so families have to live with a lot of people in the same house.
Cultural norms, stigma	Cultural taboos against talking about mental health. We weren't raised to communicate, and that's the basis of everything. Latino men don't access mental health services due to machismo.
Education about mental health	Need to educate the community more about mental health issues like stress and depression, when is it normal and when is it a problem. Parents need to learn how to listen and talk to our kids.
Decentralized services	It's hard and expensive to have to go to Santa Rosa for services. Transportation is a problem if don't have your own, buses don't run a lot.
Connectedness	We need more spaces like this. Can we meet again? Need to strengthen relationship and show solidarity between indigenous Oaxacans and other Latinx (Spanish-speaking) Latinx in the community.

Latinx Youth (Immigrant and US-born)

Themes	Illustrative Quotes
Challenged cultural and familial norms, stigma	Immigrant parents don't acknowledge mental health issues... I wish there was more services confidential services because I didn't want to go, but I felt ashamed…Need to teach parents not to judge their children when they ask for help.
Increased depression among youth	When the world stopped people had time to look at themselves and become aware of their depression. Got worse due to isolation during pandemic. After pandemic, mental health issues are more acknowledged and visible, talk about it more.
Increased stress and anxiety among youth	I know a lot of people are like stressed about like the way or I mean I know some people are kids you know scary fires…COIVD… losing people like at school shootings…First generation students are under a lot of pressure to do well at school…Children of undocumented parents have to hide, fear family separation.
Need for more resources for school-based mental health services	And then like you don't really get like to me personally I've talked to as many teachers like because I feel so comfortable with them and I'll tell them about like my own like mental health struggles or like what I'm struggling with in school and they don't get paid for that they don't get paid to therapists and sometimes I feel bad because I'm doing that to them but like at the same time I don't know who else to talk to you…We need advocacy for more mental health services at schools and increase awareness of what's available. Teachers leaving because it's overwhelming to act as therapist or deal with acting out students…can't focus on teaching…. Teachers should have QPR training to understand what's behind behavior problems to support and not label students.
Need for culturally aware and relevant services	to learn about culture and as opposed to someone who learn about it, read about it. experience being able to connect with someone who went through something similar. I feel like we should have like a lot more Latino or

Themes	Illustrative Quotes
	different cultural background as a therapist because they will understand not only their own culture but other cultures as well when they tell them that they can't do a certain thing because of their family they run the risk of getting spied on gonna say pretty much in mostly white dominated spaces but people of color it can be very intimidating like art and entering spaces can feel really uncomfortable especially like when your skin color is darker than like sort of your white counterparts you know so yeah I feel like more representation and like every aspect of like school workplace hospitals just like me but not many spaces where white people feel the most comfortable. Would be cool to have cultural affinity groups at schools. Hard to form bond with therapist when there's a cultural clash, need someone with shared experiences (not just something they learned about).
Intergenerational trauma	I feel like the more like people have children the more they they put their own trauma, their own generational trauma onto the children and they create that cycle of trauma and trauma and trauma. And I feel like parents who seek their own health not just teenagers, I feel like parents should have their own therapist and they should receive help and just have someone to listen to them and give them advice entitled, like good parents. I know that there's not going to be like, the best parent out there. Everyone makes mistakes. We all make mistakes, but I feel like parents put that much trauma onto their children and they and I know that they don't need to.
Migration-related trauma	if you're undocumented once your life before that it's not really much but crossing the crossing the border in itself, that's going to bring a country because of violence such as in the coming year and potential relationships, say their separation of families ex military. Domestic Violence, that's tomorrow. And I've seen this firsthand people in a family like both of these things and then go through them alone
Education about mental health	People need to learn how to regulate emotions, how to manage the transition from middle school to high school…Need to learn about healthy vs. abusive relationships and substance use, especially alcohol and vaping…Need more education about racism and affect on mental health.
Increased community support	Seeing more support available recently in the community, more youth involved in mental health support for Latinx population. Positive shift, destigmatizing and unlearning/learning. Still a struggle, but hopeful direction…Nonprofit, community-based organizations, school-based organizations like MECCHA, teen clinics provide good services, affordable, accessible, help build connection with therapist. Need more sessions like this one.
Need improved access to services	Need safe rides to confidential youth services so don't have to tell their parents they're going…Hard to find the right therapist and limited number of therapists available…Found a great outpatient therapist but had to quit when insurance ran out, too expensive….Denied services at large service provider, on waiting list for two years because told that others need more urgent help, my problems "not bad enough."
Characteristics of good mental health support	Patience, empathy, trust, compassion, non-judgmental, confidential, safe, space to be your authentic self and to grow, open to different kinds of people and experiences. Take youth seriously, don't minimize what we say.

LGBTQ+

Themes	Illustrative Quotes
Culturally aware and relevant services	More trained providers of mental health services trained to understand the needs of our community, especially transgender people. There are so many factors that affect people within the gay community that kind of just lead to

Themes	Illustrative Quotes
	disastrous mental health crisis. dealing with homelessness and that can come with addiction and then other mental health issues. Some people that want crisis services may not want to go into the crisis stabilization unit because they're very concerned that they're going to get misgendered or that they're going to get bullied in some way about their gender identity. So, they're concerned about accessing those services. Mental health services were kind of difficult for me to find because I'm not out [about being trans] at home. So, I'm doing the Zoom meetings through Positive Images in my room, but I mean, anybody could overhear that. People of color get overlooked when seeking out mental health services. Because with the intersections of all the people in the [SRJC] multicultural center, there is like some people have like other backgrounds who like aren't necessarily like so tolerant towards gay people. And it's like, when you kind of have that exposure, you don't necessarily get to create boundaries for a safe space, it can get very intimidating for some people. All the staff, at every level, is culturally competent and diverse in all kinds of ways, including Spanish- speaking, neurodivergent-attuned. And that they prominently promote and advertise their LGBTQ+ services and attitudes. That is super important, otherwise people won't go. We need to make is encouraging young people and specifically young people of color to get training and to pursue a career in mental health because there's a dearth of people of color in the mental health industry, businesses, or services.
Formal and informal peer support	Support groups or places that folks can come and talk about some of the stuff. I hear a lot from older adults that they don't have any place that they can go and access community support, like a support group. If someone's 50 to 65 they may feel like they don't want to go to the senior center. You know, that could feel kind of stigmatizing. They might rather just have brunches with organizations doing different community things for them. People don't come to the SRJC Intercultural Center necessarily in crisis mode looking for therapy or instant support, just looking to find a community before–and I think that's kind of the pre-stages of getting to a harsher mental state where you're kind of looking for community, but then when you don't necessarily find it, you get to that point of deep isolation and self-hatred more because you're not able to find that community.
Connectedness	When I first moved here, I was looking for the Gay and Lesbian Center in Santa Rosa. People didn't know what I was talking about. There does seem to be a couple of strong–like this–at least a couple of places to be able to come together and talk. I think that any kind of community events, you know, from like Positive Images' days at the park or the Translife picnics, to a lot of events that other groups are doing throughout community are important preventatively for mental health. So, I think just having those places that people can go and people can find community is super important. community is vital to helping strengthen the mental health of gay people here in Sonoma County. But I think there's also a sense of dread with community events, I believe, at least in my instance. Because sometimes it feels, I think, the way that gay community events are presented in time, is that they are just a shining star that just kind of goes away as soon as it's over, because there's not a continuous momentum that builds up after the event. It's like you peak and then you go back down, and then you peak again when there's a next event and then you just go back down. It's like, "Okay, when's the next event? When's the next time I get to see gay people? When's the next time I get to feel like a real person?"

Themes	Illustrative Quotes
Need increased and improved outreach and information	County needs a central number for LGBTQ+ people to call or text for resources that's really well advertised. Because I think people are just out there going, “I don't know who to call or where to reach out to.”
Expanded or new services	A suicide prevention hotline that accepts texts. The county really needs to have a DBT group for people. Maybe a lot of you don't know what that is. It's a kind of therapy that's very, very helpful for people in a lot of mental distress and emotional strain. I can't believe that the county does not offer any DBT groups. Need a community center. I think that's a huge gap in our local community. There's not a place that everyone can just find on the internet and be like, “Oh, that's the place to go to where I hook up with you know, all the resources I need.”
More sensitive, prepared providers	I used to call the phone line a lot when I was like, 18-17, just bawling my eyes out. To me it was like the people on the other end of the call just weren't readily equipped to address the issues that I was coming forward with. It was just kind of like, “Oh, yeah, like just stay on the line,” –kind of a guilt trippy kind of “stay on the line” thing. Need to have more people better equipped to like deal with our mental health needs. And unbiased workers who will listen first, try to piece together what happened later. Hopefully there's some kind of sensitivity training for the people that work in these places to make sure they're unbiased. Make sure when they see patients, they are presumed honest until proven dishonest. “You are lying,” should never be the first thought.
Stigma and discrimination	Whether it has to do with mental health stigma or being part of our [LGBTQIA+] group stigma. I think that if our local institutions including Sonoma County governments, Santa Rosa city governments, if we could get lots more really public statements in support, and, you know, “Here's what we think about all these laws that are being passed.” That would be super helpful to people's mental health. So much of our mental health in this community comes from social acceptance and non-acceptance, right? So I think a huge factor in our mental health comes from general social advocacy for laws, protection, rights, and education of cis people and het people–however that can happen. I just don't want that to get lost, because even though it seems separate, our mental health depends so much on advocacy and activism.
Increased stressors	There's a lot more storms, a lot more droughts. The storms last so much longer. Fires, snows, hails. It's more concentrated every time a really bad thing happens in the weather. I believe that the need for support is increased especially because of all of the anti-trans bills that have started ramping up like this year and this past year, there's been something like there's been a couple hundred across the country, and that really weighs on the community. The shift from COVID out of COVID has been difficult for individuals. It just has this kind of unique flavor of people almost forget how to socialize and how to be in community and it ends up kind of a little stressful, so I've noticed that in the past year as people have started to kind of emerge. Eight of 13 people here have lost someone they cared about to COVID or know somebody or are somebody who has had serious physical health effects or mental health effects from COVID.
Need for improved access to services	I sort of hate to say it, but I typically find this support when I get 5150ed, which is not a great way to find your support. And, when that happens, yeah, then people reach out to me. Maybe. Or maybe not. But it'd be nice to get more support before I get to that very, very, very low place. Sometimes have to be very, very desperate before you get any help.

Themes	Illustrative Quotes
	Once you're not poor anymore, the state will stop helping you with a lot of vital services that if you tried to pay for it by yourself, it'd be thousands upon thousands of dollars. So they would take your money, make you poor again, and then you qualify again or something. Barriers to care include lack of low-fee and competent therapists, and not having LGBTQ-friendly and safe transitional housing.
Housing and homelessness	I think a lot of people who get overlooked are people from the homeless community here too in Sonoma County. Especially like within the gay homeless community. I feel like a lot of the resources available are only available to you if you have the funds to spend on them. And that is really hard to come by if you are homeless. I think there is just like a very harsh stigma with like trying to address the needs of like homeless gay youth here in Sonoma County too.
Physical activity as mental health	If I won the lottery, I would open a gym for people with mental health issues. I've found when I have gotten exercise, it helps, but it's hard to always motivate myself to get there. I think it's easier if you're part of a gym because then you get more support, you know, than if you're just like, "Okay, I'm gonna go for a walk." I'd open a gym and then I'd have bus rides to get people to and from the gym.
Depression and suicidal ideation	As seen through suicidal ideation, anxiety, depression, the list goes on. A lot of the people that I've encountered within the gay community are very strong, silent sufferers with a mental health until they get to that breaking point of like, "Do I live? or–" making the choice of like, "do I live or do I want to kill myself?" No matter how well put together you think someone is, it's like "Whoops." It's like a dominoes effect. It just crumbles. I don't know. It's tough.

Older Adults (West County)

Themes	Illustrative Quotes
Increased loneliness and isolation	Social isolation leads to loneliness and are triggers for mental health crises.
Negative influence of social media	Harder and harder to determine what's true in social media and news, constant overload and misinformation. Hits older adults and isolated people even harder. Causes secondary trauma and stress.
Complex trauma	COVID; difficult political climate and divisions; increased isolation; witnessing deaths from disease, fires, floods; increased intolerance and polarization compound the individual traumas.
Housing crisis and homelessness	Fires increased existing housing crisis and homelessness. Being unhoused (not getting basic needs met) can lead to mental health problems and vice versa. Unhoused need more services. Need more stable, affordable housing.
Problems with accessing services	Barriers to accessing needed services include location, lack of transportation, costs, limited hours, lack of availability/waiting lists. Need more insurance accepted at clinics and more free services. Lower Russian River area is unique and needs services located here. Need phone support to know where to go for help.
Need for more sensitive providers	Some providers or organization staff don't seem sincerely interested, like they're just doing their jobs. Can feel intimidating, dismissive, or condescending. Makes it hard for people already having a hard time asking for help. Need providers to be nonjudgmental, authentically interested in me and my story.
Patient education and advocacy	People need to learn how to shop for a therapist, and to prepare for and to build resilience for the therapy process. Need to be encouraged and taught

Themes	Illustrative Quotes
	how to provide feedback about services provided and have it validated. Need advocates, because not everyone has the ability or confidence to advocate for themselves.
Formal and informal peer support	Support groups are powerful; help me and let me help others; shared vulnerability. Can find support in the community, talking to friends, to store clerks, anyone that I have an authentic relationship with. Need more qualified peer support specialists.

Sonoma County MENTAL HEALTH SERVICES ACT Newsletter

SEPTEMBER 2022 | 50TH EDITION

September is SUICIDE PREVENTION MONTH

Thriving at All Ages

People of all ages benefit from some common tenets of wellness, but the specific ways that wellness and resilience are supported change through the life span. Building resiliency is important at all ages, and strategies can be tailored depending on what is enjoyable or accessible depending on your age. Throughout our communities many people are continuing to experience mental health challenges, trauma, burn-out and fatigue due to the prolonged impacts of the pandemic and natural disasters. To support Thriving At All Ages, Californians are encouraged to take action for suicide prevention by recognizing the importance of strengthening resiliency, protective factors, and physical and emotional wellness throughout the lifespan and at different life stages.

Effective strategies for suicide prevention must address the strengths, circumstances, and challenges of the different phases of life. Resiliency can be built at any age with attention to some common protective factors that promote wellness and are necessary to thrive:

- **Strong social support networks** where people can talk through their problems and feelings, ask for help and offer help and support to others.
- **Good physical health**, and when complications occur, finding the right health regimen to promote recovery and support wellness.
- **Access to primary care services** to promote health and catch problems early. Primary care is where many people go for wide variety of concerns and is a key setting for connecting people to appropriate services and supports.
- **Access to effective behavioral health care** reduces the risk and severity of illness and supports recovery. Counseling can help strengthen strategies for problem-solving and coping with stress.
- **Meaning and purpose** can be found in a variety of ways, but their sources often shift throughout life. Meaning and purpose can be found through work or hobbies, family life, learning and studying, and religion and spirituality. Meaning and purpose can also be found through helping others by volunteering and supporting important causes.
- **Self-care** is not a luxury; it is a necessity. Self-care is too often neglected, especially when other demands seem more pressing, or when changes limit access to what once worked for wellness. Many steps to self-care are simple, free, and can be done anywhere, even with only a few minutes of time.

"We need to find meaning and build a life worth living on a daily basis no matter what age we are."
- Julie Phillips, Professor of Sociology, Rutgers University

- **Attitudes about aging** have a significant impact on wellness, especially in later years. It is possible for people of all ages to thrive. Viewing aging as a developmental stage, with its own unique opportunities for growth, allows room for adaptation to life's changes and reasons for hope.

We all have a role to play in suicide prevention. Take action to support yourself and those around you by visiting **www.takeaction4MH.com** for more information.

Learn about the signs for suicide, finding the words to check-in with someone we are concerned about, and reaching out to resources. Visit **www.suicideispreventable.org** for more information.

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

Be a Part of Our Suicide Prevention Efforts!

Join Sonoma County's Suicide Prevention & Awareness Efforts!
Sonoma County Board of Supervisors adopted a gold resolution proclaiming the month of September 2022 as Suicide Prevention Month in Sonoma County. The following efforts to prevent suicide are scheduled for Suicide Prevention Month:

- **September 6th** 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 Nicolen@buckelew.org or call 707-494-0762 to participate.
- **September 14th** 8:30am - 5:00pm
  - **Assessing and Managing Suicide Risk (AMSR)** - a free workshop for behavioral health professionals on assessing suicide risk, planning treatment, and managing the ongoing care of the at-risk client. Clinicians can earn 6.5 CEs and this training meets the BBS suicide assessment training requirements. This is an in-person only event. Click HERE for flyer with registration information.
- **September 14th & 28th** 7:00 pm - 8:30 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 or call: 415-492-0614 for more information.
- **September 21st** 12:30pm - 2:30pm
  - **Be Sensitive, Be Brave for Suicide Prevention Webinar** - infuses culture and diversity throughout a foundational workshop in suicide prevention. The workshop teaches community members to act as eyes and ears for suicidal distress and to help connect individuals with appropriate services. Click HERE to register.
- **September 29th** 4:00pm - 6:30pm, Finley Center
  - **"The S Word" Film Screening & Panel Discussion** - Join Sonoma County's Behavioral Health Division in partnership with Buckelew for a free in-person and virtual screening of "The S Word" documentary film. "THE S WORD" is a powerful feature documentary that puts a human face on suicide, a topic that has long been stigmatized and buried with the lives it has claimed. A panel discussion with resources will be available after the film. Click HERE for flyer.

New 988 - There is hope!

If you or someone you know is having thoughts of suicide or experiencing a mental health or substance use crisis, 988 provides **24/7 connection to confidential support**. There is Hope. **Just call or text 988 or chat 988lifeline.org**

Sonoma County Warmly Welcomes New Director!

Sonoma County welcomed Dr. Jan Cobaleda-Kegler as Department of Health Services Behavioral Health Division (DHS-BHD) Director in May! We are very pleased to have Dr. Cobaleda-Kegler onboard as she brings forty-six years of experience working in Behavioral Health treatment as an administrator, clinical supervisor, and provider committed to developing and providing services that are accessible, supportive, effective, and compassionate. She has worked with children, youth, adults, and families across a broad spectrum of community-based behavioral health treatment settings.

Prior to joining DHS-BHD, Dr. Cobaleda-Kegler served as Mental Health Program Chief for Contra Costa County Adult and Older Adult Behavioral Health Services where she dedicated herself to promoting the recovery and wellness of vulnerable adults and their families and to implementing numerous system improvements in an effort to improve the quality of care provided to clients. She also served as Program Manager in Contra Costa Children's System of Care, where she distinguished herself by developing and implementing training for staff across the division in Evidence Based Practices in the treatment of trauma, depression, co-occurring disorders, eating disorders, animal assisted therapy, and anxiety.

Peer Support Certification Scholarships Available!

Medi-Cal Peer Support Specialist certification is here! The Department of Health Care Services (DHCS) is offering scholarship opportunities, through CalMHSA, for peers who want to seek certification as Medi-Cal Peer Support Specialists. Sonoma County is now collecting names for local peers who want to apply for scholarships for certification. The scholarships cover the cost of the application, training, and exam. While individuals may apply on their own for certification, DHCS/CalMHSA scholarships are available only through this process.

To meet DHCS's definition of a peer, the individual must "self-identify as having experience with the process of recovery from mental illness or substance use disorder, either as a consumer of these services or as the parent, caregiver, or family member of a consumer" and must "be willing to share one's experience as a person with lived experience and recovery to help others." To meet certification requirements, the peer must also be at least 18 years old; have a high-school diploma, GED, or college degree; agree to adhere to the Medi-Cal Code of Ethics for Peer Support Specialists; and pass the state exam.

CalMHSA's Medi-Cal Peer Support Specialist Certification website has more background on California's work on peer certification and details about the scholarships.

If you live, work, or volunteer in Sonoma County and you want to apply for a certification scholarship, please contact Lisa Nosal at lisa.nosal@sonoma-county.org for information. The deadline for applying for a scholarship is September 16, 2022, and peers who are awarded scholarships must register for the exam by November 30, 2022.

Sonoma County MENTAL HEALTH SERVICES ACT Newsletter

DECEMBER 2022 | 51ST EDITION

Happy Holidays from Sonoma County's Behavioral Health Division!

REACH OUT FOR SUPPORT WITH MENTAL HEALTH DURING THE HOLIDAYS!

This season can be a joyful time of cozy get-togethers and generosity. It can also be a difficult time for people experiencing isolation, grief and loss, or those who live with anxiety or depression. Social and family expectations can also cause extra stresses and triggers.

How will you decide it's time to reach out? Consider first checking in with yourself to know if you're experiencing some or all of these signs of distress:

- Feeling sad, hopeless, or helpless
- Becoming anxious, worried, or overwhelmed all the time
- Being unable to focus on work or school
- Acting extremely moody or irritable
- Withdrawing from friends and activities
- Having difficulty coping with daily problems or stress
- Using more alcohol or drugs than usual or more often
- Drastically changing eating or sleeping patterns

If you're experiencing these, or similar signs, you are not alone. Learn more about identifying when you may need more mental health support. To take action for your own mental wellness, you can reach out to trusted friends, family, and other supportive people in your life. You can also call 988 or learn about

Here are some tips to help with winter blues:

Whatever you're feeling this season, it's important to check in on your mental health and the mental health of people around you.

Learn how to practice holiday self-care, and find support and resources for yourself and others, at TakeAction4MH.com.

If you or someone you know are depressed or thinking about suicide, **call or text the 988 Suicide & Crisis Lifeline or chat with CalHOPE Connect at CalHOPEConnect.org.**

MHSA CONTRACTOR SPOTLIGHT: LA LUZ CENTER

La Luz Center has been helping immigrants and families in the Sonoma Valley since 1985 when Ligia Booker, a Colombian philanthropist, learned that the families of vineyard workers had basic unmet needs like language skills and access to food, clothing and housing; assistance with medical, legal and financial issues presented more complicated, longer term challenges.

La Luz Center has grown and continues to develop new programs and resources to ensure residents in Sonoma Valley can improve their lives and strengthen their families by providing easily accessible services, effective programs, and culturally relevant mental health services.
Continued on page 2.

Take Action for Mental Health:

1. Exercise
2. Look for ways to enjoy social connections
3. Stick to a Sleep Routine
4. Queue Up a Stream of Laugh-Out-Loud Films
5. Warm Yourself Up With a Mug of Real Hot Cocoa
6. Give Yourself a Manageable Task to Accomplish
7. Find time for yourself
8. Don't Hesitate to See Your Healthcare Professional

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

CONTINUED FROM PAGE 1 – LA LUZ CENTER

In 2021 a contract was executed with La Luz and the County of Sonoma to provide MHSA Prevention and Early Intervention (PEI) services. PEI funds, "Your Community, Your Health/Tu Comunidad, Tu Salud" which helps address the mental health needs of the Sonoma Valley Latinx community providing no-cost culturally and linguistically competent health and wellness services.

One of the popular services available under MHSA at La Luz Center are Zumba classes which is not only a great whole body workout, but is also a stress reducer, builds confidence, and it's also a good way to meet others and build connections which is known to improve mental health.

To learn more about La Luz Center please visit: www.laluzcenter.org or call: 707- 938-5131

Looking for a mental health support group in Sonoma County? Housing resources? Other local resources? **Check out NAMI Sonoma County's Resource Directory HERE**. You are not alone, reach out for help!

Ways to learn more & get involved!

MHSA Stakeholder Committee

You are invited to 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. This meeting provides MHSA updates and current events and an opportunity to share your thoughts and ideas related to MHSA.

WHEN: Thursday, February 16, 2022
1:00pm - 3:00pm
WHERE: Zoom

To attend, please email MHSA@sonoma-county.org for Zoom link.

Sonoma County's Mental Health Board

You are also invited to attend Sonoma County's Mental Health Board meeting. This an advisory board empowered to listen to the concerns of our constituents and to help formulate policies that offer a consistent continuum of care for all those with mental health challenges. The Board advises the County Board of Supervisors on the Mental Health System of Care.

For date, time, and location of the next board meeting please visit the webpage HERE.

MHSA Winter Word Search

Find the word in the puzzle. Words can go in any direction. Words can share letters as they cross over each other.

W	E	L	L	N	E	S	S	Q	S	R	E	X	Q	C
I	Z	S	J	K	M	O	Q	C	S	D	P	M	E	O
N	D	H	G	E	S	N	L	R	E	A	C	R	S	M
T	Q	E	N	E	U	O	F	E	N	D	D	W	N	M
E	W	T	L	S	P	M	N	F	D	Z	S	X	O	U
R	A	F	N	E	P	A	O	Z	N	C	X	F	I	N
L	A	B	I	R	O	D	I	H	I	X	A	E	T	I
X	J	A	Q	V	R	Q	T	A	K	E	S	R	N	T
I	S	S	N	I	T	Y	A	C	T	I	O	N	E	Y
H	O	P	E	C	P	M	V	M	A	Y	L	V	V	V
Z	T	J	U	E	H	N	O	K	I	J	K	B	R	L
J	C	L	C	S	H	K	N	T	G	T	F	Z	E	D
T	Z	R	A	V	G	C	N	M	G	V	W	H	T	A
P	R	E	V	E	N	T	I	O	N	G	A	E	N	R
A	J	W	P	I	H	E	X	U	D	U	C	U	I	F

Action
Care
Community
Health
Hope
Innovation
Intervention
Kindness
Mental
MHSA
Prevention
Self
Services
Sonoma
Support
Take
Wellness
Winter

Sonoma County MENTAL HEALTH SERVICES ACT Newsletter

MAY 2023 | 52ND EDITION

May is Mental Health Matters Month!

Safe Spaces for Mental Health

Take a moment to consider your surroundings. Do you feel safe? Do you have access to health care and grocery stores? Does your home support you, both physically and mentally?

This Mental Health Matters Month, challenge yourself to look at your world and how different factors can affect your mental health.

Where a person is born, lives, learns, works, plays, and gathers, as well as their economic stability and social connections, are part of what is called "social determinants of health" (SDOH). The more these factors work in your favor means you are more likely to have better mental well-being. However, when it seems like the world is working against you, your mental health can suffer.

There are steps you can take to change your space and protect your well-being.

- **Work toward securing safe and stable housing**: This can be challenging, but there are a few things you can try, such as reaching out to state/local agencies to secure housing, removing safety hazards in the home, or finding another space (such as a community center or friend's home) where you can get the comfort you are missing at home.
- **Focus on your home**: Consider keeping your space tidy, sleep-friendly, and well-ventilated. Surround yourself with items that help you feel calm and positive.
- **Create bonds with your neighborhood and community**: Get to know the people living around you, join or start neighbors-helping-neighbors groups, and support local businesses to challenge gentrification.
- **Connect with nature**: Hike in a forest, sit in a city park, bring a plant inside, or keep the shades open to absorb natural light.

If you're taking steps to improve your surroundings but are still struggling with your mental health, you may be experiencing signs of a mental health condition. Take a free, private screening at mhascreening.org to help you figure out what is going on and determine next steps.

You can also call, text or chat 988 to reach trained crisis counselors who can help people experiencing suicidal, substance use, and/or mental health crisis. People can also dial 988 if they are worried about a loved one who may need crisis support.

MHSA Contractor Spotlight: LSP Youth Promotores

The LSP Promotores Program is an exciting opportunity for young people to make a difference in their community while learning valuable skills and gaining experience. This program is designed to empower youth to become leaders in their community by promoting mental health awareness, emergency preparedness, housing advocacy, and environmental education.

One of the key focuses of the LSP Promotores Program is mental health. Mental health challenges are a pandemic on their own, especially within the Latino community. The stigma surrounding mental health can prevent individuals from seeking help and support. The Promotores Program aims to de-stigmatize mental health and increase awareness of mental health resources in the Latino community. Youth promotores work on projects such as self-care, suicide prevention, teen dating violence, and substance abuse, among other important topics.

Another track in the Promotores Program is Promotores Preparados, which focuses on emergency preparedness. This track is intended to inform the Latino community on the importance of being prepared for emergencies by creating culturally and linguistically appropriate educational materials and leading discussions around emergency preparedness. The goal is to increase community resilience and improve mental health outcomes after a disaster.

Promotores de vivienda is another track in the program, which focuses on housing advocacy. Youth promotores work on projects related to housing, city planning, and civic engagement.

Continued on page 2.

If you or someone you know needs support now, call or text **988** or chat **988lifeline.org**

988 SUICIDE & CRISIS LIFELINE

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

LSP Youth Promotores (Cont'd from page 1)

The goal is to increase civic participation of the Latino community in housing policy and inform the community of the intersection between these issues and mental health wellbeing.

Lastly, Promotores verdes is a track focused on environmental education and climate science resources. Youth promotores work towards raising awareness about climate change and mental health wellbeing, with the goal of increasing the number of Latino community members who take proactive steps to address it.

The LSP Promotores Program is a fantastic opportunity for young people to get involved in their community and make a difference. By joining the program, youth are not only gaining valuable skills and experience, but also working towards overcoming stigma surrounding mental health and educating their community on important topics such as emergency preparedness, housing advocacy, and climate change.

Benjamin Rosel, a 22-year-old youth promotor, is a shining example of the positive impact that the LSP Promotores Program can have on young people. Through the program, he was able to guide virtual sessions on mental health during the pandemic and create self-care kits for those struggling in isolation. He shared his personal struggles with mental health after his mother's cancer diagnosis in 2016, and he was determined to make a difference in the Latino community's understanding and acceptance of mental health. Through the program, he discovered his passion for psychology and now works for a local nonprofit. The LSP Promotores Program is funded by the CA Department of Public Health and the Sonoma County DHS-BHD Mental Health Services Act (MHSA).

Become a leader in your community, join the LSP Promotores program today! Visit: https://latinoserviceproviders.org/youth-promotores/ to learn more about this fantastic opportunity and make a positive impact on people's lives.

Sonoma County's MHSA Three Year Update & Report!

Read Sonoma County's MHSA Plan Update for FY 2023-2026 and Program Report for FY 2021-2022, which will be posted soon on the DHS-BHD website HERE.

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. There will be two public hearings hosted by Sonoma County's Mental Health Board on May 16, 2023 at 5pm and another on June 20, 2023 at 5pm.

For more details on how to attend the Mental Health Board Meetings click HERE.

CELEBRATE MENTAL HEALTH MONTH !

May is Mental Health Matters Month, a time for Sonoma County to collectively raise awareness about mental health and wellness. We've put together a community calendar of events, activities and trainings to encourage people to **check in** virtually or in-person, **learn more** about mental health and the resources, and **get support** for yourself or others.

Click HERE or scan to access Sonoma County's May 2023 Mental Health Matters Month Community Calendar.

Modernizing Our Behavioral Health System

The Mental Health Services Act (MHSA) has fundamentally changed how we deliver mental health care in California. For those with the most serious and persistent needs, the MHSA requires every county in the state to offer a core set of services through a program called Full-Service Partnerships (FSP) that today helps provide wraparound services and the least restrictive level of care with access to peer providers and community services. Today over 80,000 Californians are enrolled in FSP programs.

Today, MHSA funds 30% of the state's mental health system. But the MHSA has never undergone full scale reform. Since its initial passing in 2004, the Affordable Care Act and parity laws have significantly shifted the landscape and the governor sees this as the time to modernize MHSA to account for expanded coverage under Medi-Cal. Governor Newsom's proposed reforms include:

1. **Require counties to dedicate 30% (roughly $1 billion annually) to pay for housing and other community-based residential solutions** to provide an ongoing source of funding for new and existing housing and residential settings that are responsive to the diverse needs across the state.
2. **Focus funding on Full-Service Partnerships and other services for the most seriously ill**, prioritizing community services and supports while including prevention and early intervention and infrastructure investments such as for capital and workforce.
3. **Require counties to bill Medi-Cal for all reimbursable services** in accordance with Medicaid State Plan and applicable waivers, to further stretch scarce dollars and leverage MHSA to maximize federal funding for services.
4. **Include those with substance use disorders** who can be served by MHSA funding, broadening the target population to include more people who need support.
5. **Improve county accountability and increase transparency** updating the Three-Year County Plan requiring counties to create comprehensive behavioral health plans, and move the Mental Health Services Act Oversight and Accountability Commission under the California Health & Human Services Agency, to increase coordination and outcomes.

For questions and inquiries regarding Newsom's proposal, please email BehavioralHealthTaskForce@chhs.ca.gov.

Sonoma County
MENTAL HEALTH SERVICES ACT
Newsletter

SEPTEMBER 2023 | 53RD EDITION

September is SUICIDE PREVENTION MONTH

Suicide Prevention is Everyone's Business

Most of us have been touched by the tragedy of suicide. We may have lost someone close to us or been moved by the loss of someone we may have never met. When a suicide happens, those left behind often experience deep shock. Even if they knew the person was struggling, they may not have expected suicide would be the result. However, many people who find themselves in a suicide crisis can and do recover. We all have a role to play in suicide prevention. There are actions you can take right now to support yourself and those around you:

- **Know the Signs:** Most people who are considering suicide show some warning signs or signals of their intentions. Learn to recognize these warning signs and how to respond to them by visiting the Know the Signs web site (www.suicideispreventable.org).
- **Find the Words:** If you are concerned about someone, ask them directly if they are thinking about suicide. This can be difficult to do, but being direct provides an opportunity for them to open up and talk about their distress and will not suggest the idea to them if they aren't already thinking about it. The "Find the Words" section of the Know the Signs web site (www.suicideispreventable.org) suggests ways to start the conversation.
- **Reach Out:** You are not alone in this. Before having the conversation, become familiar with some resources to offer to the person you are concerned about. Visit the Reach Out section of the Know the Signs web site (www.suicideispreventable.org) to identify where you can find help for your friend or loved one.

The Know the Signs campaign is one of several statewide initiatives funded by counties through the voter-approved Mental Health Services Act (Prop 63). These efforts are administered by the California Mental Health Services Authority (CalMHSA) and are part of the Take Action for Mental Health Campaign.

Prevention Works. Many people who feel suicidal don't want to die. If they can get through the crisis, treatment works. There are programs and practices that have been specifically developed to support those who are in a suicide crisis. The Suicide Prevention Resource Center hosts a registry of 160 programs, practices and resources for suicide prevention. You can learn more about them by visiting https://sprc.org/

Help is available

The Suicide Prevention Lifeline (1-800-273-8255- TALK) or 988 (call, text or chat) offers 24/7 free and confidential assistance from trained counselors. Callers are connected to the nearest available crisis center. The Lifeline is also available in Spanish, and for veterans or for those concerned about a veteran, by selecting a prompt to be connected to counselors specifically trained to support veterans.

To find local services and supports, visit the Reach Out section of the Know the Signs resources page where you will find California statewide and national resources as well as links to resources in your county: www.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 Events in September

Check out the community events, trainings, support groups and more happening this September in Sonoma County for suicide prevention awareness month!

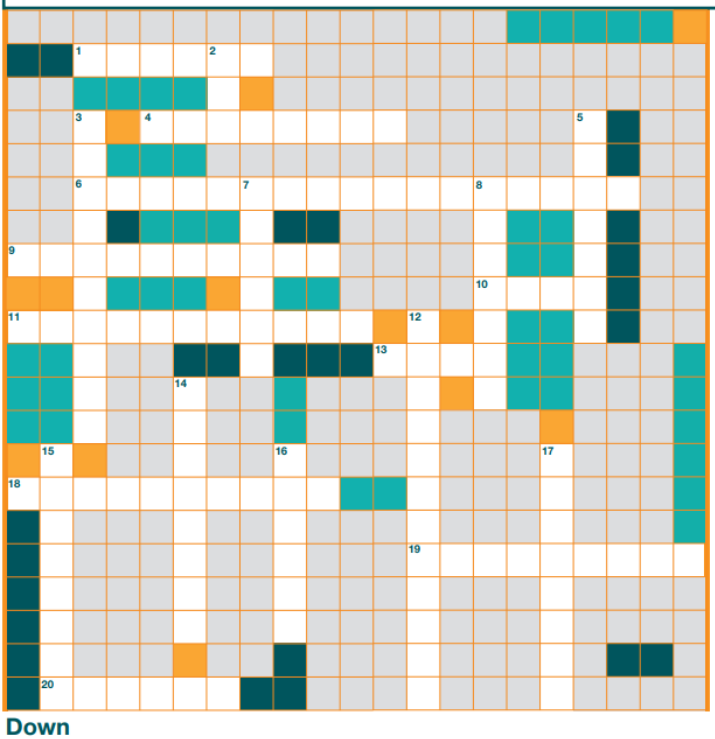
We've put together a list of the events HERE.

Join us on Sunday, September 10th for suicide prevention awareness day at Santa Rosa's Old Courthouse Square. Connect with others through art, mindfulness activities, words of affirmation and local community resources. Click HERE for flyer in English. Click HERE for flyer in Spanish.

Sonoma County's MHSA Three-Year Plan for FY 2023-2026 has been updated and is available on the DHS-BHD website HERE.

Know the Signs. Find the Words. Reach Out.

Crossword Puzzle



Across

1. The skills and strategies that children and youth gain through ___-emotional learning can increase protective factors and decrease risk factors associated with suicide
4. Conscious act one takes in order to promote their own physical, mental, and emotional health
6. Personal or environmental characteristics that help protect people from suicide
9. Promoting connectedness and teaching coping and problem-solving skills are ___ strategies
10. ___ isn't always obvious
11. If you are concerned about someone, giving away ___ is a warning sign to look for
13. Securely storing prescription medications and firearms can help keep a person ___
18. Warning sign characterized by the act of not wanting to communicate or be around other people
19. Suicide Prevention Week is in this month
20. Changes in ___ and sleeping patterns are warning signs for suicide

Down

2. We can ___ prevent suicide
3. ____ is not a necessary part of aging
5. Talking about feeling hopeless or having no reason to live is a _____ sign
7. Before starting a conversation with someone you are concerned about have a list of ___ resources
8. The causes of suicide are ___
12. Indications that someone may be in danger of suicide, either immediately or in the near future
14. Asking someone about suicide does not ___ the likelihood of suicide
15. The national suicide prevention ____ is a 24/7 toll-free, confidential hotline available to anyone in suicidal crisis or emotional distress
16. Being connected to ___ and community support can decrease suicidal thoughts and behaviors
17. If you are concerned about someone, always ask ___ about suicide

Find the Answer Key at suicideispreventable.org.

Sonoma County Launches New Innovative Residential Housing Program!

DHS-BHD is excited to announce the launch of MHSA's Innovation Project: Crossroads to Hope (C2H)! C2H will help individuals with justice involved backgrounds and a mental health illness to build a supportive network, gain healthy life skills, get connected to community resources, and establish long-term stable housing.

C2H's transitional housing program opened its doors in July 2023. This peer-led and client centered program will provide 24/7 support. Felton Institute works collaboratively with DHS-BHD as the contracted peer service provider offering onsite case management services and programming for up to six months.

Click HERE to read Crossroads to Hope's Innovation Proposal.

A Life Worth Living – Sonoma County's New Suicide Prevention Alliance

A group of dedicated mental health leaders and community representatives in Sonoma County have formed a new alliance with a mission to work collaboratively to create a community where anyone impacted by suicide is supported when and where they need it. According to the California Department of Public Health report, Sonoma County's three-year average age-adjusted suicide death rate for 2020 through 2022 was 38% higher than the average rate in California. The Alliance's vision to co-create a life worth living, helping one another safely navigate crises, and find support when needed, hopes to reduce Sonoma County's suicide rate.

The goals of this new alliance are to:

- Connect, collaborate, and build relationships
- Draft and circulate Sonoma County's Suicide Prevention Strategic Plan
- Identify needs and available resources in our community
- Implement strategic plan goals, objectives, and activities, in partnership with community and service providers
- Engage community members, stakeholders, and partners in planning and taking action

To learn more about A Life Worth Living: Suicide Prevention Alliance or to get involved email Melissa.Ladrech@sonoma-county.org.

MHSA Community Program Planning: Listening Sessions Report

Sonoma County's MHSA Community Program Planning Workgroup helped organize listening sessions with diverse communities experiencing mental health inequities. The listening sessions were co-facilitated by our consultant, Dory Escobar and trained community leaders to engage communities in important conversations. The findings and summary report will be presented on September 12, 2023 from 2pm to 4pm via Zoom and you are invited to attend! Email MHSA@sonoma-county.org for Zoom link.

Community Events for May 2023 - Mental Health Matters Month

Action Network's Community Clothing Rack and Children's Clothing Drive
May 1st – May 31st, 2023 (Monday – Friday, 10am – 4pm)
LOCATION: 200 Main Street Point Arena, CA, 95468
Action Network will be hosting a Community Clothing Rack and children's clothing drive throughout May.
For more information please call 707-882-1691 or email info@actionnetwork.info

Community Mental Health Forum presented by Supervisors + Department of Health Services
Tuesday, May 2nd, 2023
TIME: 9:00am-3:00pm
LOCATION: Finley Community Center - 2060 West College Avenue in Santa Rosa
REGISTRATION LINK: https://www.eventbrite.com/e/community-forum-on-mental-health-tickets-598602495177
A community conversation discussing crisis services, suicide prevention, substance use disorder treatment services, & workforce development.

Interlink Self-Help Center Event
Tuesday, May 2nd, 2023
TIME: 11:30am-1:30pm
LOCATION: 1033 4th St, Santa Rosa, CA 95404
Tie Dye Event, for more information call: (707) 546-4481

SRJC's Mental Health Pop-Up Event in Petaluma
Tuesday, May 2, 2023
TIME: 12pm -2pm
LOCATION: SRJC in Petaluma-At the Farmers Market next to the Student Engagement/Success Center
Silent zen-zone and other un activities for SRJC students.
For more information visit www.shs.santarosa.edu

SRJC's Mental Health Pop-Up Event in Santa Rosa
Wednesday, May 3, 2023
TIME: 11am- 1pm
LOCATION: Bertolini Quad
Silent zen-zone and other un activities for SRJC students.
For more information visit www.shs.santarosa.edu

Free Suicide Prevention: QPR Community Gatekeeper Training
Wednesday, May 3rd, 2023
TIME: 1:30-3:00pm
LOCATION: SCOE - 5340 Skylane Boulevard, Santa Rosa, CA 95403)
REGISTER: http://bit.ly/QPR_SCOE

"The Wisdom of Trauma" Film Screening & Panel Discussion
Thursday, May 4th, 2023
TIME: 1:00pm-4:30pm
LOCATION: Glaser Center
Representatives from many organizations will provide information & resource for local wellness-oriented services. At 2pm we will be hosting a screening of Garbor Mates film "The Wisdom of Trauma, which will then be followed by a panel discussion. This event is free and open to the public.
For more information please contact Micheal Reynolds Peer Programs Coordinator: 707-889-1901 or michael.reynolds@westcountyservices.org.

SCBH Family Education & Support Group
Monday, May 8th, 2023
LOCATION: Zoom
Monthly support group to increase understanding of nature of mental illness.
CONTACT: Buckelew's FSC Team at 707-494-0762 or NicoleN@Buckelew.org for Zoom link.

Potluck Gathering for those who serve our community
Tuesday, May 9th, 2023
TIME: 3:00pm-6:00pm
LOCATION: RSVP to Kiahna Bell KiahnaB@buckelew.org or 707-780-7236
Food gathering & short presentation by Susan Standen on the benefits of using recovery-oriented language in our work. Includes a small-group "thought exercise" as a discussion topic to help us learn ways to think about and re-phrase common medical-model statements.

Screening of "Crooked Beauty" at Interlink Self-Help Center
Wednesday,May 10th, 2023
TIME: 12:00pm-1:00pm
LOCATION: 1033 4th St, Santa Rosa, CA 95404
Join us for a screening of "Crooked Beauty." For more information please call (707) 546-4481.

Cannabis and Adolescent Well-Being: A Conversation for Families

Wednesday, May 10th, 2023
TIME: 4:00pm-5:30pm
LOCATION: Zoom
An organization dedicated to serving as the national leader in cannabis use prevention for young people.
For more information or for the Zoom link contact Kiahna Bell at 707-780-7236 or KiahnaB@buckelew.org

SOS: Allies for Hope

Wednesday, May 10th, 2023
TIME: 7:00pm-8:30pm
LOCATION: Zoom for zoom link contact SOSinfo@Buckelew.org
Monthly peer-to-peer group, we share strategies and skills for coping with the complex issues surrounding the loss. Introduction by Buckelew Programs, presented by Richard Von Feld, PsyD of Panaptic, an organization dedicated to serving as the national leader in cannabis use prevention for young people."

Petaluma Education and Support Groups

Thursday, May 11th, 2023
TIME: 4:00pm-5:30pm
LOCATION: Zoom, contact NicoleN@Buckelew.org for zoom link
A monthly education and support group to increase understanding of the nature of mental illness

Bike4Buckelew: Access to Mental Healthcare for All

Saturday, May 13, 2023
TIME: 8:00am-2:00pm
LOCATION: Miwok Meadows, China Camp State Park
Festivities will include organized mountain bike trail rides and guided hikes for every level, followed by a party in the woods with fabulous food, live entertainment and more. Fun for all ages!
REGISTER: https://buckelew.salsalabs.org/bike4buckelew2023/index.html

Inspiration Through Empathy

Monday, May 15th, 2023
TIME: 9:30am-11:30am
LOCATION: Zoom, contact Kiahna BellKiahnaB@buckelew.org for zoom link
A Recovery-Model approach to burnout, compassion fatigue, and increasing mental health needs in our community.

Wellness & Advocacy Center

Wednesday, May 17th, 2023
TIME: 1:00pm-3:00pm
LOCATION: 2245 Challenger Way #104, Santa Rosa, CA 95407
Mental Health Toolbox- Sharing different tools we have acquired that help us in everyday life.
For more information call 707-565-7800

Interlink Self-Help Center Event

Wednesday, May 17th, 2023
TIME: 1:00pm-2:00pm
LOCATION: 1033 4th St, Santa Rosa, CA 95404
Writing Group: Reflections on Recovery. For more information please call (707) 546-4481

Latino Service Provider's Monthly Meeting held by Youth Promotores

Thursday, May 18th, 2023
TIME: 12:00pm-1:30pm
LOCATION: 1000 Apollo Way, Santa Rosa, CA 95407
Join us to learn about LSP's Youth Promotores program, an opportunity to network and get connected to other resources.
CONTACT: Alayza Cervates: acervantes@latinoserviceproviders.org

Stomp the Stigma

Saturday, May 20th, 2023
TIME: 12:00pm-4:30pm
LOCATION: Santa Rosa Fairgrounds
Join LSP's Youth Promotores for their 4th annual event to promote mental health awareness and resources available to students in Sonoma County. Free live music, dance, workshops, food and community.
CONTACT: Alayza Cervates acervantes@latinoserviceproviders.org for more information

Community Baptist Church Collaborative Mental Health Conference

Saturday, May 20th, 2023
TIME: 11:00am-1:00pm
LOCATION: Community Baptist Church – 1620 Sonoma Ave., Santa Rosa, CA 95405
The Community Baptist Collaborative is hosting their 7th annual Mental Health Conference featuring Devonderia Sanchez LMFT, who will discuss "Mental Health and the African American Community."
Please RSVP by email to Honor Jackson: honorjackson1121@comcast.net

Petaluma Peer Recovery Center's Events
Monday, May 22nd, 2023
TIME: 11:30am-12:30pm
LOCATION: 5350 Old Redwood Hwy N #600, Petaluma, CA 94954
MH Month Bingo w/ Prizes for more information please call (707) 565-1299

Interlink Self-Help Center Event
Wednesday, May 24th, 2023
TIME: 12:00pm-2:00pm
LOCATION: 1033 4th St, Santa Rosa, CA 95404
Screening of "Healing Voices" for more information please call (707) 546-4481

Interlink Self-Help Center Event
Friday, May 26th, 2023
TIME: 1:30-3:00pm
LOCATION: 1033 4th St, Santa Rosa, CA 95404
Sharing Recovery Resources. For more information please call (707) 546-4481

Creating Safe Space for Mental Health through Connection
Tuesday, May 30th, 2023
TIME: 3:00pm-6:00pm
Hear stories of lived mental health experience with a provider panel and community circle.
REGISTER: https://www.eventbrite.com/e/creating-safe-space-for-mental-health-through-connection-tickets-619421956747

Petaluma Peer Recovery Center's Event
Wednesday, May 31st, 2023
TIME: 10:30am-12:30pm
LOCATION: 5350 Old Redwood Hwy N #600, Petaluma, CA 94954
Screening of "Healing Voices" for more information please call (707) 565-1299

Interlink Self-Help Center Event
Wednesday, May 31st, 2023
TIME: 12:00pm-2:00pm
LOCATION: 1033 4th St, Santa Rosa, CA 95404
MH Month Bingo w/ Prizes
For more information call: 707-565-7800

MAY IS MENTAL HEALTH MONTH

TAKE SOME TIME TO
LOOK AROUND, LOOK WITHIN

MHANATIONAL.ORG/MAY

Scan me!

988 SUICIDE & CRISIS LIFELINE

24/7 CALL,TEXT,CHAT

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

May 2023

Mental Health Matters Month

MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA

WELLNESS • RECOVERY • RESILIENCE

SUN	MON	TUE	WED	THU	FRI	SAT
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

Creado un Espacio Seguro para la Salud Mental a Través de la Conexión

Panel y Circulo de la Comunidad

Se les invita a reunirte con nosotros en comunidad. Colectivamente, hemos pasado por mucho en los últimos años. Nos estaremos reuniendo para escuchar historias de experiencias vividas con un panel de proveedores y un círculo comunitario.

Se le dará la oportunidad de unirse al círculo comunitario. Tenemos un maravilloso panel de proveedores que se han ofrecido a compartir sus experiencias con nosotros. El espacio del círculo comunitario será limitado. La participación en el círculo no es necesaria en absoluto.

Comenzaremos con una oración de apertura de Madonna Feather Cruz y introducción con Jan Cobaleda-Kegler, Directora de Salud del Comportamiento del Condado de Sonoma. Kenia Leon, Directora de Programas, Programas de Sonoma y Erika Klohe, Directora Regional de Salud del Comportamiento, Buckelew serán las co-facilitadores. Tendremos un panel de proveedores comunitarios, ejercicio de conexión a tierra, círculo comunitario y compartiremos una comida juntos.

¡Esperamos verlos a todos!

~ Reunamonos Juntos ~

30 de mayo, 2023
3:00- 6:00pm
2060 W College Ave
Finley Center, Santa Rosa Ca
Por favor regístrese: https://CreatingSpaceForMH.eventbrite.com.

¡Tendremos interpretación al español en el evento y compartiremos el folleto pronto!
We will have Spanish interpretation at the event & flier to share soon!

Sponsored by Mental Health Services Act, Sonoma County Behavioral Health

Adriana Arrizon

(ella)
Directora Ejecutiva
Health Action Together
Adriana Arrizon
aarrizon@hatogether.org

Adriana tiene más de 20 años de experiencia en los sectores de salud pública y comunitaria en Alameda, Stanislaus, Marin y el condado de Sonoma. Hija de trabajadores agrícolas migrantes y criada por un guerrero de la justicia social: su abuela. Adriana entiende que son las conexiones auténticas y significantes las que impulsan el cambio, y que la vitalidad de una comunidad depende en gran medida de que sus miembros estén plenamente comprometidos y sean participantes activos en su propio bienestar. La experiencia de Adriana incluye el desarrollo, implementación y evaluación de programas de salud culturalmente receptivos. Adriana ha trabajado en salud materna e infantil, cuidado a temprana edad y educación, manejo de respuesta a desastres, participación comunitaria y cívica, coordinación de sistemas sociales y de salud, y desarrollo de políticas. Adriana se convirtió en Consultora de Lactancia Certificada Internacional en el 2010 para abordar las desigualdades del sistema de salud en la comunidad latina en el condado de Sonoma. A Adriana le gusta caminar, entretener a sus amigos y aprender a ver el mundo a través de los ojos de sus dos hijos.

Teresa Bowman,

(ella)
Directora de Servicios del Uso de Substancias
Programa Buckelew
Teresa Bowman
TeresaB@buckelew.org

Teresa es nativa del condado de Marin y comenzó su carrera como adulta joven, justo después de graduarse de Tamalpais High School. Continuó su carrera con un título en negocios de Heald's Business College en San Francisco, y más tarde completó el programa de Estudios de Alcohol y Drogas de UC Berkeley para convertirse en una Especialista Certificada en Adicciones. En 1999, Teresa cofundó el Centro de Recuperación Helen Vine, también conocido como "The Vine", y se desempeñó como su Directora Ejecutiva, un papel que continúa desempeñando.

Como Directora Ejecutiva del Centro de Recuperación Helen Vine, Teresa fue galardonada con el Premio Humanitario Martin Luther King, Jr. en 2005. En 2011 The Vine se fusionó con el Programa Buckelew. Teresa ha sido fundamental para supervisar la adopción del tratamiento basado en la evidencia en The Vine y, en 2020, la adición de dos residencias sobrias críticamente necesarias.

Hoy, Teresa supervisa los Servicios de Uso de Sustancias de Buckelw y sigue dedicada a trabajar con sus colegas y personal para continuar expandiendo los servicios de tratamiento de trastornos concurrentes de Buckelew.

Madonna (Feather) Cruz
(ella)
madonnafeather@yahoo.com

MaDonna (Feather) Cruz, llamada así por su tía MaDonna Thunder Hawk, nació en Ukiah, California. MaDonna es un miembro inscrito de la reserva india de Round Valley, en Covelo, CA, y por parte de su padre Lakota Sioux. MaDonna actualmente se desempeña como Presidenta del Comité de Educación Indígena con el Distrito Escolar de la Ciudad de Santa Rosa, Directora de la radio KBBF, BOD a Ya-Ka- AMA Indian Education and Development, Inc., y miembro asesor de la comunidad para el proyecto Auntie's and Uncle's Eagle Council con Sonoma County Indian Health Project.

Lisa Diaz-McQuaid,
(ella)
Defensora de Víctimas de la Trata de Personas
Cofundador de Redemption House of the Bay Area
info@redemptionhouseoftheb ayarea.org

Lisa nació y creció en Santa Rosa, California. Ella es una sobreviviente de abuso sexual infantil y como adulta una sobreviviente de violencia doméstica, agresión sexual, tráfico laboral y trata de personas. Lisa encontró curación y la recuperación de su pasado y quiere ayudar a otros a lo largo de sus caminos de curación y descubrimiento de la autoestima, el amor propio, la libertad y el empoderamiento.

Lisa es miembro del Grupo de Trabajo contra la Trata de Personas del Condado de Sonoma y sirve en la junta como "experta en sobrevivientes de la trata" que representa a Redemption House of the Bay Area. Lisa es miembro de la mesa directiva de 'Raizes Collective' empoderando a nuestra comunidad latina a través del arte, la cultura y la educación ambiental. Lisa es miembro de varios otros grupos, iniciativas y recibió muchos premios por su servicio en la comunidad.

Sean Kelson es gerente de programas en West County Community Services y supervisa el Centro de ayuda propia de Interlink y el Centro de Recuperación de Compañeros de Petaluma. Sean ha trabajado como proveedor para compañeros por más de 15 años. Como consultor y empleado de la agencia, Sean ha proveído entrenamiento, divulgación y charlas motivacionales al personal, participantes y las agencias, en reuniones y en las calles. El celo y la capacidad de Sean para aprender, abogar y compartir información sobre la atención informada sobre el trauma, la valoración de la diversidad y la conciencia de cuándo podemos perder de vista la humanidad de otra persona, está informada por su experiencia vivida, basada en la esperanza y la recuperación.

Sean Kelson (Tu eliges)
Gerente de Programa del
Centro Interlink Self-Help
sean.kelson@westcountyservices.org

Bicultural, bilingüe hija de inmigrantes, soy una defensora apasionada con una fuerte ética de trabajo que está motivada para crear un cambio en nuestro mundo. Como terapeuta matrimonial, familiar e infantil y Consejero Clínico Licenciado en Alcohol y Drogas, mi objetivo es proporcionar atención competente, efectiva y basada en la fortaleza a nuestras poblaciones más marginadas. Centrada en la comunidad y orientada al sistema, trabajo a través de un lente de justicia restaurativo para mejorar el acceso a/y dentro de nuestro sistema de atención de salud mental.

Kenia Leon, (Ella)
Director del Programa, Sonoma
Buckelew Programs
Kenial@Buckelew.org

Jennifer Vargas es Navegadora de Sistemas en inRESPONSE, el equipo de respuesta a crisis de salud mental de Santa Rosa. Siendo mexicoamericana de primera generación, se esfuerza por tener un impacto positivo en la comunidad en la que creció, a través de su experiencia vivida en salud mental y su formación académica en psicología chicana. En su tiempo libre, a Jennifer le encanta bailar e ir a la playa.

Jennifer Vargas
(ella)
inResponse System Navigator
Buckelew Programs
JenniferV@buckelew.org

Erika Klohe, es mamá, abuela, madrina, hija, hermana, amiga y tiene experiencia vivida. Ella es una trabajadora social clínica con licenciatura, con muchos años de experiencia trabajando en la comunidad brindando servicios directos y desarrollando asociaciones en todo el condado de Sonoma. Gran parte de su trabajo se ha centrado en el análisis de barreras y desafíos, y ha apoyado el establecimiento de prácticas compartidas que aumentan el acceso al cuidado.

Erika es una firme defensora de los servicios culturalmente diversos, orientados a la recuperación, informada sobre el trauma y humanistas. Ella tiene muchos años de experiencia trabajando con los más vulnerables de nuestra comunidad, incluyendo: poblaciones nativas y latinas, personas sin hogar, personas mayores, LGBTQI, aquellos involucrados en el sistema de justicia penal, jóvenes en transición y desatendidos y sus familias.

Erika Klohe
(ella)
Directora Regional
Sonoma/Napa
Buckelew Programs
erikak@buckelew.org

En Asociación Juntos Con

inRESPONSE MENTAL HEALTH SUPPORT TEAM

WCCS West County Community Services

CSN Community Support Network

CONNECT SONOMA UNIDOS SONOMA

NAMI Sonoma County National Alliance on Mental Illness

EachMind MATTERS California's Mental Health Movement

REDEMPTION HOUSE OF THE BAY AREA

What is connection according to Brené Brown?

"I define connection as the energy that exists between people when they feel seen, heard, and valued; when they can give and receive without judgment; and when they derive sustenance and strength from the relationship." – Dr. Brene Brown

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

Buckelew Programs

Creado un Espacio Seguro para la Salud Mental a Través de la Conexión

Panel y Círculo Comunitario

Están invitados a reunirse con nosotros en comunidad. Colectivamente, hemos pasado por mucho en los últimos años. Nos estaremos reuniendo para escuchar historias de experiencias vividas con un panel de proveedores y un círculo comunitario.

Se le dará la oportunidad de unirse al círculo comunitario. Tenemos un maravilloso panel de proveedores que se han ofrecido a compartir sus experiencias con nosotros. El espacio del círculo comunitario será limitado. La participación en el círculo no es necesaria en absoluto.

Comenzaremos con una oración de apertura de Madonna Feather Cruz y introducción con Jan Cobaleda-Kegler, Directora de Salud del Comportamiento del Condado de Sonoma. Kenia Leon, Directora de Programas, Programas de Sonoma y Erika Klohe, Directora Regional de Salud del Comportamiento, Buckelew serán las co-facilitadoras. Tendremos un panel de proveedores comunitarios, ejercicio de conexión a tierra, círculo comunitario y compartiremos una cena juntos.

¡Esperamos verlos a todos!

~ Reunámonos Juntos ~

30 de mayo, 2023
3:00- 6:00pm
2060 W College Ave
Finley Center, Santa Rosa Ca
Por favor regístrese: https://CreatingSpaceForMH.eventbrite.com.

¡Tendremos interpretación al español en el evento!

Patrocinado por Mental Health Services Act, Sonoma County Behavioral Health

Adriana Arrizon

(ella)
Directora Ejecutiva
Health Action Together
Adriana Arrizon
aarrizon@hatogether.org

Adriana tiene más de 20 años de experiencia en los sectores de salud pública y comunitaria en Alameda, Stanislaus, Marin y el condado de Sonoma. Hija de trabajadores agrícolas migrantes y criada por una guerrera de la justicia social: su abuela. Adriana entiende que son las conexiones auténticas y significantes las que impulsan el cambio, y que la vitalidad de una comunidad depende en gran medida de que sus miembros estén plenamente comprometidos y sean participantes activos en su propio bienestar. La experiencia de Adriana incluye el desarrollo, implementación y evaluación de programas de salud culturalmente receptivos. Adriana ha trabajado en salud materna e infantil, en el cuidado a temprana edad y educación, manejo de respuesta a desastres, participación comunitaria y cívica, coordinación de sistemas sociales y de salud, y desarrollo de políticas. Adriana se convirtió en Consultora de Lactancia Certificada Internacional en el 2010 para abordar las desigualdades del sistema de salud en la comunidad latina en el condado de Sonoma. A Adriana le gusta caminar, entretener a sus amigos y aprender a ver el mundo a través de los ojos de sus dos hijos.

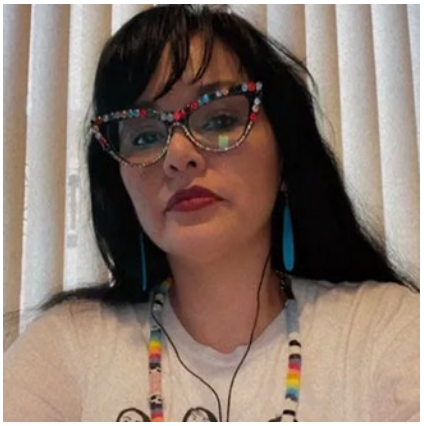
Teresa Bowman,

(ella)
Directora de Servicios del Uso de Substancias
Programa Buckelew
Teresa Bowman
TeresaB@buckelew.org

Teresa es nativa del condado de Marin y comenzó su carrera como adulta joven, justo después de graduarse de Tamalpais High School. Continuó su carrera con un título en negocios de Heald's Business College en San Francisco, y más tarde completó el programa de Estudios de Alcohol y Drogas de UC Berkeley para convertirse en una Especialista Certificada en Adicciones. En 1999, Teresa cofundó el Centro de Recuperación Helen Vine, también conocido como "The Vine", y se desempeñó como su Directora Ejecutiva, un papel que continúa desempeñando.

Como Directora Ejecutiva del Centro de Recuperación Helen Vine, Teresa fue galardonada con el Premio Humanitario Martin Luther King, Jr. en 2005. En 2011 The Vine se fusionó con el Programa Buckelew. Teresa ha sido fundamental para supervisar la adopción del tratamiento basado en la evidencia en The Vine y, en 2020, la adición de dos residencias sobrias críticamente necesarias.

Hoy, Teresa supervisa los Servicios de Uso de Sustancias de Buckelew y sigue dedicada a trabajar con sus colegas y personal para continuar expandiendo los servicios de tratamiento de trastornos concurrentes de Buckelew.



Madonna (Feather) Cruz
(ella)
madonnafeather@yahoo.com

MaDonna (Feather) Cruz, llamada así por su tía MaDonna Thunder Hawk, nació en Ukiah, California. MaDonna es un miembro inscrito de la reservasión india de Round Valley, en Covelo, CA, y por parte de su padre Lakota Sioux. MaDonna actualmente se desempeña como Presidenta del Comité de Educación Indígena con el Distrito Escolar de la Ciudad de Santa Rosa, Directora de la radio KBBF, BOD a *Ya-Ka- AMA Indian Education and Development, Inc*., y miembro asesor de la comunidad para el proyecto *Auntie's and Uncle's Eagle Council con Sonoma County Indian Health Project*.

Lisa Diaz-McQuaid,
(ella)
Defensora de Víctimas de la Trata de Personas
Cofundador de Redemption House of the Bay Area
info@redemptionhouseofthebayarea.org

Lisa nació y creció en Santa Rosa, California. Ella es una sobreviviente de abuso sexual infantil y como adulta una sobreviviente de violencia doméstica, agresión sexual, tráfico laboral y trata de personas. Lisa encontró curación y la recuperación de su pasado y quiere ayudar a otros a lo largo de sus caminos de curación y descubrimiento de la autoestima, el amor propio, la libertad y el empoderamiento.

Lisa es miembro del Grupo de Trabajo contra la Trata de Personas del Condado de Sonoma y sirve en la junta como "experta en sobrevivientes de la trata" que representa a *Redemption House of the Bay Area*. Lisa es miembro de la mesa directiva de *'Raizes Collective*' empoderando a nuestra comunidad latina a través del arte, la cultura y la educación ambiental. Lisa es miembro de varios otros grupos, iniciativas y recibió muchos premios por su servicio en la comunidad.

Sean Kelson (Tu eliges)
Gerente de Programa del
Centro Interlink Self-Help
sean.kelson@westcountyservices.org

Sean Kelson es gerente de programas en *West County Community Services* y supervisa el Centro de ayuda propia de *Interlink* y el Centro de Recuperación de Compañeros de Petaluma. Sean ha trabajado como proveedor para compañeros por más de 15 años. Como consultor y empleado de la agencia, Sean ha proveído entrenamiento, divulgación y charlas motivacionales al personal, participantes y las agencias, en reuniones y en las calles. El celo y la capacidad de Sean para aprender, abogar y compartir información sobre la atención informada sobre el trauma, la valoración de la diversidad y la conciencia de cuándo podemos perder de vista la humanidad de otra persona, está informada por su experiencia vivida, basada en la esperanza y la recuperación.

Kenia Leon, (Ella)
Director del Programa, Sonoma
Buckelew Programs
Kenial@Buckelew.org

Bicultural, bilingüe hija de inmigrantes, Kenia es una defensora apasionada con una fuerte ética de trabajo que está motivada para crear un cambio en nuestro mundo. Como terapeuta matrimonial, familiar e infantil y Consejero Clínico Licenciado en Alcohol y Drogas, su objetivo es proporcionar atención competente, efectiva y basada en la fortaleza a nuestras poblaciones más marginadas. Centrada en la comunidad y orientada al sistema, trabaja a través de un lente de justicia restaurativo para mejorar el acceso a/y dentro de nuestro sistema de atención de salud mental.

Jennifer Vargas es Navegadora de Sistemas en inRESPONSE, el equipo de respuesta a crisis de salud mental de Santa Rosa. Siendo Mexicoamericana de primera generación, se esfuerza por tener un impacto positivo en la comunidad en la que creció, a través de su experiencia vivida en salud mental y su formación académica en psicología chicana. En su tiempo libre, a Jennifer le encanta bailar e ir a la playa.

Jennifer Vargas
(ella)
inResponse System Navigator
Buckelew Programs
JenniferV@buckelew.org

Erika Klohe, es mamá, abuela, madrina, hija, hermana, amiga y tiene experiencia vivida. Ella es una trabajadora social clínica con licenciatura, con muchos años de experiencia trabajando en la comunidad brindando servicios directos y desarrollando asociaciones en todo el condado de Sonoma. Gran parte de su trabajo se ha centrado en el análisis de barreras y desafíos, y ha apoyado el establecimiento de prácticas compartidas que aumentan el acceso al cuidado.

Erika es una firme defensora de los servicios culturalmente diversos, orientados a la recuperación, informada sobre el trauma y humanistas. Ella tiene muchos años de experiencia trabajando con los más vulnerables de nuestra comunidad, incluyendo: poblaciones nativas y latinas, personas sin hogar, personas mayores, LGBTQI, aquellos involucrados en el sistema de justicia penal, jóvenes en transición y desatendidos y sus familias.

Erika Klohe
(ella)
Directora Regional
Sonoma/Napa
Buckelew Programs
erikak@buckelew.org

En Asociación Juntos Con

inRESPONSE MENTAL HEALTH SUPPORT TEAM

WCCS West County Community Services

CSN Community Support Network

CONNECT SONOMA UNIDOS SONOMA

NAMI Sonoma County National Alliance on Mental Illness

EachMind MATTERS California's Mental Health Movement

REDEMPTION HOUSE OF THE BAY AREA

¿Qué es la conexión según Brené Brown?

"Yo defino conexión como la energía que existe entre las personas cuando se sienten vistas, escuchadas y valoradas; cuando pueden dar y recibir sin juicio; y cuando obtienen sustento y fortaleza de la relación". – Dra. Brene Brown

sonoma county
DEPARTMENT OF HEALTH SERVICES

National Suicide Prevention Week

Sonoma County September 2023 Suicide Prevention Events

Date/Time	Name of Event	Location	Sponsoring Organization	Aduience / Cost	Registration	Contact Info
9/5/2023 11am-2pm	Walk in the Light @ The Lakes	Wellness Advocay Center, Santa Rosa	WCCS	Open to All Free Event	No Registration	Danette.alander@westcountyservices.org 707-565-7800
9/10/2023 10am-1pm	Connection is Prevention	Old Courthouse Square, Santa Rosa	DHS-BHD and WCCS	Open to All Free Event	No Registration	Iridian Onofre Iridian.Onofre@sonoma-county.org (707) 565-4854
9/12/2023 11am	What is QPR? A presentation	Wellness Advocay Center, Santa Rosa	WCCS	Open to All Free Event	No Registration	Danette.alander@westcountyservices.org 707-565-7800
9/23/2023 9am	Out of the Darkness Walk	Sonoma State University, Rohnert Park	AFSP	Open to All Free Event	Please Follow the link https://supporting.afsp.org/index.cfm?fuseaction=donorDrive.event&eventID=9103	Email: sonomacountyoutofthedarkness@gmail.com Phone: 707-480-8272
9/25/2023 3pm-5pm	QPR Suicide Prevention Training	SCOE	SCOE	Ages 12+ Free Event	Please Follow the link: https://docs.google.com/forms/d/e/1FAIpQLScJDXJZUfvaYac-dQcAIoJCzbbGIqce8TKnMok_eTRnRgtBLg/viewform	Mary Champion mchampion@scoe.org
9/26/2023 9am-11am	QPR Suicide Prevention Training	SCOE	SCOE	Ages 12+ Free Event	Please Follow the link: https://docs.google.com/forms/d/e/1FAIpQLScJDXJZUfvaYac-dQcAIoJCzbbGIqce8TKnMok_eTRnRgtBLg/viewform	Mary Champion mchampion@scoe.org
9/26/2023 12pm-2pm	Lethal Means Safety Counseling	Finley Center, Santa Rosa	DHS-BHD and VA		Creating link	Iridian Onofre Iridian.Onofre@sonoma-county.org (707) 565-4854

EVENT DETAILS

SUNDAY

10 SEPTEMBER 2023

Old Courthouse Sq,
Santa Rosa, CA 95407

10:00am - 1:00pm

THE POWER OF CONNECTION:

10:00am - 10:15am	Opening Ceremony
10:15am - 10:30am	Opening Remarks
10:30pm - 10:50am	Mind-Body Skill Workshop
10:50am - 11:00am	Speak Life: Open Mic
11:00am - 11:15am	Mid-Day Remarks
11:15am - 11:45am	Advance Care Plan Workshop
11:45am - 12:00pm	Speak Life: Open Mic
12:00pm - 12:15am	Community Presentation*
12:15pm - 12:30pm	Mind-Body Skills Workshop*
12:30pm - 1:00pm	Closing Remarks / Ceremony

***En Español**

FOR MORE INFORMATION, CONTACT:
MHSA@SONOMA-COUNTY.ORG

Share Hope Together
FOR SUICIDE PREVENTION

KNOW THE SIGNS. FIND THE WORDS. REACH OUT.

SUICIDE PREVENTION WEEK: SEPTEMBER 10TH - 16TH, 2023
WORLD SUICIDE PREVENTION DAY: SEPTEMBER 10TH, 2023

Take Action CalMHSA KNOW THE SIGNS

Join Us!

FREE & OPEN TO ALL!

CONNECTION IS PREVENTION

CONNECTION IS PREVENTION WITH COMMUNITY

- **Community Resources**
- **Engaging Workshops**
- **Interactive activities**
- **Self-Care skills**

Come be a part of this enriching experience and discover how fostering connections can be the key to preventing mental health challenges. Together, lets thrive and create a stronger, more supportive community.

sonoma county
DEPARTMENT OF HEALTH SERVICES

DETALLES

DOMINGO

10 DE SEPTIEMBRE 2023

Old Courthouse Sq,
Santa Rosa, CA 95407

10:00am - 1:00pm

EL PODER DE LA CONEXIÓN

10:00am - 10:15am	Ceremonia de apertura
10:15am - 10:30am	Palabras de apertura
10:30pm - 10:50am	Taller de Habilidades Mente-Cuerpo
10:50am - 11:00am	Hablar de la vida: micrófono abierto
11:00am - 11:15am	Comentarios del mediodía
11:15am - 11:45am	Taller de planes de atención anticipados
11:45am - 12:00pm	Hablar de la vida: micrófono abierto
12:00pm - 12:15am	Presentación comunitaria*
12:15pm - 12:30pm	Taller de Habilidades Mente-Cuerpo*
12:30pm - 1:00pm	Palabras de Clausura / Ceremonia

***En Español**

PARA MÁS INFORMACIÓN CONTACTE:
MHSA@SONOMA-COUNTY.ORG

Share Hope Together
FOR SUICIDE PREVENTION

KNOW THE SIGNS. FIND THE WORDS. REACH OUT.

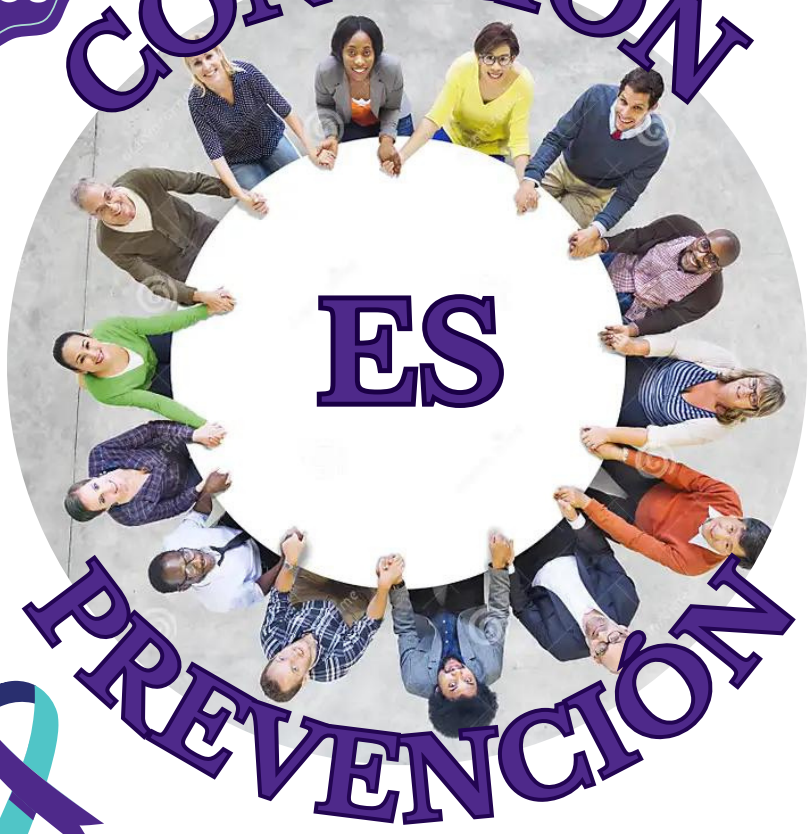
SUICIDE PREVENTION WEEK: SEPTEMBER 10TH - 16TH, 2023
WORLD SUICIDE PREVENTION DAY: SEPTEMBER 10TH, 2023

Take Action · CalMHSA · Know the Signs

GRATIS Y ABIERTO A TODOS

¡Acompáñanos!

CONEXIÓN ES PREVENCIÓN



LA CONEXIÓN ES PREVENCIÓN CON COMUNIDAD

- **RECURSOS DE LA COMUNIDAD**
- **TALLERES INTERESANTES**
- **ACTIVIDADES INTERACTIVOS**
- **HABILIDADES DE AUTOCUIDADO**

Ven y sé parte de esta enriquecedora experiencia y descubre cómo fomentar las conexiones puede ser la clave para prevenir problemas de salud mental. Juntos, prosperemos y creemos una comunidad más fuerte y solidaria.

sonoma county
DEPARTMENT OF HEALTH SERVICES

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

Sonoma County Behavioral Health Division

Free Staff Development Training

*** This Training is for all direct service staff that develop safety plans with clients having thoughts of suicide. ***

"Lethal Means Safety Counseling and Lock Box Distribution"

You MUST register for this class!

2.0 CEs provided for LCSWs, LMFTs, Registered Associates LPCCsm LEPs, RNs, and AODS Counselors

This will be a two hour (2.0 CEs) in-person presentation with time for questions and discussion. With the option of attending virtually.

Lethal Means Safety Counseling (LMSC) is an evidence-based intervention intended to promote the safety of a person in suicidal crisis or in anticipation of a crisis. LMSC facilitates collaborative discussion to assist a person with increasing time and distance between their suicidal intent and their ability to access lethal means. This training will explain the importance of addressing means safety as part of suicide prevention and how the implementation of LMSC can enhance suicide prevention efforts in your own community.

Objectives: Participants will be able to

1. List two elements of Lethal Mental Safety Counseling
2. Identify the most common method involved in death by suicide.
3. Describe the average duration of a suicidal crisis.
4. Identify two ways that reducing access to lethal means can prevent suicide.

September 26, 2023

Tuesday, 12:00pm – 2:00pm
Finley Community Center Person Auditorium
2060 West College Avenue
Santa Rosa, CA 95401

Course Schedule:

12:00pm – 12:10pm	Introduction
12:10pm – 1:00pm	Research and support for Lethal Means Safety
1:00pm – 1:45pm	Counseling How to become an effective Lethal Means
1:45pm – 2:00pm	Safety Counselor Summary, Wrap-up & Questions

Presenter: Dr. Anna Harrison

Please register using one of the following links:

https://lethal-means-safety-counseling-lockbox-distribution.eventbrite.com **(In-Person)**
https://sonomacounty.zoom.us/webinar/register/WN_aWNspVDNTEGP0y9TJ9h2zg **(Virtual)**

CE Certificates after completion of the course.
Contact: BH-Training BH-Training@sonoma-county.org for more information, ADA requests, grievances or if you are unable to attend.
Course meets the qualifications for 2 hours of continuing education credit for LMFTs, LCSWs, LPCCs and/or LEPs as required by the California Board of Behavioral Sciences.
The Sonoma County Behavioral Health Division is approved by the California Association of Marriage and Family Therapists to sponsor continuing education for LMFTs, LCSWs, & LPCCs. Sonoma County Behavioral Health Division maintains responsibility for this program/course and its content. Provider Number 135030, Exp. 02/01/2024.
This course has been approved by California Board of Registered Nursing, **B.R.N Provider No. 10298** expires 5/31/2024.
Provider approved by CCAPP-EI, Provider Number 4N-05-565-1122 for 2 CEs.

Hanna Center

sonoma county
DEPARTMENT OF HEALTH SERVICES

REMEMBRANCE & HEALING CONVERSATION

FOR THOSE IMPACTED BY SUICIDE

This day of hope and healing is often very powerful to attendees affected by suicide loss. Many loss survivors who attend and participate in Survivor Day events find a deep connection with others who have had similar experiences, developing a new understanding of their grief with the realization that they are not alone.

LOSS FROM SUICIDE IS LIKE NO OTHER LOSS...

HANNA CENTER

17000 Arnold Drive, Sonoma CA

4 PM - 6 PM

NOV
14
2023

ADDITIONAL INFORMATION

MHSA@SONOMA-COUNTY.ORG

988 SUICIDE & CRISIS LIFELINE

NAMI Sonoma County
National Alliance on Mental Illness

sonoma county
DEPARTMENT OF HEALTH SERVICES

REMEMBRANCE & HEALING CONVERSATION

FOR THOSE IMPACTED BY SUICIDE

This day of hope and healing is often very powerful to attendees affected by suicide loss. Many loss survivors who attend and participate in Survivor Day events find a deep connection with others who have had similar experiences, developing a new understanding of their grief with the realization that they are not alone.

LOSS FROM SUICIDE IS LIKE NO OTHER LOSS...

NORTH COAST BUILDERS EXCHANGE

1030 APOLLO WAY, SANTA ROSA CA

3:00 PM - 5:00 PM

NOV
16
2023

Registration link:**HTTPS://TINYURL.COM/RZ8VUYWF**

SCAN CODE TO REGISTER

988 SUICIDE & CRISIS LIFELINE

Fiscal Year 2022-2023 Sonoma County 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 EMM 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 helps 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.

Strategies of the PEI Project in FY 22/23

Funding to the PEI Project supported programs such as:

- Continued production, promotion, and dissemination of the *Take Action for Mental Health* campaign's materials and messages
- Providing technical assistance and outreach to Members contributing to the PEI Program
- Providing mental health and suicide prevention trainings to diverse audiences
- Engaging youth through the Directing Change program
- Strategizing on evaluation and best practices with RAND Corporation

Statewide achievements in FY 22/23

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 2022-2023 include:

- Take Action 4 Mental Health disseminated physical and digital materials for May is Mental Health Month, Suicide Prevention Week and Month in September, National Rural Health Day, Winter Wellness, and Student Athlete Suicide Prevention
    - See more on pages 3-9
- Directing Change Hope & Justice Held Seven Topics for Monthly Submissions
    - See more on pages 10-12
- The Suicide Prevention Technical Assistance Team conducted two statewide webinars
    - See more on page 13

- The Suicide Prevention Technical Assistance team conducted regular meetings with PEI contributing counties throughout the year to provide technical assistance and resource navigation.
    - See more on page 13

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%

May is Mental Health Matters Month Toolkit + Reporting Data

- Link to Items

Physical Toolkit

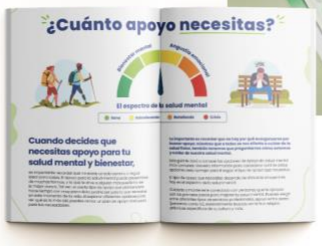
Included: Resource booklets distributed in English and Spanish, recipes cards for wellness and self-care, green ribbons, pop-It keychains, wristbands, and toiletry kits!

Keychain + Wristband

Toiletry Kit

Green Ribbons

Your Mental Wellness Plan / Tu plan de bienestar mental



Wellness + self-care recipe cards

Digital Toolkit

Included: 2023 Proclamation, web banners, eblasts, social media kit, Spotify playlist, digital versions of the resource books and recipe cards, billboard, and radio script.

Web banners

Digital billboard

Spotify playlist

2023 Proclamation

Digital Toolkit

CHECK IN LEARN MORE GET SUPPORT

CalMHSA

Influencers

Partnered with mental health advocates to share their mental health stories and *Take Action* resources, and to encourage Californians to do the same.

Amber Dee
@blackfemaletherapists

Juan Acosta
@juanacosta_

Anysa & Amaya Gray
@grayytwins

Owin Pierson
@owinpierson

Media

Promoted *Take Action* campaign through paid media to extend reach across the state and target specific audiences.

Ads included: Facebook, Instagram, Twitter, Google Search, display, Eblasts, podcasts, and Spotify.

Take Action had more than

14,589,320 touchpoints

with Californians throughout May

12,499,906	1,817,716	252,720	10,521	8,457
paid media reach	influencer post reach	total toolkit materials distributed	IG live event views	organic social media reach

Take Action had more than

5,611,261 touchpoints*

with Californians in priority populations throughout May

2,031,976	1,930,507	1,620,978	27,800
paid media reach to AAPI & Black/African American audiences	paid media reach to LMI counties	eblasts to AAPI & Black/African American audiences	total toolkit materials distributed to LMI counties

How Californians took action

131,486

sessions on the *Take Action* website

over 27X month over month

99,527

views of the Mental Health Matters Month landing page

13,514

resources were downloaded

over 9X month over month

59,474

engagements on influencer posts

10,521

IG live views

5X

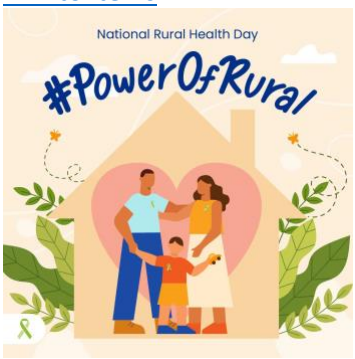
social engagement month over month

Suicide Prevention Activation Kit – September 2022: Take Action for Suicide Prevention: Thriving at all Ages

- Talking Points and Data Briefing 2022, SPW Overview and Activity Guide, Activity Challenge Tip Sheet, Video Conferencing Backgrounds, Poster, Banner, Proclamation, Daily Emails, PSA Scripts, Social Media Written Post Guides & Posts, Drop-in Articles, Older Adult Suicide Prevention 101 PowerPoint Presentation Template, Older Adult Billboard and Brochure

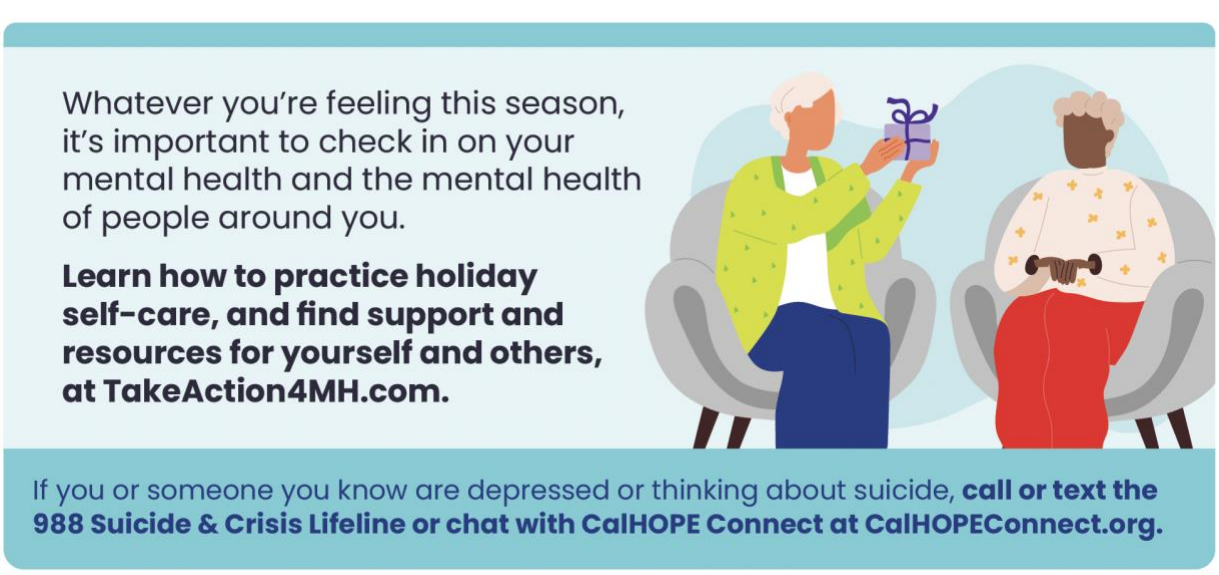
National Rural Health Day "#PowerofRural"

- Social Media Files and Drop-in Article
- Link to Items



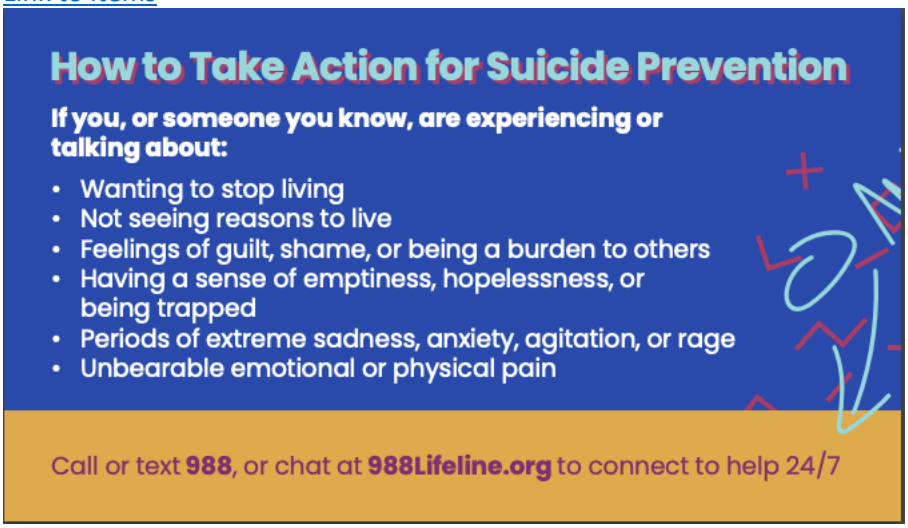
Winter Wellness Digital Toolkit

- Eblasts, Resource Cards, and Social Media Files for December 2022 and January 2023
- Link to Items



Student Athlete Suicide Prevention Digital Toolkit

- Tip Sheet for Parents, Social Media Files, Roadmap for Student Athletes, Roadmap for Coaches, Roadmap for School Administrators, Pocket Card, Poster, Flyer
- Link to Items



Directing Change Hope & Justice

- Directing Change Hope & Justice Held Seven Monthly Topics range over the following throughout the year:
    - September 2022: "Find Your Anchor"
        - Total entries: 148 (Hope: 33, Justice: 11, Monthly Prompt: 104)
    - October 2022: "What is Your Word?"
        - Total entries: 90 (Hope: 20, Justice: 5, Monthly Prompt: 60)
    - November 2022: "Mental Health Heroes"
        - Total Entries: 73 (Hope: 16, Justice: 2, Monthly Prompt: 55)
    - December 2022 and January 2023: "What are your hopes for 2023?"
        - Total entries: 41 (Hope: 12, Justice: 3, Monthly Prompt: 26)
    - February 2023: "More Than One"
        - Total entries: 89 (Hope: 15, Justice: 3, Monthly Prompt: 58, RUHS Substance Use: 13)
    - April 2023: "Celebrate Earth Day"
        - Total entries: 45 (Hope: 8, Justice: 1, Monthly Prompt: 36)
    - May 2023: "Take Action for Mental Health"
        - Total entries: 63 (Hope: 2, Justice: 1, Monthly Prompt: 60)

Suicide Prevention Technical Assistance Team

The Suicide Prevention TA Team held two statewide webinars:

- "Reclaiming 2SQT+ (Two-spirit, Queer and Trans) Youth Thriving: An Intersectional, Anti-racist and Radical Love Approach to Suicide Prevention"
    - Total number of participants: 292
    - Total counties represented: 35
- "Understanding the Complexity of Prolonged Stress and Addressing the Impacts on Parental and Child Wellbeing"
    - Total number of participants: 131
    - Total counties represented: 21

The Suicide Prevention TA Team met with Sonoma County through FY 22-23 about the following:

- *The YSM TA Team coordinated the delivery of Know the Signs bilingual pens to staff at Sonoma County. (YSM, 10.28.22)*