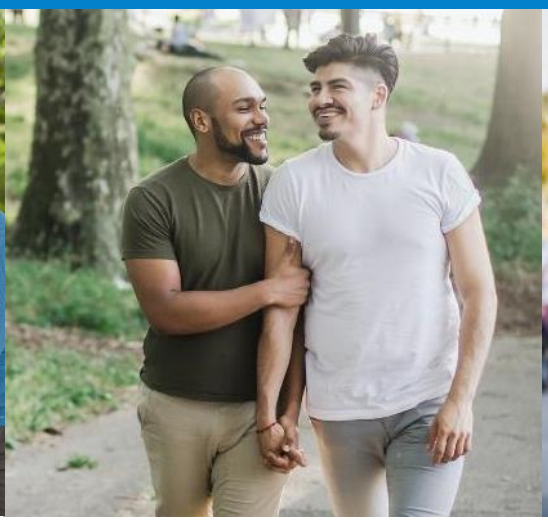
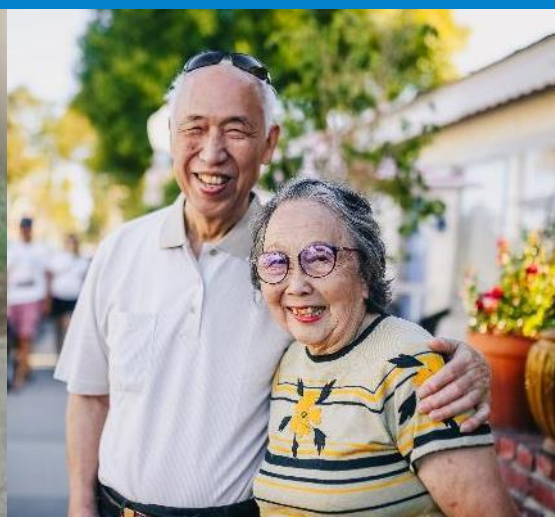


MENTAL HEALTH SERVICES ACT (MHSA)

ANNUAL UPDATE

Annual Update FY 2021-22

TRI·CITY Mental Health

MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA

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MHSA County Compliance Certification

County: TRI-CITY MENTAL HEALTH AUTHORITY

Local Mental Health Director Name: ANTONETTE (TONI) NAVARRO Telephone Number: (909) 623-6131 E-mail: anavarro@tricitymhs.org	**Program Lead** Name: RIMMI HUNDAL Telephone Number: (909) 784-3016 E-mail: rhundal@tricitymhs.org
County Mental Health Mailing Address: 1717 N. Indian Hill Boulevard Suite B, Claremont, CA 91711	

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

This MHSA Annual Update Plan has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft MHSA Annual Update Plan was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The Annual Update FY 2021-22 and Expenditure Plan, attached hereto, was adopted by the Tri-City Governing Board on June 16, 2021.

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

All documents in the attached Annual Update FY 2021-22 and Expenditure Plan are true and correct.

Antonette (Toni) Navarro		06/28/2021
Local Mental Health Director/Designee (PRINT) County: TRI-CITY MENTAL HEALTH AUTHORITY	Signature	Date

MHSA County Fiscal Accountability Certification

County/City: TRI-CITY MENTAL HEALTH AUTHORITY
___ Three-Year Program and Expenditure Plan _X_ Annual Update ___ Annual Revenue and Expenditure Report

Local Mental Health Director Name: ANTONETTE (TONI) NAVARRO Telephone Number: (909) 623-6131 E-mail: anavarro@tricitymhs.org	**County Auditor-Controller/ City Financial Officer** Name: DIANA ACOSTA Telephone Number: (909) 451-6434 E-mail: dacosta@tricitymhs.org
Local Mental Health Mailing Address: 1717 N. Indian Hill Boulevard Suite B, Claremont, CA 91711	

I hereby certify that the MHSA Annual Update Plan FY 2021-22 is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

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

Antonette (Toni) Navarro		06/28/2021
Local Mental Health Director/Designee	Signature	Date

I hereby certify that for the fiscal year ended June 30, 2020, the County/City has maintained an interest- bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated October 19, 2020 for the fiscal year ended June 30, 2020. I further certify that for the fiscal year ended June 30, 2020, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund. I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

Diana Acosta		06/29/2021
County Auditor Controller/ City Financial Officer	Signature	Date

Message from the Executive Director

Every year since 2008, from Fall through the Spring, Tri-City staff and interested stakeholders come together to review and discuss the public mental health needs of the three cities' communities, the relevance and effectiveness of the services currently provided by the Tri-City Mental Health Authority; and propose funding allocations and adjustments to Tri-City's programming for the following year in a process known as the Mental Health Services Act (MHSA) Community Planning Process.

This year's process, although not different, was highly unique given the impact of the COVID-19 pandemic. General meetings and targeted workgroups were held entirely online; and despite this, participation for every session was consistently at or above levels seen in previous years. The success of this year's annual MHSA planning process was a demonstration of a collective commitment to the overall health and well-being of the residents of Claremont, La Verne and Pomona that are served by the Tri-City system of care. More specifically, this year's MHSA Annual Update for Fiscal Year 2021-2022 is a testament to the adaptability, fortitude and resiliency of the Tri-City Mental Health Authority, its staff, its various community partners, and the three cities' residents themselves.

In Tri-City's 60 years of operation, not ever was its role as a part of the public safety net more highlighted and on display than this past year. Staff, despite their own challenges and struggles due to the COVID-19 pandemic, worked their daily shifts and sometimes beyond to ensure that those persons most at-risk in our local area had someone to turn to, someone to talk to, somewhere to get help, 24 hours a day, 7 days a week. This year's MHSA Annual Update shows that while some programs saw reductions in direct services during the COVID-19 emergency, many more saw increases, especially those focusing on helping persons newly accessing Tri-City services and persons who are early on in their experience of mental health distress.

And while the COVID-19 emergency in California has receded, the secondary impacts of the pandemic and this tumultuous time in history will linger in our three cities. Impacts as a result of isolation, long-term consequences of having been infected by COVID-19, grief and loss, unemployment, housing instability, the exposure of systemic inequity as evidenced by the disproportionate treatment and outcomes of persons and communities of color, and other impacts yet to be revealed will certainly affect the mental health and well-being of many in our region for some time to come.

In the aftermath and ongoing, Tri-City's commitment to community capacity building will remain a central focus. The Tri-City system of care presented here and none of its programs can be effective, nor can our three cities' communities be fully well without the support, collaboration, and contributions of our community partners. Thanks to the many who participated in the compilation of this Annual Update. We look forward to the year ahead as we work together to serve and empower those most vulnerable and in need of support in our three cities to overcome their life challenges and thrive.

Toni Navarro, LMFT
Executive Director, Tri-City Mental Health Authority

Executive Summary

Since 1960, Tri-City Mental Health Authority has served as the mental health provider for the Tri-City area. Through a Joint Powers Authority, TCMHA serves in a "county" capacity for the purposes of delivering quality mental health services for the cities of Claremont, La Verne, and Pomona with a combined population which exceeds 220,000.

In FY 2019-20, TCMHA served approximately 2,823 unduplicated clients who were enrolled in formal services. TCMHA currently has 1 9 0 full-time and 2 0 part-time employees and an annual operating budget of 28.1 million dollars. TCMHA strives to reflect the diversity of its communities through it hiring, language spoken, and cultural competencies.

MHSA Community Planning Process

Stakeholder engagement has always been an important component of the community planning process. Input and feedback from community members are critical to help shape the direction and planning for future MHSA programing. Historically, stakeholders are invited to attend community meetings three to four times a year where they are provided with updates related to MHSA programs, new funding and current and future legislation.

Since the onset of COVID-19, community gatherings are prohibited which makes frequent communication with stakeholders even more critical to ensure they are aware of resources and support services that are available to them and the community at large. Stakeholder meetings and workgroups were transitioned to a virtual platform in addition to emails sent with links to online trainings and virtual webinars as well as service updates.

In preparation for this Annual Update for FY 2021-22, the following virtual stakeholder events were convened:

MHSA Event	Total Number
Community Planning Process Survey	1
Stakeholder Meetings	3
MHSA Workgroups	5
Public Hearing	2

MHSA Plans and Funding Components

Passed by California voters in November 2004, Proposition 63, also known as the Mental Health Services Act (MHSA), created a dedicated 1% increase in income taxes on personal income over $1 million to be used for community mental health services.

The following chart reflects the distribution of MHSA funding among the five plans implemented by Tri- City Mental Health. Community Service and Supports (CSS), Prevention and Early Intervention (PEI), and Innovation plans (INN) have specific percentages. Workforce Education and Training (WET) and Capital Facilities and Technological Needs (CFTN) are one-time funds allocated at the

time of plan development. However, both WET and CFTN plans are eligible to receive additional funds through transfers from unspent CSS plan funds, which receives the largest allotment of MHSA funds. However, certain criteria and requirements apply.

MHSA Plan	MHSA Funding Allocation
Community Services and Supports	76%
Prevention and Early Intervention	19%
Innovation	5%
Workforce Education and Training	One-time funds eligible for transfer funds from CSS Plan
Capital Facilities and Technological Needs	One-time funds eligible for transfer funds from CSS Plan

MHSA Plans and COVID–19 Pandemic

In March of 2020, Tri-City Mental Health began to experience the prelude to the COVID-19 pandemic. By the end of March, it became clear that the outbreak of COVID-19 would dramatically change the course and method of how mental health services would be delivered in the cities of Claremont, La Verne and Pomona.

For MHSA programs, service delivery meant discontinuing in-person stakeholder meetings, Wellness Center support groups, and community trainings. These were replaced with a "virtual approach" where TC staff were quickly trained and equipped to transition to online "zoom" meetings hosted on a RingCentral platform. Equipping staff and departments with the needed technology to provide this level of tele-health and tele-training, became a high priority for Tri-City.

As a result, the outcomes and participation rates for the MHSA programs were greatly impacted. Programs that rely heavily on face-to-face communication and engagement experienced a decline in attendance and participation during the last several months of FY 2019-20. This reduction is reflected in many of the MHSA program outcomes and participate numbers indicated below. Conversely, community embedded programs such as the Intensive Outreach and Engagement Team, experienced an increase in contacts due to their continued presence outside of the Agency and acting as one of the first points of contact for individuals in the community seeking crisis services.

Community Service and Supports (CSS)

Community Service and Supports (CSS) plan provides funding to support direct services for individuals with severe mental illness. The CSS plan receives 76% of the total MHSA funding allocation with a minimum of 51% of this funding going to Full Service Partnership (FSP).

Program Name	Notable Changes FY 2019-20
Full Service Partnerships	The number of individuals served increased from 581 in FY 2018-19 to 636 in FY 2019-20.
Community Navigators	The number of individuals served decreased from 2,082 in FY 2018-19 to 1,578 in FY 2019-20.
Wellness Center	Individuals served has decreased from 2,2,64 in FY 2018-19 to 1,703 in FY 2019-20.
Supplemental Crisis Services / Intensive Outreach and Engagement Team	The number of supplemental crisis calls received decreased from 125 in FY 2018-19 to 115 in FY 2019-20. However, the number of individuals served by IOET increased from 674 in FY 2018-19 to 979 in FY 2019-20.
Field Capable Clinical Services for Older Adults	The number of unique individuals served decreased from 34 in FY 2018-19 to 26 in FY 2019-20.
Permanent Supportive Housing	Increased efforts were made to provide additional support in helping individuals maintain their housing. There was an increased from 75 in FY 2018-19 to 113 in FY 2019-20.

Prevention and Early Intervention (PEI)

This plan provides funding to help recognize the early signs of mental illness and to improve early access to services and programs, including the reduction of stigma and discrimination. The PEI plan receives 19% of the total MHSA funding allocation with a minimum of 51% allotted for programs focused on ages 0-25.

Program Name	Notable Changes FY 2019-20
Community Wellbeing Program	The number of community members represented from grantee communities increased from 2,087 in FY 2018-19 to 2,941 in FY 2019-20.
Community Mental Health Trainings	Number of individuals trained in community mental health increased from 330 in in FY 18-19 to 940 in FY 19-20. Number of community mental health trainings increased from 21 in FY 2018- 19 to 54 trainings in FY 2019-20.
Stigma Reduction and Suicide Prevention	The number of stigma reduction presentations decreased from 24 in FY 2018-19 to 15 in FY 2019-20.
TAY and Older Adult Wellbeing: Peer Mentor Program	The number of active peer mentors has remained constant from FY 2018-19 to FY 2019-20. Number of unique participants increased from 235 in FY 2018-19 to 335 in FY 2019-20.
Family Wellbeing Program	The number of unique individuals served increased from 1,230 in FY 2018-19 to 1,287 in FY 2019-20.
NAMI Ending the Silence	The number of presentations has remained constant the last two years. The number of attendees has increased from 94 in FY 2018-19 to 346 in FY 2019-20.
Housing Stability Program	The number of new landlord contacts decreased from 32 in FY 2018-19 to 22 in FY 2019-20. The number of landlord luncheons decreased from 14 in FY 2018-19 to 9 in FY 2019-20.
Therapeutic Community Gardening	The number of unique TCG individuals decreased from 164 in FY 2018-19 to 82 in FY 2019-20. The number of groups held decreased from 299 in FY 2018-19 to 225 in FY 2019-20. Also, Individuals attending groups decreased from 1,027 in FY 2018-19 to 543 in FY 2019-20.
Early Psychosis Program	The PIER and UCLA trainings scheduled for spring of 2020 were delayed until the fall of 2020 due to the pandemic. The trainings will now be virtual.
Wellness Center PEI Programs (TAY and Older Adults)	The number of unique individuals served increased from 419 in FY 2018-19 to 741 in FY 2019-20.

Please see individual summaries for detailed information regarding each of these programs.

Innovation (INN)

The Innovation Plan provides funding for short-term projects - one to five years - that explore novel efforts to strengthen aspects of the mental health system. Five percent of MHSA funding received by Counties is allotted for Innovation programing.

Program Name	Notable Changes FY 2019-20
Help@Hand/Tech Suite Project	The original Tech Suite proposal targeted older adults, TAY, and monolingual speakers. Since the onset of the pandemic, this project will expand to encompass other populations that may have been severely impacted by COVID-19.

Workforce Education and Training (WET)

The Workforce Education and Training (WET) program focuses on improving the effectiveness of people currently providing support and services in the Tri-City area as well as preparing the community for careers in mental health. Clinical and non-clinical staff, family, community caregivers and volunteers are the primary recipients of the education and training offered through the WET Plan. The WET plan received a one-time allocation of funds when originally approved, but retains the option of receiving additional monies through a transfer of unspent funds from the Community Services and Supports Plans with stakeholder approval.

Program Name	Changes observed in FY 2019-20
Staff Trainings	Number of courses completed by staff through Relias increased from 1,012 in FY 2018-19 to 2,059 in FY 2019-20.
Service Learners [i.e. Volunteers]	The number of applicants who became Service Learners decreased from 39 in FY 18-19 to 21 in FY 2019-20. Service Learner hours decreased from 4,181 in FY 18-19 to 2,232 in FY 19-20.

Capital Facilities and Technological Needs (CFTN)

Capital Facilities and Technological Needs provides funding for building projects, improving the infrastructure of mental health providers, and increasing technological capacity to improve the delivery of mental health services. The CFTN plan received a one-time allocation of funds when originally approved, but retains the option of receiving additional monies through a transfer of unspent funds from the Community Services and Supports Plans with stakeholder approval.

Program Name	Changes observed in FY 2019-20
Capital Facilities and Technological Needs	In March 2020, Tri-City's Governing Board approved the expenditure of CFTN funds in the amount of $970,968.00 to make improvements for two TCMH locations: MHSA Administration Office and the Therapeutic Community Garden. Work will begin in FY 2020-21.

Tri-City's Annual Update FY 2021-22 to the Three-Year Revenue and Expenditure Plan for FY 2020-21 through FY 2022-23, was posted for a 30-day public review and comment period from May 7, 2021 to June 8, 2021. The MHSA Public Hearing was held on June 8, 2021 and hosted by Tri-City's Mental Health Commission. At that time, the Mental Health Commission recommended approval of the MHSA Annual Update FY 2021-22 to the Tri-City Governing Board. The Tri-City Governing Board acted on this recommendation and adopted the MHSA Annual Update FY 2021-22 on June 16, 2021.

Introduction to Tri-City Mental Health Authority

Tri-City Mental Health Authority has been the leading mental health provider and authority for the cities of Claremont, La Verne, and Pomona since 1960. Through a Joint Powers Authority, Tri-City celebrates 60 years as the main gateway to quality mental health services and support. With a combined population which exceeds 220,000, these three cities are considered integrated into a single "county" while demonstrating distinct differences within each city.

The following tables indicate the total population by ethnicity:

Population Percent by Ethnicity
U.S. Census Date (2019)

City: / Ethnicity:	La Verne	Claremont	Pomona	Tri-City
White	49.6%	48.9%	10.8%	23.0%
Black/African American	3.3%	5.3%	5.6%	5.5%
American Indian/Alaska Native	0.7%	1.0%	2.4%	1.6%
Asian	9.4%	14.3%	10.2%	10.6%
Native Hawaiian/Pacific Islander	0.0%	0.0%	0.1%	0.1%
Hispanic/Latino	36.1%	25.4%	71.7%	58.8%
Two or More Races	5.7%	7.1%	4.4%	4.8%
Totals	**31,974**	**36,266**	**151,691**	**219,931**

Source: U.S. Census Data, (2019).
https://www.census.gov/quickfacts/fact/table/lavernecitycalifornia,claremontcitycalifornia,pomonacitycalifornia/PST045219

Claremont is located 30 miles east of downtown Los Angeles in the Pomona Valley, at the foot of the San Gabriel Mountains and is home to the Claremont Colleges, tree-line streets and numerous historic building. Located to the west of Claremont is the city of La Verne. Originally named Lordsburg, La Verne was known as the "Heart of the Orange Empire" due to the flourishing citrus trees which dominated the area until World War II. The largest city to make up the tri-city area is Pomona, which is located just south of the city of La Verne. Pomona is home to California State Polytechnic University, Pomona (Cal Poly Pomona) and the site of the Fairplex, which hosts the Los Angeles County Fair. The tri-city area is also home to seven colleges and universities.

The following table reflects the current demographics for the combined cities of Claremont, La Verne, and Pomona:

Selected Data for Tri-City (Pomona, Claremont, La Verne) U.S. Census Data	Tri-City (Pomona, Claremont, La Verne)
Population	
Population estimates, July 1, 2019, (V2019)	219,931
Population estimates base, April 1, 2010, (V2019)	215,035
Population, percent change - April 1, 2010 (estimates base) to July 1, 2019, (V2019)	2.3%
Population, Census, April 1, 2010	215,047
Age and Sex	
Persons under 5 years, percent	6.8%
Persons under 18 years, percent	23.8%
Persons 65 years and over, percent	12.9%
Female persons, percent	51.2%
Race and Hispanic Origin	
Black or African American alone, percent	5.5%
American Indian and Alaska Native alone, percent	1.6%
Asian alone, percent	10.6%
Native Hawaiian and Other Pacific Islander alone, percent	0.1%
Two or More Races, percent	4.8%
Hispanic or Latinx, percent	58.8%
White alone, not Hispanic or Latinx, percent	23.0%
Population Characteristics	
Veterans, 2014-2018	6769
Foreign born persons, percent, 2014-2018	29.0%
Housing	
Owner-occupied housing unit rate, 2014-2018	57.5%
Median value of owner-occupied housing units, 2014-2018	$525,033
Median selected monthly owner costs -with a mortgage, 2014-2018	$2,350
Median selected monthly owner costs -without a mortgage, 2014-2018	$579
Median gross rent, 2014-2018	$1,450
Families and Living Arrangements	
Households, 2014-2018	62,200
Persons per household, 2014-2018	3.54
Living in same house 1 year ago, percent of persons age 1 year+, 2014-2018	86.0%
Language other than English spoken at home, percent of persons age 5 years+, 2014-2018	53.9%
Computer and Internet Use	
Households with a computer, percent, 2014-2018	92.2%
Households with a broadband Internet subscription, percent, 2014-2018	84.8%
Education	
High school graduate or higher, percent of persons age 25 years+, 2014-2018	60.8%
Bachelor's degree or higher, percent of persons age 25 years+, 2014-2018	26.9%

Health	
With a disability, under age 65 years, percent, 2014-2018	7.0%
Persons without health insurance, under age 65 years, percent	11.9%
Economy	
In civilian labor force, total, percent of population age 16 years+, 2014-2018	62.2%
In civilian labor force, female, percent of population age 16 years+, 2014-2018	55.4%
Total accommodation and food services sales, 2012 ($1,000)	108,300
Total health care and social assistance receipts/revenue, 2012 ($1,000)	501,808
Total manufacturers' shipments, 2012 ($1,000)	436,916
Total merchant wholesaler sales, 2012 ($1,000)	891,550

To ensure that our workforce demographics are comparable to those of our client demographics, Tri-City's current workforce represents a culturally diverse reflection of the community we serve. With regard to recruitment and selection, Tri-City's Human Resources Department actively seeks out recruitment advertisement opportunities with a variety of culturally specific organizations and associations and advertises with and participates in employment fairs.

Hiring bicultural and bilingual staff that reflect the populations with disparities

The following chart reflects Tri-City staff demographics. The Hispanic/Latino, Black/African American and Native Hawaiian/Pacific Islander populations are successfully represented by Tri-City staff while the Asian and Native American/Alaska Native demographics continue to be a focus for recruitment.

Tri-City Mental Health Staff Demographics (May 2021)	
American Indian or Alaska Native	0.48%
Asian	9.09%
Black or African American	8.61%
Hispanic or Latino	56.46%
Native Hawaiian or Pacific Islander	0.48%
Other	8.61%
Two or More Races	1.44%
White or Caucasian	14.35%

Mental Health Services Act

Passed by California voters in November 2004, Proposition 63, also known as the Mental Health Services Act (MHSA), created a dedicated 1% increase in income taxes on personal income over $1 million to be used for community mental health services. These new tax revenues were the first expansion of funding for mental health services in many years.

To access these funds, local mental health systems like Tri-City Mental Health Authority are required to engage a broad range of stakeholders and prepare five substantive plans:

Community Service and Supports (CSS)
(CSS approved in 2009) This plan provides intensive treatment and transition services for people who experience serious and persistent mental illness or severe emotional disturbances or who are at risk of SMI/SED.

Prevention and Early Intervention (PEI)
(PEI approved in 2010) These programs focus on early intervention and prevention services in addition to anti-stigma efforts.

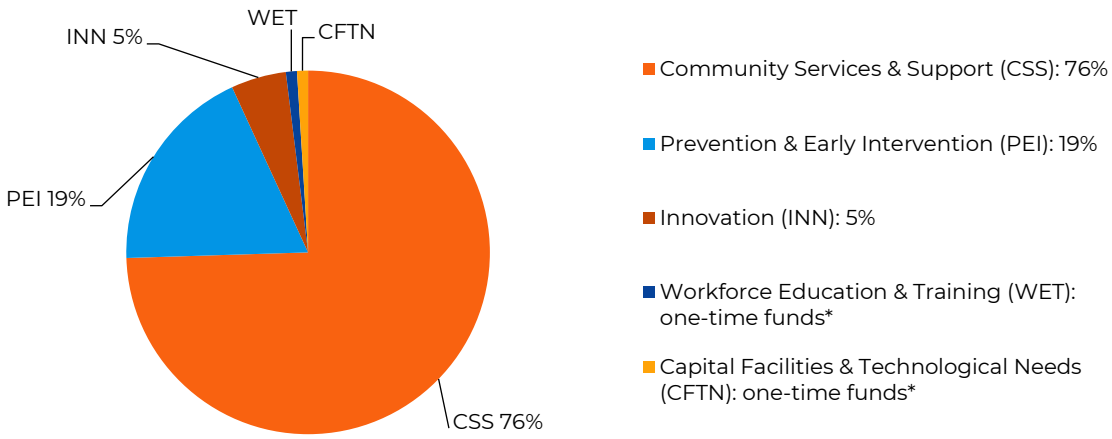
Workforce Education and Training (WET)
(WET approved in 2012) The WET efforts focus on strengthening and supporting existing staff and caregivers through trainings while also focusing on attracting new staff and volunteers to ensure future mental health personnel.

Innovation (INN)
(INN approved in 2012) Innovation consists of short–term projects, one to five years, that explore novel efforts to strengthen aspects of the mental health system.

Capital Facilities and Technological Needs (CFTN)
(CFTN approved in 2013) This plan focuses on improvements to facilities, infrastructure and technology of the local mental health system

MHSA funds allocated to counties, including Tri-City Mental Health, are distributed among the five MHSA plans based on the following percentages:

MHSA Funding Allocations



Community Planning Process

The Mental Health Services Act (MHSA) emphasizes and requires counties to implement a robust stakeholder process known as the Community Planning Process. This practice focuses on engaging a large sample of community members and professionals who provide input and actively participate in the creation of programs designed to meet the needs of the unserved and underserved populations of each county.

By fostering diverse stakeholder involvement, Tri-City Mental Health continues to value and empower these participants throughout the community planning process. Our stakeholders consist of a combination of "seasoned veterans" who have actively participated in this process since 2008 and are well versed in the history and the trends of our MHSA process. In addition, new stakeholders are recruited annually to provide a fresh perspective to this critical process.

In March of 2020, it became clear that the outbreak of the COVID -19 pandemic would dramatically change the course and method of how mental health services and stakeholder meetings would be conducted within the cities of Claremont, La Verne and Pomona. Beginning in April 2020, Tri-City launched our stakeholder meetings and workgroups virtually in response to COVID-19 restrictions. This change resulted in a reduction in participation due to a variety of issues including lack of technology or knowledge of use on the part of stakeholders, in addition to difficulty in reaching participants through emails or phone. Previous outreach efforts included in-person announcements at community meetings and distribution of flyers at local agencies, libraries, community centers and city government locations. With the widespread closures of these critical community sites, notification of stakeholder meetings was limited to email distribution lists, website posting and social media.

The following categories of stakeholders and community members were included in the community planning notifications: consumers and individuals with lived experience, local community providers; leaders of community groups in unserved and underserved communities; old adults, adults, transition age youth and families with children; representatives from the three cities of Claremont, La Verne and Pomona as well as local school districts, colleges and universities; veterans; law enforcement, primary health care providers; mental health, physical health and drug and alcohol treatment providers; faith- based community representatives; representatives from the LGBTQ community; and many others. Stakeholders participate in all aspects of the Mental Health Services Act, including policy development, planning, implementation, monitoring, improvement, evaluation, and budget allocations.

Prior to the COVID-19 pandemic, Tri-City held two identical in-person stakeholder meetings-one in the morning and one in the evening- to accommodate participant's schedules. Spanish interpreters were available for each meeting. When the community planning process began in the fall of 2020, the first virtual Stakeholder Meeting and MHSA Orientation for FY 2020-21, was held on Wednesday, September 30 with 41 participants. Of those in attendance; 40% were new stakeholders and 32% have been a part of Tri-City's stakeholder process for over 3 years. The presentation focused on providing both new and existing stakeholders with an overview of the Mental Health Services Act (MHSA) as well as a description of current MHSA programs. Following the comprehensive presentation, 100% of stakeholders polled indicated they support Tri-City's current MHSA programs as stated or agreed with the majority of the programs.

The first of the MHSA workgroups began on October 15, 2020 and focused on reviewing the Community Service and Support (CSS) and Prevention and Early Intervention (PEI) programs in

greater detail. Workgroups for the review and creation of new Innovation projects began in January 2021. The following chart reflects the MHSA community meeting schedule for FY 2020-21.

Community Planning Process FY 2020-21

Community Event	Dates	Topics
Stakeholder Meetings	09/30/2020	MHSA Orientation and Community Planning Process
CSS Workgroups	10/15/2020	Review of Community Services and Supports Programs
PEI Workgroups	10/15/2020	Review of Prevention and Early Intervention Programs
INN Workgroup	01/21/2021 02/4/2021 02/11/2021	Review of current Innovation (INN) project, Help@Hand, and new Innovation project proposals
INN Focus Group	02/16/2021 02/18/2021 02/11/2021	Focus group participants reviewed applications for Help@Hand INN Project
Stakeholder Meeting	03/04/2021	Stakeholders reviewed the new Innovation project, *Restorative Practices for Improving Mental Health (RPIMH)*, recommendations and new projects
Stakeholder Meeting	04/08/2021	Stakeholders reviewed the new Capital Facilities and Technological Needs (CFTN) plan, addition to NAMI Program, and overview of FY 2021-22 Annual Update
Draft Innovation Project – RPIMH	04/09/2021	Posted for 30-Day Comment Period
Draft CFTN Plan	04/09/2021	Posted for 30-Day Comment Period
Draft FY 2021-22 Annual Update	05/07/2021	Posted for 30-Day Comment Period
Public Hearing RPIMH Innovation Project	05/19/2021	Presented to the Mental Health Commission and Governing Board for approval
CFTN Plan	05/19/2021	Presented to the Mental Health Commission and Governing Board for approval
MHSA Public Hearing	06/08/2021	Hosted by the Mental Health Commission - Annual Update FY 2021-22 Review
Governing Board	06/16/2021	Governing Board voted to adopt the Annual Update FY 2021-22

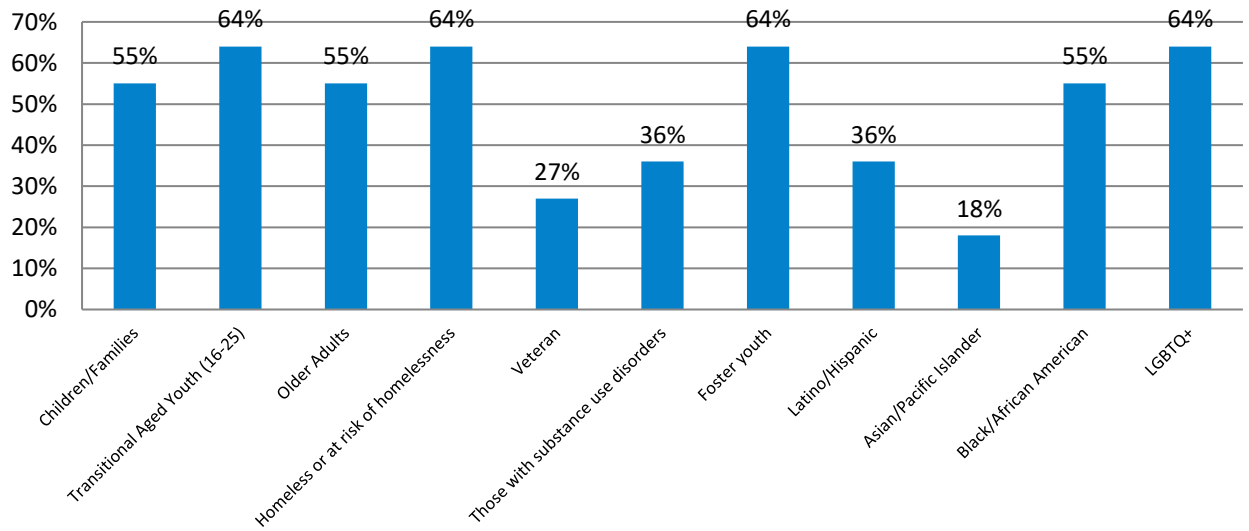
MHSA Community Planning Survey

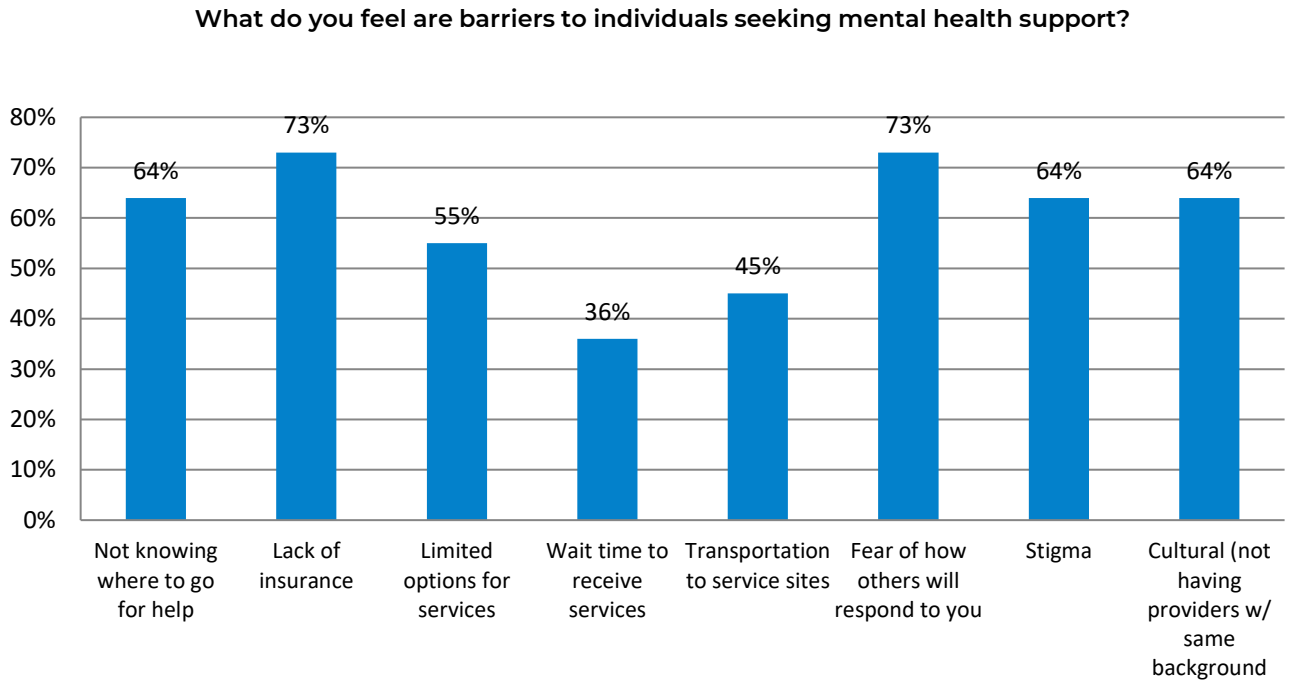
Following the September 2020 stakeholder meeting, participants were emailed and encouraged to complete Tri-City's MHSA Planning Process Survey to share their thoughts and concerns regarding the availability of support services. This annual community planning survey is used to identify the needs and priorities of the three cities. These results are then presented to workgroups who review current MHSA programing and make recommendations for staff consideration. Survey results were then shared with community stakeholders during the stakeholder workgroup and incorporated into this MHSA Annual Update for FY 2021-22. This survey is just one of many opportunities where stakeholders are able to share their voice regarding the needs of the communities.

Survey Results

As a result of the COVID -19 pandemic, there was a reduction in the number of surveys completed. The survey included questions regarding the needs of the community, perceived barriers to services and suggestions or recommendations for future services or programs that may not currently be offered. Survey results identify the top priority populations as Transition Age Youth, Homeless, Foster Youth and LGBTQ+. The most popular concerns related to barriers to services were lack of insurance and stigma.

Indicate the population(s) you feel is most unserved/underserved in the above mentioned communities. (Check all that apply.)





Complete survey results are included in the Appendix.

30-Day Public Comment Period and Public Hearing

Tri-City Mental Health's Annual Update FY 2021-22 to the Three-Year Program and Expenditure Plan for FY 2020-21 through FY 2022-23 provides a comprehensive overview of the MHSA projects and programs funded through the Mental Health Services Act, based on data collected during FY 2019-20. The draft of this Annual Update was posted on May 7, 2021 for a 30-day public comment period. Staff circulated a draft of the Annual Update by making electronic copies available on TCMH 's website and providing printed copies at various public locations, where possible, following COVID-19 guidelines. Several methods of collecting feedback were available including phone, fax, email, mail, and comment cards. Questions received during the 30-day public comment period were addressed in detail during the Public Hearing hosted by Tri-City's Mental Health Commission on June 8, 2021.

At that time, the Mental Health Commission reviewed and recommended approval of the MHSA Annual Update FY 2021-22 to the Tri-City Governing Board. The Tri-City Governing Board acted on this recommendation and adopted the MHSA Annual Update FY 2021-22 on June 16, 2021.

MHSA Workgroup Recommendations

During the recent MHSA workgroup deliberations, participants were invited to review the current Community Services and Supports (CSS) and Prevention and Early Intervention (PEI) projects and identify gaps in services as well as recommendations for general improvements and/or potential new projects to be funded through CSS dollars and/or PEI budgets. In addition, a community workgroup was convened to review both current and potential Innovation project concepts for future implementation.

The stakeholders endorsed the proposed recommendations which are included in this MHSA Annual Update and Expenditure Plan. Based on feedback provided by these participants, the following is a brief summary of the recommendations made and endorsed through the stakeholder process:

Community Services and Supports (CSS) – This plan provides funding to support direct services for individuals with severe mental illness.

Full-Service Partnership (FSP)

Full-Service Partnerships are for individuals who experience severe mental illness and are at risk of homelessness or other devastating consequences. The program uses a "whatever it takes" approach to help people recover. The plan can include all needed services, including but not limited to traditional mental health services and safe housing. Recommendations include:

- Continue the FSP programs as stated
- Increase partnering with community resources to identify housing opportunities
- Continuing to work with internal and external medication services team to connect individuals to appropriate medical resources (in-home services, medical case management and skilled nursing)
- Maintain trainings designed to engage consumers effectively through Tele-Health

Community Navigators (CN)

Community Navigators assist individuals in the Tri-City area connect to local resources, including informal community supports and available formal services. Navigators also provide education and stigma reduction services to local communities and organizations.

- Continue the Community Navigator programing as stated
- Maintain recommended COVID-19 safety guidelines
- Meet with individuals in the community or local facilities utilizing personal protection equipment (PPE)
- Utilize technology (mobile phones and laptops) to research and access resources and support services as requested by community members

Wellness Center (WC)

The Wellness Center is a community hub for activities that promote recovery, resiliency and wellness for residents of the Tri-City area. The Wellness Center is open to people of all ages, focusing especially on people in recovery and their families. The Wellness Center sponsors support groups, and provides an array of holistic services through collaboration with other community partners.

- Continue Wellness Center programing as stated
- Continue to follow recommend COVID-19 safety guidelines
- The Center anticipates opening up at 25% capacity once the state and county approves the re- opening of indoor spaces

Supplemental Crisis Services | Intensive Outreach and Engagement Team (SCS and IOET)

The Supplemental Crisis Services program provides after-hours and weekend phone support to individuals who are experiencing a crisis and who currently are not receiving TCMH services. Crisis walk-in services are also available during business hour at Tri-City's clinic location. The Intensive Outreach and Engagement Team (IOET) serves as the conduit to individuals who are unable to access mental health services on their own. The IOET also connects with individuals upon discharge from local emergency rooms to reassess them for longer term treatment and services, as needed.

- Continue Supplemental Crisis Services/Intensive Outreach and Engagement Team programs as stated
- Strive to remove barriers by adapting the environment while adhering to the polices set forth by elected officials and the agency as far as safety is concerned
- Develop PACT-Psychiatric Assessment Care Team to include a Licensed Psychiatric Technician and a Licensed Therapist to Communicate, Collaborate and Coordinate real time assessment services in the City of Claremont

Field Capable Clinical Services for Older Adults (FCCS)

Through this program, TCMH staff members provide mental health services to older adults where they are, such as in their homes, senior centers, and medical facilities.

- Continue Field Capable Clinical Services for Older Adults program as stated
- Attend elder-based trainings on integrated care
- Seek alternative ways (phone, video conferencing) to outreach to elder-based community programs

Permanent Supportive Housing (PSH)

Permanent supportive housing units are short-term living spaces where people who are homeless or at risk of homelessness, and who suffer from one or more mental illnesses, can receive an array of services designed to support their recovery.

- Continue Permanent Supportive Housing program as stated
- Create new groups that can be conducted over the phone
- Focus on providing tenants with groups for entertainment, resources, community connection within their sites, and a place for parents to share tips for their new role as teacher assistants
- Continue the Supportive Options and Referral groups to be conducted over the phone

Prevention and Early Intervention (PEI) – This plan provides funding to help recognize the early signs of mental illness and to improve early access to services and programs, including the reduction of stigma and discrimination.

Community Wellbeing Program (CWB)

This program provides small grants and technical assistance to help communities build their capacity to strengthen the wellbeing of their members and the community as a whole.

- Continue the Community Wellbeing Program as stated
- Maintain programing virtually through RingCentral
- Offer fillable forms to make it easier for grantees to sign, complete and submit forms
- Focus outreach efforts through emails, phone calls and social media

Community Mental Health Trainings (CMHT)

Community Mental Health Trainers offer community trainings including Mental Health First Aid and workshops based on the Recovery Model, Non-Suicidal Self-Harm and parenting classes.

- Continue CMHT program as stated
- Community Trainings will continue to be delivered virtually on Ring Central Webinar
- Provide a community needs assessment to see what topics/information community members/partners need/want during this time as well as look at when they are available to attend webinars (days/times)
- Offer monthly community webinars and virtual trainings to community partners per their request.
- Increase use of Tri-City's website and social media to share marketing and outreach materials with our community partners for upcoming webinars/trainings

Stigma Reduction | Suicide Prevention

Tri-City's stigma reduction efforts consist of three main components: Room4Everyone, Courageous Minds/Creative Minds, and Green Ribbon Week. Suicide prevention efforts include offering the safeTALK alertness training which provides participants with the skills needed to recognize the signs of suicide in an individual and connect them quickly and safely with the appropriate resources and support services.

- Continue Stigma Reduction and Suicide Prevention Program as stated
- Review the current community needs assessment and adapt the presentation schedule to include topics prioritized by the community.
- Convert paper program surveys to an online survey monkey which will allow them to be administered directly at the end of presentations

- Begin using short video clips as well as Facebook Live and IGTV (Instagram TV) in order to reach more individuals through social media

Older Adult Wellbeing/Transition Age Youth Wellbeing (Peer Mentor and Wellness Center Programs)

The Peer Mentor program trains volunteers from the Tri-City area who want to learn how to provide support to peers (mentees) who are in emotional distress. Individuals attending the TAY and Older Adult programing located at the Wellness Center benefit from specialized support groups and activities targeting their specific needs.

- Continue Peer Mentor Program as stated
- Peer Mentor training will be conducted via RingCentral Meeting
- Meetings with mentees will continue via telephone
- Wellness Roundtable will be hosted virtually via RingCentral and new Wellness Roundtable topics will be created (Proud to be me, Coping during COVID-19 etc.)
- Continue training, "Working with Older Adults during COVID-19", for outside agencies
- Collaborate with Claremont Scripps College and provide training and support to transition age youth during COVID-19

Family Wellbeing Program (FWB)

In this prevention program, staff and volunteers build trusting relationships and provide support to family members and caregivers of people who experience mental illness.

- Continue Family Wellbeing Program as stated
- Focus on creation of a new children's group, strengthening existing groups, and partnering with new agencies in the community
- Transition groups and events to a virtual platform
- Host a virtual summer camp, if COVID restrictions continue

Housing Stability Program (HSP)

The Housing Stability Program is a prevention program designed to help people with mental illness maintain their current housing or find more appropriate housing.

- Continue Housing Stability Project as stated
- Work with Community Trainers to identified a need and design for trainings for our property owners and landlords to address responding to tenants in difficult situations
- Adapting outreach by assisting with housing referrals that involve evictions or landlord issues

- Update Good Tenant Curriculum with new topics brought suggested by previous participants including housing information related to COVID-19
- Begin hosting regular landlord housing forums to provide a virtual round table for landlords.

Therapeutic Community Gardening (TCG)

The Therapeutic Community Gardening program helps participants decrease their isolation and experience mental health benefits through participation in horticulture/gardening activities and group therapy exercises.

- Continue Therapeutic Community Gardening Program as stated
- Connect to new community partners who work with the K-12 system to increase transition age youth (TAY) outreach options
- Maintain preexisting participation in the La Verne Youth and Family Action Committee in order to outreach to TAY and their families.
- Outreach at Pomona Fairplex, Fall in the Farm, a family event that sees hundreds of TAY during the event
- Attended events at the TAY space for outreach such as the Christmas Tree Lighting ceremony
- Ongoing internal outreach to TC staff by providing monthly harvests, flyers and emails to staff who work with TAY population

Early Psychosis Program (EPP)

The Early Psychosis Program addresses the identification and diagnosis of individuals who are suffering from psychosis and are not currently enrolled in mental health services.

- Continue Early Psychosis Program as stated
- Confirm that PIER training will occur virtually to expedite the launch of this program
- Adapt all presentation to be conducted virtually
- Adapt outreach strategies to be conducted via phone
- Provide services via telehealth and trainings via RingCentral

Innovation (INN) – This plan provides funding for short-term projects, one to five years, that explore novel efforts to strengthen aspects of the mental health system.

Help@Hand | Tech Suite Project

This project hopes to increase access to mental health care by providing a non- traditional system through the use of computers, tablets and smartphones, targeting individuals who may be reluctant to access services through a more formal clinical setting.

- Continue the Help@Hand project as stated
- Review preapproved online applications for possible pilot project
- Consider other strategies to fast-track the launch of this project

Additional proposals approved during the Community Planning Process for FY 2021-22

Capital Facilities and Technological Needs (CFTN)

Tri-City Mental Health (TCMH) intends to expend existing MHSA funds assigned to Capital Facilities and Technological Needs (CFTN) to implement a new Electronic Health Record system and client referral management platform.

The Office of the National Coordinator for Health Information Technology's (ONC) Cures Act Final Rule passed in 2020 is designed to empower patients with their health record in the modern health IT world. It supports seamless and secure access, exchange, and use of electronic health information. The rule is designed to give patients and their healthcare providers secure access to health information. It also aims to increase innovation and competition by fostering an ecosystem of new applications to provide patients with more choices in their healthcare. It calls on the healthcare industry to adopt standardized application programming interfaces (APIs), which will help allow individuals to securely and easily access structured electronic health information using smartphone applications. The rule includes a provision requiring that patients can electronically access all of their electronic health information (EHI), structured and/or unstructured, at no cost.

To meet the needs of the ONC rule, TCMH intends to migrate its current EHR platform from Welligent to the Cerner Electronic Health record platform. TCMH is seeking stakeholder approval for a portion of the implementation costs of the Cerner EHR platform.

Additionally, TCMH does not currently have a centralized referral management platform. Such a system would allow TCMH to ensure the quality of referrals delivered by TCMH, as well as allow for both increased transparency and follow-up from both the TCMH clinical and Community Navigator staff as well as the participants.

The final draft of the new Capital Facilities and Technological Needs project was endorsed by stakeholders and was posted for a 30-day public review and comment period from April 9 to May 10, 2021. Once the 30-day comment period was complete, the proposal was presented to the Mental Health Commission and Tri-City Governing Board during their joint meeting held on for May 19, 2021. At that time, the CFTN project was approved and adopted.

Technological Platform	Projected Funding
Cerner Electronic Health Record System Implementation	$270,436
Unite US Platform Implementation	$30,000

NAMI Community Capacity Building

In FY 2011-12, NAMI Pomona Valley entered into a partnership under Tri-City Mental Health's Prevention and Early Intervention Plan to provide training in schools located in the cities of Claremont, La Verne and Pomona. Under the NAMI Community Capacity Building program, this training focused on identifying the early warning signs on mental illness and how to address them. This training called Parents and Teachers as Allies, was directed at teachers and parents and played an important role in educating communities on mental illness as well as reducing stigma.

In July 2019, Parents and Teachers as Allies (PTAA) was replaced by a more comprehensive training called Ending the Silence (ETS). This replacement program included the same components as PTAA as well as a component dedicated to training students to recognize these early warning signs of MI and how to respond and support their peers. In addition, ETS contains a strong focus on suicide prevention which is considered a critical feature of this training.

In the spring of 2020, the impact of COVID-19 led to restrictions on community and school-based trainings. This created limited access of school personnel, parents and students which resulted in a decline in the number of ETS presentations made. It also sparked an increase in requests for a more generalize training on mental health. During this time, NAMI Pomona Valley began to consider the expansion of their program, NAMI 101, which serves as a gateway to other support programs offered through this organization. The strategy was to include both Ending the Silence and NAMI 101 as training options under the NAMI Community Capacity Building program.

On April 8, 2021, stakeholders unanimously agreed to add NAMI 101 to the existing Ending the Silence program thereby creating two training options for community members. The original funding allocation for ETS of $35,500 per year will remain the same and NAMI Pomona Valley will now be able to submit invoices for both programs under this revised plan.

This program modification is made part of the MHSA Annual Update for FY 2021-22 and was posted on May 7, 2021 for a 30-day comment period. After the 30-day comment period, the plan was presented to the Mental Health Commission during the Public Hearing on June 8, 2021 for endorsement, and was approved and adopted by the Tri-City Governing Board Meeting on June 16, 2021.

New Innovation Project Proposal

Restorative Practices for Improving Mental Health	
Total Amount Requested	$949,957
Duration of INN Project	Three Years: July 2021 – June 2024

In January of 2021, community members and Tri-City staff came together to begin the process of identifying a new Innovation project. Innovation workgroup participants consisted of fifteen members who reflect a diverse group of individuals. These individuals represented Tri-City staff, faith-based leaders, community members involved in juvenile justice, LGBTQ, and transition age youth.

Community engagement and collaboration have long been the driving forces behind the success of the projects and programs implemented by Tri-City Mental Health under the Mental Health Services Act. This long-standing alliance is the undertone of the Restorative Practices for Improving Mental

Health (RPIMH) project which is comprised of a combination of three evidence-based practices, SKY Breathing, Trauma Informed Yoga, and Restorative Practice Circles, which are typically delivered independently and address distinct elements related to physical health and emotional health of participants. Each of these practices are normally offered separately for a fee and as such, may not meet the individual needs of the participants. In addition, the cost is often times prohibitive for the disadvantaged youth we serve.

This project is proposing to combine these three practices into a single course of treatment or healing aimed at addressing the deficits in mental and emotional support currently available in this area. Two target populations are identified and will be engaged for this project: 1) Tri-City clinical and non-clinical staff who are experiencing the effects of COVID 19 leading to elevated stress and potential burnout; and 2) Transition Age Youth (TAY) ages 16-25, who reside within the Tri-City catchment area, including TAY who are at risk due to COVID-19, those who are residing in foster care, or identify as LGBTQ, as well as the staff that support them.

The final draft of the new Innovation project, Restorative Practices for Improving Mental Health (RPIMH), has been endorsed by stakeholders and posted for a 30-day public review and comment period from April 9 to May 10, 2021. In addition, the RPIMH project proposal was submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) for concurrent technical assistance and feedback.

After the 30-day comment period, the proposal was presented to the Mental Health Commission and Tri-City Governing Board during a Public Hearing held on May 19, 2021. At that time, the RPMH project proposal was approved and adopted. The final step will be to submit the plan for final approval to the Mental Health Services Oversight and Accountability Commission.

MHSA Programs

The following pages contain descriptions of each MHSA-funded program. The descriptions include updates to the program's development; performance outcomes; and cost per participant calculations for programs that provide direct services.

The services provided for Fiscal Year 2019-20 are highlighted in each program summary by age group, number of clients served, and average cost per person.

Community Services and Supports (CSS)

The Community Services and Supports (CSS) Plan provides intensive treatment and transition services for people who suffer with serious and persistent mental illness or severe emotional disturbances, or who are at risk of SMI/SED.

- Full-Service Partnerships
- Community Navigators
- Wellness Center
- Supplemental Crisis Services | Intensive Outreach & Engagement Team
- Field Capable Clinical Services for Older Adults
- Permanent Supportive Housing

Full-Service Partnerships

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
MHSA Plan:	_X_ CSS	___ PEI	___ INN	___ WET	____ CFTN
Target Population:	_X_ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:

Program Description

Full-Service Partnerships (FSPs) are for people who are experiencing severe mental illness and at risk of homelessness or other devastating consequences. The program uses a "whatever it takes" approach to help people recover. The plan can include all needed services, including but not limited to traditional mental health services and safe housing.

Target Population

Unserved and underserved individuals targeting four groups: Children ages 0-15, Transition Age Youth ages 16-25, Adults ages 26-59 and Older Adults ages 60 and over, with severe and persistent mental illness.

Age Groups	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+
Number Served FY 2019-20	106	147	317	66
Cost Per Person	$11,913	$12,338	$11,613	$8,232

Program Update

In FY 2019-20, the Full-Service Programs (FSP) program experienced several successes including an increase in the number of dual diagnosis clients who entered into substance use inpatient treatment programs. This improvement is attributed to strong support and collaboration between the Substance Use Disorder (SUD) program and Tri-City's clinical team.

FSP staff have also noted an upsurge in family involvement for clients. This growth is attributed to an increased focus on engagement and meeting with family members in sessions and safety planning. This has resulted in clients feeling more confident to manage their symptoms as well as an increase in "graduations" (lower level of care or no further care needed) from the FSP program.

Another successful team approach between Tri-City clinical and housing staff, has led to a reduction in the number of homeless consumers residing in motels while increasing the number of individuals who are successfully housed. This collaborative strategy includes training staff on how to identify resources available to consumers through reference guides, trainings, and how to effectively guide clients.

Challenges and Solutions

One of the most critical challenges remains adequate staffing. During FY 2019-20, the FSP program experienced a lower level of staffing which resulted in a higher caseload for each staff member.

Several times throughout the year, peaks in referrals reach as many as 10 per month. In response to this increased demand, the leadership team expedited interviewing and hiring processes as well as working with the human resource department to identify additional recruiting ideas. In response to these efforts the staffing numbers for FSP have improved.

Additional difficulties included a noted increase in consumers experiencing homelessness. To address the increase in clients struggling with homelessness, FSP staff have improved tracking and monitoring practices specific to support services offered to consumers to identify permanent stable housing. Leadership team members continue to attend community meetings and partnership meetings to develop a better understanding of the resources available. Referral guides and references were also created so that staff could efficiently support clients seeking housing.

COVID-19 Response

Some of the challenges experienced since the onset of COVID-19 include, 1) lack of comfort for clients with the new tele-health approach due to privacy issues; 2) lack of access to internet or appropriate technology to engage in tele-health; 3) difficulty locating clients who are transient and not reachable by phone; and 4) clients in the community refusing to follow safety protocol such as wearing a mask.

In response to these concerns the FSP department has designated specified “safe area” in the office to conduct in-person sessions and address crises situations. This space has proven to be very helpful for clients who are not able to use tele-health or have been difficult to engage in treatment via tele-health.

In addition, a kiosk station has been created in the office for consumers who are not able to use tele-health at home or do not have access to the internet. This allows the clients to come to the office and engage in medication appointments, assessments, or regular sessions using RingCentral on the kiosk. This option has proven successful for clients who are better able to engage in their psychiatrist appointments as well as families residing in motels or those with privacy challenges in the home.

Prior to the outbreak of COVID 19, staff were able to consult with other team members and supervisors quickly and easily due to the close proximity of their offices. Since the pandemic restrictions were imposed, there are limited staff on site. At times, staff have reported this new “normal” has required additional planning and forethought in order to anticipate the needs of the clients and respond appropriately. Initially there was a disconnect between teams resulting in a delay in response times. However, once virtual meetings and telehealth became standard procedures, this concern was alleviated.

Cultural Approach

Cultural consideration is a critical component to the delivery of services through Full Service Partnerships. Challenges include parents of children receiving services may have difficulty understanding the value of treatment due to stigma associated with mental health within their culture. Tri-City’s hiring practice of engaging staff who are reflective of the community, helps to address these concerns. At this time 9 of the 13 FSP staff are bilingual Spanish speaking and outreach and intake materials are available in multiple languages. Support staff who are able to relate to clients and/or family members on a cultural basis are available to become part of the clients support team.

Cultural bias is also address through the FSP programs. Discussion topics and trainings for staff include how implicit bias can contribute to creating barriers for underserved and unserved

consumers who are looking to access FSP programing. Open discussions regarding "school to prison pipeline" and racial disparities help staff to understand the challenges for BIPOC (Black, Indigenous and People of Color) clients when seeking mental health services. Additional efforts include:

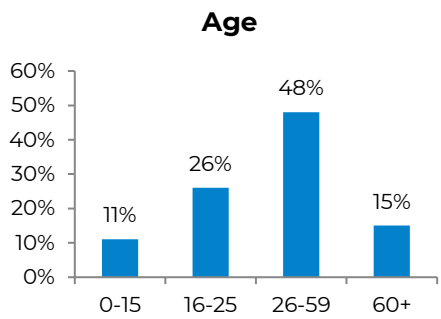
1. Ongoing conversations with staff regarding the impact of implicit bias on access to services;
2. Providing accessible times and locations for services; and
3. If tele-health is more convenient and effective for a family, exploring this as an ongoing option to provide services.

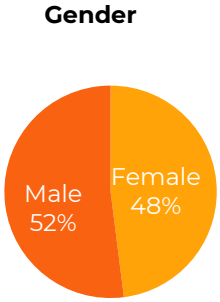
For LGBTQ+ clients, first and foremost, the FSP team strives to understand the barriers and stigma facing these individuals regarding access to services. The FSP staff assume a role of cultural humility and when possible, try to incorporate someone in the team with lived experienced that can relate to the barriers that the LGBTQ+ population experience. For family members, treatment teams attempt to provide collateral support and family sessions to increase empathy and understanding.

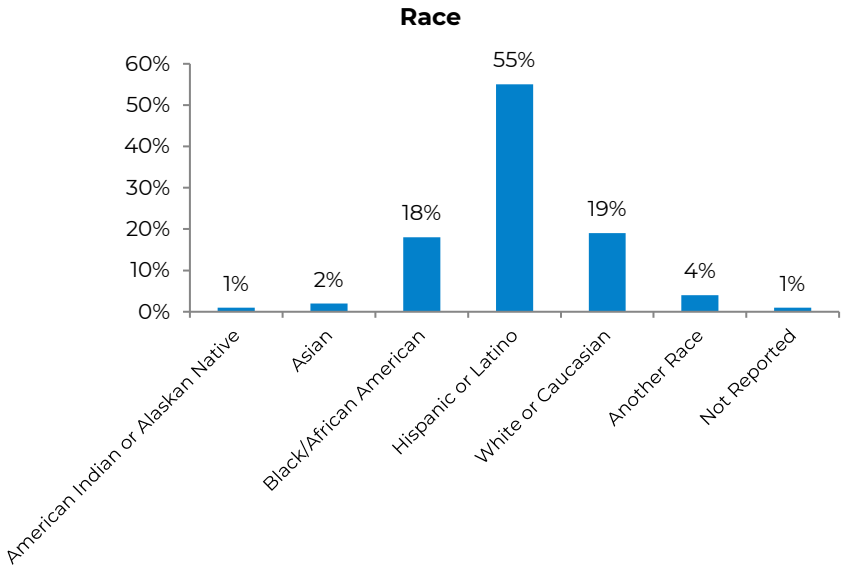
PROGRAM: Full-Service Partnerships (FSP)

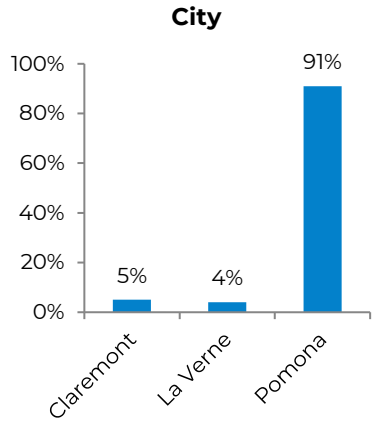
HOW MUCH DID WE DO?

636
Individuals Served



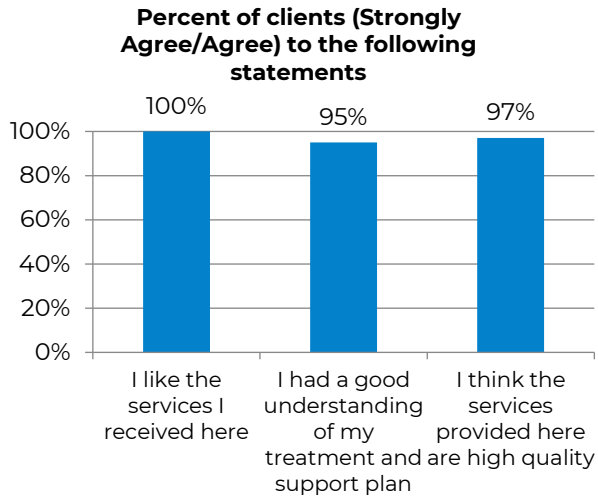




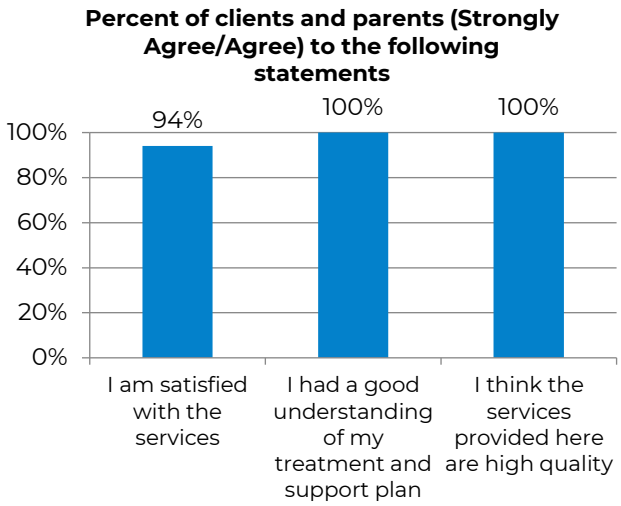


HOW WELL DID WE DO IT?

FSP Adult



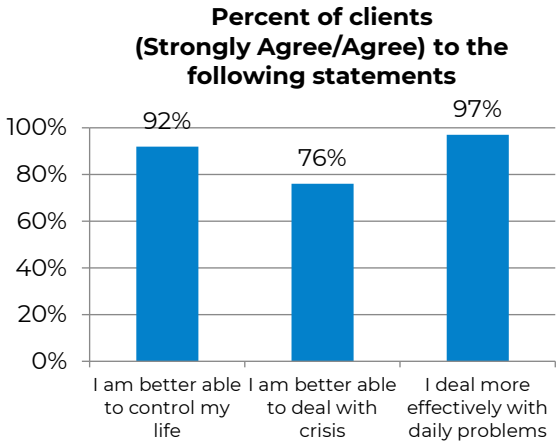
FSP Children & TAY



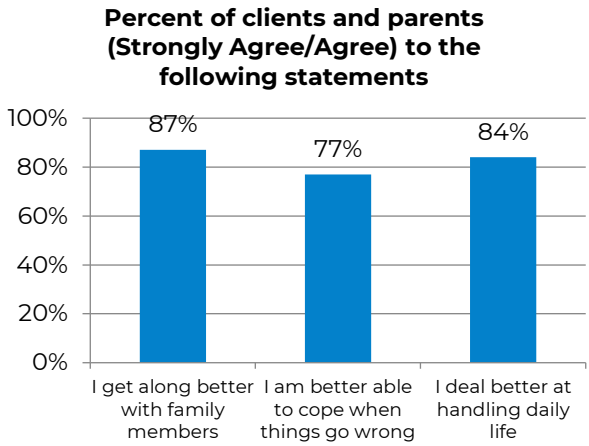
IS ANYONE BETTER OFF?

As a direct result of the services I received:

FSP Adult



FSP Children & TAY



Community Navigators

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
MHSA Plan:	_X_ CSS	___ PEI	___ INN	___ WET	____ CFTN
Target Population:	_X_ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:

Program Description

Community Navigators provide a connection to local resources, including informal community supports and available formal services. Navigators also provide education and stigma reduction services to local communities and organizations.

Target Population

Tri-City clients, staff, community members and local organizations who request referrals and linkage to clinically and culturally appropriate resources and services.

Age Groups	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+
Number Served FY 2019-20	62	167	1,148	201
Cost Per Person	$234.00	$234.00	$234.00	$234.00

Program Update

The Community Navigators continue to be a vital part of community collaboration. Their extensive knowledge of local resources and systems of support allows them to effectively bridge the gap between the needs of individuals with mental health challenges and the most appropriate level of care and communal supports. Due to funding received through Measure H (Los Angeles County sales tax designated to provide funding for homeless services and short-term housing), four additional Community Navigators were hired to expand this critical team dedicated to providing culturally appropriate community resources.

Challenges and Solutions

Limited housing and shelter options continues to be a challenge. However, the funding received through Measure H, has expanded available housing options by providing beds through the Hope for Home Services Center. In addition, the Measure H funding provided funding for short term motel vouchers for families with children experiencing homelessness. The grant also provides homeless prevention funds that Community Navigators are able to use when they are working with families or individuals at risk of losing their housing, support with rent and utility bills, or who need move in assistance once permanent housing is located.

Other limitations include psychiatrists who accept Medi-Cal health plans. Individuals who do not meet medical necessity or only require medication support find this challenge to be difficult. When assisting individuals who need strictly medication support, clients are encouraged to follow up with

their primary care physician who often times can assist with the medication support or a referral to a psychiatrist that can take the clients Medi-Cal health plan.

COVID-19 Response

As an active presence in the community, COVID-19 created a challenge for the Community Navigators as they worked quickly to establish protective protocols that would allow them to continue to provide resources and support while following safety guidelines. Tri-City was able to quickly implement many safety measures including access to Personal Protection Equipment (PPE), hand sanitizer, and disinfecting wipes, in order to appropriately meet with clients when needed.

Assistance was provided via 3-way calling using available technology to assist in connecting individuals with available resources. In-person meetings with Navigators were made possible by dividers made available when clients lose their phone or don't have one available.

COVID 19 made it more difficult to assist some individuals and families due to the sudden closure of multiple agencies. Many resources became limited or very difficult to access such as the Department of Public Social Services and Employment Development Department for unemployment which was a huge need. Access to shelters become a challenge due to quarantine requirements and additional screening and added safety measures including medical clearance. Additional resources such as local showers were forced to close during the pandemic. As temperatures began to rise, local Cooling Centers in the service area were scarce due to Community Centers remaining closed.

Finally, the work load also increased since additional case management was required. At the beginning of the pandemic, the CN's were concerned about meeting and assisting clients due to being essential workers. However, with the availability of PPE and other protections, the team was quickly able to adjust to the changes. Since the CN's are community based, they were able to expand their duties to include referrals to Project Room Key (PRK), a program for homeless individuals who are elderly or who have health issues which puts them at higher risk of complications of COVID-19. Community Navigators also assisted at Motel 6, a PRK motel located in Pomona. There they assist with resources and support. The Navigator program also started assisting at the Sheraton hotel, which is being used as an isolation center for individuals and families who are COVID positive and do not have a location to appropriately isolate.

Cultural Approach

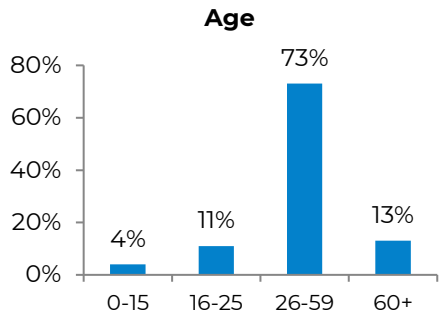
With a significant Spanish-speaking population in the tri-city area, it is critical for this program to receive assistance from bilingual staff. There are currently three languages spoken by the CN's including Spanish and Vietnamese. With the recent addition of a Vietnamese–speaking Navigator, the program will be able to increase their outreach efforts to the Vietnamese community, which has proven difficult to engage in the past.

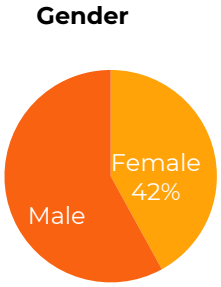
The Community Navigator program receives ongoing cultural inclusion training to better assist the populations they serve. By identifying resources that are culturally appropriate, CN's are better able to provide support for individuals who experience these additional barriers.

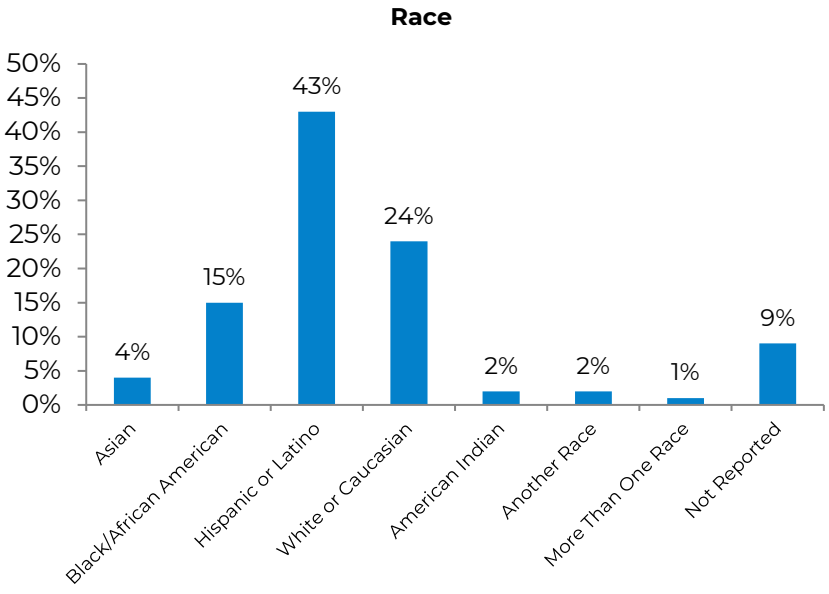
PROGRAM: Community Navigators

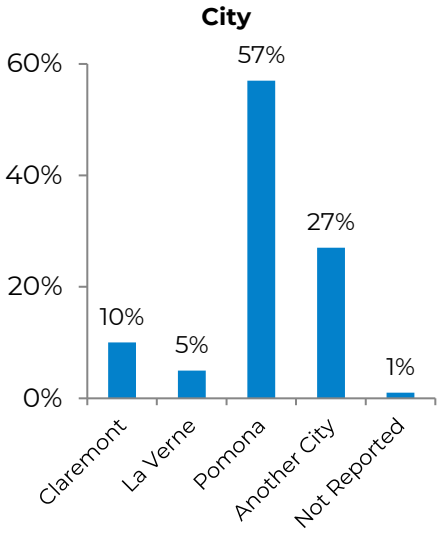
HOW MUCH DID WE DO?

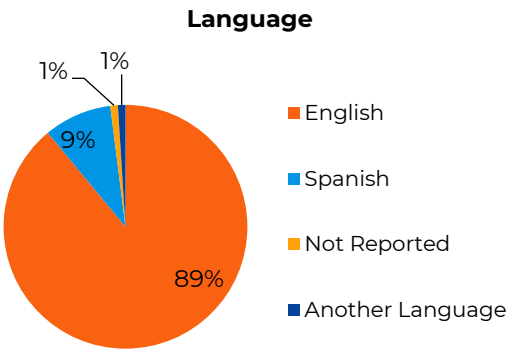
1,578
Unique Individuals Served





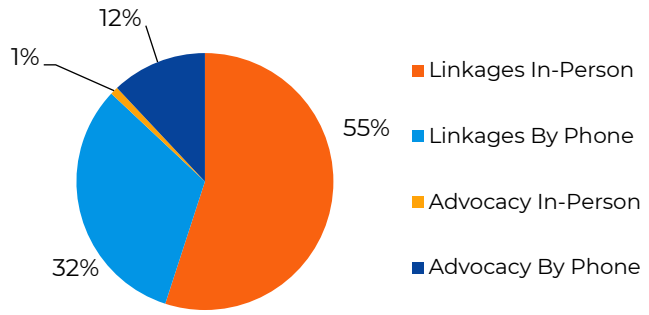






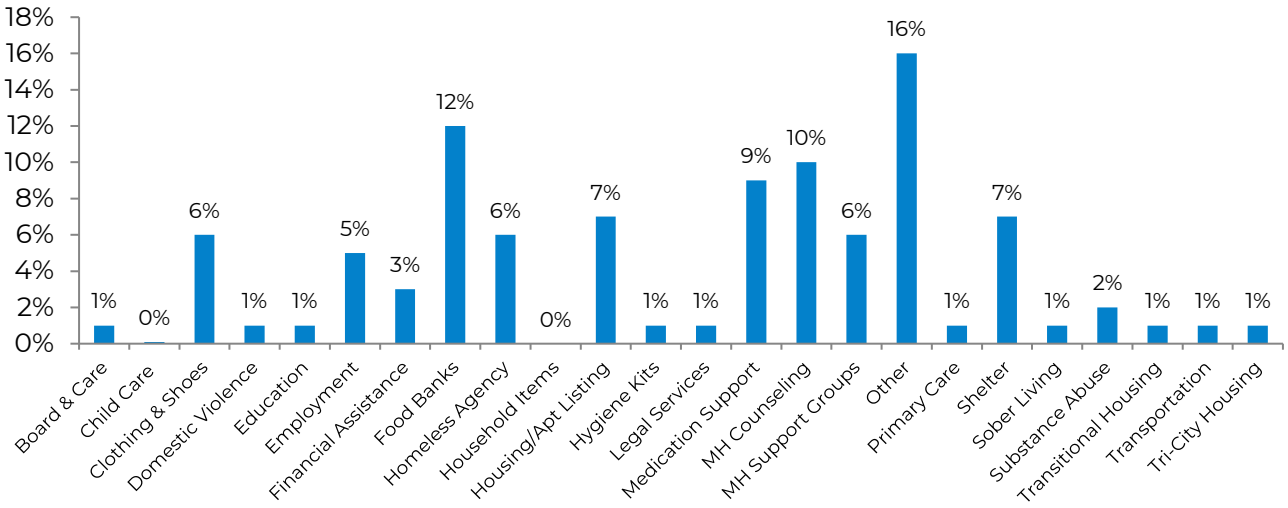
464
Unique Homeless Individuals Served/Linked to Hope of Homes

Events by Type

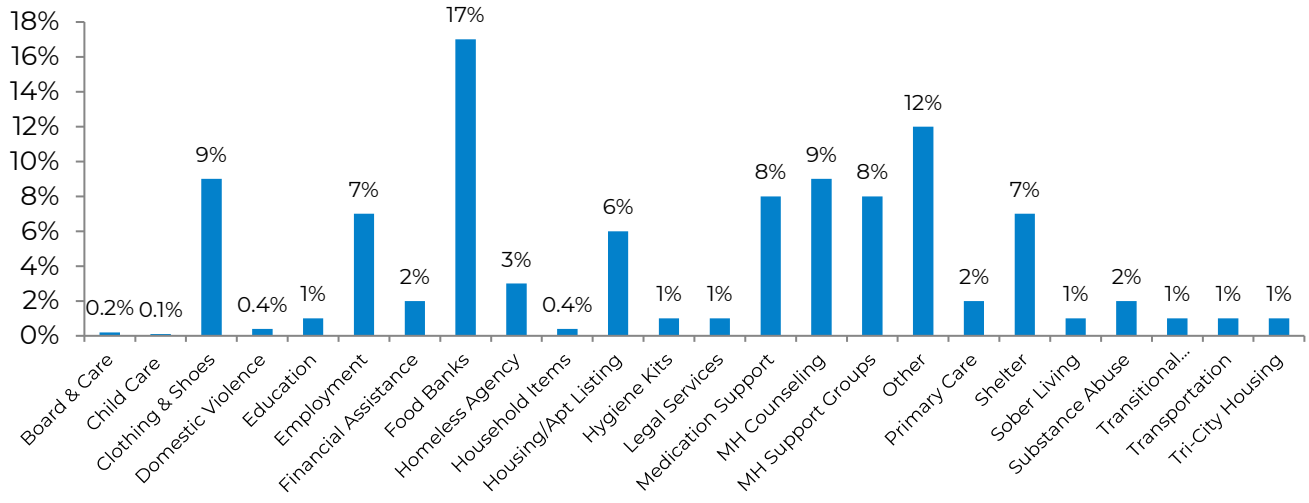


4,429
Contacts Made to Community Navigators

Linkages by Type

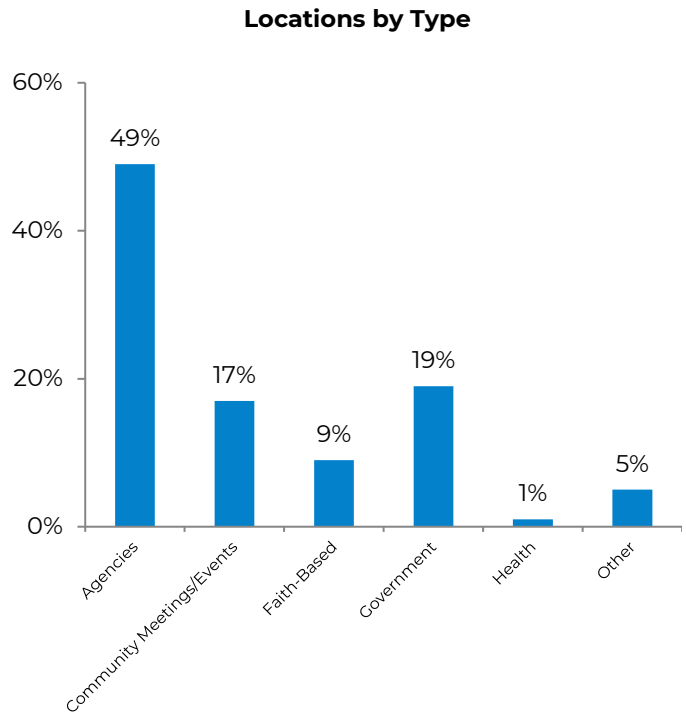


In-Person Linkages by Type

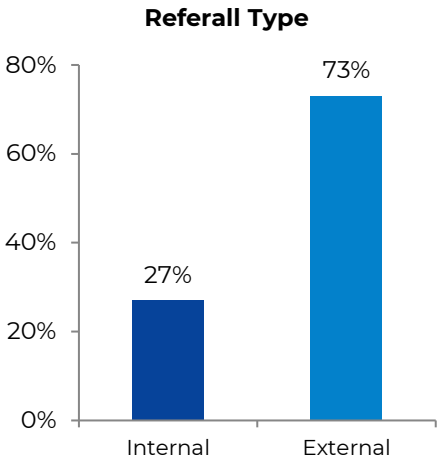


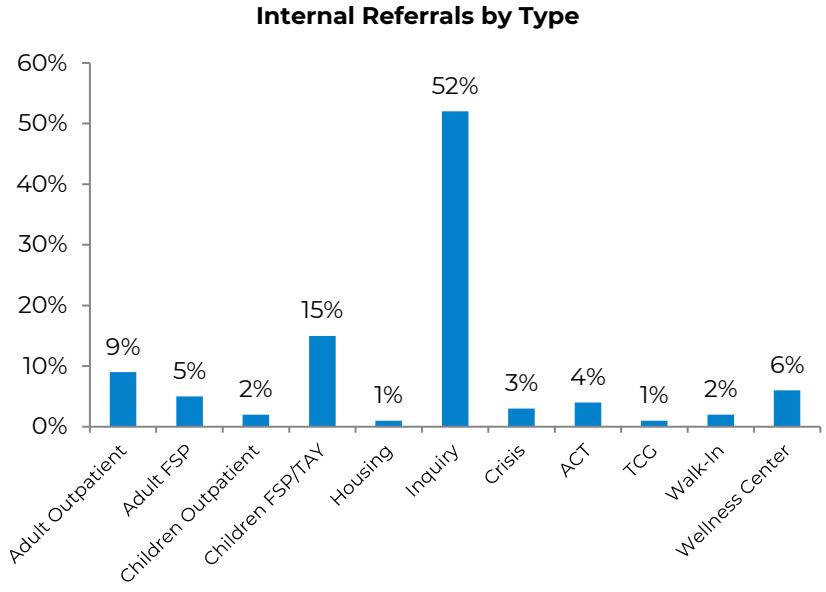
78
Locations Outreached by Navigators

1,145
Total Community Members Engaged by Navigators Through Outreach

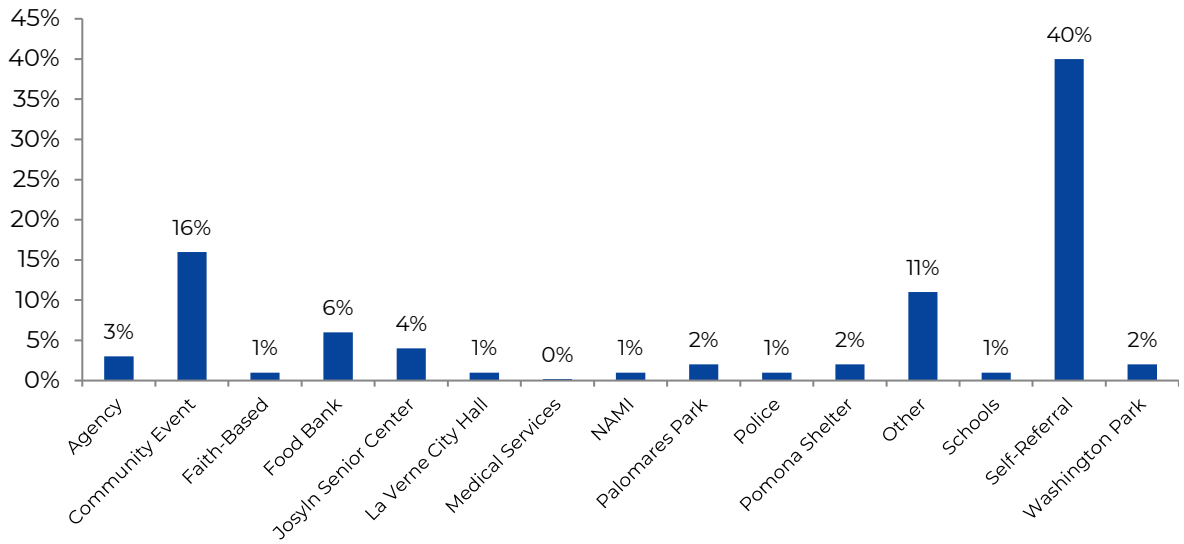


HOW WELL DID WE DO IT?

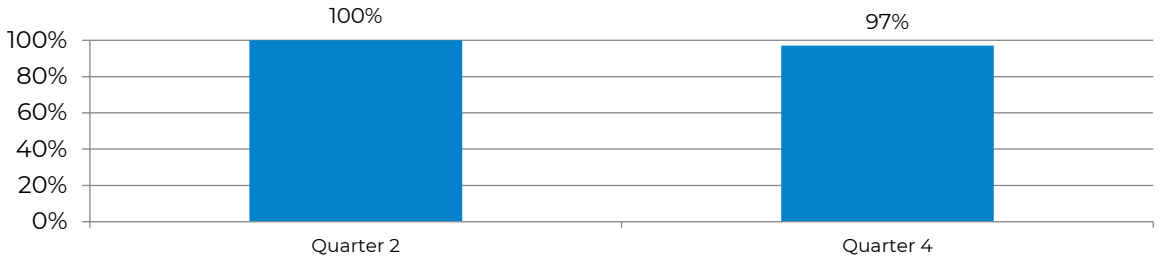




External Referrals by Type

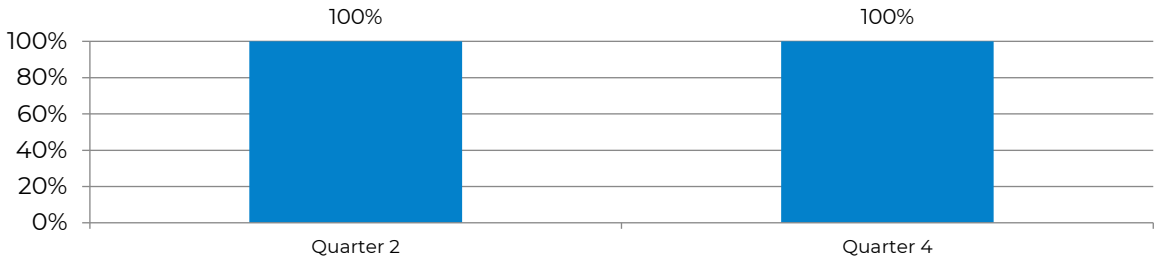


Percentage of Participants Reporting <u>Satisfaction</u> with Services Provided



IS ANYONE BETTER OFF?

Percentage of Community Partners Reporting "if needed to find community resources again, would you contact the Community Navigators?"



Wellness Center

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
MHSA Plan:	_X_ CSS	_X_ PEI	___ INN	___ WET	____ CFTN
(CSS) Target Population:	_X_ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:
(PEI) Target Population:	___ 0-15	_X_ 16-25	___ 25-69	_X_ 60+	Other:

Program Description

The Wellness Center serves as a community hub that sponsors support groups, and provides an array of holistic services through collaboration with other community partners. Specialized services include activities focused on TAY, older adults and employment support

Target Population

The Wellness Center promotes recovery, resiliency and wellness for residents of the Tri-City area. The Wellness Center is open to people of all ages, focusing especially on people in recovery and their families.

CSS Groups	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Unknown
Number Served FY 2019-20	52	406	1,128	143	23
Cost Per Person	$727.00	$727.00	$727.00	$727.00	$727.00

Program Update

As a popular center for community connection, the Wellness Center (WC) continues to provide support services for a variety of needs. One of the most critical is the extensive employment services available to individuals who are seeking employment and are looking for additional guidance through the process. Over one hundred participants obtained employment in FY 2019-20. The Wellness Center's Peers 2 Careers (peer employment pipeline) program continues to be a primary focus by offering support to individuals who are seeking help with vocational goals.

Programing dedicated to transition age youth, (TAY) continues its efforts to outreach and engage with local community organizations which serve this important age group. By partnering with local organizations such as the Compass Point Center located at the David & Margaret Youth and Family Services, WC staff are able to provide support to TAY that will utilize the drop in center once it reopens.

Challenges and Solutions

Challenges experienced during FY 2019-20 for the Wellness Center include engaging the homeless populations, specifically transition age youth. In order to attract this essential population, the hours of

operation for groups and activities were modified to better match their schedules. TAY staff have actively engaged with local organizations that serve TAY with the goal of hosting groups at their sites in hopes of connecting these individuals to the Wellness Center.

Senior programing continues to struggle during this past year. In response to this, the WC created a position specifically dedicated to targeting the needs of the old adult population. This new position will focus on identifying the needs of older adults and coordinate services and support groups to meet their unique requirements.

COVID-19 Response

Due to the COVID 19 pandemic, the Wellness Center suspended all in-person groups and quickly switched to a virtual format. One of the main challenges that the Center faced in this new format pertains to technological challenges. On the one hand, staff experienced a steep learning curve as the transition to the tele-health platform was implemented. Equipment shortages and access to system networks posed a challenge at the onset. Additional challenges include connecting with participants due to the digital divide. Most participants were hesitant to engage over this new platform due to either lacking the right type of equipment (i.e. phone, email) or their mental health symptomology.

Targeting this digital divide is one way in which the Center intends to enhance their practices. Limited technology disproportionately affects the communities we serve. Thus, making it a priority to ensure that any barriers stemming from technology are addressed.

In spite of these challenges, the Wellness Center continues to operate albeit with a reduction in accessibility, while following all Center for Disease Control (CDC), state and county safety guidelines. The computer lab remains open with modified capacity due to social distancing and mask regulations.

Cultural Approach

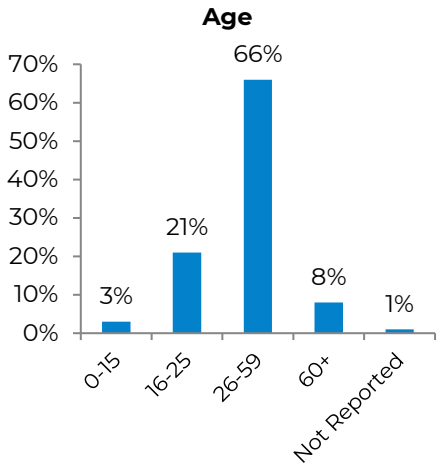
The Wellness Center is considered to be one of the most ethnically diverse programs within the Agency. The program addresses linguistic barriers through bilingual staff, along with the Agency's language lines. All informational materials are available in the three major languages spoken by the local community; English, Spanish, and Vietnamese.

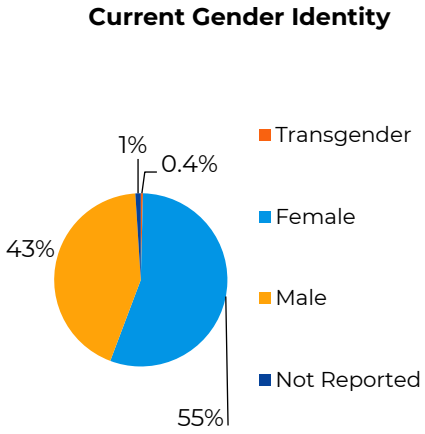
Outreach efforts are coordinated to align with the cultural and linguistic needs of the target community. This is achieved by building trusted and matching individuals with reliable staff members that have similar experiences and a vested interest in each group's well-being.

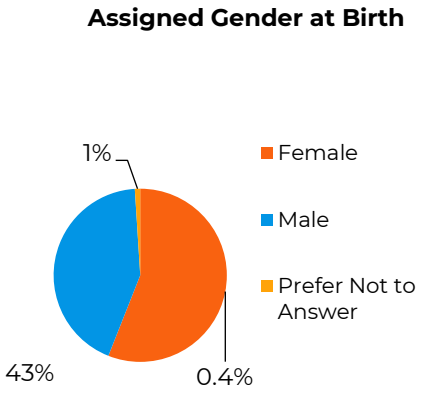
PROGRAM: Wellness Center – CSS

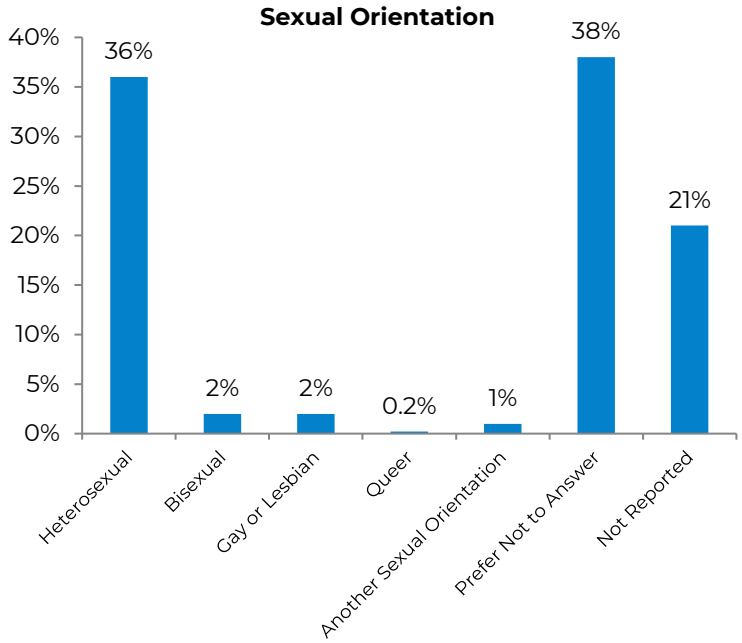
HOW MUCH DID WE DO?

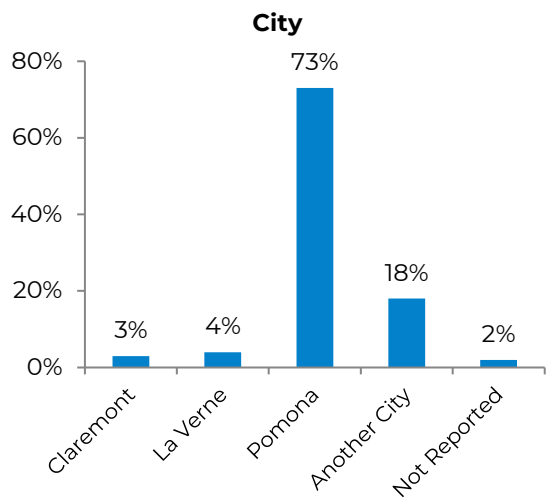
1,703
Unique Individuals Attending Wellness Center

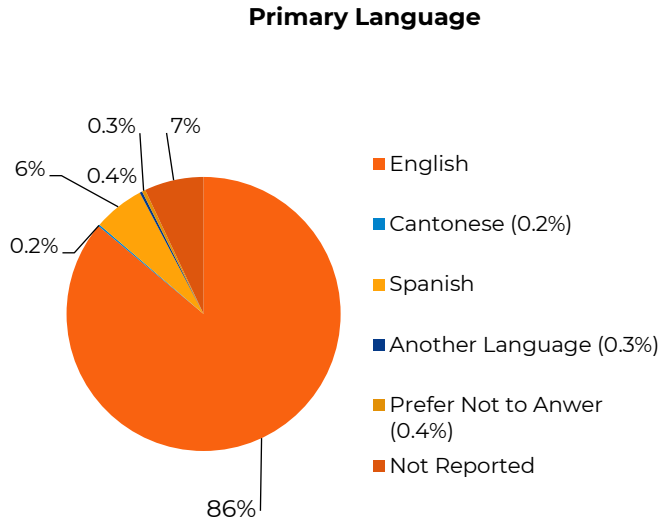


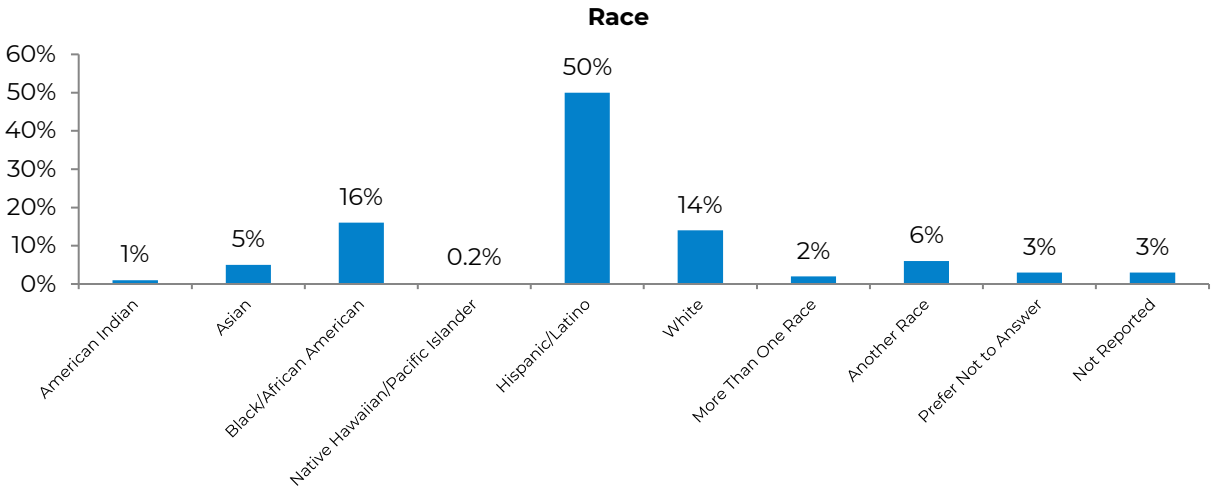







City
80%
60%
40%
20%
0%
73%
18%
3%
4%
2%
Claremont
La Verne
Pomona
Another City
Not Reported


Primary Language
0.3%
7%
6%
0.4%
0.2%
86%
English
Cantonese (0.2%)
Spanish
Another Language (0.3%)
Prefer Not to Anwer (0.4%)
Not Reported


Race
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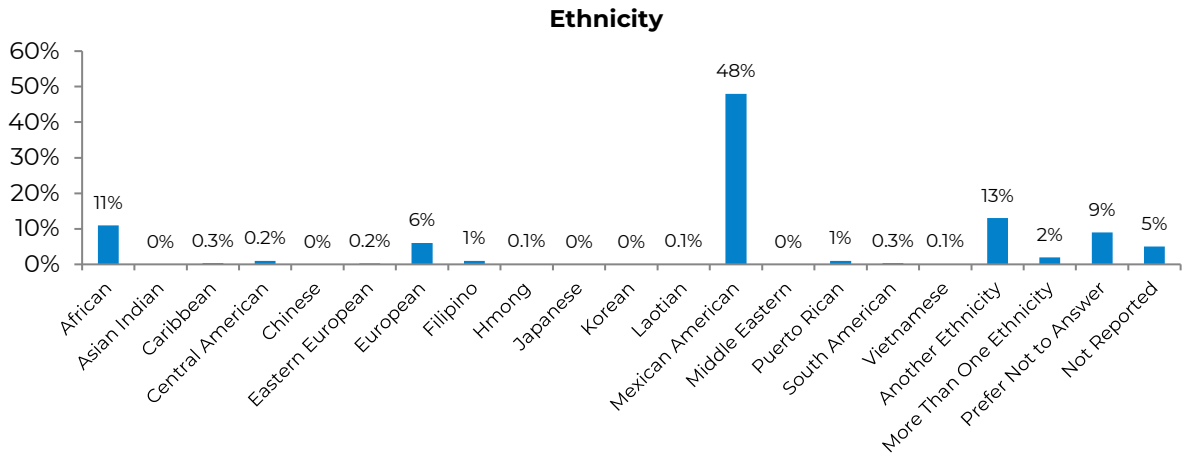
50%
40%
30%
20%
10%
0%
1%
5%
16%
0.2%
50%
14%
2%
6%
3%
3%
American Indian
Asian
Black/African American
Native Hawaiian/Pacific Islander
Hispanic/Latino
White
More Than One Race
Another Race
Prefer Not to Answer
Not Reported


Ethnicity
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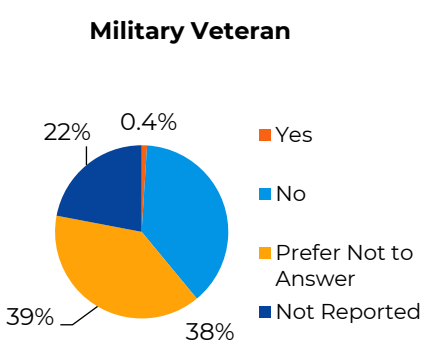
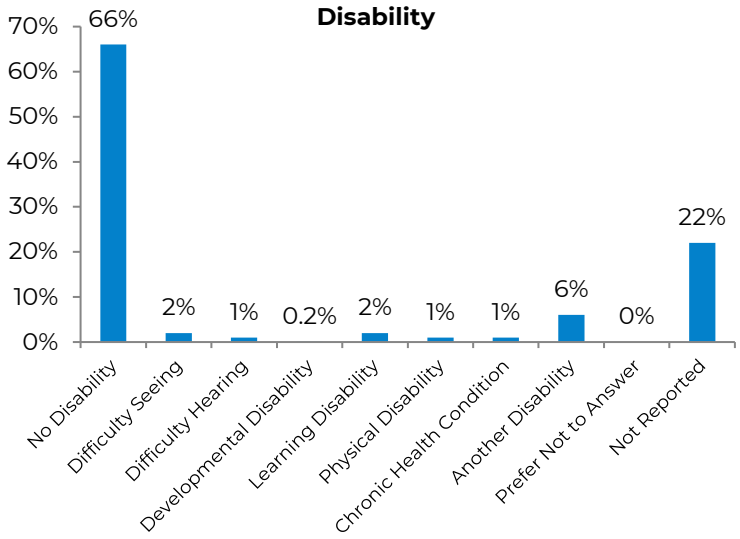
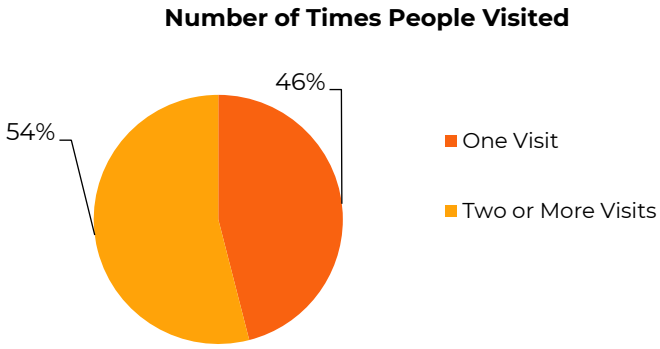
40%
30%
20%
10%
0%
11%
0%
0.3%
0.2%
0%
0.2%
6%
1%
0.1%
0%
0%
0.1%
48%
0%
1%
0.3%
0.1%
13%
2%
9%
5%
African
Asian Indian
Caribbean
Central American
Chinese
Eastern European
European
Filipino
Hmong
Japanese
Korean
Laotian
Mexican American
Middle Eastern
Puerto Rican
South American
Vietnamese
Another Ethnicity
More Than One Ethnicity
Prefer Not to Answer
Not Reported





HOW WELL DID WE DO IT?

15,380
Number of Attendees at Wellness Center Events



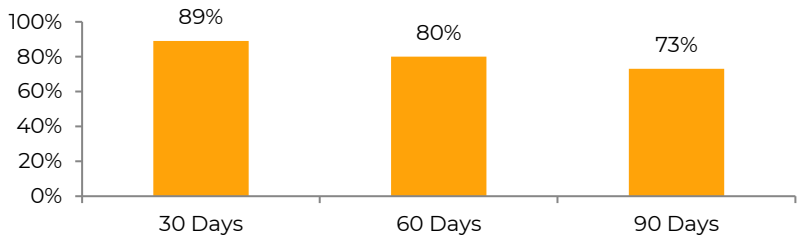
Group Name	Number of Times Group Was Held
Community Meeting PUSD	1
Group – Adult Orientation	25
Group – Anger Management	74
Group – Anxiety	44
Group – Anxiety Relief	44
Group – Anxiety Relief (Heavenly)	7
Group – Attendance Letter	48
Group – Brief Check-in	4

Group – Dual Recovery Anonymous	105
Group – Freedom Through Reality	50
Group - Lose the Blues	50
Group – Men's Depression	51
Group – Obsessive Compulsive D/O	15
Group – One-One-One	13
Group – Positive Direction	39
Group – Phone Call	84
Group – Senior Calm	2
Group – Strong Women	44
Group – Tranquility	41
Group – Wellness Center Committee	7
Group – Women's Self-Esteem	36
Group – Yoga	2
Group Español – Dirección Positiva	35
Group Español – Sobrellevando La Ansiedad	45
Group Español – Socialization	45
Other – Meeting	187
Other – PC Lab	252
Other – Volunteer	8
Vocational – Attendance Letter	8
Vocational – Computer Classes (Advanced)	15
Vocational – Computer Classes (Intermediate)	13
Vocational – Computer Classes (Beginner)	19

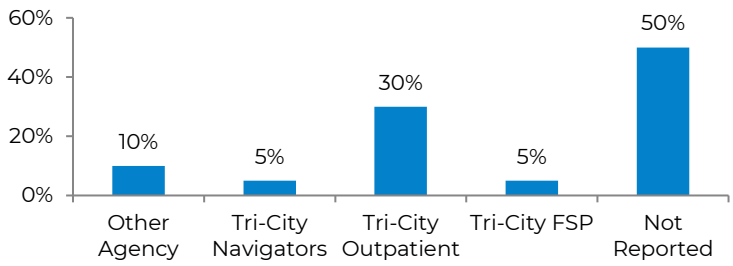
Vocational – Educational/School	44
Vocational – Employment Workshop	106
Vocational – GED Prep	27
Vocational – Hiring Event	15
Vocational – IRS Tax Credit	3
Vocational – Job Search	236
Vocational – Literacy Group	29
Vocational – Money Management	9
Vocational – One-on-One	80
Vocational – Peers to Careers	4
Vocational – Phone Call	163
Vocational – Resume/Interview	47
Vocational – Work Maintenance	66
Blank Events	55

71
Individuals Secured Employment

Percentage of Participants Who Maintain Employment at 30 Days - 60 Days - 90 Days

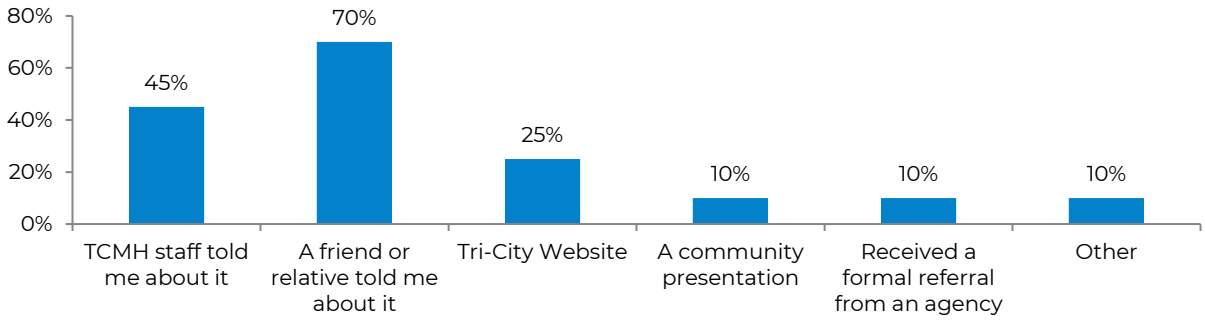


Referral Source



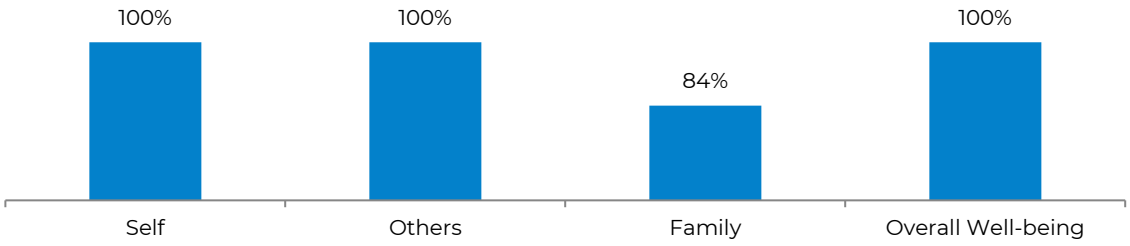
95%
Satisfied with Wellness Center Programs

How Did You Learn About the Wellness Center Programs? (Choose All That Apply)



IS ANYONE BETTER OFF?

Percentage of people who report improved relationships with the following because of the help they receive from the Wellness Center Programs:



Supplemental Crisis Services

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
MHSA Plan:	_X_ CSS	___ PEI	___ INN	___ WET	____ CFTN
Target Population:	_X_ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:

Program Description

The Supplemental Crisis Services (SCS) program provides after-hours and weekend phone support to individuals who are experiencing a crisis and who currently are not receiving TCMHC services. Crisis walk-in services are also available during business hours at Tri-City's clinic location. Through follow-up efforts by the Intensive Outreach and Engagement Team (IOET), individuals located in the community who are having difficulty connecting with and maintaining mental health support are able to receive services in an effort to help reduce the number of repeat hospitalizations and guide these individuals to the most appropriate care.

Target Population

Individuals in crisis and currently not enrolled in Tri-City for services, who are seeking mental health support after-hours. Individuals located in the community who are having difficulty connecting with and maintaining mental health support.

Age Groups	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Unknown
Number Served FY 2019-20	53	144	639	120	202
Cost Per Person	$636.00	$636.00	$636.00	$636.00	$636.00

Program Update

During FY 2019-20, the crisis calls remained consistent with 115 Supplemental Crisis contacts received. The primary reason for these contacts were individuals experiencing mental health symptoms and seeking support. Additional reasons include calls made regarding support for someone else's wellbeing and seeking resources.

However, there is a noted increase in the number of contacts for the Intensive Outreach and Engagement Team compared with the previous year. In FY 2018-19 there were 674 IOET contacts compared to 979 contacts in FY 2019-20. In addition, there is a significant increase in the number of IOET cases that were open for services going from 300 in FY 2018-19 to 450 in FY 2019-20. This increase speaks to the increased need generated by the COVID 19 pandemic and the critical role this team plays in the ability to connect with community members in crisis and guide them into appropriate services based on their needs and input.

The foundation of the Intensive Outreach and Engagement (IOE) team rests on the philosophy of inclusion and striving to meet every individual they serve, where they are. The IOE team utilizes a

field-based team approach that allows access to the known “hot spots” (locations where disenfranchised individuals gather) within the communities they serve. This includes, but is not limited to; encampments, parks, abandoned buildings, freeway underpasses, Hope 4 Home service center and even home visits. A “whole person system of care” approach is applied where all aspects of the individual are addressed.

Challenges and Solutions

As a community response team, the IOET provides a flexible approach to working within the community and adapting the environment while adhering to policies set by officials and the Agency regarding safety and service. Changes in staff during FY 2019-20, included the loss of a psychiatric technician; and addition of a case manager and therapist.

COVID-19 Response

Since the COVID 19 pandemic, the Supplemental Crisis Services (SCS), Intensive Outreach and Engagement Team (IOET), and Medication Support Team (MST) have continued to work on site. Workloads have increased as expected for the IOET and MST located at Tri-City’s Adult Clinic. While other departments are forced to work remotely, the IOET, MST and SCS teams have become the “go to teams” for a majority of client services and provision of care which include real-time follow-ups, medication services, linkages, assessments, referrals, etc.

Staff continue to follow county and state safety guidelines while navigating barriers presented due to the pandemic, in order to provide a “whole person system of care” approach to services.

Future efforts include the development of the PACT-Psychiatric Assessment Care Team. This additional support service is designed to aid the city of Claremont, by providing a licensed psychiatric technician and licensed therapist to communicate, collaborate and coordinate real-time assessment services within this city.

Cultural Approach

In order to provide culturally linguistic support, bilingual therapists are available to respond to calls triaged through the Supplemental Crisis call lines. In addition, the Community Navigators coordinate with the SCS team to link callers to culturally appropriate resources and services.

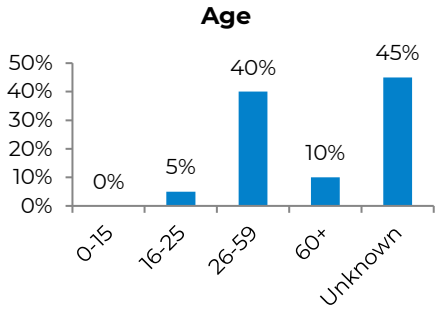
The Intensive Outreach and Engagement team (IOE) was specifically designed to reach underserved populations. The IOE team is comprised of eight staff members; 5 are bi-lingual. All IOE team brochures are in available in both English and Spanish, and when needed, the IOE team utilizes the Agency’s Language Line to connect individuals to multiple systems of care, and to ensure that there are no disruptions/delays to accessing systems of care.

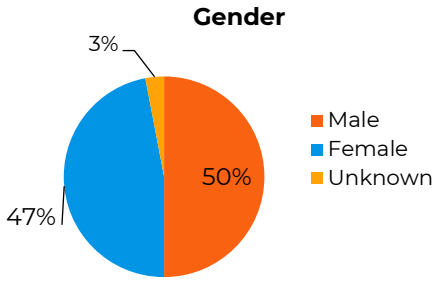
The IOE team is supportive of the LGTBQ+ community, and incorporates literature regarding resources and referrals that are inclusive and informative on how to access both formal and informal services though a number of different avenues (traditional office, phone, or other electronic media). In addition, the IOE team is represented on the Agency’s Cultural Competence Committee, where this representative is able to regularly disseminate information regarding trauma and stigma based awareness, as well as support groups that are specifically designed to meet the needs of the LGBTQ+ community.

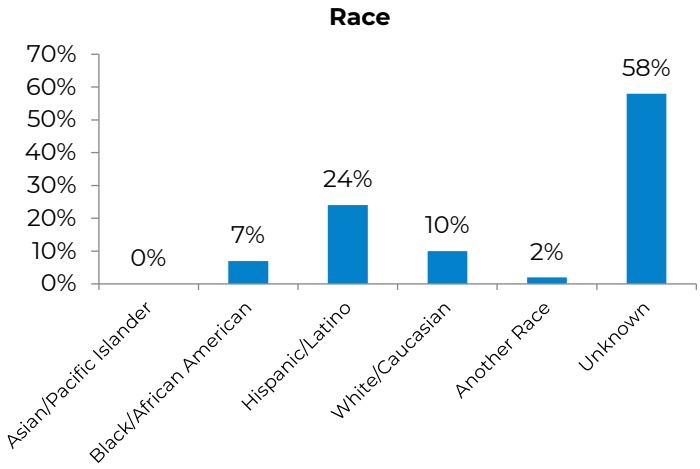
PROGRAM: Supplemental Crisis Services

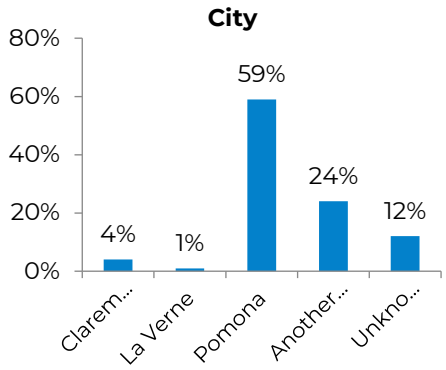
HOW MUCH DID WE DO?

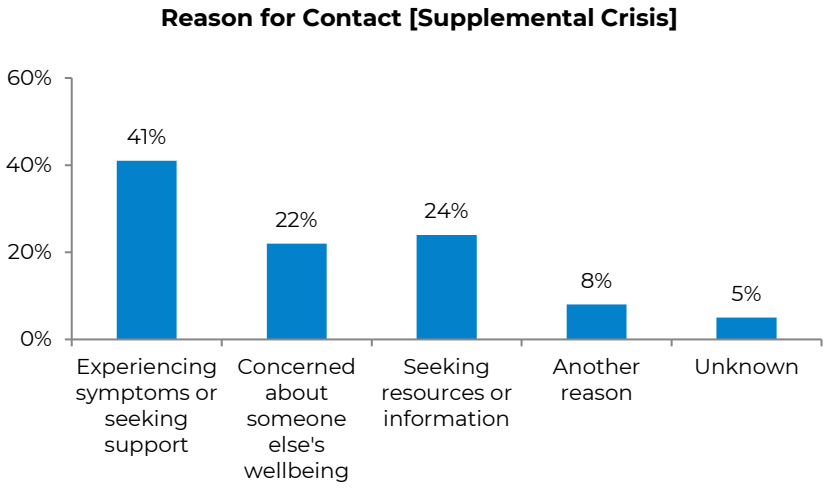
636
Individuals Served

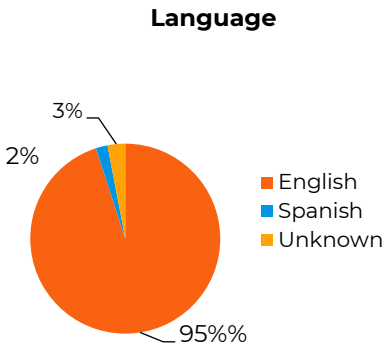






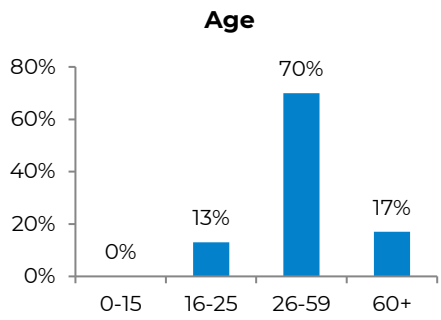


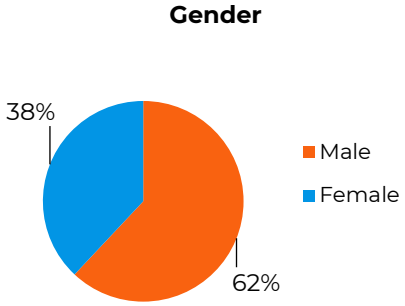


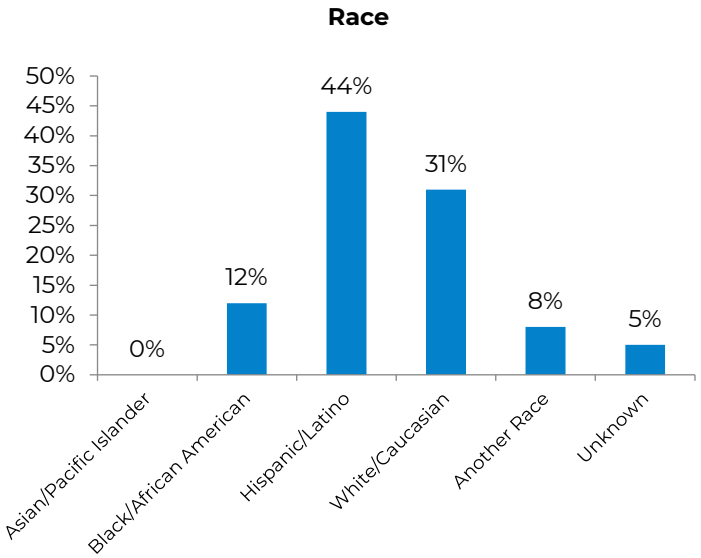


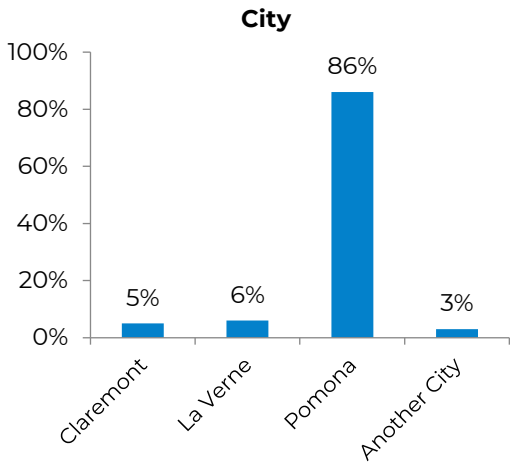
Crisis Walk-in

64
Individuals Served





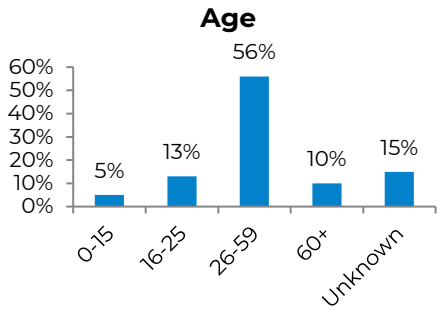


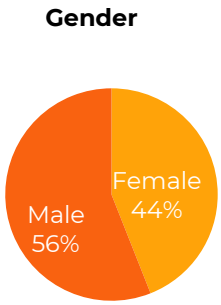


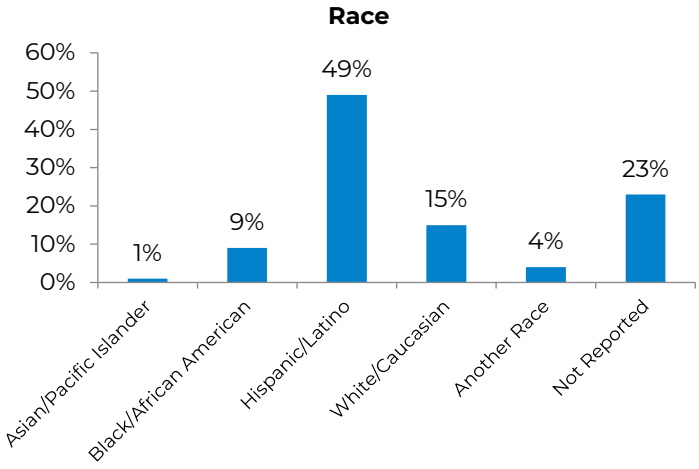
80%
Crisis Walk-Ins Also Outreached by the Intensive Outreach and Engagement Team

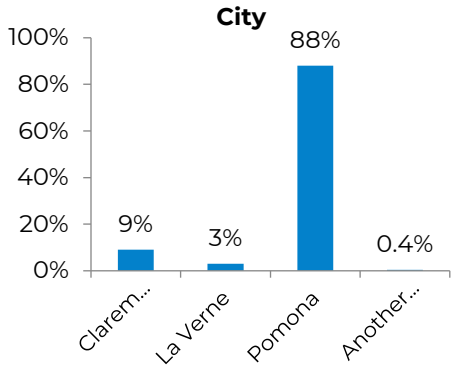
Intensive Outreach and Engagement Team (IOET)

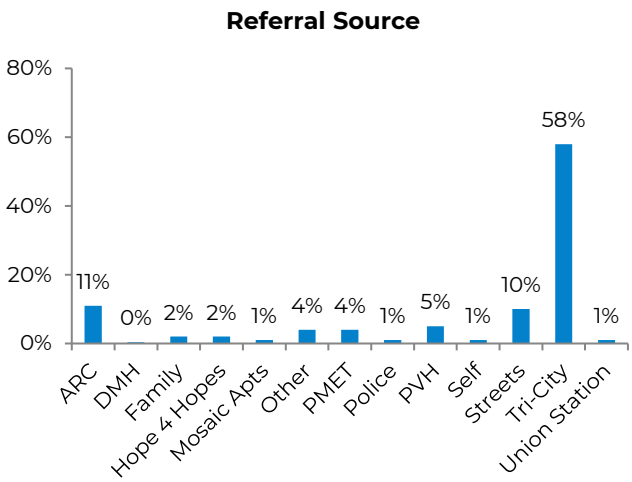
979
Individuals Served

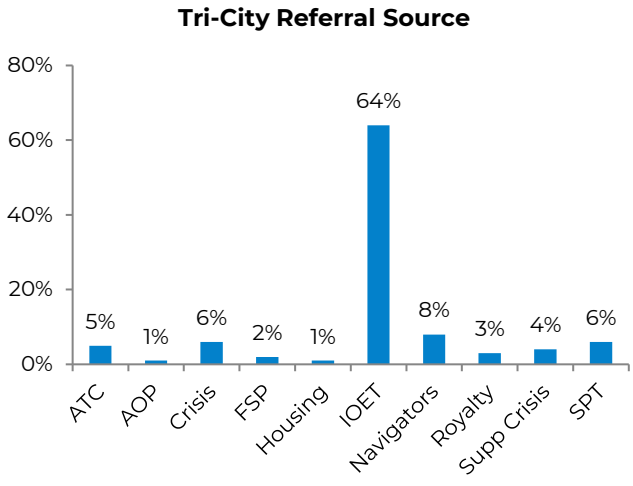










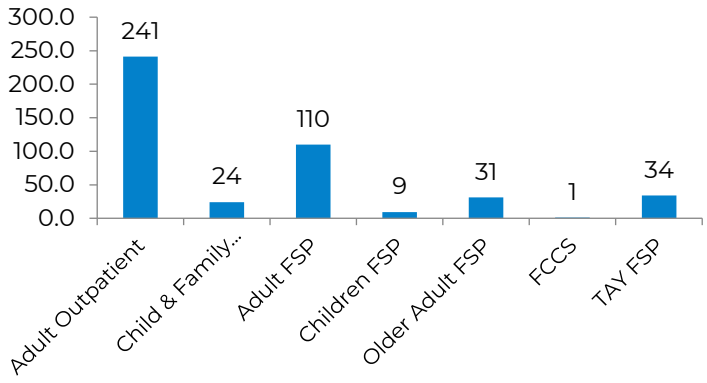


HOW WELL DID WE DO IT?

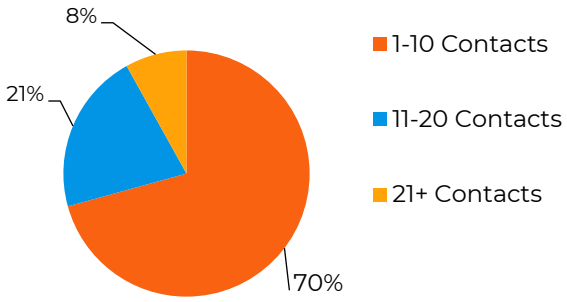
450

Individuals were Opened for Services at Tri-City through the Intensive Outreach and Engagement Team

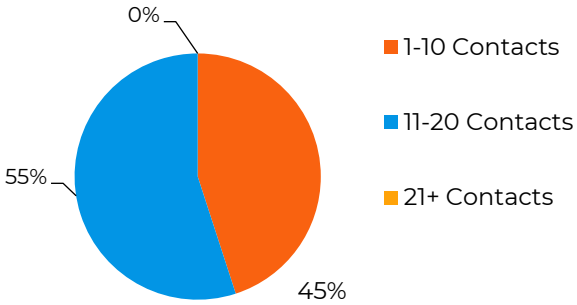
Individuals Opened for Tri-City Services



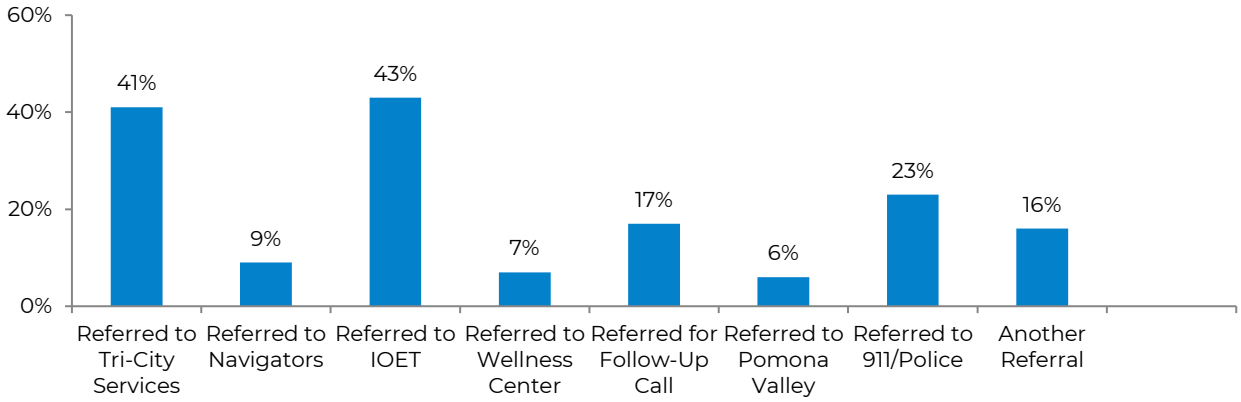
Percentage of IOET Contacts for Closed Cases



Percentage of IOET Contacts for Currently Open Cases



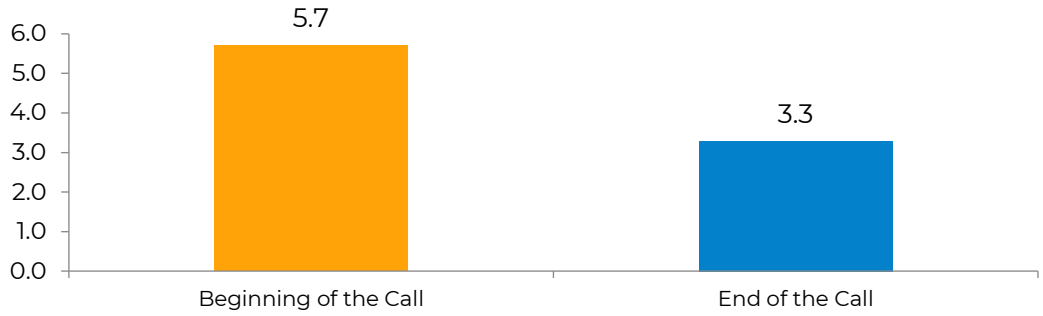
Disposition of Crisis Calls



IS ANYONE BETTER OFF?

Level of Distress for Crisis Callers

Callers rated their level of distress at the beginning of the phone call and at the end of the call on a 1 to 10 scale where 1 = mild and 10 = severe (higher rating meaning greater level of distress)



Field Capable Clinical Services for Older Adults

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
MHSA Plan:	_X_ CSS	___ PEI	___ INN	___ WET	____ CFTN
Target Population:	___ 0-15	___ 16-25	___ 25-69	_X_ 60+	Other:

Program Description

Through the Field Capable Clinical Services for Older Adults (FCCS) program, TCMH staff members provide mental health services to older adults at their location including their home, senior centers, and medical facilities.

Target Population

Older adults, ages 60 and over, who are experiencing barriers to mental health service due to a variety of issues including lack of transportation, stigma or isolation.

Age Groups	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+
Number Served FY 2019-20	N/A	N/A	N/A	26
Cost Per Person	N/A	N/A	N/A	$2,526

Program Update

The Field Capable Clinical Services for Older Adults (FCCS) continues to be a dedicated program to serve the needs of older adults, ages 60 and over. In FY 2019-20, the program experienced a loss of staff when the assigned FCCS clinician left the program in December 2019. However, this program was originally designed to be a continuation of the Full-Service Partnership (FSP) program for this critical population. In response to this loss of staff, clients were reassigned to FSP staff who were able to provide the same high quality of service and continuity of support for each client. A new FCCS clinician was hired in June of 2020 and is currently supporting these clients as well.

Challenges and Solutions

A portion of the FCCS clients seem to struggle with “graduating” from the FCCS program and transitioning to their insurance-designated primary care provider. Staff have addressed this issue by lending support with ongoing connections to Tri-City’s system of care and other MHSA programs including the Wellness Center, Peer Mentors, and the Therapeutic Community Garden which contribute to increasing socialization and healthy relationship formation.

COVID-19 Response

The COVID 19 pandemic greatly impacted the ability of FCCS staff to provide regular field-based services. In response to this, staff quickly implemented video conferencing/phone sessions where FCCS clients were provided with cell phones, as needed. Staff noted an increased need for support

related to food resources. Staff began delivering groceries to clients while also locating alternative food resources, including food delivery services. Field visits for wellness checks continued with staff utilizing appropriate safety precautions including using personal protective equipment and social distancing.

Cultural Approach

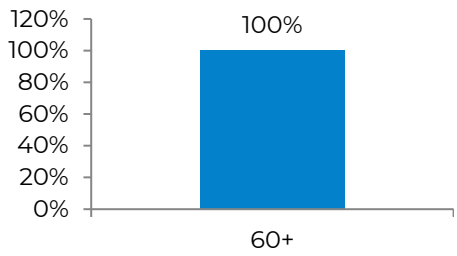
Program staff include a diverse group of individuals, (racial, cultural, gender, age) led by a bilingual (Spanish speaking) FCCS clinician. Community Navigators are utilized to identify and provide culturally appropriate resources for clients as needed. All program brochures are available in both English and Spanish and an approved language line is also available.

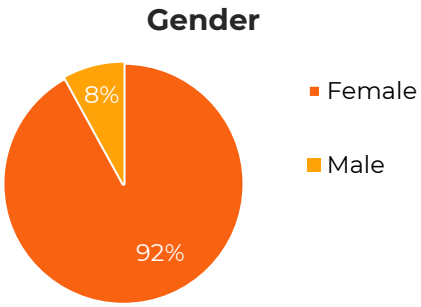
As staffing stabilizes, program goals include increasing outreach efforts utilizing the bilingual FCCS clinician to increase FCCS enrollment and community collaboration, as well as more fully develop the FCCS program. Additionally, efforts are underway to identify trainings that specifically focus on integrated care for elders with the goal of enhancing current services.

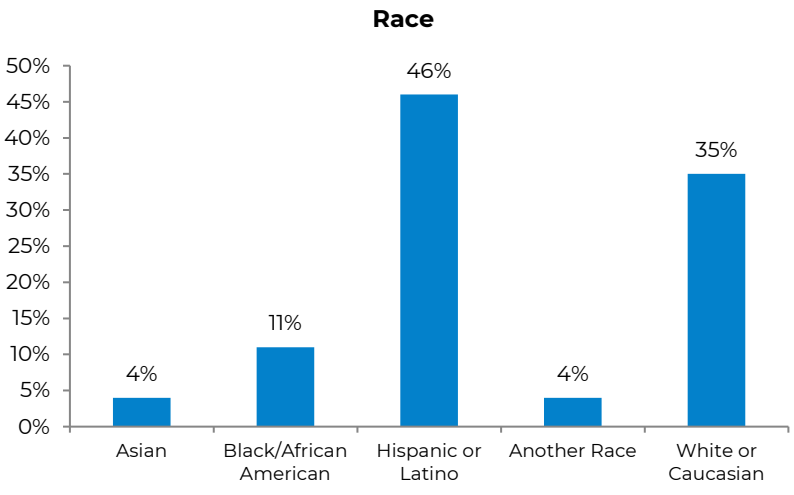
PROGRAM: Field Capable Clinical Services for Older Adults (FCCS)

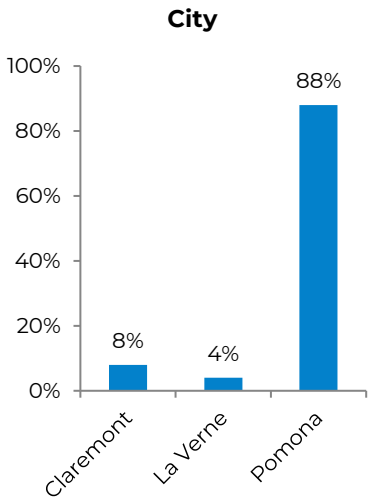
HOW MUCH DID WE DO?

26
Unique Individuals Served

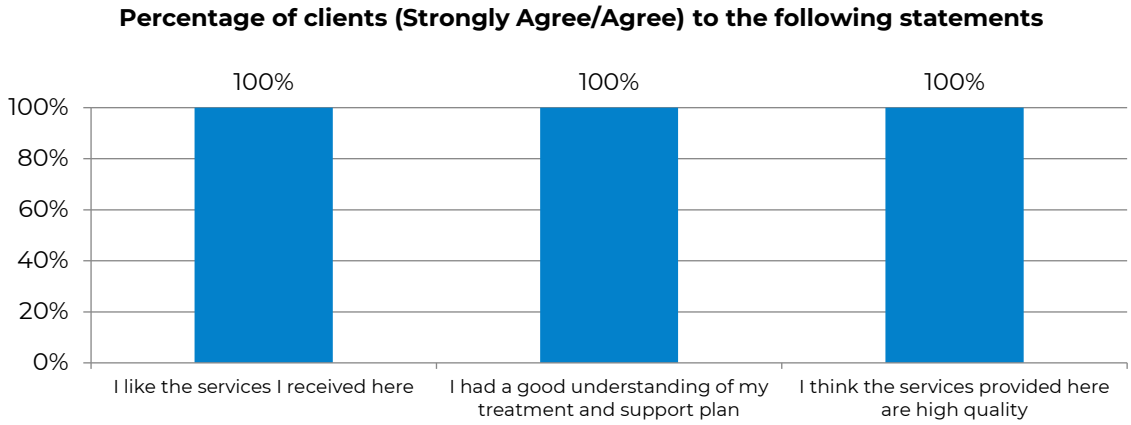


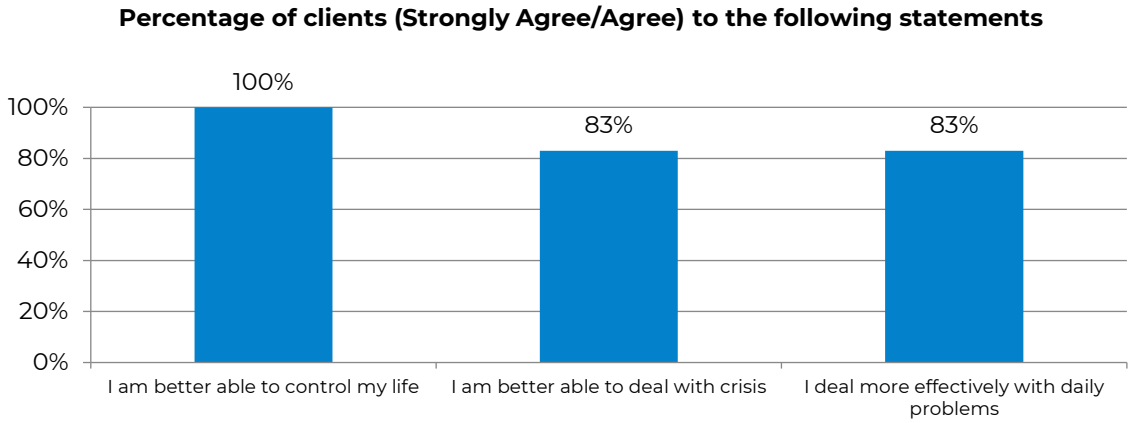






IS ANYONE BETTER OFF?





Permanent Supportive Housing

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
MHSA Plan:	_X_ CSS	___ PEI	___ INN	___ WET	____ CFTN
Target Population:	_X_ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:

Program Description

Permanent supportive housing units are living spaces where individuals who are homeless or at risk of homelessness and suffer from one or more mental illness, can receive an array of services designed to support their recovery. Permanent supportive housing has proven to be a significant part of successful recovery plans for many people with serious mental illness. Such housing enables successful pathways to recovery and, ultimately, can reduce the cost of other services such as emergency room visits and incarceration.

Target Population

Tri-City clients living with severe and persistent mental illness and their family members.

MHSA Housing Projects						
Location	Studio	One Bedroom	Two Bedroom	Three Bedroom	Notes and Amenities	Total Units
Parkside Apartments	0	16	5	0	Computer stations, lounge area and kitchen	21
Cedar Springs Apartments	0	5	3	0	TAY (ages 16-25) with family	8
Holt Family Apartments	0	11	11	3	Opening April 30	25
Claremont / Baseline Project (Home)	0	0	2	0	Two separate wings with large living room and kitchen. Two bedrooms on each side.	2
Park Ave Apartments	2	6	0	0	Programs provided on site	8
Total Units	2	38	21	3		64

Program Update

In July of 2019, the City of Pomona reached out to Tri City Mental Health regarding new housing vouchers, offered through Anthem Blue Cross, that were available for individuals who were homeless in Pomona. In response, Tri-City's Permanent Supportive Housing (PSH) team collaborated with the

City of Pomona, Volunteers of America, Union Station Homeless Services, Prototypes, and Hathaway Sycamores Child and Family Services, to support 17 individuals to apply for the vouchers and secure housing by the end of August, 2019. Anthem Blue Cross identified this first round of vouchers as a pilot process and, due to the PSH's swift response and diligence in getting all vouchers secured, created an opportunity for more vouchers in the future.

Regular check-ins as well as responding to the needs of Tri-City's tenants, is a critical component to the success of this housing program. During conversations held between Parkside Family Apartments and the Residential Service Coordinators, they noted that multiple residents mentioned their struggles with maintaining their sobriety as the site's entrance and exit face a liquor store. In response, the PSH team reached out to Tri-City's Substance Use Disorder team and identified a need for an on-site substance use support group. By October 2019, staff launched a Wellness and Recovery group where all tenants are able to attend without leaving the property and thereby avoiding blatant temptation.

Challenges and Solutions

One of the ongoing challenges for this program is helping individuals accept and manage their expectations regarding affordable housing in the Tri-City area. When following-up with client housing referrals from Tri-City's clinical teams, staff encountered a number of individuals who were focused on securing subsidized housing through project or tenant-based vouchers. While they remained firm on their requests, staff explained that these types of housing resources are limited and that the process through the county's Coordinate Entry System doesn't allow Tri-City the ability to readily offer these options when requested. While discussing other housing options with these individuals on fixed incomes, they were reluctant to work with the housing team to look for more affordable single rooms for rent, which they would qualify for based on their current income. Knowing other individuals who were able to secure this desirable level of housing can make it difficult for them to accept it may not be an eligible option for them.

Through the Coordinated Entry System, a streamlined system designed to efficiently match people experiencing homelessness to available housing, shelter, and services, PHS staff are able to help individuals and families apply for diverse housing opportunities. However, this requires extensive application documentation and staff have noted that the application process can be prolonged due the need to gather documents, specifically, verifications of homelessness and disability. However, as staff become more familiar with the new application process and the required documentation, staff are engaging in proactive conversations with clients so they are prepared once they are matched to a housing option.

Future efforts include identifying a group of individuals who previously struggled with obtaining and maintaining housing and would like to share their stories with others who are currently trying to obtain housing. These "alumni" individuals would be able to share a real perspective on the investment of time and effort to ensure a successful housing journey. By hearing it from their peers, we hope it helps clients understand and become receptive to the housing plans identified for them.

COVID-19 Response

In March 2020, the majority of communication moved to a virtual platform. All partner meetings are held virtually and communication continues via phone or email outside of those meetings. Team meetings with housing referrals and clinical teams have mostly been virtual or over the phone.

Residential Service Coordinators (Tri-City staff assigned to housing sites) continued their regular communication with MHSA tenants via phone. Not all clients have access to smart phones, laptops, or are savvy when it comes to technology. Staff also recognize in-person support benefits some clients so staff have arranged meetings where one housing or clinical staff is present with the client and the rest of the team joins virtually.

PSH staff conduct regular visits, using personal protective equipment, at the Transition Housing site, to confirm that all building needs are being met and to identify resources residents may need. Since staff are no longer physically located at the properties, there is a loss of visual contact that usually helps them to better understanding how their tenants are doing.

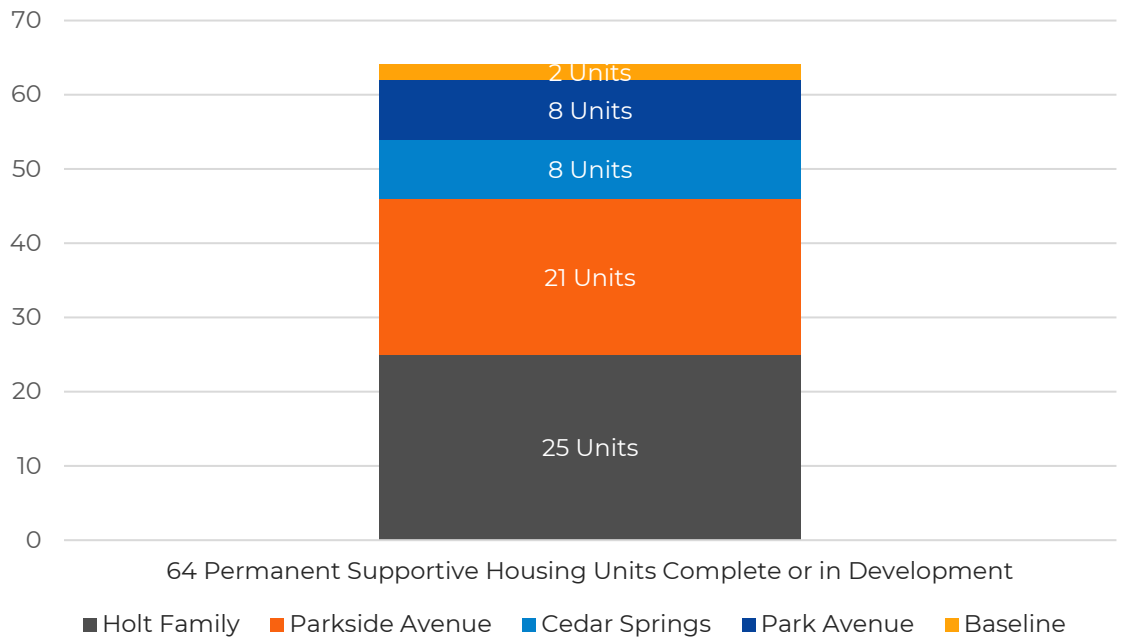
Cultural Approach

Recognizing the cultural influences and needs of clients is important when considering housing options. Four of the six housing staff are bilingual in English and Spanish. In addition, staff are able to connect individuals with the official Language Line for additional assistance, if needed.

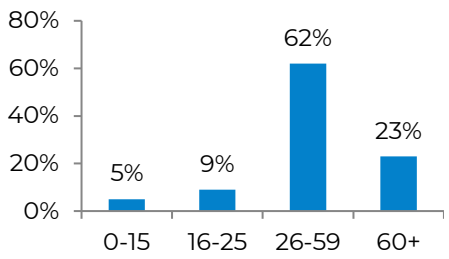
In serving clients in Tri-City's housing programs, staff are able to assist clients who express concern regarding their rights as tenants. By referencing laws related to Housing Rights, staff are able to help clients identify if a situation violates the Fair Housing Laws and help them understand what steps they can take to address them. Tri-City clinicians are encouraged to refer clients to PSH's Open Door group to allow them to engage in conversations with other residents and become better informed of their rights and responsibilities as tenants.

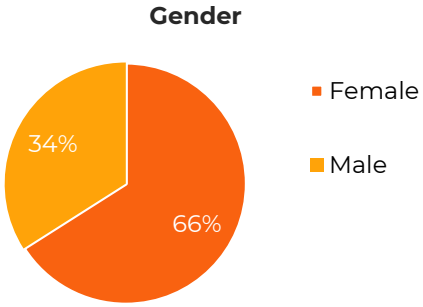
PROGRAM: Permanent Supportive Housing (PSH)

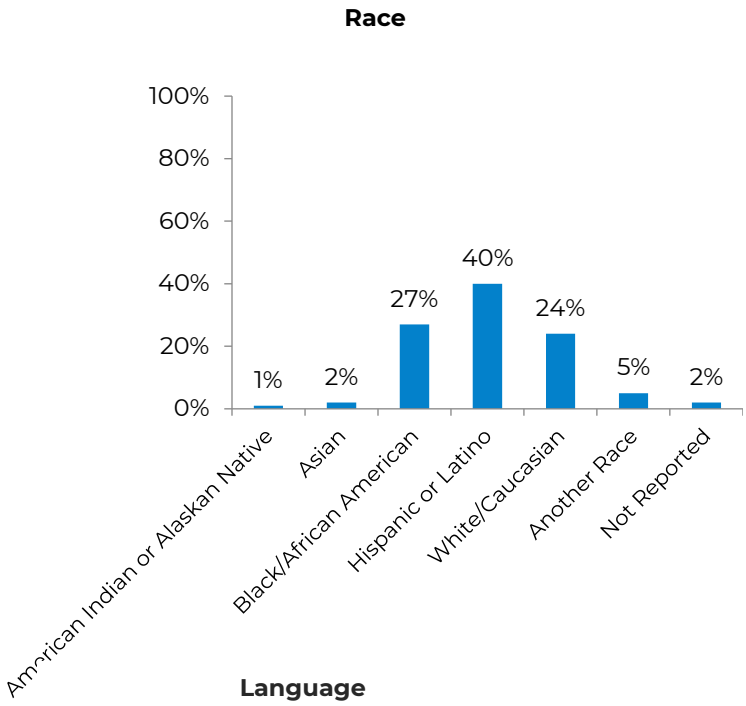
HOW MUCH DID WE DO?

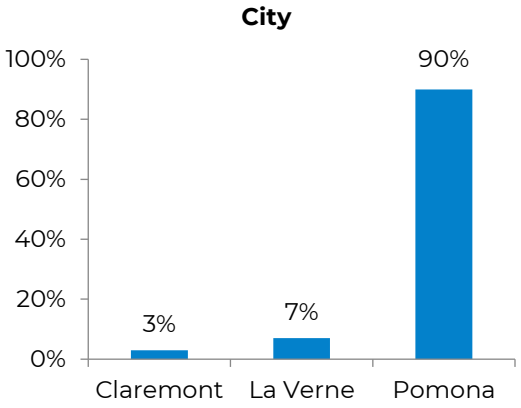


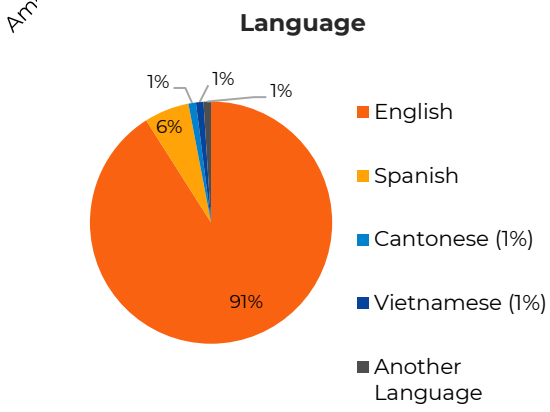
250
Individuals Served with Housing Needs

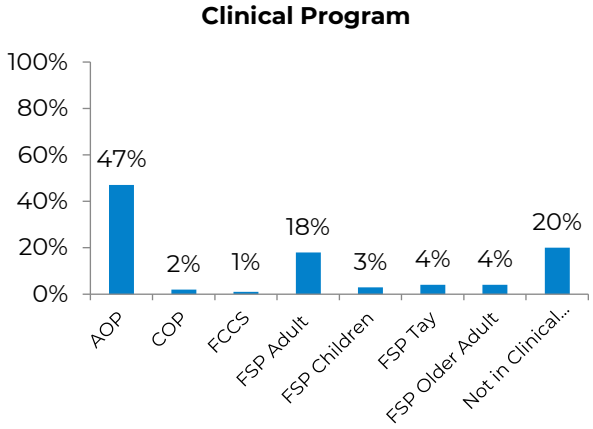










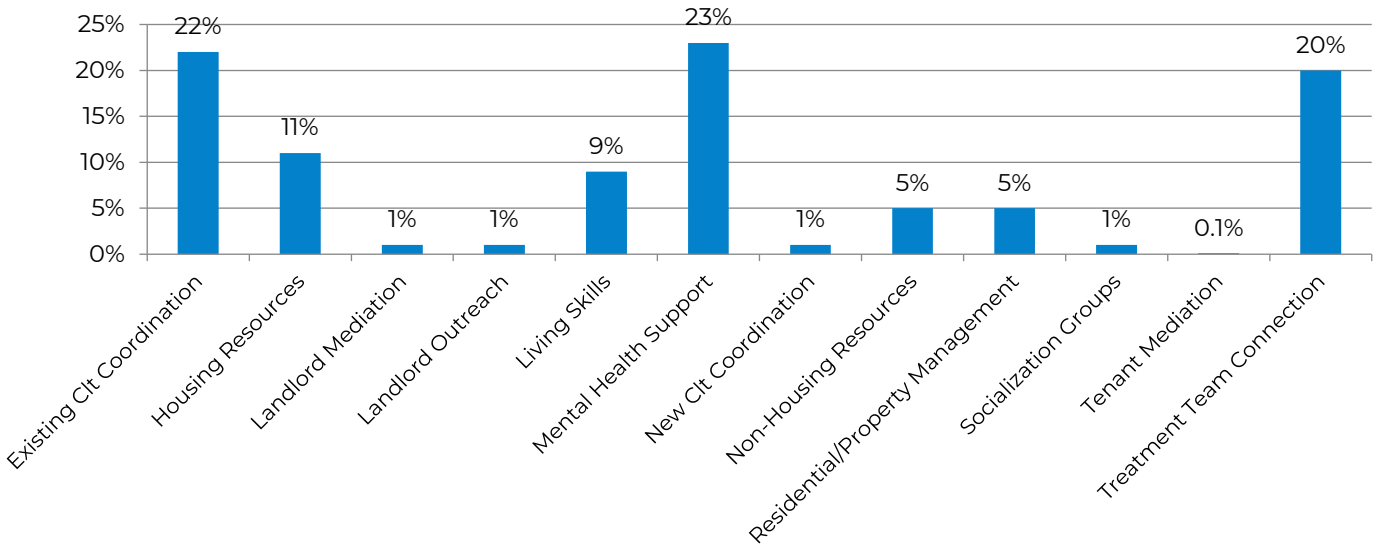


HOW WELL DID WE DO IT?

28
Housing Clients Discharged Due to Lower Level of Care or No Further Care Needed

938
Housing Actions

Additional Types of Services Provided



IS ANYONE BETTER OFF?

4 Unique Individuals Assisted with Eviction Prevention	**113** Unique Individuals Assisted with Maintaining Their Housing	**23** Unique Individuals Secured Housing Either in Tri-City or Elsewhere	**66** Unique Individuals Assisted with Obtaining Housing	**69** Unique Individuals Connected to Housing Resources

MHSA Regulations for Prevention and Early Intervention

"The County shall identify each Program funded with Prevention and Early Intervention funds as a Prevention Program, Early Intervention Program, Outreach for Increasing Recognition of Early Signs of Mental Illness Program, Stigma and Discrimination Reduction Program, Suicide Prevention Program, Access and Linkage to Treatment Program, or Program to Improve Timely Access to Services for Underserved Populations".

Prevention and Early Intervention Regulations/July 1, 2018
(Title 9 California Code of Regulations, Division 1, Chapter 14 MHSA)

Per the Regulations stated above, Counties are required to identify each program funded under their Prevention and Early Intervention Plan by one or more of the following categories:

Prevention and Early Intervention Plan Required Categories/Programs

1. **Prevention Program**
    a. Housing Stability Program
    b. Therapeutic Community Gardening
2. **Early Intervention Program**
    a. Early Psychosis Program
    b. TAY and Older Adult Wellbeing (Peer Mentor Program)
    c. Therapeutic Community Gardening
3. **Access and Linkage to Treatment Program**
    a. Early Psychosis Program
    b. Family Wellbeing Program
    c. Housing Stability Program
    d. TAY and Older Adult Wellbeing (Peer Mentor Program)
    e. Therapeutic Community Gardening
    f. Wellness Center (TAY and Older Adults)
4. **Stigma and Discrimination Reduction**
    a. Community Mental Health Trainings
    b. Community Wellbeing Program
    c. Early Psychosis Program
    d. Family Wellbeing Program
    e. Housing Stability Program
    f. TAY and Older Adult Wellbeing (Peer Mentor Program)
    g. Therapeutic Community Gardening
    h. Wellness Center (TAY and Older Adults)
5. **Outreach for Increasing Recognition for Early Signs of Mental Illness Program**
    a. Community Mental Health Trainings
    b. Community Wellbeing Program
    c. Early Psychosis Program
    d. Family Wellbeing Program
    e. Housing Stability Program
    f. TAY and Older Adult Wellbeing (Peer Mentor Program)
    g. Therapeutic Community Gardening
    h. Wellness Center (TAY and Older Adults)
6. **Suicide Prevention**
    a. Stigma Reduction/Suicide Prevention
    b. NAMI: Ending the Silence
    c. TAY and Older Adult Wellbeing (Peer Mentor Program)

Community Wellbeing Program

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
Target Population:	_X_ 0-15	_X_ 16-25	___ 25-69	___ 60+	Other:
Type of Program:	_X_ Prevention	___ Early Intervention	___ Prevention and Early Intervention		

Program Description

The program provides small grants up to $10,000 and technical assistance to help communities build their capacity to strengthen the wellbeing of their members and the community as a whole. The program focuses on providing support to communities at greater risk for mental illness.

Target Population

Local communities (defined as a group of individuals who rely on each other for support and can act together) who are interested in building their own capacity to strengthen the wellbeing of their members.

Age Groups	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+
Number Served FY 2019-20	2,794	59	59	29

Program Update

The Community Wellbeing Grant program awarded 11 grants in FY 2019-20. These grantees represent 2,941 individuals and the following agencies and organizations: City of Pomona After School Recreation, Claremont Unified School District, Gente Organizada, Kennedy Austin Foundation, NAMI African American Parents, NAMI Padres Efectivos, Newcomers Access Center, Parkside Boys and Girls Club, Simons Middle School, STEM Club City of Knowledge and The Greener STEMs Club. Programs offered through this groups include afterschool learning activities, tutoring, gardening, parenting classes, support groups, public speaking skills, STEM clubs, that improved the wellbeing of their communities.

Challenges and Solutions

There were not significant challenges for this program in FY 2019-20. One notable change was the transition of the Community Capacity Organizer to another position. However, this position was quickly filled and the grant process continued seamlessly and with continued support.

COVID-19 Response

As with other MHSA programing, the Community Wellbeing Grant program was moved to a virtual platform with staff working remotely. Meetings that previously took place in person were now conducted through RingCentral.

Beginning with the onset of COVID 19, all grantees were required to make modifications to their projects. Participants identified how their communities were impacted by the pandemic and how these modifications would be implemented. All correspondence and communication were handled through RingCentral, phone calls and emails.

When preparing for the next round of grants, the CWB staff modified their application and interview process to comply with local, state and federal guidelines regarding COVID-19. This included conducting all application reviews and participant interviews via RingCentral. Future protocol for this program will continue as stated until the COVID 19 restrictions are lifted.

Cultural Approach

The Community Wellbeing Program collaborates with an array of grantees that provide services to the underserved and unserved communities. These grantees also network and collaborate with each other to continue to provide services to these communities. In addition, staff continue to outreach and network with local agencies who focus on providing services to the underserved and unserved communities.

In response to addressing barriers to service; grantees are notified via email of any upcoming Tri-City programs, services, webinars, community connections webinars, mental health trainings that address these barriers. Grantees are encouraged to spread the word within their communities so they can participate in any of these educational opportunities.

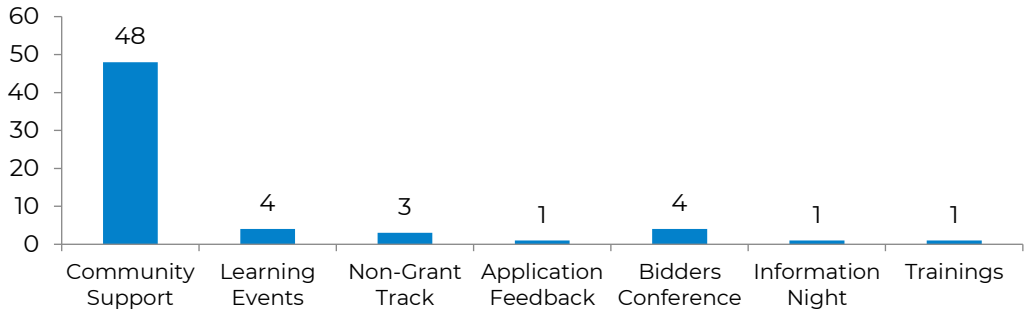
The Community Capacity Organizer for this program is bilingual and able to communicate effectively in both English and Spanish. In addition, all flyers, brochures, grant applications, and supporting documents are available in both English and Spanish.

PROGRAM: Community Wellbeing Program (CWB)

HOW MUCH DID WE DO?

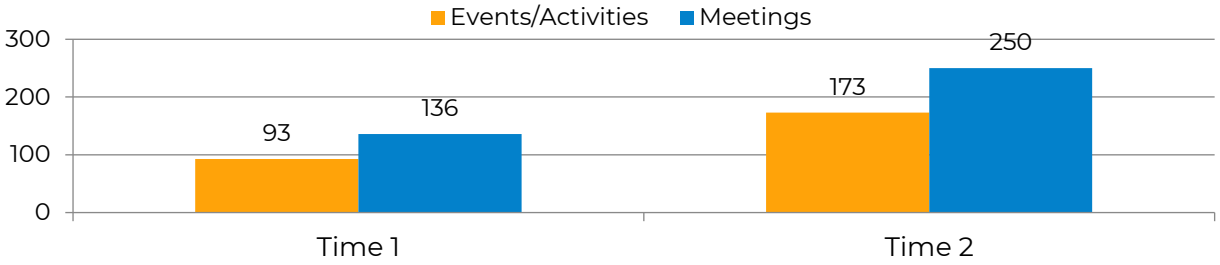
11	2,941	1,781
Community Grantees Chosen	Community Members Represented in 10 out of 11 Grantees	Number of People Who Benefited from Grantee Activities from 10 out of 11 Grantees

Number of Events Held by Community Capacity Organizer



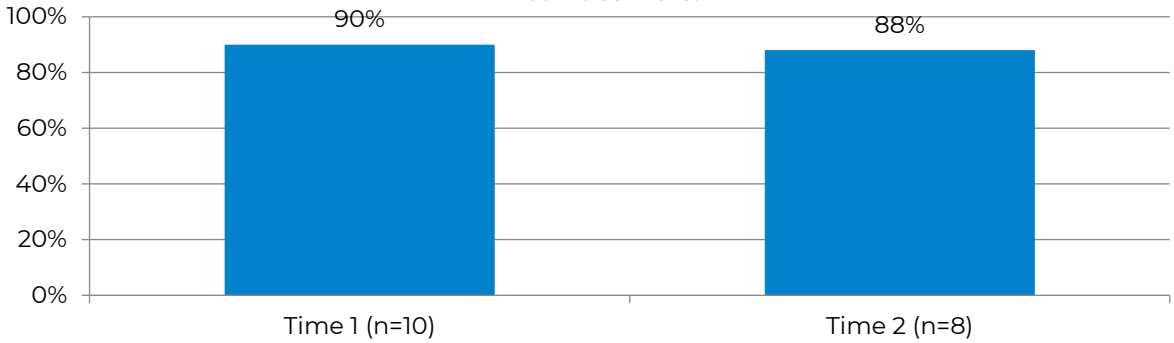
389
Attendees

Number of Community Events/Activities and Meetings

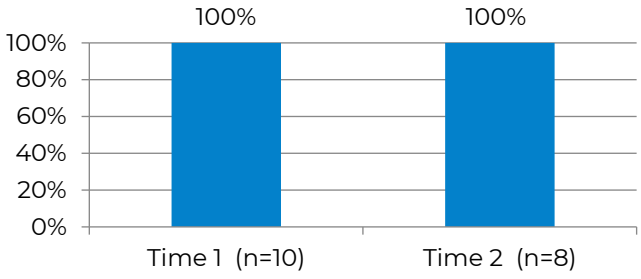


HOW WELL DID WE DO IT?

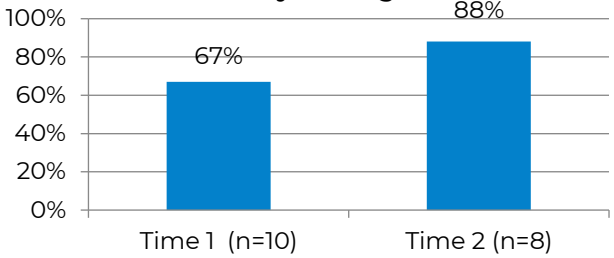
Percentage of Grantees who Report How Successful Their Community's Activities were:



Percentage of Grantees Who Report Improvement in Supporting Each Other

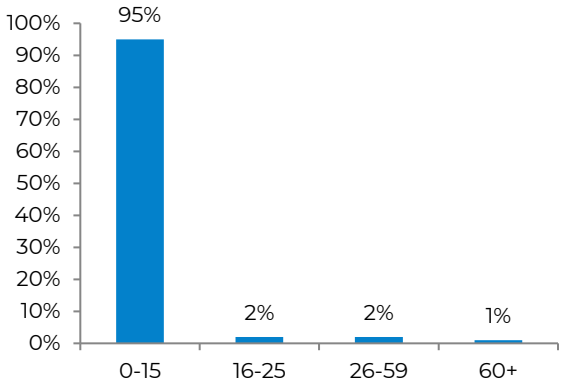


Percentage of Grantees Who Report Improvement in Their Ability to Effectively Act Together

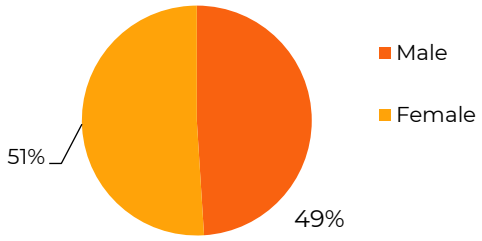


PEI DEMOGRAPHICS

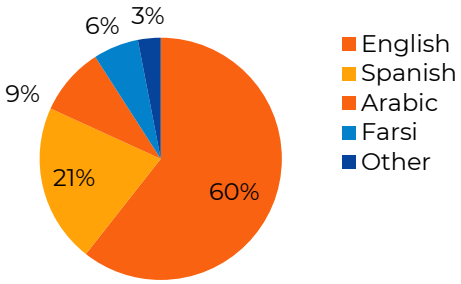
Age



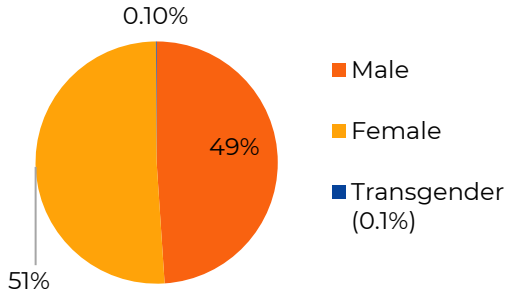
Assigned Gender at Birth



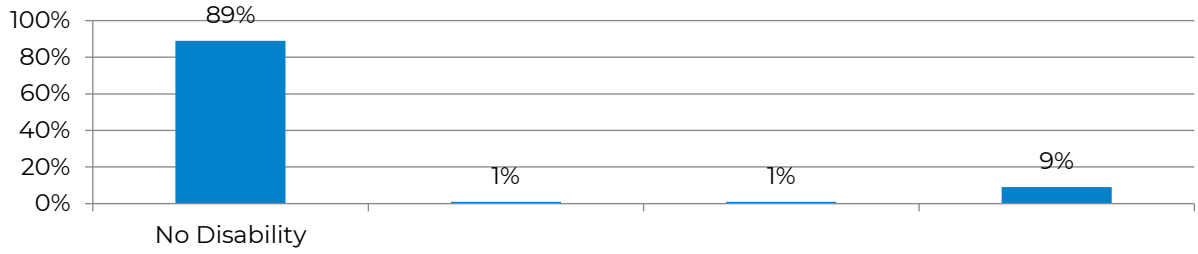
Primary Language



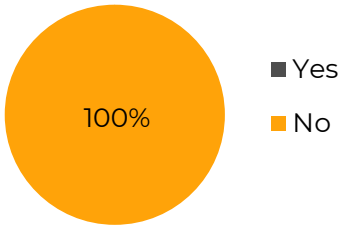
Gender Identity



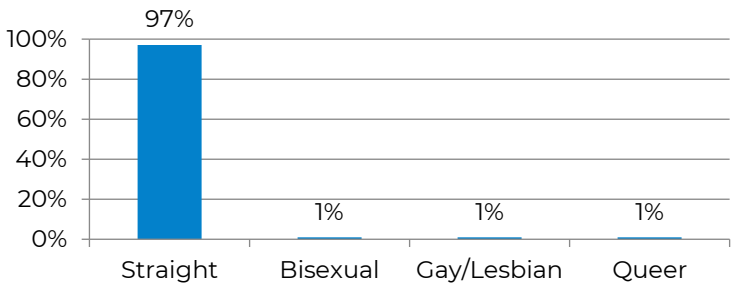
Disability



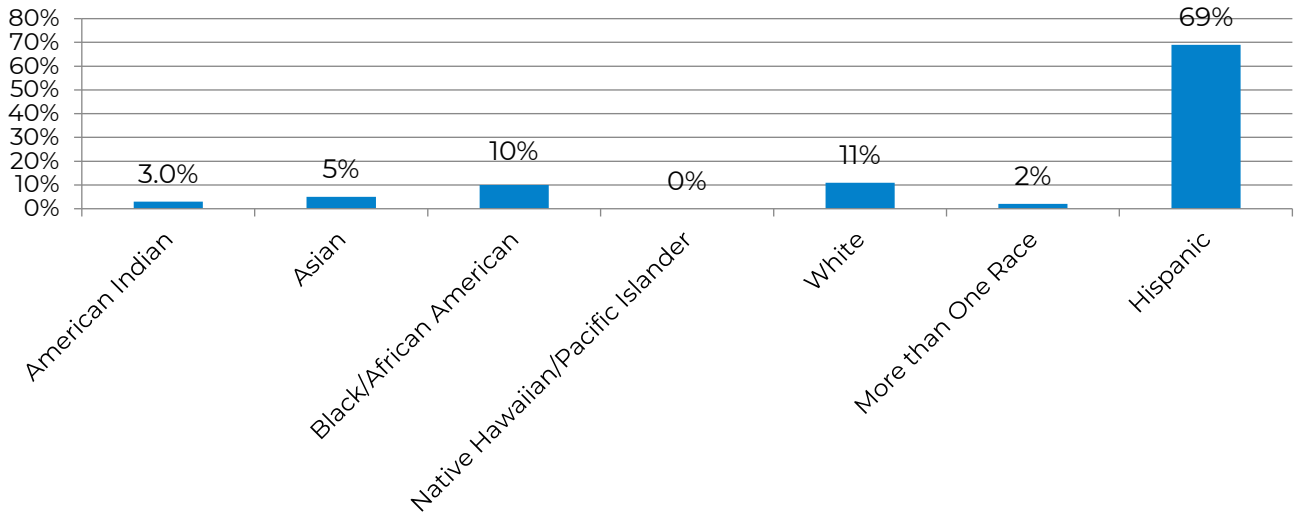
Military Veteran



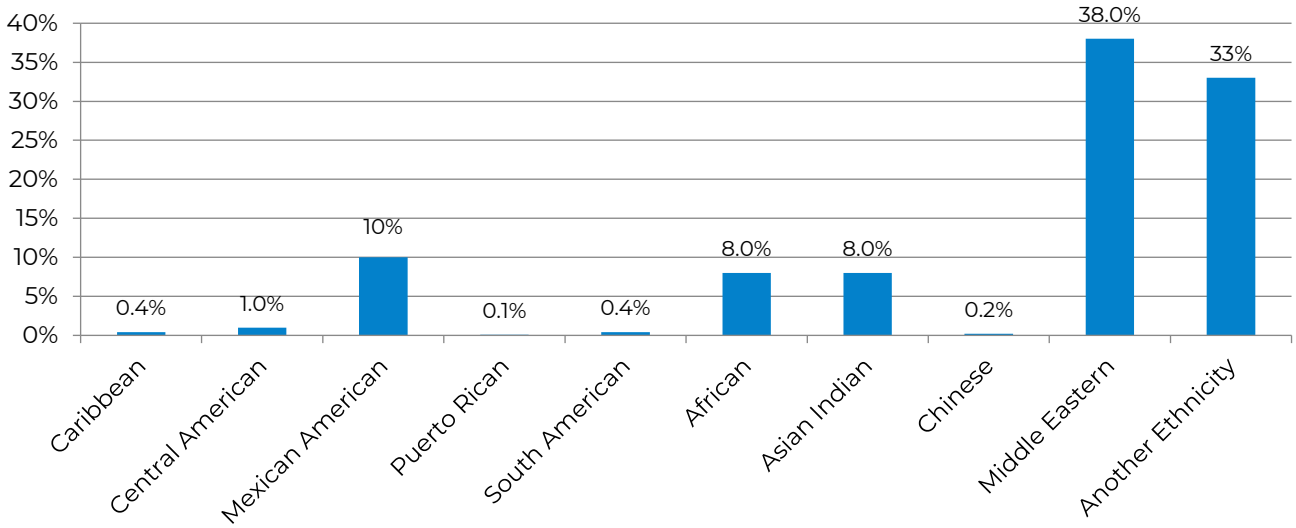
Sexual Orientation



Race



Ethnicity

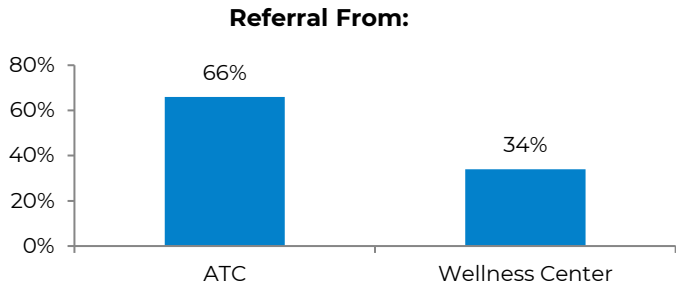


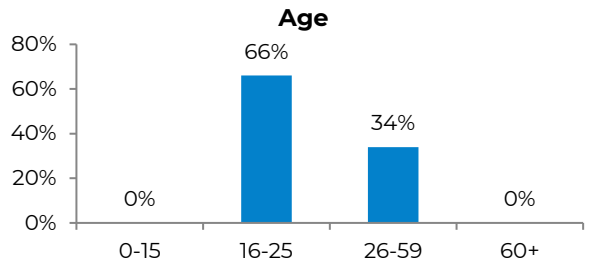
Number of Potential Responders	2,941
Setting in Which Responders were Engaged	Community, Schools, Health Centers, Workplace and Outdoors
Type of Responders Engaged	TAY, teachers, LGBTQ+, families, religious leaders, and those with lived experience
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

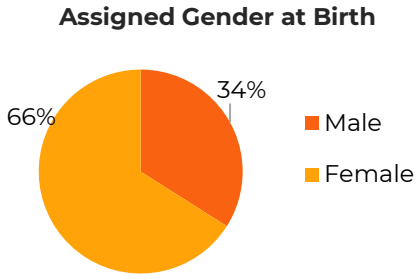
TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY:

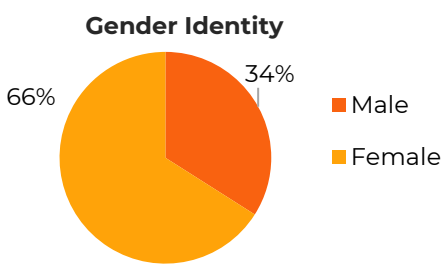
PEI Demographics Based on MHSA Referrals

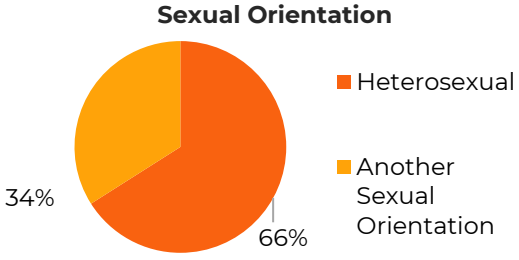
3
MHSA Referrals to Community Wellbeing Program



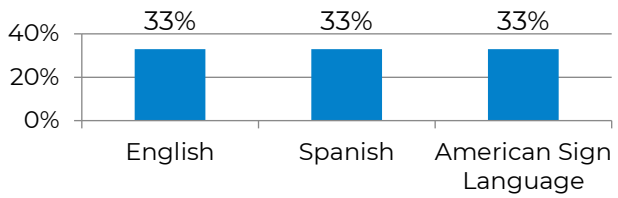




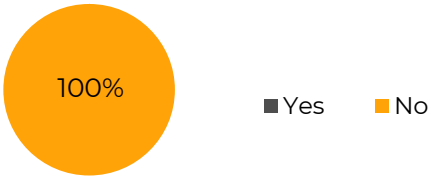




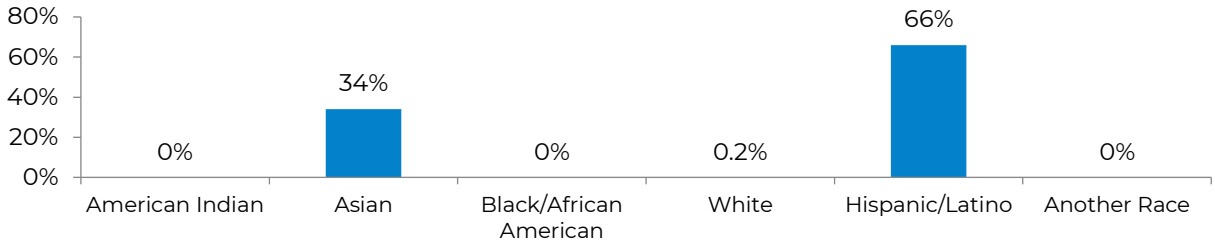
Language



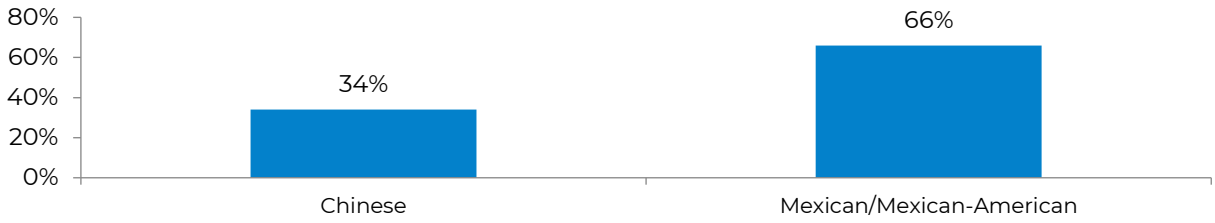
Military Veteran



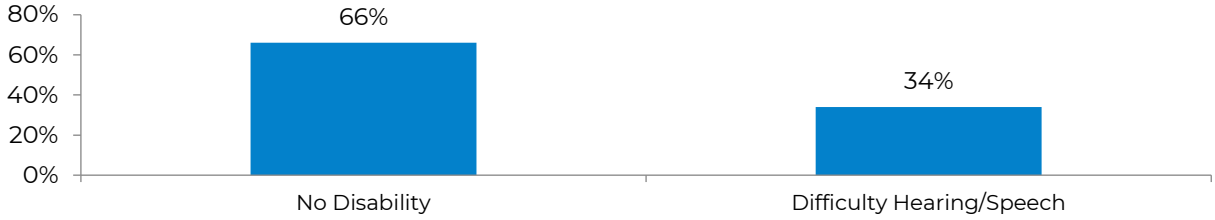
Race



Ethnicity



Disability



Community Mental Health Trainings

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
Target Population:	___ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:
Type of Program:	_X_ Prevention	___ Early Intervention	___ Prevention and Early Intervention		

Program Description

Community Mental Health Trainers offer free group trainings including Mental Health First Aid (MHFA), Adverse Childhood Experiences [ACE], Community Resiliency Model [CRM], Motivational Interviewing [MI], and Everyday Mental Health [EMH] as well as workshops based on the Recovery Model, Non-Suicidal Self-Harm and parenting classes. Since the onset of COVID-19, these trainings are now offered virtually.

Target Population

Tri-City staff, community members, local schools and agencies who are interested in learning how to recognize the early warning signs of mental illness and appropriately intervene to provide support.

Community Mental Health Trainings FY 2019-20	54
Individuals Trained	940

Program Update

The Community Mental Health Trainings continue to be a popular program within the tri-city area. The extensive menu of training options, and the flexibility of Tri-City's staff in adapting trainings to their audiences, has allowed this program to expand the type of trainings offered.

In July 2019, Pomona Unified School District (PUSD) asked Tri-City to host a series of mental health and wellness workshops for PUSD summer students and exchange students from China. Claremont Graduate University's Social Work Program, in collaboration with Western Colleges' Nursing Program requested a series of Tri-City trainings on Adverse Childhood Experiences [ACE], Community Resiliency Model [CRM], Motivational Interviewing [MI], and Everyday Mental Health [EMH] to graduate students in each of their programs. Western University invited Tri-City to provide an ACES presentation to over 100 of their medical students from their Pomona campus and a satellite campus in Oregon virtually ACEs Aware Grant.

Challenges and Solutions

With this growing popularity, it became clear that a dedicated program staff/trainer was needed to oversee this essential program. A second challenge was the limited curriculum available in Spanish in addition to the lack of a bilingual trainers. These issues were addressed and resolved when this position was filled in July 2020.

COVID-19 Response

As with all MHSA programing, staff began working remotely with all communication conducted through RingCentral, email and/or by phone. Similar to staff, all communication with community partners were managed through phone/email.

As expected, all scheduled events, trainings, and programs had to be canceled due to physical/social distancing requirements without the ability to reschedule. Instead, communication focused on providing resources, information, updates, and virtual webinars regarding COVID-19.

COVID-19 significantly impacted the ability to immediately provide the same level of trainings as prior to the pandemic. Access to a virtual platform and the modification to the "in-person" trainings took time to execute. Many community partners did not have a virtual platform in place in order to receive the training virtually. In addition, the pandemic caused many community partners to shut down which limited communication for a significant period of time, including local school districts and colleges who were busy transitioning to a virtual learning environment with very little notice or preparation.

As of April 2020, all community trainings were offered virtually through the RingCentral Webinar platform. CMHT began providing weekly webinars on topics that were already a part of Tri-City's training series. Notification of these trainings were posted on Tri-City's webpage, social media accounts, and emails.

Cultural Approach

Prior to COVID-19, Community Mental Health trainers (CMHT) were able to address cultural barriers through in-person connections with under/unserved communities and by building relationships with organization that work, serve, and support these communities, by providing information, services, and trainings.

By working closely with Tri-City's Stigma Reduction Program, CMHTs share information on how to reduce stigma that impacts community partners from seeking, accessing, and utilizing services. By reaching out to organizations to set-up trainings, share information, and educate them on what mental illness/wellness is, it's impact, and accessible services, staff are able to share resources available to help prevent and support someone who's experiencing a mental health challenge.

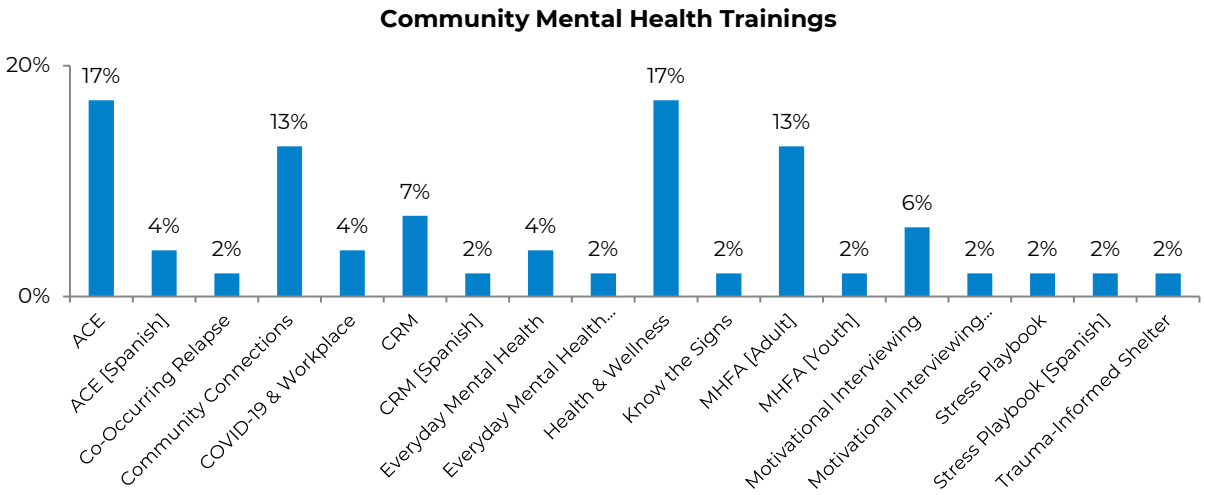
Tri-City has hired a bilingual/Spanish full-time program staff to provide trainings in Spanish. Trainings and webinars will be available in English and Spanish in addition to marketing materials available in both languages as well.

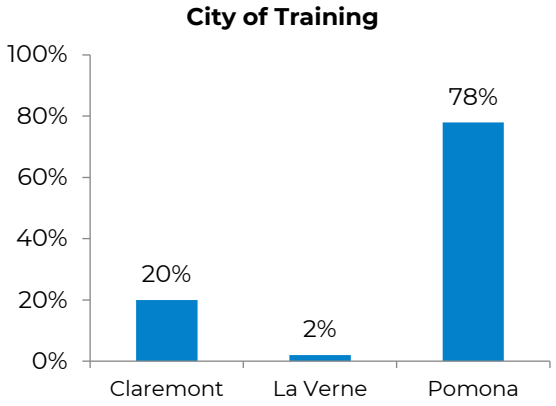
PROGRAM: Community Mental Health Trainings (CMHT)

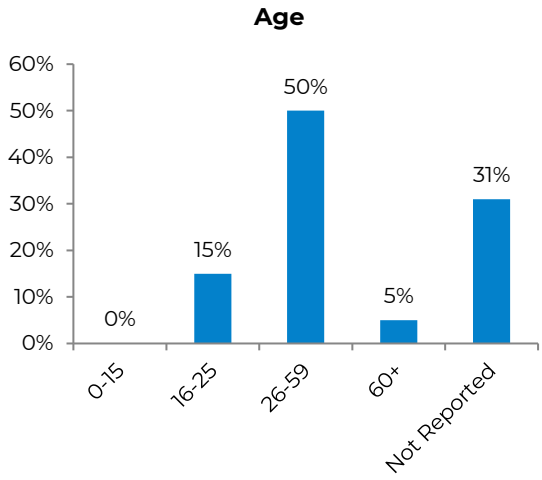
HOW MUCH DID WE DO?

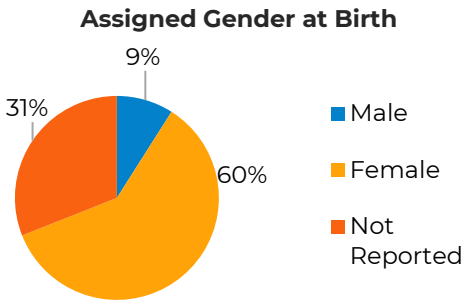
940
Individuals Served

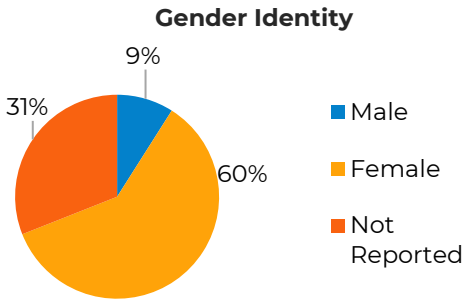
54
Community Mental Health Trainings

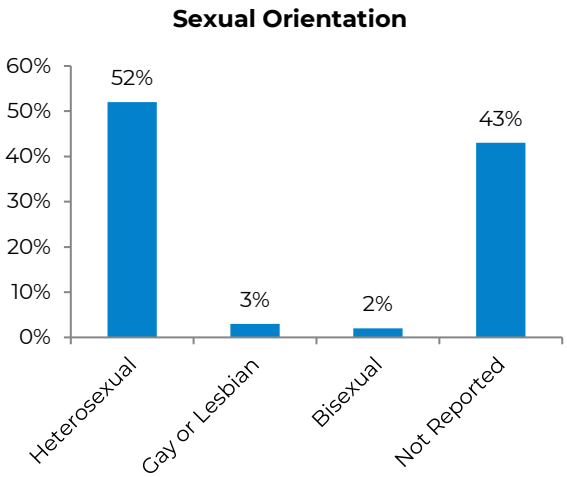

Community Mental Health Trainings
20%
0%
17%
4%
2%
13%
4%
7%
2%
4%
2%
17%
2%
13%
2%
6%
2%
2%
2%
2%
ACE
ACE [Spanish]
Co-Occurring Relapse
Community Connections
COVID-19 & Workplace
CRM
CRM [Spanish]
Everyday Mental Health
Everyday Mental Health...
Health & Wellness
Know the Signs
MHFA [Adult]
MHFA [Youth]
Motivational Interviewing
Motivational Interviewing...
Stress Playbook
Stress Playbook [Spanish]
Trauma-Informed Shelter

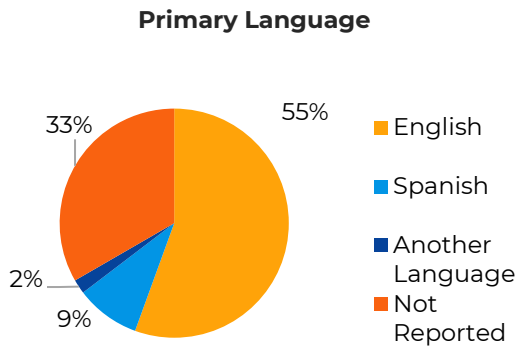

City of Training
100%
80%
60%
40%
20%
0%
20%
2%
78%
Claremont
La Verne
Pomona

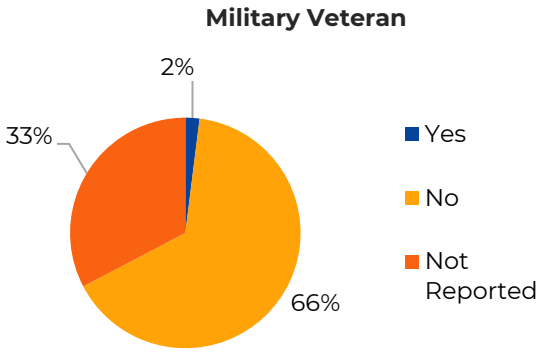

Age
60%
50%
40%
30%
20%
10%
0%
0%
15%
50%
5%
31%
0-15
16-25
26-59
60+
Not Reported

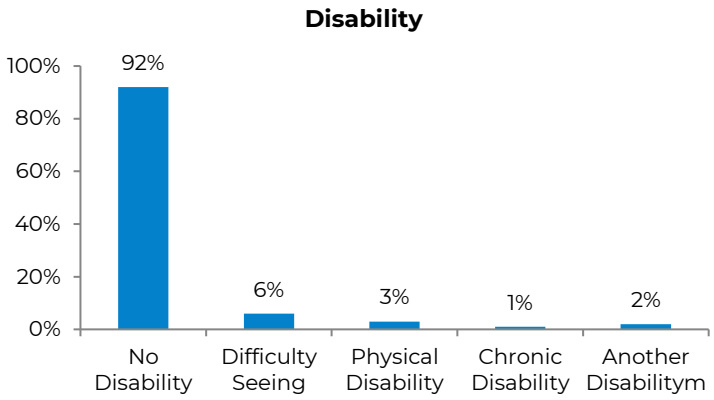

Assigned Gender at Birth
9%
31%
60%
Male
Female
Not Reported

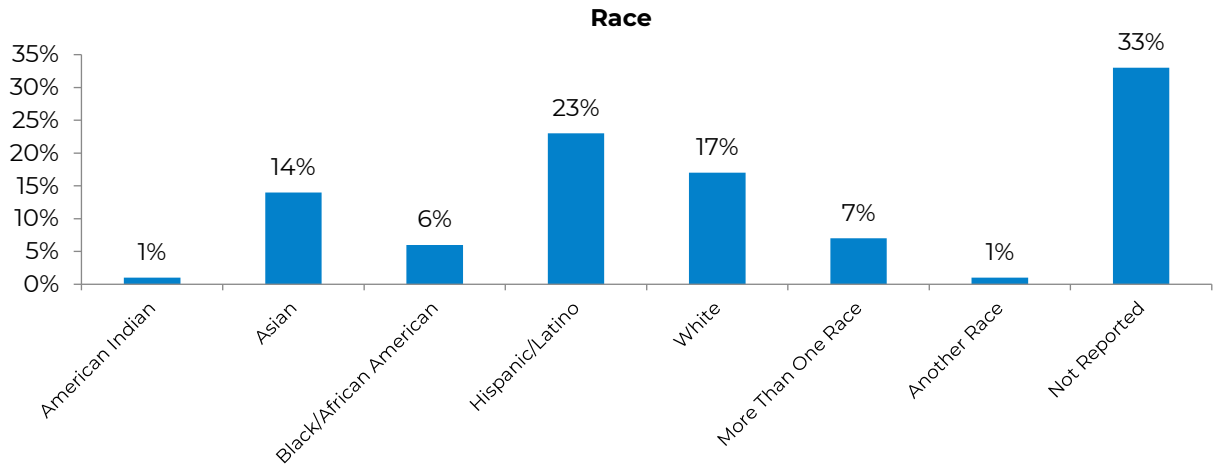

Gender Identity
9%
31%
60%
Male
Female
Not Reported

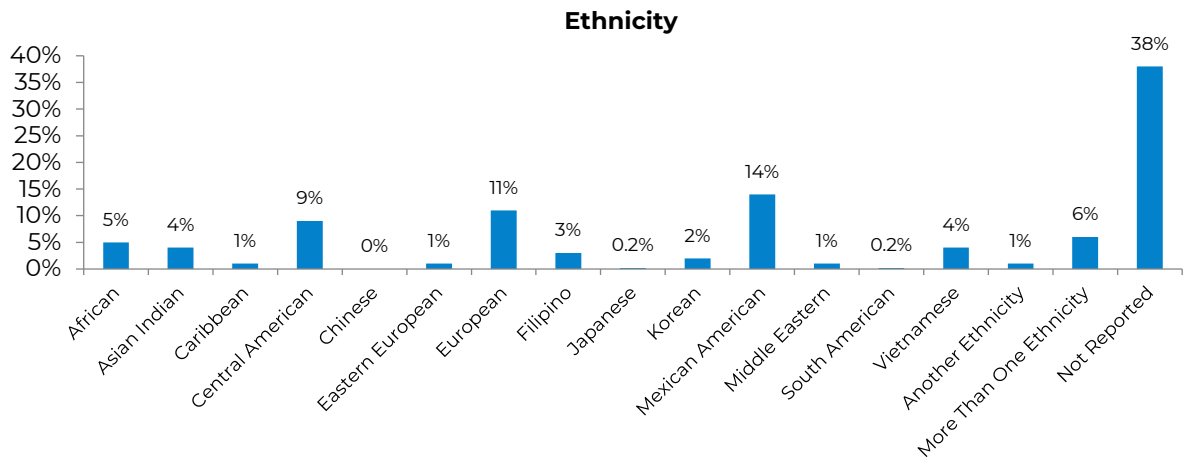

Sexual Orientation
60%
50%
40%
30%
20%
10%
0%
52%
3%
2%
43%
Heterosexual
Gay or Lesbian
Bisexual
Not Reported


Primary Language
33%
55%
2%
9%
English
Spanish
Another Language
Not Reported


Military Veteran
2%
33%
66%
Yes
No
Not Reported

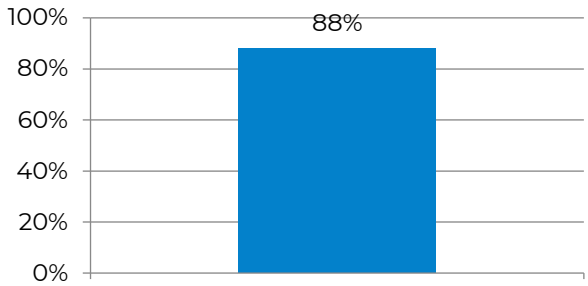

Disability
100%
80%
60%
40%
20%
0%
92%
6%
3%
1%
2%
No Disability
Difficulty Seeing
Physical Disability
Chronic Disability
Another Disabilitym


Race
35%
30%
25%
20%
15%
10%
5%
0%
1%
14%
6%
23%
17%
7%
1%
33%
American Indian
Asian
Black/African American
Hispanic/Latino
White
More Than One Race
Another Race
Not Reported

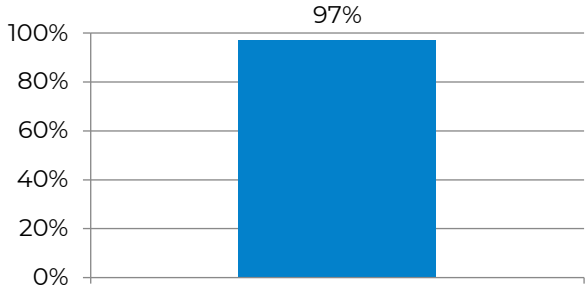


HOW WELL DID WE DO IT?

Percentage of participants who report the training was relevant to their day to day activities:

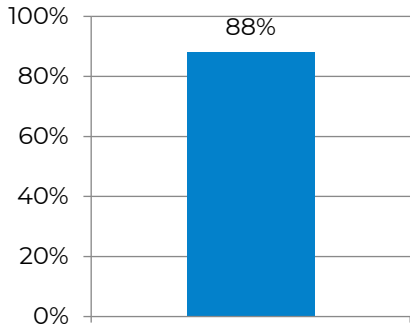


Percentage of participants who rated the training session as good or excellent

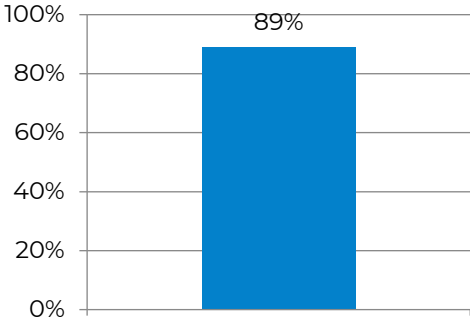


IS ANYONE BETTER OFF?

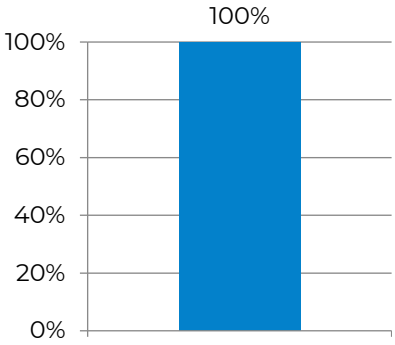
Percentage of participants who report feeling confident in using or applying the skills learned in the training:



Percentage of participants who report feeling more confident reaching out to someone who may be experiencing a mental health challenge or crisis



Percentage of participants who would recommend the training to others:

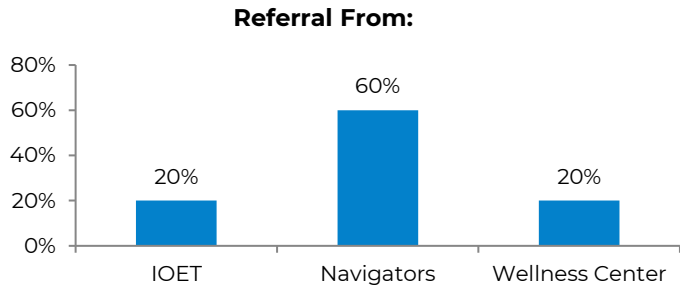


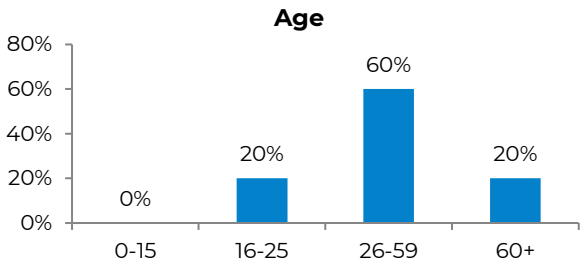
Number of Potential Responders	940
Setting in Which Responders were Engaged	Community, schools and colleges
Type of Responders Engaged	TAY, adults, seniors, landlords and students
Underserved Populations	Black/African American, Asian American/Pacific Islander, Hispanic/Latino, Native American, Refugee/Immigrant, Lesbian/Gay/Bisexual/Transgender/Questioning, Transition Age Youth, Older Adults, and those with a physical disability
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

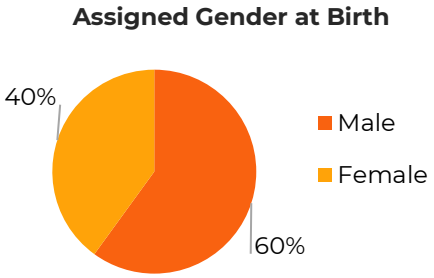
TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY:

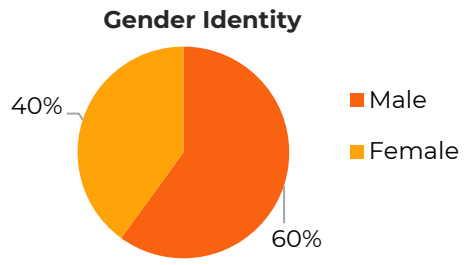
PEI Demographics Based on MHSA Referrals

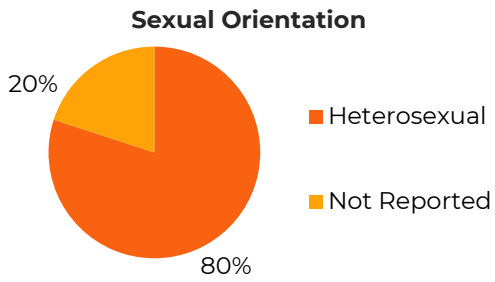
5
MHSA Referrals to Community Mental Health Trainings

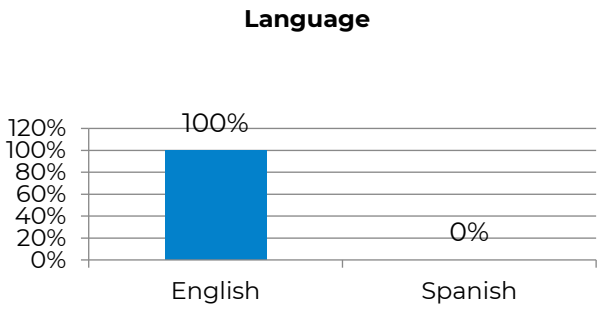


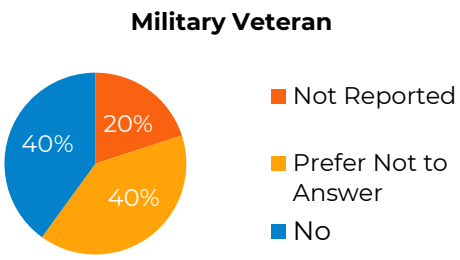


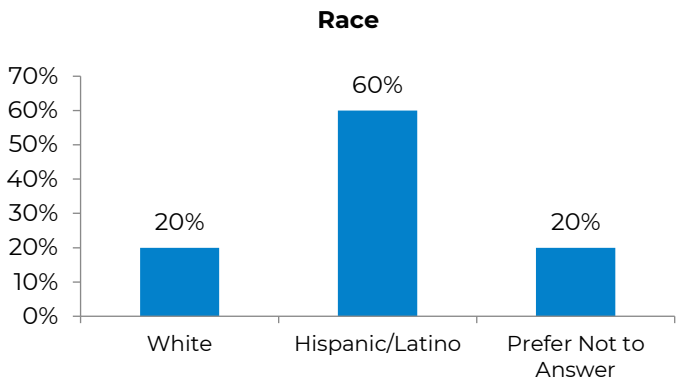


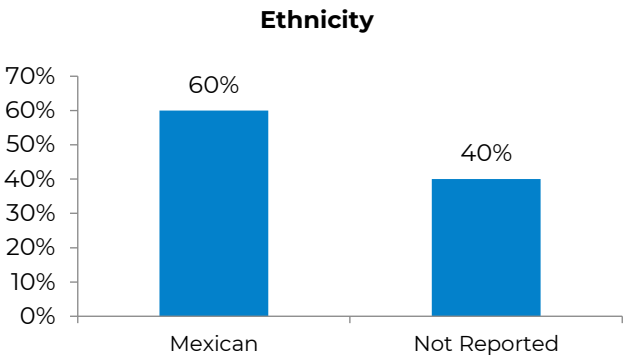

Gender Identity
40%
60%
Male
Female

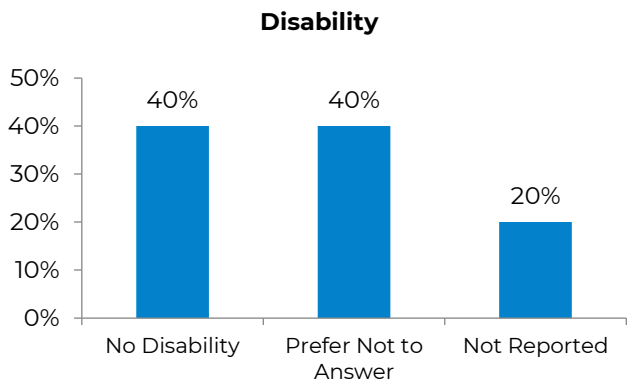

Sexual Orientation
20%
80%
Heterosexual
Not Reported


Language
120%
100%
80%
60%
40%
20%
0%
100%
0%
English
Spanish


Military Veteran
40%
20%
40%
Not Reported
Prefer Not to Answer
No


Race
70%
60%
50%
40%
30%
20%
10%
0%
20%
60%
20%
White
Hispanic/Latino
Prefer Not to Answer


Ethnicity
70%
60%
50%
40%
30%
20%
10%
0%
60%
40%
Mexican
Not Reported


Disability
50%
40%
30%
20%
10%
0%
40%
40%
20%
No Disability
Prefer Not to Answer
Not Reported

Stigma Reduction and Suicide Prevention

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
Target Population:	_X_ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:
Type of Program:	_X_ Prevention	___ Early Intervention	___ Prevention and Early Intervention		

Program Description

Tri-City's stigma reduction effort is encompassed under Room4Everyone and includes a website focused on stigma reduction, along with several other components designed to empower individuals suffering with mental health challenges and awareness to the stigma related to mental illness. Suicide prevention efforts include offering the safeTALK alertness training which provides participants with the skills needed to recognize the signs of suicide in an individual and connect them quickly and safely with the appropriate resources and support services.

Target Population

Community members, agencies and organizations located in the Tri-City region (cities of Claremont, Pomona, and La Verne).

Number of Individuals Served FY 2019-20	206

Program Update

On September 10, 2019, a World Suicide Prevention Day event was hosted in collaboration with NAMI Pomona Valley. This public event screened the documentary "Suicide: The Ripple Effect', a feature length film which documents the suicide attempt of Kevin Hines, the impact of his suicide attempt on others, and his later work as a mental health advocate. We Connect, We Live, We Thrive was the theme of the event. It focused on screening the film, stories of suicide survivors and community partners who have opportunity for community members to connect and get involved right away.

The annual Creative Minds Art Gallery reception theme was 'Let's Celebrate'. Notable entries included a class project submitted by Claremont High School's photography class. This was a wonderful example of collaboration between Tri-City and local schools in raising awareness of the connection of mental health and the arts.

Challenges and Solutions

Challenges during this period included the fact that the curriculum used for suicide prevention, SAFETALK, continues to be only available in English. In addition, the training is four hours long and some participants feel this is too long. The topic of suicide can be very sensitive and challenging for participants to stay engaged for that extended period of time or feel comfortable asking questions.

In response to these concerns, staff have started using Know the Signs, another suicide prevention training/presentation, which is available in Spanish, and can be presented by any staff member.

A second challenge focuses on the stigma reduction presentations which are delivered by a Courageous Minds speaker (person who identifies with lived experience). However, due to scheduling and personal responsibilities, it has been a challenge to maintain speakers to be a part of this program. Staff have connected with Tri-City clinicians and MHSA programs to identify potential clients/participants who would be a great fit for this speaker program.

COVID-19 Response

The impact of COVID 19 for this program primarily involved the cancellation of community events including Green Ribbon Week, a popular week-long series of events focusing on stigma reduction. Outreach efforts were also curtailed since local schools, agencies, and community-based sites were closing in response to the pandemic.

By utilizing RingCentral, a virtual platform, staff were able to offer webinars focusing on a wide-range of topics and promote virtual events, presentations and trainings. In consideration of the impact of individuals in the community being socially isolated, staff designed weekly session called Community Connections that highlighted a specific skill or topic each week and allowed attendees to participate virtually through their cameras and microphones.

Cultural Approach

Striving to offer and provide trainings, presentations and information to diverse communities and neighborhoods across all three cities is one way the stigma reduction program attempts to reach as many individuals as possible. Multi- language trainings are made possible through the collaboration of program staff and bilingual staff members who co-facilitate. When promoting events like art workshops and art reception, flyers are available in both English and Spanish.

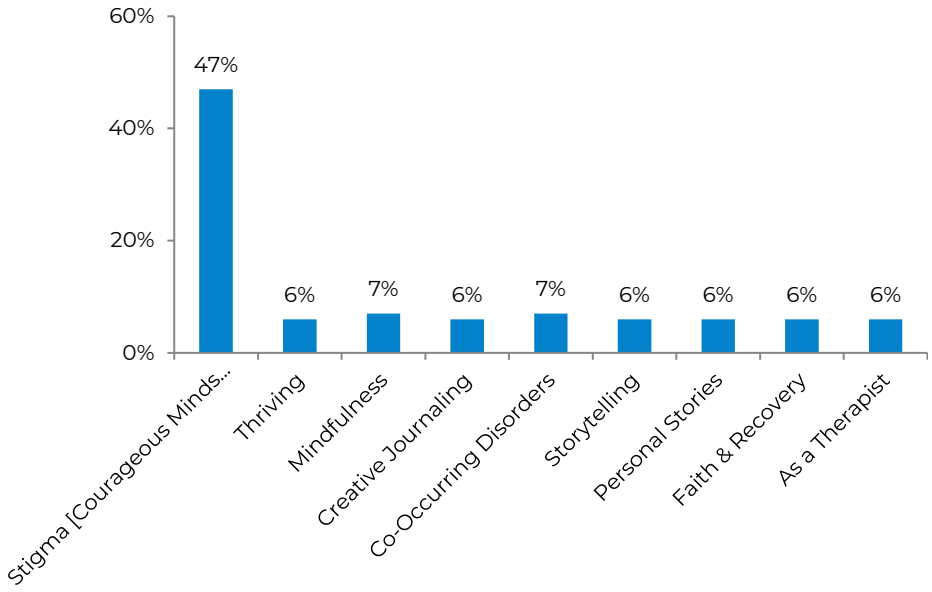
The Stigma Reduction program works on reducing stigma by creating a safe space for presentations and trainings that are culturally sensitive and beneficial for all participants. The meaning of "Room4Everyone" expands beyond those with and without mental health conditions. It also refers to finding ways we are more alike than different, no matter what the differences are. Barriers experienced by the LGBTQ community are reduced by having materials that reflect the specifics of mental health on members of their community. Presentations and trainings dedicated to this important population touches on topics that are relevant and provides an opportunity for discussions, provide inclusion, and allow for questions from heterosexual and cisgender attendees to help increase their understanding.

PROGRAM: Stigma Reduction and Suicide Prevention

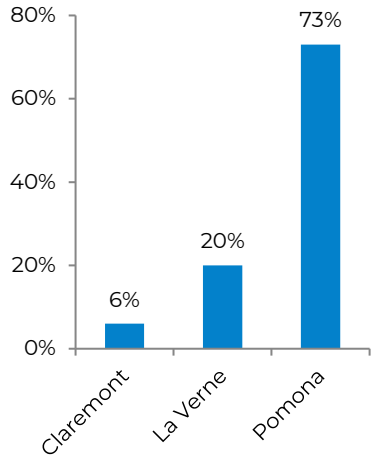
HOW MUCH DID WE DO? Stigma Reduction

15	20
Stigma Reduction Presentations	Courageous Minds Speakers Shared

Type of Stigma Reduction Presentations

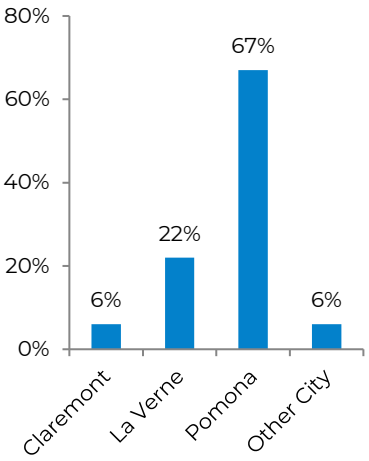


Presentations by City

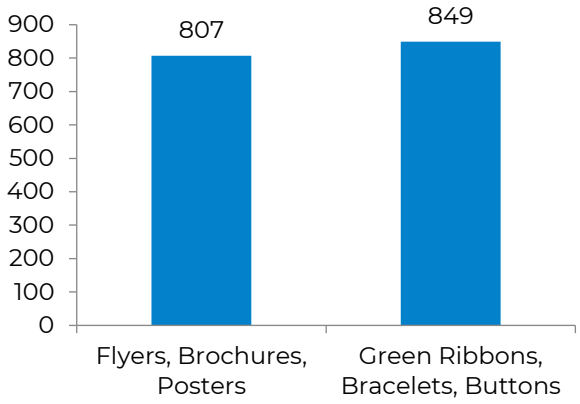


1,656
Promotional Materials Distributed

City of Promotional Materials

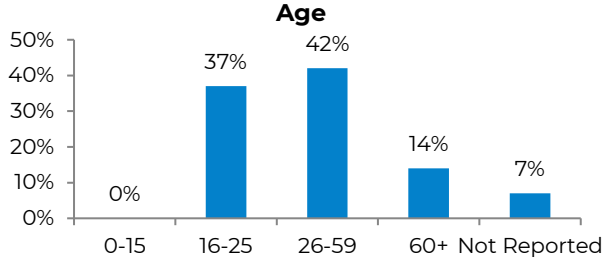


Type of Distributed Promotional Materials

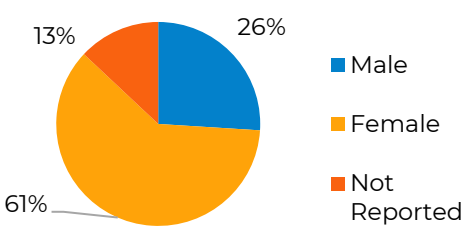


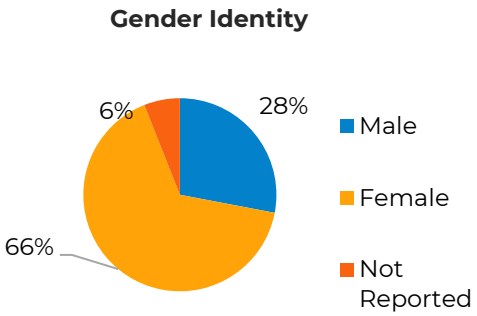
Demographics Based on Participants Who Completed Stigma Reduction Surveys (n=117)

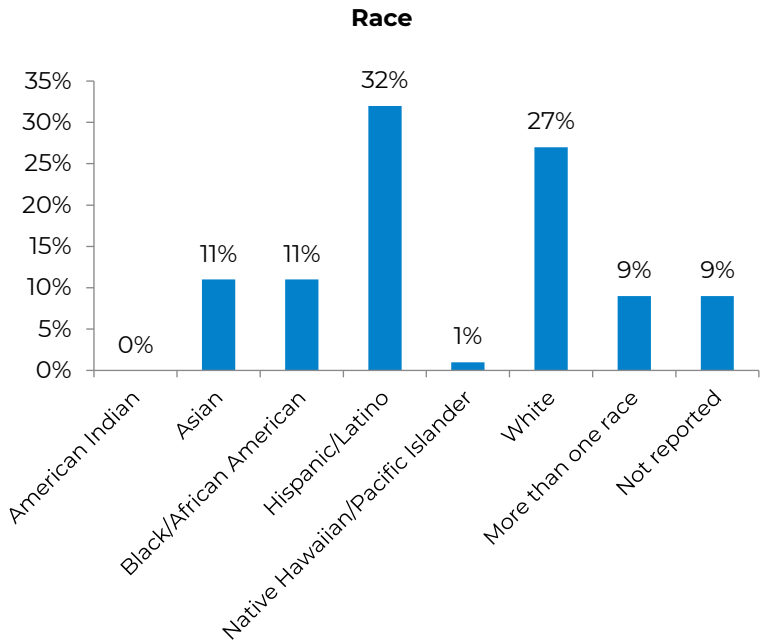
Age

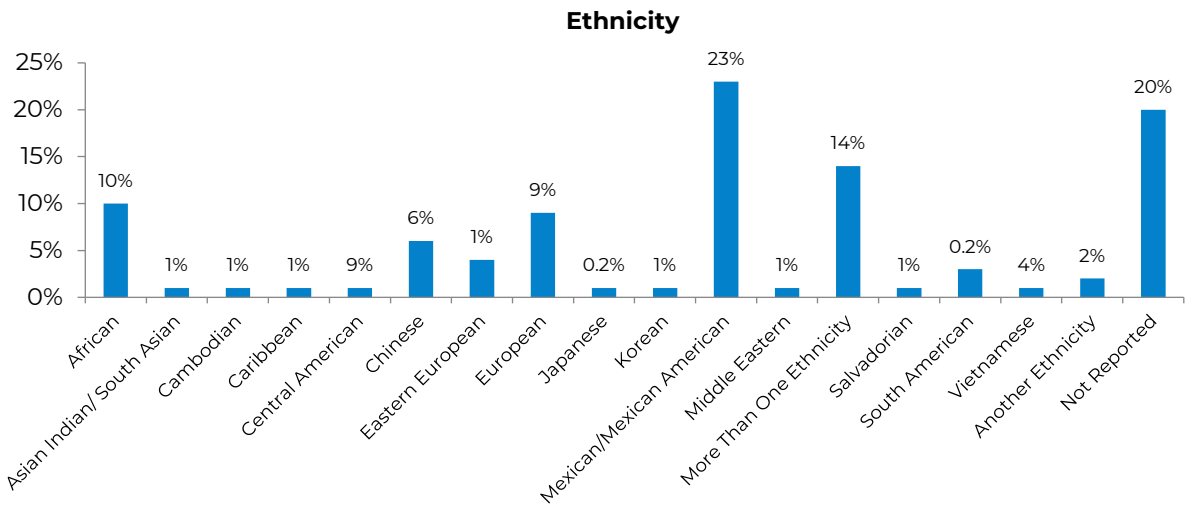


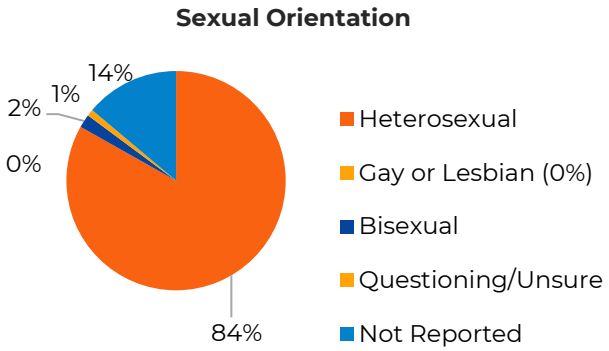
Assigned Gender at Birth

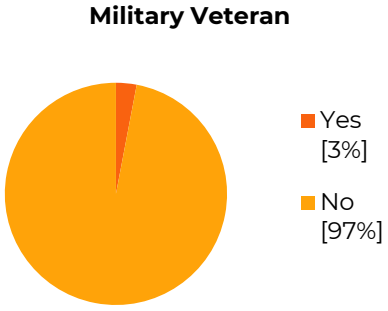


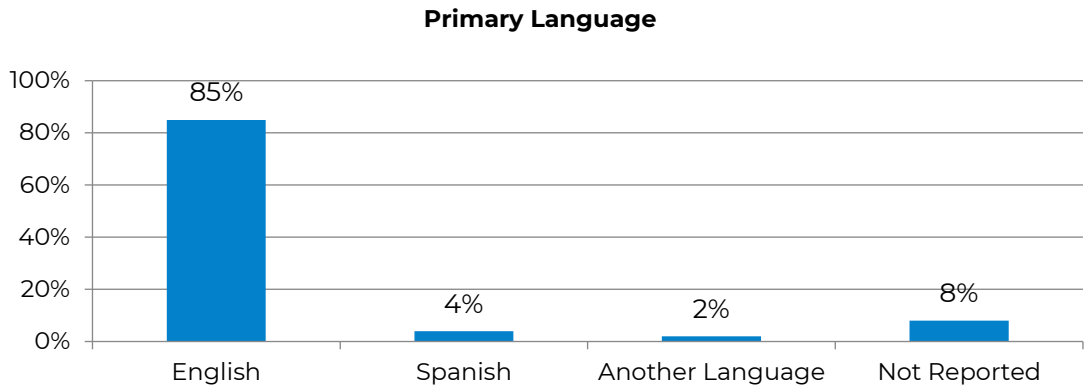

Gender Identity
6%
28%
66%
Male
Female
Not Reported

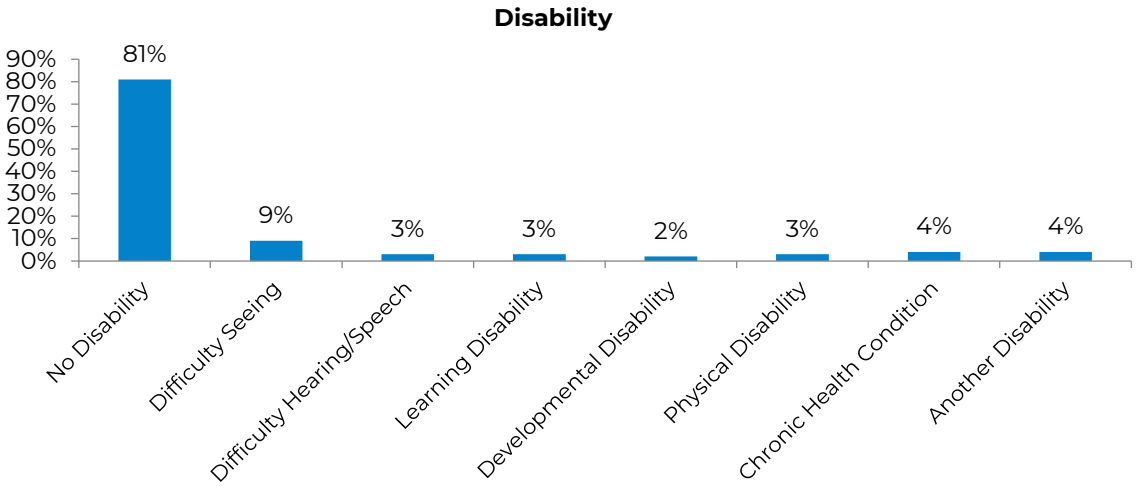

Race
35%
30%
25%
20%
15%
10%
5%
0%
0%
11%
11%
32%
1%
27%
9%
9%
American Indian
Asian
Black/African American
Hispanic/Latino
Native Hawaiian/Pacific Islander
White
More than one race
Not reported


Ethnicity
25%
20%
15%
10%
5%
0%
10%
1%
1%
1%
9%
6%
1%
9%
0.2%
1%
23%
1%
14%
1%
0.2%
4%
2%
20%
African
Asian Indian/ South Asian
Cambodian
Caribbean
Central American
Chinese
Eastern European
European
Japanese
Korean
Mexican/Mexican American
Middle Eastern
More Than One Ethnicity
Salvadorian
South American
Vietnamese
Another Ethnicity
Not Reported


Sexual Orientation
14%
1%
2%
0%
84%
Heterosexual
Gay or Lesbian (0%)
Bisexual
Questioning/Unsure
Not Reported

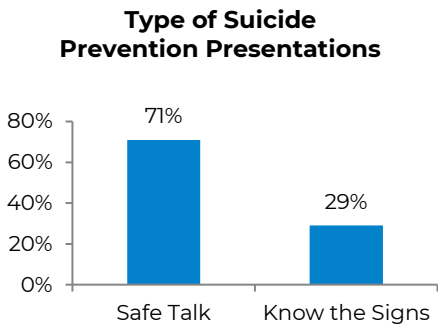

Military Veteran
Yes [3%]
No [97%]

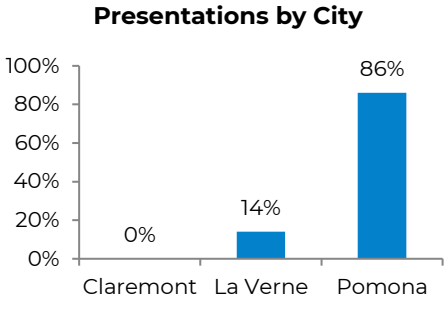




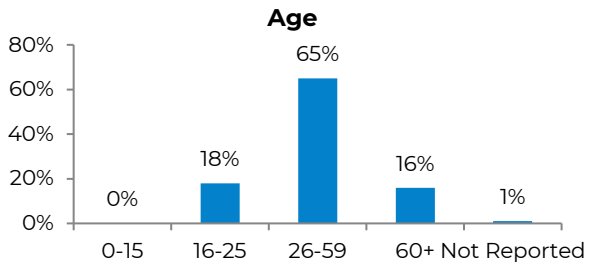
HOW MUCH DID WE DO? Suicide Prevention

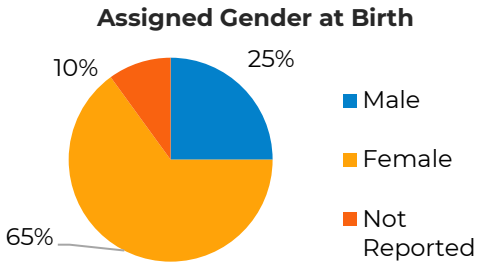
7
Suicide Prevention Trainings and Presentations

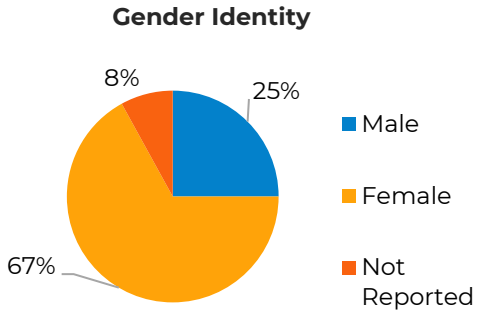


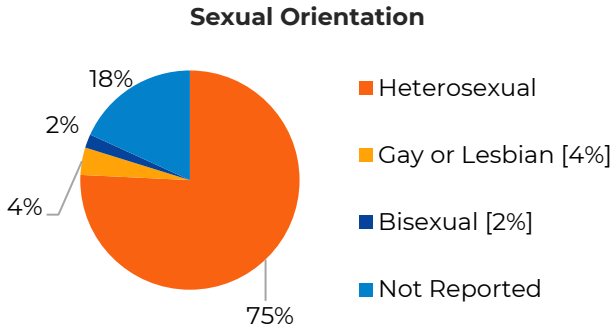


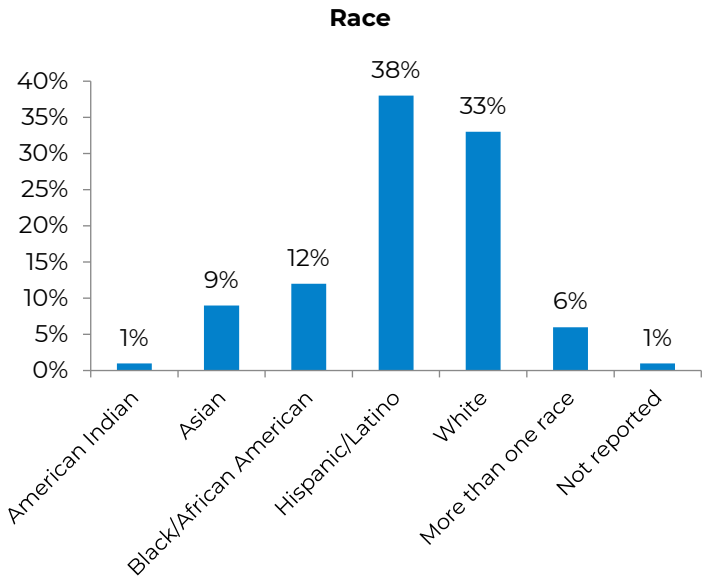
Demographics Based on Participants Who Completed Safe Talk Surveys (n=89)

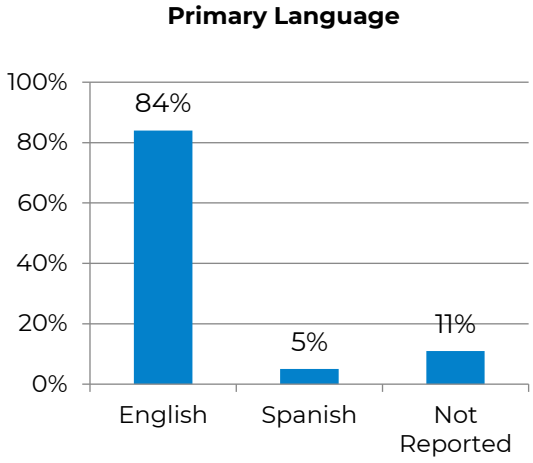


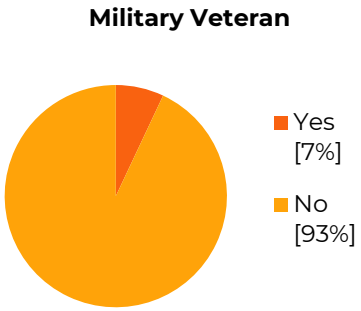


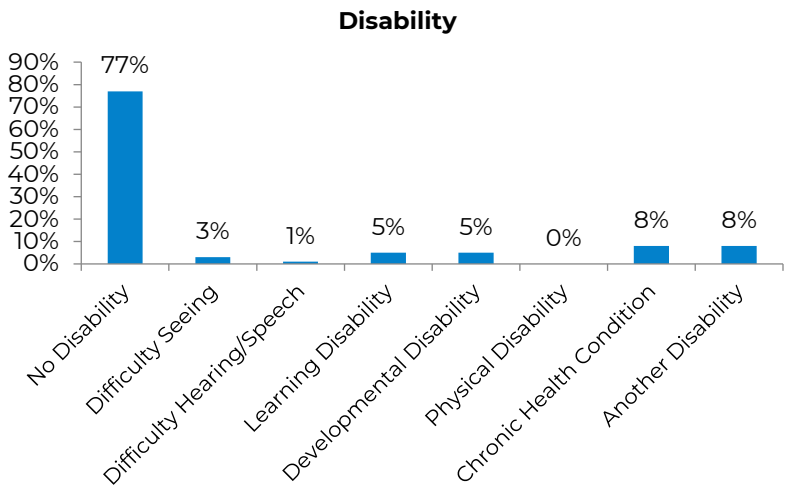


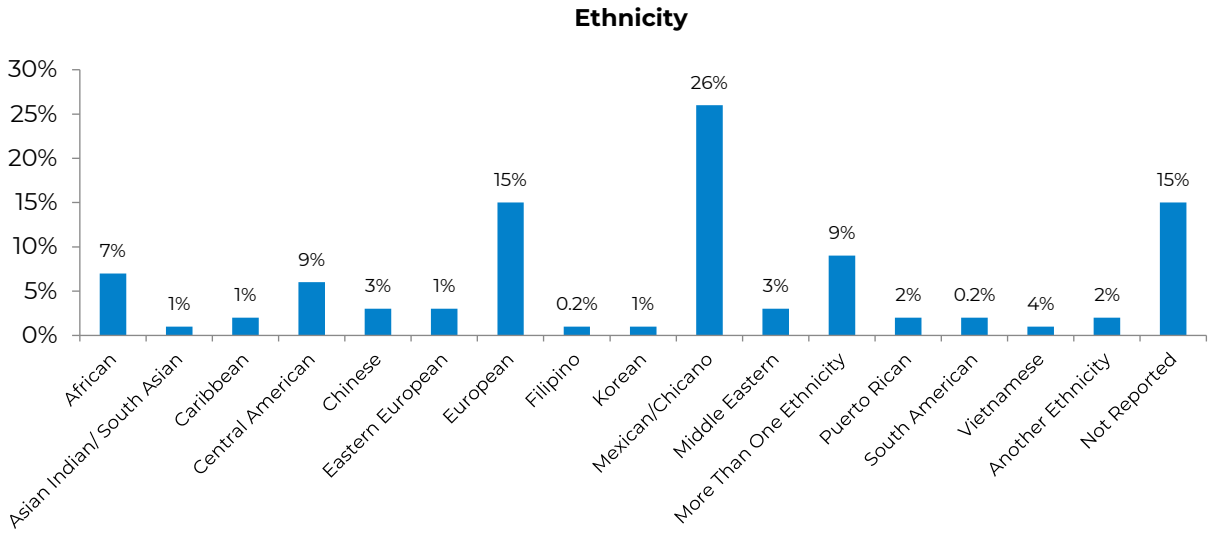








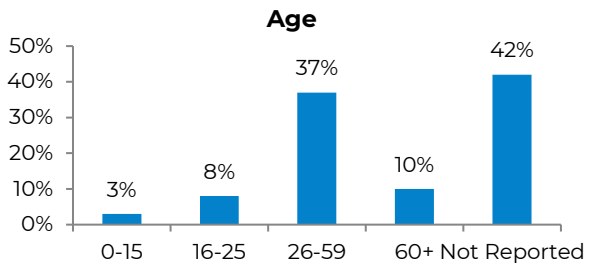


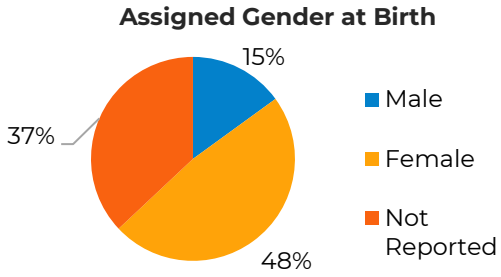


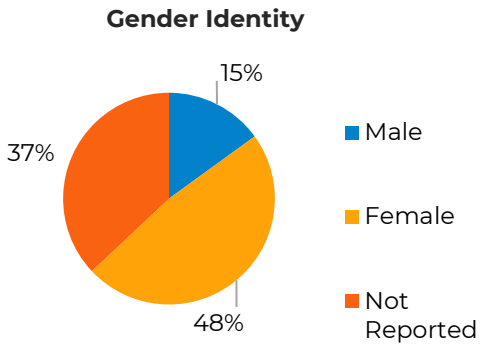
HOW MUCH DID WE DO? Creative Minds Art Gallery

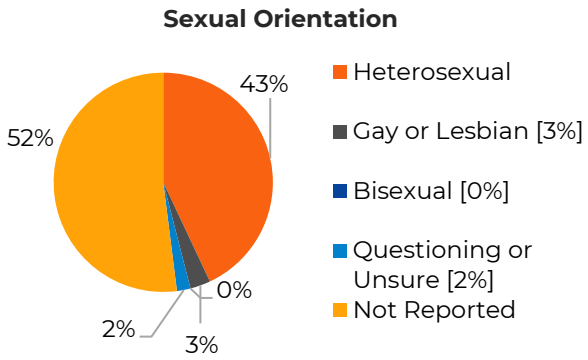
3	98	81
Creative Minds Art Events Were Held	Individuals Participated in Creative Minds Art Workshop and Gallery	Art Pieces Were Submitted to the Creative Minds Art Gallery

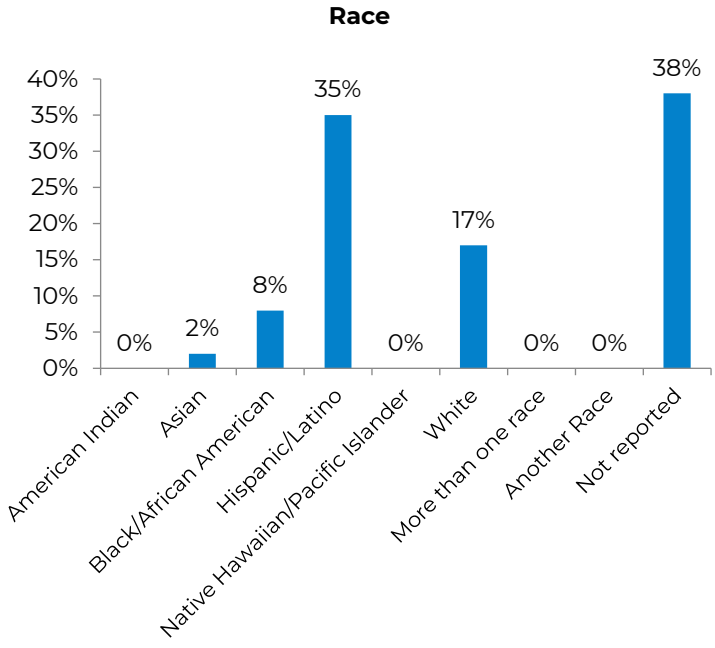
Demographics Based on Participants Who Completed Art Workshop Surveys

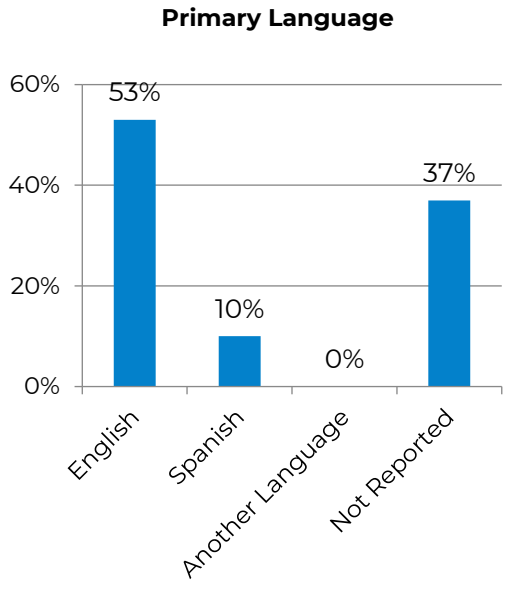


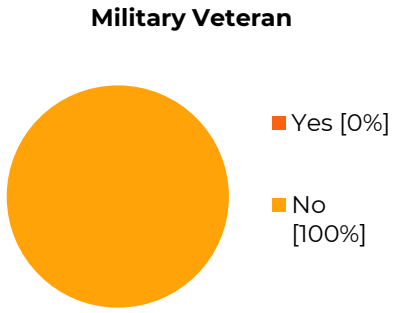


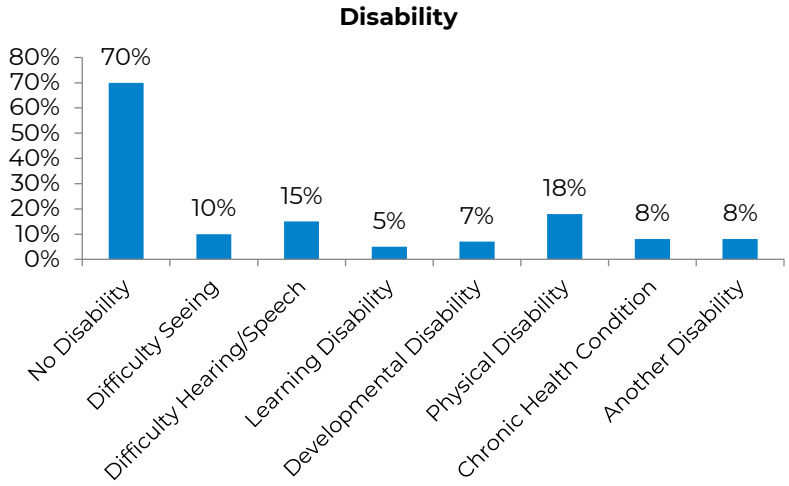


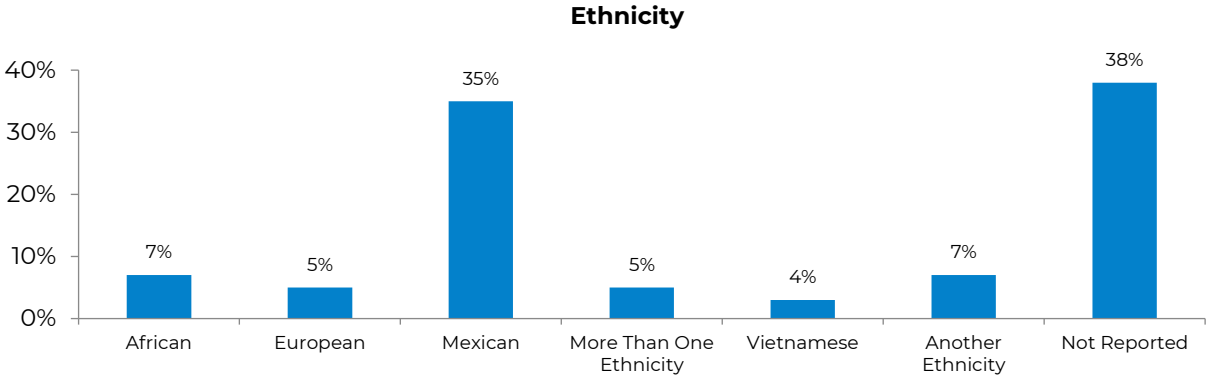












HOW WELL DID WE DO IT?

176
Attendees for Stigma Reduction Presentations

145
Attendees for Safe Talk Suicide Prevention Presentations

80
Attendees for Creative Minds Art Gallery Receptions

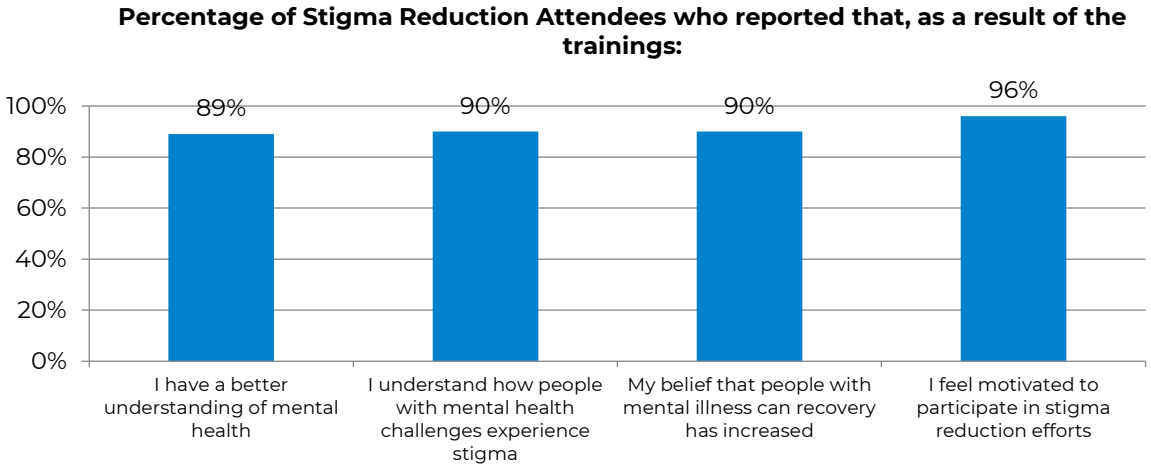
42,847
Visits to the Room4Everyone Website

11,975
Unique Visits to the Room4Everyone Website

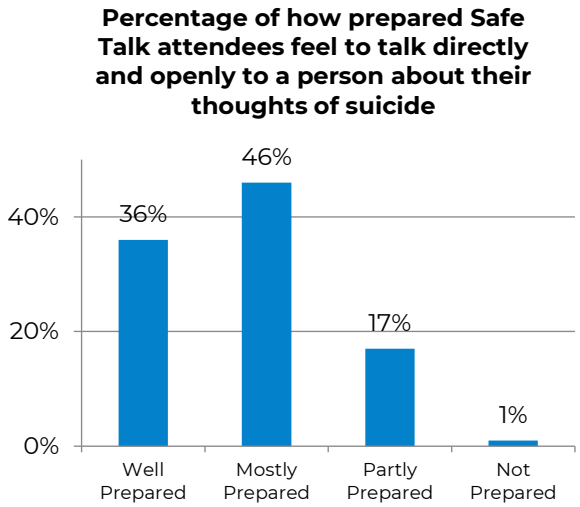
Website Hits Data from July 2019 to December 2019

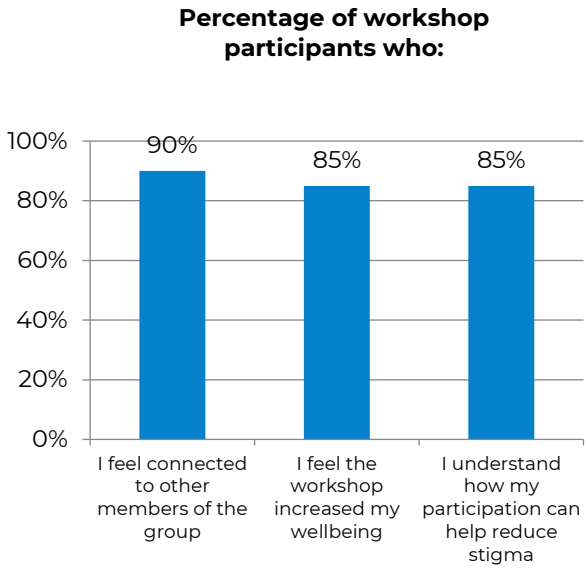
IS ANYONE BETTER OFF?

Stigma Reduction



Suicide Prevention





Number of Potential Responders	401
Setting in Which Responders were Engaged	Community, schools, colleges, health centers, workplace, shelters, online and outdoors
Type of Responders Engaged	TAY, adults, seniors, teachers, LGBTQ+, families, suicide attempters/survivors, religious leaders and those with lived experience
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY:

0
MHSA Referrals to Stigma Reduction or Suicide Prevention Programs

Older Adult and Transition Age Youth Wellbeing

Both the Older Adult Wellbeing and the Transition Age Youth Wellbeing programs are comprised of two projects: Peer mentoring and specialty groups/programing offered at the Wellness Center specific to TAY and older adults needs.

Peer Mentor and Wellness Center PEI Programs

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
Target Population:	___ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:
Type of Program:	___ Prevention	___ Early Intervention	_X_ Prevention and Early Intervention		

Program Description

Trained volunteers (peer mentors) from the tri-city area provide support to peers (mentees) who are in emotional distress. Peer mentors offer both individual and group support, and additional assistance through linkage to community resources that are both age and culturally matched to each individual mentee. Individuals attending the TAY and Older Adult programing located at the Wellness Center benefit from specialized support groups and activities targeting their specific needs.

Target Population

Transition Age Youth (TAY ages 18-25) and Older Adults (ages 60 and over)

Peer Mentor/Mentees				
Age Groups	TAY 18-25	Adults 26-59	Older Adults 60+	Unknown
Mentors FY 2019-20	14	12	4	0
Mentees FY 2019-20	25	39	23	0
Groups FY 2019-20	0	29	20	286
Cost Per Person	$109	$119	$119	N/A

Wellness Center (PEI TAY and Older Adults)					
Age Groups	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Unknown
Number Served FY 2019-20	56	502	56	99	4
Cost Per Person	$727	$727	$727	$727	$727

Peer Mentor Program

Program Update

The Peer Mentor program continues to support both mentors (individuals providing the support) and mentees (individuals receiving the support). Peer Mentors focused on engaging individuals with lived experience who apply and then are trained to provide support to community members who are seeking a non- clinical level of care. These services are offered in English, Spanish, Vietnamese and Cantonese.

In FY 2019-20, this program sustained 30 dedicated and highly trained community mentors. Of these 30 mentors, 19 identified with lived experience who were able to provide an empathic level of support based on personal experience.

In addition to one-on-one sessions, this program offers support groups as well. Two of the critical populations supported through these groups include older adults and the LGBTQ+.

Challenges and Solutions

The number of mentors identifying themselves with lived experience continue to increase each year. This can be a significant benefit for mentees who are looking to connect with another peer. However, one of the challenges for staff has been to provide adequate and meaningful support for the needs of our mentors as well.

Additional challenges include engaging the homeless population and older adults. Over the next fiscal year, staff will continue to work on engaging these individuals through one-on-one support via telephone. Efforts will also include an increase focus on self-care and wellbeing to help mentors, specifically those who identify with lived experience, to ensure that they receive adequate support to help minimize/reduce any mental health symptoms.

COVID-19 Response

Since the outbreak of COVID-19, the Peer Mentor Program moved its service delivery to phone and virtual platforms. Historically, many mentors take a summer break and return in the fall. However, with the onset of COVID-19, several of the mentors continued to offer support throughout summer break due to the increased need since the onset of the pandemic. Trainings continued as well in order to provide the mentors with up-to-date COVID-19 information and how they can best support their mentees. The Peer Mentor wellbeing activities, normally held in person, were temporarily put on hold. However, staff began to brainstorm to create virtual wellness roundtables where the groups can continue to meet virtually.

As expected with the pandemic, there was an increase in referrals in a short period of time thereby increasing the number of mentees each mentor had on their case load. Since the majority of mentors who provide services to the community identify themselves with lived experience, group meetings and individual supervisions were also increased to provide extra support to these mentors as they continued to provide extra support to mentees.

Cultural Approach

Peer mentors identify with numerous local communities (African American, Asian, Latino, Bisexual, Gay, Native American, TAY, Older Adult and Physically disabled). The majority of the mentors are bilingual and provide services in English, Spanish, Tamil, Hindi, Malayalam, Korean, Cantonese. In addition, the PM program currently has mentors who identify in the LGBTQ+ community who provide input and feedback on how to engage with others in the community.

Peer Mentoring programing focus on providing serves to individuals with limited mobility, limited access to transportation, monolingual individuals, LGBTQ, homelessness, and transition age youth. Presentations also focus on the veteran population in addition to providing multiple wellbeing activities in the communities. In addition, the program provides bilingual and monolingual senior socialization groups at local parks and mental wellbeing activities at senior living locations where residents may experience limited mobility and lack of transportation.

Wellness Center Programs: Transition Age Youth and Older Adults

Transition age youth (TAY) and older adults are considered critical populations in need of support yet tend to be some of the most difficult to engage. Reasons include issues related to stigma and difficulty with transportation. In an effort to meet the needs of these individuals, the Wellness Center has created programs utilizing Prevention and Early Intervention (PEI) funding to create programing specific to the needs and interests of these, often considered, at-risk individuals.

Program Update

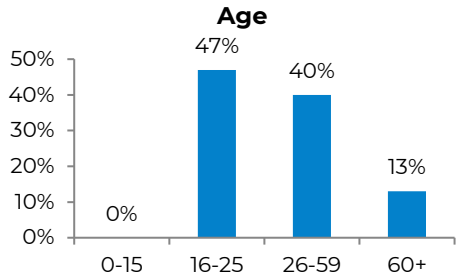
In an effort to build participation in the TAY programing, Wellness Center staff have focused their outreach efforts on collaborating with local service organizations who work with this age group. Prior to COVID-19, the Wellness Center saw a slight increase in the number of groups offered as well as the number of unique individuals who attended the Center. Although the COVID -19 pandemic has since impacted onsite groups, efforts continue to build a relationship with these community organizations which will allow for a smooth transition for TAY to come to the Wellness Center once the pandemic has abated.

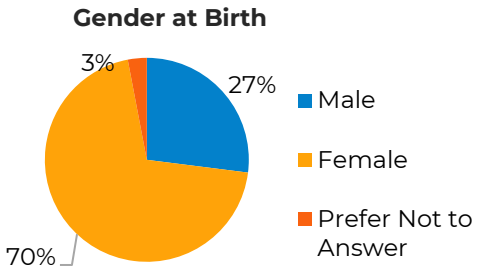
The Wellness Center's older adult programing continues to struggle with engagement and attendance. Recognizing the unique needs of this population, the Center created a Mental Health Specialist position where this staff member is dedicated to engaging older adults throughout the community and developing age appropriate activities and support groups based on their needs.

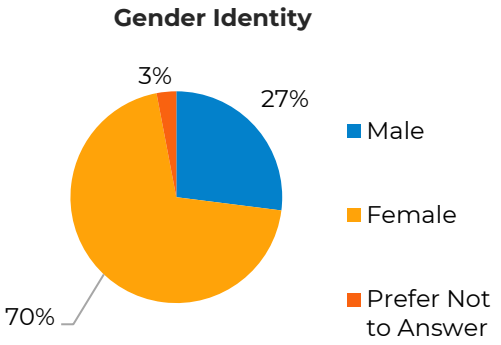
PROGRAM: Peer Mentoring

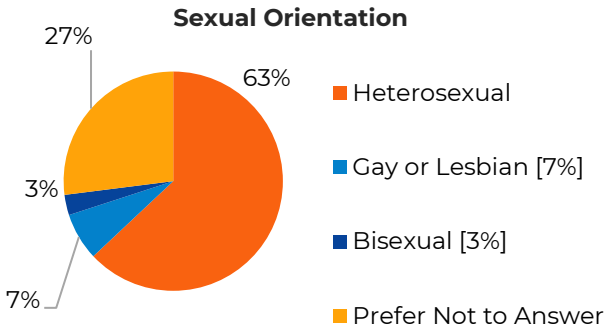
HOW MUCH DID WE DO?

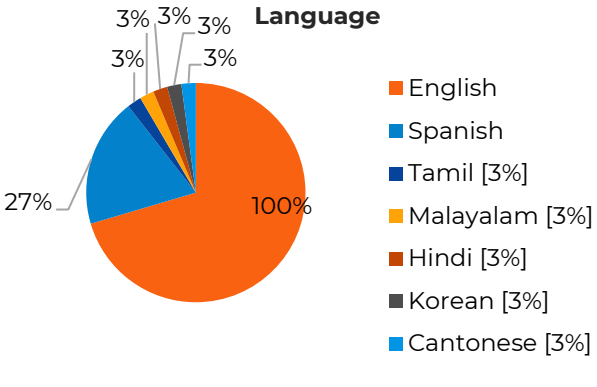
30
Active Peer Mentors

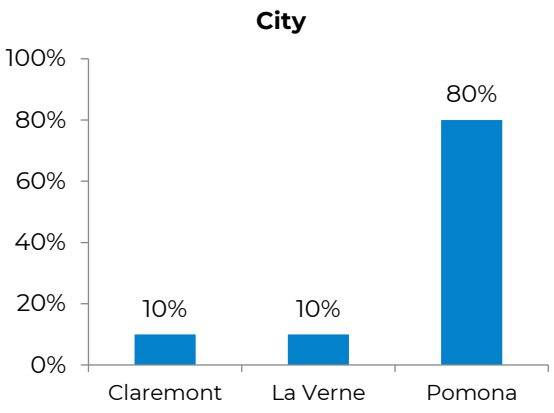


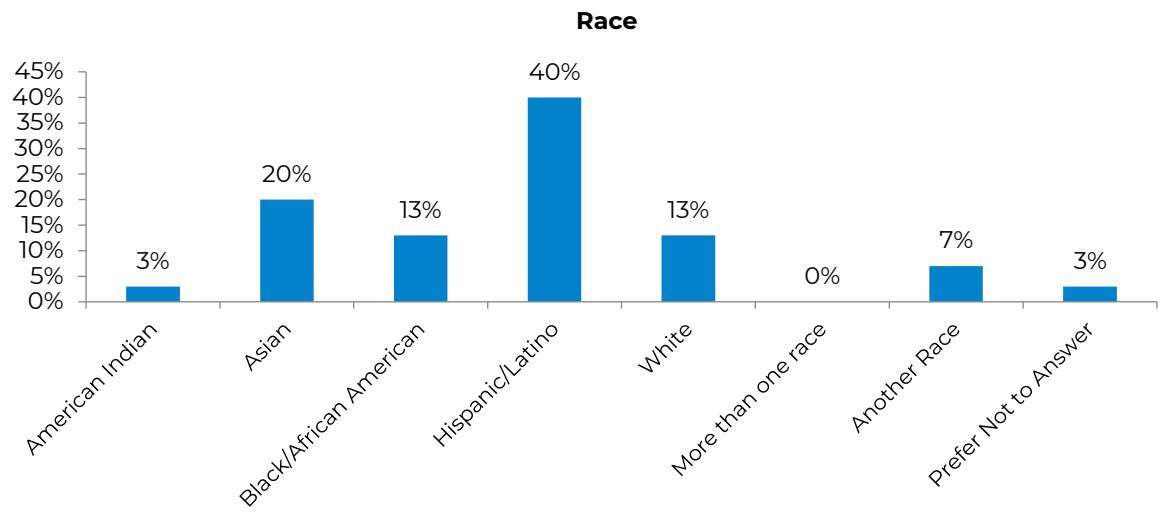


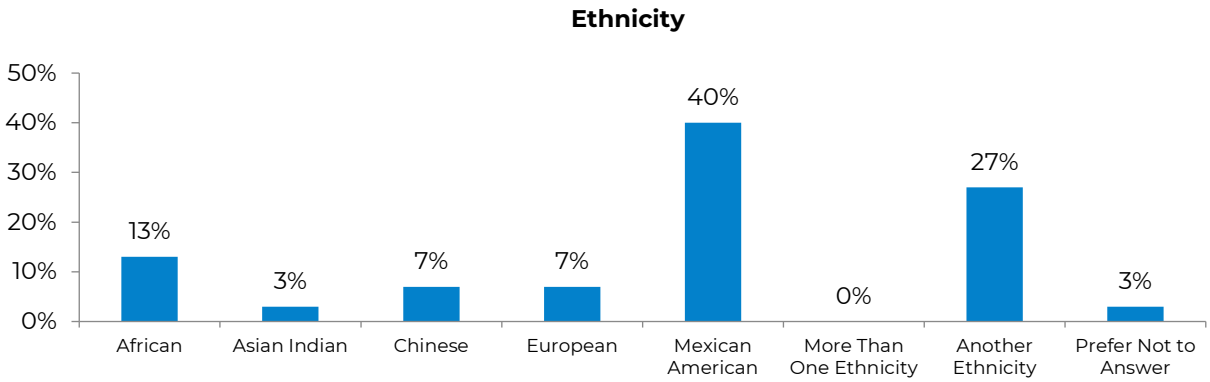


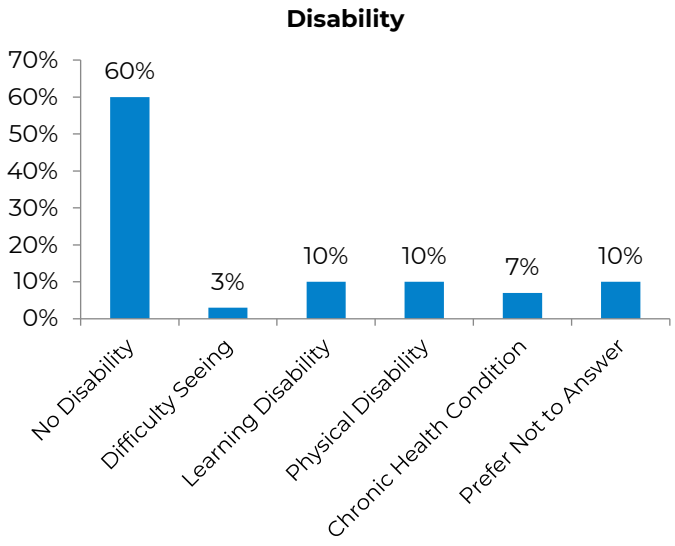


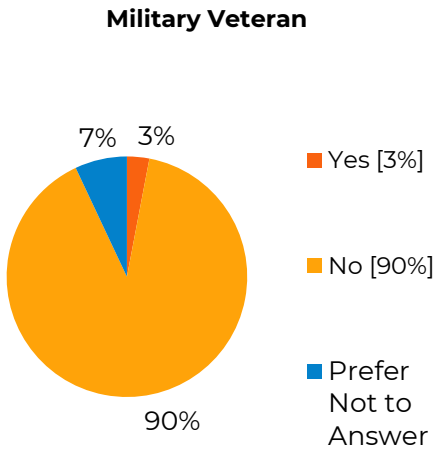





Race
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
3%
20%
13%
40%
13%
0%
7%
3%
American Indian
Asian
Black/African American
Hispanic/Latino
White
More than one race
Another Race
Prefer Not to Answer

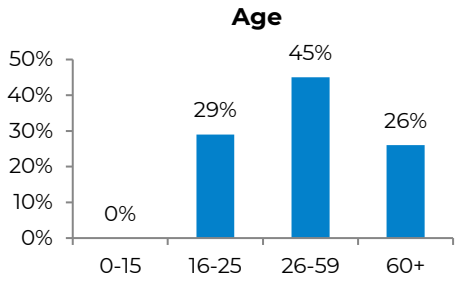

Ethnicity
50%
40%
30%
20%
10%
0%
13%
3%
7%
7%
40%
0%
27%
3%
African
Asian Indian
Chinese
European
Mexican American
More Than One Ethnicity
Another Ethnicity
Prefer Not to Answer

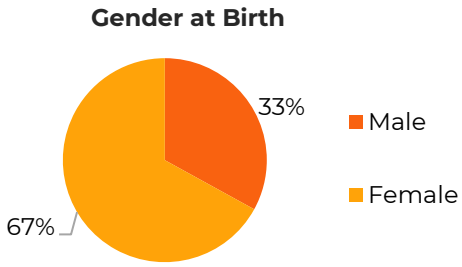

Disability
70%
60%
50%
40%
30%
20%
10%
0%
60%
3%
10%
10%
7%
10%
No Disability
Difficulty Seeing
Learning Disability
Physical Disability
Chronic Health Condition
Prefer Not to Answer

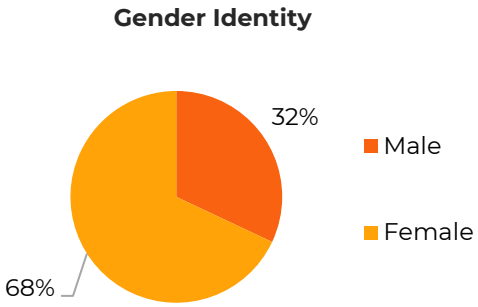

Military Veteran
7%
3%
90%
Yes [3%]
No [90%]
Prefer Not to Answer

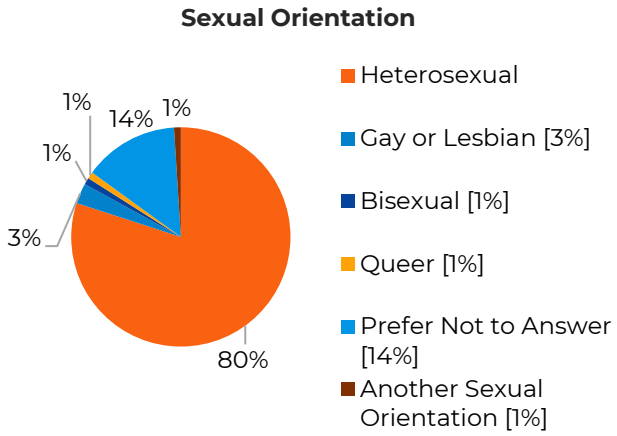
Peer Mentee Demographics

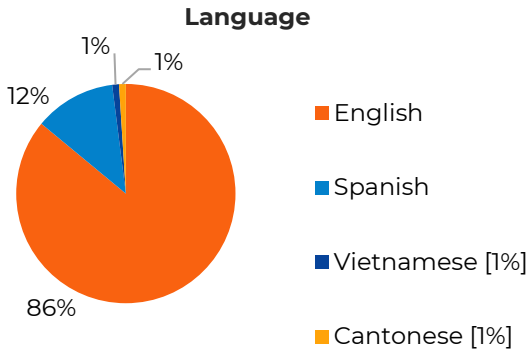
87
Peer Mentees Served

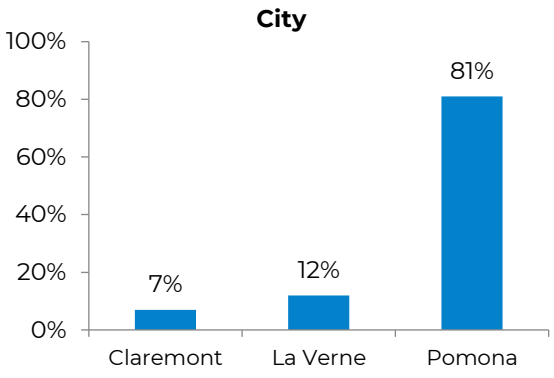


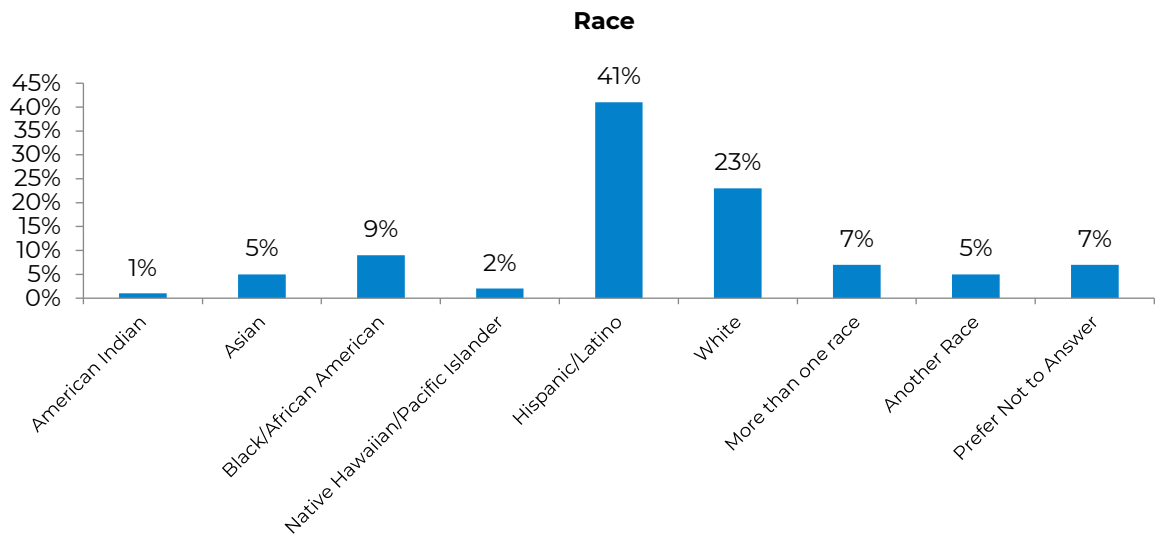


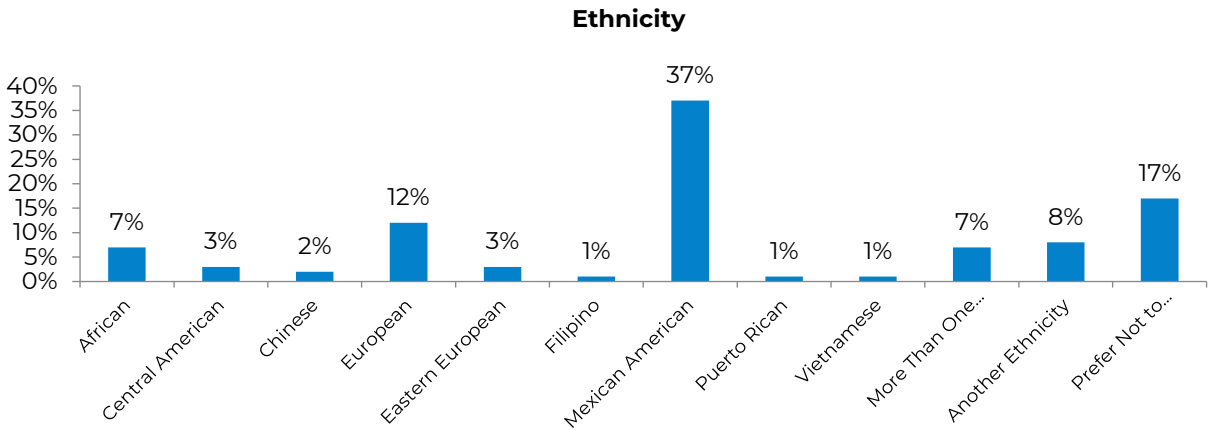


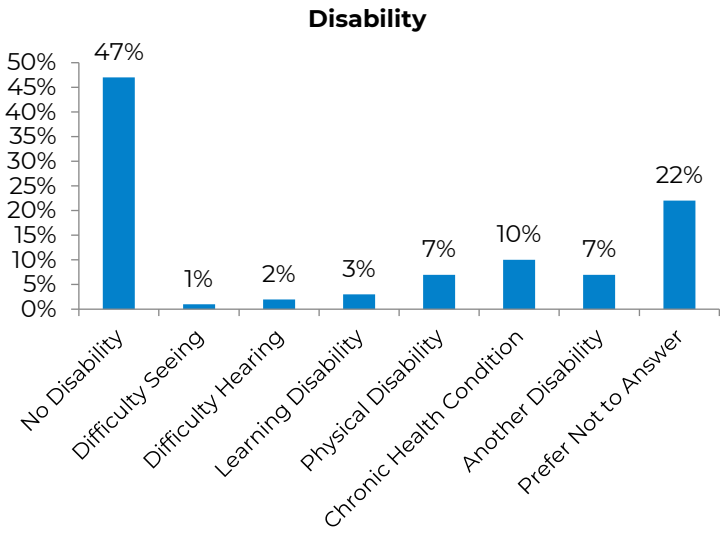


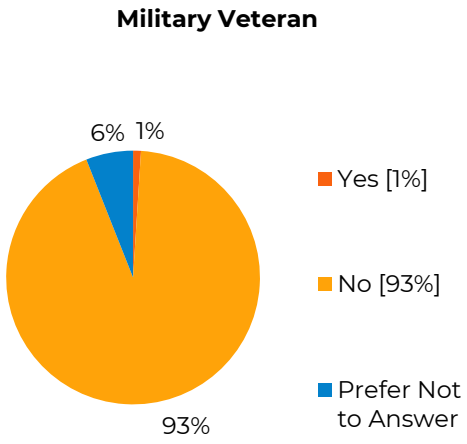





Race
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
1%
5%
9%
2%
41%
23%
7%
5%
7%
American Indian
Asian
Black/African American
Native Hawaiian/Pacific Islander
Hispanic/Latino
White
More than one race
Another Race
Prefer Not to Answer


Ethnicity
40%
35%
30%
25%
20%
15%
10%
5%
0%
7%
3%
2%
12%
3%
1%
37%
1%
1%
7%
8%
17%
African
Central American
Chinese
European
Eastern European
Filipino
Mexican American
Puerto Rican
Vietnamese
More Than One...
Another Ethnicity
Prefer Not to...

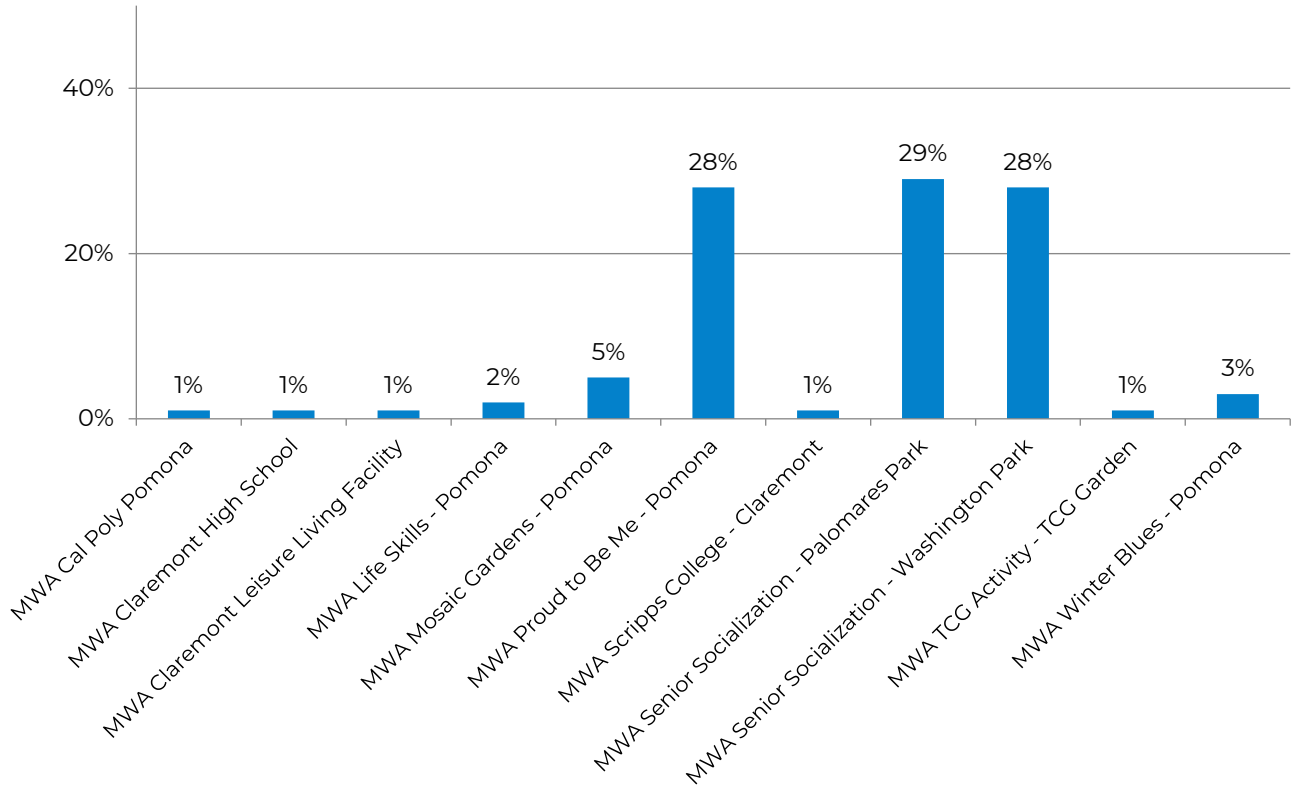

Disability
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
47%
1%
2%
3%
7%
10%
7%
22%
No Disability
Difficulty Seeing
Difficulty Hearing
Learning Disability
Physical Disability
Chronic Health Condition
Another Disability
Prefer Not to Answer


Military Veteran
6%
1%
93%
Yes [1%]
No [93%]
Prefer Not to Answer

Mental Wellbeing Activities Occurred from July 2019 through March 2020

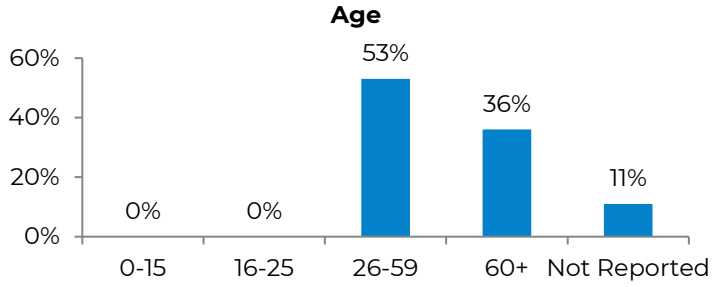
335	856
Unique Participants at Peer Mentor Mental Wellbeing Activities	Duplicated Participants at Peer Mentor Mental Wellbeing Activities

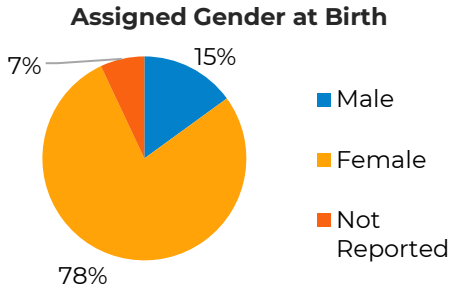
117 Mental Wellbeing Activities (MWA) Held by Name and Location

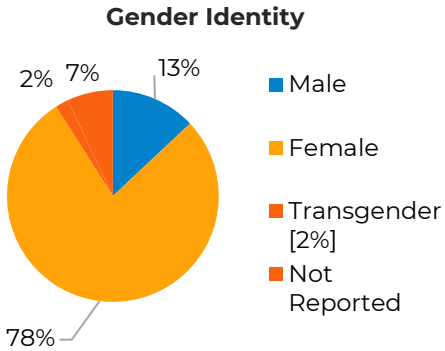


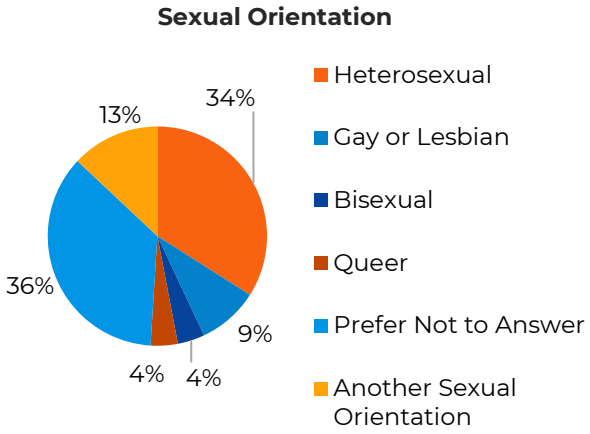
29
Peer Mentor Trainings

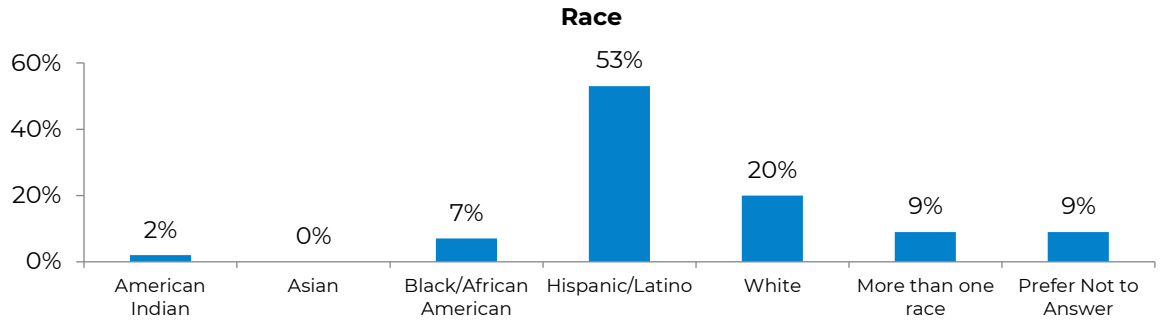
PEI Demographics Based on Mental Wellbeing Participants Who Completed Mental Wellbeing Mentor Surveys (n=55)

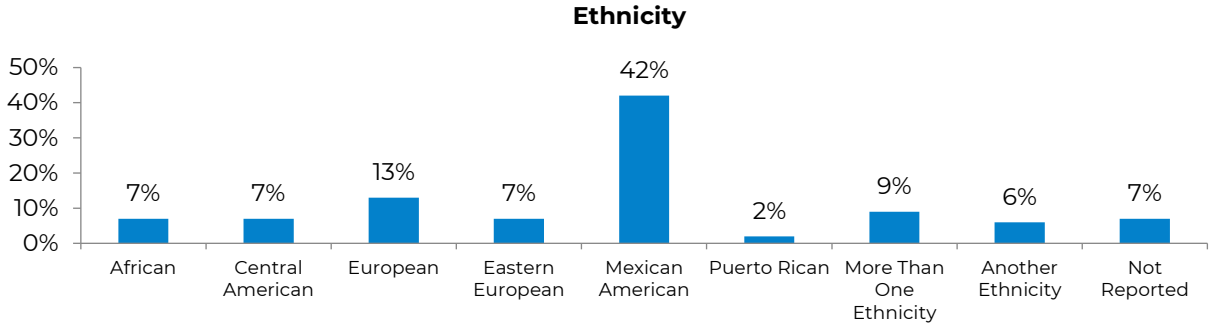




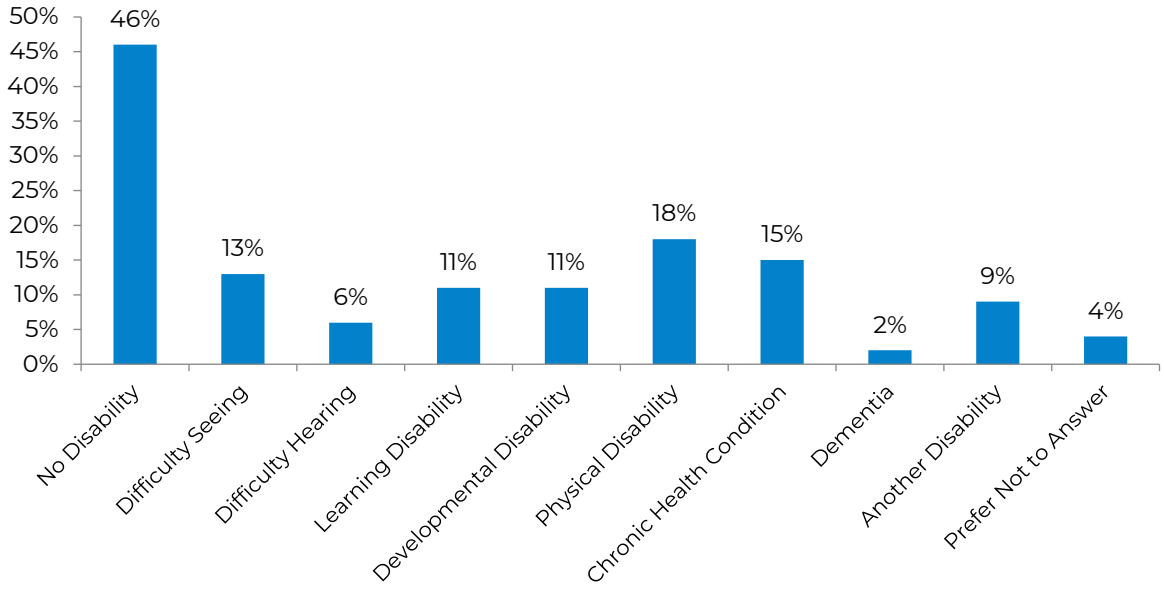




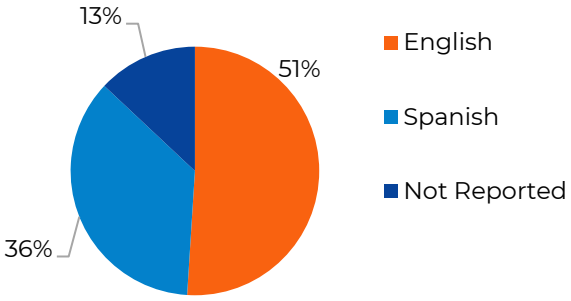




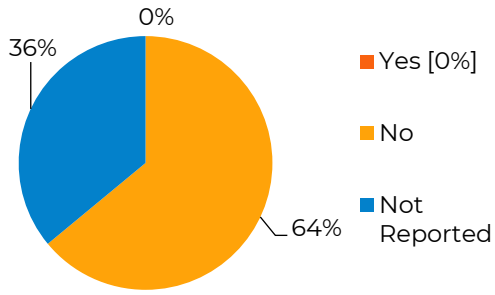
Disability



Language



Military Veteran



HOW WELL DID WE DO IT?

77%	100%	1,419	96%	19
59 out of 77 Referrals Became Mentees	Peer Mentees Reported Feeling Comfortable with Their Peer Mentor	Service Learner Hours Completed by Peer Mentors	Individuals Enjoy Participating in Peer Mentor Mental Wellbeing Activities	Peer Mentors Self-Identify with Lived Experience, 8 of those 19 Being New Peer Mentors

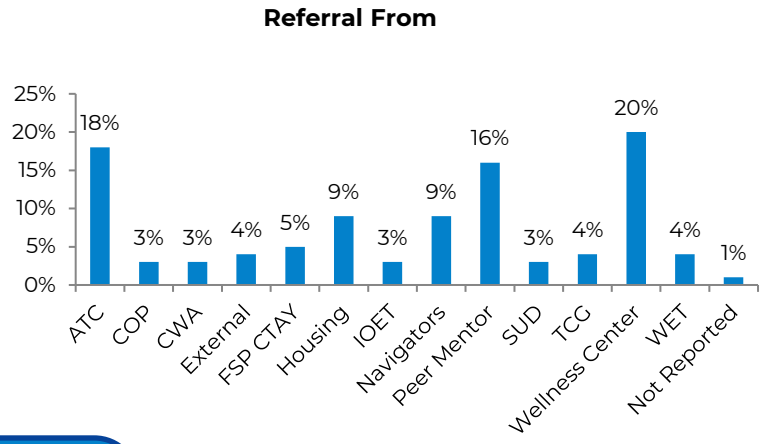
IS ANYONE BETTER OFF?

100%	100%	85%
Peer Mentors Reported Becoming a Peer Mentor Has Made a Positive Impact in Their Lives	Peer Mentees Agreed Peer Mentors Provided Helpful Support in Their First Session	Individuals Feel More Confident from the Skills Learned in Peer Mentor Mental Wellbeing Activities

Number of Potential Responders	442
Setting in Which Responders were Engaged	Community
Type of Responders Engaged	TAY, adults, seniors, and those with lived experience
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition age youth, older adults, and those with a physical disability
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

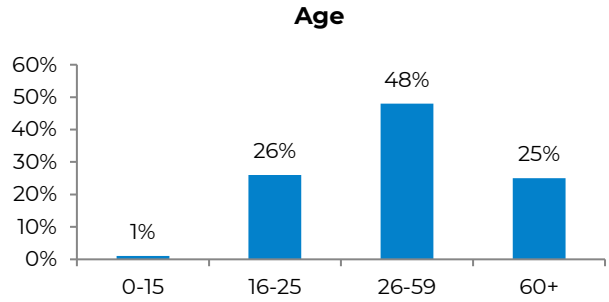
TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY:

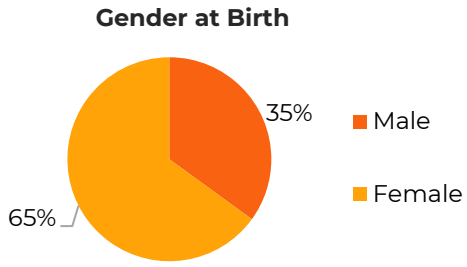
77
MHSA Referrals to Peer Mentor Program

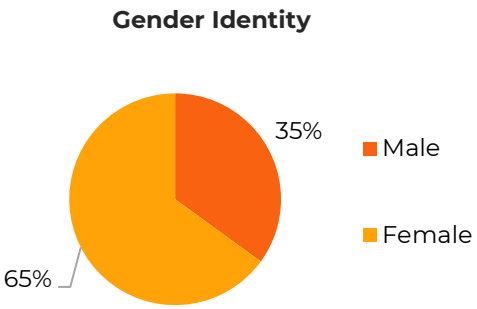


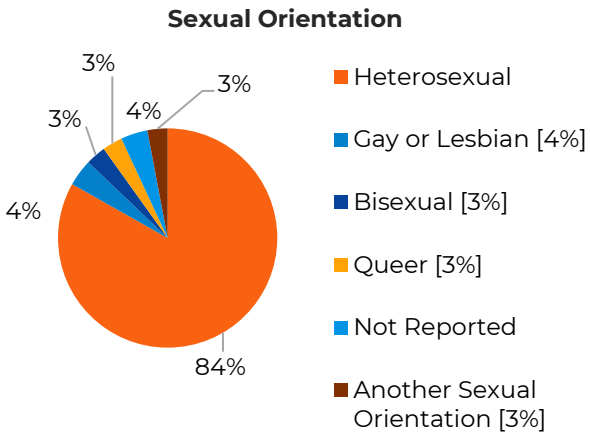
2.5 Days
Average Time Between Referral and Contact from Peer Mentor Program

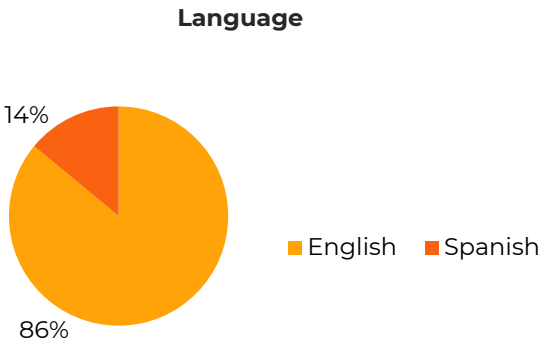
PEI Demographics Based on MHSA Referrals

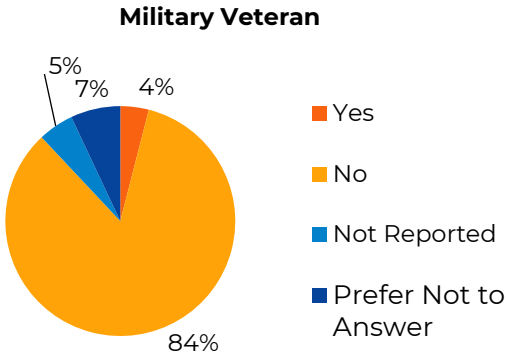


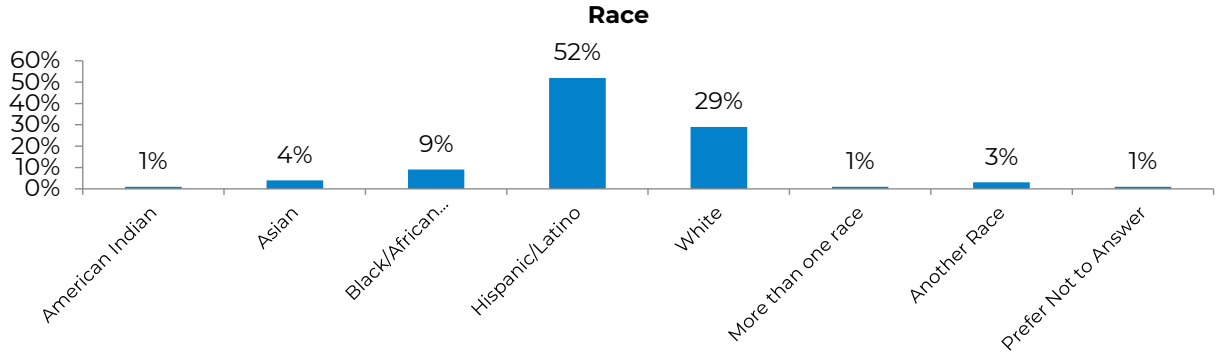


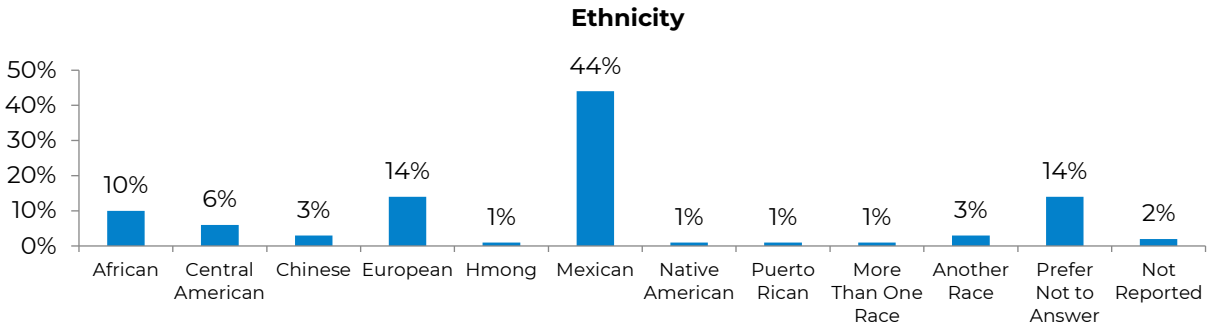


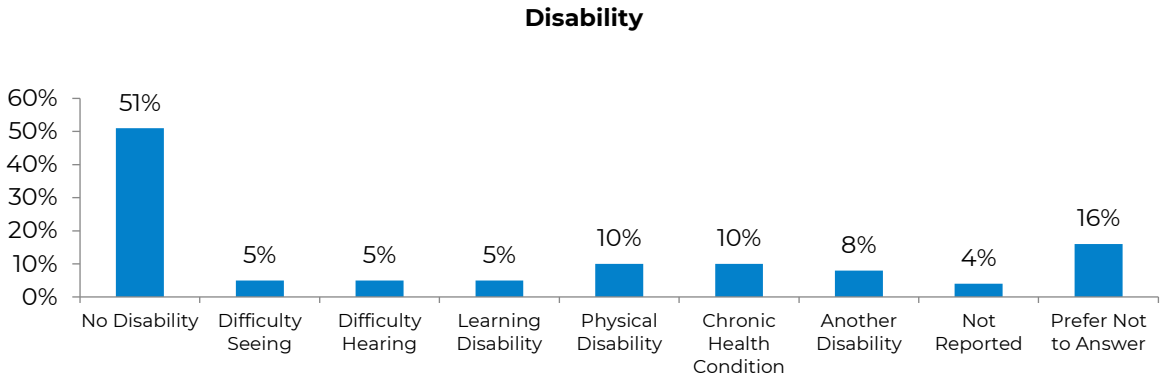



Language
14%
86%
English
Spanish


Military Veteran
5%
7%
4%
84%
Yes
No
Not Reported
Prefer Not to Answer


Race
60%
50%
40%
30%
20%
10%
0%
1%
4%
9%
52%
29%
1%
3%
1%
American Indian
Asian
Black/African...
Hispanic/Latino
White
More than one race
Another Race
Prefer Not to Answer

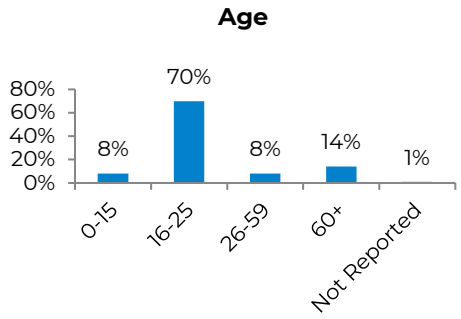

Ethnicity
50%
40%
30%
20%
10%
0%
10%
6%
3%
14%
1%
44%
1%
1%
1%
3%
14%
2%
African
Central American
Chinese
European
Hmong
Mexican
Native American
Puerto Rican
More Than One Race
Another Race
Prefer Not to Answer
Not Reported

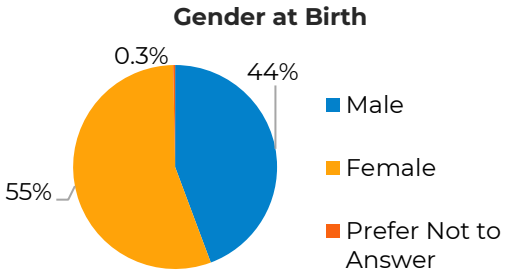

Disability
60%
50%
40%
30%
20%
10%
0%
51%
5%
5%
5%
10%
10%
8%
4%
16%
No Disability
Difficulty Seeing
Difficulty Hearing
Learning Disability
Physical Disability
Chronic Health Condition
Another Disability
Not Reported
Prefer Not to Answer

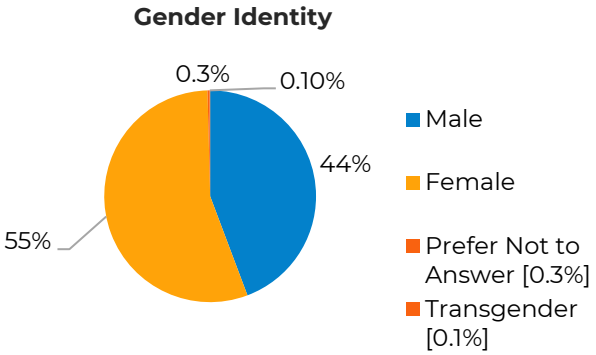
PROGRAM: Wellness Center - PEI

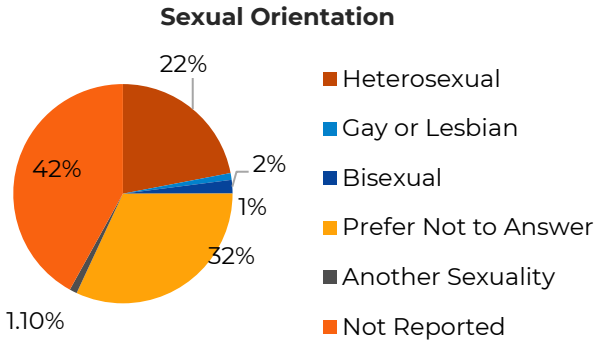
HOW MUCH DID WE DO?

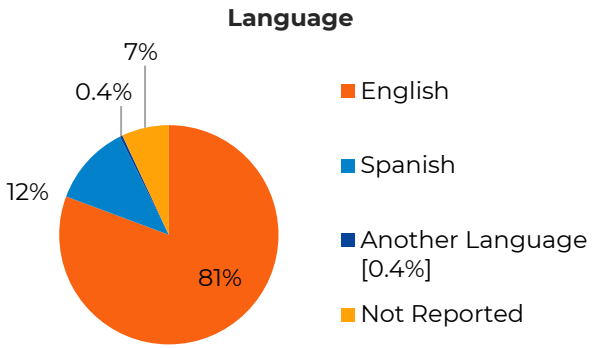
741
Unique Individuals Served

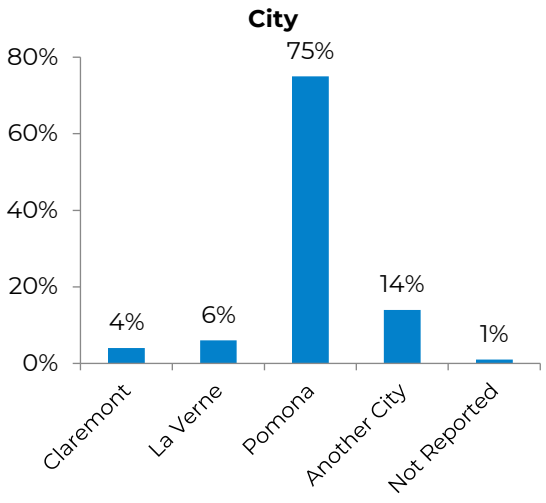




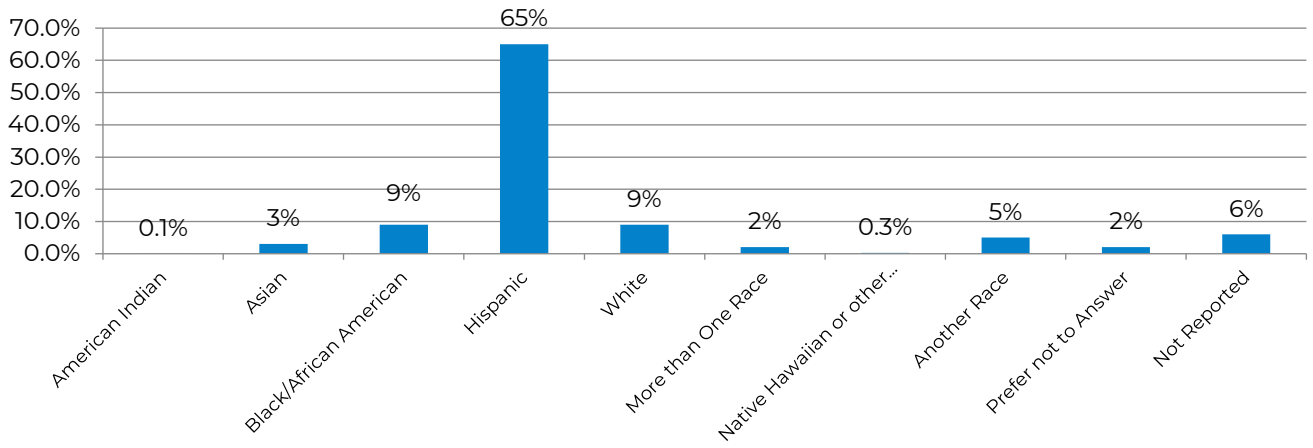




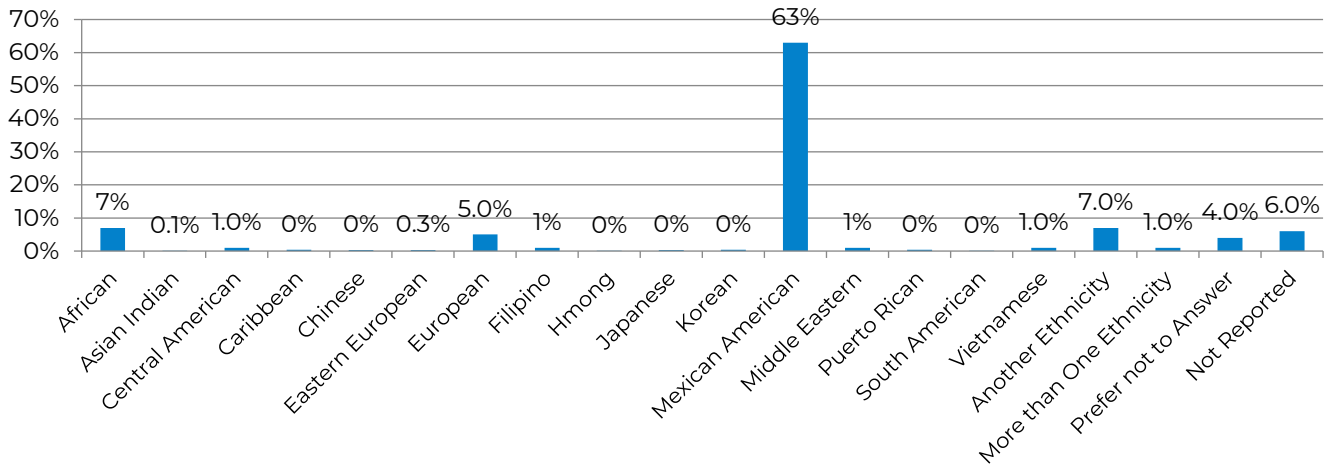




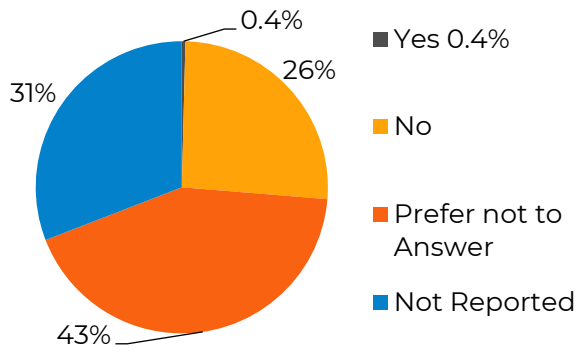
Race



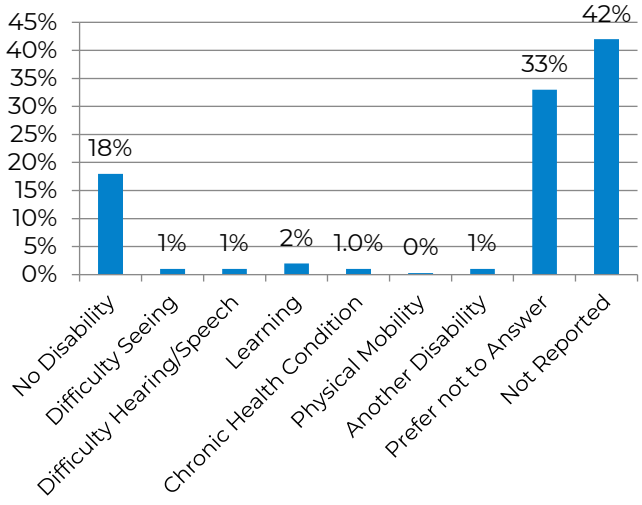
Ethnicity



Military Veteran

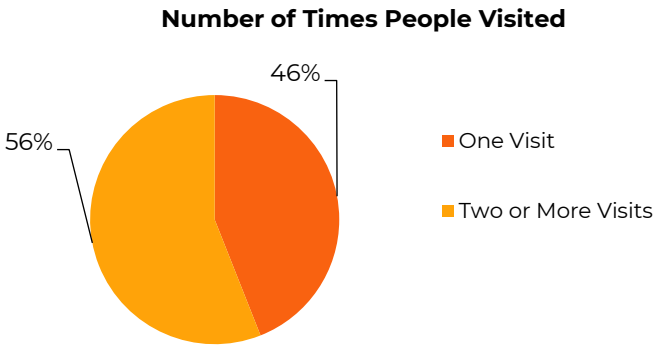


Disability



HOW WELL DID WE DO IT?

3,625
Number of Attendees at Wellness Center Events (Duplicated Individuals)

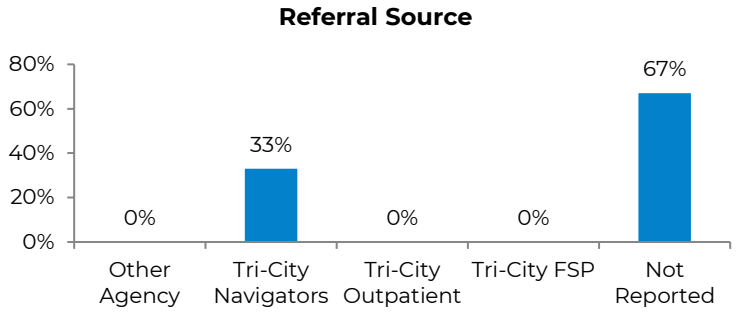


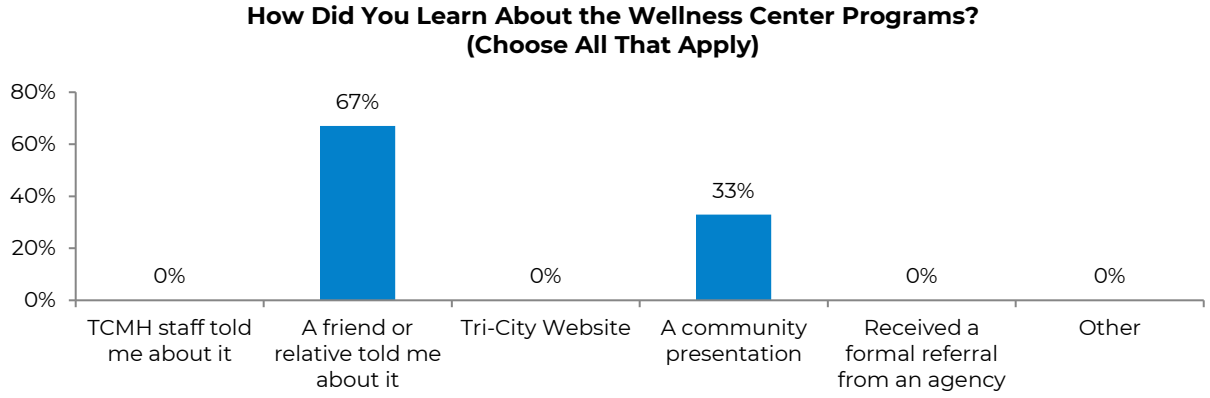
Group Name	Number of Times Group Was Held
Group – Senior Socialization	47
Group (Español) – Comadres y Compadres	50
TAY – Autism Empowerment	2
TAY – RealTalk	20
TAY – Anger Management	39
TAY – Cooking Class	8
TAY – DRA	33
TAY – Friendship Circle	6
TAY – Gaming Group	19
TAY – Karaoke	9
TAY – Literacy Alliance	9
TAY – Positive Painting	6
TAY – Pride	19
TAY – Sacred Heart	6
TAY – Socialization	4

TAY – Stress Me Not	34
TAY – TAY Leadership Committee	8
TAY – TCB	21
TAY – Together We Stand	43
TAY – Walking Group	24

Contacts by Type	Number of Times Contact was Made
TAY – Outing	19
TAY – PC Lab	207
TAY – Phone Call	1,423
TAY – Volunteering	4
TAY – YCES	3

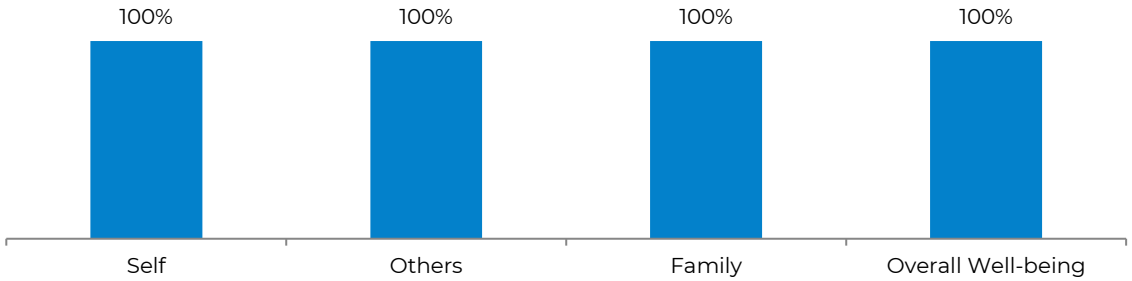
100%
Individuals Satisfied with Wellness Center Programs





IS ANYONE BETTER OFF?

Percentage of people who report improved relationships with the following because of the help they receive from the Wellness Center Programs:

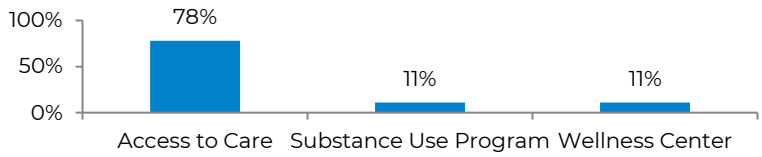


Number of Potential Responders	741
Setting in Which Responders were Engaged	Community, Wellness Center
Type of Responders Engaged	TAY, adults, seniors
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-aged youth, older adult and those with a physical disability
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY

9
MHSA Referrals to Wellness Center

Referral From

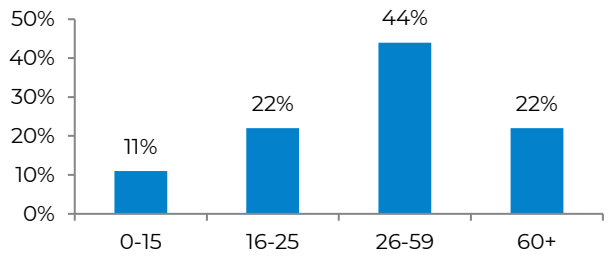


8 out of 9
Referrals Participated in Wellness Center Programs

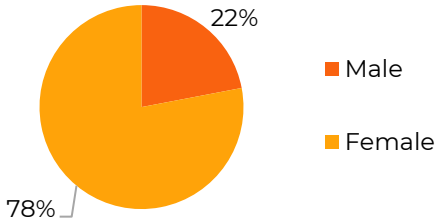
8 Days
Average Time Between Referrals and Participation in Wellness Center

PEI Demographics Based on MHSA Referrals

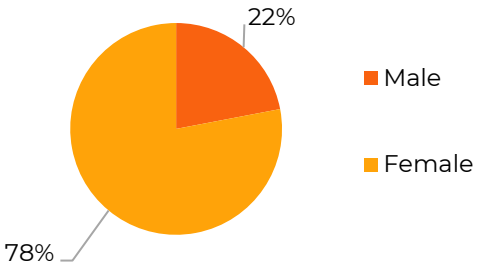
Age



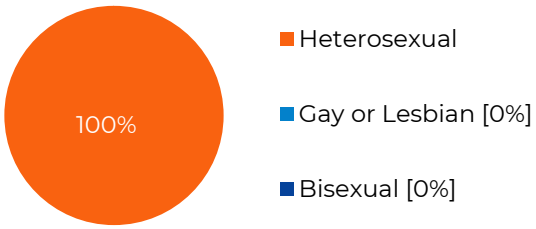
Gender at Birth



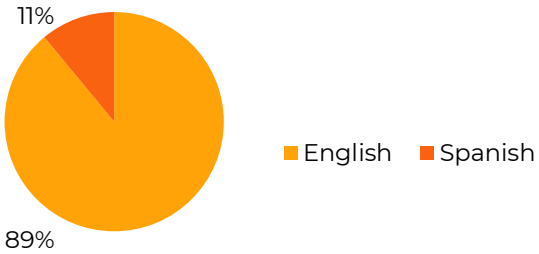
Gender Identity



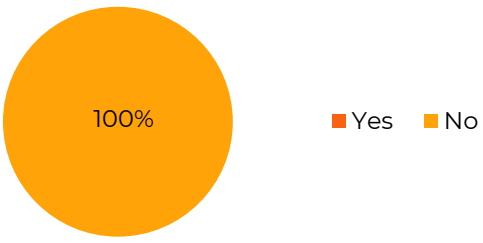
Sexual Orientation

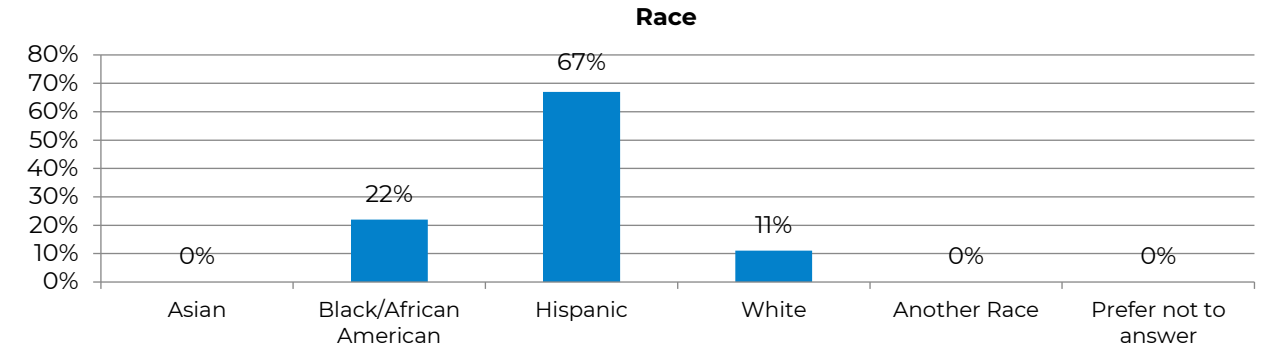


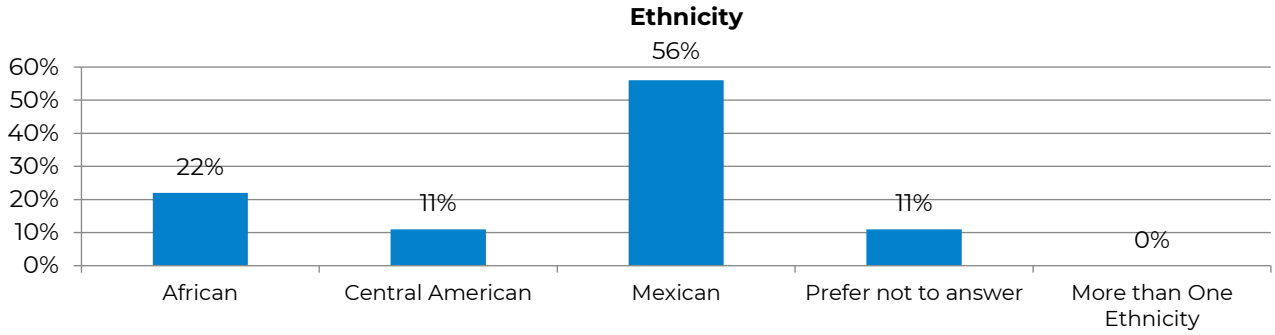
Language

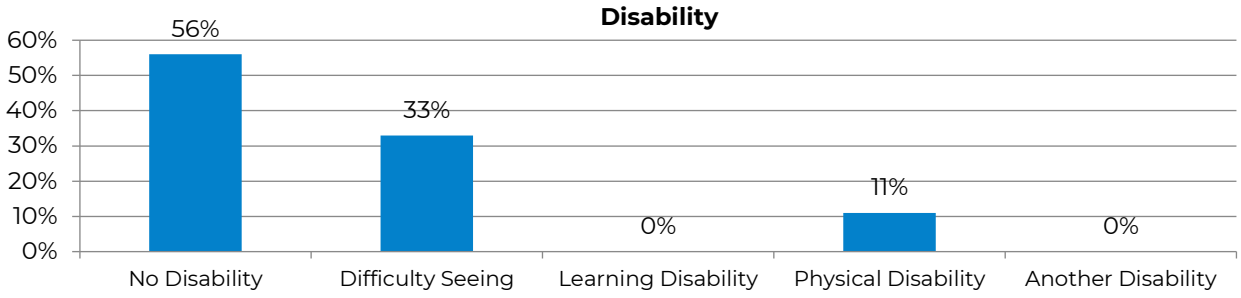


Military Veteran




Race
80%
70%
60%
50%
40%
30%
20%
10%
0%
0%
22%
67%
11%
0%
0%
Asian
Black/African American
Hispanic
White
Another Race
Prefer not to answer


Ethnicity
60%
50%
40%
30%
20%
10%
0%
22%
11%
56%
11%
0%
African
Central American
Mexican
Prefer not to answer
More than One Ethnicity


Disability
60%
50%
40%
30%
20%
10%
0%
56%
33%
0%
11%
0%
No Disability
Difficulty Seeing
Learning Disability
Physical Disability
Another Disability

Family Wellbeing Program

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
Target Population:	_X_ 0-15	_X_ 16-25	_X_ 25-69	___ 60+	Other:
Type of Program:	_X_ Prevention	___ Early Intervention	___ Prevention and Early Intervention		

Program Description

The Family Wellbeing program consists of a dynamic set of programing focused on addressing the needs of the family. Programming includes support groups, 1-1 support, and an array of culturally appropriate activities focused on wellness (e.g. exercise, cooking) and other interests that can attract family members and caregivers from vulnerable communities into peer-supported experiences.

Target Population

Family members and caregivers of people who struggle with mental illness from unserved and under-served communities.

Age Groups	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Unknown
Number Served FY 2019-20	368	144	605	62	108
Cost Per Person	$71.00	$71.00	$71.00	$71.00	$71.00

Program Update

Prior to the COVID-19 outbreak, the Family Wellbeing (FW) program was focused on creating a new children's group, strengthening existing groups, expanding opportunities for community involvement, and partnering with new agencies in the community.

In September 2019, Family Wellbeing brought back a kid's group for ages 7-12 based on community feedback. Prior to COVID-19, the group averaged 5-7 participants weekly, and this number has remained steady since the pandemic, albeit now being hosted on a virtual platform.

Family Wellbeing also focused on strengthening existing groups, as a way to both bolster participation and attendance. As evidenced by holding a United Family Potluck for families. This event was well received with 34 participants, making up a total of 13 families, served that day.

During FY 2019-20, and prior to the outbreak of COVID-19, United Family also aimed to increase participant involvement in community events held by Tri-City. Two notable events where Family Wellbeing participants took an active role, were the Annual Tree Lighting event at the Wellness Center and the Pomona Christmas Parade in the month of December. During both events, participants from Family Wellbeing Karaoke Group were present to represent Tri-City while singing Holiday carols.

Challenges and Solutions

Two challenges encountered for FWB staff include outreaching to new populations, and transportation issues. When receiving feedback from families in the community, staff found that transportation was a longstanding issue. Family Wellbeing also looked to access new cohorts by connecting with new community hubs that have emerged in the tri-city area.

In hopes of addressing these challenges, and prior to COVID-19, the Family Wellbeing program began hosting groups outside of the Wellness Center. Family Wellbeing had partnered with Pomona Wellness Community to host an Arts and Crafts group that was averaging 10 participants, and looking to begin hosting multiple other groups there as well. These efforts will continue once the pandemic restrictions are lifted.

COVID-19 Response

Following the outbreak of COVID 19, Family Wellbeing was impacted significantly. Due to changes in both staffing locations and the restrictions on providing in-person services, Family Wellbeing programing stopped completely and slowly began a re-building phase using a virtual platform. With this dramatic change in mind, FWB was charged with finding innovative ways to provide service. Options included the use of phones, email, and virtual platforms which for most families, was a viable method of communication. However, for some families, these options were limited based on lack of access. Community agency connections were somewhat easier to maintain.

A major challenge encountered was transitioning all FWB programing to a virtual platform, including Summer Camp, which was originally designed to be an in-person format. During the summer of 2020, Summer Camp was successfully transitioned to a virtually format. This popular program served 12 campers and their families. Campers were provided with a platform to use as well as supplies needed to complete activities, all delivered to their door using contactless delivery methods. Campers met virtually once a week, and maintained communication via phone and email. The feedback from the campers and parents was positive with families expressing gratitude for the opportunity to maintain some sense of normalcy during a difficult time. Seventy-five percent of participants were returning campers from previous sessions.

Cultural Approach

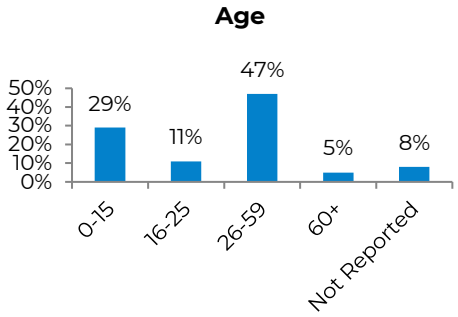
The Family Wellbeing program is available in both English and Spanish. Staff are bilingual and information brochures are available in multiple languages.

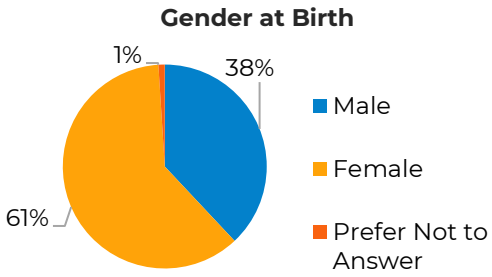
Another asset to the Family Wellbeing team is having staff who identify at LGBTQ+. These individuals attempt to address issues that can lead to barriers to seeking services as well stigma concerns. Also, FWB is meeting the community “where they are” by hosting groups at locations they are familiar with or current gathering.

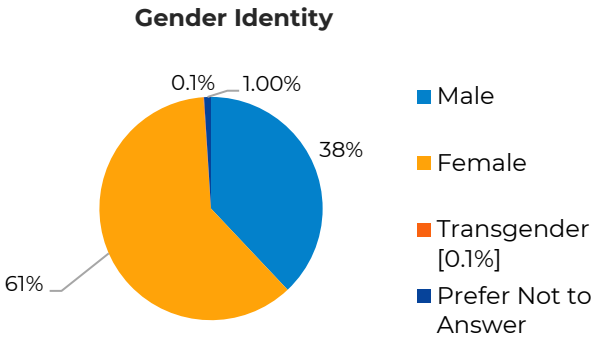
PROGRAM: Family Wellbeing Program

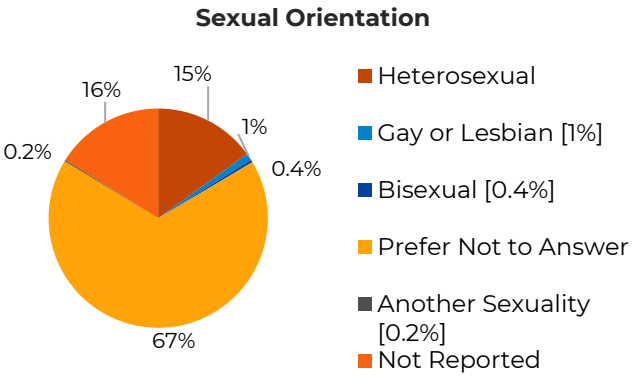
HOW MUCH DID WE DO?

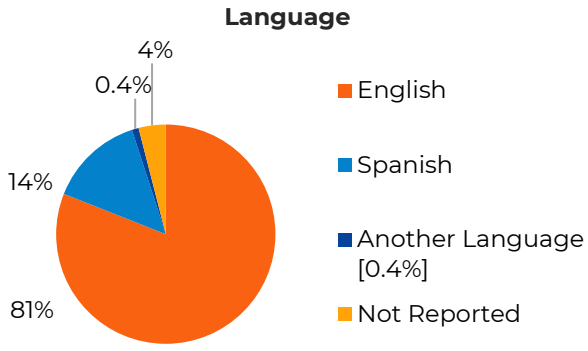
1,287
Unique Individuals Served

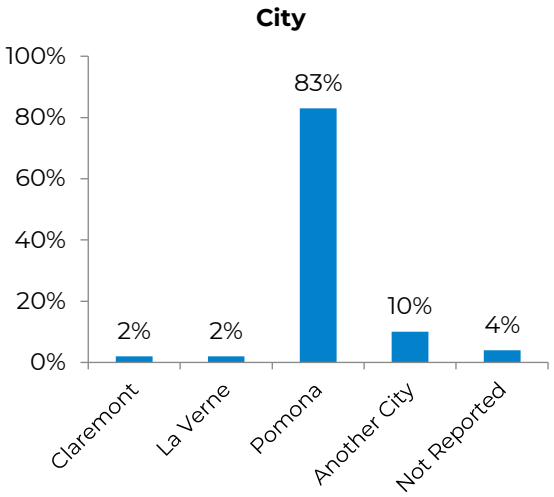




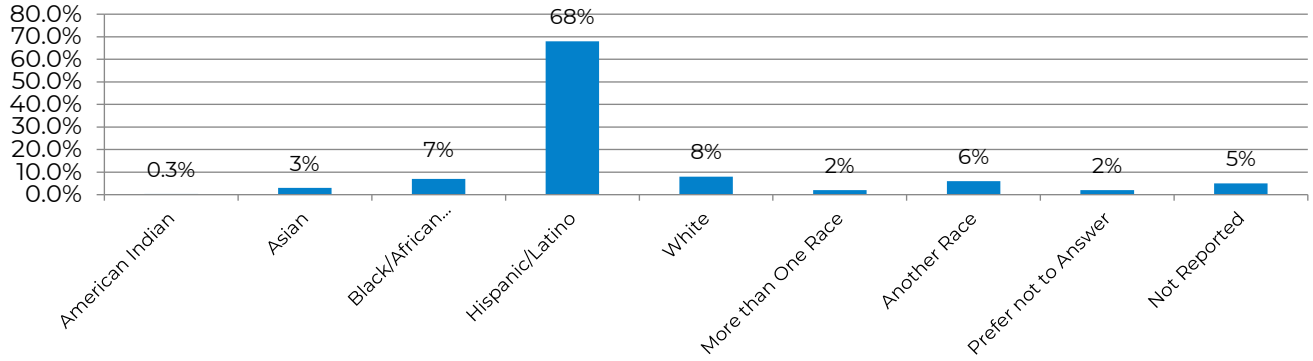




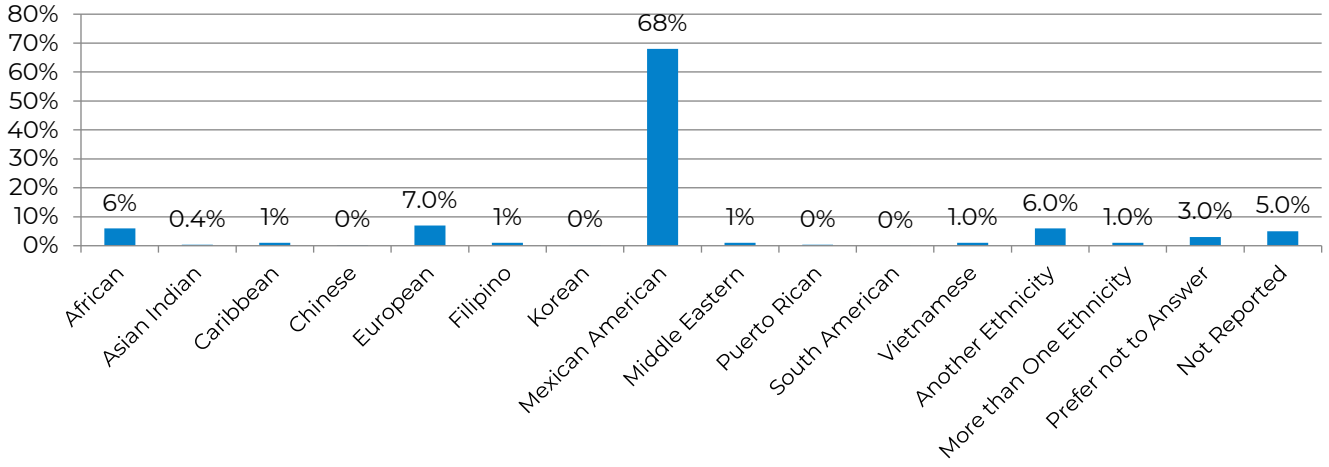




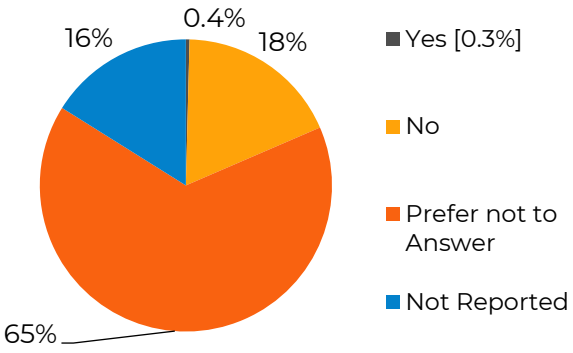
Race



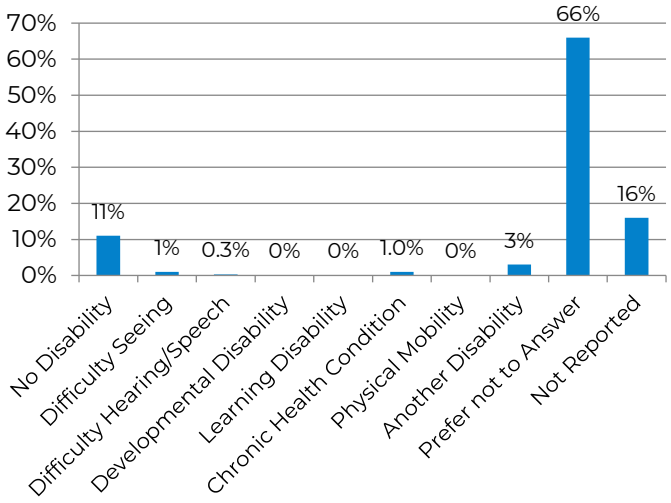
Ethnicity



Military Veteran

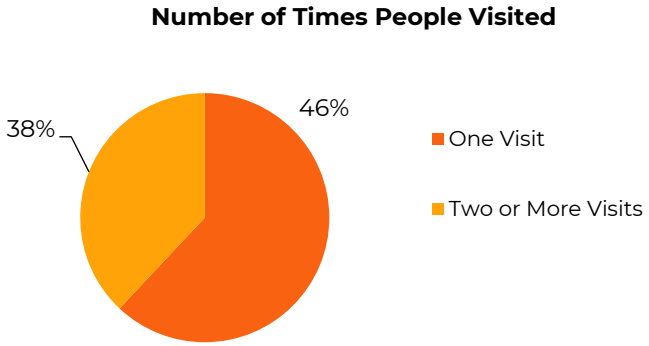


Disability



HOW WELL DID WE DO IT?

5,284
Number of Attendees at Family Wellbeing Events

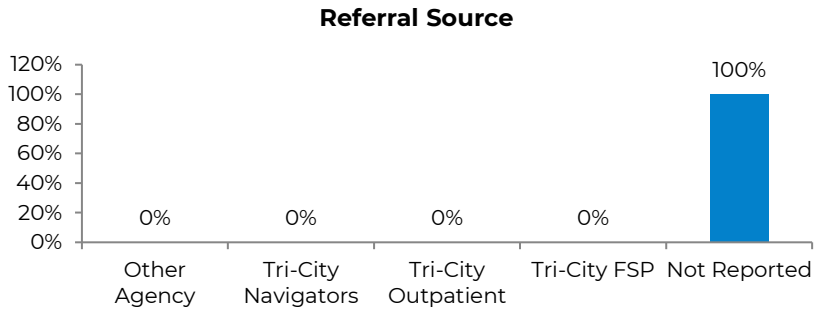


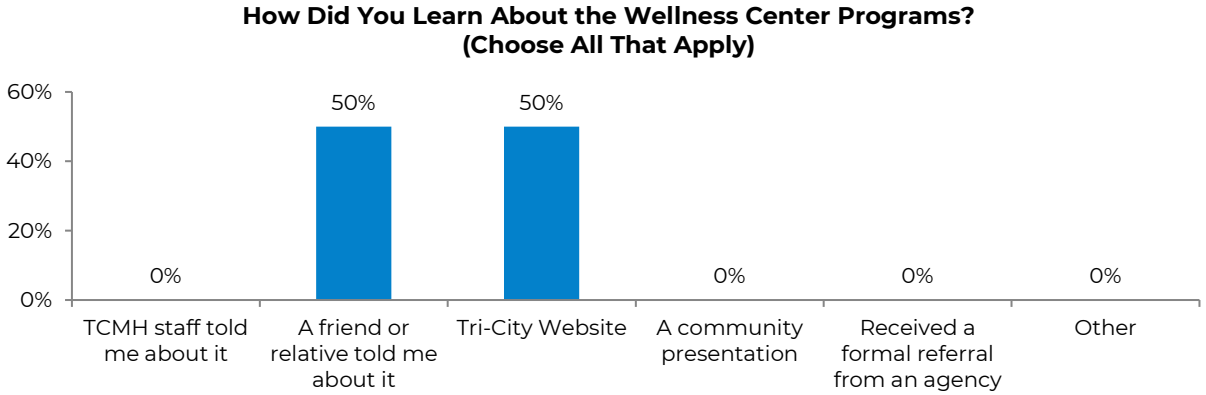
Group Name	Number of Times Group Was Held
FWS – Arts & Crafts	22
FWS – Attendance Letter	61
FWS – Bore No More	7
FWS – Cooking Class	2
FWS – Creative Writing	15
FWS – Grief & Loss	37
FWS – Kid's Hour	25
FWS – Limited to Limitless	43
FWS – Mommy & Me	24
FWS – Movie Night	34
FWS – Music	35
FWS – Sacred Heart	12
FWS – Spirituality	35
FWS – STEP Anger Management	1
FWS – Summer Camp	22
FWS – Teen Anger Management	25

FWS – Teen Hour	37
FWS – United Family	34
FWS – Walking Adventure	36
FWS – Writing to Heal	31

Contacts by Type	Number of Times Contact was Made
FWS – Brief Check-in	527
FWS – One-on-One	99
FWS – Other	83
FWS – Phone Call	892

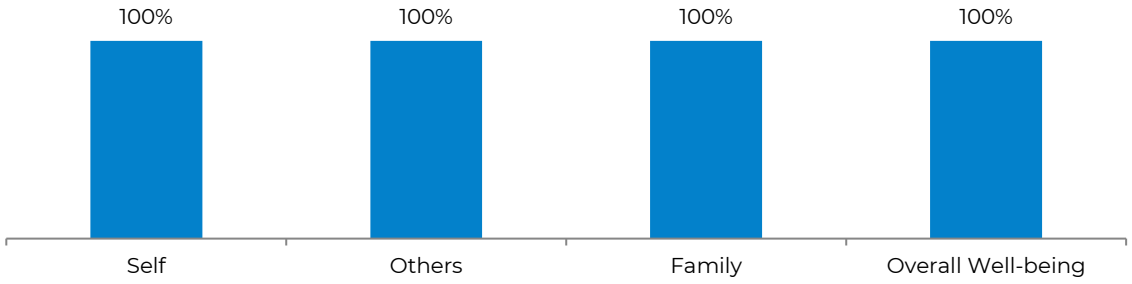
100%
Individuals Family Wellbeing Program





IS ANYONE BETTER OFF?

Percentage of people who report improved relationships with the following because of the help they receive from the Family Wellbeing Program:

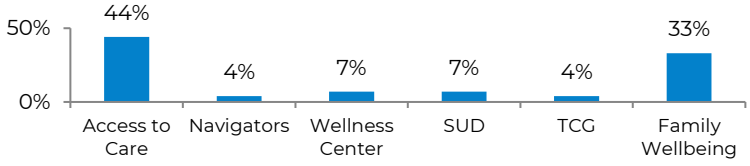


Number of Potential Responders	1,287
Setting in Which Responders were Engaged	Community
Type of Responders Engaged	Parents and children
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-age youth, older adults and those with a physical disability
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY

27
MHSA Referrals to Family Wellbeing

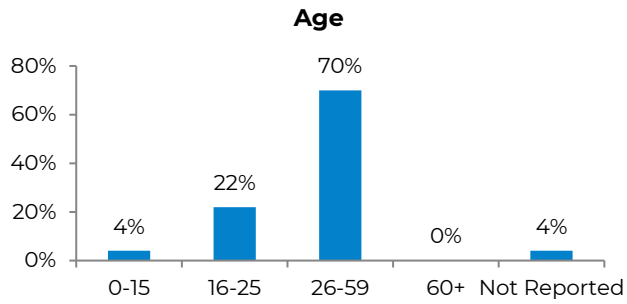
Referral Source

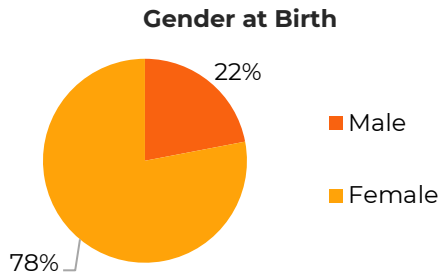


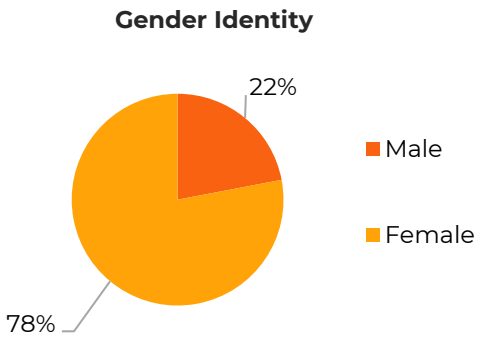
23 out of 27
Referrals Participated in Family Wellbeing Program

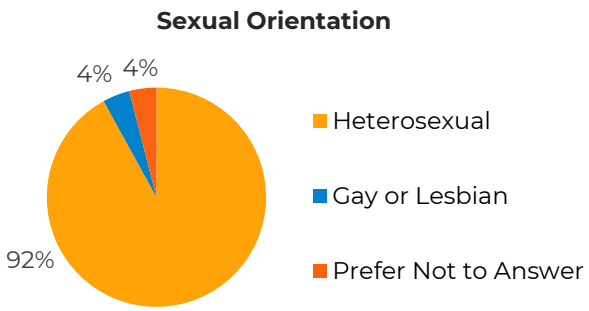
12 Days
Average Time Between Referrals and Participation in Family Wellbeing

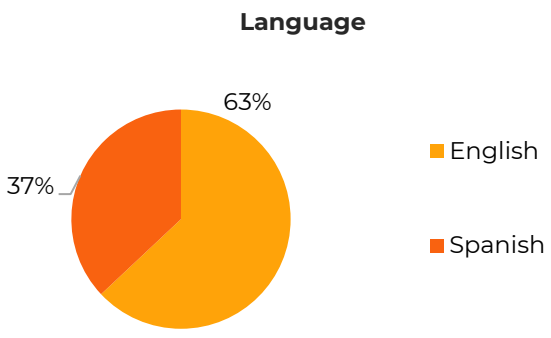
PEI Demographics Based on MHSA Referrals

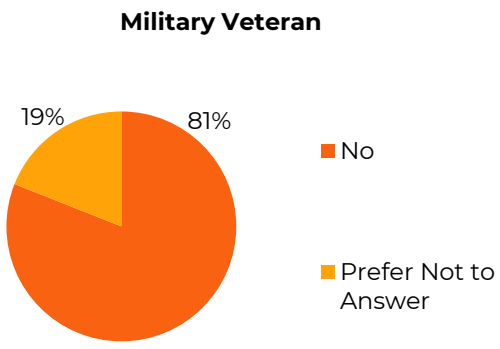




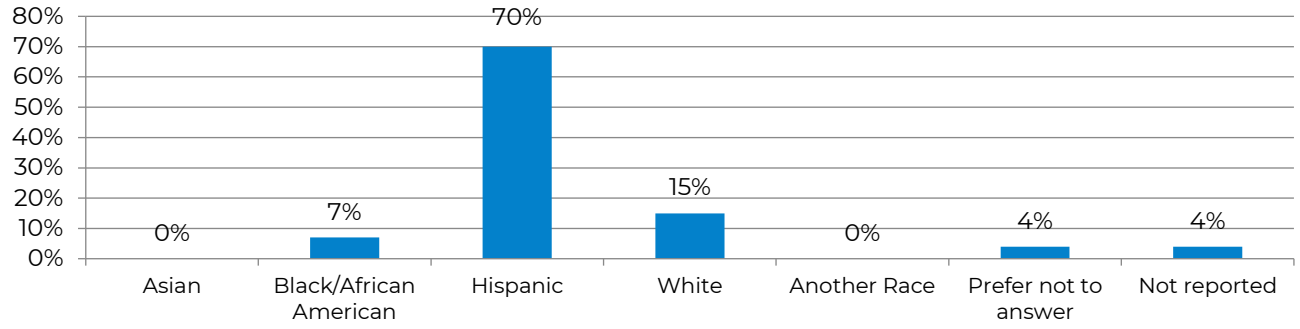




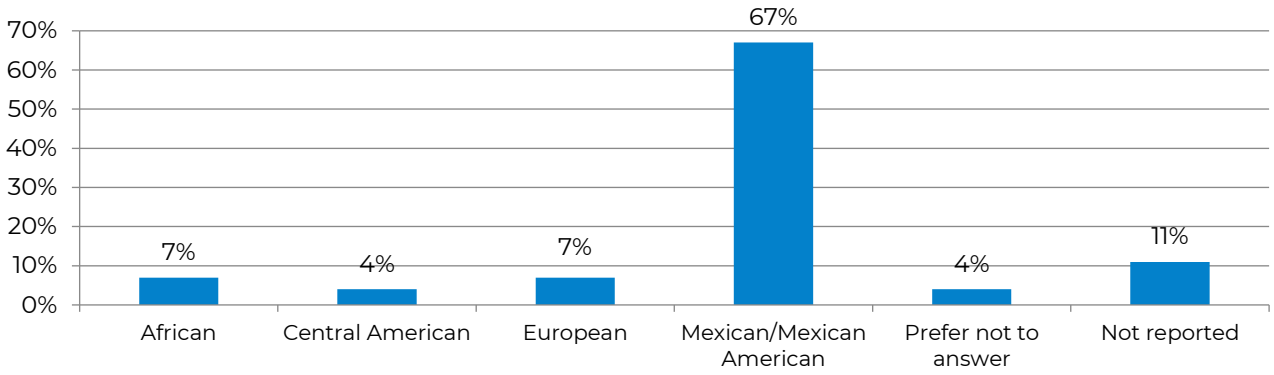




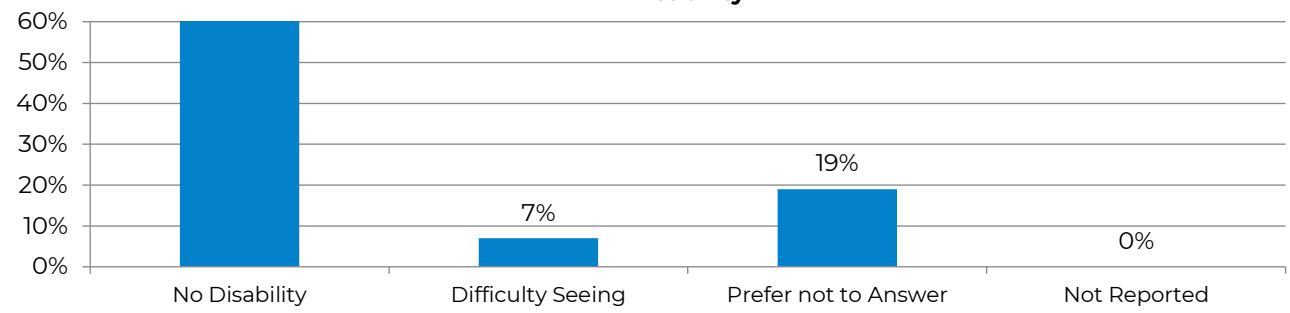
Race



Ethnicity



Disability



NAMI: Ending the Silence

Status of Program:	_X_ New	___ Continuing	___ Modified	___ Discontinued	
Target Population:	_X_ 0-15	_X_ 16-25	_X_ 25-69	___ 60+	Other:
Type of Program:	_X_ Prevention	___ Early Intervention	___ Prevention and Early Intervention		

Program Description

Ending the Silence is a community presentation offered by the National Alliance on Mental Illness (NAMI). This 50-minute program is designed to teach students, school staff and families to recognize the warning signs of mental health issues and what steps to take when they observe these symptoms in their students, friends or loved ones.

Target Population

Ending the Silence offers three separate presentations targeting; 1) middle and high school students; 2) teachers and school staff; and 3) adults with middle or high school youth.

Number of Trainings for FY 2019-20	8
Number of Attendees for FY 2019-20	346

Program Update

Prior to the COVID-19 outbreak, NAMI Pomona Valley (NPV) was on track to increase collaboration with local community partners and, thereby, increasing participation in their support and education programs. Additionally, NPV made plans to increase awareness among community stakeholders with an eye toward promoting the Ending the Silence (ETS) program, as well as support groups offered through the Community Services and Supports program. Notably, the Spanish language outreach efforts had increased.

Challenges and Solutions

Challenges with ETS continues to be logistical. As a school-based program, the mechanics of contacting schools, and confirming a commitment to host the training has proven to take an inordinate amount of time. Convincing school official of the value of this training, as well as scheduling the time for these presentations, continues to be an obstacle to implementing this training on a larger scale. In response to this, NPV has secured an intern who is dedicated to contact and coordinate with school officials in hopes of building a strong collaboration which will include this essential training.

COVID-19 Response

The Ending the Silence program was devastated by the COVID-19 outbreak insofar as the schools shut down eliminated the opportunity to provide the in-person ETS presentations. Although NPV

attempted to transition the presentations to a virtual platform, these efforts were largely unsuccessful when the shutdown first happened as schools were grappling with more fundamental issues. As a result of the school shut down, getting a response from school personnel proved all but impossible. Therefore, presentations could not be arranged. However, efforts continue to try and improve the delivery of the ETS presentations and evaluation process using an online and web-based format.

Cultural Approach

NAMI is highly committed to cultural inclusion and offers the Ending the Silence program in both English and Spanish. In addition, efforts are made to recruit diverse populations as program leaders. All outreach and program materials are available in both English and Spanish. At this time, NAMI PV does not have a dedicated strategy to addressing barriers to the LGBTQ+ community who may be seeking services. Future efforts include distinct and consistent efforts to outreach to underserved and unserved groups and organizations, in the hopes of enhancing current practices in providing access to services.

PROGRAM: NAMI – Ending the Silence

HOW MUCH DID WE DO?

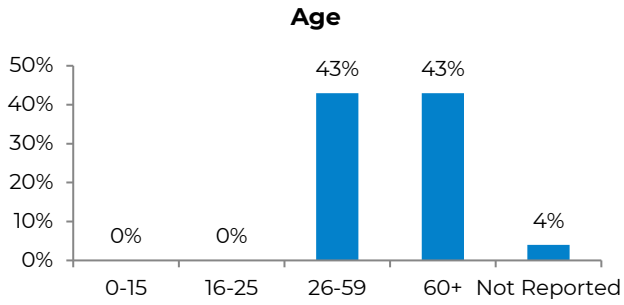
8	346
Presentations	Attendees

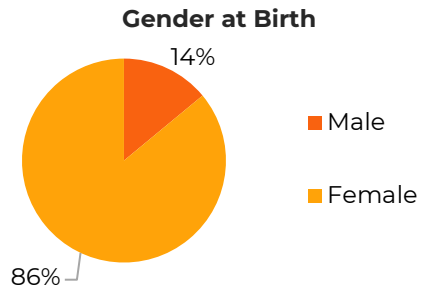
HOW WELL DID WE DO IT?

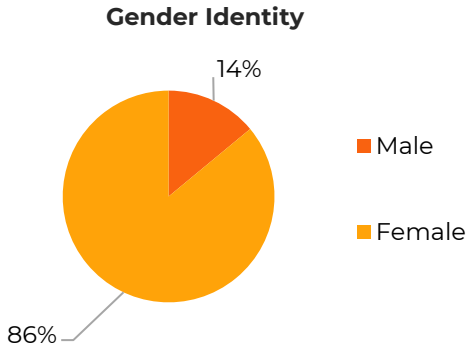
100%	100%
Agreed or strongly agreed that the presentation increased their understanding of symptoms associated with mental health challenges	Agreed or strongly agreed that the presentation will help them recognize early warning signs of mental health challenges

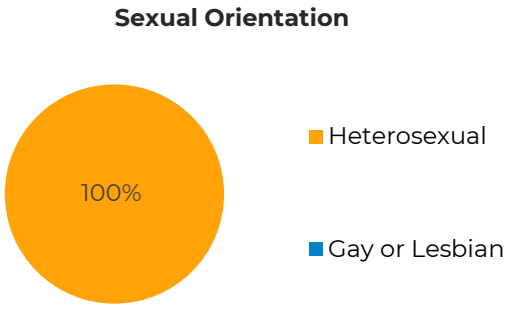
IS ANYONE BETTER OFF?

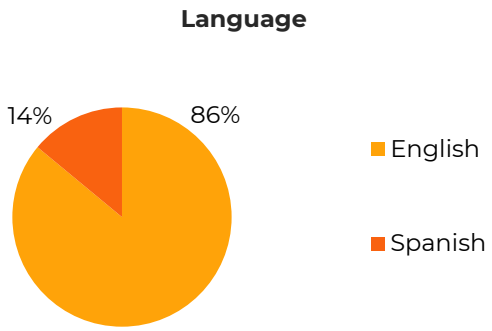
100%	100%
Agreed or strongly agreed that the presentation provided them with new and useful resources	Agreed or strongly agreed that the presentation helped them understand the impact of untreated mental health challenges

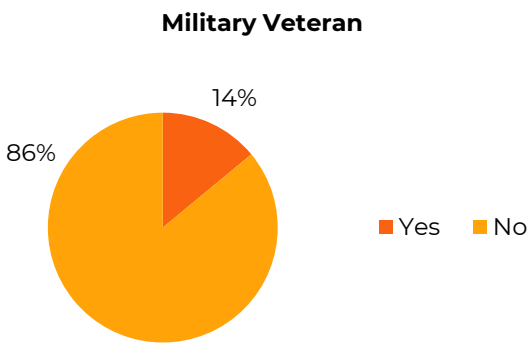

Age
50%
40%
30%
20%
10%
0%
0%
0%
43%
43%
4%
0-15
16-25
26-59
60+
Not Reported

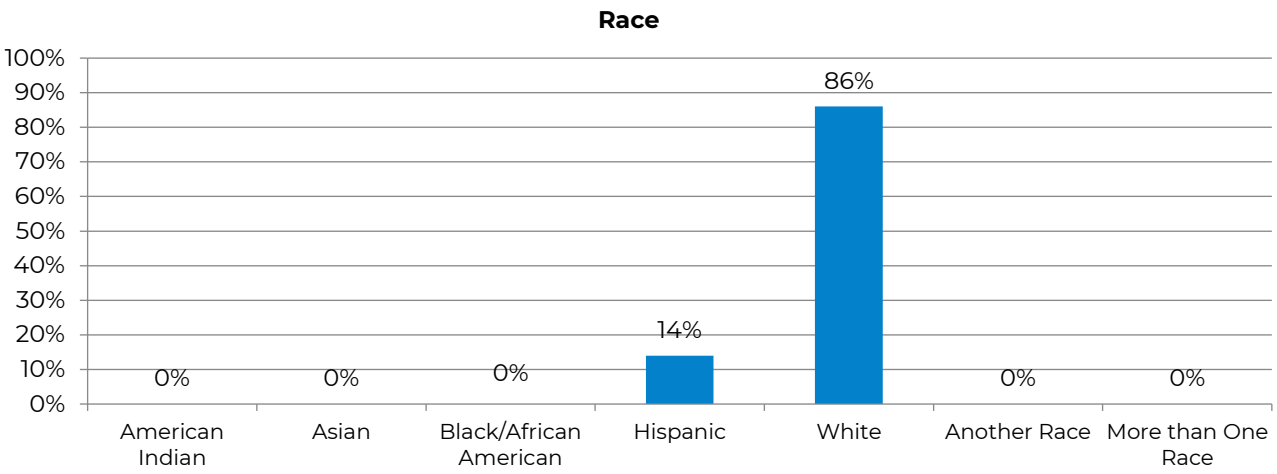

Gender at Birth
14%
86%
Male
Female

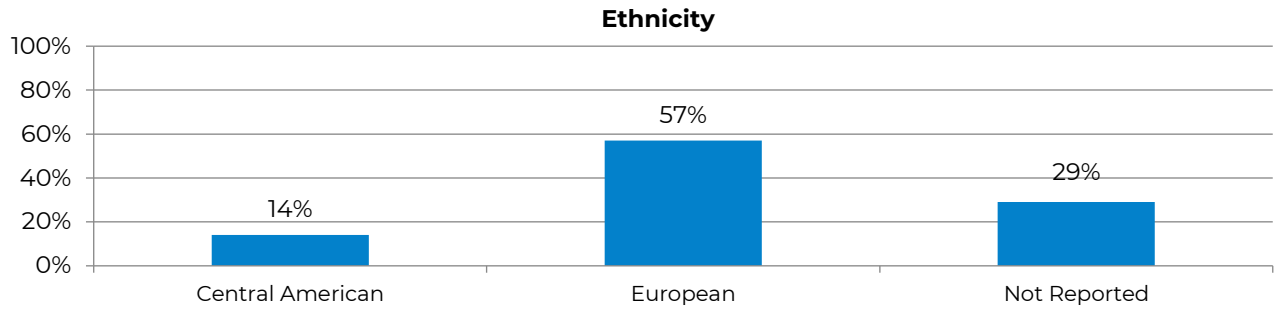

Gender Identity
14%
86%
Male
Female

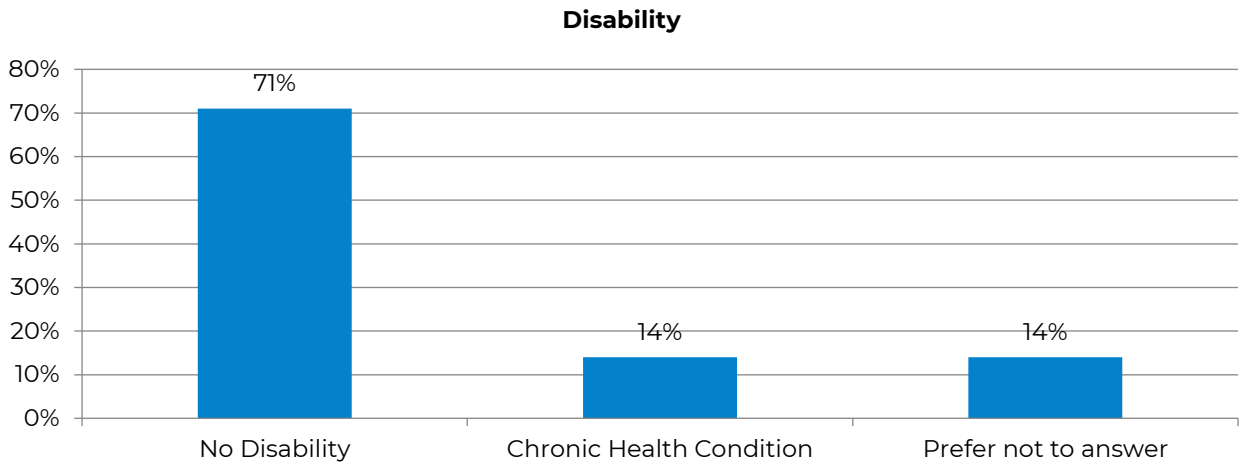

Sexual Orientation
100%
Heterosexual
Gay or Lesbian


Language
14%
86%
English
Spanish


Military Veteran
14%
86%
Yes
No


Race
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
0%
0%
0%
14%
86%
0%
0%
American Indian
Asian
Black/African American
Hispanic
White
Another Race
More than One Race


Ethnicity
100%
80%
60%
40%
20%
0%
14%
57%
29%
Central American
European
Not Reported

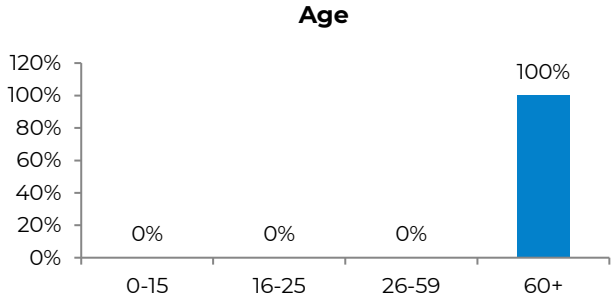

Disability
80%
70%
60%
50%
40%
30%
20%
10%
0%
71%
14%
14%
No Disability
Chronic Health Condition
Prefer not to answer

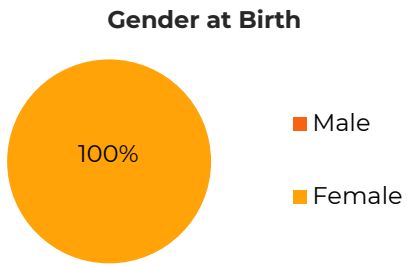
Number of Potential Responders	346
Setting in Which Responders were Engaged	Schools
Type of Responders Engaged	Teachers and school staff, middle and high school students, adults with middle or high school youth
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-aged youth, older adult and those with a physical disability
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

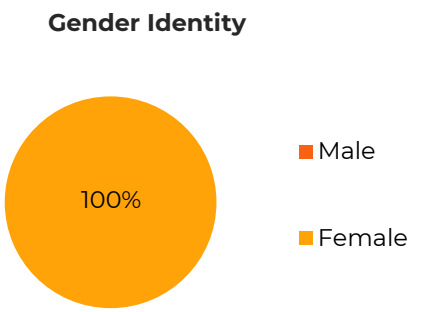
TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY

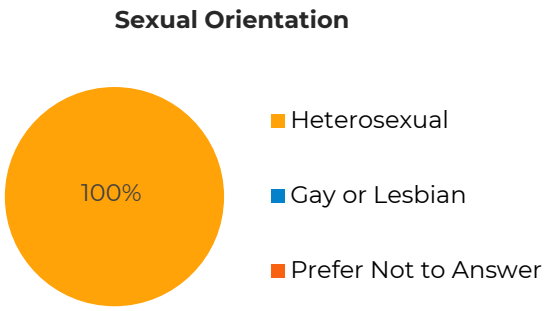
1
MHSA Referral to NAMI

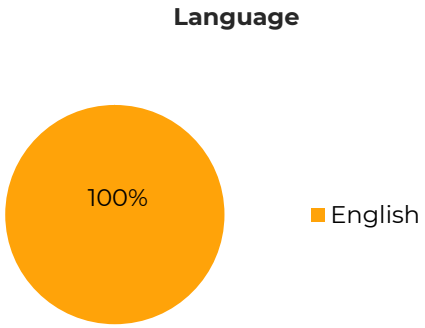
PEI Demographics Based on MHSA Referrals (n=1)

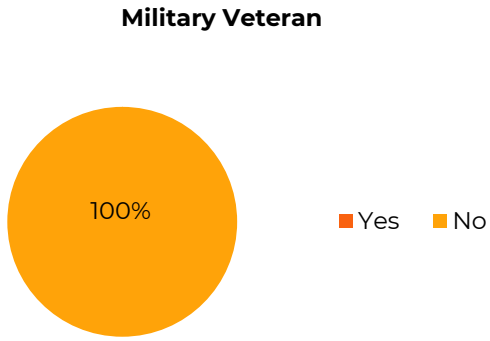


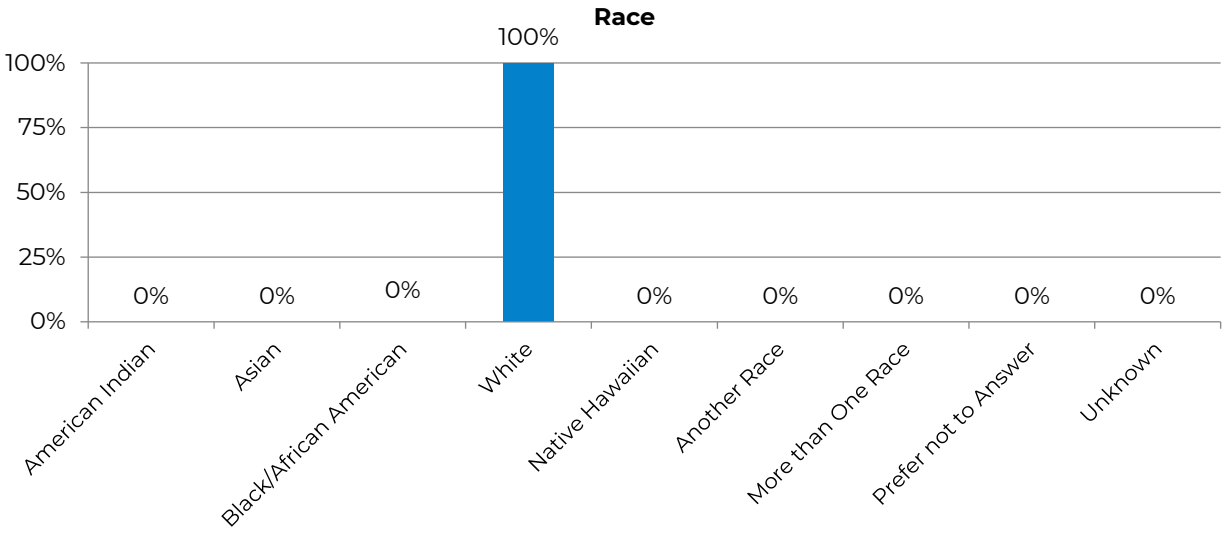


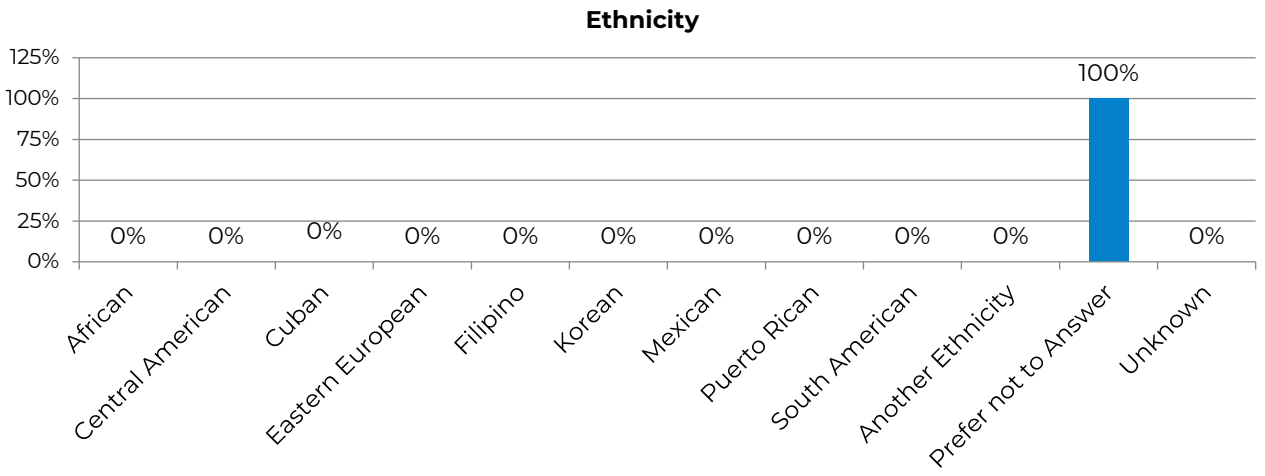

Gender Identity
100%
Male
Female


Sexual Orientation
100%
Heterosexual
Gay or Lesbian
Prefer Not to Answer


Language
100%
English


Military Veteran
100%
Yes
No


Race
100%
75%
50%
25%
0%
0%
0%
0%
100%
0%
0%
0%
0%
0%
American Indian
Asian
Black/African American
White
Native Hawaiian
Another Race
More than One Race
Prefer not to Answer
Unknown


Ethnicity
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100%
75%
50%
25%
0%
0%
0%
0%
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0%
0%
0%
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0%
0%
100%
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Cuban
Eastern European
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Korean
Mexican
Puerto Rican
South American
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Prefer not to Answer
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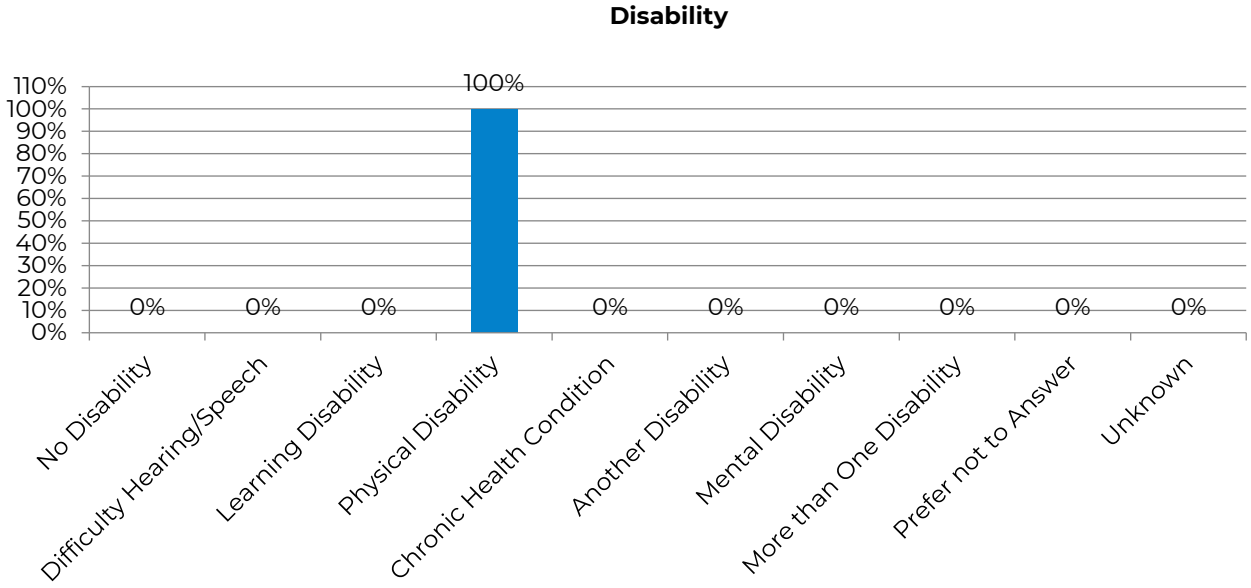

Disability
110%
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
0%
0%
0%
100%
0%
0%
0%
0%
0%
0%
No Disability
Difficulty Hearing/Speech
Learning Disability
Physical Disability
Chronic Health Condition
Another Disability
Mental Disability
More than One Disability
Prefer not to Answer
Unknown

Housing Stability Program

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
Target Population:	___ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:
Type of Program:	_X_ Prevention	___ Early Intervention	___ Prevention and Early Intervention		

Program Description

Stable housing is a necessary foundation to be able to create wellbeing and support a person's mental health. Tri-City Housing staff work diligently with clients, mental health service providers, landlords, and property managers to secure housing placements, mediate conflicts, and strengthen relationships. The Housing Stability Program is a prevention program designed to help people with mental illness maintain their current housing or find more appropriate housing.

Target Population

Landlords, property owners and property managers in the Tri-City area who could have tenants experiencing mental illness who need support to maintain their current housing or to find a more appropriate place of residence. Program staff members work with clients, mental health service providers, landlords, and property managers to secure housing placements, mediate conflicts, and strengthen relationships.

New Landlords Engaged	Landlord Luncheons Held	Attendees (Unique)	Repeat Attendees (Duplicates)
22	9	114	165

Program Update

In August of 2019, the Housing Stability Program (HSP) hosted the annual Housing Summit with the largest attendance for this event at 52 attendees. The event expanded from just providing regular update of the housing laws and regulations to guests such as the Los Angeles County Development Authority who presented their Homelessness Incentive Program which included a panel of previously homeless individuals, who shared their journey to being housed. The goal is to encourage owners to be more open to working with individuals using housing vouchers and to identity various resources that can be shared with existing tenants to help them address areas of need that could impact their housing.

Challenges and Solutions

The HSP staff began offering the "Good Tenant Curriculum" to tenants residing at properties funded through MHSA. However, tenants at these sites did not appear motivated to attend the group despite a "graduation gift" that was promoted. There were only a few instances where the presenter encountered language barriers as the tenants spoke a language other than English or Spanish.

In response, HSP staff will review surveys from past attendees and revise the curriculum to cover topics and address questions from previous groups in hopes that this updated information will be applicable and of interest to these tenants.

During FY 2019-20, the HSP added a new community group, Open Door. Through this group, staff facilitate a round table discussion for anyone that has questions regarding housing, with the purpose of clarifying any misconceptions of the availability of housing. It also provides an opportunity for community members to engage in conversations with each other to identify ways in which they have overcome housing obstacles.

COVID-19 Response

With the onset of the COVID-19 pandemic, the HSP staff quickly moved the Open Door Group to a virtual platform, as well as the monthly landlord meetings. As the pandemic created regular changes to housing regulations, community emails were sent reminding individuals of the Housing Rights Center which presents multiple options to receive support on housing rights and concerns.

Previously scheduled events, such as the first Housing Fair, inspired by job fairs held at the Wellness Center, were canceled. Outreach efforts were curtailed due to social distancing and a reduction with "in-person" meetings with landlords and property managers.

RingCentral, an online meeting platform, proved to be a valuable resource for staff when hosting groups, meetings, and webinars. Trainings such as the Good Tenant Curriculum, were modified to be available for a call-in group format. Efforts are underway with community partners to add WIFI and computer stations so the Good Tenant Curriculum can be offered virtually as well.

Future efforts include working with Tri-City community trainers to expand the Mental Health First Aid trainings for property owners and landlords to help them when responding to difficult interactions with tenants. A new curriculum will be introduced in the future entitled Landlord Everyday Mental Health.

Housing staff will also begin hosting regular landlord housing forums to provide a virtual round table for landlords. Participants will be able to offer support to each other while identifying areas where resources and future education is needed.

Cultural Approach

Cultural inclusion is an important component to the Housing Stability Program. Five of the eight housing staff are bilingual in English and Spanish. Tri-City staff maintain strong alliances with various agencies throughout the county that serve diverse communities. Information and resources gleaned from these relationships are then provided to participants during the Landlord Luncheons.

Stigma regarding mental illness is also a concern and the Open Door group is structured to focus on individuals who are considered underserved, and offer support and resources as they express their experience with barriers or discriminations. Mental Health First Aid training is offered for landlords, owners, and property managers in order to help them better understand and be able to support tenants with mental health conditions.

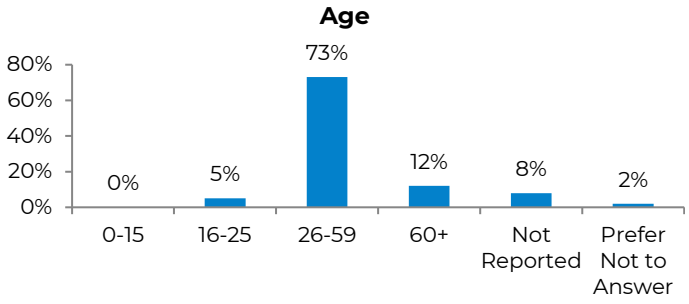
PROGRAM: Housing Stability Program (HSP)

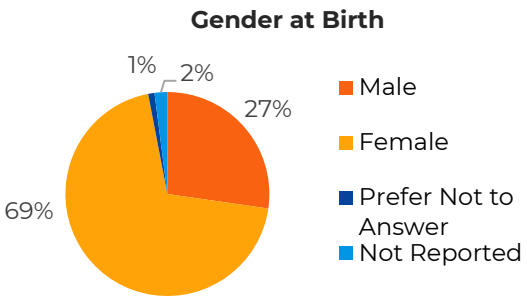
HOW MUCH DID WE DO?

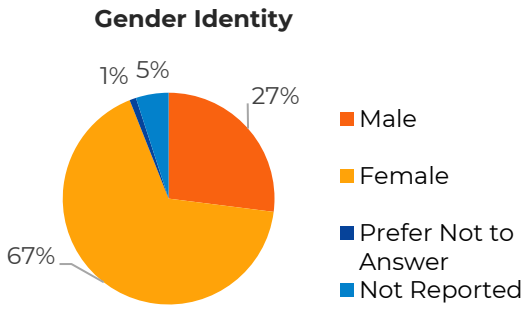
22	81	9	166	114
New Landlord Contacts	Landlord Follow-Ups	Landlord Luncheons Held	Landlord Luncheon Attendees (Duplicated)	Landlord Luncheon Attendees (Unique)

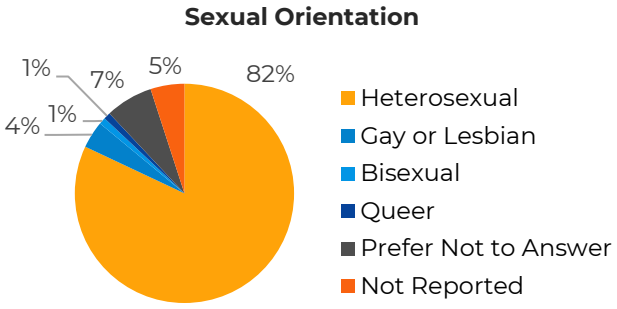
43	81	29	11	18
Landlord Tenant Curriculum Groups	Group Attendees (Duplicated)	Group Attendees (Unique)	Open Door Events Held	Open Door Event Attendees (Duplicated)

PEI Demographics, Including Housing Participants

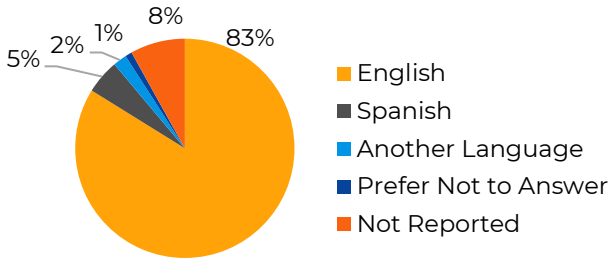




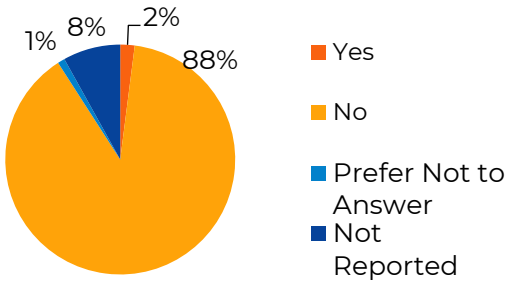




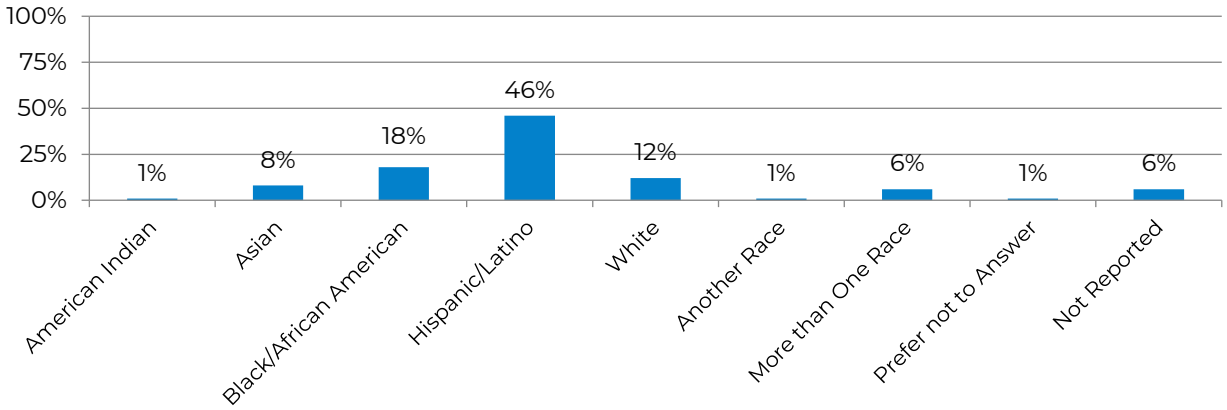
Language



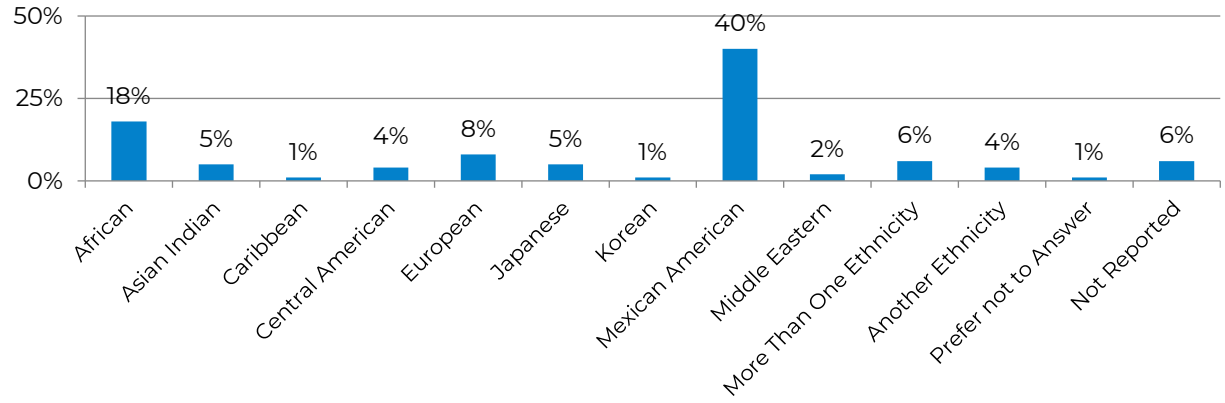
Military Veteran

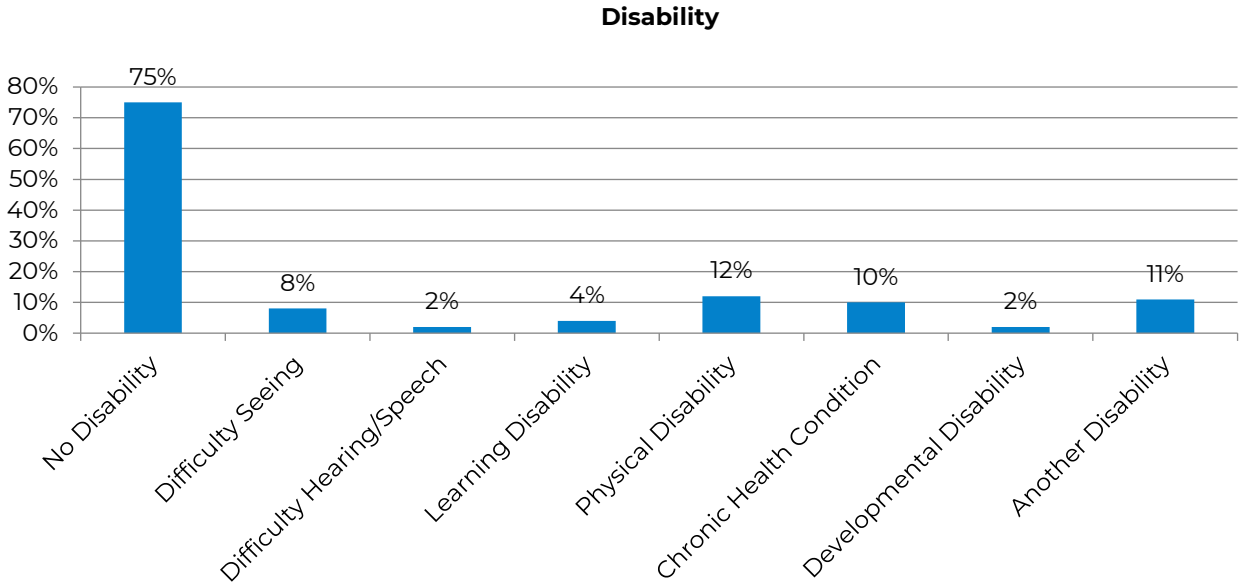


Race

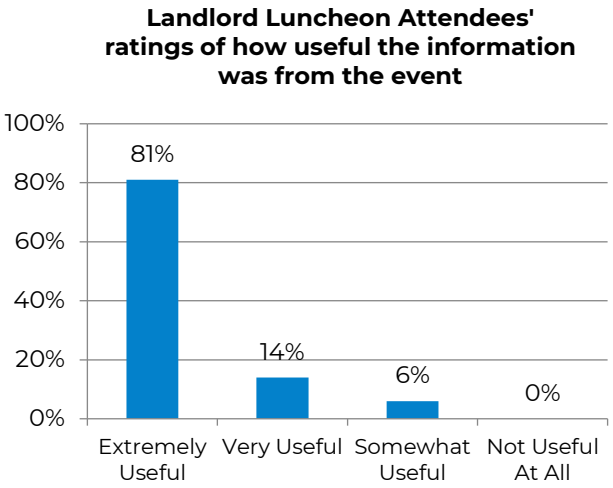


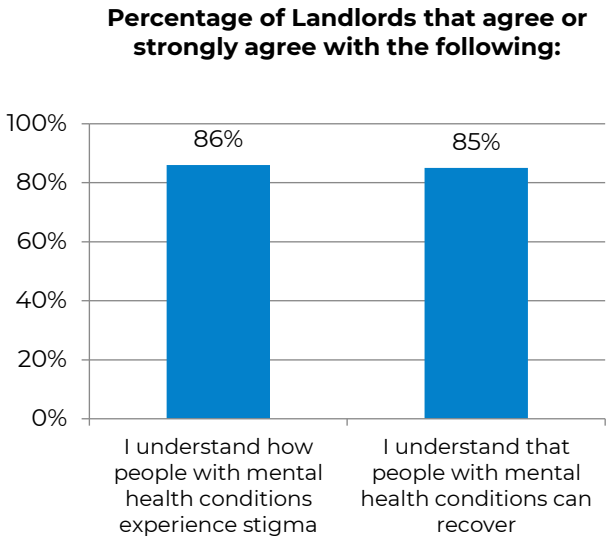
Ethnicity





HOW WELL DID WE DO IT?



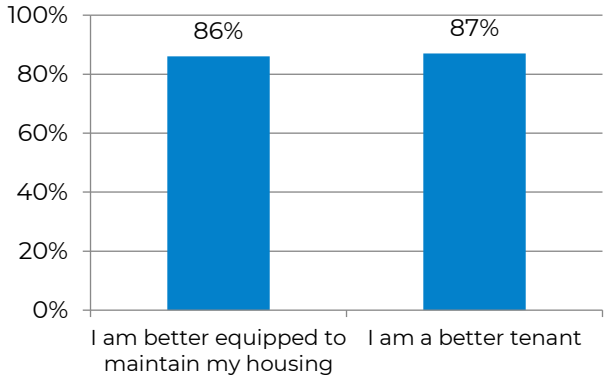


94%
Good Tenant Curriculum Participants Would Recommend This Curriculum to Others

93%
Good Tenant Curriculum Participants Reported the Presenter was Engaging and Approachable

IS ANYONE BETTER OFF?

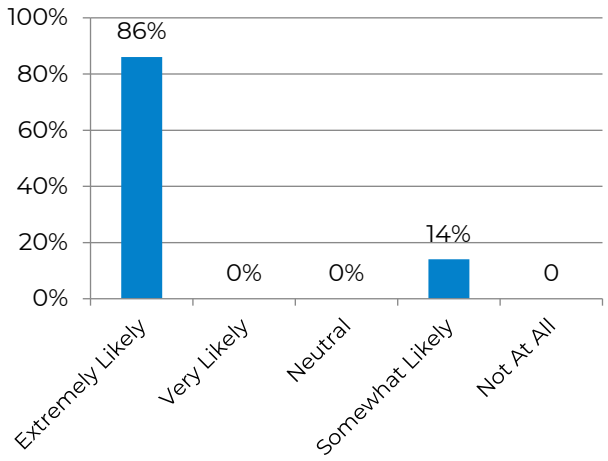
Percentage of Good Tenant Curriculum participants that, as a result this training:



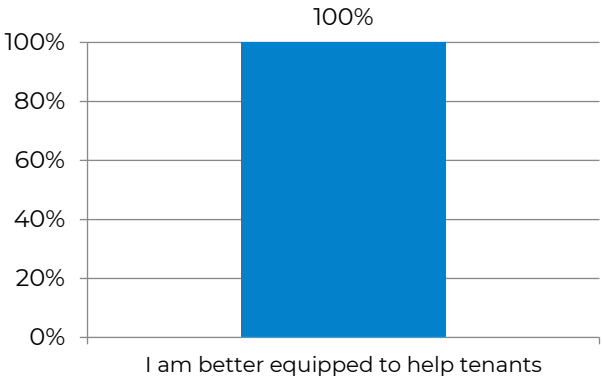
92%

Good Tenant Curriculum Participants Reported That Staff Helped Them Obtain the Information Needed to Accomplish Their Housing Goals

How likely are you to reach out to Tri-City if you suspect someone has a mental health challenge?



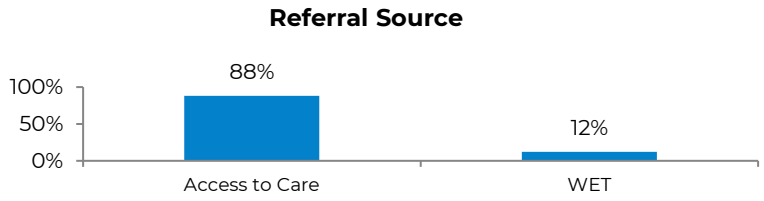
Percentage of landlord participants that, as a result of this training:



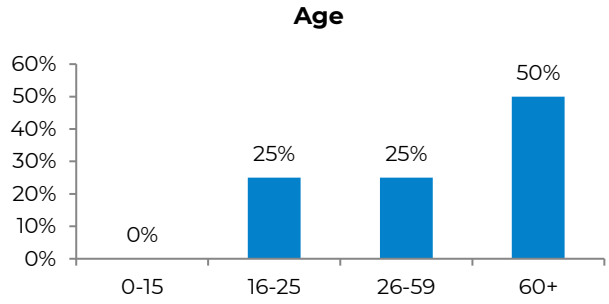
Number of Potential Responders	143
Setting in Which Responders were Engaged	Community
Type of Responders Engaged	Landlords and community members
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-age youth, older adults and those with a physical disability
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

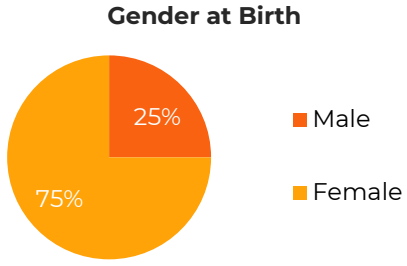
TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY

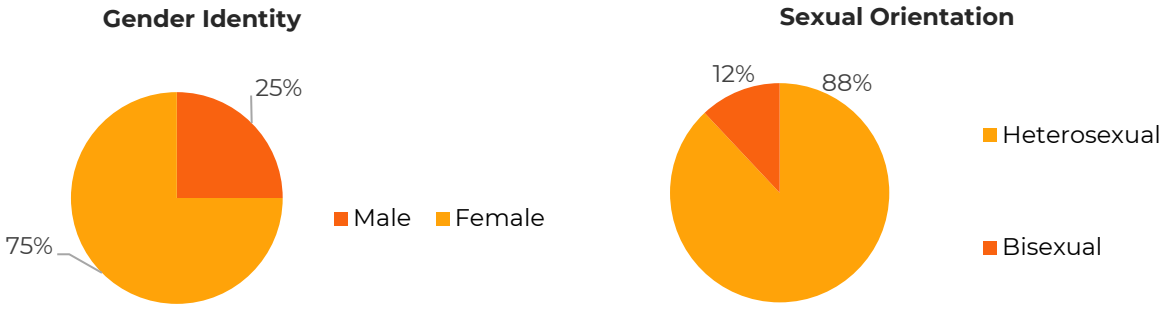
8
MHSA Referral to Housing Stability

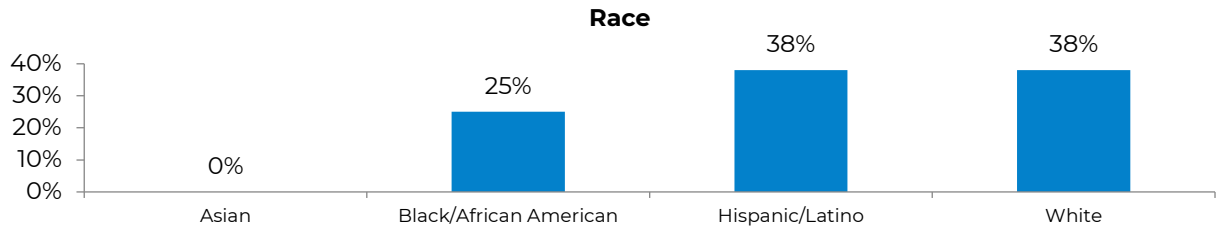


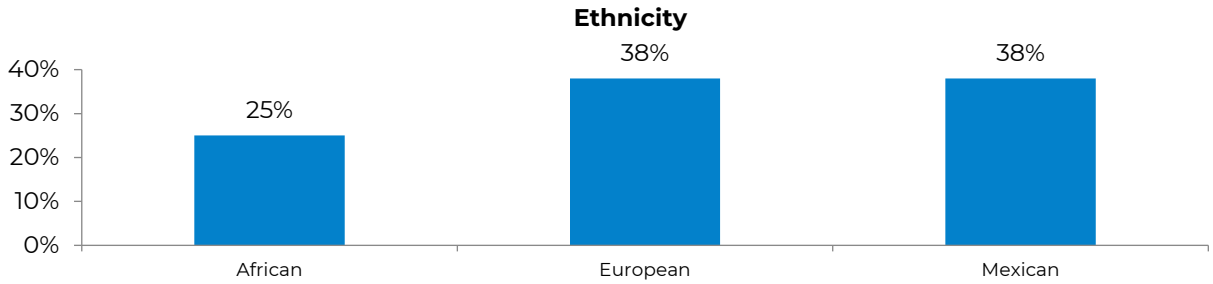
PEI Demographics Based on MHSA Referrals

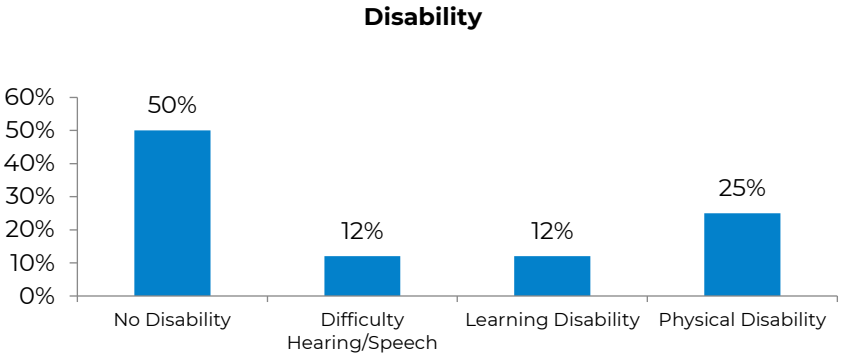


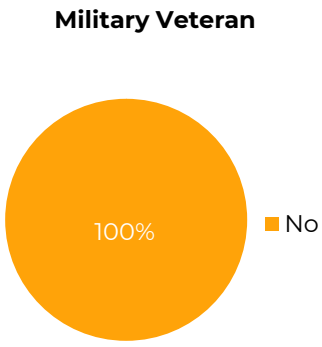



Gender Identity
25%
75%
Male
Female
Sexual Orientation
12%
88%
Heterosexual
Bisexual


Race
40%
30%
20%
10%
0%
0%
25%
38%
38%
Asian
Black/African American
Hispanic/Latino
White


Ethnicity
40%
30%
20%
10%
0%
25%
38%
38%
African
European
Mexican


Disability
60%
50%
40%
30%
20%
10%
0%
50%
12%
12%
25%
No Disability
Difficulty Hearing/Speech
Learning Disability
Physical Disability


Military Veteran
100%
No

Therapeutic Community Gardening

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
Target Population:	_X_ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:
Type of Program:	___ Prevention	___ Early Intervention	_X_ Prevention and Early Intervention		

Program Description

The Therapeutic Community Gardening program helps participants decrease their isolation and experience mental health benefits through participation in horticulture/gardening activities and group therapy exercises.

Target Population

Unserved and underserved populations including adults, youth ages 16-25, families with children, older adults, and veterans.

Age Groups	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Unknown
Number Served FY 2019-20	11	8	40	19	4
Cost Per Person	$3,316.00	$3,316.00	$3,316.00	$3,316.00	$3,316.00

Program Update

The Therapeutic Community Garden (TCG) program continues to be a popular option for community members and staff referrals. Community participation is a fundamental foundation for this program and staff are able to support this concept through hosting and participating in local events such as a resource fair at Cal Poly Pomona Veteran's Resource Center and Fall at the Farm hosted at the Pomona Fairplex. Additional events were sponsored by Tri-City and included the adult outpatient graduation ceremony, Wellness Center Tree Lighting Event, and Harvest Feast at Tri-City's Royalty location.

During FY 2019-20, TCG staff also hosted workshops at the Jocelyn Senior Center for older adults, Simon Middle School, and a monolingual group for parents in the Claremont Unified School Districts book club in the Therapeutic Community Garden. One of their most popular gatherings was a winter event help in the Garden which drew 55 attendees.

Challenges and Solutions

One of the challenges experienced by this team included a low turnout for groups located at various Tri- City housing locations. Transition age youth (TAY) continue to be a difficult population to engage, enroll and maintain in TCG groups.

To increase future attendance in TAY groups, TCG staff will be collaborating with community partners who support this age specific group. These efforts include maintaining preexisting relationships with TAY organizations as well as hosting workshops and events that target this essential age group.

COVID-19 Response

TCG operations were impacted dramatically due to COVID 19. In March 2020, all groups were put on hold due to concerns with public and staff safety. The majority of services rendered through TCG were through groups prior to COVID 19; therefore, all direct services were put on hold. However, weekly wellness calls to TCG participants began and continue to this day.

Groups for TCG shifted to a virtual platform in July of 2020. TCG staff are currently utilizing social media platforms to provide information regarding the Garden to the public. Adapting to the virtual world of delivering services via telehealth presented many challenges. A few of those challenges included: adapting to and learning technology related to delivering services virtually; assisting TCG clients to download and learn technology to be able to log-in to virtual groups and making accommodations for individuals that were not comfortable receiving services through telehealth. Curriculum and program development, disseminating information to the public, and ensuring proper HIPAA (Health Insurance Portability and Accountability Act) and documentation guidelines were followed delayed the process of offering services virtually. At this time, TCG groups are now being conducted virtually.

Finally, TCG staff-initiated harvest drop-off/pick-ups of items from the garden to TCG participants and worked with local non-profit agency to offer donations of fruit.

Cultural Approach

The Therapeutic Community Garden is diligent is addressing barriers for underserved and unserved communities. Efforts include:

- Full time Spanish-speaking Mental Health Specialists and monolingual Spanish groups
- English and Spanish speaking adult and older adult groups
- Transitional Aged Youth, youth and family aged group
- Wellness Center group (indoors) for participants who are unable to be in the garden.
- Modifying TCG activities for individuals with learning impairments (as needed)
- Curriculum development includes discussions about diversity, culture and how differences between plants can benefit each other (companion planting and crop rotation)
- Participation in events that bring awareness to diversity and inclusion
- Attendance to trainings and webinars that focus on increasing cultural competency and awareness

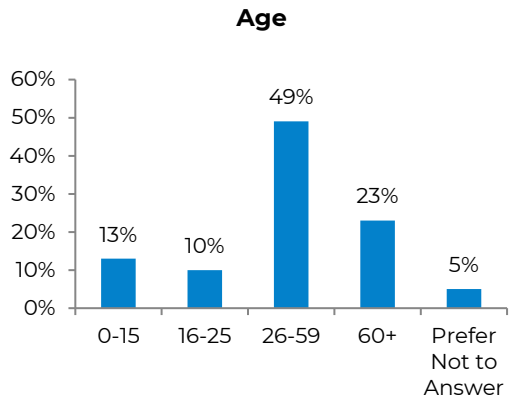
- A majority of program materials are available in Spanish (i.e. waivers, enrollment sheet, referral forms, questionnaires, flyers, labels for garden beds)

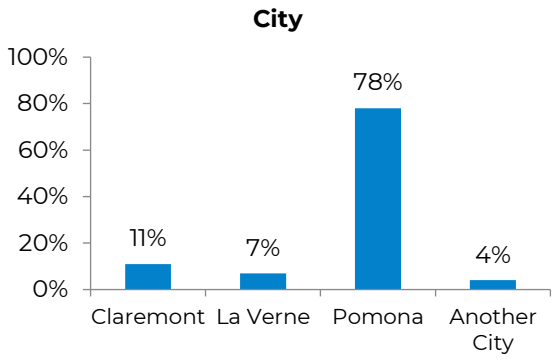
PROGRAM: Therapeutic Community Gardening (TCG)

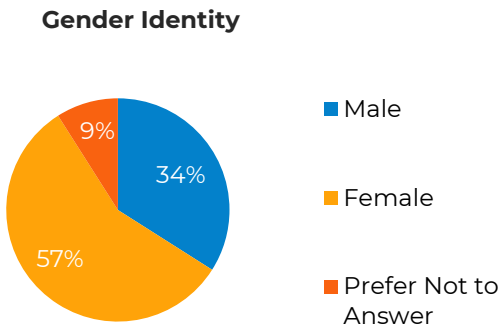
HOW MUCH DID WE DO?

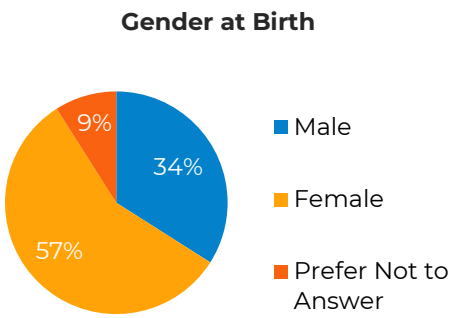
82
Unique Individuals Served

349 Days
Average Length of Time Individuals Enrolled in TCG

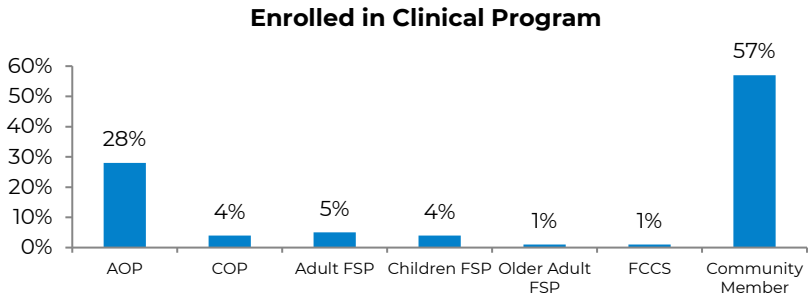


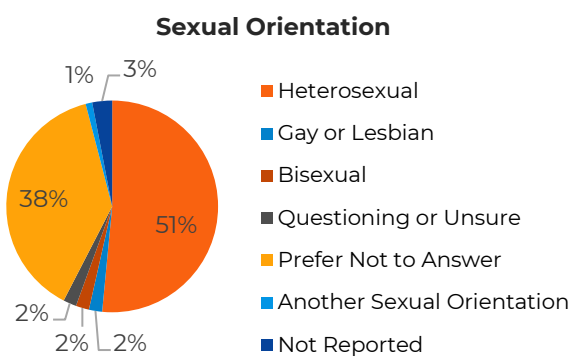


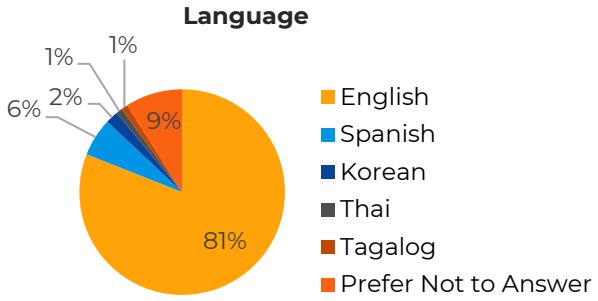


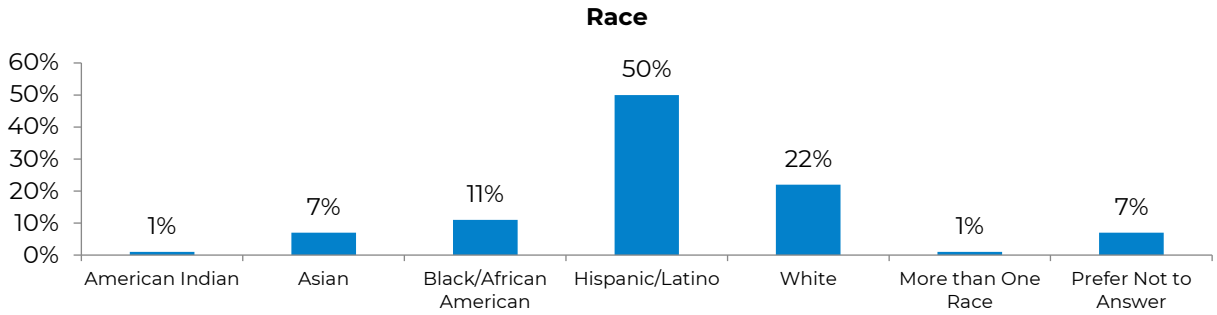


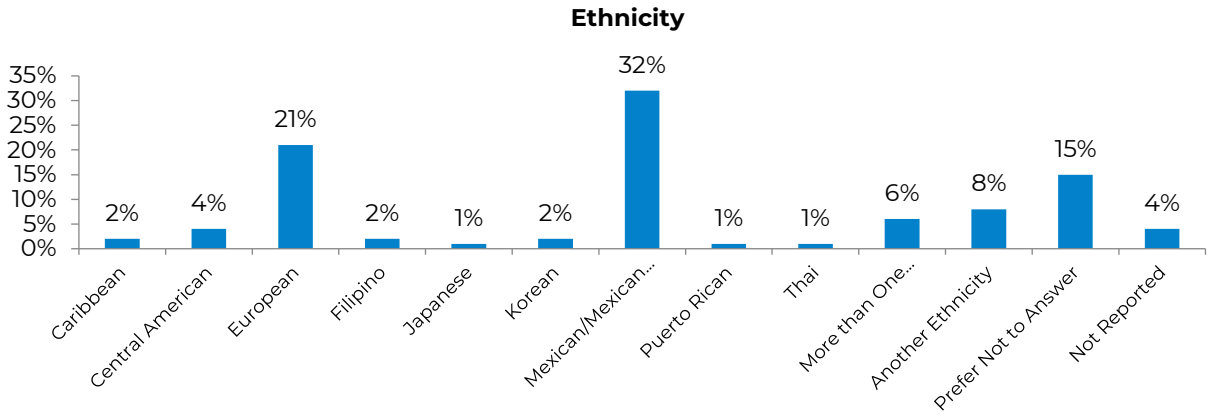
43%
Individuals are Clinical Clients

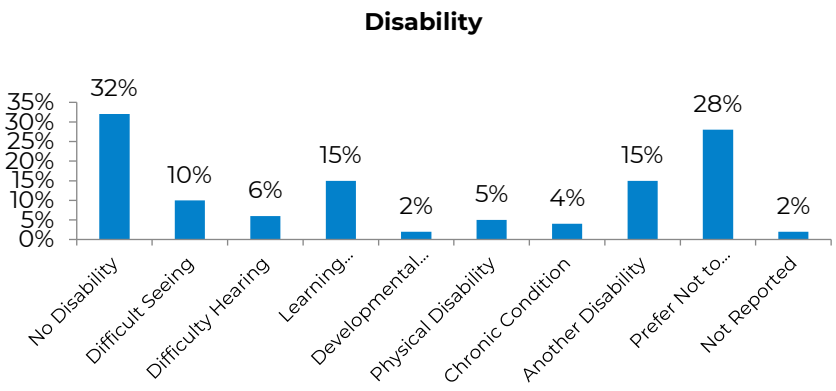


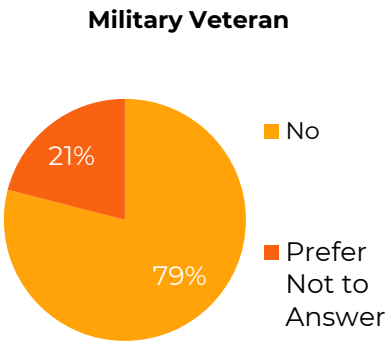

Sexual Orientation
1%
3%
38%
51%
2%
2%
2%
Heterosexual
Gay or Lesbian
Bisexual
Questioning or Unsure
Prefer Not to Answer
Another Sexual Orientation
Not Reported


Language
1%
1%
6%
2%
9%
81%
English
Spanish
Korean
Thai
Tagalog
Prefer Not to Answer


Race
60%
50%
40%
30%
20%
10%
0%
1%
7%
11%
50%
22%
1%
7%
American Indian
Asian
Black/African American
Hispanic/Latino
White
More than One Race
Prefer Not to Answer


Ethnicity
35%
30%
25%
20%
15%
10%
5%
0%
2%
4%
21%
2%
1%
2%
32%
1%
1%
6%
8%
15%
4%
Caribbean
Central American
European
Filipino
Japanese
Korean
Mexican/Mexican...
Puerto Rican
Thai
More than One...
Another Ethnicity
Prefer Not to Answer
Not Reported


Disability
35%
30%
25%
20%
15%
10%
5%
0%
32%
10%
6%
15%
2%
5%
4%
15%
28%
2%
No Disability
Difficult Seeing
Difficulty Hearing
Learning...
Developmental...
Physical Disability
Chronic Condition
Another Disability
Prefer Not to...
Not Reported

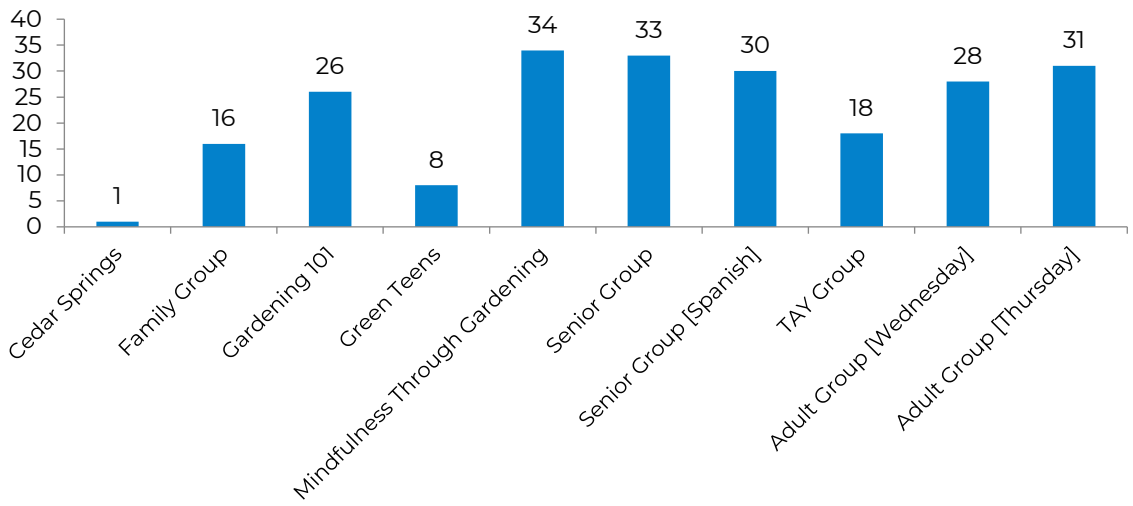

Military Veteran
21%
79%
No
Prefer Not to Answer

HOW WELL DID WE DO IT?

TCG Groups Occurred from July 2019 to March 11, 2020

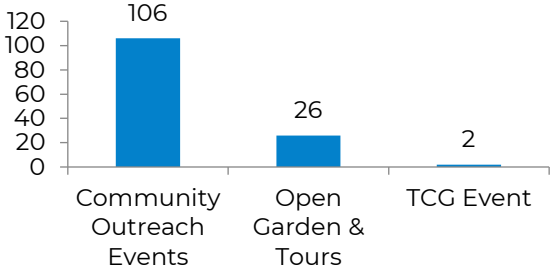
225	543	6
TCG Groups Held	Duplicated Participants at TCG Groups	Average TCG Groups Held Per Week

Types of TCG Groups

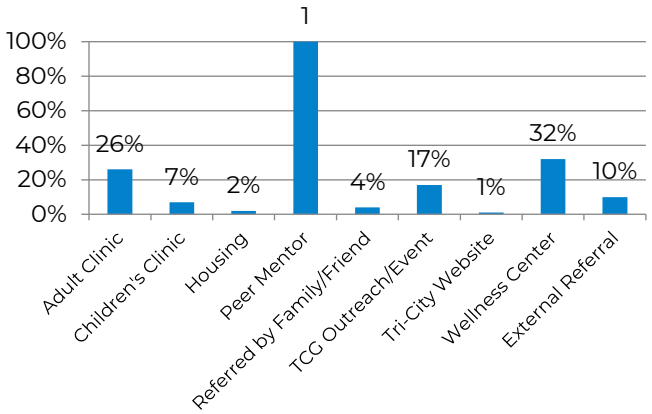


275	134	1,402
Wellness Phone Calls Made to TCG Participants [March 2020 – June 2020]	Outreach Events	Individuals Engaged

Type of Outreach



Referral Source



IS ANYONE BETTER OFF?

100%	91%	96%	96%	86%
TCG Participants Enjoy Attending TCG Groups	TCG Participants Feel More Connected to Others [Peers, Family, etc.] Because of TCG Groups	TCG Participants Feel Their Symptoms Have Improved Because of Their Work at the Garden	TCG Participants Feel More Confident from the Skills Learned in TCG Groups	TCG Participants Have Better Communication with Others Because of TCG Groups

TCG Participant Feedback

"So glad I came to TCG, networked with other community members."

"I've learned more."

"I have always benefited. It is easier for me."

"I enjoy it. I want to plant new things."

"I have gained so much knowledge and experiences."

"I learned a lot of practical skills and I love the opportunity to socialize."

"I like TCG a lot!"

"Being here makes me feel comfortable and good."

"I'm here to keep learning the group talk strategies."

"I feel more positive in how I feel, Thank you for our case workers too!"

"Being active, the groups are great!"

"I'm calmer, more able to deal with life's challenges and how I was before I started coming."

"It calms me down."

"Walking and working in the garden makes me feel good."

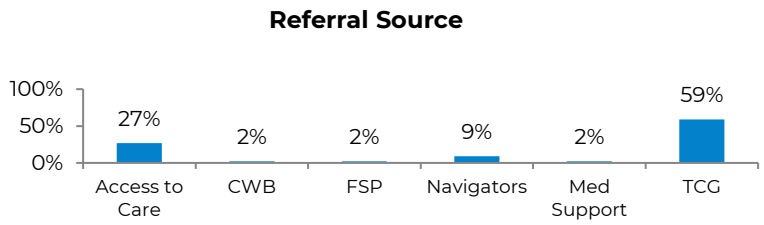
"I completely like learning about nature and garden."

"I feel very happy, can't wait for Friday group!"

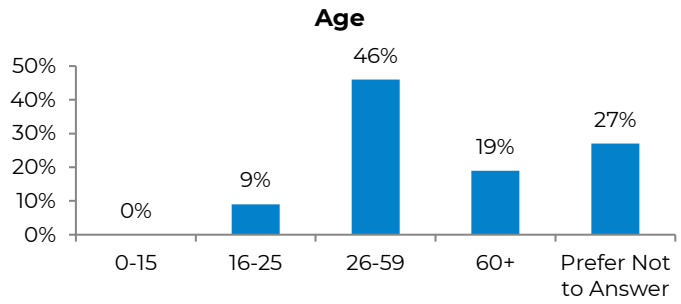
Number of Potential Responders	82
Setting in Which Responders were Engaged	Community, schools, health centers, workplace and outdoors
Type of Responders Engaged	TAY, teachers, LGBTQ+, families, religious leaders and those with lived experience
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

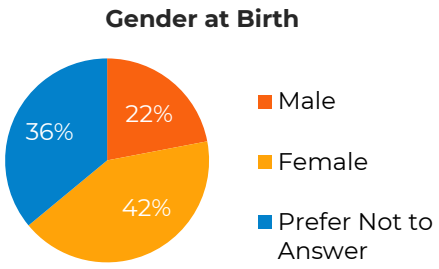
TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY

59
MHSA Referral to TCG Program

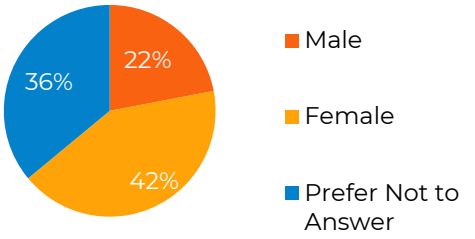


PEI Demographics Based on MHSA Referrals

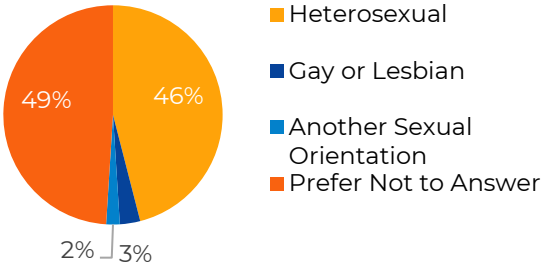




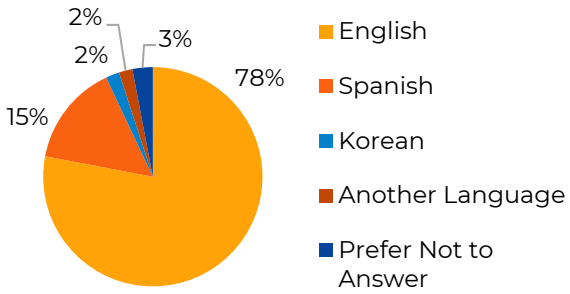
Gender Identity



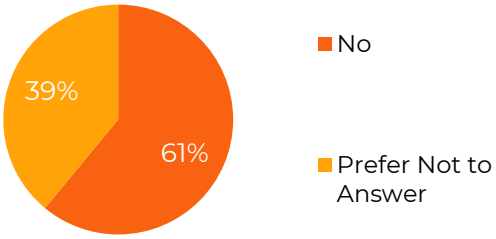
Sexual Orientation



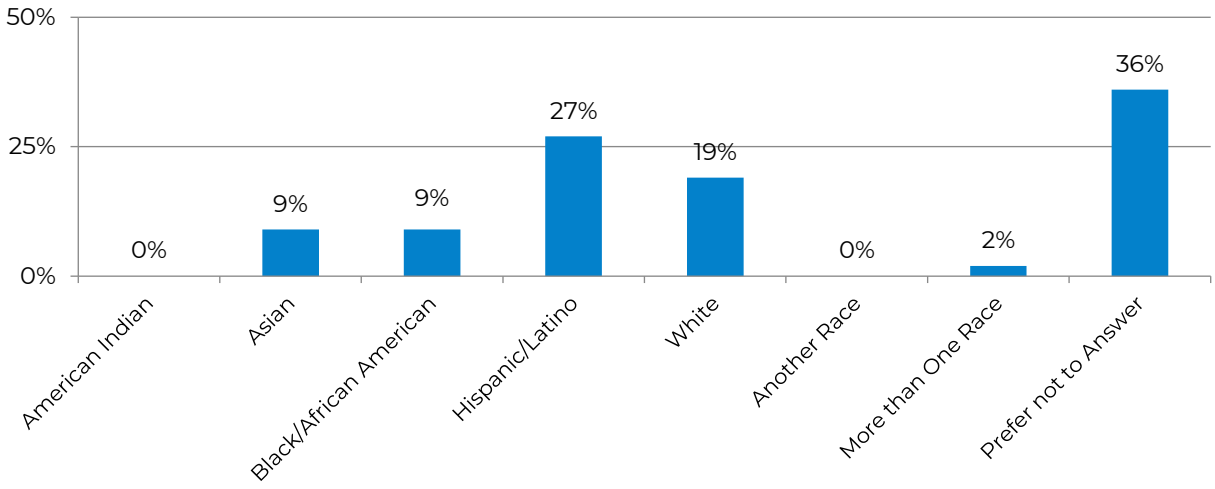
Language

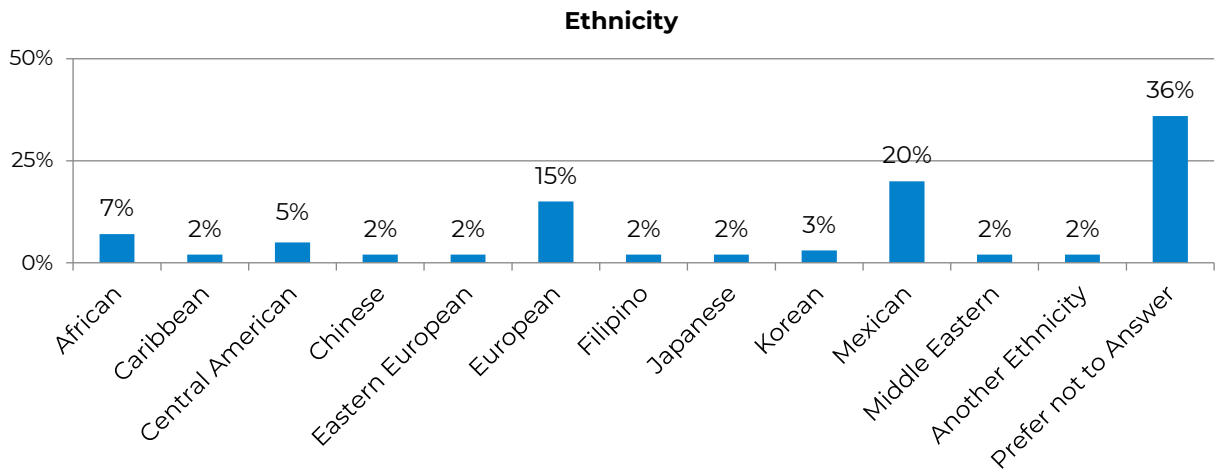


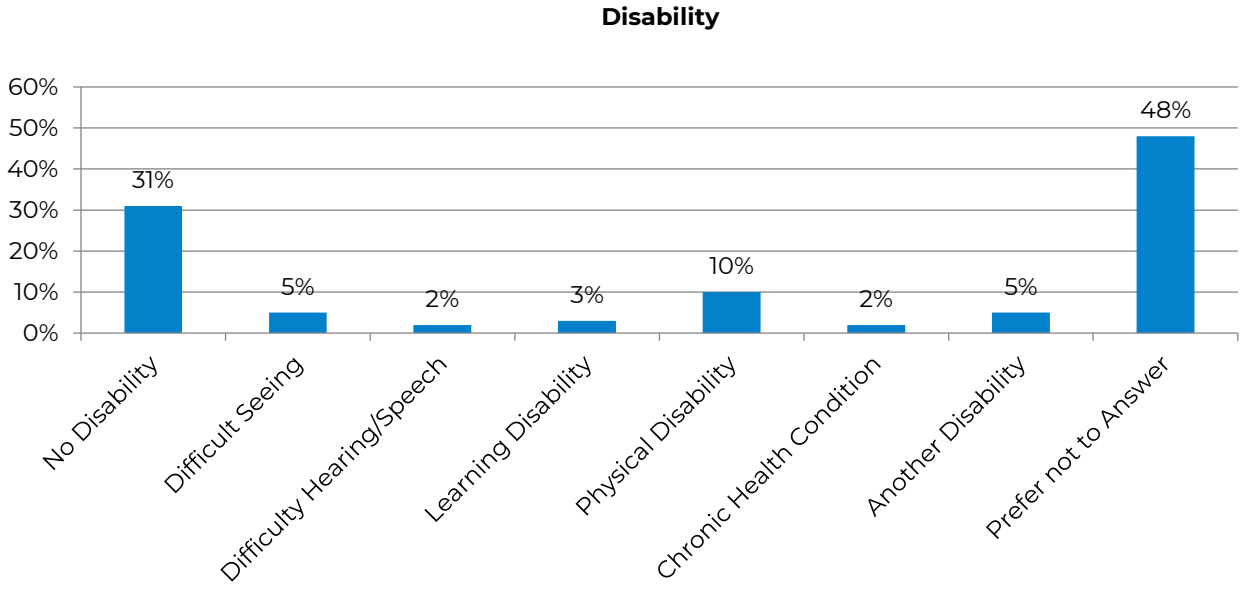
Military Veteran



Race




Ethnicity
50%
25%
0%
7%
2%
5%
2%
2%
15%
2%
2%
3%
20%
2%
2%
36%
African
Caribbean
Central American
Chinese
Eastern European
European
Filipino
Japanese
Korean
Mexican
Middle Eastern
Another Ethnicity
Prefer not to Answer


Disability
60%
50%
40%
30%
20%
10%
0%
31%
5%
2%
3%
10%
2%
5%
48%
No Disability
Difficult Seeing
Difficulty Hearing/Speech
Learning Disability
Physical Disability
Chronic Health Condition
Another Disability
Prefer not to Answer

Early Psychosis Program

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
Target Population:	___ 0-15	_X_ 16-25	___ 25-69	___ 60+	Other:
Type of Program:	___ Prevention	_X_ Early Intervention	___ Prevention and Early Intervention		

Program Description

Utilizing the PIER (Prevention, Intervention, Enforcement and Reentry) model, Tri-City staff host workshops and trainings for community members and school personnel focused on recognizing and addressing the earliest symptoms of mental illness. This evidence-based treatment option uses three key components- community outreach, assessment and treatment to reduce symptoms, improved function and decrease relapse. The goal for this program includes increasing awareness among community members in recognizing the signs and symptoms of early psychosis and how to connect individuals to services as well as to reduce the time of untreated psychosis and severe mental illness.

Target Population

Transition Age Youth (TAY) ages 16 to 25 who are experiencing psychosis and are not currently enrolled in mental health services.

Number of Workshops for FY 2019-20	7
Number of Attendees for FY 2019-20	75

Program Update

Beginning in July 2020, Tri-City staff implement the Portland Identification and Early Referral (PIER) model as the basis for their Early Psychosis Program (ESP). This model utilizes a team-based system of early detection and intervention in psychosis. This first year of implementation included the completion of the Memo of Understanding with PIER as well as the last of the hiring (occupational therapist) needed to complete the PEIR team.

Challenges and Solutions

Challenges for this program included making the shift from a research focus to an action/implementation focus. This included finalizing the hiring of staff and developing the phases of implementation including outreach and trainings. By establishing training dates early on with community partners, this ensured that outreach presentations were on their calendars in order to spread the word and increase referrals to the program.

COVID-19 Response

With the onset of COVID 19, the PIER trainings and training with UCLA, another adjunct program for staff, were delayed. Although these trainings were originally scheduled to begin in April/May of 2020

and to be completed over the summer, the pandemic required the trainings to be modified to be presented via a virtual platform. This delay resulted in the PIER trainings being rescheduled to be completed by the second week of November 2020 and the UCLA training is now estimated to be completed by January 2021. The outreach portion of these trainings were also impacted as community partners also shifted their focus to addressing their own internal priorities which left little time for adjunct presentations or trainings.

In response to these challenges, Tri-City staff are working to adapt these new training practices to be conducted virtually with clients via telehealth. In addition, outreach efforts were also adapted to be conducted virtually via phone or webinars.

Cultural Approach

In addressing cultural inclusion, the ESP employs staff that are reflective of the community served and make it a practice to approach the work with cultural humility. Ongoing discussions of race, culture, and health disparities in department meetings, group and individual supervisions with staff, has proven to be effective in instilling this approach.

In addition, staff ensure that assessment and new PIER training material are available in other threshold languages, including Spanish. Flyers, assessments, and forms are available in Spanish and other languages as needed. Presentations on outreach are available in Spanish. The material is also presented in a manner that is easy to understand even if English is not their primary language.

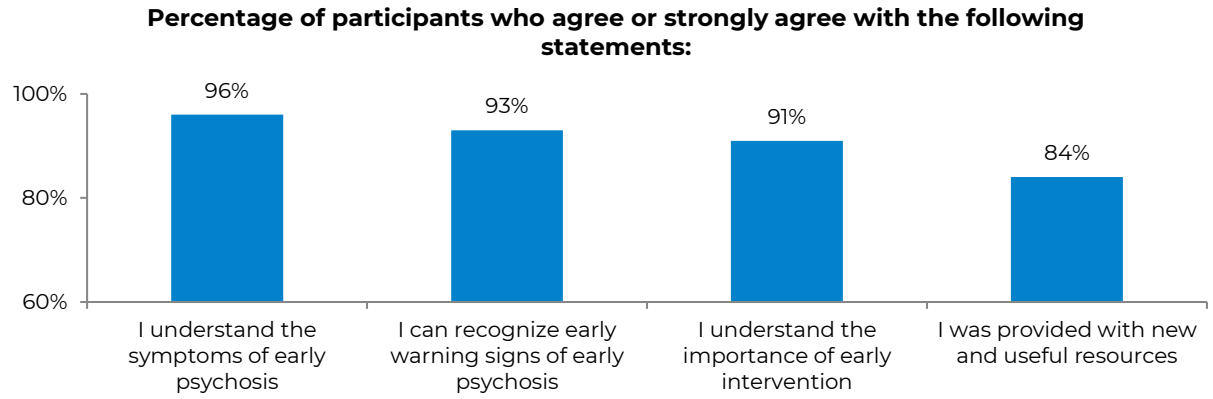
PROGRAM: Early Psychosis

HOW MUCH DID WE DO?

7
Workshops Held

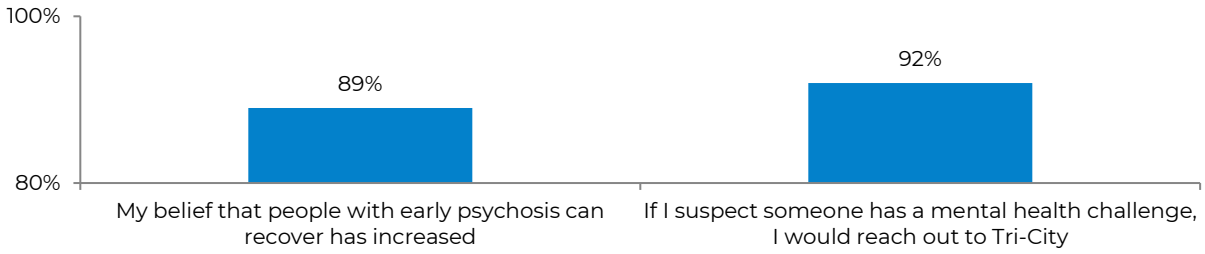
75
Participants

HOW WELL DID WE DO IT?



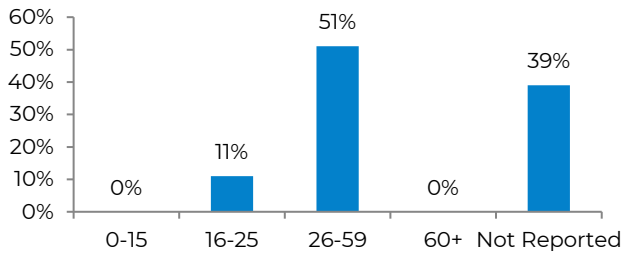
IS ANYONE BETTER OFF?

Percentage of participants who agree or strongly agree with the following statements:

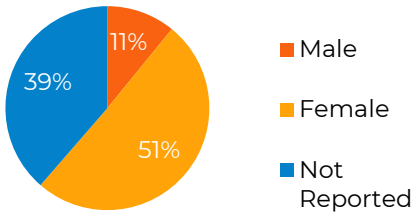


PEI Demographics

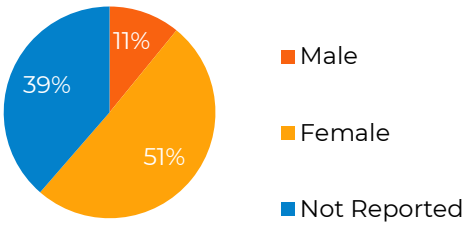
Age



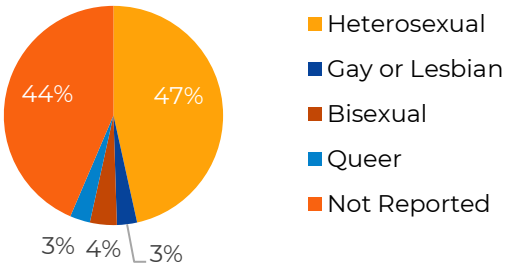
Gender at Birth



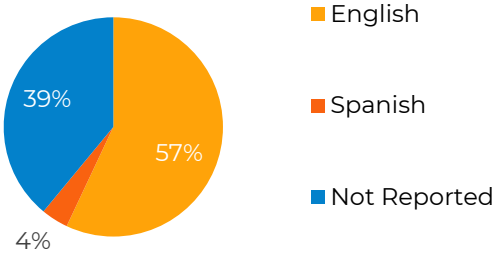
Gender Identity



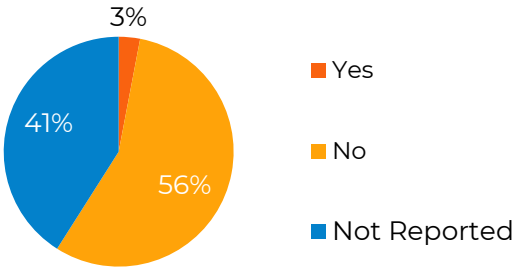
Sexual Orientation



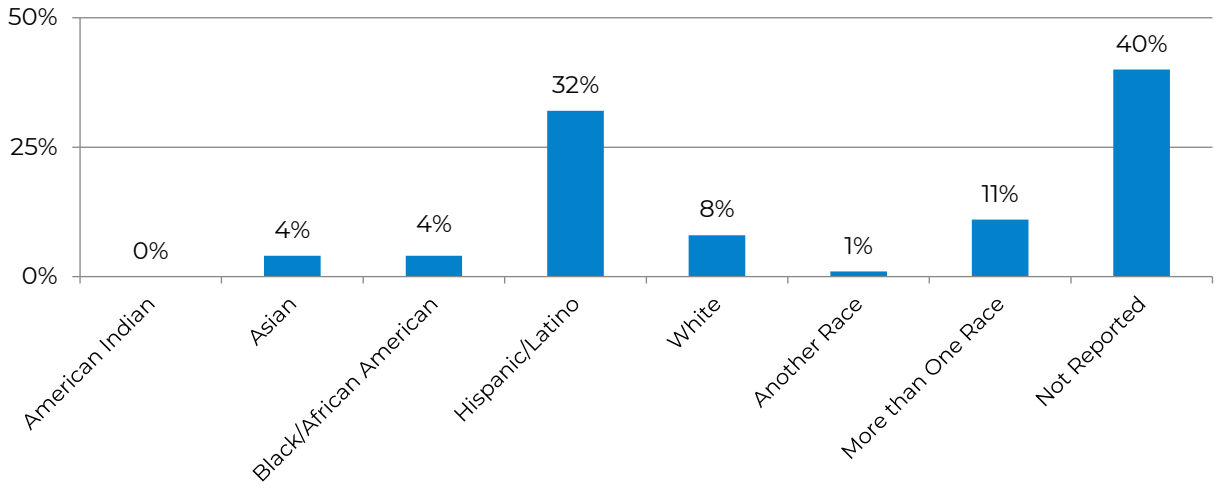
Language



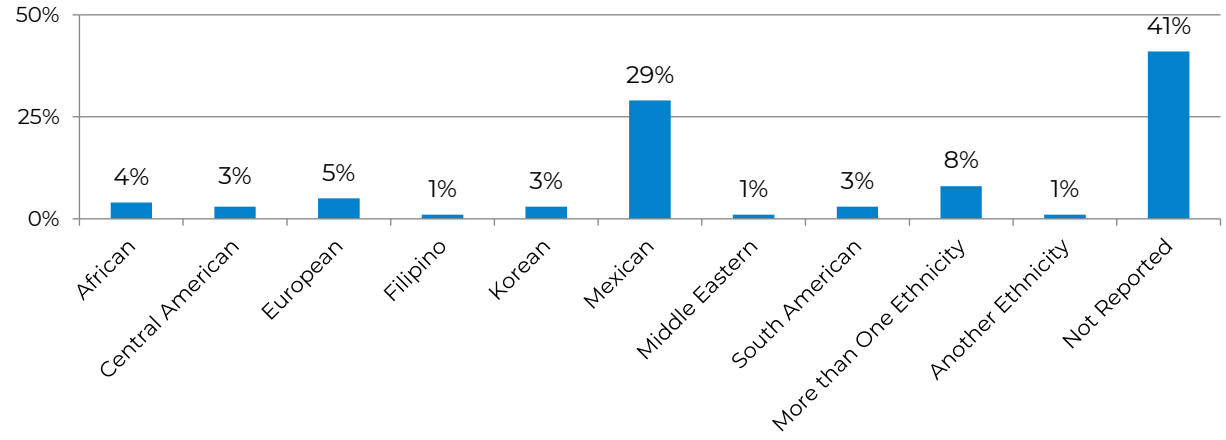
Military Veteran



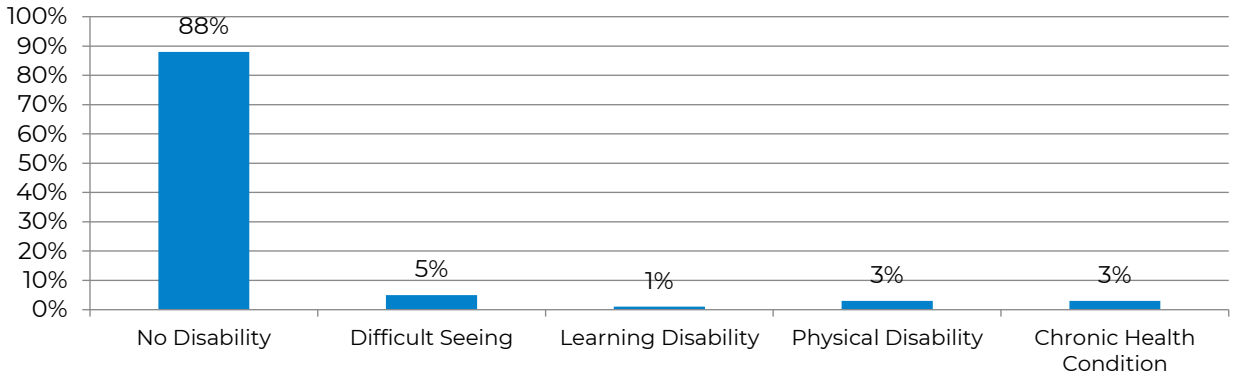
Race



Ethnicity



Disability



Number of Potential Responders	75
Setting in Which Responders were Engaged	Community
Type of Responders Engaged	Community members
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-age youth, older adults and those with a physical disability
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY

0
MHSA Referral to Early Psychosis

Innovation (INN)

Help@Hand Tech Suite Project

Innovation consists of short-term projects, one to five years, that explore novel efforts to strengthen aspects of the mental health system.

Help@Hand Tech Suite Project

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
MHSA Plan:	___ CSS	___ PEI	_X_ INN	___ WET	___: CFTN
Target Population:	___ 0-15	_X_ 16-25	___ 25-69	_X_ 60+	Other: Monolingual Speakers

Program Description

The primary purpose of this project is to increase access to mental health care by providing a non-traditional system for individuals who may be reluctant to access services through a more formal clinical setting. Through the use of computers, tablets and smartphones, community members will be able to access a suite of technology-based mental health services focused on prevention, early intervention, and family and social support with the intent to: decrease emergency care services; reduce psychiatric hospitalizations; and reduce the duration of untreated mental illness.

Help@Hand Tech Suite Project	
Projected Funding Amount	$1,674,700.00
Duration of INN Project	September 28, 2018 to June 30, 2021
Revised Project Dates	January 1, 2019 to January 1, 2024 Originally designed to be a three-year project, the Collaborative as a whole voted to extend the project to five years to allow adequate time to complete the implementation phase and learning goals for this project. No additional funds are requested or required at this time.

Target Population

- Transition age youth and college students (up to age 25) who are seeking peer support or who are interested in offering their support as trained peer listeners.
- Older adults (ages 60+) who lack transportation or are unable to access traditional services.
- Non-English speaking clients and community members who may be experiencing stigma and language barriers.

Program Update

Tri-City's initial concept of Help@Hand was to provide ways for clients to stay active in their personal wellness between appointments and for the greater community to have access to tools that promote mental wellbeing.

Now that we are in the midst of a global pandemic that encourages physical distancing as a means prevention, the technology that will be used by Help@Hand becomes even more essential. Tri-City is aware that this pandemic can be triggering for some individuals and can also contribute to isolation. The goal is to be able to use the different technologies in the suite of applications to provide support in this "new normal". There will be apps that clinicians can use with their clients in conjunction with individual treatment plans. There will also be apps to support those in isolation by providing a virtual community of connectedness.

The original Help@Hand/Tech Suite proposal highlighted the targeted groups of older adults, transition age youth, and monolingual Spanish speakers. It has now become clear that moving forward, this project will expand those target populations to encompass other populations that may also have been severely impacted by COVID-19.

During FY 2019-20, the Innovation Plan Coordinator position was filled following an extensive hiring search. In addition, local efforts include convening a focus group consisting of Wellness Advocates/Peers who were charged with reviewing potential applications for a future pilot program.

Milestones for FY 2019-20 include:

- A focus group comprised of Wellness Advocates, MHSA staff, and the IT consultant, participated in a product testing process.
- Through the collaboration, various wellness apps have made accessing their apps free for participating counties/agencies and Tri-City has been taking advantage of the opportunity by providing the resources to staff and clients.
- CalMHSA created Digital Mental Health Literacy training videos and Tri-City will be utilizing the videos for clients and community members on-boarding.
- Tri-City continued to send useful wellness app information to our staff for self-care (and some client resources).
- Tri-City Wellness Advocates started planning for a Community Connections webinar to teach our clients and community members how to be safe online. They will be using the skills and information they acquired during the train-the-trainer session of the February Help@Hand Peer Summit.

Challenges and Solutions

In September 2019, Tri-City hired a new Innovation program coordinator after having this position vacant for an extended period of time. However, this project continued to move forward in collaboration with other counties who are a part of the Tech Suite project. A focus group was convened to review a potential application, WYSA, for a pilot project. Although this process proved promising, the pilot project was delayed due to COVID-19.

COVID-19 Response

The major impact of COVID 19 was the stalling of workgroups that were envisioned for the pilot process. Revisions to this plan included moving into virtual meetings and creating innovative ways to continue the outreach to potential participants. One of these creative virtual outreach efforts

included a community webinar hosted by Tri-City Wellness Advocates that focused on how to be safe online. Materials for this webinar were provided by Help@Hand, the Tech Suite Collaborative.

Cultural Approach

By providing an equally accessible way for individuals to access wellness, Help@Hand eliminates some of the traditional barriers to seeking service such as stigma, language and need for transportation. Additionally, as two of the primary populations designated for this project, there is a specific goal to create access and pay special attention to monolingual Spanish speakers and older adults.

Applications under consideration by Tri-City for this project will have the capacity for non-English language translation. In addition, training videos and outreach materials will be available in both English and Spanish to accommodate the primary populations residing in the Tri-City area.

Tech Suite/Help@Hand Collaboration Update (Provided by CalMHSA)

FY 2019-20 Overview

Help@Hand is a statewide Collaborative project that began in 2018 with fourteen Counties and Cities leveraging interactive technology-based mental health solutions to help shape the future and improve accessibility and outcomes to connect people with care across the state. Technology has many benefits, but there are also many challenges and questions. The participating Cities/Counties are at the forefront of innovation to understand how technology is introduced and works, within the public behavioral health system of care. This means Help@Hand is not one project, but many projects across multiple Cities and Counties. The Collaborative offers the benefit of a shared learning experience that increases choices for Counties/Cities, accelerates learning, and adds in cost sharing. The focus of Help@Hand remains on pursuing a shared vision and common goals. Change at the scale of this project necessitates a robust readiness and change management approach. The project team has focused on building in activities to address these areas for both the project team and the community.

Impact

During FY 2019-20, the Help@Hand project had many successes and challenges. Some of the most notable impacts of the project during this time were work with the Peer community and the Cities' and Counties' exploration of mental health products to find those that best fit the needs of their stakeholder community.

Peers

Peers identified and raised the need for Digital Mental Health Literacy (DMHL) to empower California communities to make informed decisions about how they engage with technology. Listening sessions were held by the Peer and Community Engagement Manager to gather topics that would facilitate understanding and adoption of technology. There were 20 Digital Mental Health Literacy discovery sessions held in eleven different Counties with over 300 stakeholders from June – November 2019. These sessions led to the development of a DMHL video series, and a DMHL Curriculum that includes smaller coaching sessions (Q1-Q3 '19 & '20). Additionally, there were two Peer Summits held, in May and September 2019, to support Collaboration of Peer Leads from across the state for project learning, connection, and problem solving (Q1 2019). Monthly Peer Collaboration meetings were held to serve as a space for Peers to connect and share County/City project updates.

Technology Exploration

In early 2020, after the results of the Request for Statement of Qualifications (RFSQ) were released, the collaborative cities and counties began engaging their community stakeholders and conducting focus groups to explore new technologies available to the project and receive additional feedback on products that would be a good fit for their communities.

Challenges and Solutions

There are many things to consider when integrating technology into existing systems of care. The Help@Hand Collaborative has addressed many challenges in this work. Some of the challenges experienced by the Collaborative during FY 19-20 include:

COVID-19 Response

The beginning of 2020 brought significant challenges to Help@Hand participating cities and counties due to the COVID-19 pandemic. Many Collaborative members' focus changed quickly in March 2020 as they were asked to respond to evolving pandemic response request and care needs in their local communities.

Rapid Response - The early months of the pandemic saw Cities and Counties challenged to understand how they could quickly leverage mental health technology to meet growing community needs. Help@Hand worked quickly to develop a streamlined approach that supported Cities and Counties in launching a technology to their respective communities in direct response to growing mental health needs related to quarantine and COVID-19. Each step of the technology selection, readiness and deployment process is essential. Therefore, the rapid response approach did not reduce or eliminate critical steps but streamlined them by working to establish common features and functionality with the vendors and reducing variation among Cities and Counties. This effort is ongoing.

See attached CalMHSA Support for City and County's MHSA Annual Report

Workforce Education and Training (WET)

The WET efforts focus on strengthening and supporting existing staff and caregivers through trainings while focusing on attracting new staff and volunteers to ensure future mental health personnel.

Workforce Education and Training (WET)

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
MHSA Plan:	___ CSS	___ PEI	___ INN	_X_ WET	____ CFTN
Target Population:	___ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:

Program Description

The Workforce Education and Training (WET) program is providing a learning environment for staff to take and facilitate trainings for their personal and professional development. Also, the program serves as a learning hub for students, peers and the community by providing service learning opportunities to gain experience in the mental health field.

Target Population

The population served is transition age youth (TAY) through older adults. The service-learner program is focused on high school and college students, peers, veterans, retirees and anyone who is interested in gaining experience in the mental health field.

Relias online courses completed by Tri-City staff for FY 2019-20	2,059
Number of Service-Learner hours logged for FY 2019-20	2,232
Number of Service-Learners hired by Tri-City staff for FY 2019-20	5

Program Update

In keeping with Tri-City's commitment to ensuring staff are sufficiently trained and educated to meet the needs of our clients, the Workforce Education and Training (WET) program offered trainings both online and in-person. In total, during Fiscal year 2019-2020, staff, volunteers, and interns participated in 2,255 online courses covering a variety of topics. Additionally, prior to COVID-19 restrictions, several trainings were provided in- person.

Notably, all staff were required to attend trainings related to Trauma Informed Care. All clinical staff were required to attend the Trauma Resiliency Model Training, and non-clinical staff were required to attend the Community Resiliency Model. These trainings provide practical tools to support a person who is reacting to trauma, and offers Tri-City staff a common language to address this critical issue faced by so many of Tri-City's clients. Additional trainings include Mental Health First Aid, Adverse Childhood Experiences (ACEs), and Motivational Interviewing.

Through the Southern California Regional Partnership, Tri-City offered a series of Trauma Focused trainings conducted by Dr. Gabriela Grant. Specific topics included Trauma Foundations, The Neurobiology of Trauma, Trauma and Eating Disorders, and Trauma and Disasters.

During FY 2019-2020, Service Learners (volunteers) contributed 768.15 hours towards Tri-City Mental Health's workforce (excluding peer mentors and summer camp volunteers). The WET department, in partnership with Tri-City's Prevention and Early Intervention's Peer Mentor Program, and others,

launched the Peer 2 Career program; a comprehensive training plan to help volunteers, and participants with lived experience to be better prepared for a career in community mental health.

Challenges and Solutions

The WET Supervisor resigned his position in August 2019, and the position was filled in October 2019. This change lead to some revisions in processes and roles for this position. The Communications Coordinator and Director of MHSA and Ethnic Services performed the duties of this position during the period of recruitment which ensured continuity of services and a smooth transition for the new supervisor.

COVID-19 Response

WET program staff are currently working from home in accordance with company policy and state regulations. Staff meetings are conducted via Ring Central. Because of the restrictions on gatherings, in- person trainings have been eliminated and focus is now exclusively on online trainings. Conducting trainings virtually offers unique challenges that are difficult to overcome. Previously, trainings included components of group work, large and small discussions, hands-on activities, etc. Our virtual platforms have enabled Tri-City Mental Health to incorporate many of these experiences into virtual trainings. However, hands-on activities remain a challenge, and group discussions are presumably less impactful.

Most trainings that were previously held live, have been converted to a virtual platform, when possible. Some in-person trainings that are dictated by agencies outside of Tri-City are unavailable at this time and will resume once it is feasible.

The Service-Learner program was significantly reduced. Many service learners volunteer at Tri-City as part of college course requirements, but that requirement has been lifted by many local colleges. Service Learners that continue to volunteer are working remotely. However, service learners are utilized less frequently because of the need to prioritize the safety of everyone.

The WET program staff also manages Tri-City's social media accounts, including Facebook, Instagram, Twitter, and LinkedIn. This has grown to be one of the primary methods of interacting with the public, and renewed effort has been made to offer new and relevant content across all social media platforms.

Cultural Approach

Tri-City's approach to social media images and content is meant to be inclusive of the diversity and culture reflective of our communities. Tri-City intentionally includes topics that appeal to a wide variety of experiences and present them in ways consistent with those differences.

Trainings for staff are often directly related to supporting clients that are diverse including supporting members of the LGBTQ+ communities.

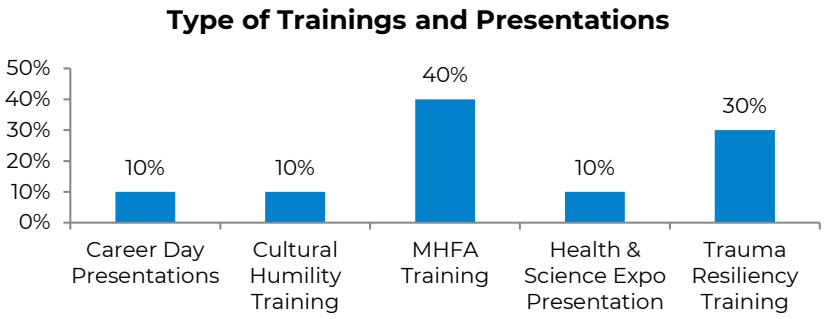
Both internal and external communications are offed in English and Spanish. Many Service-Learners are fluent in multiple languages and are able to include their cultural perspectives on the work they perform for Tri-City.

PROGRAM: Workforce Education and Training (WET)

HOW MUCH DID WE DO?

2,232	20	13
Service Learner Hours	Service Learner Applications	Clients Participated in the WISH Program

10
Trainings, Conferences and Educational Opportunities for Staff



HOW WELL DID WE DO IT?

21	5	2,255
Applicants Became Service Learners	Service Learners were Hired at Tri-City	Courses Completed by Staff Through the Relias Online Training

Capital Facilities and Technological Needs (CFTN)

The CFTN plan focuses on improvements to facilities, infrastructure and technology of the local mental health system.

Capital Facilities and Technological Needs

Status of Program:	___ New	_X_ Continuing	___ Modified	___ Discontinued	
MHSA Plan:	___ CSS	___ PEI	___ INN	___ WET	_X_ CFTN
Target Population:	_X_ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:

Program Description

Capital Facilities and Technological Needs provides funding for building projects, improving the infrastructure of mental health providers, and increasing technological capacity to improve the delivery of mental health services.

In keeping with key goals of MHSA to modernize and transform the mental health service system, Tri-City's Capital Facilities and Technological Needs (CFTN) Plan launched two strategic phases:

1. Supporting and empowering mental health service recipients and providers by creating greater access to technology, and establishing a higher level of program monitoring and outcome analysis. The technology portion of this plan launched an integrated information system with increased and upgraded infrastructure and modernized administrative and clinical processes such as clinical charts and billing systems.

2. Providing suitable space to accommodate Tri-City's growing MHSA workforce. Tri-City purchased an existing building consisting of multiple staff offices, a conference room and oversized meeting space. This refurbished building now provides a permanent location for Tri-City's expanding MHSA staff as well as a convenient place for hosting community stakeholder meetings.

Program Updates

On March 18, 2020, Tri-City Mental Health's Governing Board approved the expenditure of Capital Facilities and Technological Needs funds in the amount of $970,968.00 to make improvements for two TCMH locations. Although funding was already available in the CFTN Plan, as allocated by stakeholders in previous years, this project proposal outlines in greater detail how the funds will be spent.

Beginning with the MHSA building located at 2001 N. Garey Ave, Pomona, improvements will focus on upgrading the electrical infrastructure and will address the current outdated electrical system. In addition, this proposal will include redesigning and re-purposing existing meeting space to accommodate new offices to support the continued growth and expansion of MHSA personnel. The electrical upgrade and office space remodel located at 2001 N. Garey Ave, Pomona, 91767 is estimated to be in the amount of $509,208.00.

The second renovation will take place at the undeveloped garden located adjacent to the TCMH clinic at 2008 N. Garey Ave, Pomona. This garden will include concrete walkways, raised planting beds, complete ADA access, fencing, entry gate located on Garey Ave, benches, vegetable garden beds, planting, irrigation and shade pavilion with a sink and washing station and will also include a storage shed.

The capital improvements to the Therapeutic Community Garden located at 2008 N. Garey Ave., Pomona, 91767 is estimated to be in the amount of $461,760.00.

With the impact of the COVID –19 pandemic, the Facilities Department began looking at all office space, and updating floor plans, at each Tri-City site to ensure the 6 ft. social distancing requirement is enforced and to prepare for when staff return to work.

Cultural Competence Plan Update

Cultural Competence Plan Update

In July, 2010, Tri-City Mental Health developed a comprehensive Cultural Competence Plan based on criteria provided by the Office of Multicultural Services/Department of Mental Health. This plan provided TCMHA an opportunity to describe in great detail this agency's commitment to support the growth and development of racially and ethnically focused services with an emphasis on attempting to close the cultural disparity gap in mental health care offered within the three cities of Claremont, Pomona, and La Verne.

In December 2020, Tri-City prepared a Three-Year Cultural Competence Plan and thereby renewed its commitment to deliver quality and individualized care tailored to the social, cultural and linguistic needs of clients and community members residing within the catchment area. As a culturally proficient health care provider, Tri-City distinguishes itself as a leader in health care services focused on recovery with a person-centered approach.

Tri-City engaged with community members who contributed to the universal goals of reducing health care disparities and promote diversity within the agency and the community served. Through the development of active partnerships with advisory councils including the Cultural Inclusion and Diversity Committee (CIDC), the African American Family Wellness Advisory Council (AAFWAC), ¡Adelante! Latinx Wellness Advisory Council and the LGBTQ+ Advisory Council, Tri-City is able to address challenges related to accessing services including language barriers, health education and cultural differences in communication styles.

Tri-City Advisory Councils

The following advisory councils demonstrate Tri-City's new initiatives and focuses on leadership and delivery of culturally relevant services dedicated to the undisputable call for health care equity.

Cultural Inclusion and Diversity Committee (CIDC)

Tri-City Mental Health's (Tri-City) Cultural Inclusion and Diversity Committee (CIDC) is committed to the advancement of quality mental health services that are culturally compatible and respectful of the diverse healthcare beliefs of the people we serve. It is the mission of this Cultural Inclusion and Diversity Committee to guide and support the staff of Tri-City to ensure cultural and linguistically appropriate programs and services are available for community members residing in the cities of Claremont, Pomona and La Verne.

African American Family Wellness Advisory Council (AAFWAC)

The African American Family Wellness Advisory Council (AAFWAC) was established in December 2019. As a result, this advisory council and its goals are still in the early development stages. Its primary goal is to nurture hope and wellness within the African American community through mental health advocacy and treatment referral.

¡Adelante! Latinx Wellness Advisory Council

¡Adelante! Latinx Wellness Advisory Council was established in September 2020. As a result, this advisory council and its goals are still in the early development stages. Its primary goal is to instill

hope and wellness by empowering community members within the Latinx community to advocate and share their experience, knowledge and feedback.

LGBTQ+ Wellness Advisory Council

The LGBTQ+ Wellness Advisory Council was established in September 2020. As a result, this advisory council and its goals are still in the early development stages. Its primary goal is to give a voice to LGBTQ+ communities by empowering members to advocate and share their experience, knowledge and feedback.

Asian American and Pacific Islander (AAPI) and Native Indigenous Communities

Asian American and Pacific Islanders (AAPI) and Native Indigenous communities have also been identified as unserved and underserved populations in the Tri-City service area. Over the next three years, the CIDC plans to outreach and engage with these communities to develop advisory councils, with the intention to empower members to advocate their community's mental health needs and bridge gaps in delivery and access to services.

Plan Update

As mental healthcare professionals, Tri-City is committed not only to developing strong clinical skills but to ensure each individual who represents this agency values diversity and is competent to understand and respond to cultural differences with each client. This commitment includes participation in cultural inclusive groups that contribute to the delivery of culturally and linguistically inclusive services.

Below is a list of activities/trainings/meetings which occurred during FY 2019-20.

Summary of Cultural Competence Activities During FY 2019-20		
Date	**Name of Activity, Meeting or Training**	**Type of Activitity**
07/11/2019	Cultural Inclusion and Diversity Committee Meeting	Meeting
07/25/2019	**Enhancing Cultural Humility** Jonathan Martines, PhD, CSUN	Staff Training
07/30/2019	Community Inclusion, Diversity and Wellness Fair	Community Event
08/05/2019	**Improving Behavioral Health for Latino Population** Webinar	Staff Training
08/15/2019	Cultural Inclusion and Diversity Committee Meeting	Meeting
09/04/2019	**Latinx Intersectionality: Strength, Power & Change** 2019 Latino Mental Health Conference California Endowment Center, Los Angeles	Staff Training
09/12/2019	Cultural Inclusion and Diversity Committee Meeting	Meeting

09/18/2019	**Latino and Hispanic Heritage Celebration** Staff Video	Staff Activity for Community
10/02/2019	**Allies Ally Advocacy Training** Dr. D M Hunter	Staff Training
10/07/2019	**Family History Month Toolkit** E-Newsletter	Staff Education & Awareness
10/10/2019	Cultural Inclusion and Diversity Committee Meeting	Meeting
10/31/2019	**Tri-City Fall Harvest Festival** CIDC Cultural Booth	Community Event for Clients and Consumers
11/08/2019	**Honoring Our Veterans** Veterans Day Staff Video	Staff Education & Awareness
11/14/2019	Cultural Inclusion and Diversity Committee Meeting	Meeting
12/09/2019	**Overcoming the Holiday Blues** Self-Care E Newsletter for Staff and Clients	Staff and Community Education & Awareness
01/04/2020	January/February CIDC Staff Newsletter	Staff Education & Awareness
01/09/2020	Cultural Inclusion and Diversity Committee Meeting	Meeting
01/14/2020	CIDC Presentation Tri-City Mental Health Commission	Meeting
02/13/2020	Cultural Inclusion and Diversity Committee Meeting	Meeting
02/20/2020	**African American Heritage** Lunch & Learn	Staff Training & Education
03/26/2020	**COVID-19 Resource and Support Guide** Website Resource Page	Community Awareness
03/26/2020	**The Impact of COVID-19 on the LGBTQ+ Community** Webinar by the National Coalition LGBT Health	Staff Training
05/04/2020	**Working with Older Adults During COVID-19** City of Pomona, Neighborhood Services Department Presented by Tri-City Mental Health	Community Training
05/14/2020	Cultural Inclusion and Diversity Committee Meeting	Meeting
05/21/2020	**AAPI & Mental Health Infographic and Resources** Asian American and Pacific Islander (AAPI) Heritage Month	Staff Education & Awareness
05/21/2020	**Countering Stigma During May Mental Health Month** Advertorial in La Nueva Voz Pomona Newspaper	Community Awareness

05/27/2020	**Lessons from the Past:** **Yellow Peril and COVID-19 Times Webinar** The Japanese American Citizens League, The Asian American Psychological Association, The South East Asian Resource Center, The National Council of Asian Pacific Americans, and The Heart Mountain Wyoming Foundation	Staff Education & Awareness
06/08/2020	**Maintaining Positive Emotions During Tough Times** Tri-City Mental Health Webinar Tri-City's African American Family Wellness Advisory Council (AAFWAC) with presenter, Dr. Gloria Morrow	Staff and Community Education & Awareness
06/11/2020	Cultural Inclusion and Diversity Committee Meeting	Meeting
06/24/2020	**The ABC's of LGBTQ+** Tri-City Mental Health Webinar	Staff and Community Education & Awareness
06/11/2020	**LGBTQ+ Mental Health Resources Newsletter** LGBTQ+ Pride Month	Staff Education & Awareness

MHSA Expenditure Plan

MHSA Expenditure Plan

Cost Per Participant Summary

The services provided in Fiscal Year 2019-20 by age group, number of clients served, and average cost per person are summarized in the table below per the guidelines for this Annual Update:

Summary of MHSA Programs Serving Children, Including TAY			
Program Name	**Type of Program**	**Unique Clients Served**	**Cost Per Person**
Full Service Partnership (Child)	CSS	106	$11,913
Full Service Partnership (TAY)	CSS	147	$12,338
Community Navigators	CSS	229	$234**
Wellness Center	CSS	522	$727**
Supplemental Crisis Services	CSS	238	$636**
Family Wellbeing Program	Prevention	559	$71**
Peer Mentor Program (TAY Wellbeing)	Prevention and Early Intervention	541	$109
Therapeutic Community Gardening	Early Intervention	19	$3,316**

Summary of MHSA Programs Serving Adults and Older Adults, Including TAY			
Program Name	**Type of Program**	**Unique Clients Served**	**Cost Per Person**
Full Service Partnership (TAY)	CSS	147	$12,338
Full Service Partnership (Adult)	CSS	317	$11,623
Full Service Partnership (Older Adult)	CSS	66	$8,232
Community Navigators	CSS	1,516	$234**
Wellness Center	CSS	1,615	$727**

Supplemental Crisis Services	CSS	1,093	$636**
Field Capable Clinical Services for Older Adults	CSS	26	$2,526
Family Wellbeing Program	Prevention	885	$71**
Peer Mentor Program (Older Adult Wellbeing)	Prevention and Early Intervention	1,053	$119
Therapeutic Community Gardening	Early Intervention	71	$3,316**

**** These programs do not collect costs by client age group; therefore, these cost amounts reflect the average cost per client served for all age groups combined.**

In FY 2019-20, Tri-City served approximately 2,823 unduplicated clients who were enrolled in formal services. Tri-City currently has 190full-time and 20 part-time employees and an annual operating budget of 28.1 million dollars. Tri-City strives to reflect the diversity of its communities through it hiring, language spoken, and cultural competencies.

Regarding shortages in personnel, the most difficult to fill positions are Clinical Therapists and Clinical Supervisors. The most difficult to retain position is Clinical Therapist. Below is a list of current open positions.

Position	Full-Time Equivalent (FTE)	Department
Accountant	1	Finance
Clinical Supervisor I	2	Child & Family Outpatient (COP)/ School-Based Team
Clinical Therapist I/II	3	Adult FSP
Clinical Therapist I/II	3	Adult Outpatient (AOP)
Clinical Therapist I/II	1	TAY FSP
Clinical Therapist I/II	2	Child & Family Outpatient (COP)
Clinical Therapist I/II	1	Child & Family Outpatient (COP) School Partnership Program (SPT)
Mental Health Specialist	3	Adult FSP
Community Navigator I/II	2	MHSA
Program Support Assistant II	1	Medical Records
Psychiatric Technician I/II/III	2	Crisis Support

FY 2021/22 Mental Health Services Act Annual Update
Funding Summary

County: **TRI-CITY MENTAL HEALTH AUTHORITY** Date: 4/9/21

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2021/22 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	12,756,841	2,231,564	2,139,830	241,051	1,262,404	
2. Estimated New FY 2021/22 Funding	9,557,444	2,389,361	628,779			
3. Transfer in FY 2021/22[a/]	0	0	0	0	0	0
4. Access Local Prudent Reserve in FY 2021/22	0	0				0
5. Estimated Available Funding for FY 2021/22	22,314,285	4,620,925	2,768,609	241,051	1,262,404	
B. Estimated FY 2021/22 MHSA Expenditures	9,210,946	2,355,742	304,266	214,083	961,968	
G. Estimated FY 2021/22 Unspent Fund Balance	13,103,339	2,265,183	2,464,343	26,968	300,436	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2021	2,352,603
2. Contributions to the Local Prudent Reserve in FY 2021/22	16,604
3. Distributions from the Local Prudent Reserve in FY 2021/22	0
4. Estimated Local Prudent Reserve Balance on June 30, 2022	2,369,207

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

FY 2021/22 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: **TRI-CITY MENTAL HEALTH AUTHORITY** Date: 4/9/21

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. 1a-Child FSP	1,312,498	463,267	424,616		424,616	
2. 1b-TAY FSP	1,986,864	1,030,522	658,725		297,617	
3. 1c-Adult FSP	3,314,495	2,011,087	1,303,407			
4. 1d-Older Adult FSP	431,488	335,663	95,825			
Non-FSP Programs						
1. Community Navigators	477,822	477,822				
2. Wellness Center	1,273,080	1,273,080				
3. Supplemental Crisis Services	723,947	723,947				
4. Field Capable Clinical Services for Older Adults	111,392	111,392				
5. Permanent Supportive Housing	362,927	307,927				55,000
CSS Administration	3,035,119	2,476,239	432,695		126,184	
CSS MHSA Housing Program Assigned Funds	0	0				
Total CSS Program Estimated Expenditures	13,029,631	9,210,946	2,915,268	0	848,417	55,000
FSP Programs as Percent of Total	76.5%					

FY 2021/22 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: **TRI-CITY MENTAL HEALTH AUTHORITY** Date: 4/9/21

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Family Wellbeing	95,261	95,261				
2. Older Adult Wellbeing (Peer Mentor)	79,313	79,313				
3. Transition-Age Youth Wellbeing (Peer Mentor)	74,641	74,641				
4. Community Capacity Building (Community Wellbeing, Stigma Reduction and Suicide Prevention, and Community Mental Health Training)	520,882	520,882				
5. NAMI Community Capacity Building Program (Ending the Silence)	35,500	35,500				
6. Housing Stability Program	206,875	206,875				
PEI Programs - Early Intervention						
7. Older Adult Wellbeing (Peer Mentor)	79,313	79,313				
8. Transition-Age Youth Wellbeing (Peer Mentor)	74,641	74,641				
9. Therapeutic Community Gardening	333,150	333,150				
10. Early Psychosis	207,399	207,399				
PEI Programs - Other						
11.	0	0				
12.	0	0				
13.	0	0				
PEI Administration	606,767	606,767				
PEI Assigned Funds	42,000	42,000				
Total PEI Program Estimated Expenditures	2,313,742	2,355,742	0	0	0	0

FY 2021/22 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: **TRI-CITY MENTAL HEALTH AUTHORITY** Date: 4/9/21

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Help @ Hand	304,266	304,266				
2.	0	0				
3.	0	0				
4.	0	0				
INN Administration	0	0				
Total INN Program Estimated Expenditures	304,266	304,266	0	0	0	0

FY 2021/22 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: **TRI-CITY MENTAL HEALTH AUTHORITY** Date: 4/9/21

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. A Systematic Approach to Learning and Improvement	109,934	109,934				
2. Engaging Volunteers and Future Employees	34,836	34,836				
WET Administration	69,313	69,313				
Total WET Program Estimated Expenditures	214,083	214,083	0	0	0	0

FY 2021/22 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: **TRI-CITY MENTAL HEALTH AUTHORITY** Date: 4/9/21

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Electrical Upgrade & Office Space Remodel	504,208	504,208				
2. Capital Improvements to Therapeutic Community Garden	457,760	457,760				
CFTN Programs - Technological Needs Projects						
3.	0	0				
4.	0	0				
5.	0	0				
CFTN Administration	0	0				
Total CFTN Program Estimated Expenditures	961,968	961,968	0	0	0	0

Appendix

Prevention and Early Intervention Annual Report FY 2019-20

PREVENTION AND EARLY INTERVENTION ANNUAL REPORT JUNE 2021

TABLE OF CONTENTS

To: Mental Health Services Oversight and Accountability Commission

Subject: MHSA Three-Year Prevention and Early Intervention Evaluation Report

This report is prepared in compliance with California Code of Regulations, Title 9, Section 3560.010(2)(1), Prevention and Early Intervention Program and Evaluation Report.

Tri-City Mental Health Authority (TCMHA) was created in 1960 as a result of a Joint Powers Authority adopted by the cities of Claremont, La Verne, and Pomona. TCMHA and the city of Berkley are the only cities in California considered a "county" and serve as the mental health authority, although not the mental health plan, for a specific area.

Tri-City Mental Health engaged in a robust stakeholder and community planning process beginning in September of 2021. A total of three stakeholder meetings were held in addition to a stakeholder workgroup dedicated to the review of the PEI programs. During this time, participants received updates as well as the opportunity to provide feedback, make suggestions and recommend changes for consideration by Tri-City staff.

The following report is contained in Tri-City's Annual Update for FY 2021-22 and was posted for a 30-day public review and comment period from May 7, 2021 to June 8, 2021. The MHSA Public Hearing was held on June 8, 2021 and hosted by Tri-City's Mental Health Commission. At that time, the Mental Health Commission recommended approval of the MHSA Annual Update for FY 2021-22. The Tri-City Governing Board acted on this recommendation and adopted the Annual Update for FY 2021-22 on June 16, 2021.

With this timeline in mind, we respectfully submit the following information, vetted through our community planning process, and pending approval by TCMHA's Governing Board.

Prevention and Early Intervention program information and data for FY 2019-20
Prevention and Early Intervention Regulation Data Reporting Status

Please feel free to contact me with any questions.

Regards,

Rimmi Hundal
Director of MHSA and Ethnic Services
Tri-City Mental Health Services
(909) 326-4626
rhundal@tricitymhs.org

Prevention and Early Intervention Programs

Community Capacity Building

Community Wellbeing Program

Status of Program:	___New	_X_ Continuing	___Modified	___Discontinued	
Target Population:	_X_ 0-15	_X_ 16-25	___25-69	___60+	Other:
Type of Program:	_X_ Prevention	___Early Intervention	___Prevention and Early Intervention		

Program Description

The program provides small grants up to $10,000 and technical assistance to help communities build their capacity to strengthen the wellbeing of their members and the community as a whole. The program focuses on providing support to communities at greater risk for mental illness.

Target Population

Local communities (defined as a group of individuals who rely on each other for support and can act together) who are interested in building their own capacity to strengthen the wellbeing of their members.

Age Groups	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+
Number Served FY 2019-20	2,794	59	59	29

Program Update

The Community Wellbeing Grant program awarded 11 grants in FY 2019-20. These grantees represent 2,941 individuals and the following agencies and organizations: City of Pomona After School Recreation, Claremont Unified School District, Gente Organizada, Kennedy Austin Foundation, NAMI African American Parents, NAMI Padres Efectivos, Newcomers Access Center, Parkside Boys and Girls Club, Simons Middle School, STEM Club City of Knowledge and The Greener STEMs Club. Programs offered through this groups include afterschool learning activities, tutoring, gardening, parenting classes, support groups, public speaking skills, STEM clubs, that improved the wellbeing of their communities.

Challenges and Solutions

There were not significant challenges for this program in FY 2019-20. One notable change was the transition of the Community Capacity Organizer to another position. However, this position was quickly filled and the grant process continued seamlessly and with continued support.

COVID-19 Response

As with other MHSA programing, the Community Wellbeing Grant program was moved to a virtual platform with staff working remotely. Meetings that previously took place in person were now conducted through RingCentral.

Beginning with the onset of COVID 19, all grantees were required to make modifications to their projects. Participants identified how their communities were impacted by the pandemic and how these modifications would be implemented. All correspondence and communication were handled through RingCentral, phone calls and emails.

When preparing for the next round of grants, the CWB staff modified their application and interview process to comply with local, state and federal guidelines regarding COVID-19. This included conducting all application reviews and participant interviews via RingCentral. Future protocol for this program will continue as stated until the COVID 19 restrictions are lifted.

Cultural Approach

The Community Wellbeing Program collaborates with an array of grantees that provide services to the underserved and unserved communities. These grantees also network and collaborate with each other to continue to provide services to these communities. In addition, staff continue to outreach and network with local agencies who focus on providing services to the underserved and unserved communities.

In response to addressing barriers to service; grantees are notified via email of any upcoming Tri-City programs, services, webinars, community connections webinars, mental health trainings that address these barriers. Grantees are encouraged to spread the word within their communities so they can participate in any of these educational opportunities.

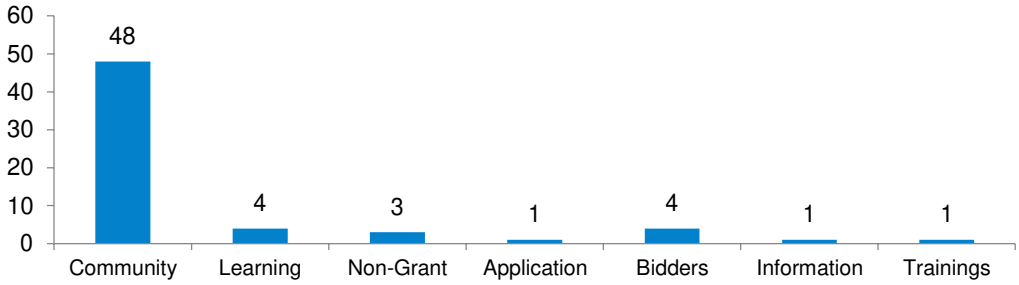
The Community Capacity Organizer for this program is bilingual and able to communicate effectively in both English and Spanish. In addition, all flyers, brochures, grant applications, and supporting documents are available in both English and Spanish.

PROGRAM: Community Wellbeing Program (CWB)

HOW MUCH DID WE DO?

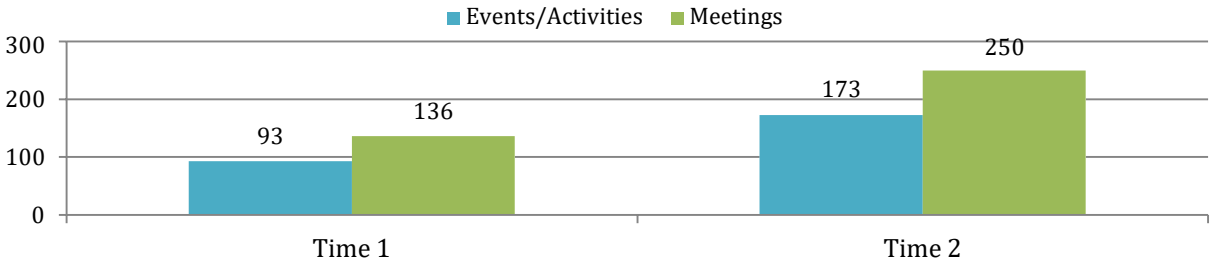
11 Community Grantees Chosen	2,941 Community Members Represented in 10 out of 11 Grantees	1,781 Number of People Who Benefited from Grantee Activities from 10 out of 11 Grantees

Number of Events Held by Community Capacity Organizer



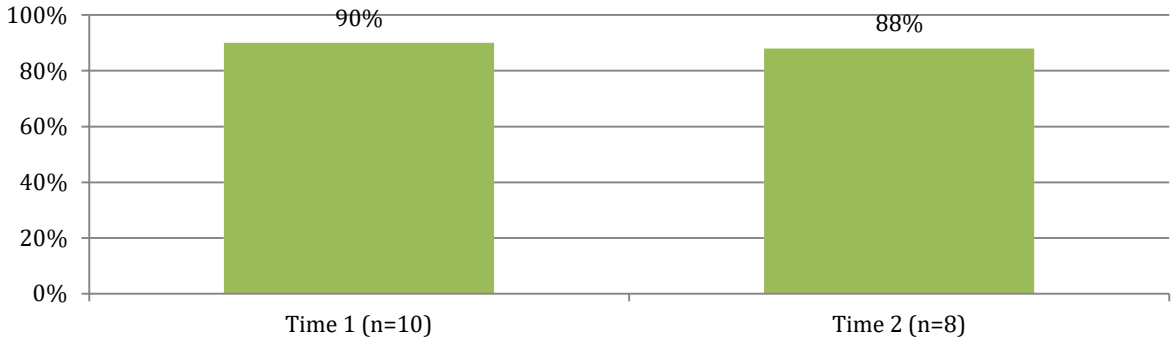
389
Attendees

Number of Community Events/Activities and Meetings

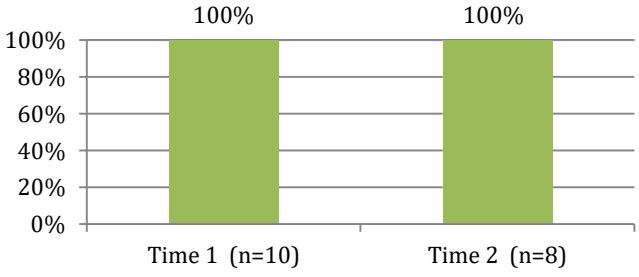


HOW WELL DID WE DO IT?

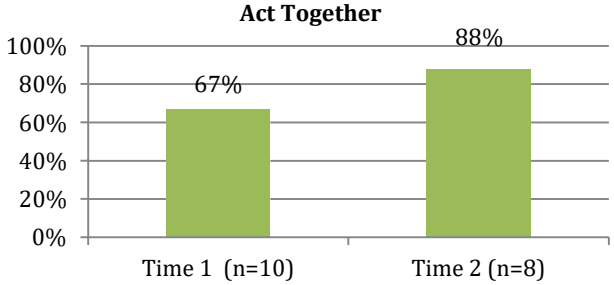
Percentage of Grantees who Report How Successful Their Community's Activities were:



Percentage of Grantees Who Report Improvement in Supporting Each Other

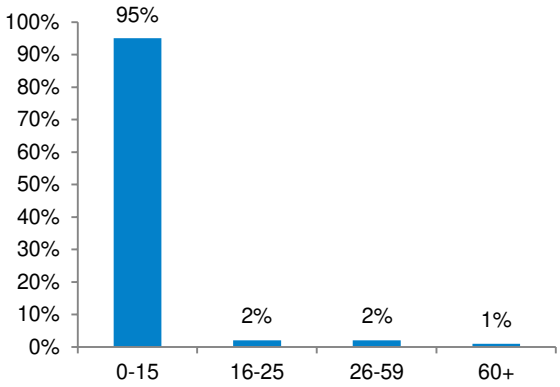


Percentage of Grantees Who Report Improvement in Their Ability to Effectively Act Together

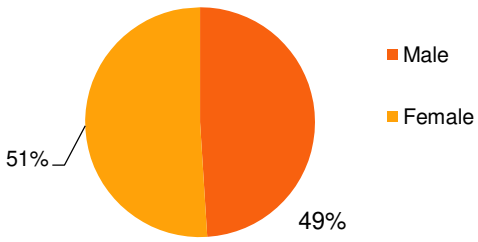


PEI DEMOGRAPHICS

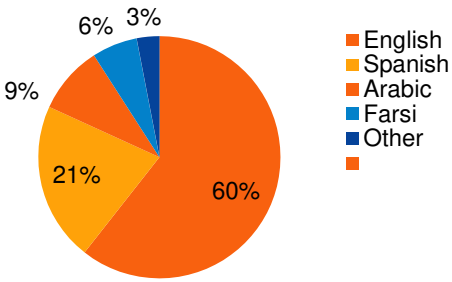
Age



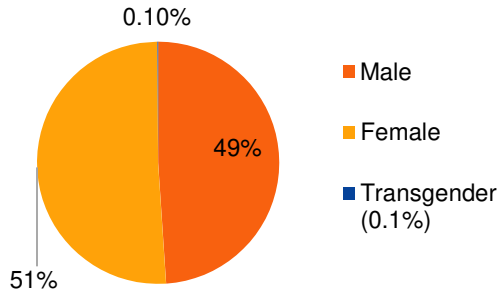
Assigned Gender at Birth



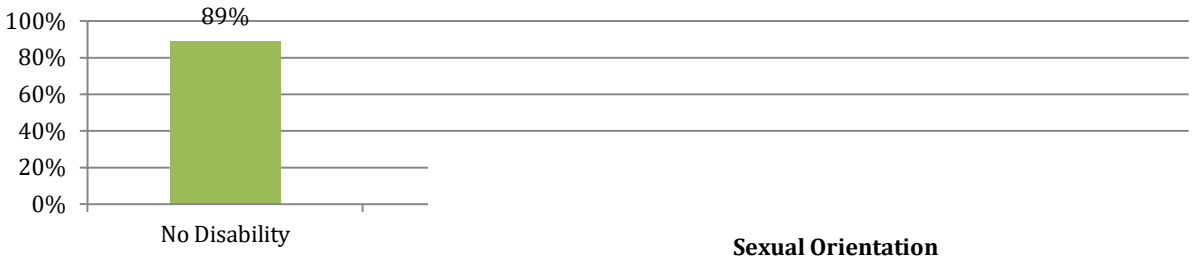
Primary Language



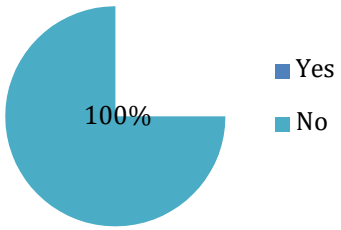
Gender Identity



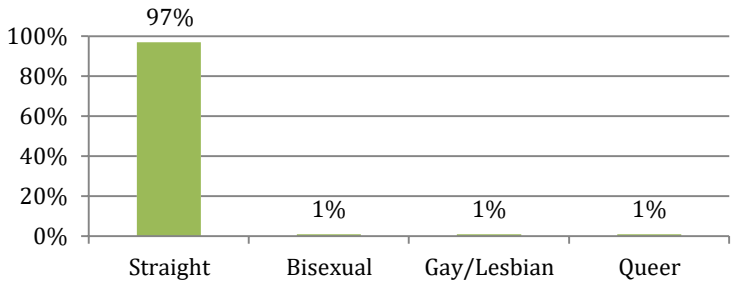
Disability



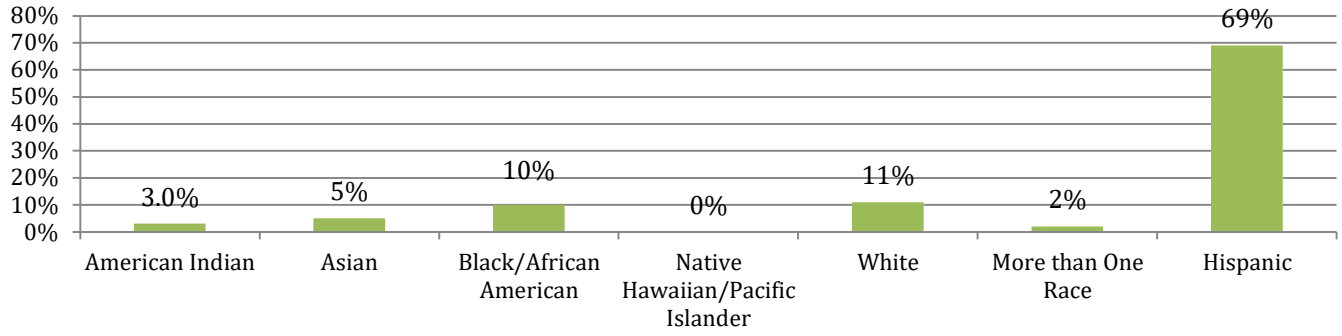
Military Veteran



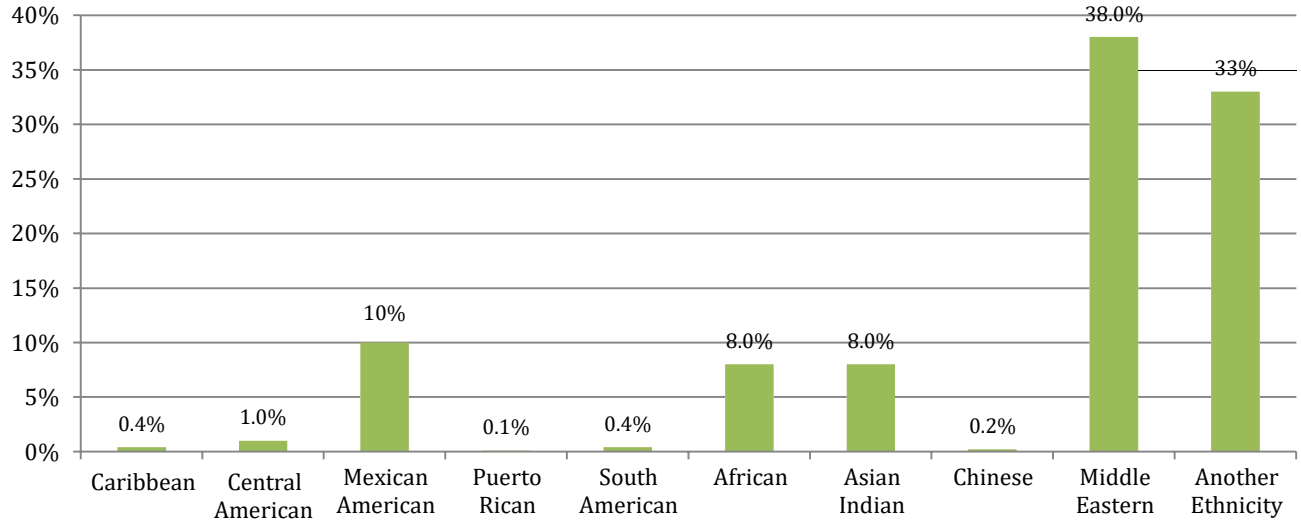
Sexual Orientation



Race



Ethnicity

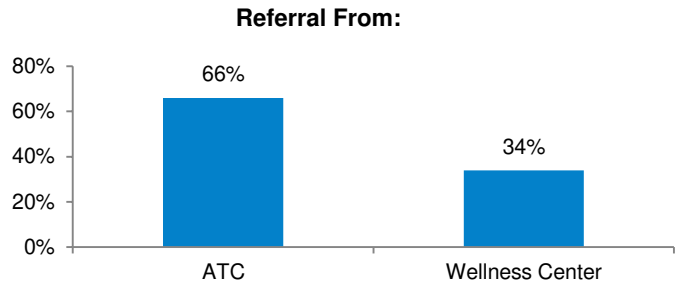


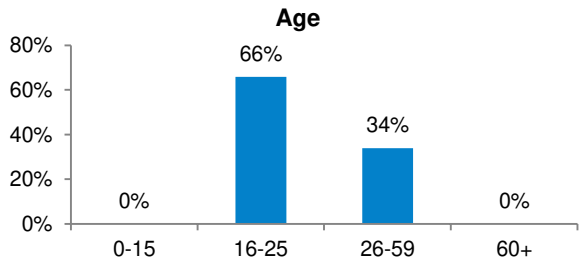
Number of Potential Responders	2,941
Setting in Which Responders were Engaged	Community, Schools, Health Centers, Workplace and Outdoors
Type of Responders Engaged	TAY, teachers, LGBTQ+, families, religious leaders, and those with lived experience
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

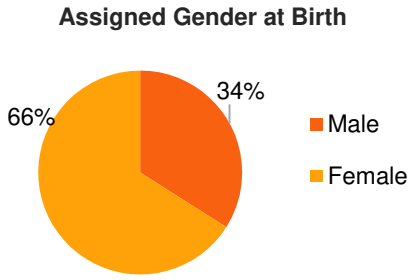
TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY:

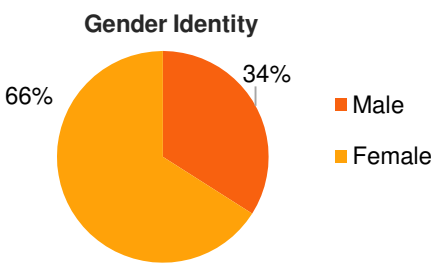
PEI Demographics Based on MHSA Referrals

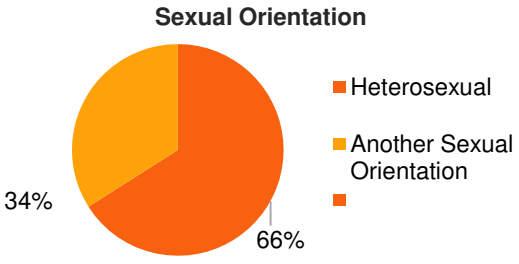
3
MHSA Referrals to Community Wellbeing Program

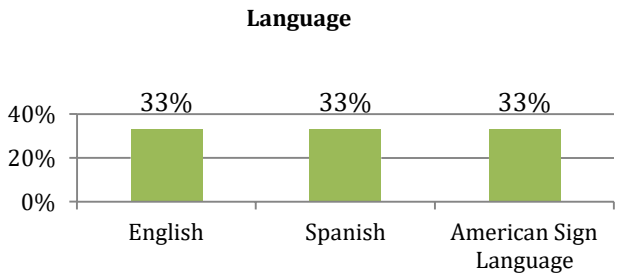


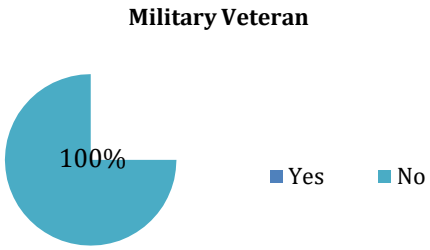


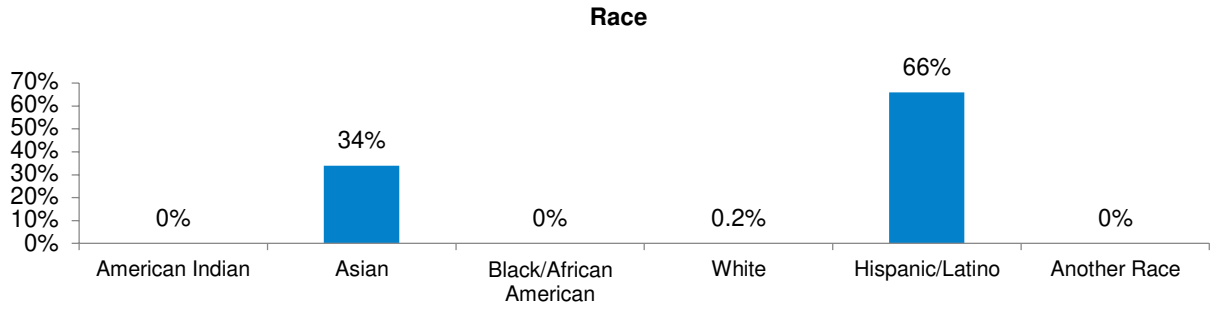


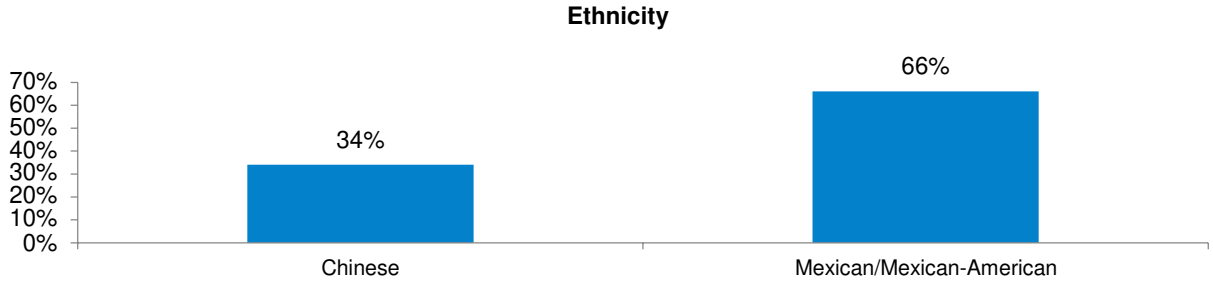


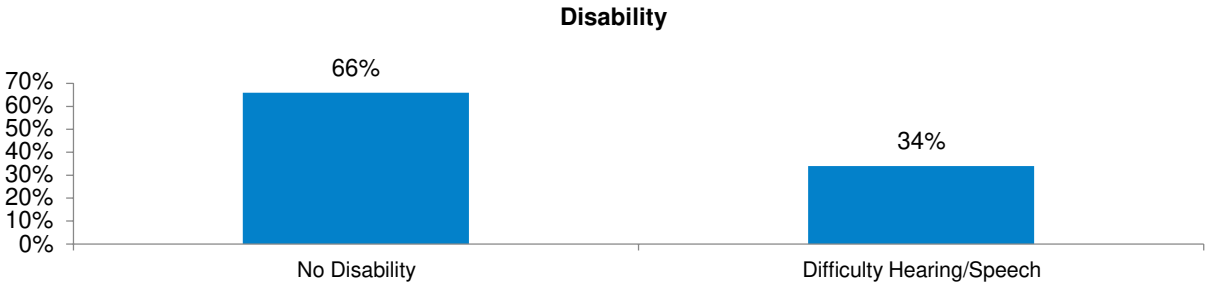



Language
40%
20%
0%
33%
33%
33%
English
Spanish
American Sign Language


Military Veteran
100%
Yes
No


Race
70%
60%
50%
40%
30%
20%
10%
0%
0%
34%
0%
0.2%
66%
0%
American Indian
Asian
Black/African American
White
Hispanic/Latino
Another Race


Ethnicity
70%
60%
50%
40%
30%
20%
10%
0%
34%
66%
Chinese
Mexican/Mexican-American


Disability
70%
60%
50%
40%
30%
20%
10%
0%
66%
34%
No Disability
Difficulty Hearing/Speech

Community Mental Health Trainings

Status of Program:	___New	_X_ Continuing	___Modified	___Discontinued	
Target Population:	___0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:
Type of Program:	_X_ Prevention	___Early Intervention	___Prevention and Early Intervention		

Program Description

Community Mental Health Trainers offer free group trainings including Mental Health First Aid (MHFA), Adverse Childhood Experiences [ACE], Community Resiliency Model [CRM], Motivational Interviewing [MI], and Everyday Mental Health [EMH] as well as workshops based on the Recovery Model, Non-Suicidal Self-Harm and parenting classes. Since the onset of COVID-19, these trainings are now offered virtually.

Target Population

Tri-City staff, community members, local schools and agencies who are interested in learning how to recognize the early warning signs of mental illness and appropriately intervene to provide support.

Community Mental Health Trainings FY 2019-20	54
Individuals Trained	940

Program Update

The Community Mental Health Trainings continue to be a popular program within the tri-city area. The extensive menu of training options, and the flexibility of Tri-City's staff in adapting trainings to their audiences, has allowed this program to expand the type of trainings offered.
In July 2019, Pomona Unified School District (PUSD) asked Tri-City to host a series of mental health and wellness workshops for PUSD summer students and exchange students from China. Claremont Graduate University's Social Work Program, in collaboration with Western Colleges' Nursing Program requested a series of Tri-City trainings on Adverse Childhood Experiences [ACE], Community Resiliency Model [CRM], Motivational Interviewing [MI], and Everyday Mental Health [EMH] to graduate students in each of their programs. Western University invited Tri-City to provide an ACES presentation to over 100 of their medical students from their Pomona campus and a satellite campus in Oregon virtually ACEs Aware Grant.

Challenges and Solutions

With this growing popularity, it became clear that a dedicated program staff/trainer was needed to oversee this essential program. A second challenge was the limited curriculum available in Spanish in addition to the lack of a bilingual trainers. These issues were addressed and resolved when this position was filled in July 2020.

COVID-19 Response

As with all MHSA programing, staff began working remotely with all communication conducted through RingCentral, email and/or by phone. Similar to staff, all communication with community partners were managed through phone/email.

As expected, all scheduled events, trainings, and programs had to be canceled due to physical/social distancing requirements without the ability to reschedule. Instead, communication focused on providing resources, information, updates, and virtual webinars regarding COVID-19.

COVID-19 significantly impacted the ability to immediately provide the same level of trainings as prior to the pandemic. Access to a virtual platform and the modification to the "in-person" trainings took time to execute. Many community partners did not have a virtual platform in place in order to receive the training virtually. In addition, the pandemic caused many community partners to shut down which limited communication for a significant period of time, including local school districts and colleges who were busy transitioning to a virtual learning environment with very little notice or preparation.

As of April 2020, all community trainings were offered virtually through the RingCentral Webinar platform. CMHT began providing weekly webinars on topics that were already a part of Tri-City's training series. Notification of these trainings were posted on Tri-City's webpage, social media accounts, and emails.

Cultural Approach

Prior to COVID-19, Community Mental Health trainers (CMHT) were able to address cultural barriers through in-person connections with under/unserved communities and by building relationships with organization that work, serve, and support these communities, by providing information, services, and trainings.

By working closely with Tri-City's Stigma Reduction Program, CMHTs share information on how to reduce stigma that impacts community partners from seeking, accessing, and utilizing services. By reaching out to organizations to set-up trainings, share information, and educate them on what mental illness/wellness is, it's impact, and accessible services, staff are able to share resources available to help prevent and support someone who's experiencing a mental health challenge.

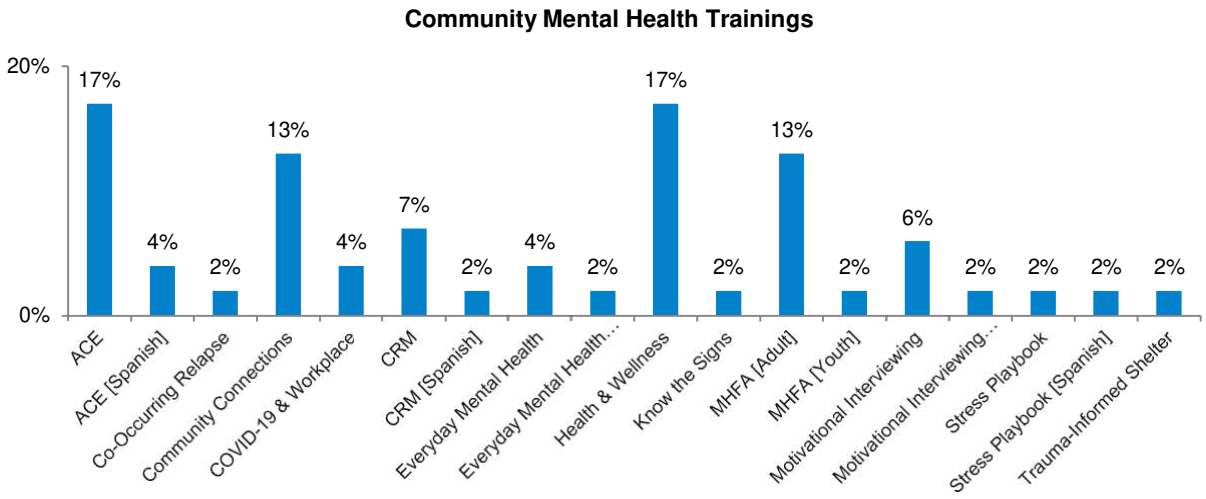
Tri-City has hired a bilingual/Spanish full-time program staff to provide trainings in Spanish. Trainings and webinars will be available in English and Spanish in addition to marketing materials available in both languages as well.

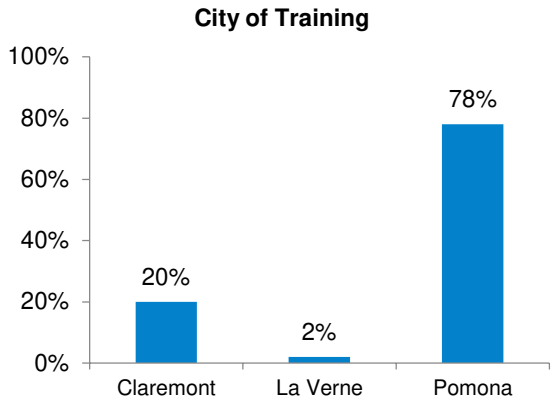
PROGRAM: Community Mental Health Trainings (CMHT)

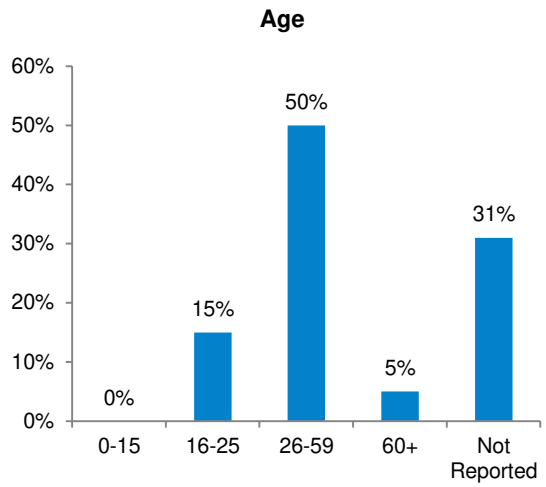
HOW MUCH DID WE DO?

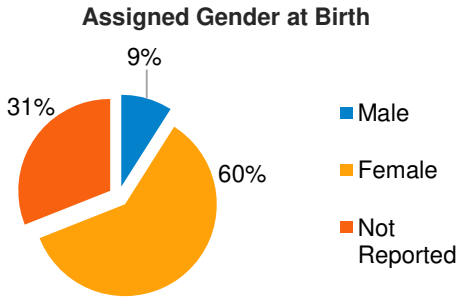
940
Individuals Served

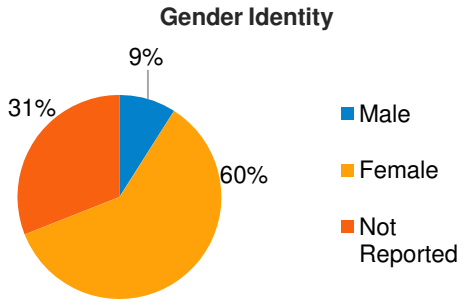
54
Community Mental Health Trainings

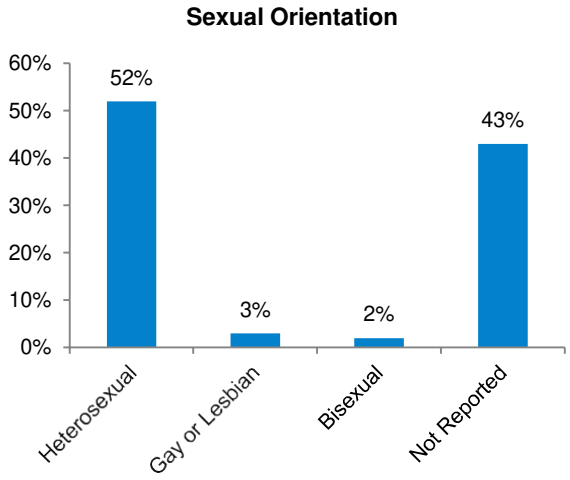

Community Mental Health Trainings
20%
0%
17%
4%
2%
13%
4%
7%
2%
4%
2%
17%
2%
13%
2%
6%
2%
2%
2%
2%
ACE
ACE [Spanish]
Co-Occurring Relapse
Community Connections
COVID-19 & Workplace
CRM
CRM [Spanish]
Everyday Mental Health
Everyday Mental Health…
Health & Wellness
Know the Signs
MHFA [Adult]
MHFA [Youth]
Motivational Interviewing
Motivational Interviewing…
Stress Playbook
Stress Playbook [Spanish]
Trauma-Informed Shelter

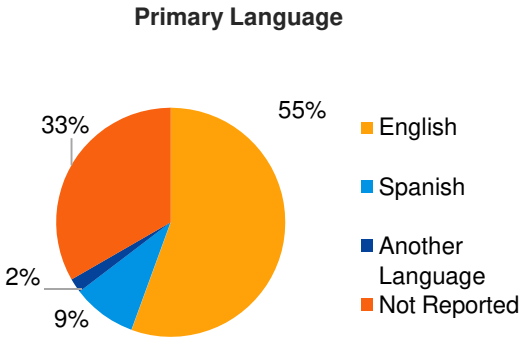

City of Training
100%
80%
60%
40%
20%
0%
20%
2%
78%
Claremont
La Verne
Pomona

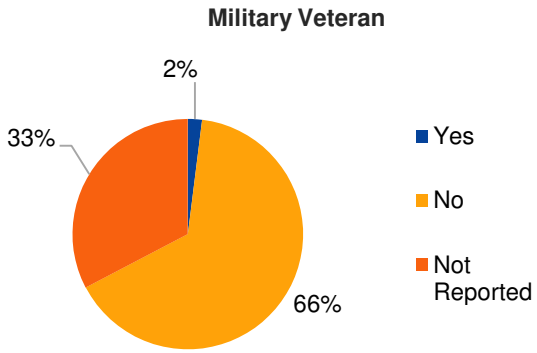

Age
60%
50%
40%
30%
20%
10%
0%
0%
15%
50%
5%
31%
0-15
16-25
26-59
60+
Not Reported

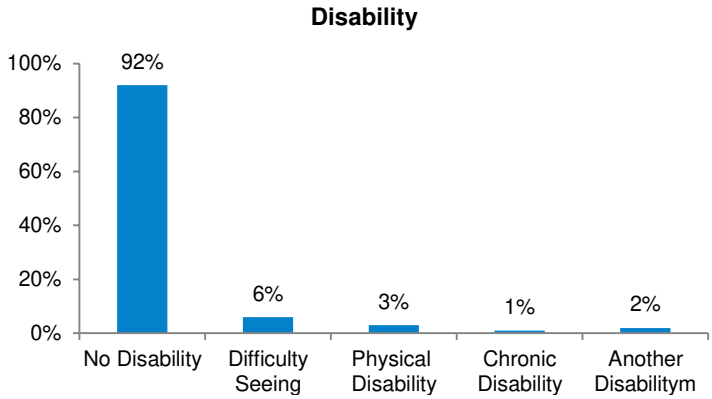

Assigned Gender at Birth
9%
31%
60%
Male
Female
Not Reported

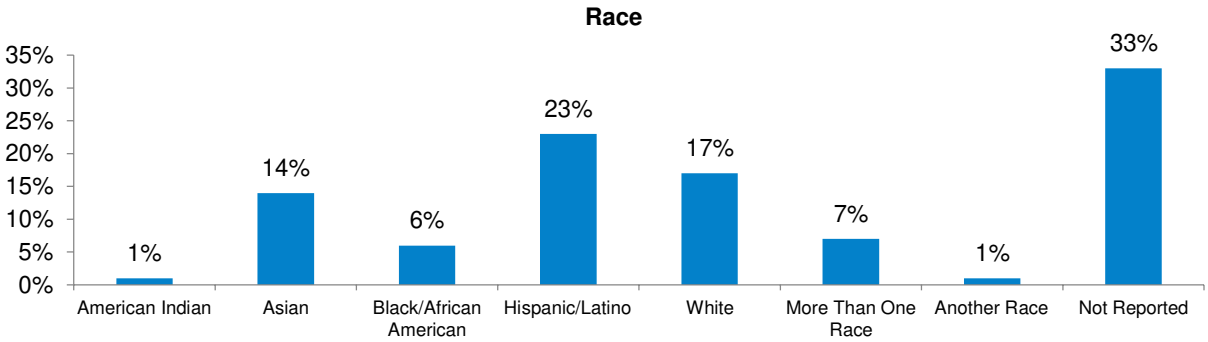

Gender Identity
9%
31%
60%
Male
Female
Not Reported

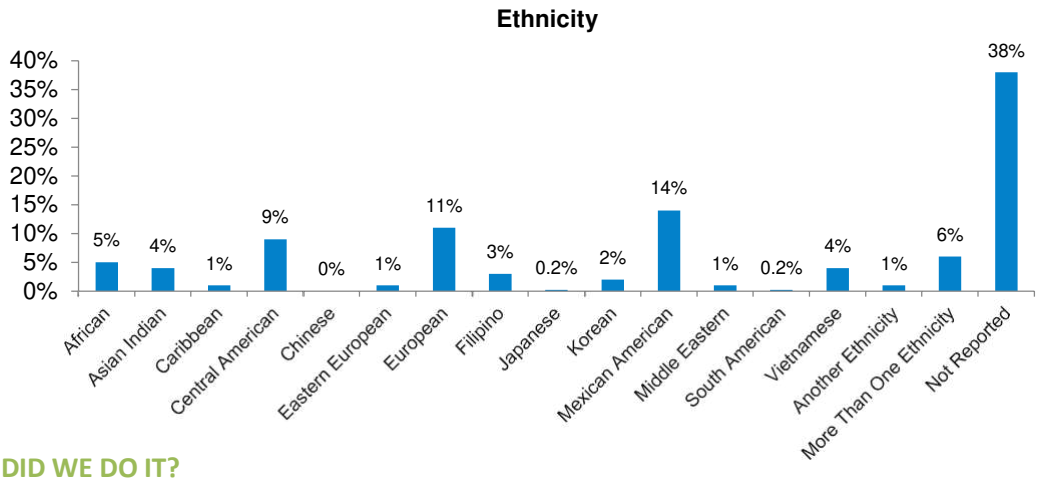

Sexual Orientation
60%
50%
40%
30%
20%
10%
0%
52%
3%
2%
43%
Heterosexual
Gay or Lesbian
Bisexual
Not Reported


Primary Language
33%
55%
2%
9%
English
Spanish
Another Language
Not Reported


Military Veteran
2%
33%
66%
Yes
No
Not Reported

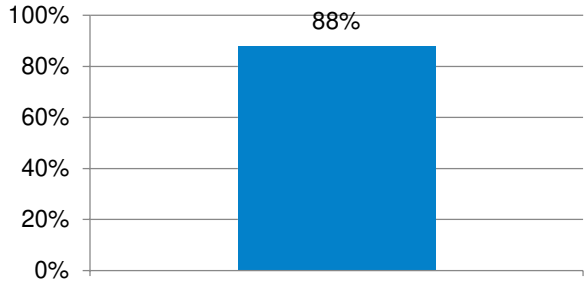

Disability
100%
80%
60%
40%
20%
0%
92%
6%
3%
1%
2%
No Disability
Difficulty Seeing
Physical Disability
Chronic Disability
Another Disabilitym


Race
35%
30%
25%
20%
15%
10%
5%
0%
1%
14%
6%
23%
17%
7%
1%
33%
American Indian
Asian
Black/African American
Hispanic/Latino
White
More Than One Race
Another Race
Not Reported

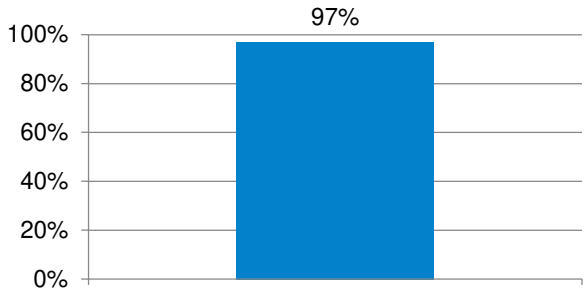


HOW WELL DID WE DO IT?

Percentage of participants who report the training was relevant to their day to day activities:

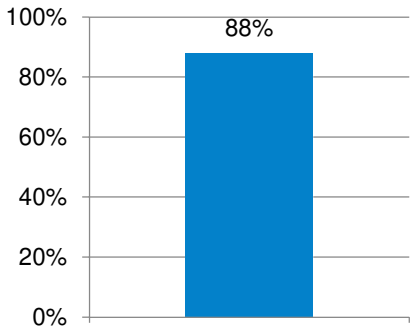


Percentage of participants who rated the training session as good or excellent

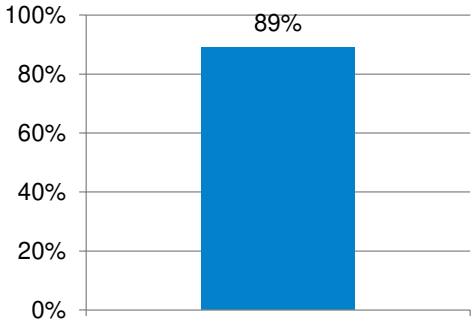


IS ANYONE BETTER OFF?

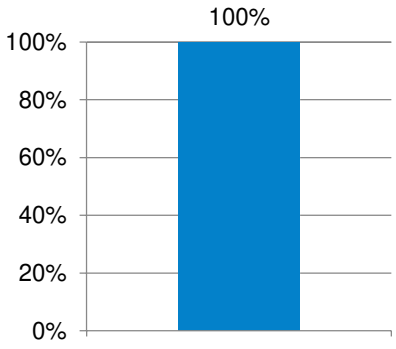
Percentage of participants who report feeling confident in using or applying the skills learned in the training:



Percentage of participants who report feeling more confident reaching out to someone who may be experiencing a mental health challenge or crisis



Percentage of participants who would recommend the training to others:

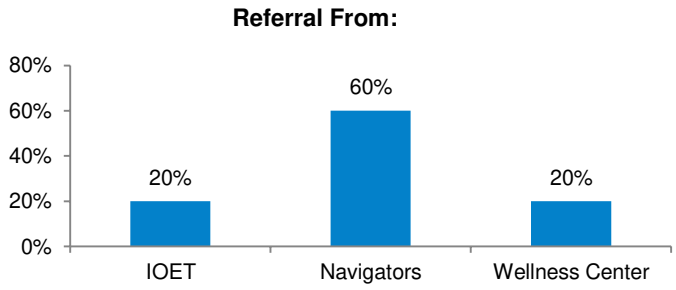


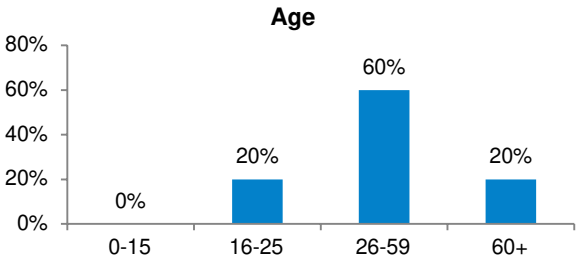
Number of Potential Responders	940
Setting in Which Responders were Engaged	Community, schools and colleges
Type of Responders Engaged	TAY, adults, seniors, landlords and students
Underserved Populations	Black/African American, Asian American/Pacific Islander, Hispanic/Latino, Native American, Refugee/Immigrant, Lesbian/Gay/Bisexual/Transgender/Questioning, Transition Age Youth, Older Adults, and those with a physical disability
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

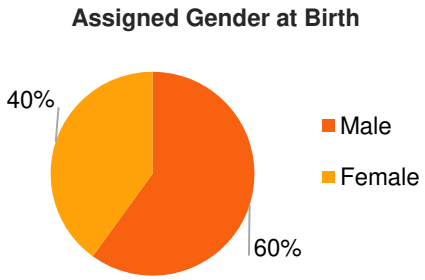
TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY:

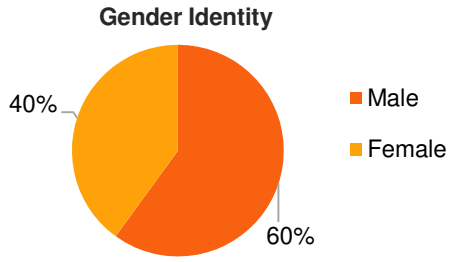
PEI Demographics Based on MHSA Referrals

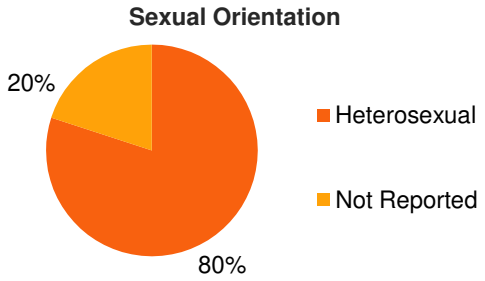
5
MHSA Referrals to Community Mental Health Trainings

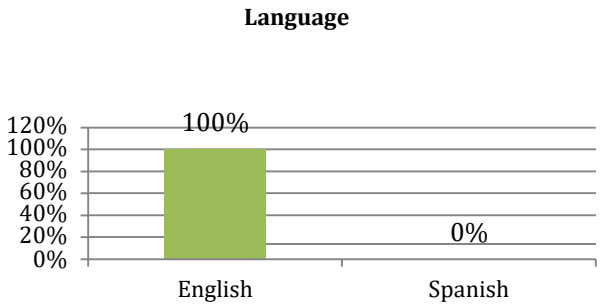


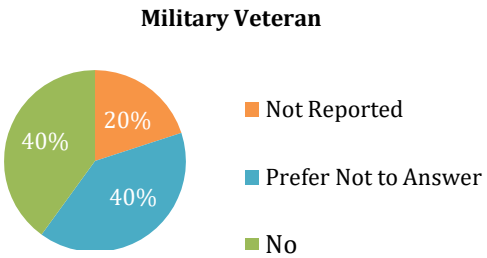


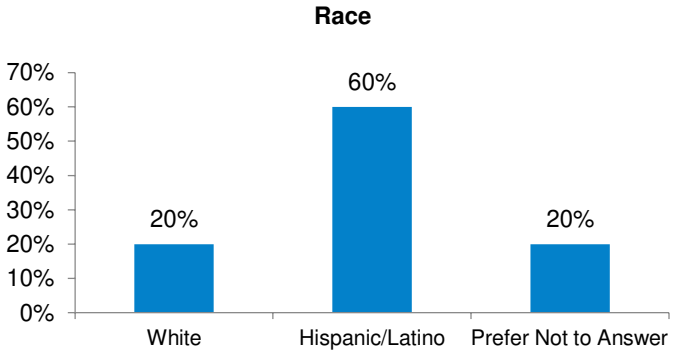


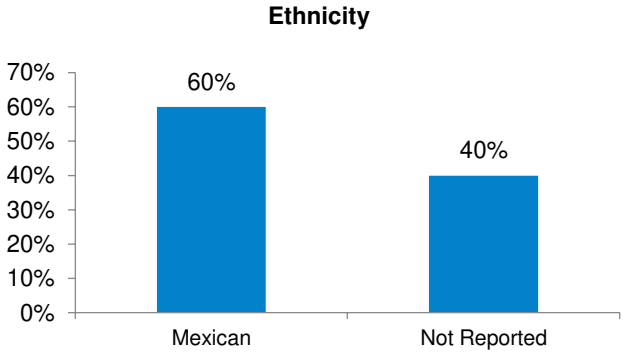

Gender Identity
40%
60%
Male
Female

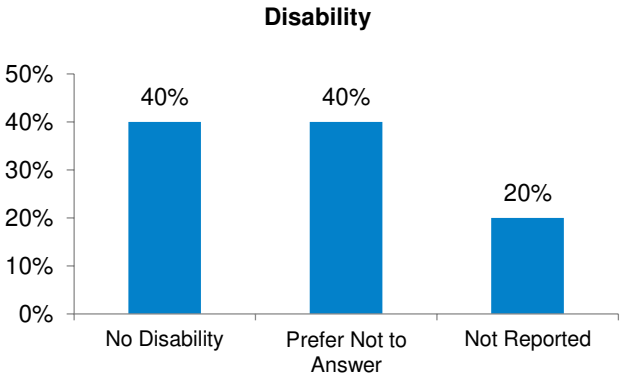

Sexual Orientation
20%
80%
Heterosexual
Not Reported


Language
120%
100%
80%
60%
40%
20%
0%
100%
0%
English
Spanish


Military Veteran
40%
20%
40%
Not Reported
Prefer Not to Answer
No


Race
70%
60%
50%
40%
30%
20%
10%
0%
20%
60%
20%
White
Hispanic/Latino
Prefer Not to Answer


Ethnicity
70%
60%
50%
40%
30%
20%
10%
0%
60%
40%
Mexican
Not Reported


Disability
50%
40%
30%
20%
10%
0%
40%
40%
20%
No Disability
Prefer Not to Answer
Not Reported

Stigma Reduction and Suicide Prevention

Status of Program:	___New	_X_ Continuing	___Modified	___Discontinued	
Target Population:	_X_ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:
Type of Program:	_X_ Prevention	___Early Intervention	___Prevention and Early Intervention		

Program Description

Tri-City's stigma reduction effort is encompassed under Room4Everyone and includes a website focused on stigma reduction, along with several other components designed to empower individuals suffering with mental health challenges and awareness to the stigma related to mental illness. Suicide prevention efforts include offering the safeTALK alertness training which provides participants with the skills needed to recognize the signs of suicide in an individual and connect them quickly and safely with the appropriate resources and support services.

Target Population

Community members, agencies and organizations located in the Tri-City region (cities of Claremont, Pomona, and La Verne).

Number of Individuals Served FY 2019-20	206

Program Update

On September 10, 2019, a World Suicide Prevention Day event was hosted in collaboration with NAMI Pomona Valley. This public event screened the documentary "Suicide: The Ripple Effect', a feature length film which documents the suicide attempt of Kevin Hines, the impact of his suicide attempt on others, and his later work as a mental health advocate. We Connect, We Live, We Thrive was the theme of the event. It focused on screening the film, stories of suicide survivors and community partners who have opportunity for community members to connect and get involved right away.

The annual Creative Minds Art Gallery reception theme was 'Let's Celebrate'. Notable entries included a class project submitted by Claremont High School's photography class. This was a wonderful example of collaboration between Tri-City and local schools in raising awareness of the connection of mental health and the arts.

Challenges and Solutions

Challenges during this period included the fact that the curriculum used for suicide prevention, SAFETALK, continues to be only available in English. In addition, the training is four hours long and some participants feel this is too long. The topic of suicide can be very sensitive and challenging for participants to stay engaged for that extended period of time or feel comfortable asking questions.

In response to these concerns, staff have started using Know the Signs, another suicide prevention training/presentation, which is available in Spanish, and can be presented by any staff member.

A second challenge focuses on the stigma reduction presentations which are delivered by a Courageous Minds speaker (person who identifies with lived experience). However, due to scheduling and personal responsibilities, it has been a challenge to maintain speakers to be a part of this program. Staff have connected with Tri-City clinicians and MHSA programs to identify potential clients/participants who would be a great fit for this speaker program.

COVID-19 Response

The impact of COVID 19 for this program primarily involved the cancellation of community events including Green Ribbon Week, a popular week-long series of events focusing on stigma reduction. Outreach efforts were also curtailed since local schools, agencies, and community-based sites were closing in response to the pandemic.

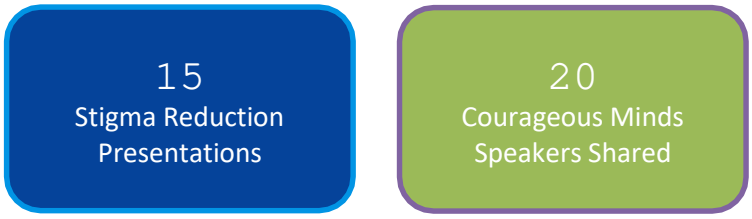
By utilizing RingCentral, a virtual platform, staff were able to offer webinars focusing on a wide-range of topics and promote virtual events, presentations and trainings. In consideration of the impact of individuals in the community being socially isolated, staff designed weekly session called Community Connections that highlighted a specific skill or topic each week and allowed attendees to participate virtually through their cameras and microphones.

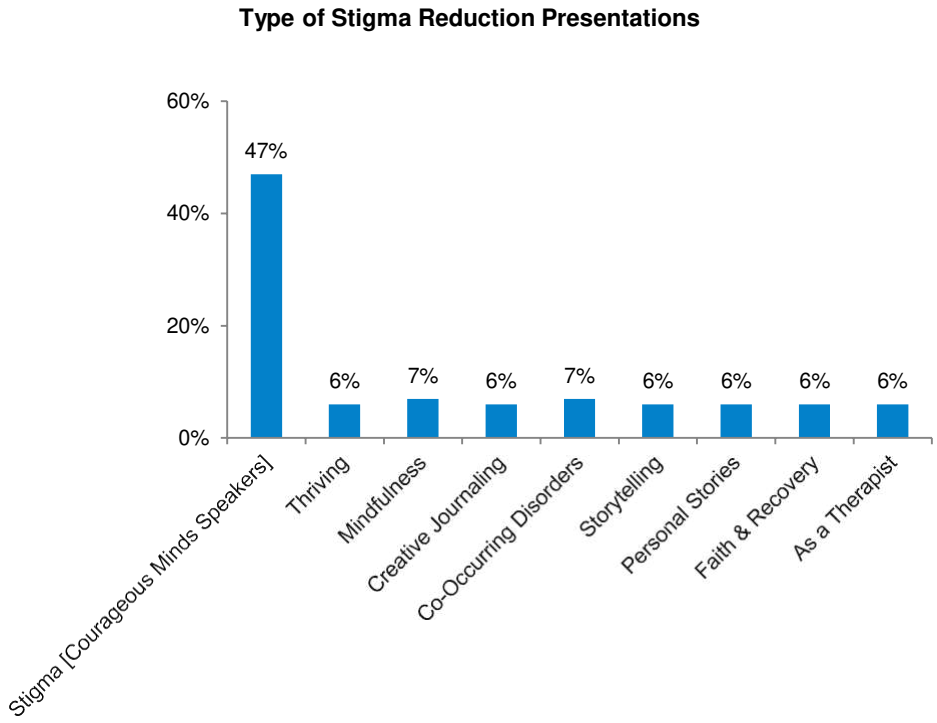
Cultural Approach

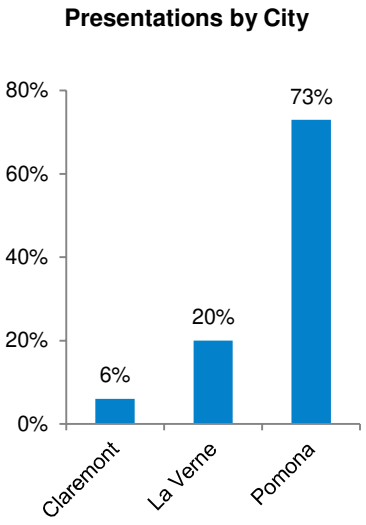
Striving to offer and provide trainings, presentations and information to diverse communities and neighborhoods across all three cities is one way the stigma reduction program attempts to reach as many individuals as possible. Multi- language trainings are made possible through the collaboration of program staff and bilingual staff members who co-facilitate. When promoting events like art workshops and art reception, flyers are available in both English and Spanish.

The Stigma Reduction program works on reducing stigma by creating a safe space for presentations and trainings that are culturally sensitive and beneficial for all participants. The meaning of "Room4Everyone" expands beyond those with and without mental health conditions. It also refers to finding ways we are more alike than different, no matter what the differences are. Barriers experienced by the LGBTQ community are reduced by having materials that reflect the specifics of mental health on members of their community. Presentations and trainings dedicated to this important population touches on topics that are relevant and provides an opportunity for discussions, provide inclusion, and allow for questions from heterosexual and cisgender attendees to help increase their understanding.

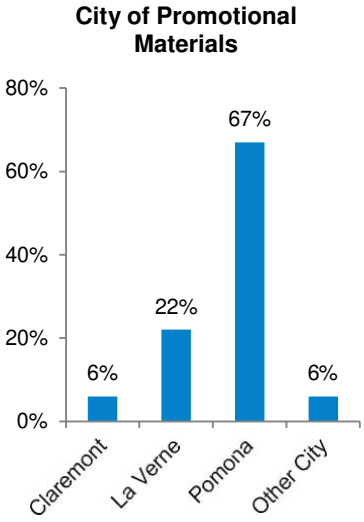
PROGRAM: Stigma Reduction and Suicide Prevention
HOW MUCH DID WE DO? Stigma Reduction

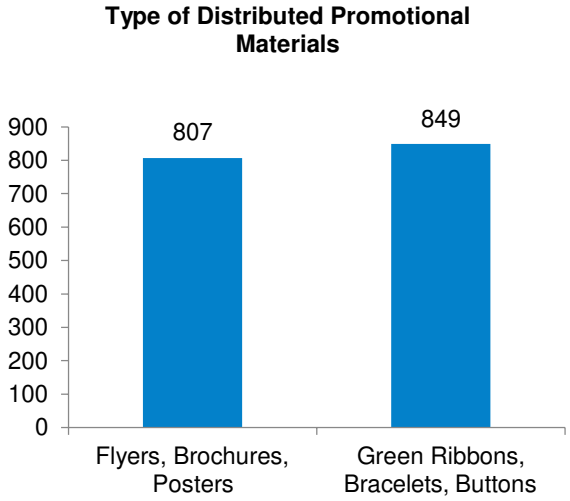




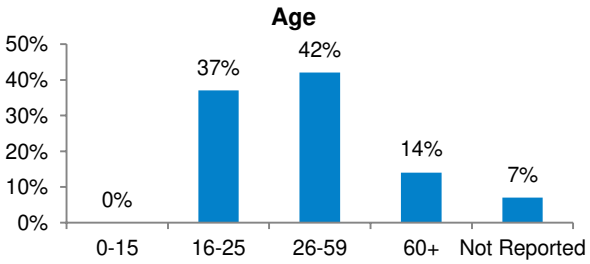


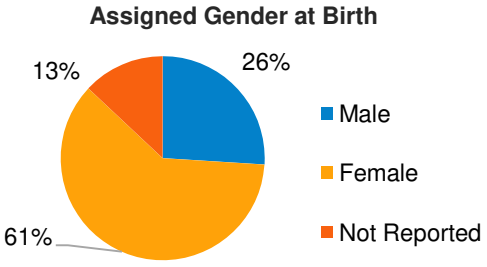
1,656
Promotional Materials Distributed

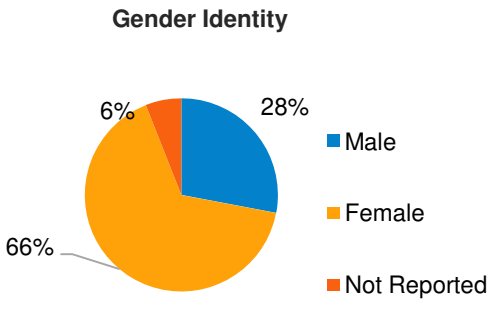


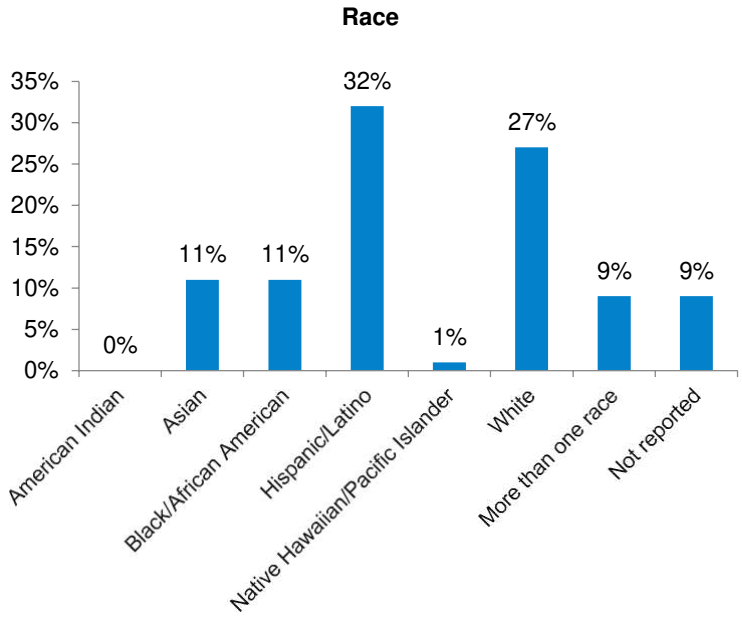


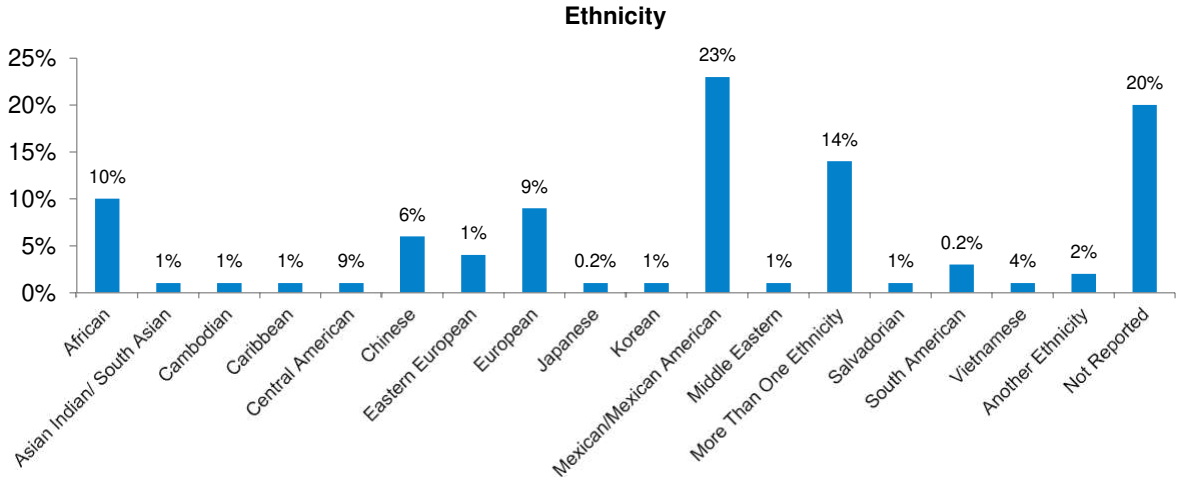
Demographics Based on Participants Who Completed Stigma Reduction Surveys (n=117)

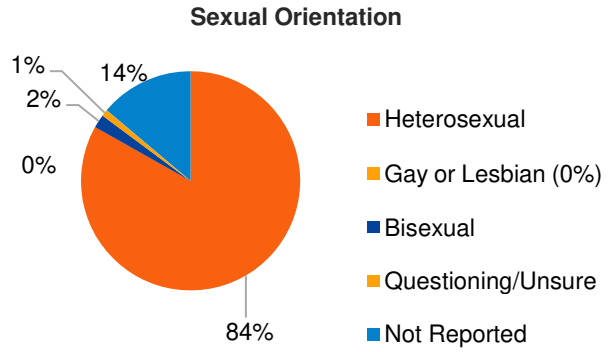


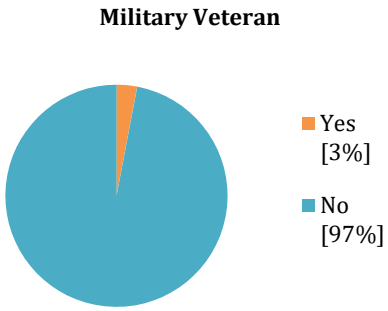


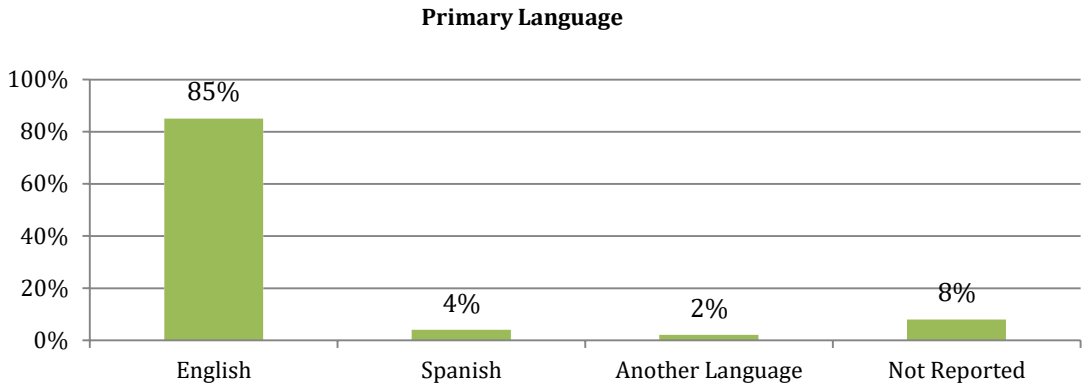

Gender Identity
6%
28%
66%
Male
Female
Not Reported

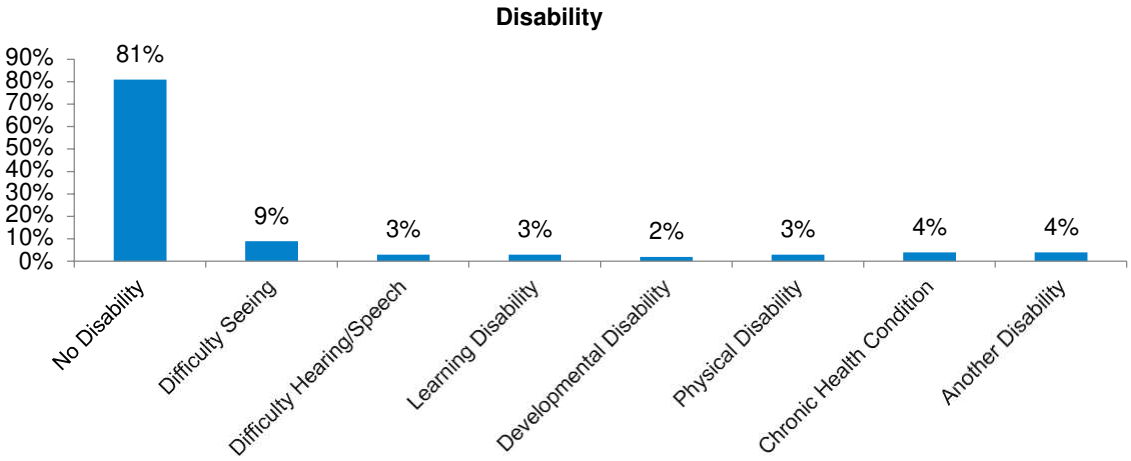

Race
35%
30%
25%
20%
15%
10%
5%
0%
0%
11%
11%
32%
1%
27%
9%
9%
American Indian
Asian
Black/African American
Hispanic/Latino
Native Hawaiian/Pacific Islander
White
More than one race
Not reported


Ethnicity
25%
20%
15%
10%
5%
0%
10%
1%
1%
1%
9%
6%
1%
9%
0.2%
1%
23%
1%
14%
1%
0.2%
4%
2%
20%
African
Asian Indian/ South Asian
Cambodian
Caribbean
Central American
Chinese
Eastern European
European
Japanese
Korean
Mexican/Mexican American
Middle Eastern
More Than One Ethnicity
Salvadorian
South American
Vietnamese
Another Ethnicity
Not Reported


Sexual Orientation
1%
14%
2%
0%
84%
Heterosexual
Gay or Lesbian (0%)
Bisexual
Questioning/Unsure
Not Reported

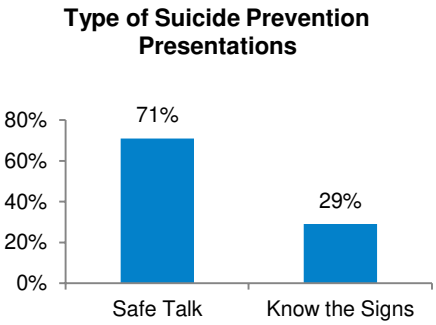

Military Veteran
Yes [3%]
No [97%]

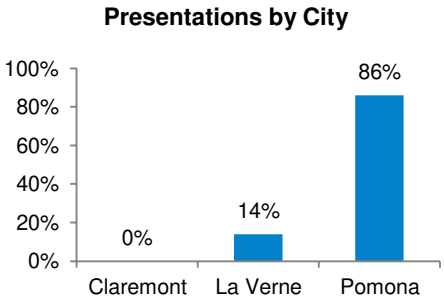




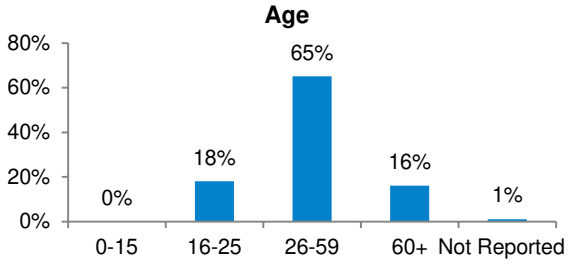
HOW MUCH DID WE DO? Suicide Prevention

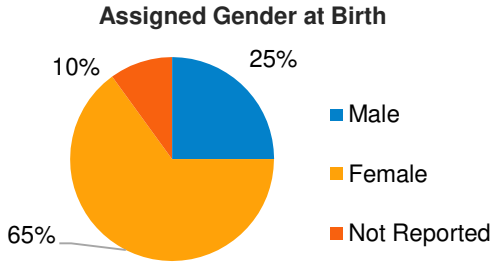
7
Suicide Prevention Trainings and Presentations

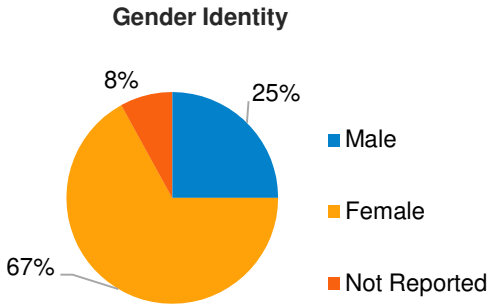


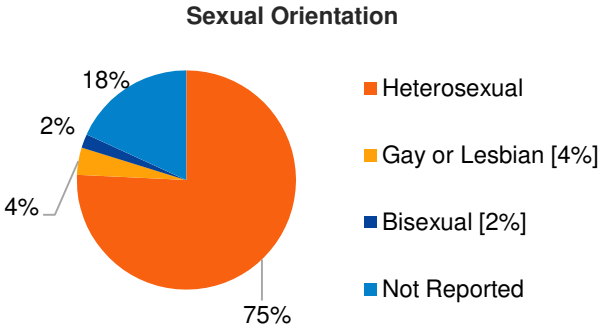


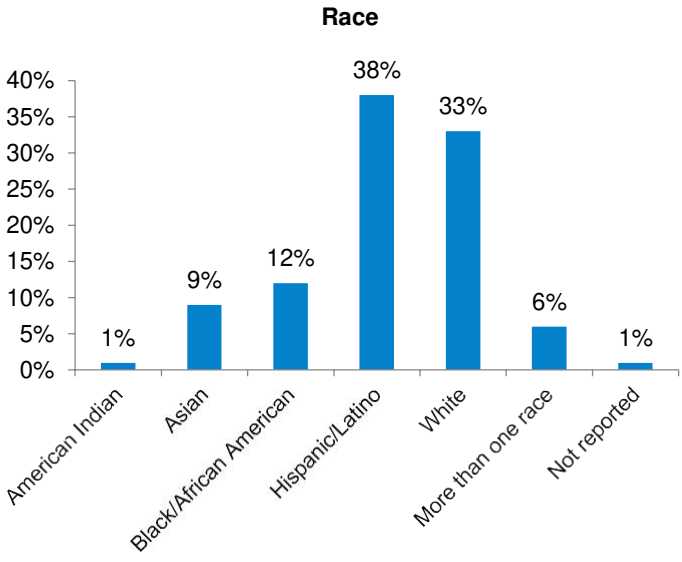
Demographics Based on Participants Who Completed Safe Talk Surveys (n=89)

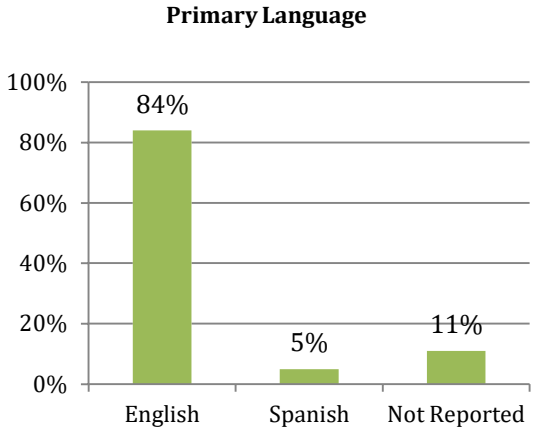


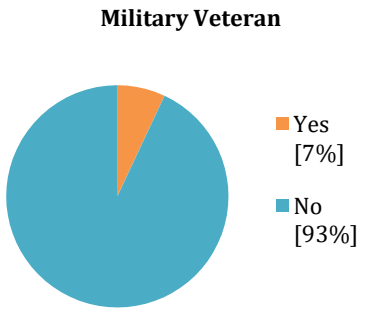


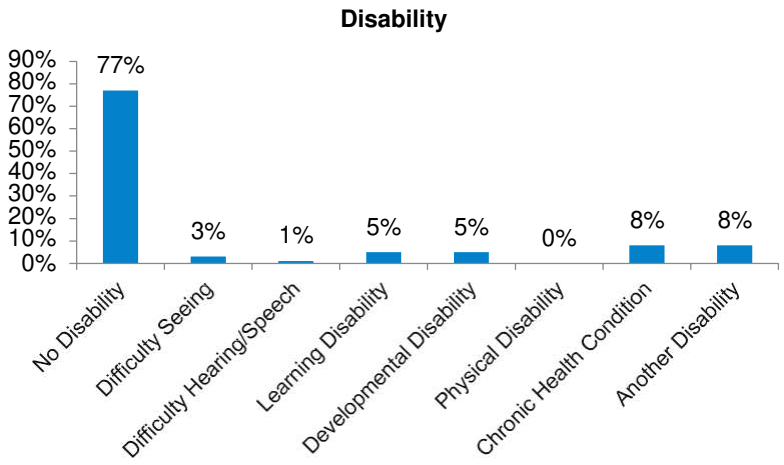


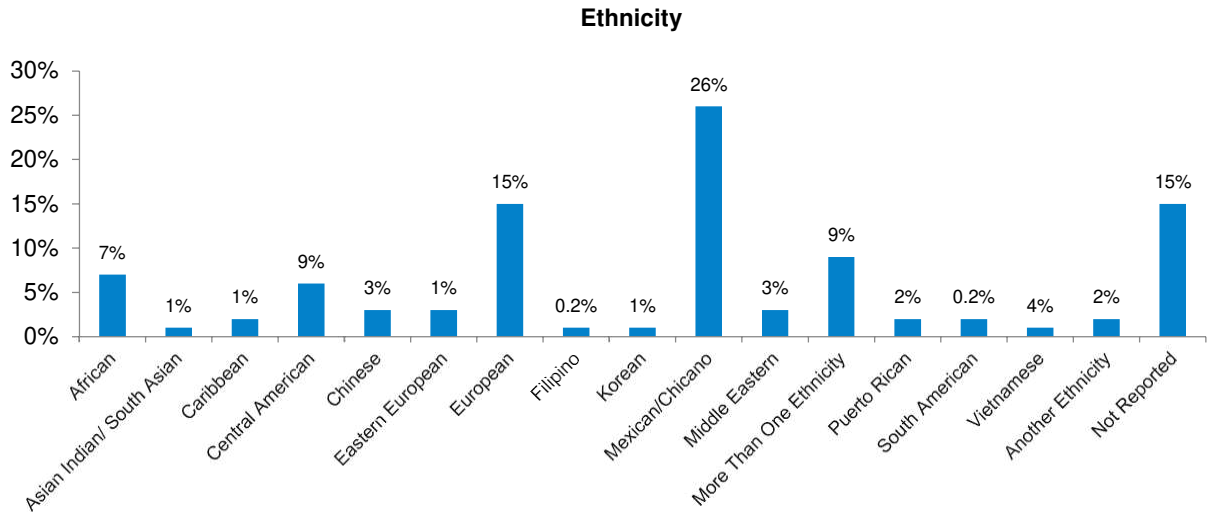








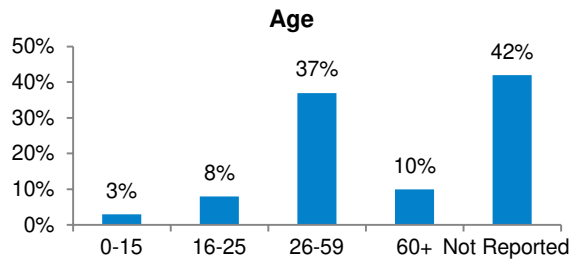


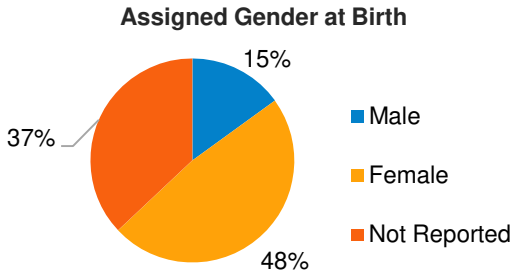


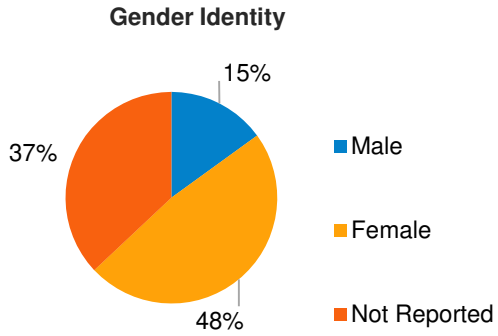
HOW MUCH DID WE DO? Creative Minds Art Gallery

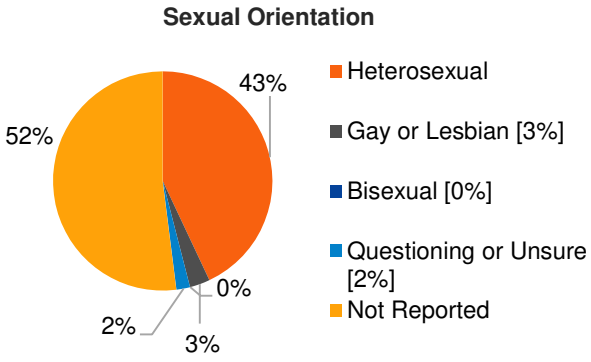
3	98	81
Creative Minds Art Events Were Held	Individuals Participated in Creative Minds Art Workshop and Gallery	Art Pieces Were Submitted to the Creative Minds Art Gallery

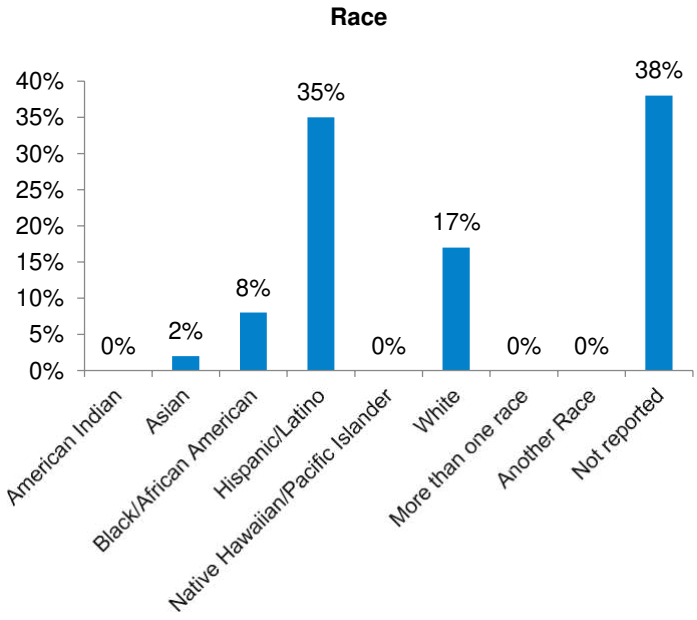
Demographics Based on Participants Who Completed Art Workshop Surveys

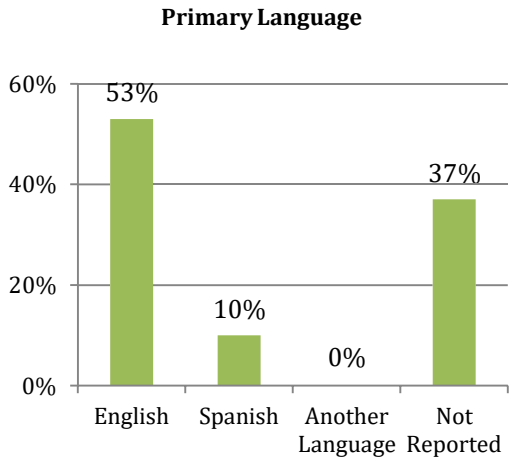


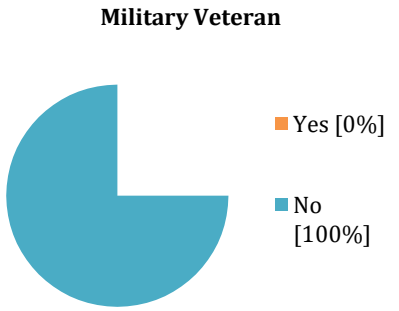


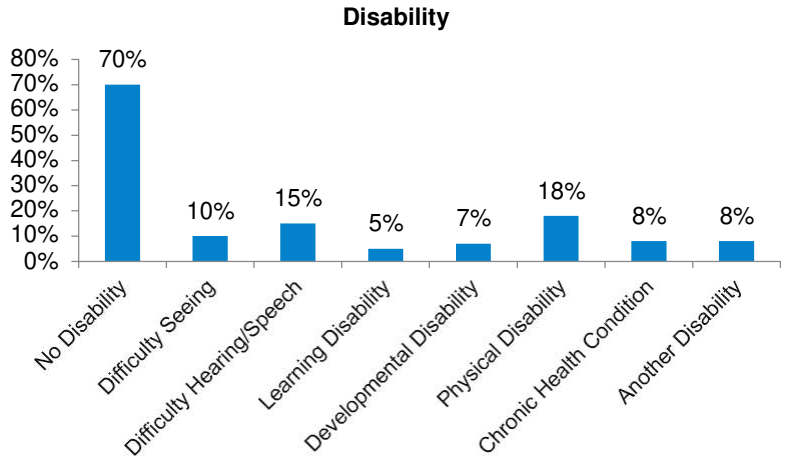


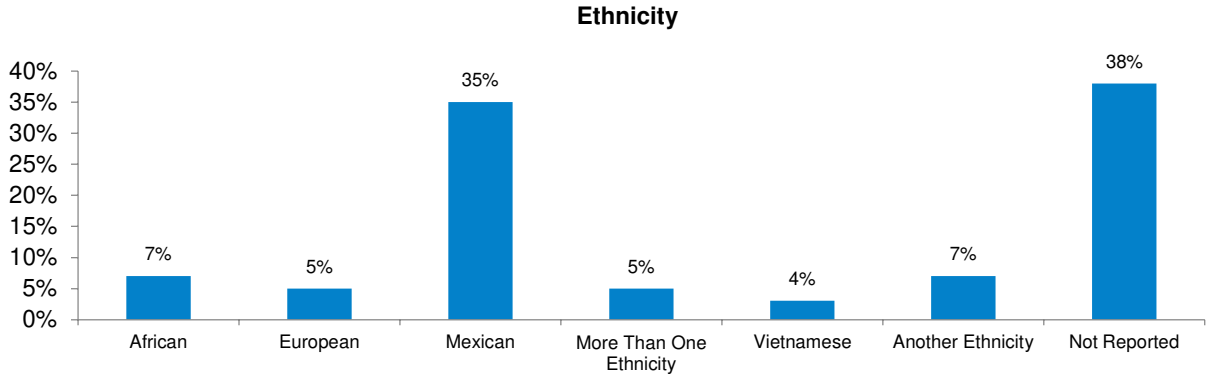












HOW WELL DID WE DO IT?

176
Attendees for Stigma Reduction Presentations

145
Attendees for Safe Talk Suicide Prevention Presentations

80
Attendees for Creative Minds Art Gallery Receptions

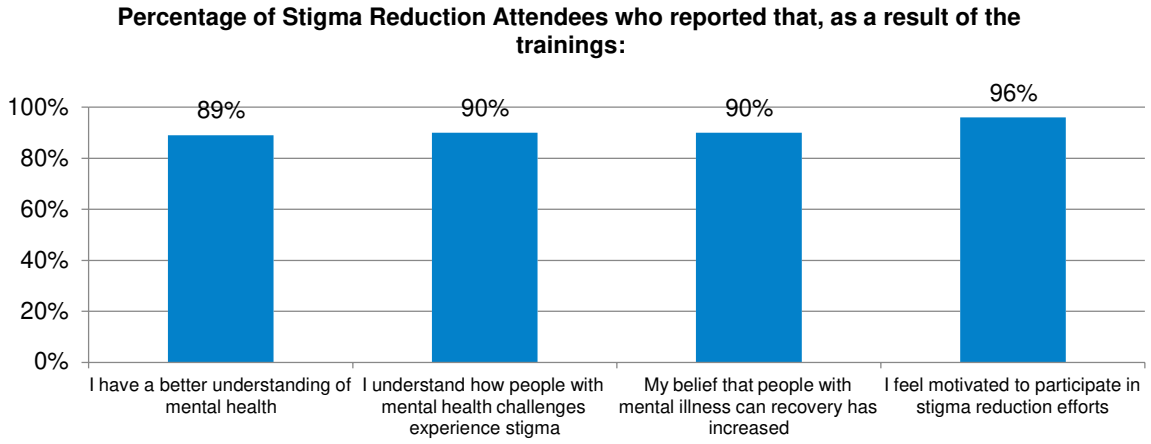
42,847
Visits to the Room4Everyone Website

11,975
Unique Visits to the Room4Everyone Website

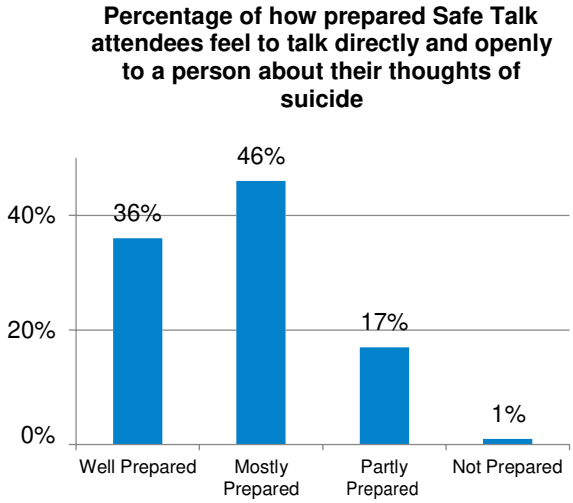
Website Hits Data from July 2019 to December 2019

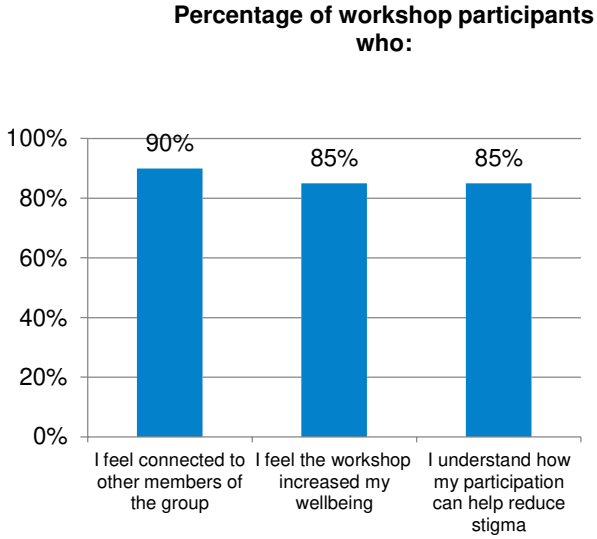
IS ANYONE BETTER OFF?

Stigma Reduction



Suicide Prevention





Number of Potential Responders	401
Setting in Which Responders were Engaged	Community, schools, colleges, health centers, workplace, shelters, online and outdoors
Type of Responders Engaged	TAY, adults, seniors, teachers, LGBTQ+, families, suicide attempters/survivors, religious leaders and those with lived experience
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY:

0
MHSA Referrals to Stigma Reduction or Suicide Prevention Programs

Older Adult and Transition Age Youth Wellbeing

Both the Older Adult Wellbeing and the Transition Age Youth Wellbeing programs are comprised of two projects: Peer mentoring and specialty groups/programing offered at the Wellness Center specific to TAY and older adults needs.

Peer Mentor and Wellness Center PEI Programs

Status of Program:	___New	_X_ Continuing	___Modified	___Discontinued	
Target Population:	___0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:
Type of Program:	___Prevention	___Early Intervention	_X_ Prevention and Early Intervention		

Program Description

Trained volunteers (peer mentors) from the tri-city area provide support to peers (mentees) who are in emotional distress. Peer mentors offer both individual and group support, and additional assistance through linkage to community resources that are both age and culturally matched to each individual mentee. Individuals attending the TAY and Older Adult programing located at the Wellness Center benefit from specialized support groups and activities targeting their specific needs.

Target Population

Transition Age Youth (TAY ages 18-25) and Older Adults (ages 60 and over)

Peer Mentor/Mentees

Age Groups	TAY 18-25	Adults 26-59	Older Adults 60+	Unknown
Mentors FY 2019-20	14	12	4	0
Mentees FY 2019-20	25	39	23	0
Groups FY 2019-20	0	29	20	286
Cost Per Person	$109	$119	$119	N/A

Wellness Center (PEI TAY and Older Adults)					
Age Groups	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Unknown
Number Served FY 2019-20	56	502	56	99	4
Cost Per Person	$727	$727	$727	$727	$727

Peer Mentor Program

Program Update

The Peer Mentor program continues to support both mentors (individuals providing the support) and mentees (individuals receiving the support). Peer Mentors focused on engaging individuals with lived experience who apply and then are trained to provide support to community members who are seeking a non- clinical level of care. These services are offered in English, Spanish, Vietnamese and Cantonese.

In FY 2019-20, this program sustained 30 dedicated and highly trained community mentors. Of these 30 mentors, 19 identified with lived experience who were able to provide an empathic level of support based on personal experience.

In addition to one-on-one sessions, this program offers support groups as well. Two of the critical populations supported through these groups include older adults and the LGBTQ+.

Challenges and Solutions

The number of mentors identifying themselves with lived experience continue to increase each year. This can be a significant benefit for mentees who are looking to connect with another peer. However, one of the challenges for staff has been to provide adequate and meaningful support for the needs of our mentors as well.

Additional challenges include engaging the homeless population and older adults. Over the next fiscal year, staff will continue to work on engaging these individuals through one-on-one support via telephone. Efforts will also include an increase focus on self-care and wellbeing to help mentors, specifically those who identify with lived experience, to ensure that they receive adequate support to help minimize/reduce any mental health symptoms.

COVID-19 Response

Since the outbreak of COVID-19, the Peer Mentor Program moved its service delivery to phone and virtual platforms. Historically, many mentors take a summer break and return in the fall. However, with the onset of COVID-19, several of the mentors continued to offer support throughout summer break due to the increased need since the onset of the pandemic. Trainings continued as well in order to provide the mentors with up-to-date COVID-19 information and how they can best support their mentees. The Peer Mentor wellbeing activities, normally held in person, were temporarily put on hold.

However, staff began to brainstorm to create virtual wellness roundtables where the groups can continue to meet virtually.

As expected with the pandemic, there was an increase in referrals in a short period of time thereby increasing the number of mentees each mentor had on their case load. Since the majority of mentors who provide services to the community identify themselves with lived experience, group meetings and individual supervisions were also increased to provide extra support to these mentors as they continued to provide extra support to mentees.

Cultural Approach

Peer mentors identify with numerous local communities (African American, Asian, Latino, Bisexual, Gay, Native American, TAY, Older Adult and Physically disabled). The majority of the mentors are bilingual and provide services in English, Spanish, Tamil, Hindi, Malayalam, Korean, Cantonese. In addition, the PM program currently has mentors who identify in the LGBTQ+ community who provide input and feedback on how to engage with others in the community.

Peer Mentoring programing focus on providing serves to individuals with limited mobility, limited access to transportation, monolingual individuals, LGBTQ, homelessness, and transition age youth. Presentations also focus on the veteran population in addition to providing multiple wellbeing activities in the communities. In addition, the program provides bilingual and monolingual senior socialization groups at local parks and mental wellbeing activities at senior living locations where residents may experience limited mobility and lack of transportation.

Wellness Center Programs: Transition Age Youth and Older Adults

Transition age youth (TAY) and older adults are considered critical populations in need of support yet tend to be some of the most difficult to engage. Reasons include issues related to stigma and difficulty with transportation. In an effort to meet the needs of these individuals, the Wellness Center has created programs utilizing Prevention and Early Intervention (PEI) funding to create programing specific to the needs and interests of these, often considered, at-risk individuals.

Program Update

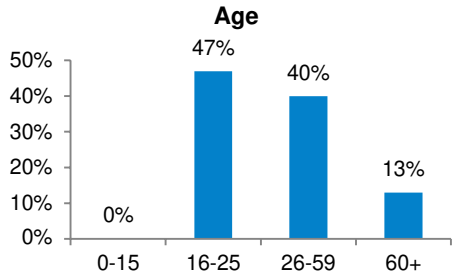
In an effort to build participation in the TAY programing, Wellness Center staff have focused their outreach efforts on collaborating with local service organizations who work with this age group. Prior to COVID-19, the Wellness Center saw a slight increase in the number of groups offered as well as the number of unique individuals who attended the Center. Although the COVID -19 pandemic has since impacted onsite groups, efforts continue to build a relationship with these community organizations which will allow for a smooth transition for TAY to come to the Wellness Center once the pandemic has abated.

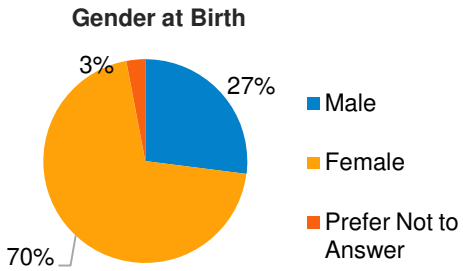
The Wellness Center's older adult programing continues to struggle with engagement and attendance. Recognizing the unique needs of this population, the Center created a Mental Health Specialist position where this staff member is dedicated to engaging older adults throughout the community and developing age appropriate activities and support groups based on their needs.

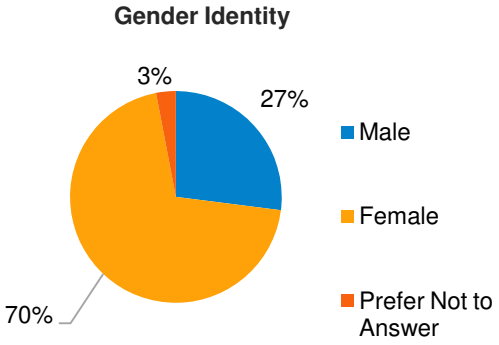
PROGRAM: Peer Mentoring

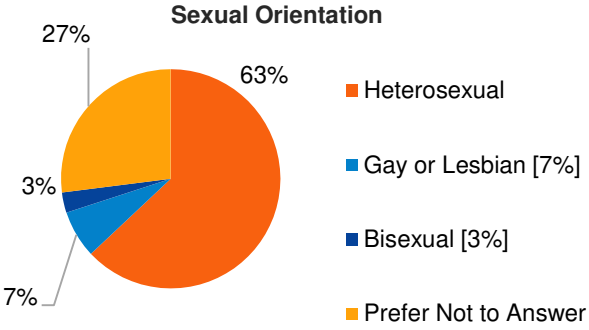
HOW MUCH DID WE DO?

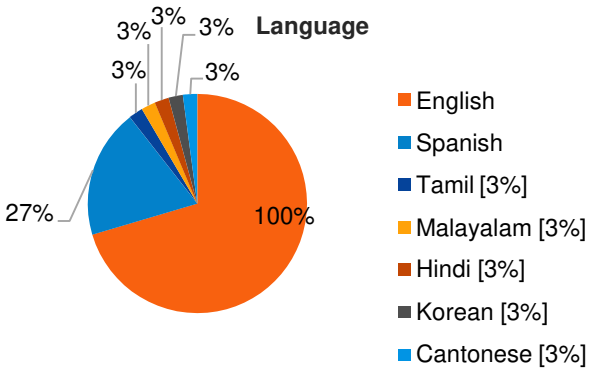
30
Active Peer Mentors

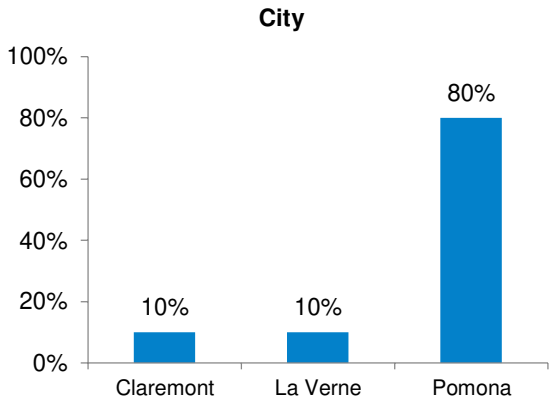


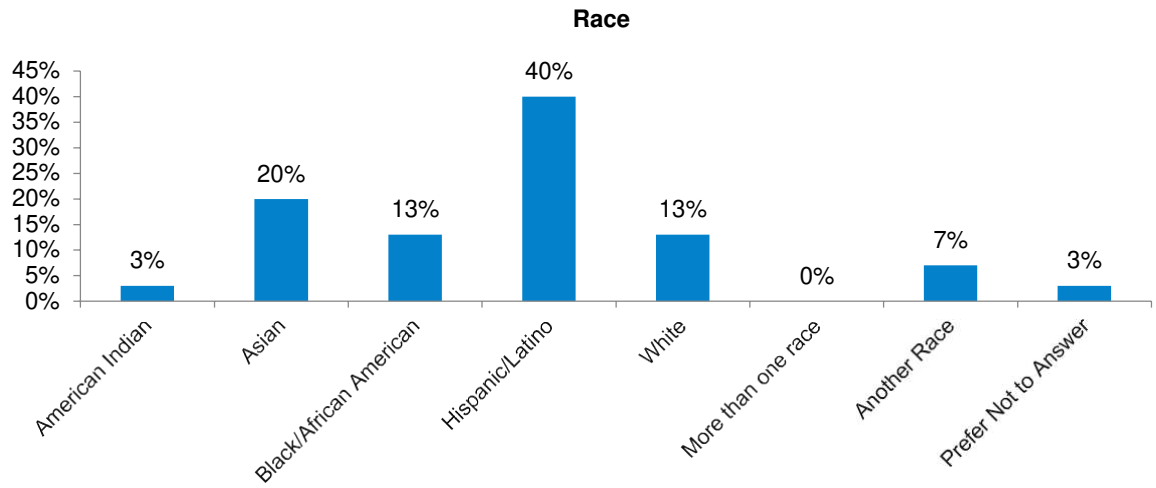











Race
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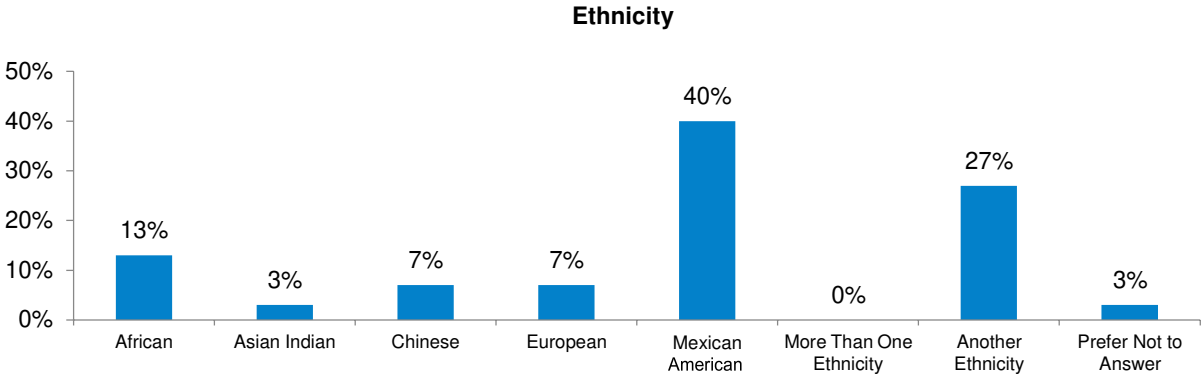
40%
35%
30%
25%
20%
15%
10%
5%
0%
3%
20%
13%
40%
13%
0%
7%
3%
American Indian
Asian
Black/African American
Hispanic/Latino
White
More than one race
Another Race
Prefer Not to Answer


Ethnicity
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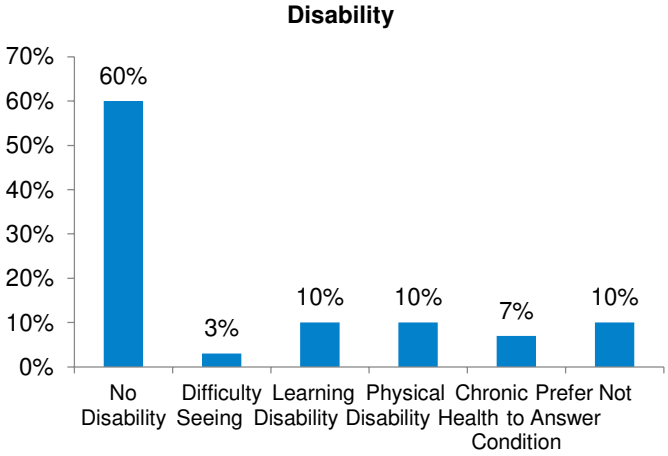
30%
20%
10%
0%
13%
3%
7%
7%
40%
0%
27%
3%
African
Asian Indian
Chinese
European
Mexican American
More Than One Ethnicity
Another Ethnicity
Prefer Not to Answer


Disability
70%
60%
50%
40%
30%
20%
10%
0%
60%
3%
10%
10%
7%
10%
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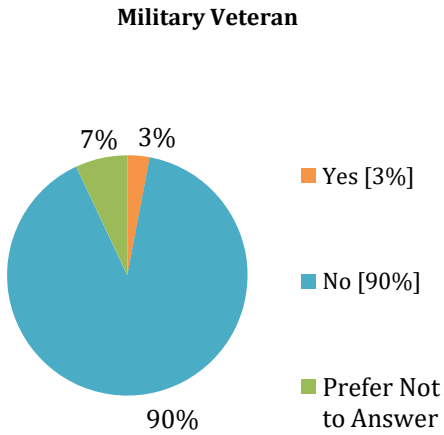
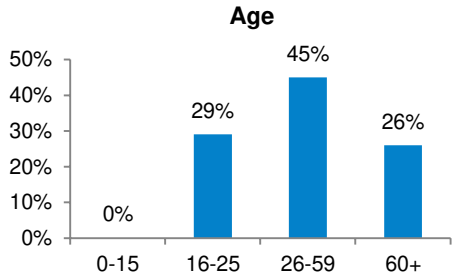
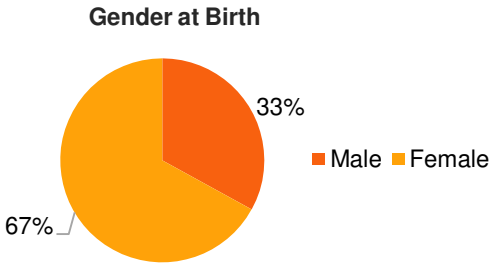
Difficulty Seeing
Learning Disability
Physical Disability
Chronic Health Condition
Prefer Not to Answer

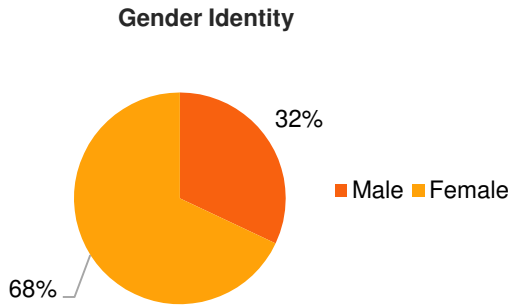

Military Veteran
7%
3%
90%
Yes [3%]
No [90%]
Prefer Not to Answer

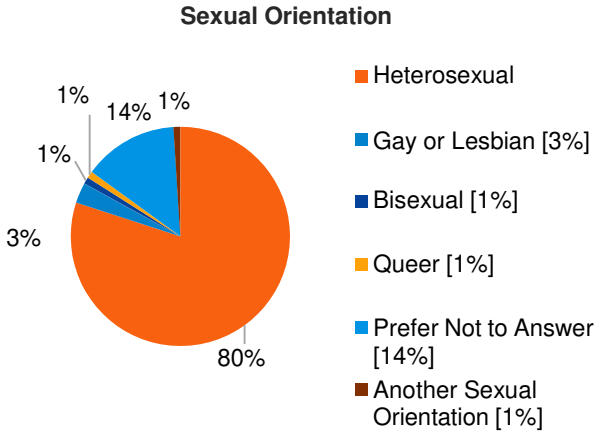
Peer Mentee Demographics

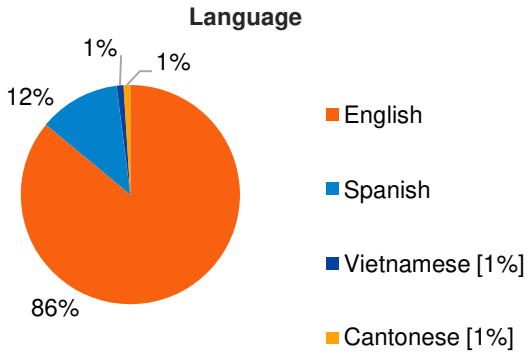
87
Peer Mentees Served

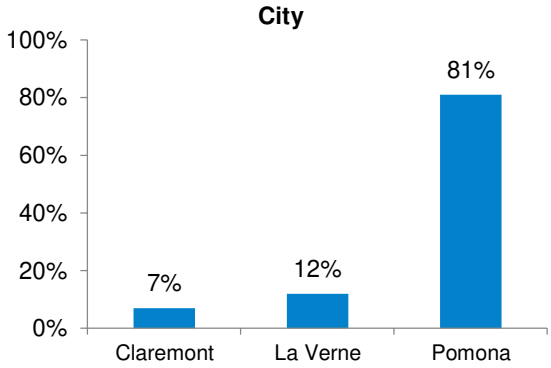








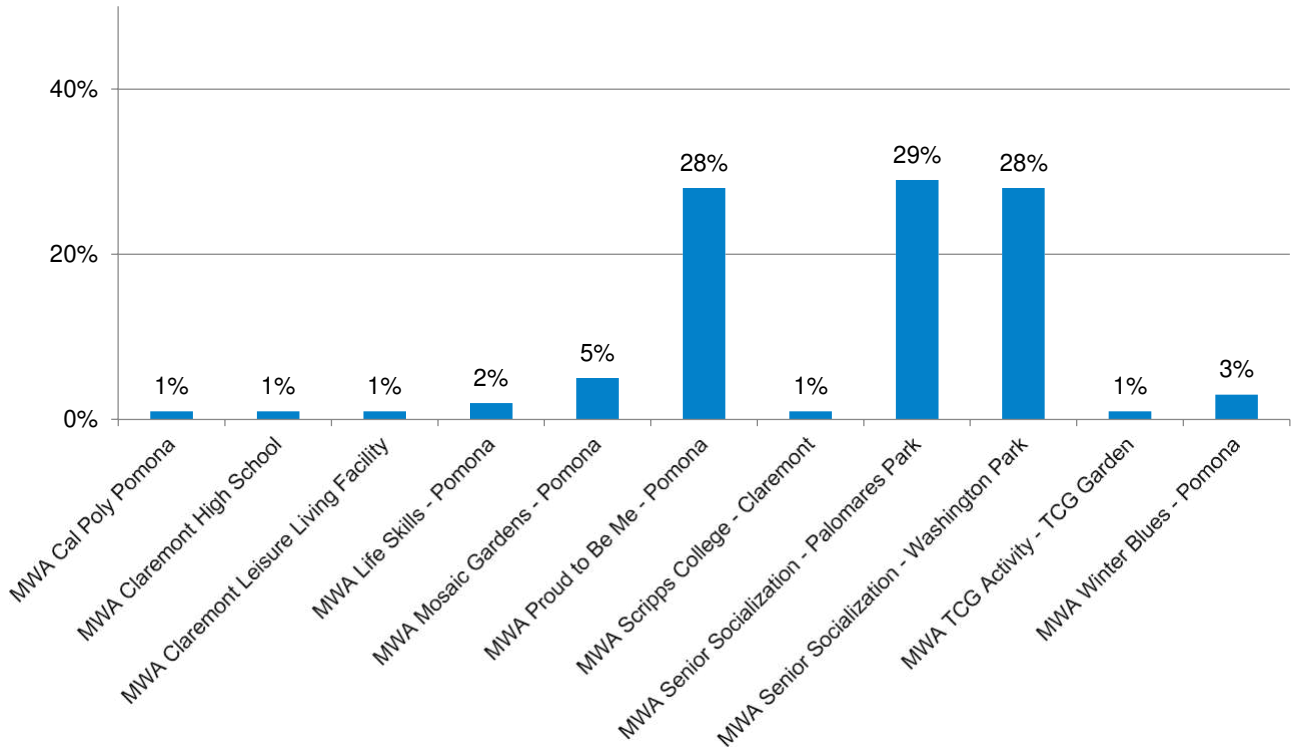




Mental Wellbeing Activities Occurred from July 2019 through March 2020

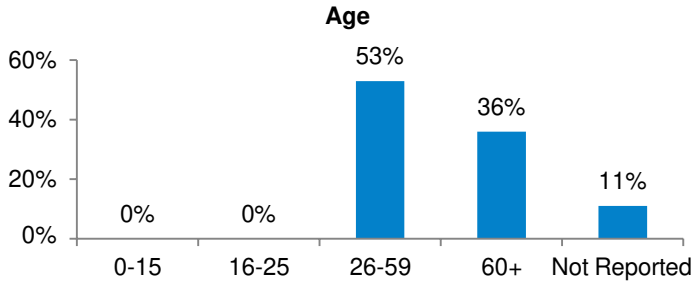
335	856
Unique Participants at Peer Mentor Mental Wellbeing Activities	Duplicated Participants at Peer Mentor Mental Wellbeing Activities

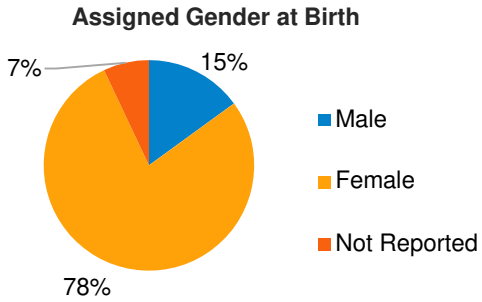
117 Mental Wellbeing Activities (MWA) Held by Name and Location

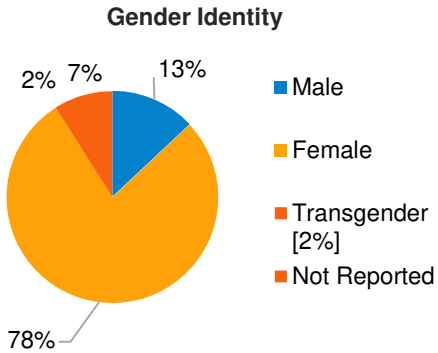


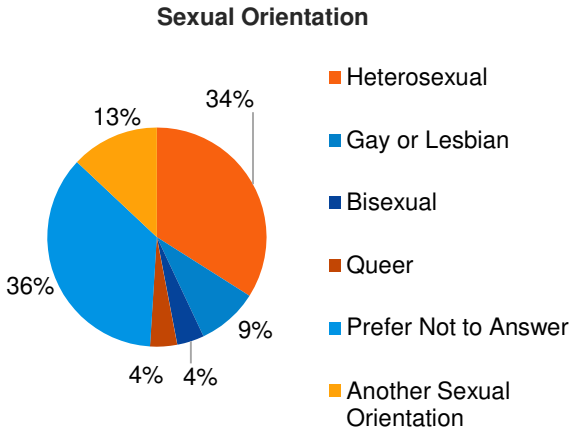
29
Peer Mentor Trainings

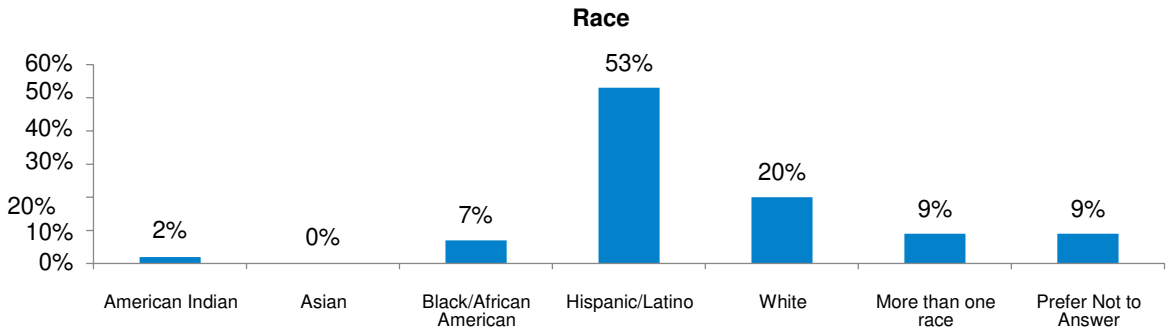
PEI Demographics Based on Mental Wellbeing Participants Who Completed Mental Wellbeing Mentor Surveys (n=55)

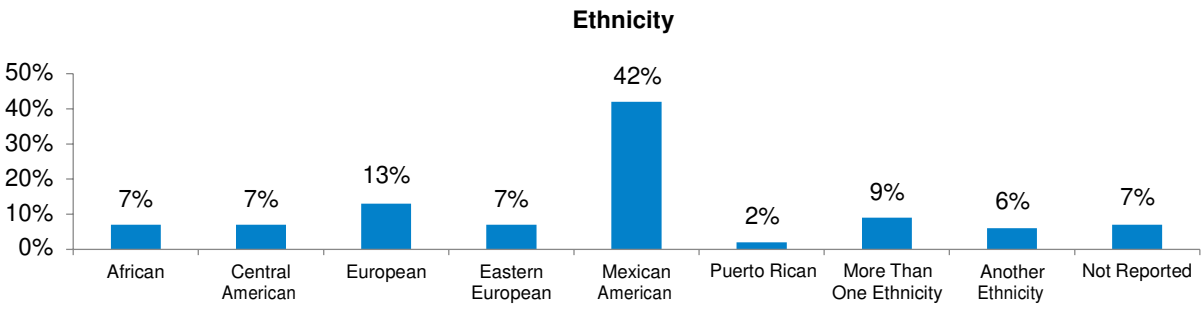


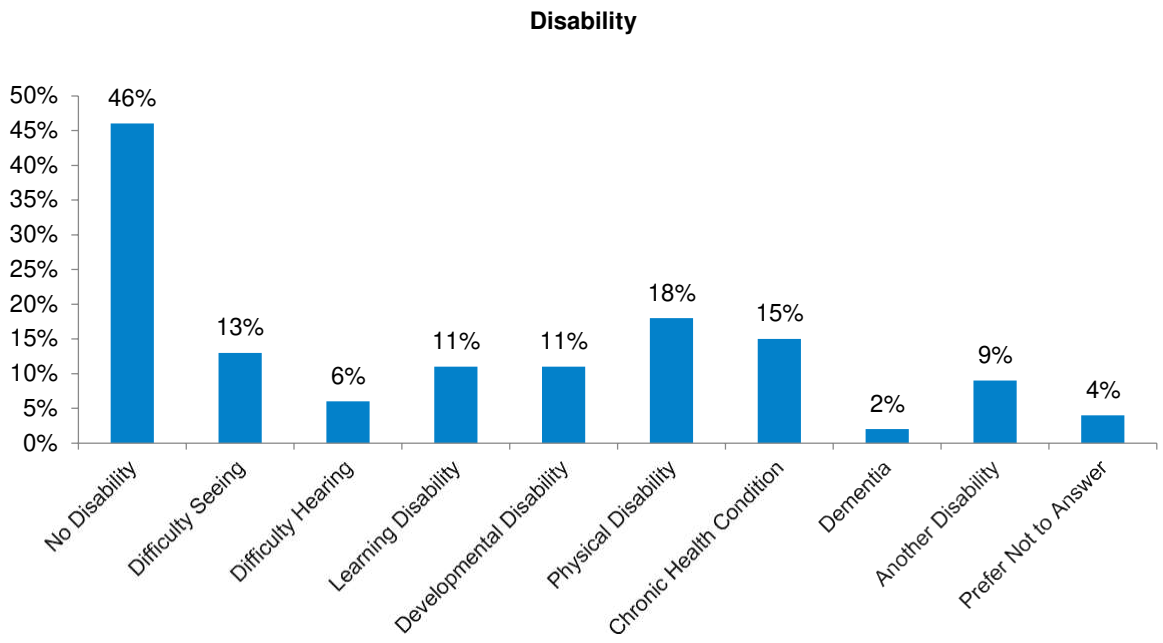








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35%
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25%
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10%
5%
0%
46%
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6%
11%
11%
18%
15%
2%
9%
4%
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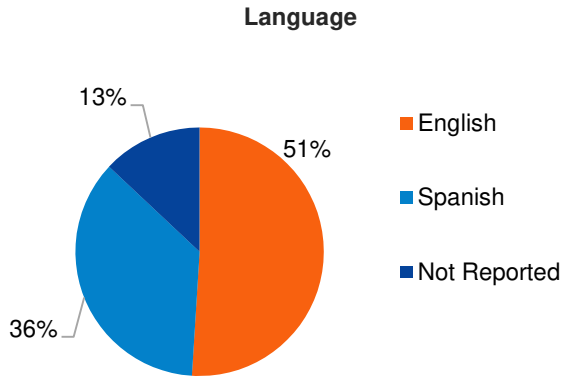
Difficulty Seeing
Difficulty Hearing
Learning Disability
Developmental Disability
Physical Disability
Chronic Health Condition
Dementia
Another Disability
Prefer Not to Answer


Language
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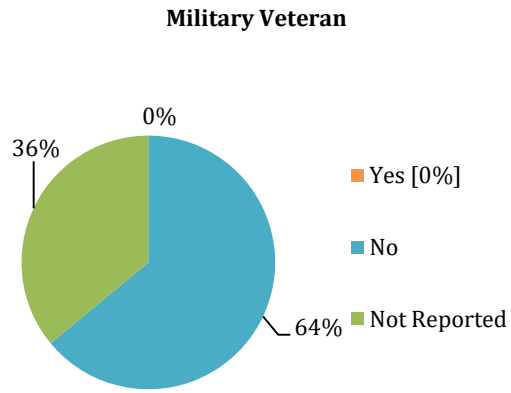
36%
English
Spanish
Not Reported


Military Veteran
0%
36%
64%
Yes [0%]
No
Not Reported

HOW WELL DID WE DO IT?

77% 59 out of 77 Referrals Became Mentees	100% Peer Mentees Reported Feeling Comfortable with Their Peer Mentor	1,419 Service Learner Hours Completed by Peer Mentors	96% Individuals Enjoy Participating in Peer Mentor Mental Wellbeing Activities	19 Peer Mentors Self-Identify with Lived Experience, 8 of those 19 Being New Peer Mentors

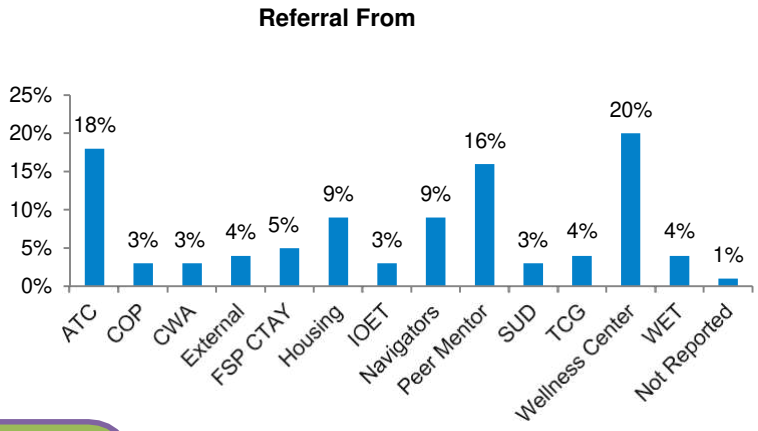
IS ANYONE BETTER OFF?

100% Peer Mentors Reported Becoming a Peer Mentor Has Made a Positive Impact in Their Lives	100% Peer Mentees Agreed Peer Mentors Provided Helpful Support in Their First Session	85% Individuals Feel More Confident from the Skills Learned in Peer Mentor Mental Wellbeing Activities

Number of Potential Responders	442
Setting in Which Responders were Engaged	Community
Type of Responders Engaged	TAY, adults, seniors, and those with lived experience
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition age youth, older adults, and those with a physical disability
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

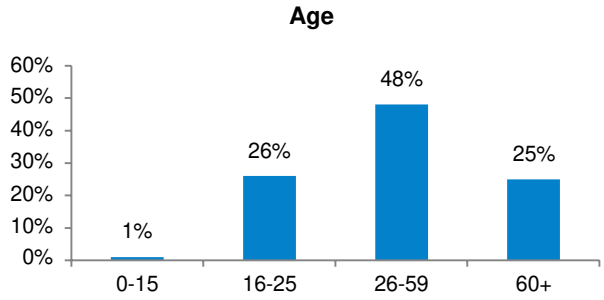
TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY:

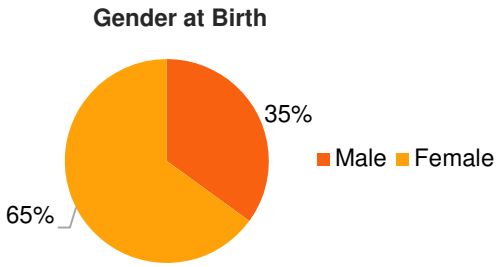
77
MHSA Referrals to Peer Mentor Program

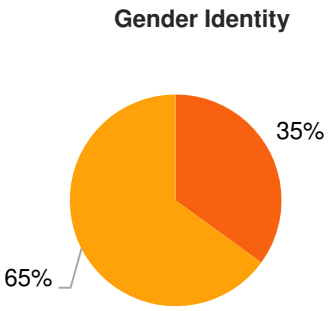


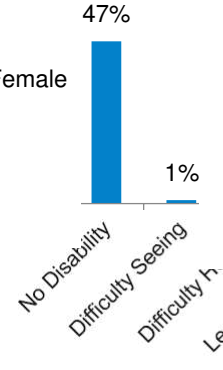
2.5 Days
Average Time Between Referral and Contact from Peer Mentor Program

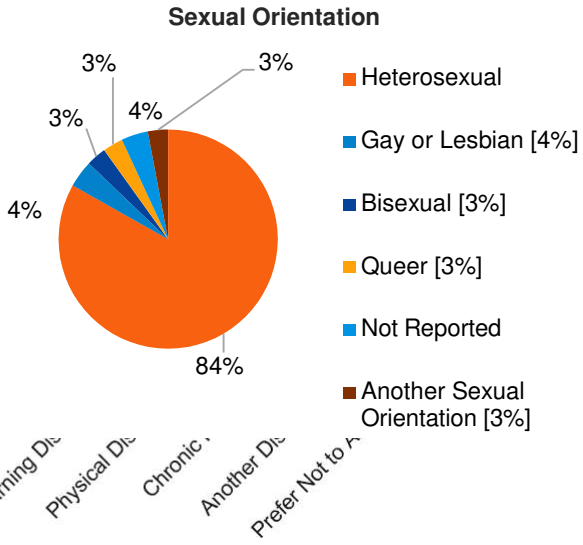
PEI Demographics Based on MHSA Referrals

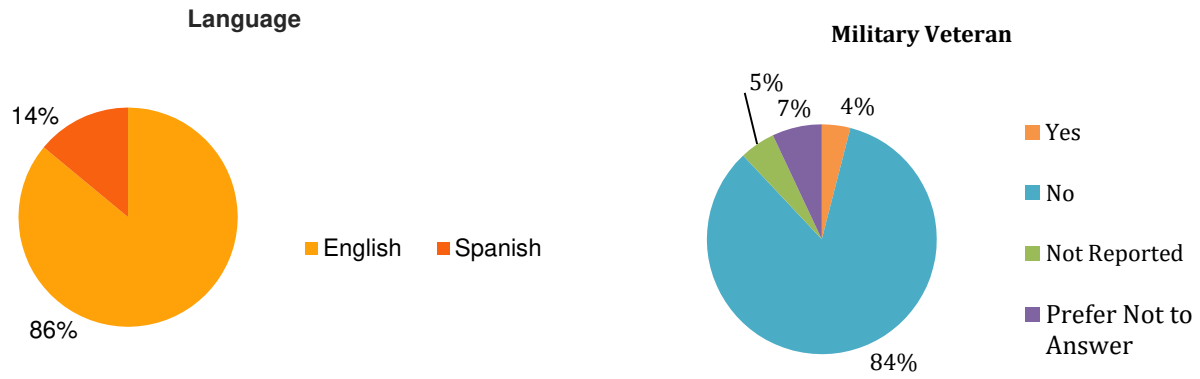











Language
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English
Spanish
Military Veteran
5%
7%
4%
84%
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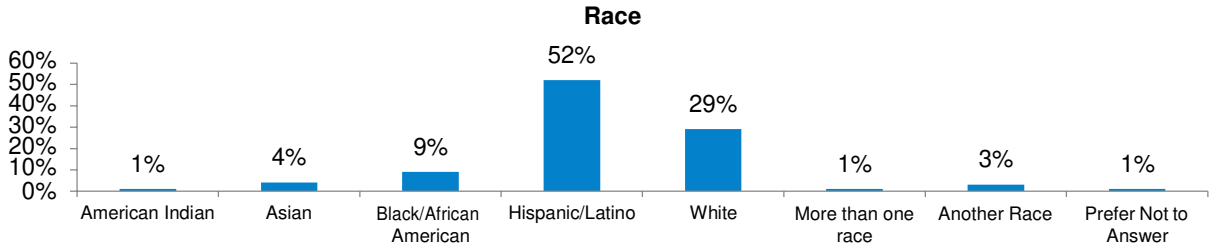
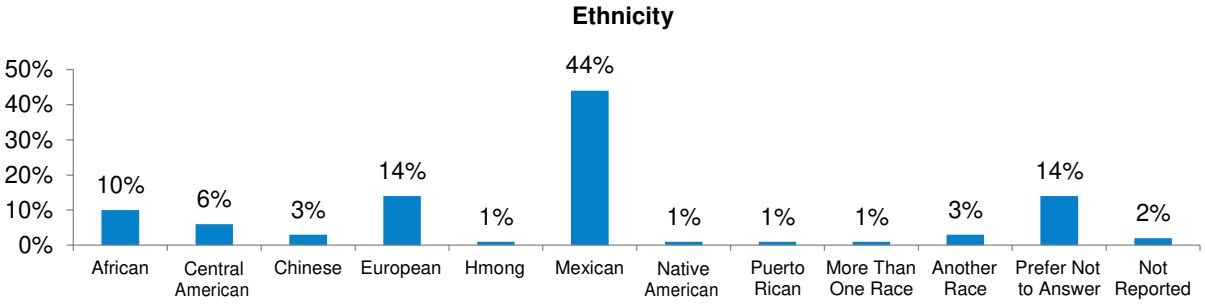
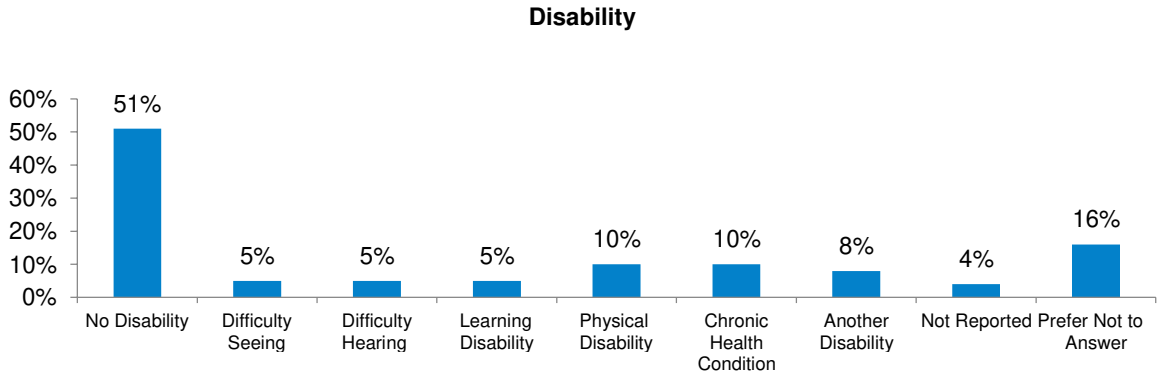
No
Not Reported
Prefer Not to Answer


Race
60%
50%
40%
30%
20%
10%
0%
1%
4%
9%
52%
29%
1%
3%
1%
American Indian
Asian
Black/African American
Hispanic/Latino
White
More than one race
Another Race
Prefer Not to Answer

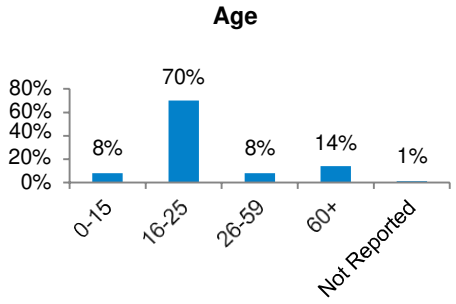

Ethnicity
50%
40%
30%
20%
10%
0%
10%
6%
3%
14%
1%
44%
1%
1%
1%
3%
14%
2%
African
Central American
Chinese
European
Hmong
Mexican
Native American
Puerto Rican
More Than One Race
Another Race
Prefer Not to Answer
Not Reported

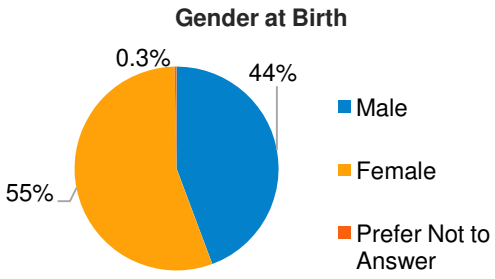

Disability
60%
50%
40%
30%
20%
10%
0%
51%
5%
5%
5%
10%
10%
8%
4%
16%
No Disability
Difficulty Seeing
Difficulty Hearing
Learning Disability
Physical Disability
Chronic Health Condition
Another Disability
Not Reported
Prefer Not to Answer

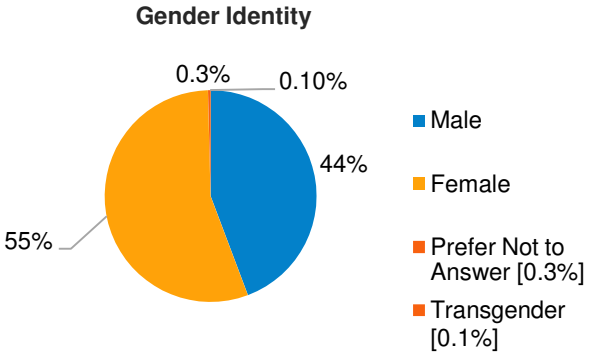
PROGRAM: Wellness Center - PEI

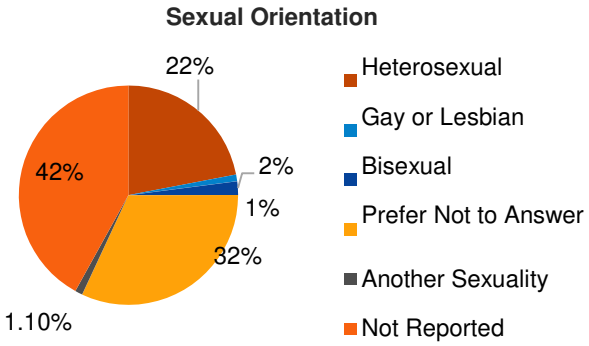
HOW MUCH DID WE DO?

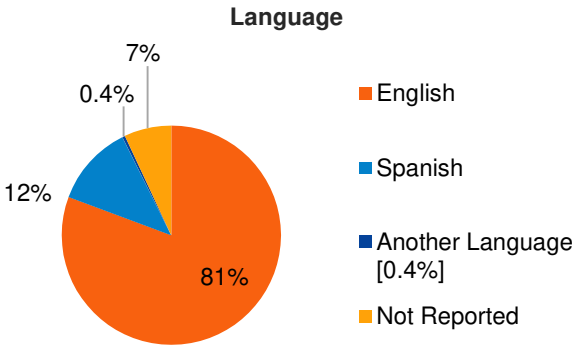
741
Unique Individuals Served

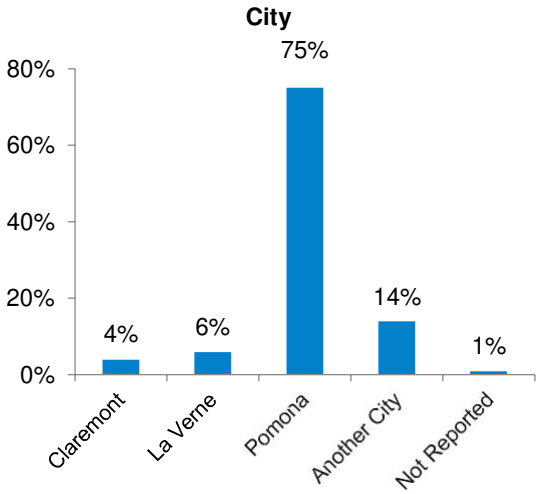




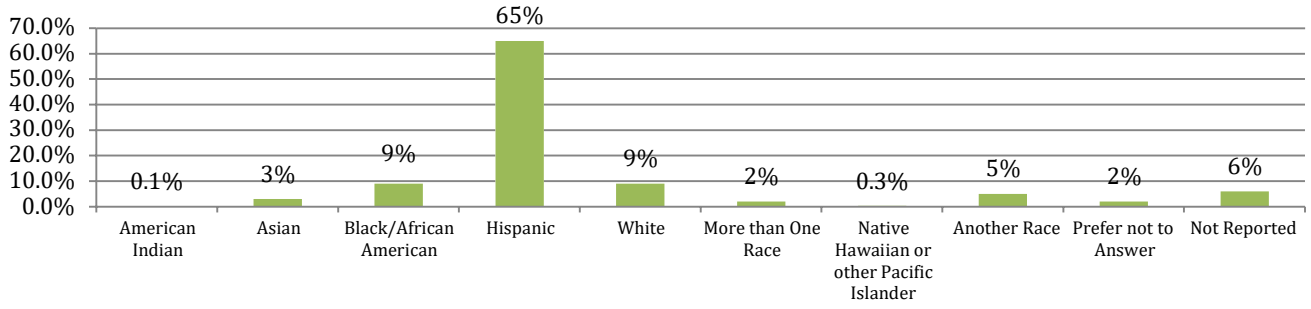




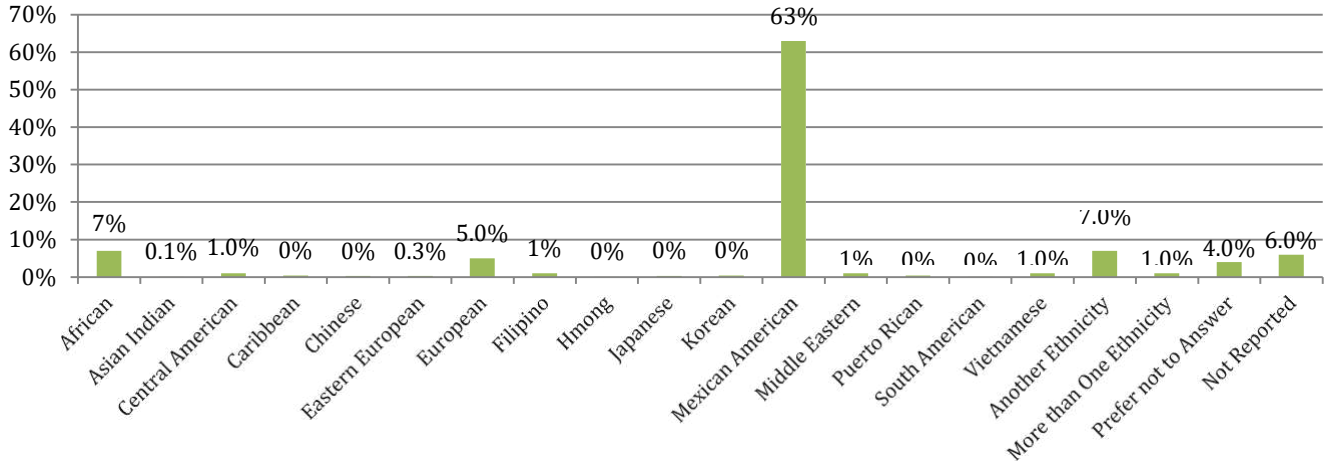




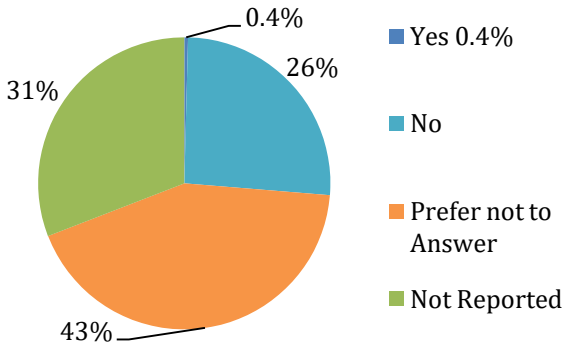
Race



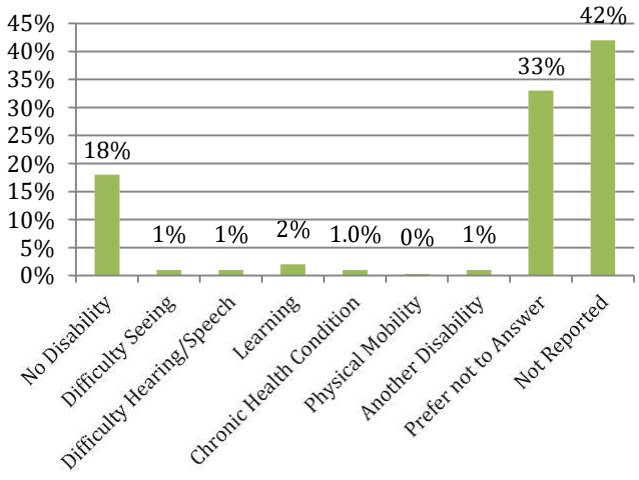
Ethnicity



Military Veteran

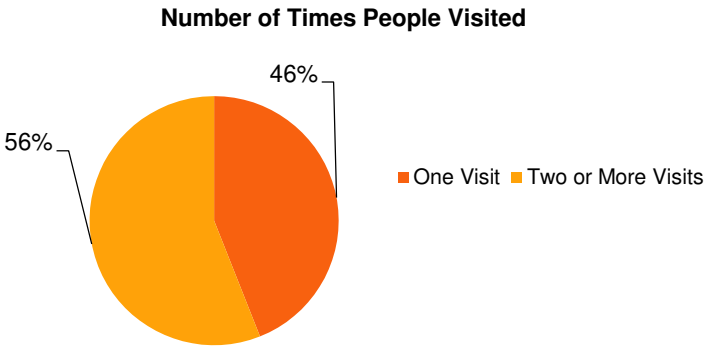


Disability



HOW WELL DID WE DO IT?

3,625
Number of Attendees at Wellness Center Events (Duplicated Individuals)

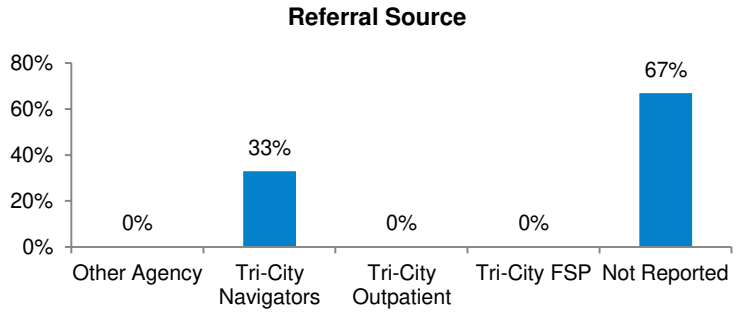


Group Name	Number of Times Group Was Held
Group – Senior Socialization	47
Group (Español) – Comadres y Compadres	50
TAY – Autism Empowerment	2
TAY – RealTalk	20
TAY – Anger Management	39
TAY – Cooking Class	8
TAY – DRA	33
TAY – Friendship Circle	6
TAY – Gaming Group	19
TAY – Karaoke	9
TAY – Literacy Alliance	9
TAY – Positive Painting	6
TAY – Pride	19
TAY – Sacred Heart	6
TAY – Socialization	4
TAY – Stress Me Not	34
TAY – TAY Leadership Committee	8
TAY – TCB	21

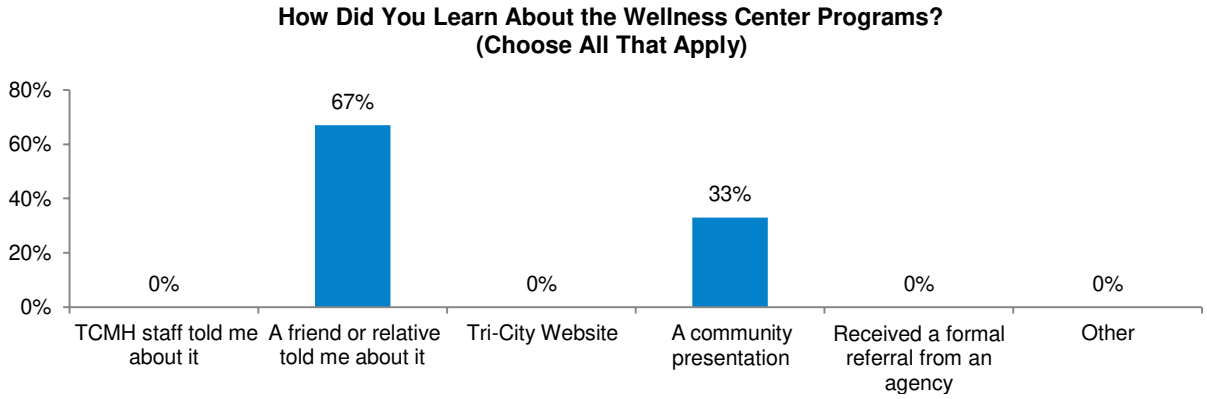
TAY – Together We Stand	43
TAY – Walking Group	24

Contacts by Type	Number of Times Contact was Made
TAY – Outing	19
TAY – PC Lab	207
TAY – Phone Call	1,423
TAY – Volunteering	4
TAY – YCES	3

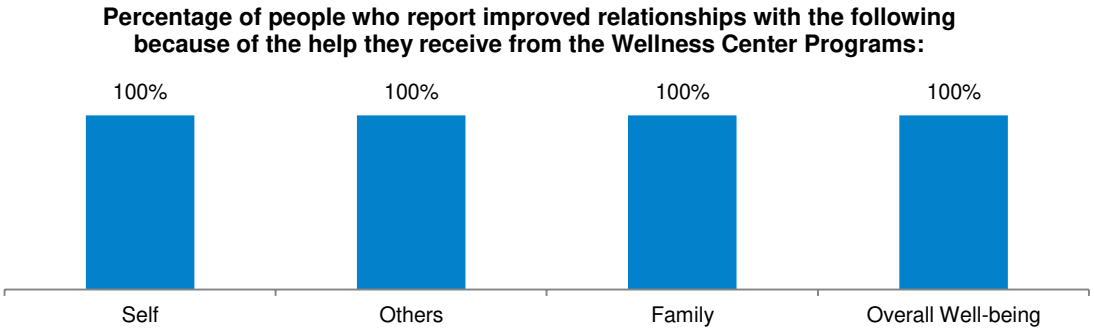
100%
Individuals Satisfied with Wellness Center Programs



IS ANYONE BETTER OFF?



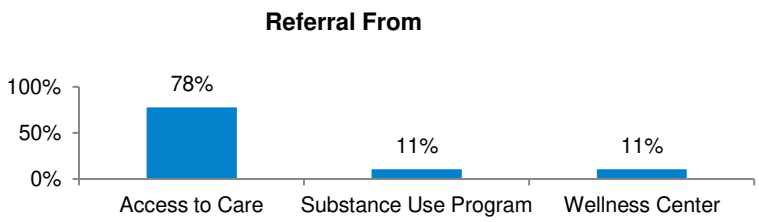
IS ANYONE BETTER OFF?



Number of Potential Responders	741
Setting in Which Responders were Engaged	Community, Wellness Center
Type of Responders Engaged	TAY, adults, seniors
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-aged youth, older adult and those with a physical disability
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY

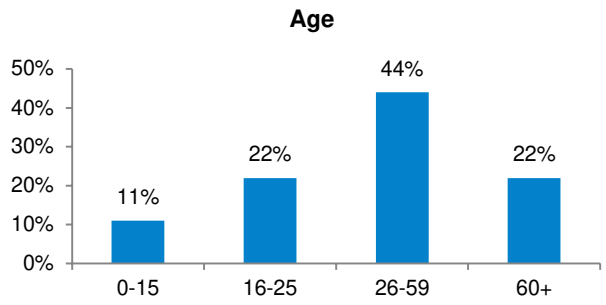
9
MHSA Referrals to Wellness Center

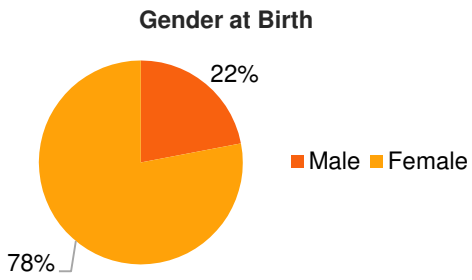


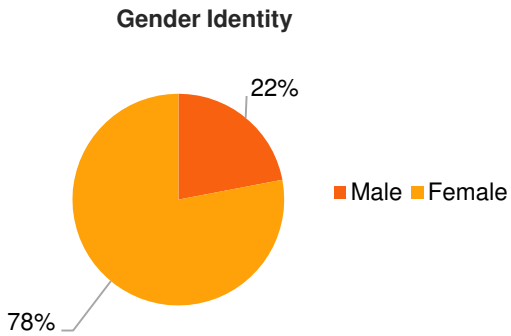
8 out of 9
Referrals Participated in Wellness Center Programs

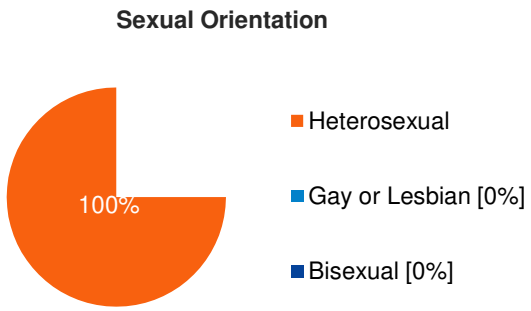
8 Days
Average Time Between Referrals and Participation in Wellness Center

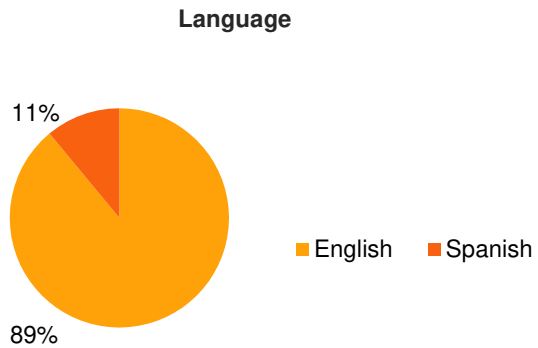
PEI Demographics Based on MHSA Referrals

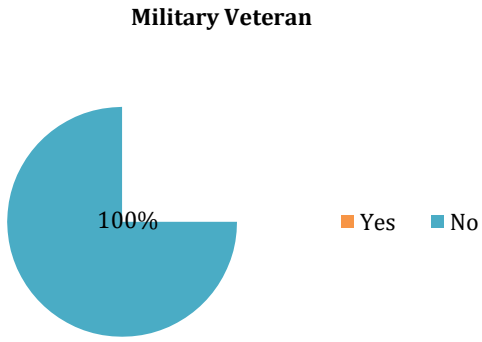


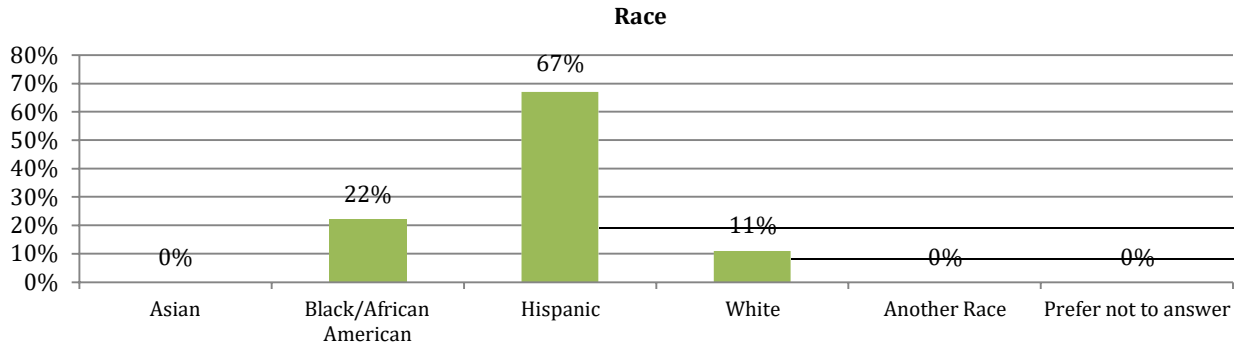


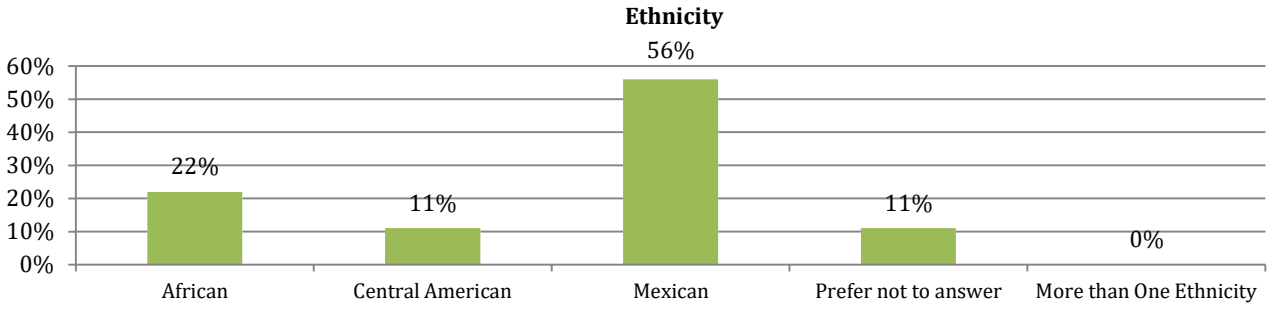


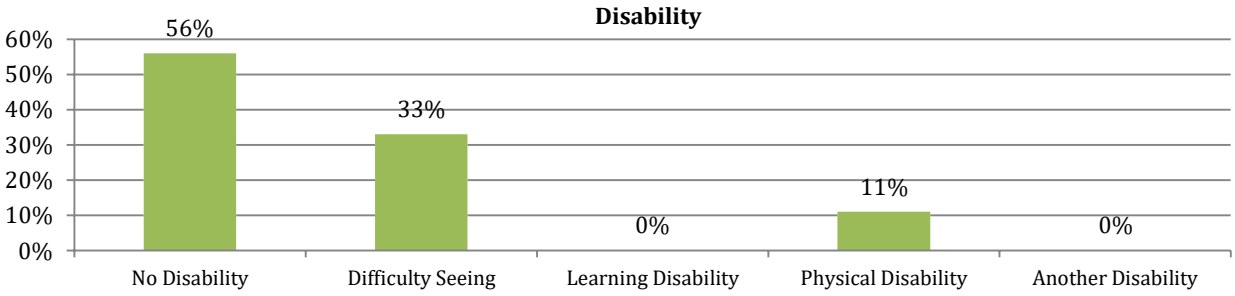







Race
80%
70%
60%
50%
40%
30%
20%
10%
0%
0%
22%
67%
11%
0%
0%
Asian
Black/African American
Hispanic
White
Another Race
Prefer not to answer


Ethnicity
60%
50%
40%
30%
20%
10%
0%
22%
11%
56%
11%
0%
African
Central American
Mexican
Prefer not to answer
More than One Ethnicity


Disability
60%
50%
40%
30%
20%
10%
0%
56%
33%
0%
11%
0%
No Disability
Difficulty Seeing
Learning Disability
Physical Disability
Another Disability

Family Wellbeing Program

Status of Program:	___New	_X_ Continuing	___Modified	___Discontinued	
Target Population:	_X_ 0-15	_X_ 16-25	_X_ 25-69	___60+	Other:
Type of Program:	_X_ Prevention	___Early Intervention	___Prevention and Early Intervention		

Program Description

The Family Wellbeing program consists of a dynamic set of programing focused on addressing the needs of the family. Programming includes support groups, 1-1 support, and an array of culturally appropriate activities focused on wellness (e.g. exercise, cooking) and other interests that can attract family members and caregivers from vulnerable communities into peer-supported experiences.

Target Population

Family members and caregivers of people who struggle with mental illness from unserved and under-served communities.

Age Groups	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Unknown
Number Served FY 2019-20	368	144	605	62	108
Cost Per Person	$71.00	$71.00	$71.00	$71.00	$71.00

Program Update

Prior to the COVID-19 outbreak, the Family Wellbeing (FW) program was focused on creating a new children's group, strengthening existing groups, expanding opportunities for community involvement, and partnering with new agencies in the community.

In September 2019, Family Wellbeing brought back a kid's group for ages 7-12 based on community feedback. Prior to COVID-19, the group averaged 5-7 participants weekly, and this number has remained steady since the pandemic, albeit now being hosted on a virtual platform.

Family Wellbeing also focused on strengthening existing groups, as a way to both bolster participation and attendance. As evidenced by holding a United Family Potluck for families. This event was well received with 34 participants, making up a total of 13 families, served that day.

During FY 2019-20, and prior to the outbreak of COVID-19, United Family also aimed to increase participant involvement in community events held by Tri-City. Two notable events where Family Wellbeing participants took an active role, were the Annual Tree Lighting event at the Wellness Center and the Pomona Christmas Parade in the month of December. During both events, participants from Family Wellbeing Karaoke Group were present to represent Tri-City while singing Holiday carols.

Challenges and Solutions

Two challenges encountered for FWB staff include outreaching to new populations, and transportation issues. When receiving feedback from families in the community, staff found that transportation was a longstanding issue. Family Wellbeing also looked to access new cohorts by connecting with new community hubs that have emerged in the tri-city area.

In hopes of addressing these challenges, and prior to COVID-19, the Family Wellbeing program began hosting groups outside of the Wellness Center. Family Wellbeing had partnered with Pomona Wellness Community to host an Arts and Crafts group that was averaging 10 participants, and looking to begin hosting multiple other groups there as well. These efforts will continue once the pandemic restrictions are lifted.

COVID-19 Response

Following the outbreak of COVID 19, Family Wellbeing was impacted significantly. Due to changes in both staffing locations and the restrictions on providing in-person services, Family Wellbeing programing stopped completely and slowly began a re-building phase using a virtual platform. With this dramatic change in mind, FWB was charged with finding innovative ways to provide service. Options included the use of phones, email, and virtual platforms which for most families, was a viable method of communication. However, for some families, these options were limited based on lack of access. Community agency connections were somewhat easier to maintain.

A major challenge encountered was transitioning all FWB programing to a virtual platform, including Summer Camp, which was originally designed to be an in-person format. During the summer of 2020, Summer Camp was successfully transitioned to a virtually format. This popular program served 12 campers and their families. Campers were provided with a platform to use as well as supplies needed to complete activities, all delivered to their door using contactless delivery methods. Campers met virtually once a week, and maintained communication via phone and email. The feedback from the campers and parents was positive with families expressing gratitude for the opportunity to maintain some sense of normalcy during a difficult time. Seventy-five percent of participants were returning campers from previous sessions.

Cultural Approach

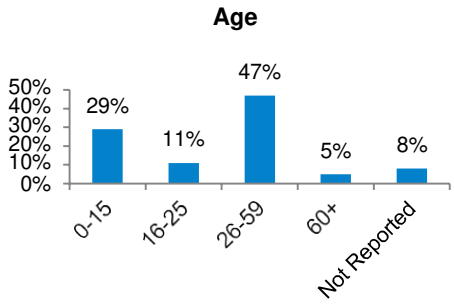
The Family Wellbeing program is available in both English and Spanish. Staff are bilingual and information brochures are available in multiple languages.

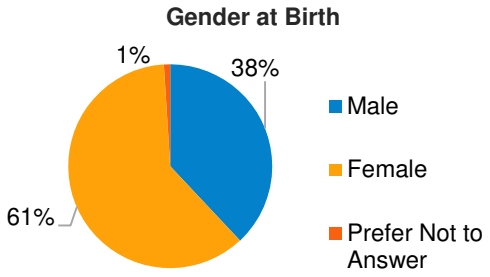
Another asset to the Family Wellbeing team is having staff who identify at LGBTQ+. These individuals attempt to address issues that can lead to barriers to seeking services as well stigma concerns. Also, FWB is meeting the community “where they are” by hosting groups at locations they are familiar with or current gathering.

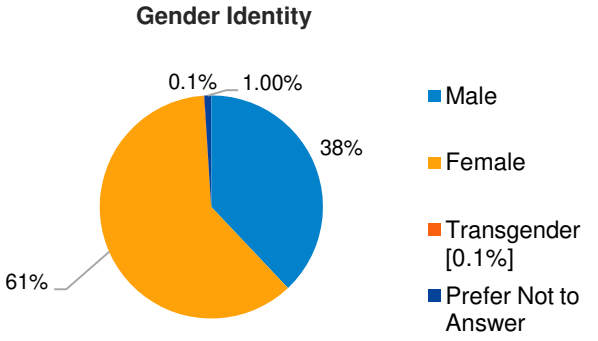
PROGRAM: Family Wellbeing Program

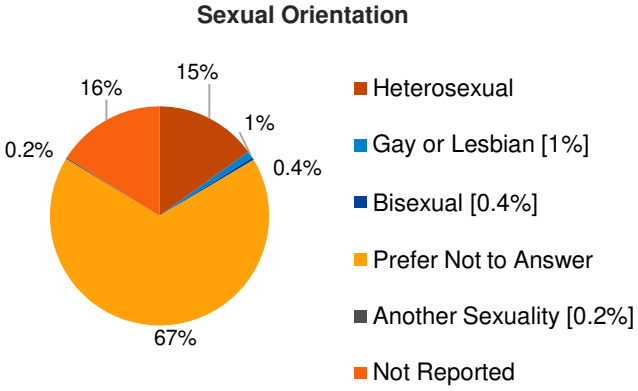
HOW MUCH DID WE DO?

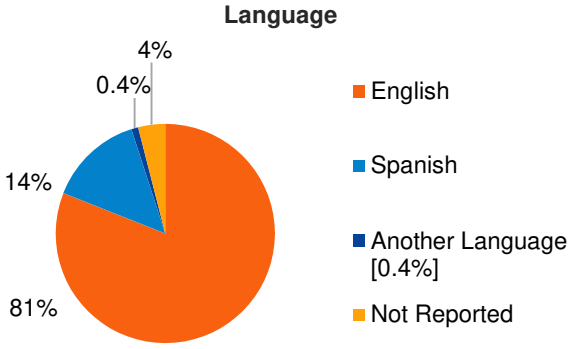
1,287
Unique Individuals Served

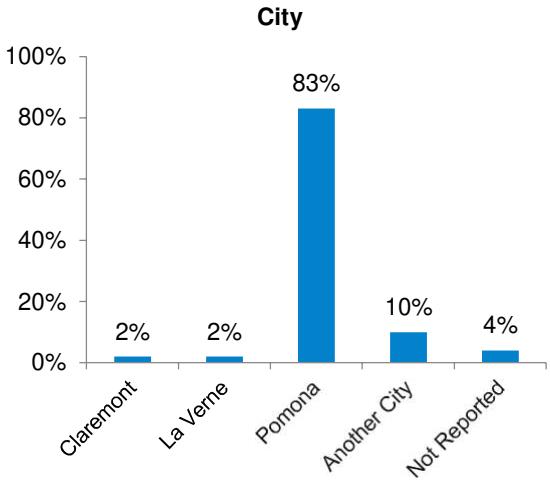




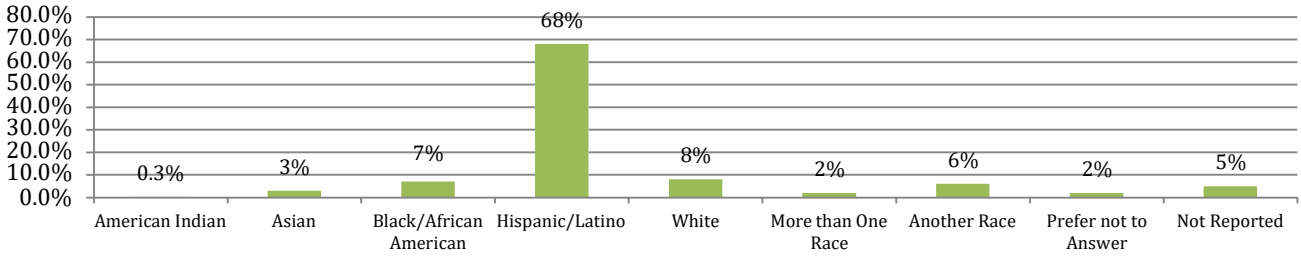




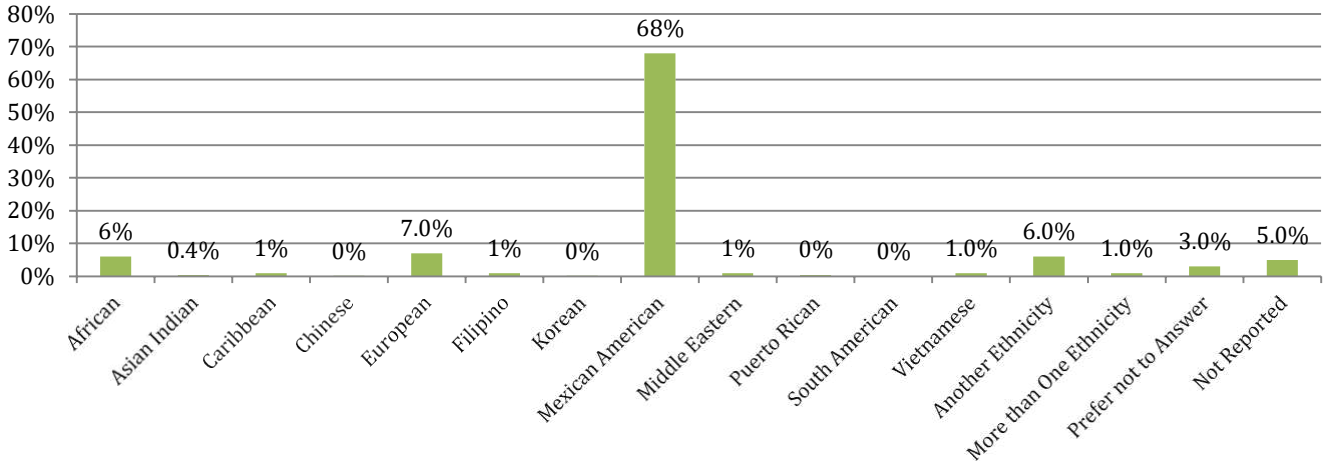




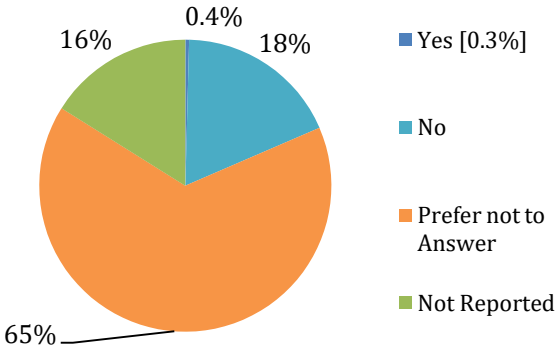
Race



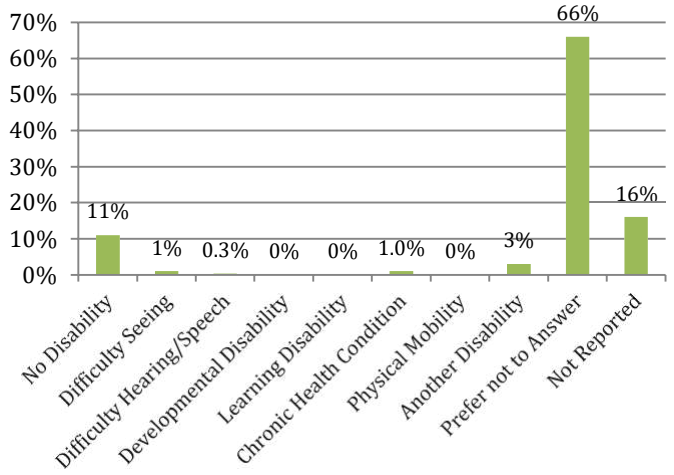
Ethnicity



Military Veteran



Disability



HOW WELL DID WE DO IT?

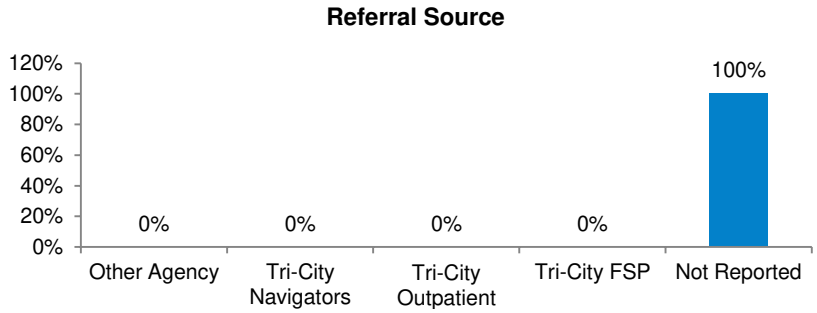
5,284
Number of Attendees at Family Wellbeing Events

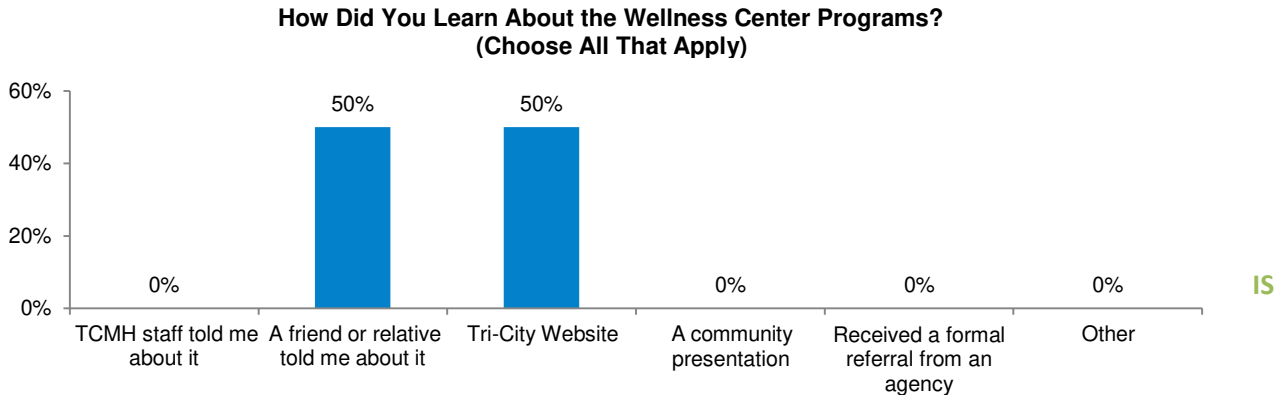
Group Name	Number of Times Group Was Held
FWS – Arts & Crafts	22
FWS – Attendance Letter	61
FWS – Bore No More	7
FWS – Cooking Class	2
FWS – Creative Writing	15
FWS – Grief & Loss	37
FWS – Kid's Hour	25
FWS – Limited to Limitless	43
FWS – Mommy & Me	24
FWS – Movie Night	34
FWS – Music	35
FWS – Sacred Heart	12
FWS – Spirituality	35
FWS – STEP Anger Management	1
FWS – Summer Camp	22
FWS – Teen Anger Management	25
FWS – Teen Hour	37

FWS – United Family	34
FWS – Walking Adventure	36
FWS – Writing to Heal	31

Contacts by Type	Number of Times Contact was Made
FWS – Brief Check-in	527
FWS – One-on-One	99
FWS – Other	83
FWS – Phone Call	892

100%
Individuals Family Wellbeing Program

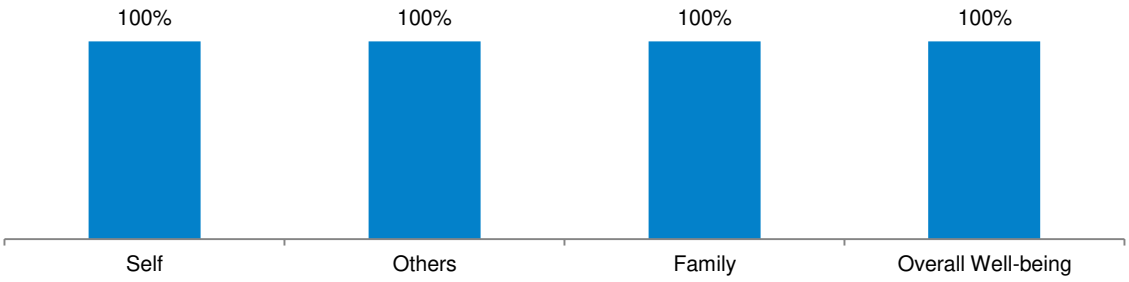




IS

ANYONE BETTER OFF?

Percentage of people who report improved relationships with the following because of the help they receive from the Family Wellbeing Program:

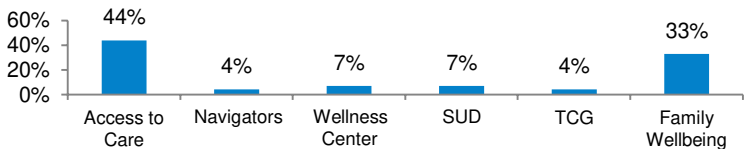


Number of Potential Responders	1,287
Setting in Which Responders were Engaged	Community
Type of Responders Engaged	Parents and children
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-age youth, older adults and those with a physical disability
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY

27
MHSA Referrals to Family Wellbeing

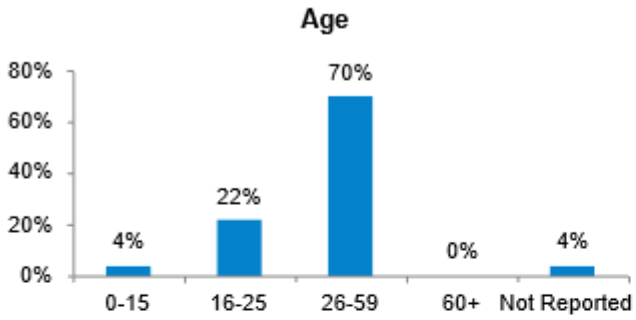
Referral Source

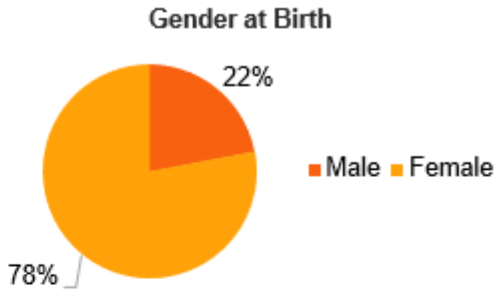


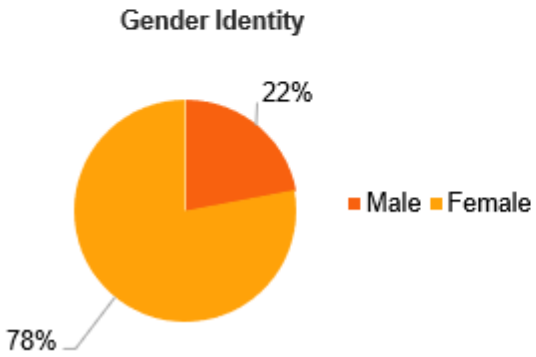
23 out of 27
Referrals Participated in Family Wellbeing Program

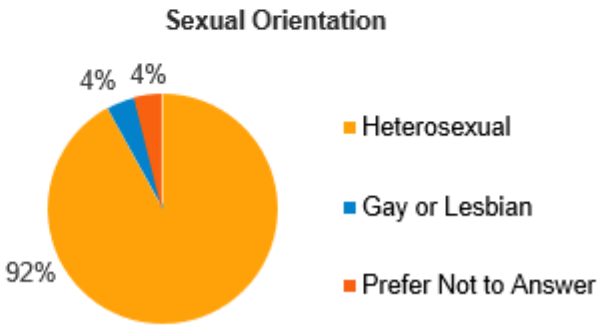
12 Days
Average Time Between Referrals and Participation in Family Wellbeing

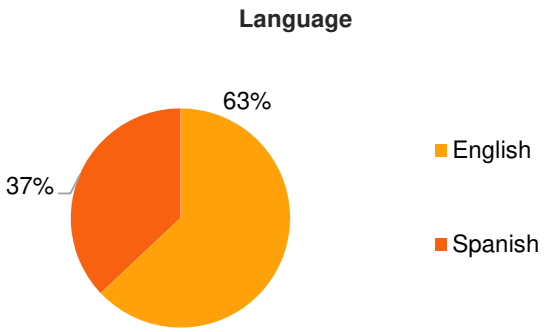
PEI Demographics Based on MHSA Referrals

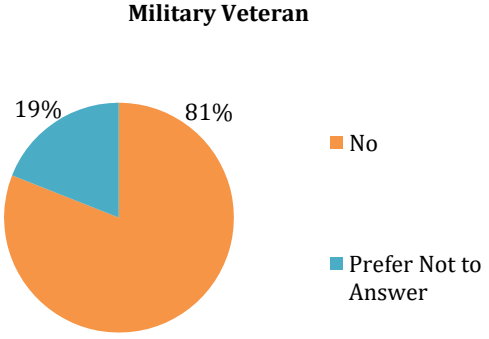




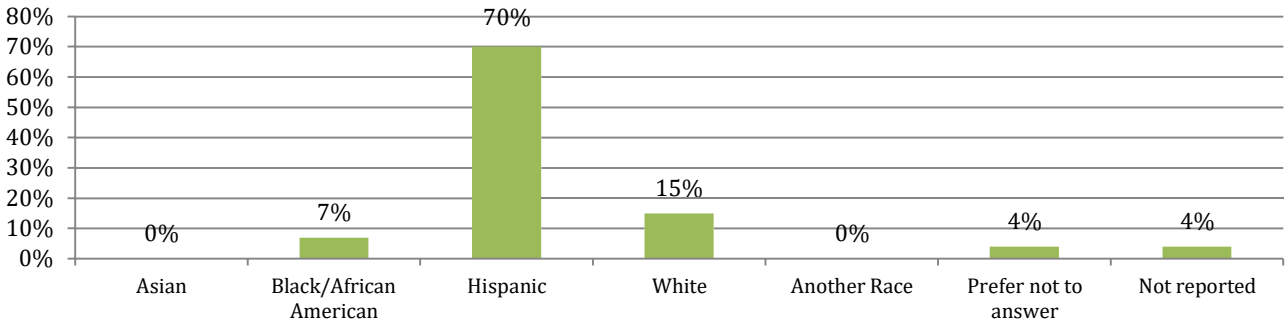




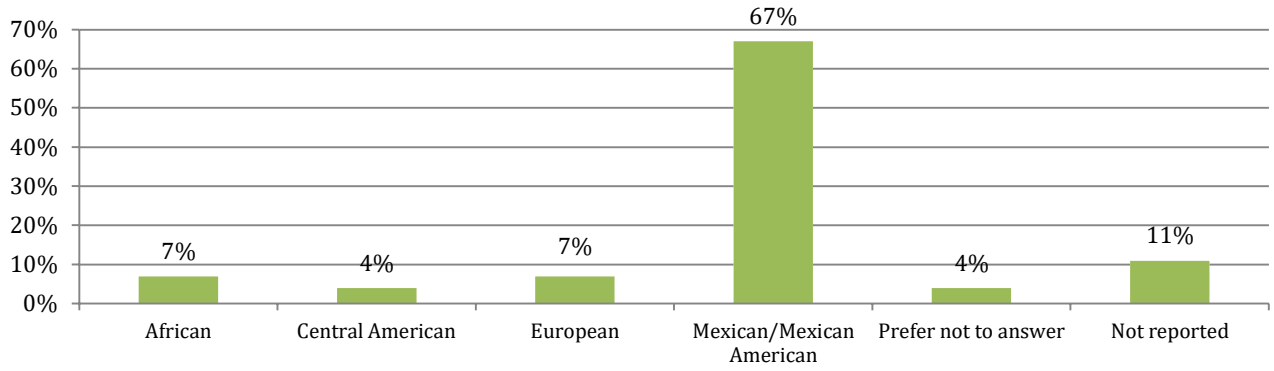




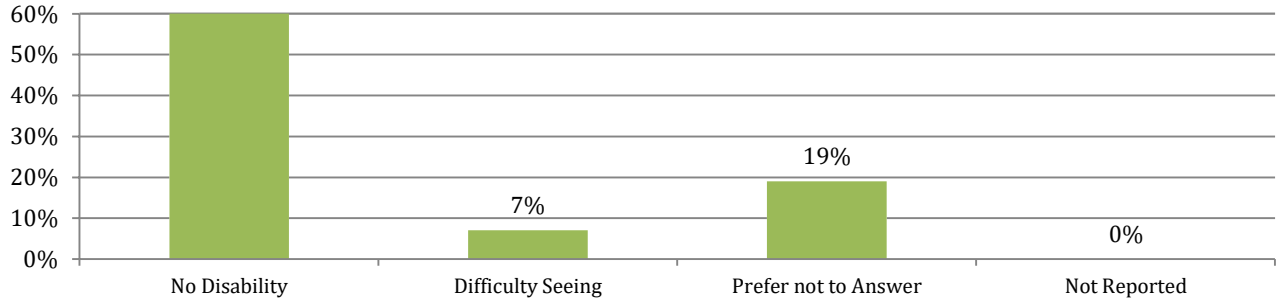
Race



Ethnicity



Disability



NAMI: Ending the Silence

Status of Program:	_X_ New	___Continuing	___Modified	___Discontinued	
Target Population:	_X_ 0-15	_X_ 16-25	_X_ 25-69	___60+	Other:
Type of Program:	_X_ Prevention	___Early Intervention		___Prevention and Early Intervention	

Program Description

Ending the Silence is a community presentation offered by the National Alliance on Mental Illness (NAMI). This 50-minute program is designed to teach students, school staff and families to recognize the warning signs of mental health issues and what steps to take when they observe these symptoms in their students, friends or loved ones.

Target Population

Ending the Silence offers three separate presentations targeting; 1) middle and high school students; 2) teachers and school staff; and 3) adults with middle or high school youth.

Number of Trainings for FY 2019-20	8
Number of Attendees for FY 2019-20	346

Program Update

Prior to the COVID-19 outbreak, NAMI Pomona Valley (NPV) was on track to increase collaboration with local community partners and, thereby, increasing participation in their support and education programs. Additionally, NPV made plans to increase awareness among community stakeholders with an eye toward promoting the Ending the Silence (ETS) program, as well as support groups offered through the Community Services and Supports program. Notably, the Spanish language outreach efforts had increased.

Challenges and Solutions

Challenges with ETS continues to be logistical. As a school-based program, the mechanics of contacting schools, and confirming a commitment to host the training has proven to take an inordinate amount of time. Convincing school official of the value of this training, as well as scheduling the time for these presentations, continues to be an obstacle to implementing this training on a larger scale. In response to this, NPV has secured an intern who is dedicated to contact and coordinate with school officials in hopes of building a strong collaboration which will include this essential training.

COVID-19 Response

The Ending the Silence program was devastated by the COVID-19 outbreak insofar as the schools shut down eliminated the opportunity to provide the in-person ETS presentations. Although NPV attempted to transition the presentations to a virtual platform, these efforts were largely unsuccessful when the shutdown first happened as schools were grappling with more fundamental issues. As a result of the school shut down, getting a response from school personnel proved all but impossible. Therefore,

presentations could not be arranged. However, efforts continue to try and improve the delivery of the ETS presentations and evaluation process using an online and web- based format.

Cultural Approach

NAMI is highly committed to cultural inclusion and offers the Ending the Silence program in both English and Spanish. In addition, efforts are made to recruit diverse populations as program leaders. All outreach and program materials are available in both English and Spanish. At this time, NAMI PV does not have a dedicated strategy to addressing barriers to the LGBTQ+ community who may be seeking services. Future efforts include distinct and consistent efforts to outreach to underserved and unserved groups and organizations, in the hopes of enhancing current practices in providing access to services.

PROGRAM: NAMI – Ending the Silence

HOW MUCH DID WE DO?

8
Presentations

HOW WELL DID WE DO IT?

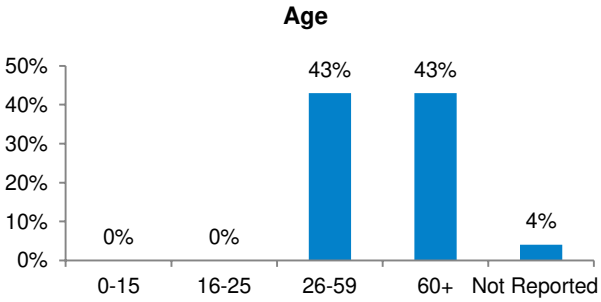
100%
Agreed or strongly agreed that the presentation increased their understanding of symptoms associated with mental health challenges

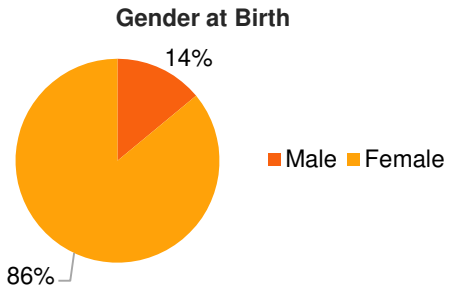
100%
Agreed or strongly agreed that the presentation will help them recognize early warning signs of mental health challenges

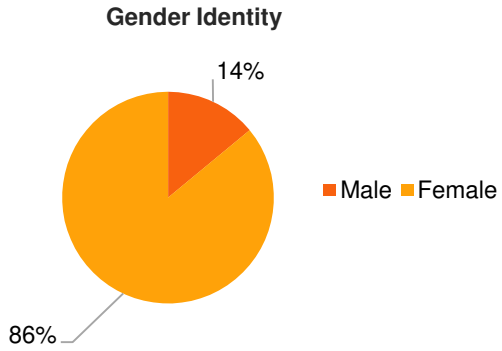
IS ANYONE BETTER OFF?

100%
Agreed or strongly agreed that the presentation provided them with new and useful resources

100%
Agreed or strongly agreed that the presentation helped them understand the impact of untreated mental health challenges


Age
50%
40%
30%
20%
10%
0%
0%
0%
43%
43%
4%
0-15
16-25
26-59
60+
Not Reported


Gender at Birth
14%
86%
Male
Female


Gender Identity
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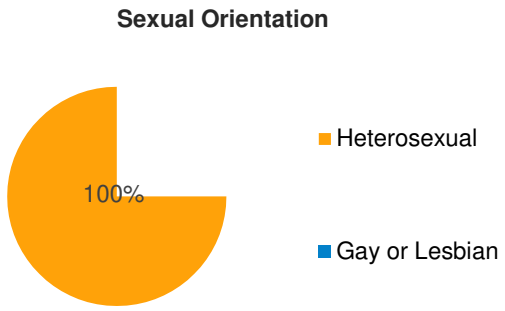
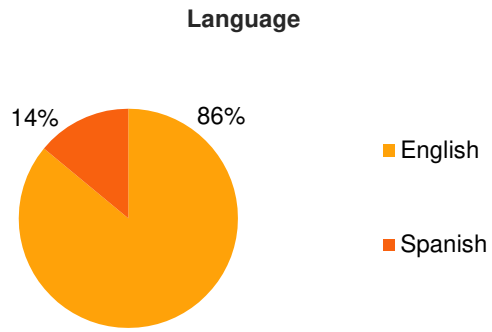
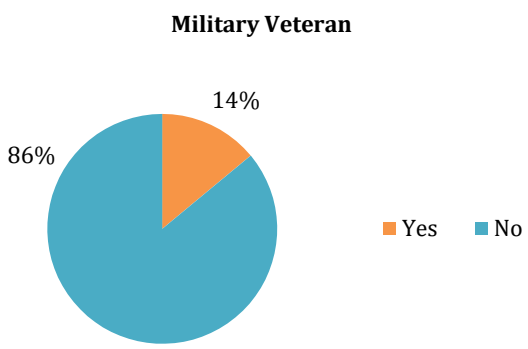
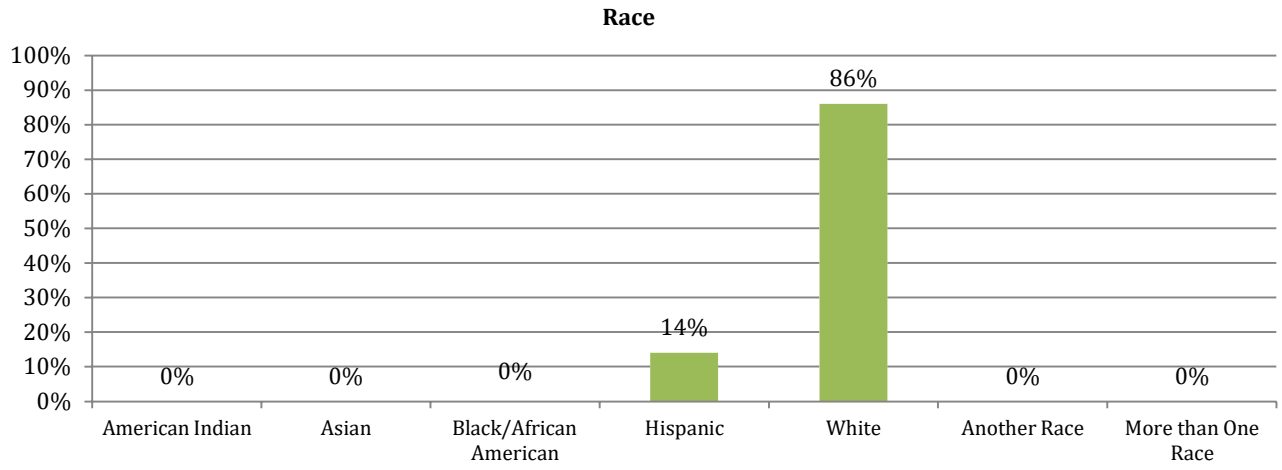
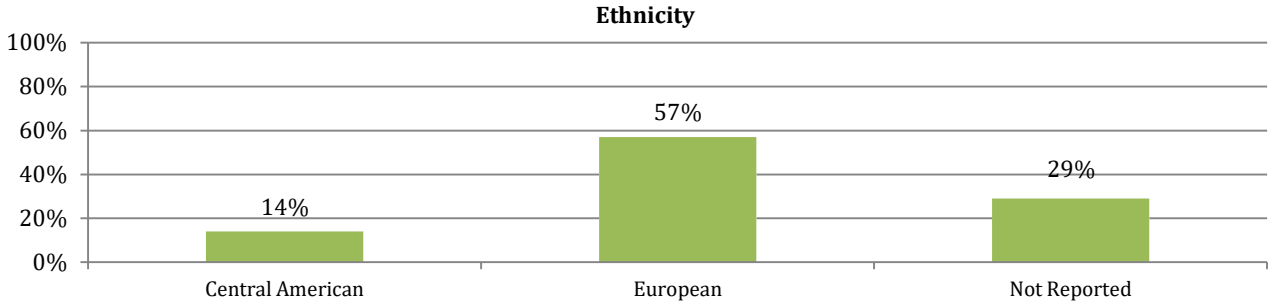
86%
Male
Female


Sexual Orientation
100%
Heterosexual
Gay or Lesbian


Language
14%
86%
English
Spanish


Military Veteran
14%
86%
Yes
No


Race
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
0%
0%
0%
14%
86%
0%
0%
American Indian
Asian
Black/African American
Hispanic
White
Another Race
More than One Race


Ethnicity
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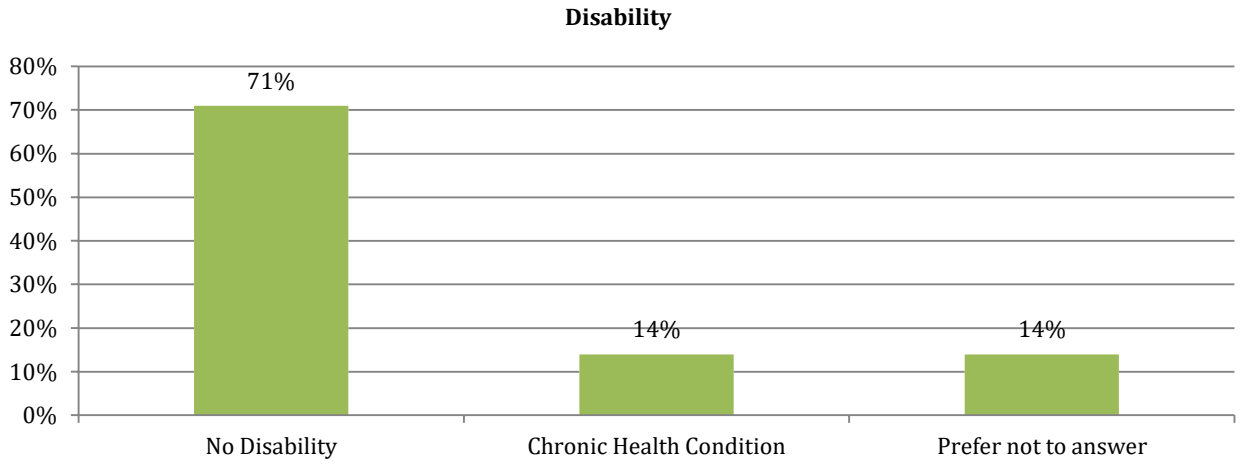
80%
60%
40%
20%
0%
14%
57%
29%
Central American
European
Not Reported

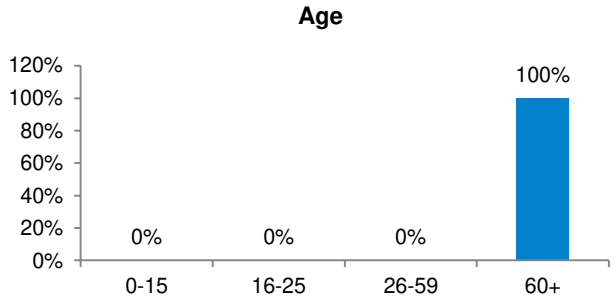

Disability
80%
70%
60%
50%
40%
30%
20%
10%
0%
71%
14%
14%
No Disability
Chronic Health Condition
Prefer not to answer

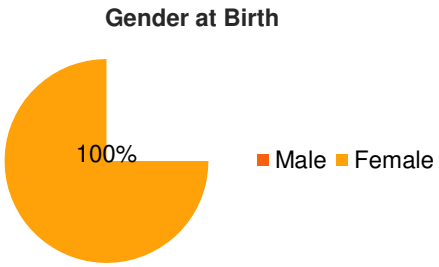
Number of Potential Responders	346
Setting in Which Responders were Engaged	Schools
Type of Responders Engaged	Teachers and school staff, middle and high school students, adults with middle or high school youth
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-aged youth, older adult and those with a physical disability
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

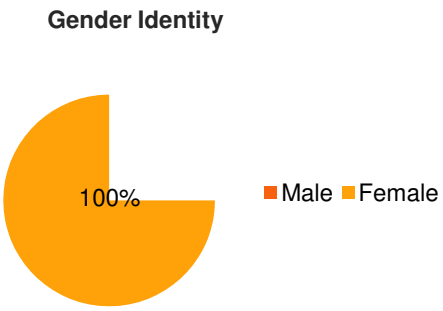
TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY

1
MHSA Referral to NAMI

PEI Demographics Based on MHSA Referrals (n=1)






Gender Identity
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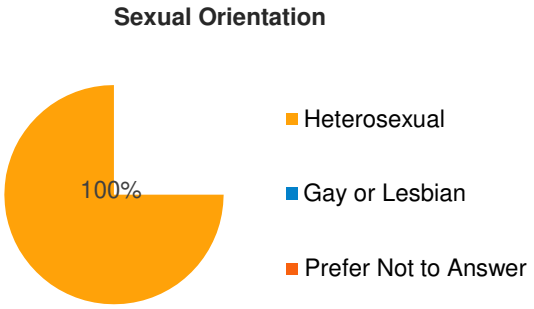
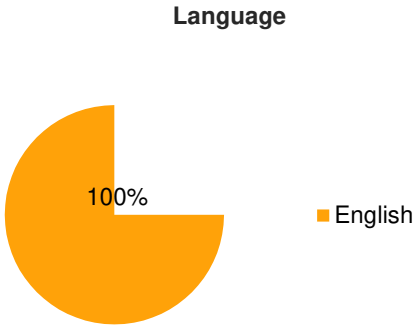
Male
Female


Sexual Orientation
100%
Heterosexual
Gay or Lesbian
Prefer Not to Answer


Language
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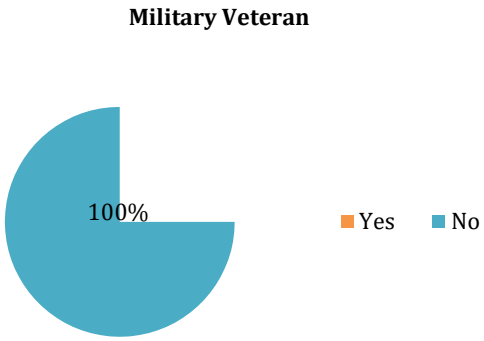
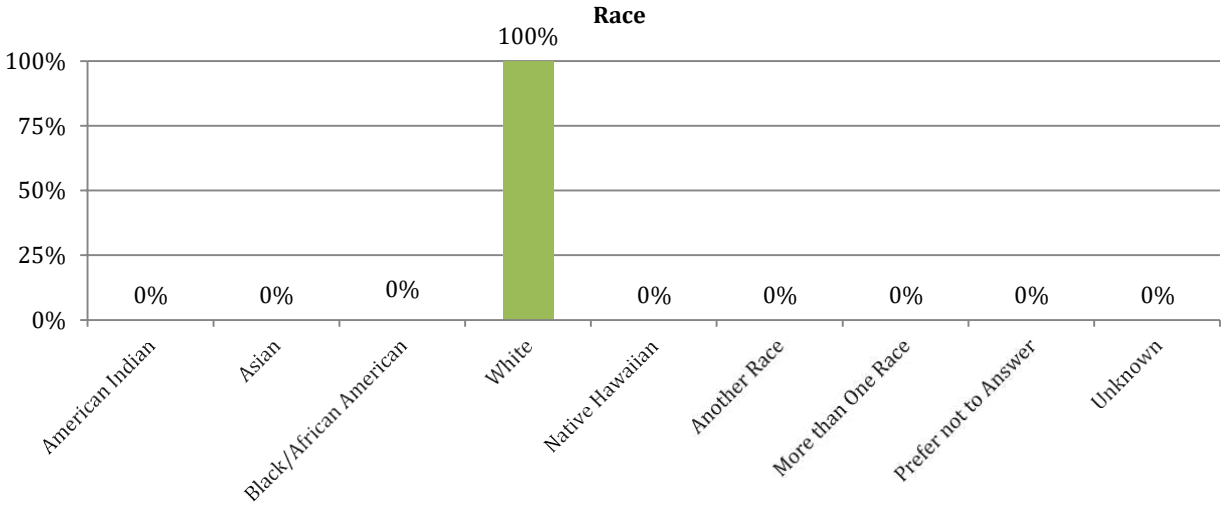
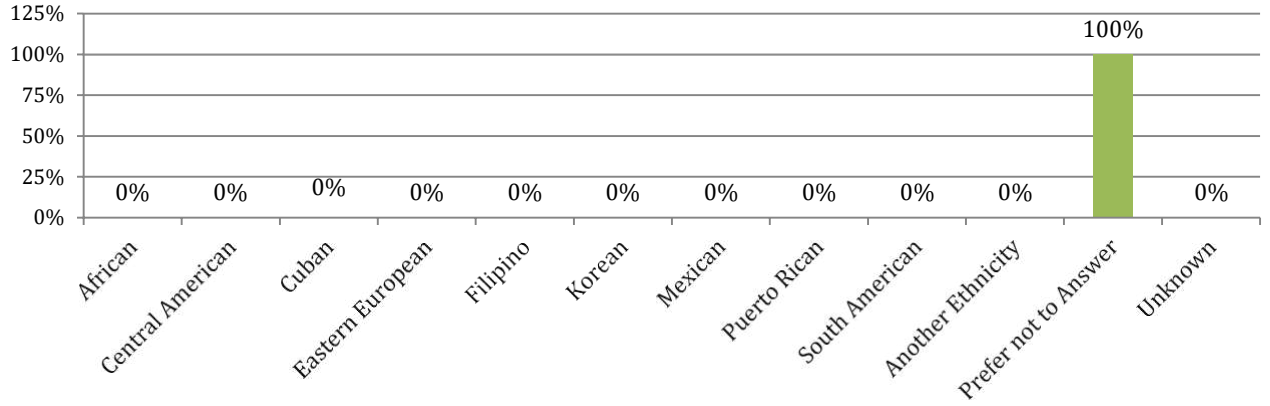
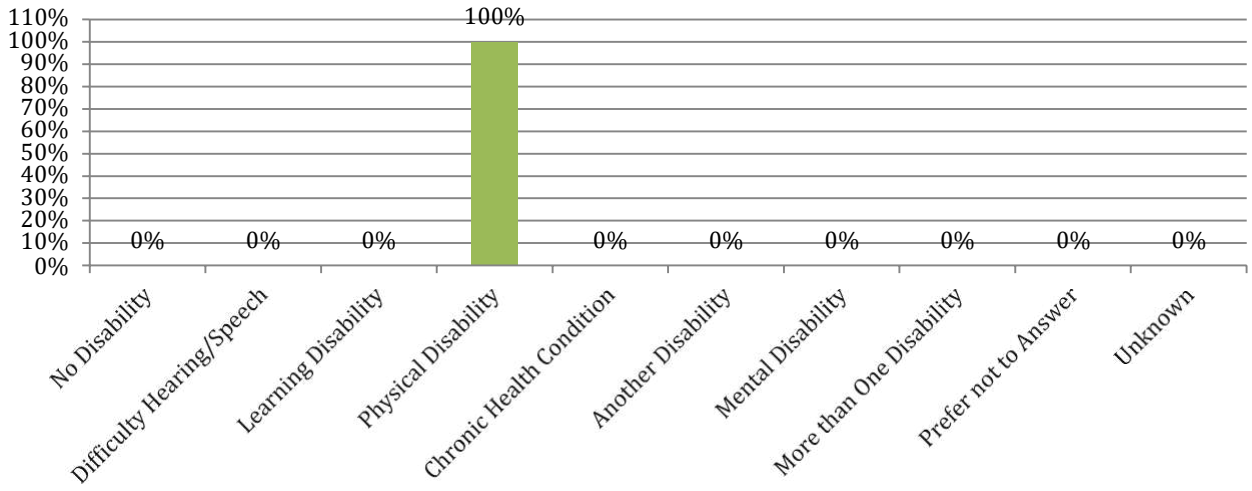

Military Veteran
100%
Yes
No


Race
100%
75%
50%
25%
0%
0%
0%
0%
100%
0%
0%
0%
0%
0%
American Indian
Asian
Black/African American
White
Native Hawaiian
Another Race
More than One Race
Prefer not to Answer
Unknown

Ethnicity



Disability



Housing Stability Program

Status of Program:	___New	_X_ Continuing	___Modified	___Discontinued	
Target Population:	___0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:
Type of Program:	_X_ Prevention	___Early Intervention		___Prevention and Early Intervention	

Program Description

Stable housing is a necessary foundation to be able to create wellbeing and support a person's mental health. Tri-City Housing staff work diligently with clients, mental health service providers, landlords, and property managers to secure housing placements, mediate conflicts, and strengthen relationships. The Housing Stability Program is a prevention program designed to help people with mental illness maintain their current housing or find more appropriate housing.

Target Population

Individuals experiencing mental illness who need support to maintain their current housing or find a more appropriate place of residence. Program staff members work with clients, mental health service providers, landlords, and property managers to secure housing placements, mediate conflicts, and strengthen relationships.

New Landlords Engaged	Landlord Luncheons Held	Attendees (Unique)	Repeat Attendees (Duplicates)
22	9	114	165

Program Update

In August of 2019, the Housing Stability Program (HSP) hosted the annual Housing Summit with the largest attendance for this event at 52 attendees. The event expanded from just providing regular update of the housing laws and regulations to guests such as the Los Angeles County Development Authority who presented their Homelessness Incentive Program which included a panel of previously homeless individuals, who shared their journey to being housed. The goal is to encourage owners to be more open to working with individuals using housing vouchers.

Challenges and Solutions

The HSP staff began offering the "Good Tenant Curriculum" to tenants residing at properties funded through MHSA. However, tenants at these sites did not appear motivated to attend the group despite a "graduation gift" that was promoted. There were only a few instances where the presenter encountered language barriers as the tenants spoke a language other than English or Spanish.

In response, HSP staff will review surveys from past attendees and revise the curriculum to cover topics and address questions from previous groups in hopes that this updated information will be applicable and of interest to these tenants.

During FY 2019-20, the HSP added a new community group, Open Door. Through this group, staff are able to provide general housing listings created biweekly. This new, bi-weekly, group is a round table discussion for anyone that has questions regarding housing, with the purpose of clarifying any misconceptions of the availability of housing. It also provides an opportunity for community members to engage in conversations with each other to identify ways in which they have overcome housing obstacles.

COVID-19 Response

With the onset of the COVID 19 pandemic, the HSP staff quickly moved the Open Door Group to a virtual platform. In addition, the monthly landlord meetings were moved to a virtual platform as well. Community emails were sent referring individuals directly to the Housing Rights Center to offer support regarding housing rights and concerns.

Previously scheduled events, such as the first Housing Fair, inspired by job fairs held at the Wellness Center, were scheduled in compliance with state and federal restrictions. Outreach efforts were curtailed due to social distancing and a reduction with "in-person" meetings with landlords and property managers.

RingCentral, an online meeting platform, proved to be a valuable resource for staff when hosting groups, meetings, summits, and webinars. Trainings such as the Good Tenant Curriculum, were modified to be available for a call-in group format. Efforts are underway with community partners to add WIFI and computer stations so the Good Tenant Curriculum can be offered virtually as well.

Future efforts include working with Tri-City community trainers to expand the Mental Health First Aid trainings for property owners and landlords to help them when responding to difficult interactions with tenants. A new curriculum will be introduced in the future entitled Landlord Everyday Mental Health. Housing staff will also begin hosting regular landlord housing forums to provide a virtual round table for landlords. Participants will be able to offer support to each other while identifying areas where resources and future education is needed.

Cultural Approach

Cultural inclusion is an important component to the Housing Stability Program. Five of the eight housing staff are bilingual in English and Spanish. Tri-City staff maintain strong alliances with various agencies throughout the county that serve diverse communities. Information and resources gleaned from these relationships are then provided to participants during the Landlord Luncheons.

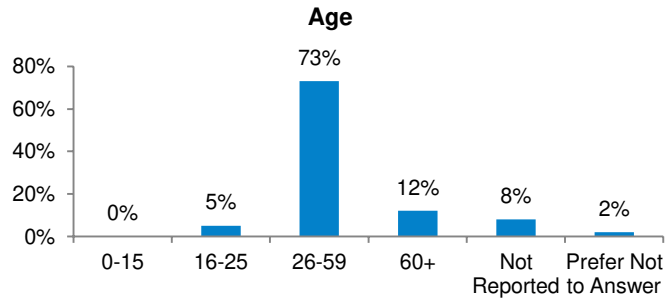
Stigma regarding mental illness is also a concern and the Open Door group is structured to focus on individuals who are considered underserved, and offer support and resources as they express their experience with barriers or discriminations. Mental Health First Aid training is offered for landlords, owners, and property managers in order to help them better understand and be able to support tenants with mental health conditions.

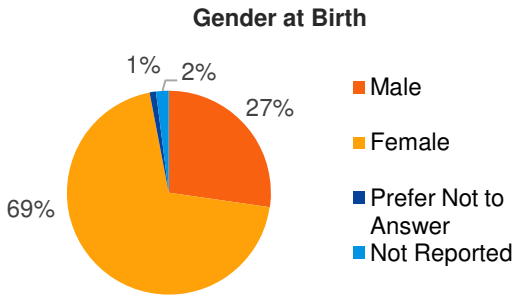
PROGRAM: Housing Stability Program (HSP)

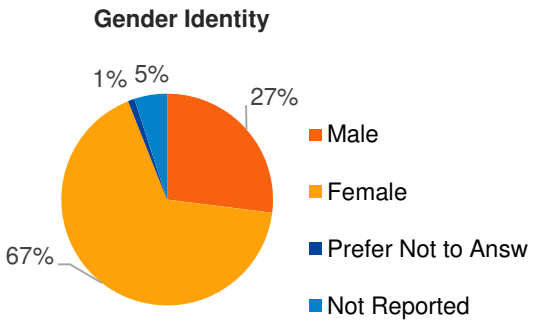
HOW MUCH DID WE DO?

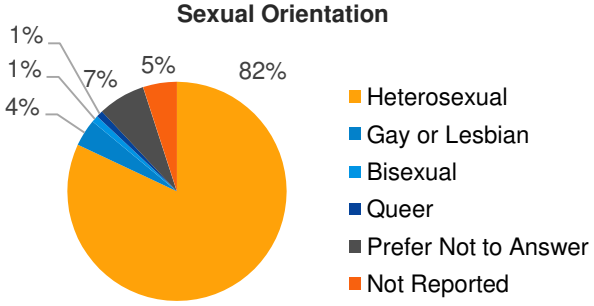
22 New Landlord Contacts	81 Landlord Follow-Ups	9 Landlord Luncheons Held	166 Landlord Luncheon Attendees (Duplicated)	114 Landlord Luncheon Attendees (Unique)
43 Landlord Tenant Curriculum Groups	81 Group Attendees (Duplicated)	29 Group Attendees (Unique)	11 Open Door Events Held	18 Open Door Event Attendees (Duplicated)

PEI Demographics, Including Housing Participants

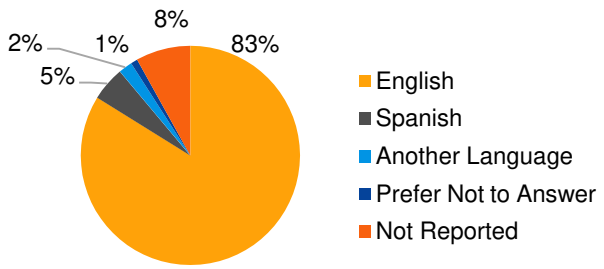




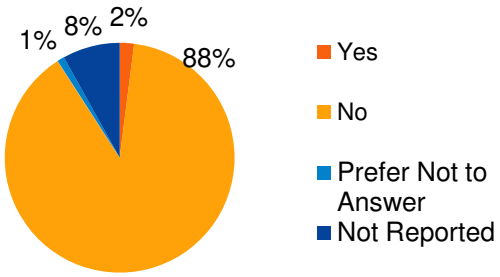




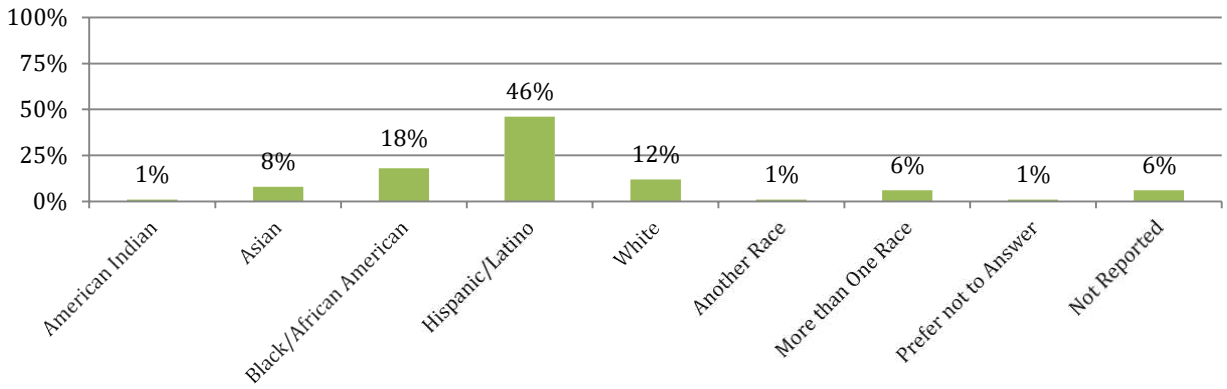
Language



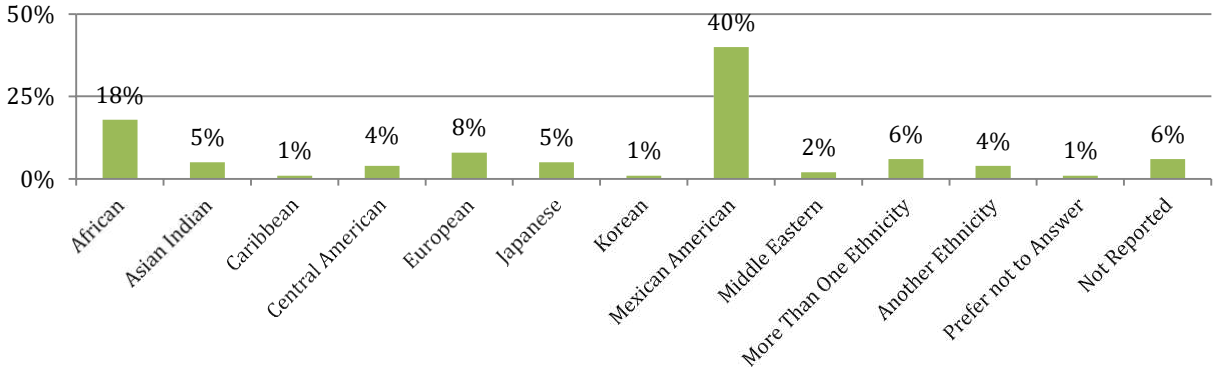
Military Veteran

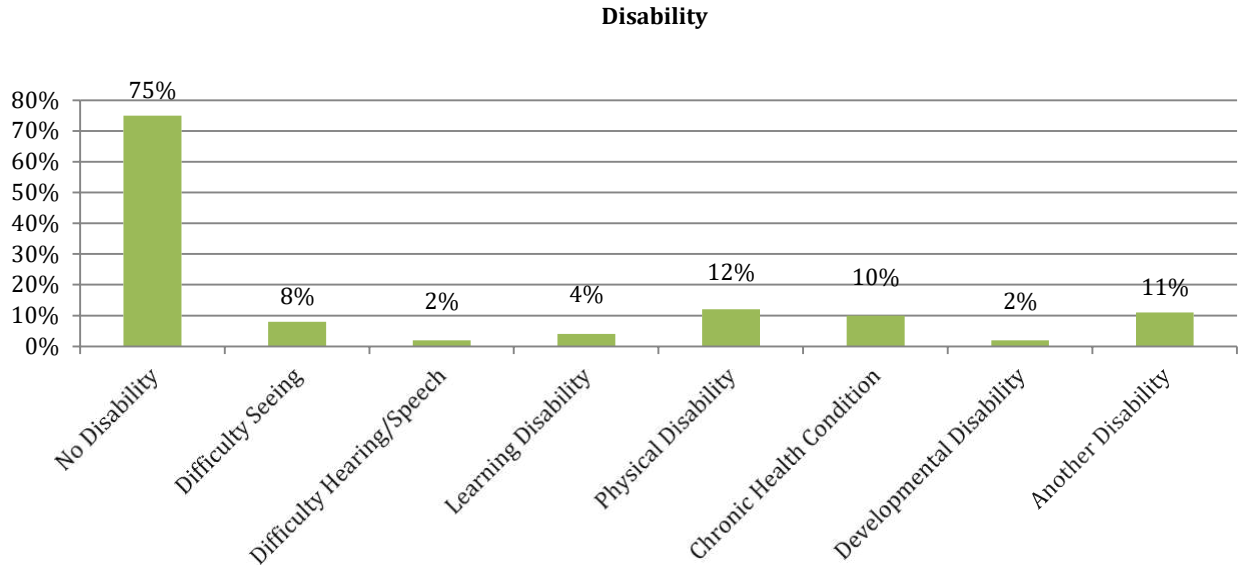


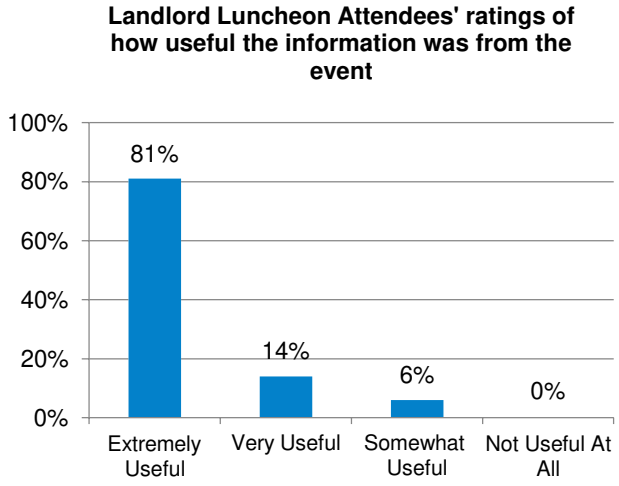
Race

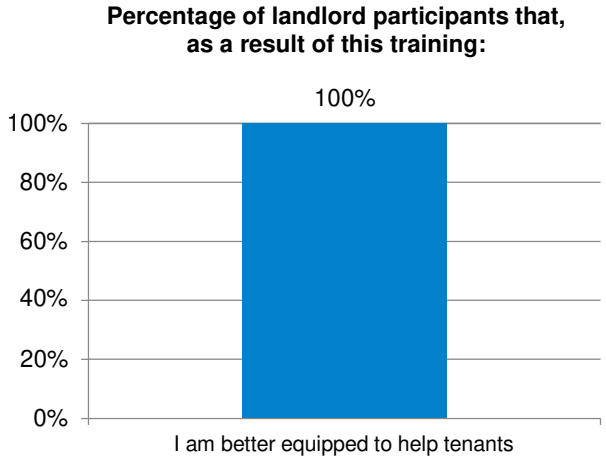


Ethnicity









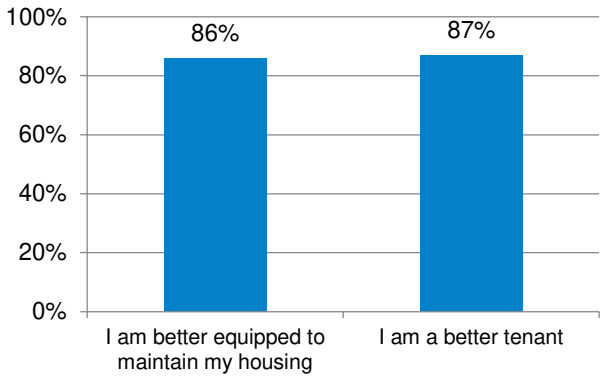
HOW WELL DID WE DO IT?

94%
Good Tenant Curriculum Participants Would Recommend This Curriculum to Others

93%
Good Tenant Curriculum Participants Reported the Presenter was Engaging and Approachable

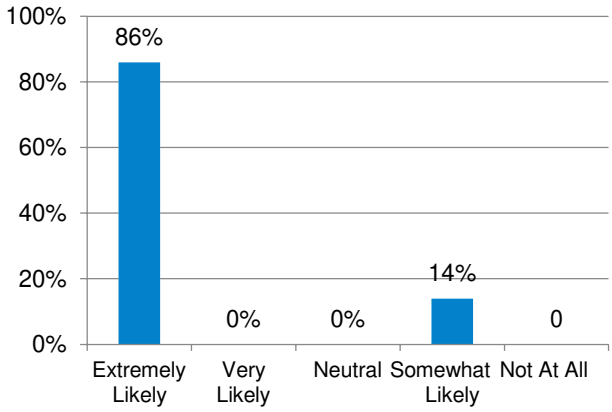
IS ANYONE BETTER OFF?

Percentage of Good Tenant Curriculum participants that, as a result this training:

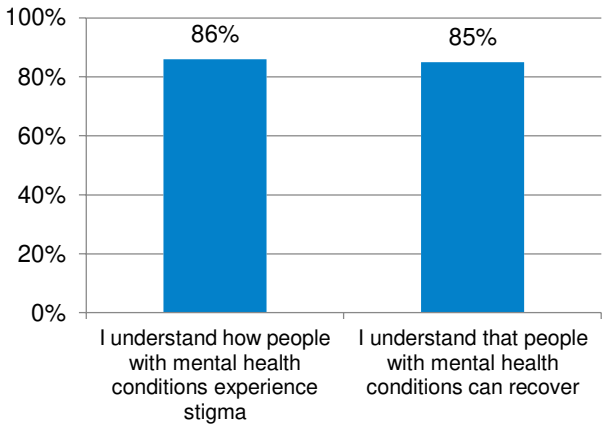


92%
Good Tenant Curriculum Participants Reported That Staff Helped Them Obtain the Information Needed to Accomplish Their Housing Goals

How likely are you to reach out to Tri-City if you suspect someone has a mental health challenge?



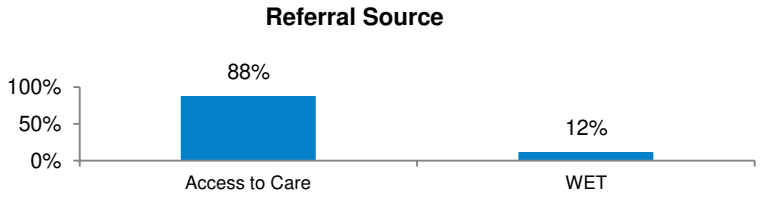
Percentage of Landlords that agree or strongly agree with the following:



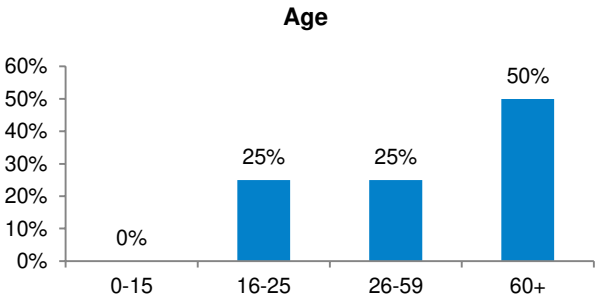
Number of Potential Responders	143
Setting in Which Responders were Engaged	Community
Type of Responders Engaged	Landlords and community members
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-age youth, older adults and those with a physical disability
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

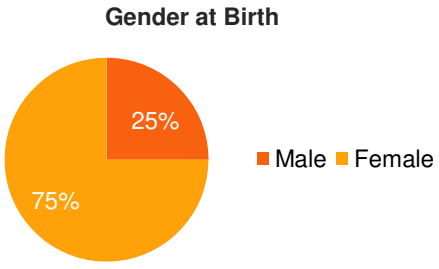
TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY

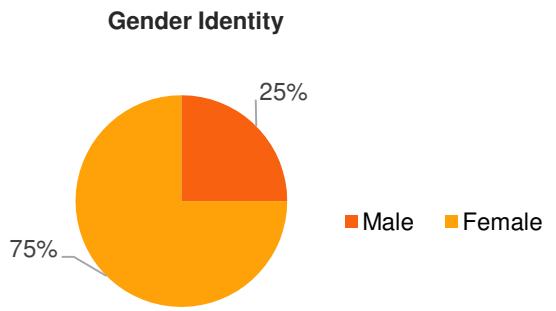
8
MHSA Referral to Housing Stability

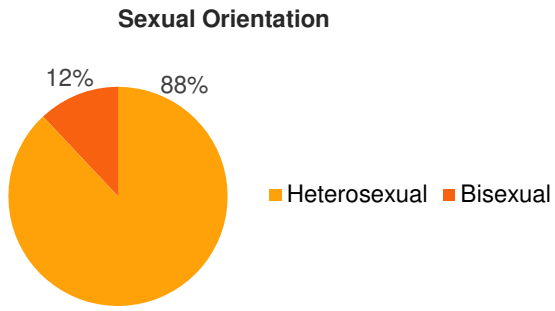


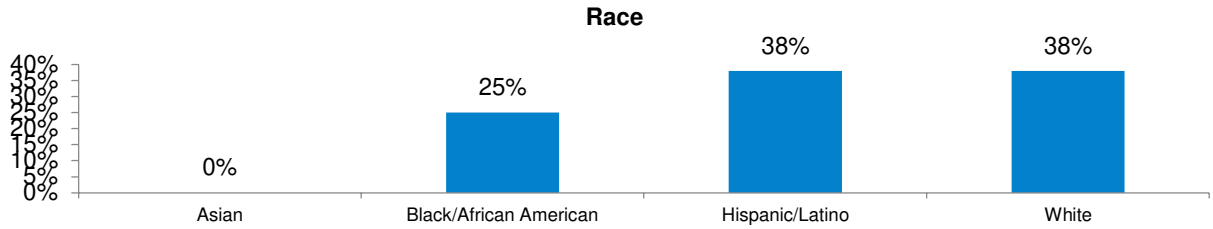
PEI Demographics Based on MHSA Referrals

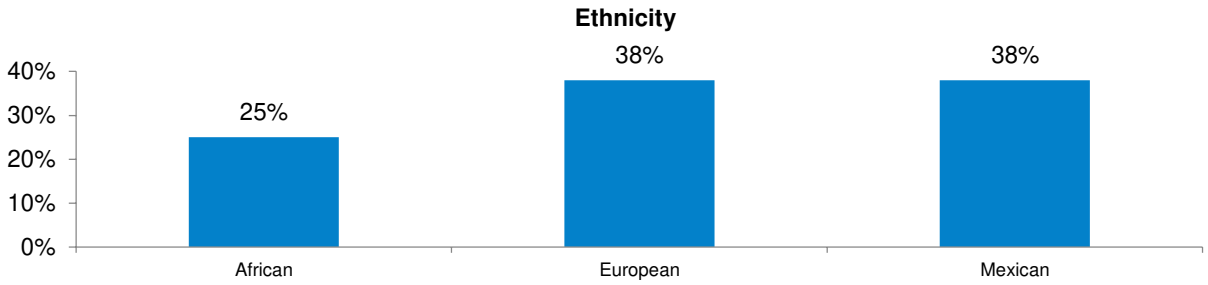


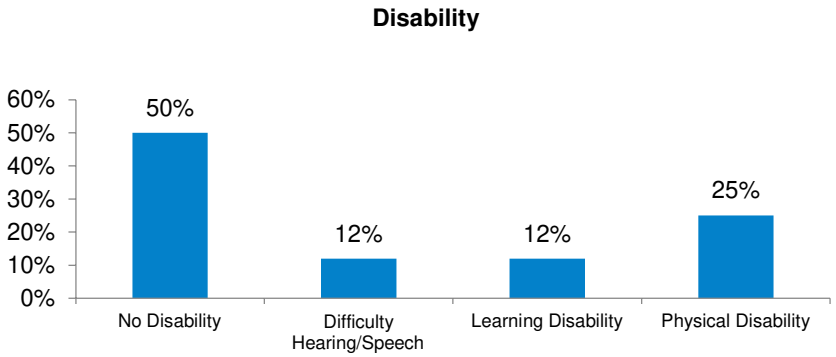


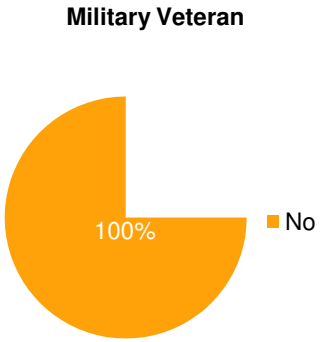

Gender Identity
25%
75%
Male
Female


Sexual Orientation
12%
88%
Heterosexual
Bisexual


Race
40%
0%
25%
38%
38%
Asian
Black/African American
Hispanic/Latino
White


Ethnicity
40%
30%
20%
10%
0%
25%
38%
38%
African
European
Mexican


Disability
60%
50%
40%
30%
20%
10%
0%
50%
12%
12%
25%
No Disability
Difficulty Hearing/Speech
Learning Disability
Physical Disability


Military Veteran
100%
No

Therapeutic Community Gardening

Status of Program:	___New	_X_ Continuing	___Modified	___Discontinued	
Target Population:	_X_ 0-15	_X_ 16-25	_X_ 25-69	_X_ 60+	Other:
Type of Program:	___Prevention	__ Early Intervention	_X_Prevention and Early Intervention		

Program Description

The Therapeutic Community Gardening program helps participants decrease their isolation and experience mental health benefits through participation in horticulture/gardening activities and group therapy exercises.

Target Population

Unserved and underserved populations including adults, youth ages 16-25, families with children, older adults, and veterans.

Age Groups	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Unknown
Number Served FY 2019-20	11	8	40	19	4
Cost Per Person	$3,316.00	$3,316.00	$3,316.00	$3,316.00	$3,316.00

Program Update

The Therapeutic Community Garden (TCG) program continues to be a popular option for community members and staff referrals. Community participation is a fundamental foundation for this program and staff are able to support this concept through hosting and participating in local events such as a resource fair at Cal Poly Pomona Veteran's Resource Center and Fall at the Farm hosted at the Pomona Fairplex. Additional events were sponsored by Tri-City and included the adult outpatient graduation ceremony, Wellness Center Tree Lighting Event, and Harvest Feast at Tri-City's Royalty location.

During FY 2019-20, TCG staff also hosted workshops at the Jocelyn Senior Center for older adults, Simon Middle School, and a monolingual group for parents in the Claremont Unified School Districts book club in the Therapeutic Community Garden. One of their most popular gatherings was a winter event help in the Garden which drew 55 attendees.

Challenges and Solutions

One of the challenges experienced by this team included a low turnout for groups located at various Tri- City housing locations. Transition age youth (TAY) continue to be a difficult population to engage, enroll and maintain in TCG groups.

To increase future attendance in TAY groups, TCG staff will be collaborating with community partners who support this age specific group. These efforts include maintaining preexisting relationships with TAY organizations as well as hosting workshops and events that target this essential age group.

COVID-19 Response

TCG operations were impacted dramatically due to COVID 19. In March 2020, all groups were put on hold due to concerns with public and staff safety. The majority of services rendered through TCG were through groups prior to COVID 19; therefore, all direct services were put on hold. However, weekly wellness calls to TCG participants began and continue to this day.

Groups for TCG shifted to a virtual platform in July of 2020. TCG staff are currently utilizing social media platforms to provide information regarding the Garden to the public. Adapting to the virtual world of delivering services via telehealth presented many challenges. A few of those challenges included: adapting to and learning technology related to delivering services virtually; assisting TCG clients to download and learn technology to be able to log-in to virtual groups and making accommodations for individuals that were not comfortable receiving services through telehealth.

Curriculum and program development, disseminating information to the public, and ensuring proper HIPAA (Health Insurance Portability and Accountability Act) and documentation guidelines were followed delayed the process of offering services virtually. At this time, TCG groups are now being conducted virtually.

Finally, TCG staff-initiated harvest drop-off/pick-ups of items from the garden to TCG participants and worked with local non-profit agency to offer donations of fruit.

Cultural Approach

The Therapeutic Community Garden is diligent is addressing barriers for underserved and unserved communities. Efforts include:

- Full time Spanish-speaking Mental Health Specialists and monolingual Spanish groups
- English and Spanish speaking adult and older adult groups
- Transitional Aged Youth, youth and family aged group
- Wellness Center group (indoors) for participants who are unable to be in the garden.
- Modifying TCG activities for individuals with learning impairments (as needed)
- Curriculum development includes discussions about diversity, culture and how differences between plants can benefit each other (companion planting and crop rotation)
- Participation in events that bring awareness to diversity and inclusion
- Attendance to trainings and webinars that focus on increasing cultural competency and awareness
- A majority of program materials are available in Spanish (i.e. waivers, enrollment sheet, referral forms, questionnaires, flyers, labels for garden beds)

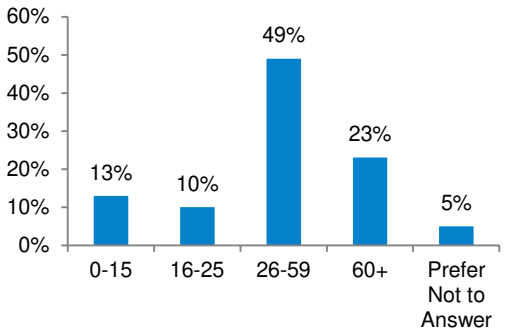
PROGRAM: Therapeutic Community Gardening (TCG)

HOW MUCH DID WE DO?

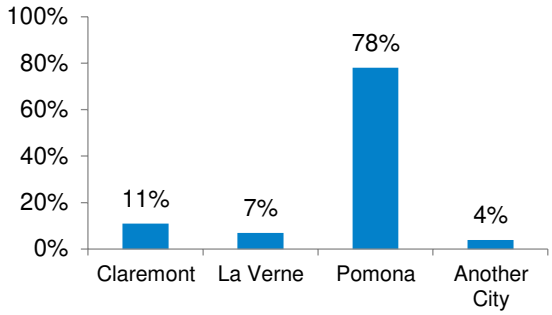
82
Unique Individuals Served

349 Days
Average Length of Time
Individuals Enrolled in TCG

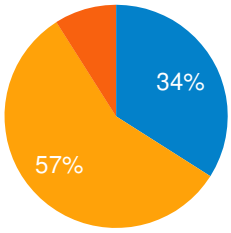
Age



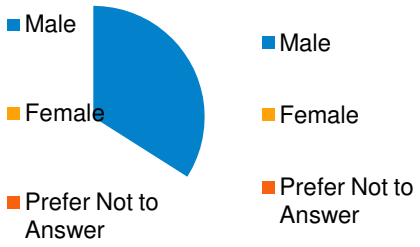
City



Gender Identity

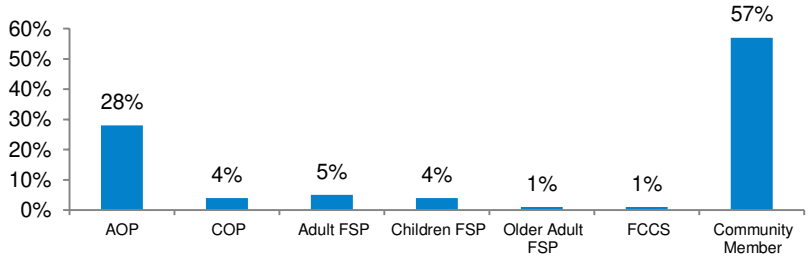


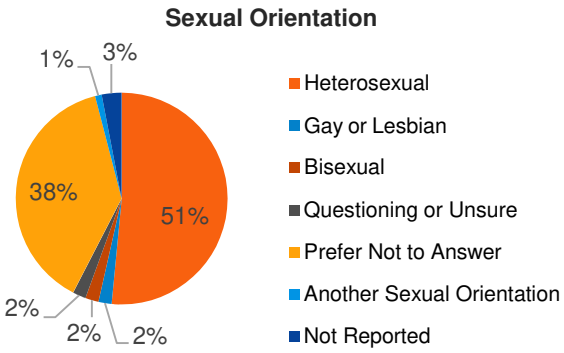
Gender at Birth

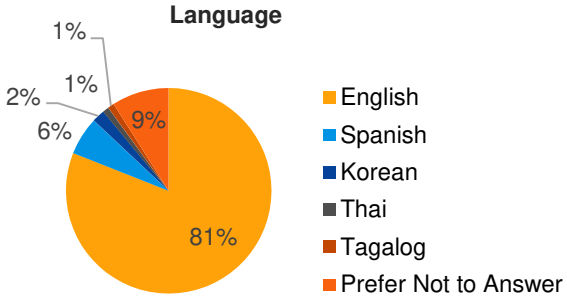


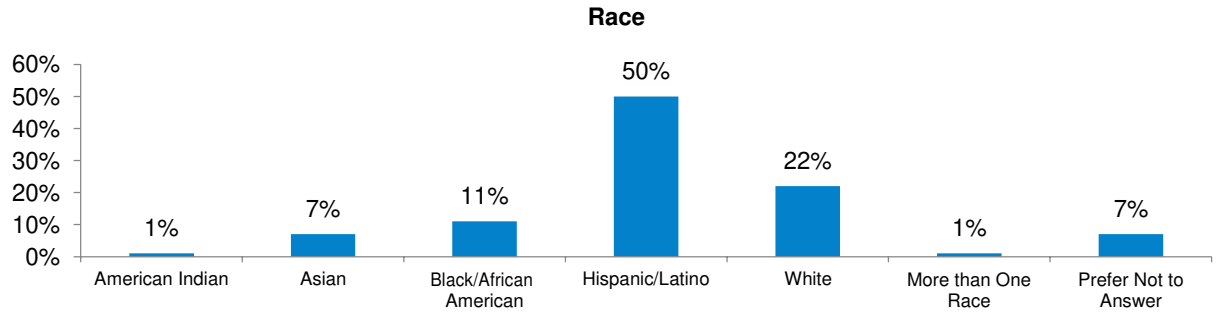
43%
Individuals are
Clinical Clients

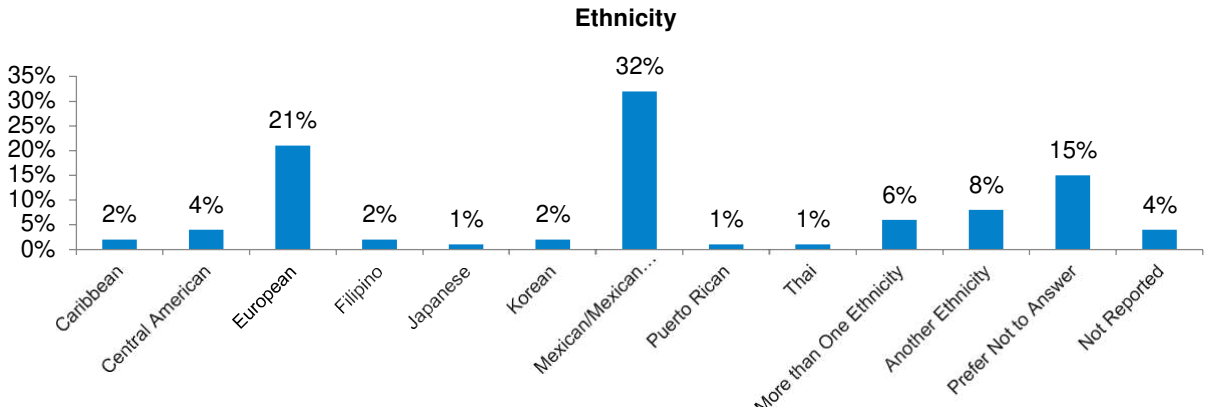
Enrolled in Clinical Program

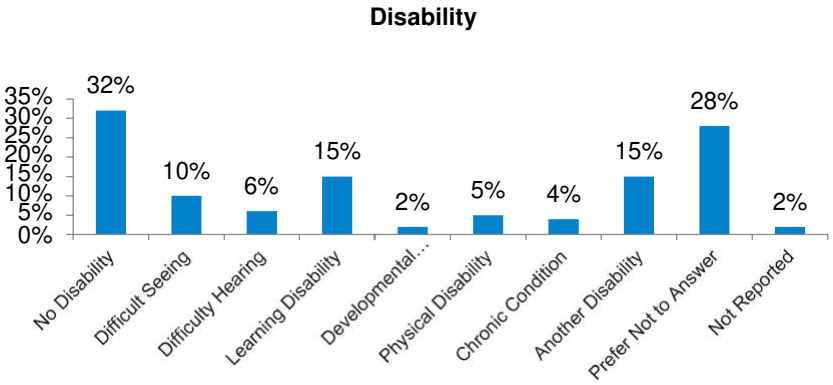


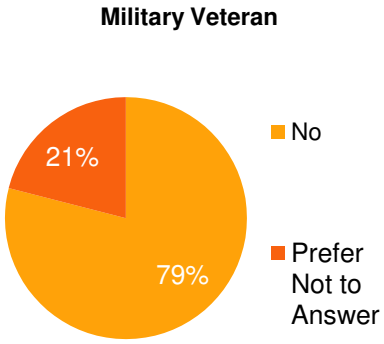

Sexual Orientation
1%
3%
38%
51%
2%
2%
2%
Heterosexual
Gay or Lesbian
Bisexual
Questioning or Unsure
Prefer Not to Answer
Another Sexual Orientation
Not Reported


Language
1%
2%
1%
6%
9%
81%
English
Spanish
Korean
Thai
Tagalog
Prefer Not to Answer


Race
60%
50%
40%
30%
20%
10%
0%
1%
7%
11%
50%
22%
1%
7%
American Indian
Asian
Black/African American
Hispanic/Latino
White
More than One Race
Prefer Not to Answer


Ethnicity
35%
30%
25%
20%
15%
10%
5%
0%
2%
4%
21%
2%
1%
2%
32%
1%
1%
6%
8%
15%
4%
Caribbean
Central American
European
Filipino
Japanese
Korean
Mexican/Mexican...
Puerto Rican
Thai
More than One Ethnicity
Another Ethnicity
Prefer Not to Answer
Not Reported

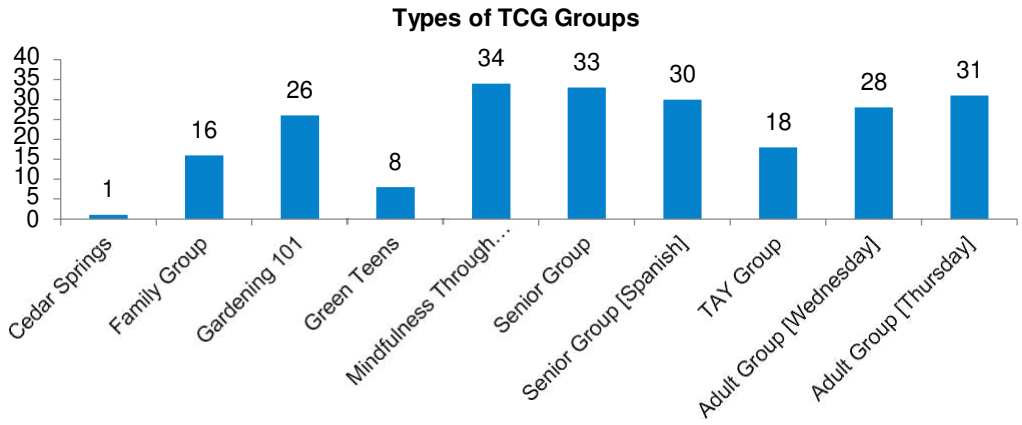

Disability
35%
30%
25%
20%
15%
10%
5%
0%
32%
10%
6%
15%
2%
5%
4%
15%
28%
2%
No Disability
Difficult Seeing
Difficulty Hearing
Learning Disability
Developmental...
Physical Disability
Chronic Condition
Another Disability
Prefer Not to Answer
Not Reported


Military Veteran
21%
79%
No
Prefer Not to Answer

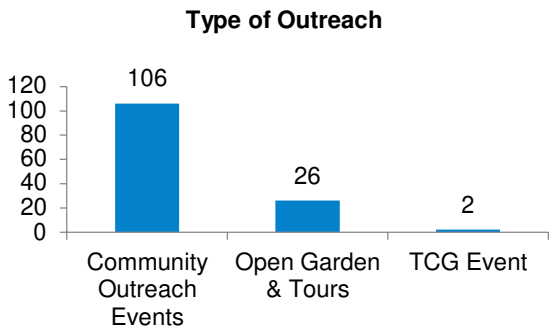
HOW WELL DID WE DO IT?

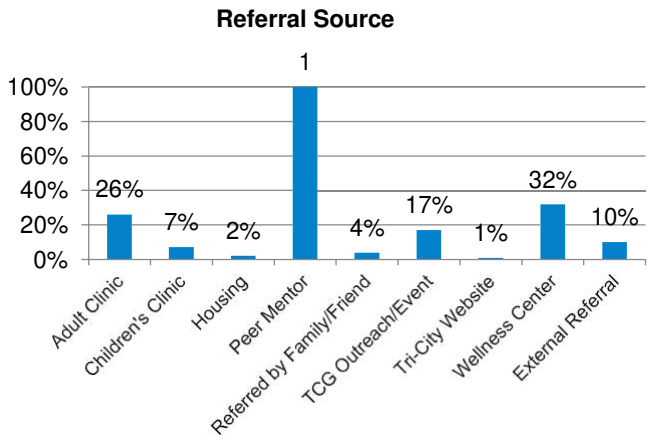
TCG Groups Occurred from July 2019 to March 11, 2020

225	543	6
TCG Groups Held	Duplicated Participants at TCG Groups	Average TCG Groups Held Per Week



275	134	1,402
Wellness Phone Calls Made to TCG Participants [March 2020 – June 2020]	Outreach Events	Individuals Engaged





IS ANYONE BETTER OFF?

100%	91%	96%	96%	86%
TCG Participants Enjoy Attending TCG Groups	TCG Participants Feel More Connected to Others [Peers, Family, etc.] Because of TCG Groups	TCG Participants Feel Their Symptoms Have Improved Because of Their Work at the Garden	TCG Participants Feel More Confident from the Skills Learned in TCG Groups	TCG Participants Have Better Communication with Others Because of TCG Groups

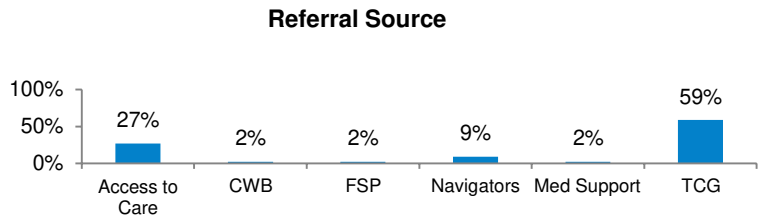
TCG Participant Feedback

"So glad I came to TCG, networked with other community members."
"I've learned more."
"I have always benefited. It is easier for me."
"I enjoy it. I want to plant new things."
"I have gained so much knowledge and experiences."
"I learned a lot of practical skills and I love the opportunity to socialize."
"I like TCG a lot!"
"Being here makes me feel comfortable and good."
"I'm here to keep learning the group talk strategies."
"I feel more positive in how I feel, Thank you for our case workers too!"
"Being active, the groups are great!"
"I'm calmer, more able to deal with life's challenges and how I was before I started coming."
"It calms me down."
"Walking and working in the garden makes me feel good."
"I completely like learning about nature and garden."
"I feel very happy, can't wait for Friday group!"

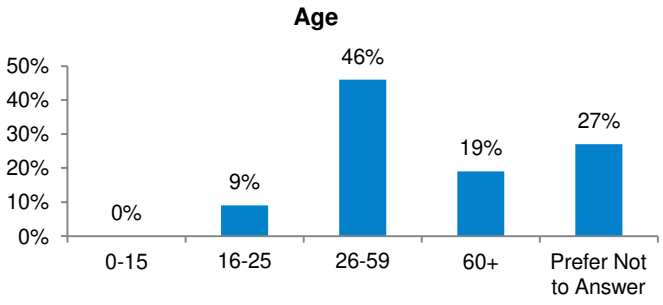
Number of Potential Responders	82
Setting in Which Responders were Engaged	Community, schools, health centers, workplace and outdoors
Type of Responders Engaged	TAY, teachers, LGBTQ+, families, religious leaders and those with lived experience
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

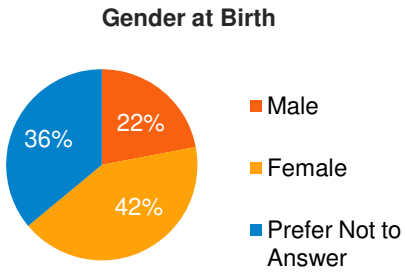
TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY

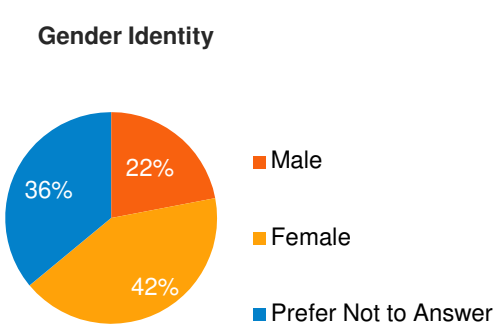
59
MHSA Referral to TCG Program

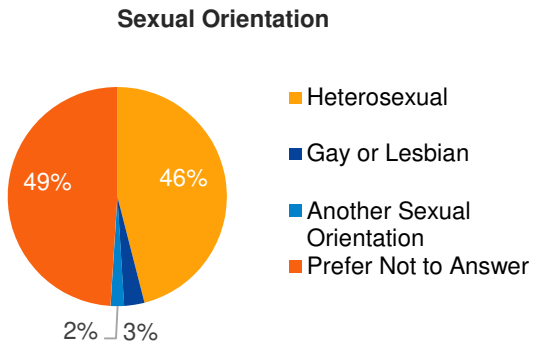


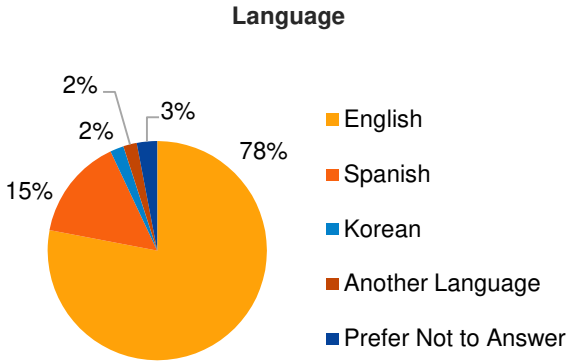
PEI Demographics Based on MHSA Referrals

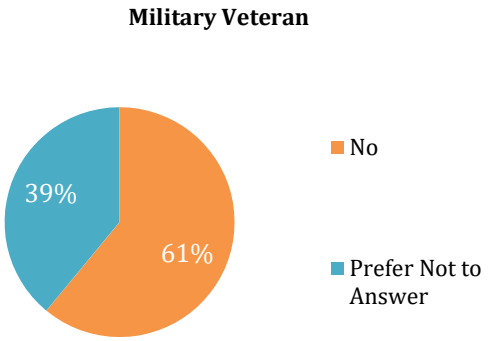


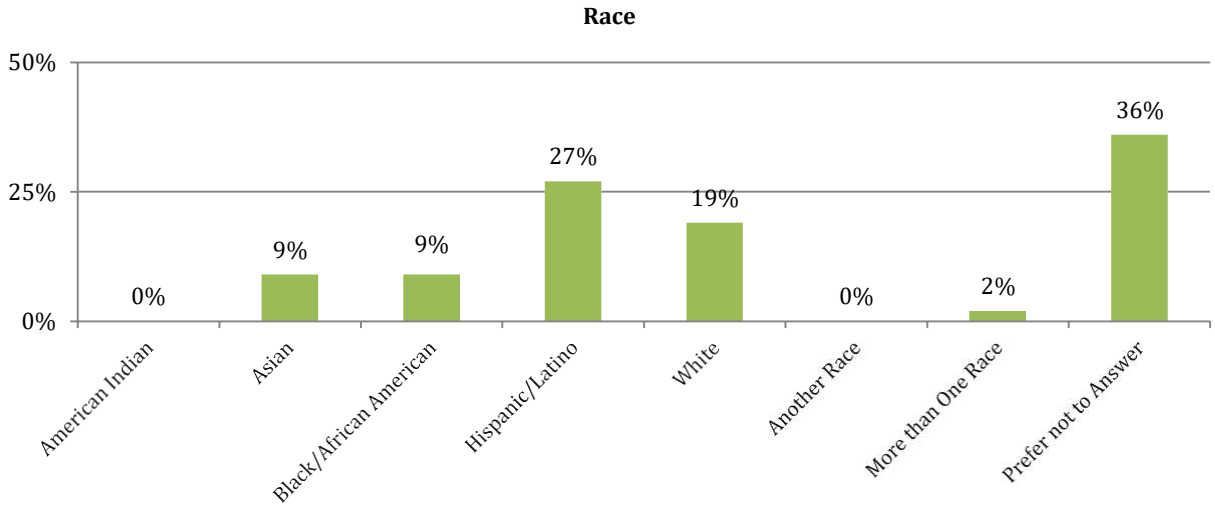



Gender Identity
22%
36%
42%
Male
Female
Prefer Not to Answer

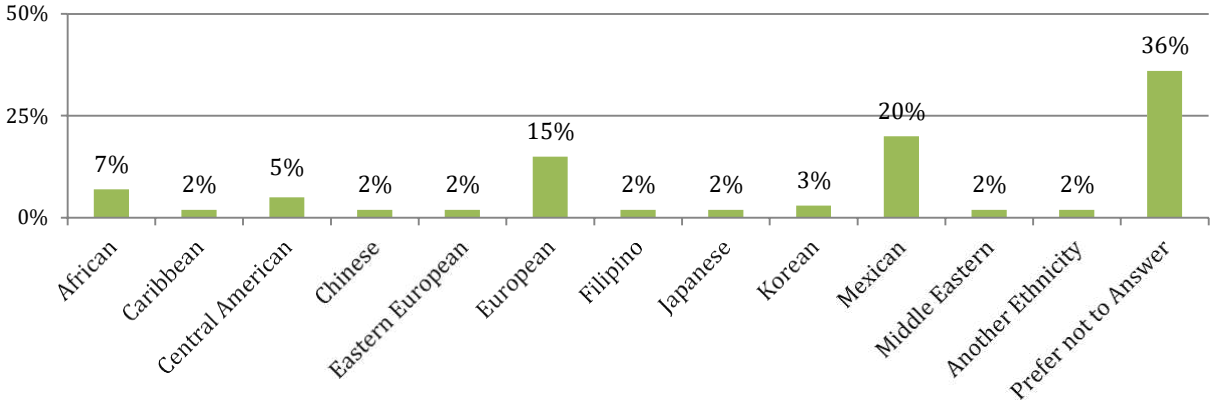

Sexual Orientation
49%
46%
2%
3%
Heterosexual
Gay or Lesbian
Another Sexual Orientation
Prefer Not to Answer


Language
2%
3%
2%
78%
15%
English
Spanish
Korean
Another Language
Prefer Not to Answer

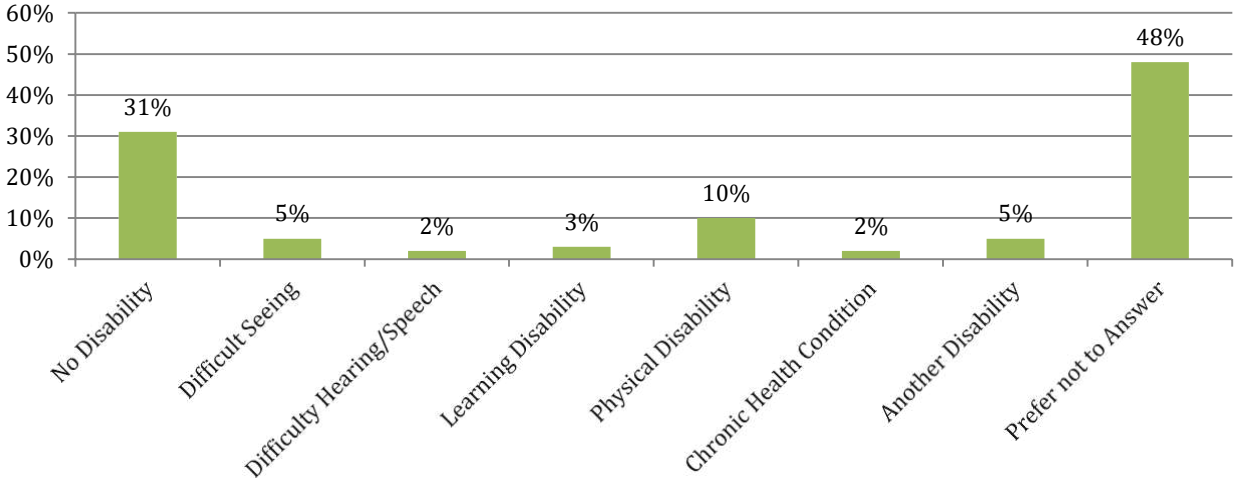

Military Veteran
39%
61%
No
Prefer Not to Answer


Race
50%
25%
0%
0%
9%
9%
27%
19%
0%
2%
36%
American Indian
Asian
Black/African American
Hispanic/Latino
White
Another Race
More than One Race
Prefer not to Answer

Ethnicity



Disability



Early Psychosis Program

Status of Program:	___New	_X_ Continuing	___Modified	___Discontinued	
Target Population:	___0-15	_X_ 16-25	___25-69	___60+	Other:
Type of Program:	___Prevention	_X_ Early Intervention		___Prevention and Early Intervention	

Program Description

Utilizing the PIER (Prevention, Intervention, Enforcement and Reentry) model, Tri-City staff host workshops and trainings for community members and school personnel focused on recognizing and addressing the earliest symptoms of mental illness. This evidence-based treatment option uses three key components- community outreach, assessment and treatment to reduce symptoms, improved function and decrease relapse. The goal for this program includes increasing awareness among community members in recognizing the signs and symptoms of early psychosis and how to connect individuals to services as well as to reduce the time of untreated psychosis and severe mental illness.

Target Population

Transition Age Youth (TAY) ages 16 to 25 who are experiencing psychosis and are not currently enrolled in mental health services.

Number of Workshops for FY 2019-20	7
Number of Attendees for FY 2019-20	75

Program Update

Beginning in July 2020, Tri-City staff implement the Portland Identification and Early Referral (PIER) model as the basis for their Early Psychosis Program (ESP). This model utilizes a team-based system of early detection and intervention in psychosis. This first year of implementation included the completion of the Memo of Understanding with PIER as well as the last of the hiring (occupational therapist) needed to complete the PEIR team.

Challenges and Solutions

Challenges for this program included making the shift from a research focus to an action/implementation focus. This included finalizing the hiring of staff and developing the phases of implementation including outreach and trainings. By establishing training dates early on with community partners, this ensured that outreach presentations were on their calendars in order to spread the word and increase referrals to the program.

COVID-19 Response

With the onset of COVID 19, the PIER trainings and training with UCLA, another adjunct program for staff, were delayed. Although these trainings were originally scheduled to begin in April/May of 2020

and to be completed over the summer, the pandemic required the trainings to be modified to be presented via a virtual platform. This delay resulted in the PIER trainings being rescheduled to be completed by the second week of November 2020 and the UCLA training is now estimated to be completed by January 2021. The outreach portion of these trainings were also impacted as community partners also shifted their focus to addressing their own internal priorities which left little time for adjunct presentations or trainings.

In response to these challenges, Tri-City staff are working to adapt these new training practices to be conducted virtually with clients via telehealth. In addition, outreach efforts were also adapted to be conducted virtually via phone or webinars.

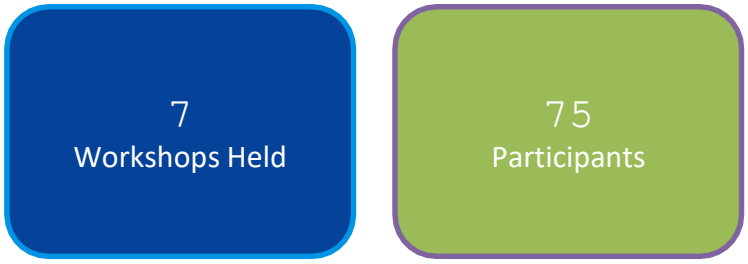
Cultural Approach

In addressing cultural inclusion, the ESP employs staff that are reflective of the community served and make it a practice to approach the work with cultural humility. Ongoing discussions of race, culture, and health disparities in department meetings, group and individual supervisions with staff, has proven to be effective in instilling this approach.

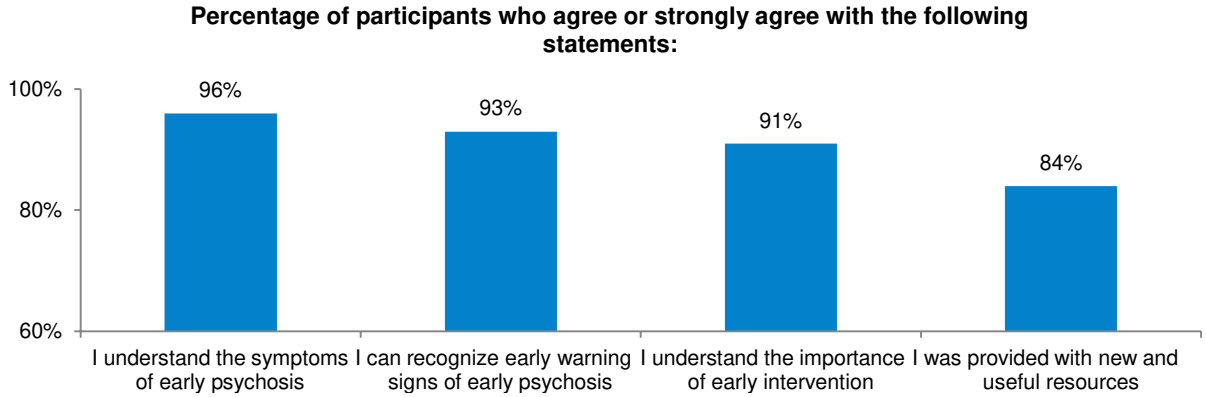
In addition, staff ensure that assessment and new PIER training material are available in other threshold languages, including Spanish. Flyers, assessments, and forms are available in Spanish and other languages as needed. Presentations on outreach are available in Spanish. The material is also presented in a manner that is easy to understand even if English is not their primary language.

PROGRAM: Early Psychosis

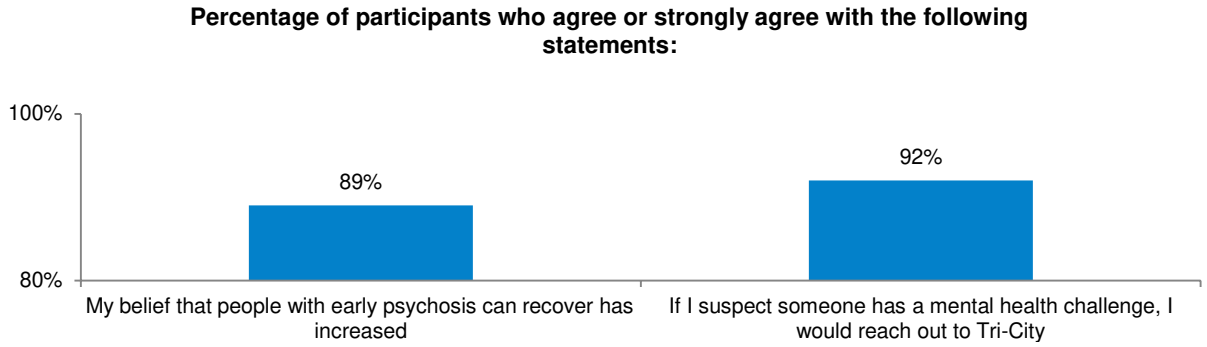
HOW MUCH DID WE DO?



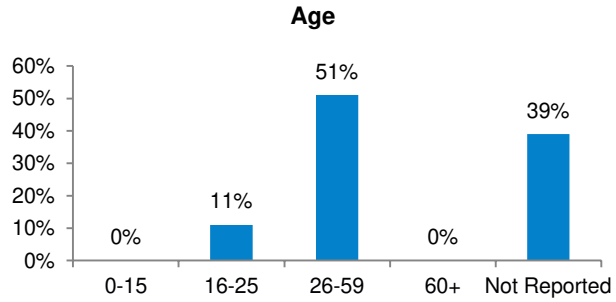
HOW WELL DID WE DO IT?

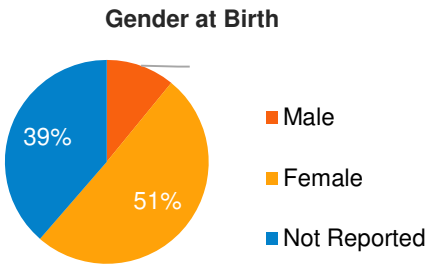


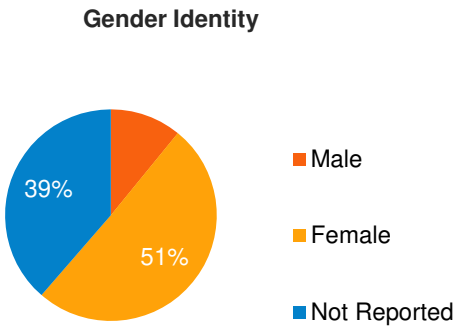
IS ANYONE BETTER OFF?

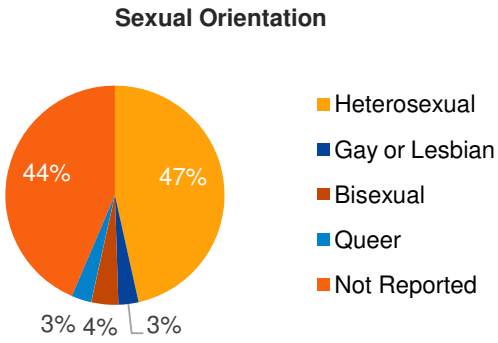


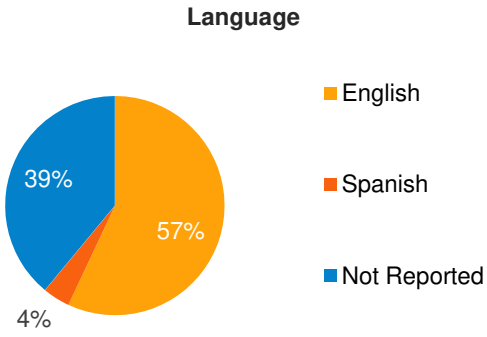
PEI Demographics

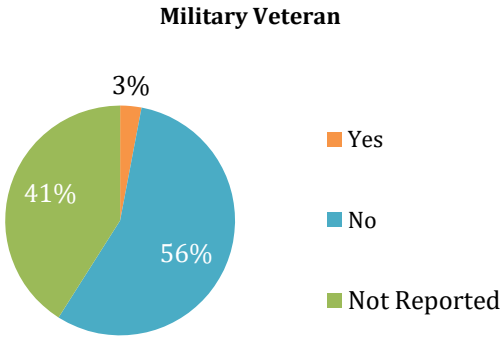




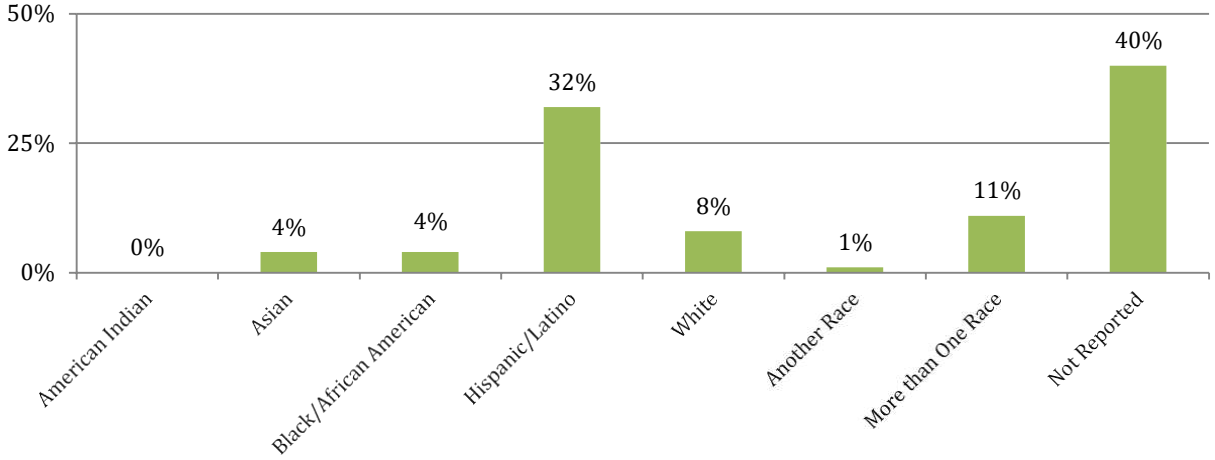




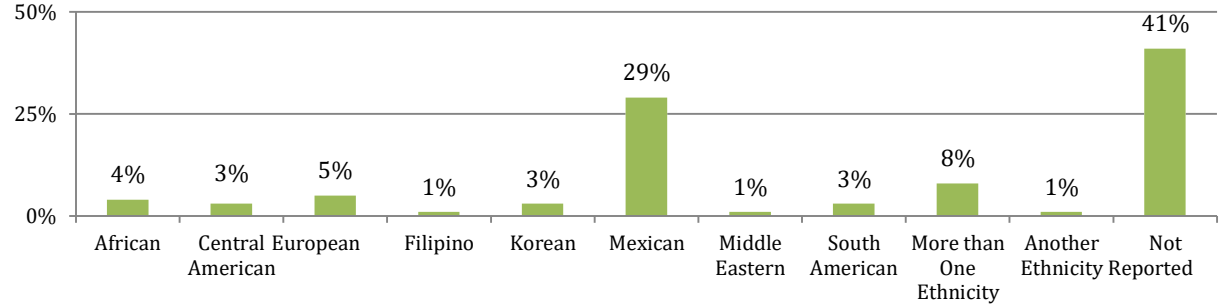




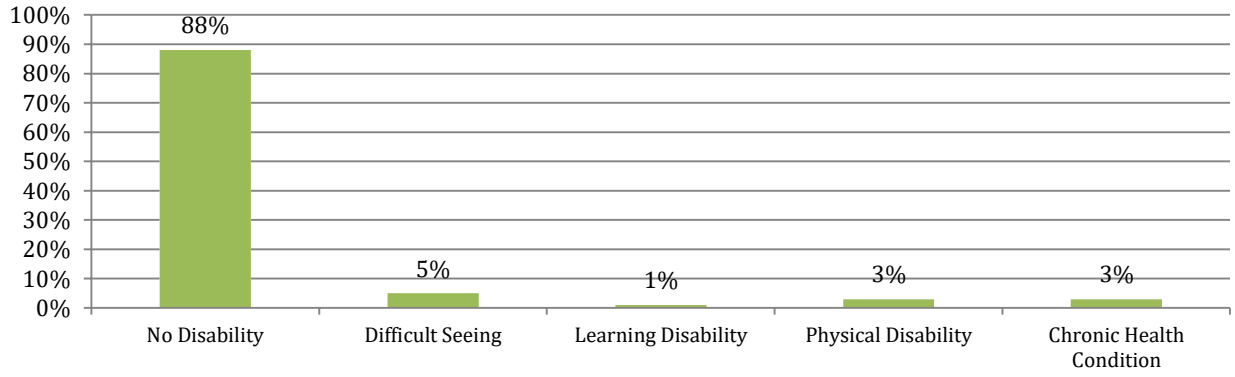
Race



Ethnicity



Disability



Number of Potential Responders	75
Setting in Which Responders were Engaged	Community
Type of Responders Engaged	Community members
Underserved Population	African American, Asian/Pacific Islander, Latino Lesbian/Gay/Bisexual/Transgender/Questioning, Native American, Refugee/Immigrant, transition-age youth, older adults and those with a physical disability
Access and Linkage to Treatment Strategy	There were no referrals for individuals with serious mental illness referred to treatment from this program. Tri-City encouraged access to services by creating a referral form, identifying point people in each program to promote, receive, and follow-up on referrals. Regular meetings were held to improve the process and identify referrals to the agency's PEI programs.

TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS STRATEGY

0
MHSA Referral to Early Psychosis

EXPENDITURE REPORTS

A	B	C	D	E	F	G	H
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention							
1.	Family Wellbeing	95,261	95,261				
2.	Older Adult Wellbeing (Peer Mentor)	79,313	79,313				
3.	Transition-Age Youth Wellbeing (Peer Mentor)	74,641	74,641				
4.	Community Capacity Building (Community Wellbei	520,882	520,882				
	Stigma Reduction and Suicide Prevention,						
	and Community Mental Health Training)						
5.	NAMI Community Capacity Building Program	35,500	35,500				
	(Ending the Silence)						
6.	Housing Stability Program	206,875	206,875				
PEI Programs - Early Intervention							
7.	Older Adult Wellbeing (Peer Mentor)	79,313	79,313				
8.	Transition-Age Youth Wellbeing (Peer Mentor)	74,641	74,641				
9.	Therapeutic Community Gardening	333,150	333,150				
10.	Early Psychosis	207,399	207,399				
PEI Programs - Other							
11.		0	0				
12.		0	0				
13.		0	0				
PEI Administration		606,767	606,767				
PEI Assigned Funds		42,000	42,000				
Total PEI Program Estimated Expenditures		2,313,742	2,355,742	0	0	0	0

APPENDEX

MHSA Regulations for Prevention and Early Intervention

"The County shall identify each Program funded with Prevention and Early Intervention funds as a Prevention Program, Early Intervention Program, Outreach for Increasing Recognition of Early Signs of Mental Illness Program, Stigma and Discrimination Reduction Program, Suicide Prevention Program, Access and Linkage to Treatment Program, or Program to Improve Timely Access to Services for Underserved Populations".

Prevention and Early Intervention Regulations/July 1, 2018
(Title 9 California Code of Regulations, Division 1, Chapter 14 MHSA)

Per the Regulations stated above, Counties are required to identify each program funded under their Prevention and Early Intervention Plan by one or more of the following categories:

Prevention and Early Intervention Plan Required Categories/Programs

1. Prevention Program
    a. Housing Stability Program
    b. Therapeutic Community Gardening
2. Early Intervention Program
    a. Early Psychosis Program
    b. TAY and Older Adult Wellbeing (Peer Mentor Program)
    c. Therapeutic Community Gardening
3. Access and Linkage to Treatment Program
    a. Early Psychosis Program
    b. Family Wellbeing Program
    c. Housing Stability Program
    d. TAY and Older Adult Wellbeing (Peer Mentor Program)
    e. Therapeutic Community Gardening
    f. Wellness Center (TAY and Older Adults)
4. Stigma and Discrimination Reduction
    a. Community Mental Health Trainings
    b. Community Wellbeing Program
    c. Early Psychosis Program
    d. Family Wellbeing Program
    e. Housing Stability Program
    f. TAY and Older Adult Wellbeing (Peer Mentor Program)
    g. Therapeutic Community Gardening
    h. Wellness Center (TAY and Older Adults)
5. Outreach for Increasing Recognition for Early Signs of Mental Illness Program
    a. Community Mental Health Trainings
    b. Community Wellbeing Program
    c. Early Psychosis Program
    d. Family Wellbeing Program
    e. Housing Stability Program
    f. TAY and Older Adult Wellbeing (Peer Mentor Program)
    g. Therapeutic Community Gardening
    h. Wellness Center (TAY and Older Adults)
6. Suicide Prevention
    a. Stigma Reduction/Suicide Prevention
    b. NAMI: Ending the Silence
    c. TAY and Older Adult Wellbeing (Peer Mentor Program)

Innovation Annual Report
FY 2019-20

MHSA INNOVATION ANNUAL REPORT JUNE 2021

TABLE OF CONTENTS

To: Mental Health Services Oversight and Accountability Commission

Subject: Innovation Project

This report is prepared in compliance with California Code of Regulations, Title 9, Section 3580, Innovation Project Report.

Tri-City Mental Health Authority (TCMHA) was created in 1960 as a result of a Joint Powers Authority adopted by the cities of Claremont, La Verne, and Pomona. TCMHA and the city of Berkley are the only cities in California considered a "county" and serve as the mental health authority, although not the mental health plan, for a specific area.

Tri-City Mental Health engaged in a robust stakeholder and community planning process beginning in September of 2021. A total of three stakeholder meetings were held in addition to four stakeholder workgroup/focus groups dedicated to the review of this project as well as the testing of a new application for the pending pilot project, myStrength. During this time, participants received updates regarding the Help@Hand project as well as the opportunity to test the new application, myStrength, provide feedback, make suggestions and recommend changes for consideration by staff.

The following report is contained in Tri-City's Annual Update for FY 2021-22 and was posted for a 30-day public review and comment period from May 7, 2021 to June 8, 2021. The MHSA Public Hearing was held on June 8, 2021 and hosted by Tri-City's Mental Health Commission. At that time, the Mental Health Commission recommended approval of the MHSA Annual Update for FY 2021-22. The Tri-City Governing Board acted on this recommendation and adopted the Annual Update for FY 2021-22 on June 16, 2021.

With this timeline in mind, we respectfully submit the following information, vetted through our community planning process, and pending approval by TCMHA's Governing Board.

- Innovation project information and data for FY 2019-20
- Expenditure report for INN program
- Innovation Technology Suite Status Report-CalMHSA

Please feel free to contact me with any questions.
Regards,
Rimmi Hundal
Director of MHSA and Ethnic Services
Tri-City Mental Health Services
(909) 326-4626
rhundal@tricitymhs.org

Community Stakeholder Meetings

9/30/2020
3/4/2021
4/8/2021

INN Workgroup/Focus Group

Help@Hand/Tech Suite:
1/21/2021
2/11/2021
2/16/2021
2/18/2021

Innovation Project

Help@Hand

Originally named “Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions (Tech Suite)”

Help@Hand Tech Suite Project

Status of Program:	____New	_X_ Continuing	____Modified	____Discontinued	
MHSA Plan:	____CSS	____PEI	_X_ INN	____WET	___: CFTN
Target Population:	____0-15	_X_ 16-25	____25-69	_X_ 60+	Other: Monolingual Speakers

Program Description

The primary purpose of this project is to increase access to mental health care by providing a non-traditional system for individuals who may be reluctant to access services through a more formal clinical setting. Through the use of computers, tablets and smartphones, community members will be able to access a suite of technology-based mental health services focused on prevention, early intervention, and family and social support with the intent to: decrease emergency care services; reduce psychiatric hospitalizations; and reduce the duration of untreated mental illness.

Help@Hand Tech Suite Project	
Projected Funding Amount	$1,674,700.00
Duration of INN Project	September 28, 2018 to June 30, 2021
Revised Project Dates	January 1, 2019 to January 1, 2024 Originally designed to be a three-year project, the Collaborative as a whole voted to extend the project to five years to allow adequate time to complete the implementation phase and learning goals for this project. No additional funds are requested or required at this time.

Target Population

- Transition age youth and college students (up to age 25) who are seeking peer support or who are interested in offering their support as trained peer listeners.
- Older adults (ages 60+) who lack transportation or are unable to access traditional services.
- Non-English speaking clients and community members who may be experiencing stigma and language barriers.

Program Update

Tri-City's initial concept of Help@Hand was to provide ways for clients to stay active in their personal wellness between appointments and for the greater community to have access to tools that promote mental wellbeing.

Now that we are in the midst of a global pandemic that encourages physical distancing as a means prevention, the technology that will be used by Help@Hand becomes even more essential. Tri-City is aware that this pandemic can be triggering for some individuals and can also contribute to isolation. The goal is to be able to use the different technologies in the suite of applications to provide support in this "new normal". There will be apps that clinicians can use with their clients in conjunction with individual treatment plans. There will also be apps to support those in isolation by providing a virtual community of connectedness.

The original Help@Hand/Tech Suite proposal highlighted the targeted groups of older adults, transition age youth, and monolingual Spanish speakers. It has now become clear that moving forward, this project will expand those target populations to encompass other populations that may also have been severely impacted by COVID-19.

During FY 2019-20, the Innovation Plan Coordinator position was filled following an extensive hiring search. In addition, local efforts include convening a focus group consisting of Wellness Advocates/Peers who were charged with reviewing potential applications for a future pilot program.

Milestones for FY 2019-20 include:

- A focus group comprised of Wellness Advocates, MHSA staff, and the IT consultant, participated in a product testing process.
- Through the collaboration, various wellness apps have made accessing their apps free for participating counties/agencies and Tri-City has been taking advantage of the opportunity by providing the resources to staff and clients.
- CalMHSA created Digital Mental Health Literacy training videos and Tri-City will be utilizing the videos for clients and community members on-boarding.
- Tri-City continued to send useful wellness app information to our staff for self-care (and some client resources).
- Tri-City Wellness Advocates started planning for a Community Connections webinar to teach our clients and community members how to be safe online. They will be using the skills and information they acquired during the train-the-trainer session of the February Help@Hand Peer Summit.

<u>Challenges and Solutions</u>

In September 2019, Tri-City hired a new Innovation program coordinator after having this position vacant for an extended period of time. However, this project continued to move forward in collaboration with other counties who are a part of the Tech Suite project. A focus group was convened to review a potential application, WYSA, for a pilot project. Although this process proved promising, the pilot project was delayed due to COVID-19.

COVID-19 Response

The major impact of COVID 19 was the stalling of workgroups that were envisioned for the pilot process. Revisions to this plan included moving into virtual meetings and creating innovative ways to continue the outreach to potential participants. One of these creative virtual outreach efforts included a community webinar hosted by Tri-City Wellness Advocates that focused on how to be safe online. Materials for this webinar were provided by Help@Hand, the Tech Suite Collaborative.

Cultural Approach

By providing an equally accessible way for individuals to access wellness, Help@Hand eliminates some of the traditional barriers to seeking service such as stigma, language and need for transportation. Additionally, as two of the primary populations designated for this project, there is a specific goal to create access and pay special attention to monolingual Spanish speakers and older adults.

Applications under consideration by Tri-City for this project will have the capacity for non-English language translation. In addition, training videos and outreach materials will be available in both English and Spanish to accommodate the primary populations residing in the Tri-City area.

Tech Suite/Help@Hand Collaboration Update (Provided by CalMHSA)

FY 2019-20 Overview

Help@Hand is a statewide Collaborative project that began in 2018 with fourteen Counties and Cities leveraging interactive technology-based mental health solutions to help shape the future and improve accessibility and outcomes to connect people with care across the state. Technology has many benefits, but there are also many challenges and questions. The participating Cities/Counties are at the forefront of innovation to understand how technology is introduced and works, within the public behavioral health system of care. This means Help@Hand is not one project, but many projects across multiple Cities and Counties. The Collaborative offers the benefit of a shared learning experience that increases choices for Counties/Cities, accelerates learning, and adds in cost sharing. The focus of Help@Hand remains on pursuing a shared vision and common goals. Change at the scale of this project necessitates a robust readiness and change management approach. The project team has focused on building in activities to address these areas for both the project team and the community.

Impact

During FY 2019-20, the Help@Hand project had many successes and challenges. Some of the most notable impacts of the project during this time were work with the Peer community and the Cities' and Counties' exploration of mental health products to find those that best fit the needs of their stakeholder community.

Peers

Peers identified and raised the need for Digital Mental Health Literacy (DMHL) to empower California communities to make informed decisions about how they engage with technology. Listening sessions were held by the Peer and Community Engagement Manager to gather topics that would facilitate understanding and adoption of technology. There were 20 Digital Mental Health Literacy discovery sessions held in eleven different Counties with over 300 stakeholders

from June – November 2019. These sessions led to the development of a DMHL video series, and a DMHL Curriculum that includes smaller coaching sessions (Q1-Q3 '19 & '20). Additionally, there were two Peer Summits held, in May and September 2019, to support Collaboration of Peer Leads from across the state for project learning, connection, and problem solving (Q1 2019). Monthly Peer Collaboration meetings were held to serve as a space for Peers to connect and share County/City project updates.

Technology Exploration

In early 2020, after the results of the Request for Statement of Qualifications (RFSQ) were released, the collaborative cities and counties began engaging their community stakeholders and conducting focus groups to explore new technologies available to the project and receive additional feedback on products that would be a good fit for their communities.

Challenges and Solutions

There are many things to consider when integrating technology into existing systems of care. The Help@Hand Collaborative has addressed many challenges in this work. Some of the challenges experienced by the Collaborative during FY 19-20 include:

COVID-19 Response

The beginning of 2020 brought significant challenges to Help@Hand participating cities and counties due to the COVID-19 pandemic. Many Collaborative members' focus changed quickly in March 2020 as they were asked to respond to evolving pandemic response request and care needs in their local communities.

Rapid Response - The early months of the pandemic saw Cities and Counties challenged to understand how they could quickly leverage mental health technology to meet growing community needs. Help@Hand worked quickly to develop a streamlined approach that supported Cities and Counties in launching a technology to their respective communities in direct response to growing mental health needs related to quarantine and COVID-19. Each step of the technology selection, readiness and deployment process is essential. Therefore, the rapid response approach did not reduce or eliminate critical steps but streamlined them by working to establish common features and functionality with the vendors and reducing variation among Cities and Counties. This effort is ongoing.

See attached CalMHSA Support for City and County's MHSA Annual Report

INNOVATION
EXPENDITURE REPORT

County:	TRI-CITY MENTAL HEALTH AUTHORITY						Date:	4/9/21
		Fiscal Year 2021/22						
		A	B	C	D	E	F	
		Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding	
INN Programs								
1.	Help @ Hand	304,266	304,266					
2.		0	0					
3.		0	0					
4.		0	0					
INN Administration		0	0					
Total INN Program Estimated Expenditures		304,266	304,266	0	0	0	0	

INNOVATION TECHNOLOGY SUITE STATUS REPORT

THE FOLLOWING STATUS REPORT WAS PREPARED BY THE CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY (CALMHSA) FOR THE MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION (MHSOAC) AND PROVIDES A DETAILED OVERVIEW OF THE PROJECT FROM A COLLABORATIVE PERSPECTIVE.

CalMHSA Help@Hand Annual Report
FY 2019-20

Date: April 6, 2021

To: Help@Hand Collaborative Cities and Counties
From: CalMHSA
Re: CalMHSA Comments on Help@Hand Year 2 Annual Evaluation Report

Dear Help@Hand Cities and Counties,

CalMHSA is proud to support this multi-year innovation project in which 14 California Cities and Counties work together to explore mental health solutions through the use of technology. At publication of this report, the Help@Hand project has seen:

- Four product launches
- Stakeholder engagement through webinars, listening sessions, local input opportunities and focus groups
- Streamlined processes and rapid-response deployments to support communities during the COVID-19 pandemic

A key component of the project is evaluation, which results reports on a quarterly and annual basis. This annual report encompasses Year 2 (January 1, 2020 – December 31, 2020) of the Help@Hand evaluation and synthesizes evaluation findings across Cities/Counties.

The analysis and findings presented are those of the University of California, Irvine's (UCI) Help@Hand evaluation team. CalMHSA works collaboratively with UCI throughout the project and reviews the report for confidentiality, but neither CalMHSA, nor Cities/Counties are authors of the report.

How to Read This Report

Evaluation Reports are written with the Help@Hand Cities/Counties in mind as the target audience, however the project understands there are many other stakeholders who also have interest in these reports. Annual evaluation reports provide Help@Hand Cities/Counties with a larger perspective of the work in progress. Different from the quarterly evaluation reports, which are not intended to be exhaustive, the annual reports provide a more thorough view of the activities which took place throughout the year. Despite the comprehensive approach the annual report takes, readers should note the analysis and findings outlined in the report are still in summary and do not constitute all City/County, collaborative or project management activities completed during this evaluation period.

CalMHSA invites Help@Hand Cities/Counties to consider the following as they review the report:

- **Reflect** – Review and acknowledge the incredible work that has been done to date. Please take the time to recognize those on your teams, and in your communities, who have worked diligently to bring the project this far.
- **Learn** – One of the primary intentions of the Help@Hand innovation project is to learn. Learning includes both acknowledgement of successes and consideration of opportunities to improve. CalMHSA respects the openness and vulnerability of all project participants in embracing a learning mindset through which we explore and discover innovative solutions to improve our communities and save lives.
- **Respond** – Help@Hand project participants in particular should consider where and how to integrate the recommendations and learnings captured in this report. All audiences who have questions or wish to provide comments related to this report may email feedback to CalMHSA at helpathand@calmhsa.org and to UCI at dsorkin@uci.edu.

This report is a lengthy document in excess of 160 pages. To assist you in navigating, here is a preview of how the report is organized:

- Executive Summary (pages 5-6)
- Summary of Activities (pages 10-14)
- Recommendations (page 97)
- Spotlights (pages 14, 17, 21, 47, 61, 78,)
- Report Chapters are structured in the following format:
  - Key points for chapter
  - Overview and outline
  - Methods & Findings
  - Learnings

Preview of Activities in Year 3, Quarter 1

- Three additional product pilots and launches
- Monterey county RFP closed, scoring completed and intent to award notification made
- Recruitment for the Peer Program Coordinator role
- Completion of SharePoint redesign to facilitate communication and information sharing
- Facilitation of next collaborative Lessons Learned presentation
- Revised evaluation scope of work

Thank you for your interest in the learnings from Help@Hand. Questions or comments can be provided by contacting CalMHSA at helpathand@calmhsa.org and to UCI at dsorkin@uci.edu.

4/6/2020

help @ hand™ Evaluation

Mental Health Services Act (MHSA) Innovation Technology Suite Evaluation

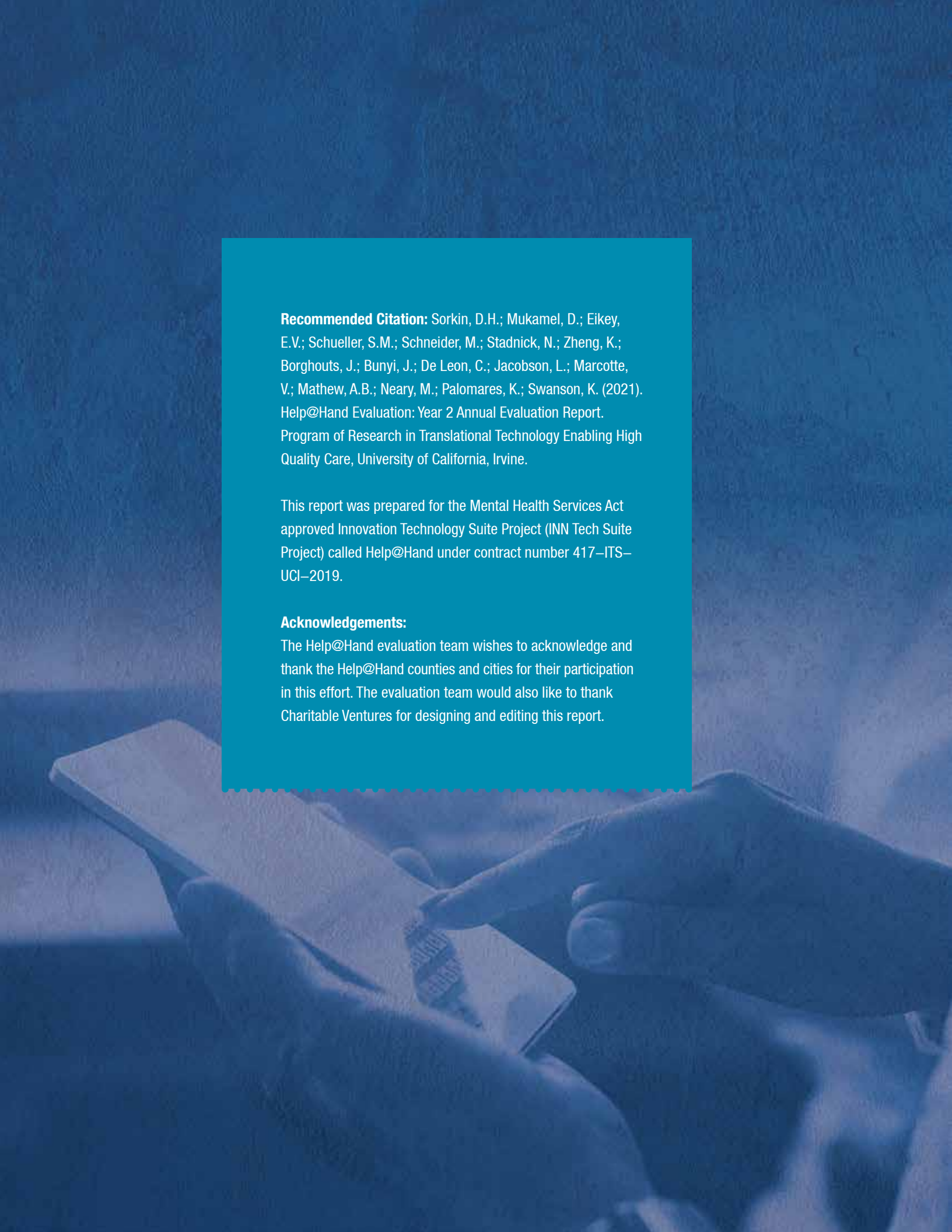
Principal Investigators:
Dara H. Sorkin, PhD
Dana Mukamel, PhD

Faculty: Elizabeth V. Eikey, PhD; Stephen M. Schueller, PhD; Margaret Schneider, PhD; Nicole Stadnick, PhD; Kai Zheng, PhD

Staff: Judith Borghouts, PhD; John Bunyi, MMFT; Cinthia De Leon, MPH; Leanne Jacobson, MA Veronique Marcotte, MS; Bessie Mathew, MPH; Martha Neary, MSc; Kristina Palomares, BA; Kera Swanson, MPH

University of California, Irvine

Year 2 Annual Evaluation Report
January – December 2020
Submitted February 2021



Recommended Citation: Sorkin, D.H.; Mukamel, D.; Eikey, E.V.; Schueller, S.M.; Schneider, M.; Stadnick, N.; Zheng, K.; Borghouts, J.; Bunyi, J.; De Leon, C.; Jacobson, L.; Marcotte, V.; Mathew, A.B.; Neary, M.; Palomares, K.; Swanson, K. (2021). Help@Hand Evaluation: Year 2 Annual Evaluation Report. Program of Research in Translational Technology Enabling High Quality Care, University of California, Irvine.

This report was prepared for the Mental Health Services Act approved Innovation Technology Suite Project (INN Tech Suite Project) called Help@Hand under contract number 417–ITS–UCI–2019.

Acknowledgements:
The Help@Hand evaluation team wishes to acknowledge and thank the Help@Hand counties and cities for their participation in this effort. The evaluation team would also like to thank Charitable Ventures for designing and editing this report.

TABLE OF CONTENTS

INTRODUCTION

Year 2 of the Help@Hand project was marked by the same critical ruptures, social upheavals, and unprecedented challenges that have shaped 2020 for all of us, and have made the work of providing targeted and accessible digital mental health therapeutics newly profound for our communities.

The COVID-19 pandemic has revealed itself to be a generation-defining complex of interrelated crises—not only the public health emergency which is still overwhelming Help@Hand counties/cities, but also new crises of rampant unemployment, housing issues, and much more. Meanwhile, 2020 witnessed thousands of protests that have demanded an evolution of the conversation around systemic racism and its effects in communities of color. And through all of this, the year in politics culminated in the national election in November, with Joseph R. Biden Jr. and Kamala D. Harris, respectively, selected as the President and Vice President of the United States.

The past year had several challenges, but also gave way for communities to speak loudly and clearly about their needs, strengths, fears, and hopes. 2020 revealed all of these needs to be inextricably linked, and emphasized the collective toll on mental health. And yet, Year 2 of the Help@Hand program has afforded a vital opportunity to respond to community need with renewed dedication and community-driven effort.

Year 2 of the project was a year of careful community needs assessments, rigorous assessment of digital therapeutic technologies and market surveillance, thoughtful piloting and implementation phases, and vital shared learnings across the collaborative with an emphasis on even greater cross-unit collaboration moving forward. Critical insights into the needs and trends of different linguistic communities, age groups, and regions with respect to the use of digital and online mental health tools were gained. A high-level overview of Year 2 program and evaluation activities as well as learnings is provided below. As the program looks ahead to Year 3, it will continue to build upon the successes and learnings of this unparalleled, yet incredibly formative year.

HELP@HAND EVALUATION ACTIVITIES AND LEARNINGS

SYSTEM EVALUATION- MARKET SURVEILLANCE, ENVIRONMENTAL SCAN, AND COLLABORATIVE PROCESS EVALUATION

The Year 2 system evaluation focuses on evaluating system-related factors that may affect Help@Hand. It presents evaluation activities and learnings from the market surveillance, as well as the status of the environmental scan and the collaborative process evaluation. Findings include:

- User experience assessment suggests that many mental health apps offer interesting, engaging, and easy-to-use support. However, limited accessibility features indicate that not everyone can get on-demand support from these apps and may face barriers beyond ease of use.
- User experience, downloads, and engagement were higher for chatbot apps than for meditation or peer support apps.
- Digital phenotyping, an approved component of Help@Hand technologies, is not a widely available feature in publicly available mental health apps.
- Apps identified through Help@Hand's most recent Request for Statement of Qualification (RFSQ) tended to underperform in the marketplace in terms of number of downloads and number of monthly active users.

PEER EVALUATION

The evaluation of the Peer component carried out in Year 2 documents Peer activities, identifies successes and challenges to implementing the Peer component, and shares lessons learned across the Collaborative. Findings include:

- Peers are playing an active role in supporting the Help@Hand program across the Collaborative. There is enthusiasm overall for the contribution of the Peer component to the Help@Hand project.
- Digital educational materials can be delivered remotely to address digital literacy, in response to the in-person constraints brought about by COVID-19.
- Peers have been engaged in digital product testing throughout Year 2, and counties/cities plan to sustain this engagement into Year 3.
- Over time, more counties/cities are reporting successes with incorporating Peer input into Help@Hand decisions, but challenges to program implementation are being reported by an increasing number of counties/cities.

COUNTY/CITY TECHNOLOGY, USER EXPERIENCE, AND IMPLEMENTATION EVALUATION

In Year 2, the Help@Hand evaluation team conducted needs assessments to assure that technologies remain appealing and accessible to all users throughout the reach of the Collaborative. In particular, the needs of Los Angeles community college students and individuals within the Riverside County Deaf and Hard of Hearing Community were assessed, and plans for additional assessments with Orange County were initiated.

Marin, Riverside, San Francisco, and San Mateo Counties, as well as City of Berkeley and Tri-City explored different technologies with target populations to provide valuable feedback about how well or poorly specific technologies were received, which in turn will inform the pilot and implementation phase of selected technologies.

Meanwhile, Los Angeles, Marin, San Francisco, San Mateo, Santa Barbara, and Tehama Counties planned pilots to test potential technologies. A few of these pilots were paused or discontinued for various reasons. At the same time, Los Angeles and Orange Counties implemented technologies, with the intention of offering these technologies to a larger group of community members or using them for the remainder of the project.

In addition, the Help@Hand Collaborative developed a framework to rapidly launch technologies to respond to the needs of their communities during COVID-19. Riverside County developed and launched a peer-chat app called Take my Hand in 2020. San Francisco County is planning to partner with Riverside County on piloting this app as well in 2021. Another technology launched was Headspace, which Los Angeles and San Mateo Counties began offering to county residents in 2020. San Francisco plans to launch Headspace in their county in 2021.

Also, Monterey and Los Angeles Counties released a Request for Information and created a Request for Proposal as part of their development of a tool that screens and refers residents of Monterey County.

Finally, Kern and Modoc Counties completed their projects and transitioned off of Help@Hand. Exit interviews were conducted with both counties.

OUTCOMES EVALUATION AND DATA DASHBOARDS

The outcomes evaluation assesses Help@Hand's overall impact in the state of California. Key findings include:

- For both teens and adults, individuals with higher distress levels were more likely to have used online tools to connect with other individuals living with similar addiction or mental health conditions.

- California Health and Human Services (CHHS) and its Institutional Review Board (IRB) approved the Help@Hand evaluation team request for data from vital statistics, which allowed the evaluation team to start analyzing data regarding suicides, and drug and alcohol overdoses. The analysis of the five-year baseline period from 2015 to 2019 revealed that the general rates of suicide and overdose are generally slightly higher in comparison counties than in Help@Hand counties.

RECOMMENDATIONS

Recommendations based on evaluation learnings are provided on page 97 for the Help@Hand Collaborative and the individual Help@Hand counties/cities.

INTRODUCTION

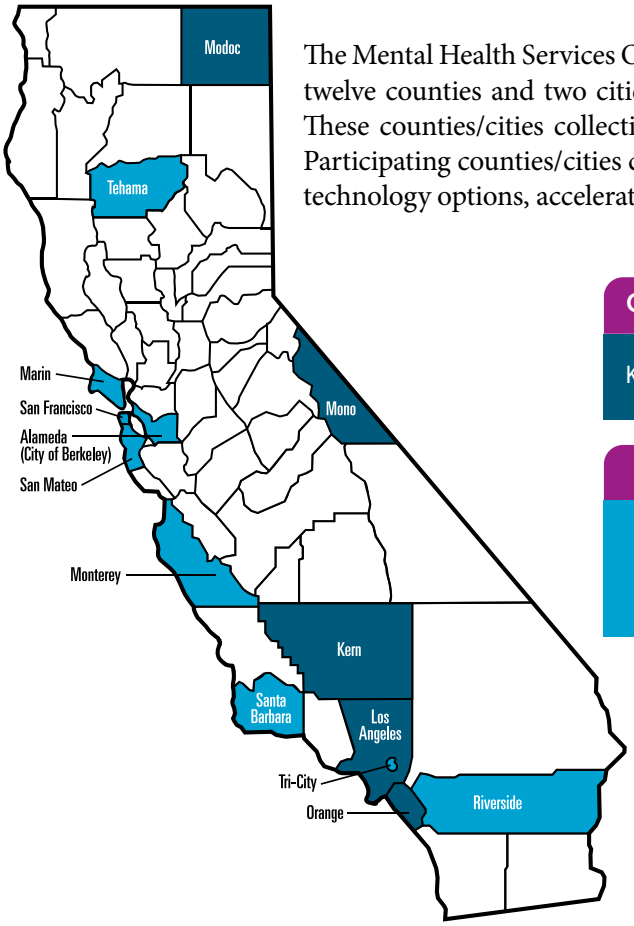
help @ hand™ Evaluation

The Innovation Technology Suite (branded as Help@Hand in 2019) is a five-year[1] statewide demonstration funded by Prop 63 (now known as the Mental Health Services Act) and has a total budget of approximately $101 million. It is designed to bring a set (or "suite") of mental health digital therapeutic technologies into the public mental health system. The program intends to provide people across California with free access to high quality, digital mental health therapeutics. In addition, Help@Hand leads innovation efforts by integrating Peers[2] throughout the program.

The efforts of Help@Hand are guided by the following five shared objectives:

1. Detect and acknowledge mental health symptoms sooner;
2. Reduce stigma associated with mental illness by promoting mental wellness;
3. Increase access to the appropriate level of support and care;
4. Increase purpose, belonging, and social connectedness of individuals served;
5. Analyze and collect data to improve mental health needs assessment and service delivery.

[1] The project was originally designated as a 3-year effort.
[2] Help@Hand defines a Peer as a person who publicly self-identifies with having a personal lived experience of a mental health/co-occurring issue accompanied by the experience of recovery. A Peer has training to use that experience to support the people they serve.



The Mental Health Services Oversight and Accountability Commission (MHSOAC) approved twelve counties and two cities across the state of California to participate in the program.[3] These counties/cities collectively represent nearly one-half of the population in California. Participating counties/cities collaborate to develop a shared learning experience that expands technology options, accelerates learning, and improves cost sharing.

Cohort #1 Counties:

Kern County, Los Angeles County, Modoc County, Mono County, Orange County

Cohort #2 Counties/Cities:

City of Berkeley, Marin County, Monterey County, Riverside County, San Francisco County, San Mateo County, Santa Barbara County, Tehama County, Tri–City

ABOUT THE EVALUATION

The University of California, Irvine (UCI) in partnership with the University of California, San Diego (UCSD) is conducting a comprehensive formative evaluation of Help@Hand. The formative evaluation observes and assesses the program as it happens in order to provide real-time feedback and learnings.

This evaluation report presents learnings from Year 2 (January-December 2020). The report is organized as follows:

- **Summary of Activities – Describes key activities and milestones accomplished during the period**
- **Evaluation – Reports activities and learnings on:**
  - o System Evaluation
  - o Peer Evaluation
  - o County/City Technology, User Experience, and Implementation Evaluation
  - o Outcomes Evaluation and Data Dashboards
- **Help@Hand Evaluation Advisory Board Recommendations – Presents recommendations based on learnings**

[3] Counties and cities can participate by submitting a proposal to the MHSOAC. Upon approval, counties and cities contract with CalMHSA, which serves as the administrative and fiscal intermediary for the program. Inyo County began participating in 2018, but later withdrew in 2018 due to insufficient internal resource capacity.

SUMMARY OF ACTIVITIES

Word cloud generated by Tech Leads to describe 2020

QUARTER 1 (JAN-MAR 2020)

Oversight and Help@Hand Leadership

- Published semi–annual report and presented update to the MHOAC (Help@Hand Collaborative)
- Approved pilot evaluation plan (Help@Hand Leadership)
- Convened Roadmap workgroup and Linguistic and Cultural Adaptation workgroup (Help@Hand Leadership)
- Announced resignation of Peer and Community Engagement Manager (CalMHSA)
- Created business continuity plans in response to COVID–19 crisis (Help@Hand Collaborative)
- Examined feasibility of statewide rapid response to COVID–19 pandemic (Help@Hand Collaborative)

County/City Activities

- Began exploring technologies and/or pilot planning (Los Angeles, Riverside, San Mateo, Santa Barbara, Tri–City)
- Presented 2nd edition of app guide to several stakeholders and worked on 3rd edition (Kern)
- Prepared to launch Take my Hand, a county–developed peer chat website (Riverside)
- Continued planning screening and referral tool (Monterey)
- Continued planning for Mindstrong implementation (Orange)
- Convened Digital Mental Health Literacy Train–the–Trainer workshop (Help@Hand Collaborative)

CRISIS

At the beginning of Year 2, the Help@Hand Collaborative made major strides to plan successful launches of technologies within their communities. Los Angeles, Riverside, San Mateo, and Santa Barbara Counties, as well as Tri-City, began planning pilots, which involved: exploring and vetting apps with staff, community members, and other stakeholders; meeting with vendors to learn more about their technologies; and engaging members of target populations with technology and the project through app guides, "AppyHours," and other outreach activities. Riverside County prepared to launch a pilot of their own peer chat website, Take my Hand. Meanwhile, Monterey and Orange Counties continued to plan their technology implementations. The project management team consulted experts and developed templates, tools, processes, and guidance to support these various planning endeavors. A description of some support can be found in the spotlight on page 14.

In addition, workgroups were convened to operationalize key strategic project priorities as well as address linguistic and cultural community needs. A Digital Mental Health Literacy (DMHL) train-the-trainer workshop was hosted by CalMHSA and held in Kern County with 30 Peers. The workshop provided training on a number of topics, including CalMHSA's digital mental health literacy curriculum and coaching sessions. CalMHSA also launched

- Held virtual Help@Hand Collaboration meeting (Help@Hand Collaborative)

Project Management

- Contracted with expert to provide clinical guidance for risk and liability (CalMHSA)
- Created and shared new vendor contract template and pilot proposal template (CalMHSA)
- Developed organizational change management tool, product matrix tool and Digital Behavioral Health Questionnaire (DBHQ) risk assessment tool (CalMHSA)
- Established pilot process and procurement process for county/city purchases (CalMHSA)
- Provided guidance for short code messaging and to operationalize Help@Hand branding (CalMHSA)
- Created interactive dashboard on project–related metrics
- Developed digital mental health literacy video series (CalMHSA)
- Launched HelpAtHandCa.org website (CalMHSA)
- Hosted webinar on Help@Hand for stakeholders and the general public (Help@Hand Collaborative)

QUARTER 2 (APR-JUN 2020)

Oversight and Help@Hand Leadership

- Approved 3 pilot proposals received from Los Angeles County (Help@Hand Leadership)
- Developed a rapid response option for counties/cities to deploy a rapid response solution in response to COVID–19 (Help@Hand Collaborative)
- Began recruiting for a new Peer and Community Engagement Manager (CalMHSA)
- Revisited project budget model, including evaluation scope of work (Help@Hand Collaborative)
- Approved and published grievance policy on Help@Hand website (Help@Hand Leadership)

County/CIty Activities

- Conducted college student needs assessment (Los Angeles, Help@Hand evaluation team)
- Explored technologies and/or planned pilots (Marin, Riverside, San Francisco, San Mateo, Santa Barbara, Tehama, Tri–City)
- Released Request for Information (RFI) to inform planning of screening and referral tool development (Monterey, Los Angeles)
- Began negotiating contract with MindLAMP to replace MindStrong for electronic diary card in Dialectical Behavior Therapy (DBT) program (Los Angeles)
- Launched Take my Hand COVID–19 Rapid Response (Riverside)
- Launched Headspace COVID–19 Rapid Response (Los Angeles)
- Began planning Headspace COVID–19 Rapid Response (San Mateo)
- Launched Mindstrong (Orange)

the Help@Hand website (HelpAtHandCa.org) and hosted a webinar to inform stakeholders and the general public about the Help@Hand program.

In March 2020, the program faced a major crisis with the arrival of the global COVID-19 pandemic and California's subsequent stay-at-home order. In response, CalMHSA actively worked with counties/cities to create business continuity plans and began to examine the feasibility of rapidly deploying technologies to immediately help communities during the COVID-19 pandemic. Several counties/cities quickly presented pilot proposals for Help@Hand Leadership approval in order to launch technologies to help communities. Others adapted planning activities for virtual formats. For example, Marin County and Tri-City began planning remote app exploration sessions with their target groups.

CALIBRATION

During quarter 2, the COVID-19 pandemic continued to impact the physical health, mental health, and economic security of individuals worldwide, and residents of the Help@Hand counties/cities were no exception. Meanwhile, the prevalence of systemic racism in the U.S. drew global attention, as high-profile cases of police violence erupted into an unprecedented series of sustained protests and civil unrest. While raising awareness and sparking dialogue on race and social justice issues, these highly traumatic public events also compounded the need for mental health and other much needed services in communities of color.

Several Help@Hand counties/cities worked tirelessly to explore technologies and plan technology pilots and implementations to meet community needs. In addition, the Help@Hand Leadership developed the Rapid COVID-19 Response framework in order to calibrate to the immediate needs of communities. The framework streamlined the process to launch technologies and allowed those counties/cities who were ready to deploy technologies to both target populations and the general public to quickly do so. Two counties– Los Angeles and Riverside – launched efforts via the framework. San Mateo County began to plan a launch of Headspace using the framework. While these counties pursued rapid response interventions, Orange County launched its Mindstrong implementation with psychiatric patients seen at UCI Health Psychiatry Services.

Meanwhile, many counties/cities paused activities while their local leadership assessed their organizational impacts amid the uncertainty brought about by the pandemic. These assessments helped inform how counties/

Project Management

- Developed Hybrid Pilot Implementation process (CalMHSA)
- Published product profiles to consolidate key information about RFSQ products and vendors (CalMHSA)
- Assessed current product certifications, licensures, and other accreditation of healthcare technology companies (CalMHSA)
- Developed Recommended Staff Expertise guidance and project onboarding materials for new Collaborative members (CalMHSA)
- Published Stakeholder Report on Help@Hand website (helpathand–ca.org)

QUARTER 3 (JUL-SEPT 2020)

Oversight and Help@Hand Leadership

- Onboarded new CalMHSA Executive Director (CalMHSA, Help@Hand Collaborative)
- Instituted new Help@Hand budget (Help@Hand Collaborative)
- Continued discussions on Help@Hand evaluation's scope of work (Help@Hand Leadership)
- Approved Tehama County's pilot proposal (Help@Hand Leadership)
- Approved funding for translation of six documents into Spanish (Help@Hand Leadership)

County/CIty Activities

- Began planning needs assessment with behavioral health clients (Orange, Help@Hand evaluation team)
- Explored technologies and/or planned pilots (Berkeley, Marin, Riv–erside, San Francisco, San Mateo, Tehama, Tri–City)
- Expanded implementation to allow more clinicians to refer patients to Mindstrong (Orange)
- Began developing Request for Proposal (RFP) development for screening and referral tool (Monterey, Los Angeles)
- Implemented Headspace using Rapid COVID–19 Response (Los Angeles, San Mateo)
- Assessed Take my Hand Rapid COVID–19 Response (Riverside)
- Announced pause in Help@Hand work until January 2021 (Tri–City)

Project Management

- Added county and city resources to the County Collaboration Center on SharePoint (CalMHSA)
- Began coordinating how to collect and share lessons learned with counties/cities (CalMHSA, Help@Hand evaluation team)
- Developed Digital Mental Health Literacy (DMHL) Planning Guide (CalMHSA)
- Adapted DMHL courses and supplemented Facilitator Guides for virtual delivery (CalMHSA)
- Developed video tutorial series on Zoom Features (CalMHSA)
- Worked on vendor contracts for Los Angeles, Orange, San Mateo, Tehama, Tri–City (CalMHSA)
- Designed Marketing Outreach Recommendations document (CalM–HSA)
- Updated Helpathandca.org website and Help@Hand project dash–board (CalMHSA)

cities could adapt and re-calibrate Help@Hand activities. For example, Santa Barbara County paused their technology pilot planning to focus on impact of COVID-19 within the agency. During this pause, Santa Barbara re-directed its efforts on developing a Peer Ambassador Program.

COLLABORATION

Collaboration was discussed at the leadership level in quarter 3. In July 2020, CalMHSA's Board and the Help@Hand Collaborative welcomed a new Executive Director, Amie Miller, PsyD. As part of her on-boarding, she met with each county/city in order to understand their projects and strengthen collaboration.

Project activities also reflected greater collaboration during the quarter. Each county/city gathered lessons learned from their technology planning and implementations, which they began to readily share with other counties/cities in the Help@Hand Collaborative. Cross-collaboration learnings were shared on several weekly Tech Lead calls. Painted Brain, who subcontracted with a number of Help@Hand counties/cities, also shared learnings from these collaborations (see spotlight on page 17). CalMHSA and the Help@Hand evaluation team began to strategize for how to better collect and share lessons learned with counties/cities. A central county collaboration center was also created on SharePoint to save local resources for other to use as well.

In addition to collaborative learnings, technology collaborations were explored. For example, Monterey County partnered with Los Angeles County on the development of a screening and referral tool. Both counties discussed expanding their collaboration on the tool to other counties/cities. Similarly, several counties/cities discussed potential technology collaborations with Take my Hand, Mindstrong, and Wysa.

Lastly, collaborative solutions were created to address common challenges. For example, the Collaborative approved a subcontract with a translation vendor to ensure linguistic and cultural appropriateness—a common challenge among all counties/cities (see spotlight on page 21). CalMHSA also created several guides and tutorials to address another common challenge, helping counties/cities provide outreach virtually, while looking into addressing contracting challenges with technology vendors.

CONTINUATION AND CHANGE

Significant changes occurred at the end of Year 2. Kern and Modoc Counties announced they completed their projects and met their project objectives. As such, they

QUARTER 4 (OCT-DEC 2020)

Oversight and Help@Hand Leadership

- Separated from the George Hills Company (CalMHSA)
- Approved Marin County's pilot proposal (Help@Hand Leadership)
- Announced project completion (Kern, Modoc)

County/CIty Activities

- Conducted Deaf and Hard of Hearing Community needs assessment (Riverside, Help@Hand evaluation team)
- Explored technologies and/or planned pilots (Berkeley, Marin, Riverside, San Francisco, San Mateo, Tehama, Tri–City)
- Began planning Headspace Rapid COVID–19 Response (San Fran–cisco)

Project Management

- Initiated thorough research on resources to help inform a county/city's approach to equitable device distribution (CalMHSA)
- Developed and shared a communication plan template to ac–company new project artifacts so that the purpose, goal(s), and objectives of each new item are clear and can be shared with the Collaborative (CalMHSA)
- Updated website based on initial feedback (CalMHSA)
- Translated and shared the Digital Mental Health Literacy curriculum from English to Spanish (CalMHSA)
- Shared insights on Terms of Service development (Riverside)

The noted list of activities is meant to describe programmatic highlights and does not necessarily reflect all effort across the various levels of the program.

would transition off Help@Hand. In addition, CalMHSA separated from George Hills, a firm who had provided CalMHSA administrative functions for several years. The separation involved some initial disruptions, such as issues with the projects website and SharePoint as well as CalMHSA's email and Zoom accounts.

At the same time though, counties/cities continued to make significant strides with their project planning, pilots, and implementations. For example, Marin County developed pilot plans, which were reviewed and approved by the Help@Hand Leadership. Additionally, some counties/cities also explored and planned new technology launches. A needs assessment was conducted with Riverside County's Deaf and Hard of Hearing Community. New technologies were also explored with Riverside County behavioral health clients.

Despite unexpected challenges in Year 2, the Help@Hand program has had many successes and learnings that poised them for continued progress in Year 3.

SPOTLIGHT
Foundational Knowledge

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The Help@Hand project seeks to build a complementary support system that offers a bridge to care, helps identify early signs of mental health changes, offers timely support, removes barriers, and seeks to include new avenues of care for communities not connected to conventional county services. In the implementation of emerging technologies in the behavioral health space, Help@Hand, through a collaborative of California cities and counties, hopes to enable this complementary support system. A primary component of the project is the identification and evaluation of feasibility to implement these technologies within the regional government structures.

In order to be successful, Help@Hand has identified the need to provide and support implementation of behavioral health applications through technology industry methodologies and standards, project management, and organizational change management (OCM).

TECHNOLOGY

Technical Basics

In supporting innovative technology applications representing the latest and greatest products, it is critical that collaborative partners and decision makers have the foundational knowledge of software system engineering, methodologies and best practices in order to make informed decisions.

Some of these practices include:

- Understanding of technology industry common vernacular and language
- An overview of the Software Development Lifecycle (SDLC) and the steps involved
- Agile and Waterfall software development methods
- The importance of testing, even with an off-the-shelf product, to verify the technology meets government regulations and standards, as well as consumer needs
- Roles and responsibilities in software development as the custodians and implementers of products

Expectations

Setting expectations and needs around the support infrastructure for technology applications and implementations is critical. The identification of partner vendors and purchasing of technology applications is not enough. Successful implementation and supporting consumer adoption requires a lot of work. This includes supporting administration and compliance with city, county, and state standards. Understanding and supporting the difficulty and complexity of technology in terms of the level of support required to make decisions, negotiate partnerships, make changes (e.g. translations, customizations with city and county specific information), and navigating local and state policies and standards.

Deploying a product that is successfully launched and used by the community requires cities and counties to find the right solution and take the right approach to meet the needs of their community. This includes understanding local risk tolerances, the number of changes to a product that is needed and weighing the pros and cons of finding that right solution.

Some of the Tactics Help@Hand Used:

- Overview of Agile Methods
- SDLC Panel Discussion
- Digital Behavioral Health Questionnaire
- Product Vendor Profiles
- Product Vendor Security Questionnaire
- Digital Mental Health Literacy
- Facilitating vendor and City/County planning discussions

CHANGE MANAGEMENT

What is Change Management

Organizational Change Management (OCM) is support for the people-aspect of change projects. Adoption of new technologies and supporting communities that may not be as familiar with innovative technology requires a great deal of effort to establish common goals, align expectations and keep stakeholder apprised of the project. While a significant level of effort, this level of engagement is essential to be a good partner to project stakeholders and the communities served, as well as to mitigate the risk of future hurdles that may arise when a stakeholder group is uninformed. At the collaborative and local levels, Help@Hand has identified and supported the need to draw from industry subject matter experts and integrate change management throughout the project.

Communication

Communication is vital to stakeholders and the communities that are being served by technology. The frequency of communication is often much greater than anticipated, both within the city and county internal networks and to community members. However, communication is not a 1-way channel. Feedback from the collaborative members on project expectations and where there may be a lack of clarity is crucial to refining communication approaches including channels and messages. In addition, feedback and engagement from the stakeholder community to inform technology product selection is equally vital in helping counties select a product that resonates with their communities.

Alignment

In all projects, but especially in a collaborative setting, alignment is a tremendous influence on how successfully the project moves forward. Simply put, alignment means project leaders and decision-makers have a unified perspective of what it means for the project to be successful and they work together to achieve that goal. On a complex and collaborative project, this becomes even more challenging partly due to the larger number of decision-makers and key stakeholders, including community stakeholders, Peers, oversight agencies, budget, risk, legal, and technology.

- Take time to build common goals & expectations and check back on them frequently
- Recognize internal partnerships (IT, Peers, Legal, Program)

- Recognize external partnerships (Collaborative members, Stakeholders, CBOs)
- Anticipate areas of concern or potential resistance by gathering regular feedback and proactively addressing areas of concern as they arise

Stakeholders

Identification and support of stakeholders to provide guidance and transparency in technology selection and evaluation is a necessity. This requires significant organizational change needs and communication strategies. As a public innovation project supporting the behavioral health community, Help@Hand has worked to increase stakeholder involvement through focus groups, regular status reporting and creating forums for open discussion. Stakeholder groups include Peers, community, government oversight and evaluation

Some of the Tactics Help@Hand Used:

- OCM Plans
- OCM Training
- OCM Coaching
- Lesson Learned
- Highlighted Examples from Other Counties
- Collaborative Roadmap
- Executive Alignment Workshop
- County Strategic Plan Template
- Stakeholder Webinar & Report
- Local Stakeholder Meetings
- Polling during tech lead calls

SPOTLIGHT

Painted Brain: Working with Multiple Counties to Address Digital Literacy

For Santa Barbara and San Mateo counties, digital literacy became a critical issue in Year 2 of the Help@Hand program. While efforts were being taken towards the implementation of the Help@Hand program, for both counties, it became increasingly clear that many in their communities did not know how to use a smartphone or tablet – let alone understand how to use an app that is on that device. With such a gap in understanding, both counties understood that raising digital literacy was key to the success of the program. Painted Brain, an organization with a history of teaching digital literacy in behavioral settings and with vulnerable populations, was separately contracted by both counties to address this gap. Painted Brain, according to Rayshell Chambers, Chief Operating Officer and one of the original founders,

> *"Meets people where they are at. They understand the needs of communities of color and other disenfranchised communities and being able to develop the curriculum and other outreach and engagement strategies that are culturally responsive and linguistically appropriate to address the digital divide in isolated communities and counties across the state of California."*

Santa Barbara

Painted Brain was contracted by Santa Barbara to integrate digital literacy into traditional mental health settings. To do this, Painted Brain provided four services – designing a brochure, training Santa Barbara's workforce, developing a digital literacy curriculum for the TAY community, and providing ongoing technical support, Appy Hours. The impact of these services has been substantial. Although in different formats, digital literacy support has been provided in Santa Barbara County to older adults, TAY, adults and youth leaving a hospital after a psychiatric hold, and Santa Barbara County's peer workforce.

Brochure

To support individuals with mental health issues, Painted Brain in collaboration with Santa Barbara created a brochure, Guide to Wellbeing Apps. Based on Painted Brain's assessment and evaluation of several mental health apps, this brochure lists 12 apps that support overall wellbeing. Other resources are also provided including contact information those in crisis or suicidal,

Lifeline, a 24-hour toll-free Access line, and a QR code to access Santa Barbara County's Mental Health, Alcohol & Substance Use Information, Referrals & Crisis Support website and information about the 8 Dimensions of Wellness. This brochure along with a smartphone are given to adults and youth getting out of hospitals on psychiatric holds.

Workforce Training

Painted Brain also trained the Santa Barbara County Department of Behavioral Wellness' peer workforce. The purpose of the training was twofold. The first goal of the training was to enhance the digital literacy skills of Santa Barbara County's peer workforce. The second goal of the training was for Peers to have the skills to support client's use of digital devices. In other words, the purpose of the training was for Peers to become proficient in the use of digital devices as well as learn how to support others in their use of mobile devices. To fulfill both goals, Painted Brain used a train-the-trainer model that fits the needs of the community members they serve. A digital health curriculum created by Painted Brain that covered such topics as setting up a gmail account, downloading an app, and using a phone camera provided the structure of the training. To assure that Peers would be able to support their specific community members, lessons were framed within the context and the community that Peers would be working in. Peers who completed the training became the first cohort of peer digital ambassadors – a new role created for the Help@Hand program. Equipped with digital understanding and the skills to teach others the same, the next step for peer digital ambassadors will be to use the curriculum to facilitate groups on digital wellness.

Appy Hours

Appy Hours is a regular opportunity for older adults in the Santa Barbara area to learn and optimize their mobile device knowledge. Specific topics, such as how to scan a QR reader and creating a YouTube account as well as opportunities for attendees to ask specific questions are given. Adapted from the in-person Appy Hours offered prior to covid, Appy Hours take place online via Zoom. Knowing the importance of making what can be a stressful topic fun, informative and engaging, Painted Brain includes games, polls, music, videos, and opportunities to win gift cards throughout the event.

Their efforts appear to be successful too. Chambers explained that Painted Brain has received positive feedback from those who attend the Appy Hours and from family members whose parent attends them too. As an example, Chambers shared that one family member described the impact of the Appy Hours on their mother as "transformational" and that it raised her "confidence".

TAY curriculum

Most recently, Painted Brain has been contracted by Santa Barbara County to create a digital health literacy curriculum for the TAY community. Still in the design phase, the focus of the curriculum will be digital wellness and recovery. It will cover the topics of recovery & resilience; online safety practices; and basic computer skills. Gaby Garcia, Program Analyst for Painted Brain explained that "each topic will focus on how technology can support TAY's overall wellness". To guide the development of the curriculum, Painted Brain, in collaboration with local colleges, is hosting listening sessions with TAY throughout the region. According to Chambers the listening sessions have been informative. Within the TAY community they've heard from TAY who "saw no purpose of basic digital literacy skills – like email set-up and email maintenance. Then, there were TAY at the community college that said we need this so bad". For the TAY who wanted to learn about digital literacy, they are interested in learning about email maintenance as well as using email for personal advocacy and professional use. The advantages Painted Brain gains from the listening sessions expand beyond using responses to develop the curriculum. It also is a unique opportunity for Painted Brain to share what they learned with Santa Barbara County colleagues.

San Mateo

Painted Brain's work with San Mateo began after the County had launched the distribution of mobile devices to community members. Having quickly mobilized the requisition and begun the delivery of smartphones or tablets to community members, San Mateo learned that the challenges to the effort were not logistics, instead it was the support that individuals were seeking from the peer workers who were delivering them. That is, peer workers were reporting that when they delivered the mobile devices, they were being asked questions about how to use the devices – how to turn it on, how to make phone calls, etc. While willing to help, Peers were not skilled at offering digital support. Recognizing that there was a need for digital literacy training within their community, San Mateo, who had heard about the positive work that Painted Brain was doing in other Counties, decided on a plan that would meet the needs of their workforce and the community they served. Like Santa Barbara, they chose to contract Painted Brain to train their workforce on digital literacy. With this training, Peers, in turn, would be able to use their newly acquired digital literacy skills to support the San Mateo community.

Workforce Training

Painted Brain chose to use a train-the-trainer model for the workforce training. As they did with the Santa Barbara peer workforce training, Painted Brain taught topics from their digital literacy curriculum including online security and privacy, introduction to digital peer navigation, email set-up and maintenance on a computer and a mobile device as well as telehealth. Importantly, the training was geared toward San Mateo County's needs. Painted Brain, first, identified community needs then during the training incorporated topics that the peer workforce had already encountered while distributing mobile devices. As Painted Brain staff member, Rashawn Morris, explained "I think the main thing is that we're trying to come from the perspective of what their Peers may need and what Peers themselves are going to need to train others". He also explained that "The whole time we are going through different training modalities to support people even wanting to be a part of this digital world".

Two trainings were completed by the end of 2020. The first was for the County peer workforce while the other was open to the workforces of the organizations that San Mateo has contracted with for the distribution of the mobile devices. Morris summarized training participants in the following quote "both times they've been very receptive to the information we are giving, and they have also been able to speak on their experience". Both trainings received positive feedback.

Next Steps

For 2021, San Mateo will continue using Painted Brain to offer digital literacy education to their community. Digital literacy education will be offered in three contexts. First, another set of workforce trainings will be offered to the organizations that are assisting with the distribution of the mobile devices. Second, an intermediate

level training on online platforms and facilitation methods will be provided for community organizations Last, Painted Brain will host online Tech Cafés to all San Mateo County community members. This additional work has the potential to greatly impact the County. As explained by Chambers "We're hitting three sectors of their population. We're hitting internal peer workforce, their community-based organizations(their contractors) and we're hitting their communities".

Workforce Trainings

A total of 18 organizations have received mobile devices for their clients. with over 1,000 devices having been distributed. The need for digital literacy education has been noticeable by many in the workforce. To support workforces from all organizations, Painted Brain will replicate the Fall 2020 trainings. Two additional trainings will be offered. Chambers explained that the goal of the trainings is to "build their current workforce's capacity to understand digital literacy topics and be able to interact and work with clients around digital literacy topics".

Tech Cafés

With the peer workforce trained in digital literacy, San Mateo County Health learned that community members were routinely reaching out to them for technical support. Workforce trainings had focused on peer workers having the skills to support individuals in the first steps of using a mobile device. They weren't, however, supposed to become technical support. To address this need, Painted Brain will host Tech Cafés. Similar to the Appy Hours provided in Santa Barbara, Tech Cafés will cover various digital literacy topics, address questions, and engage attendees with games, polls, music and opportunities to win gift cards. Tech Cafes are offered community-wide.

Zoom Training

To support community-based organization providers who had shared during a townhall on race and equity that they too struggled with technology, apps and offering support services online, Painted Brain will develop and provide an online facilitation training. Still in development, Chambers explained that the training would "provide the opportunity for participants to learn the various aspects of the teleconferencing platforms as well as group facilitation techniques that supports individuals social and emotional well-being, behavioral health, physical health, and workforce development. Training will discuss the intersection between the need for: technical skills to conduct virtual groups and the employment of inclusive facilitation techniques that are grounded in anti-racist and equitable practices". The training is planned to be at an intermediate level. Examples of topic include using the chat box, creating community agreements, facilitation from a racial equitable lens, and encouraging participation.

SPOTLIGHT
A Collaborative Driven Approach to Language Vendor Selection

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Introduction

One of Help@Hand's principles for collaboration is to "Maintain accountability and transparency with all stakeholders." Included in this initiative is ensuring language access. Spanish is the most common threshold language across all the Collaborative Counties and Cities. So, in the Spring of 2020 during a Tech Lead Collaboration Meeting the members decided to solicit a vendor to translate major stakeholder update materials from English to Spanish.

CalMHSA supported collaborative members by providing recommendations for vendors to work with, developing the scope of work, and supporting the contract process to execute the translation work.

The Collaborative materials in this scope of work included the:

- Stakeholder Update Report (Q2 2020)
- Help@Hand Update to the MHSOAC (Q4 2019)
- Digital Mental Health Literacy (DMHL) Curriculum
- Digital Mental Health Literacy video series
- Help@Hand webpage

The overall process for this initiative included:

1. CalMHSA research cost and vendor qualifications for the scope of work
2. Get feedback from the Tech Leads/Collaborative on vendor selection
3. Collaborative vote for vendor approval

Informed decision making

Collaborative members shared their requirements to assess language translation vendors with the CalMHSA team during Tech Lead calls. These requirements informed CalMHSA's approach to solicit vendors and communicate the project needs with potential vendors.

Initially CalMHSA researched and provided three recommendations for vendors the collaborative could work with. Upon presenting this information during a Tech Lead call, collaborative members requested more information on the vendors, such as work samples, and shared additional requirements they were looking for vendors to fulfill. This prompted CalMHSA to receive additional vendor recommendations from the Cities and Counties and reach out to the vendors that better met the Collaborative's needs. Throughout the process Collaborative members were encouraged to voice any questions they had for the vendors to the CalMHSA team who consolidated these questions to communicate out to the prospective vendors.

The Collaborative outlined the following requirements of vendors:

- Vendors provide their background experience and/or certification.
- Vendors have experience with behavioral health subject matter and vocabulary to trust that they would capture nuances in the language.
- Vendors provide samples of their work as part of the vendor selection process.
- That the translation process has a "back translation" step included.
    - This was specifically outlined as: Person A will translate the document, Person B will back translate the document, then A+B will confer.

After collecting this information from each vendor under consideration, CalMHSA compiled packets for Collaborative members to review.

These packets included:

- The vendors quote(s) for the outlined scope of work
- File(s) documenting the vendor's certification and/or background
- Up to 3 samples of the vendor's work.

The collaborative discussed the vendor selection and translation process at the following Tech Lead meetings:

- April 4, 2020 – Initial translation discussion with expectation setting
- May 19, 2020 – Scope of work outlined
- June 19, 2020 – Presentation of research and vendor recommendations
- July 14, 2020 – Update on vendor quotes and expertise and follow up discussion
- July 21, 2020 – Back translation process outlined
- August 18, 2020 – Presentation of three additional vendor recommendations
- August 25, 2020 – Reminder to Collaborative to send their rank order choices of the translation vendors

After the vendor option packets were shared with the collaborative, members voted in rank order for their top two vendor choices. These votes were collected by CalMHSA to tally. The results were shared with the Collaborative and confirmed during a Tech Lead Collaboration meeting announcement. Following the vendor selection choice by the collaborative, CalMHSA entered a contract with the vendor for the elected translation services.

Lessons Learned

Each county/city has their own local process for document translation, through the vendor selection process CalMHSA learned some cities/counties have more resources to translate their materials than others, resulting in different expectations for working with vendors. A few Collaborative members shared they typically outsource the work to translate materials to Spanish, but that they also build the "back translation" step into the process, while others use internal staffing resources to translate documents. Consensus showed that having Collaborative wide stakeholder materials translated with CalMHSA's support was the best way to uphold the project level principle of accountability and transparency.

A best practice recommendation from this process is to understand the city/county's process for the work before shortlisting potential vendors. This will help to ensure the vendor selections meet all collaborative members' minimum criteria. For example, the first three vendors CalMHSA shortlisted did not provide samples of their work. The collaborative provided feedback that receiving samples is a standard practice in their county and city processes prompting CalMHSA to find additional vendors that were willing to provide work samples. These additional vendors ultimately made it on the short list that the Collaborative chose from.

1 SYSTEM EVALUATION

Key Points

- User experience of apps reviewed in the market surveillance suggest that many mental health apps offer interesting, engaging, and easy-to-use support. However, limited accessibility features (e.g. languages, assistive technologies, and internet requirements) indicate that not everyone can get on-demand support from these apps and may face barriers beyond ease of use.
- User experience, downloads, and engagement were higher for chatbot apps than for meditation or peer support apps. This may mean that people are more likely to download and use apps with better user experiences.
- Digital phenotyping, an approved component of Help@Hand technologies, is not a widely available feature in publicly available mental health apps. Many digital phenotyping apps are still in the research and development phase.
- Apps identified through Help@Hand's most recent Request for Statement of Qualification (RFSQ) tended to underperform in the marketplace in terms of number of downloads and number of monthly active users.

OVERVIEW

This section focuses on evaluating system-related factors that may affect Help@Hand. It presents evaluation activities and learnings from the market surveillance, as well as the status of the environmental scan and the collaborative process evaluation.

The **market surveillance** is a review of apps within and outside of Help@Hand. In Year 2, three types of apps were reviewed (meditation, peer support, and chatbot apps) and assessed for their accessibility, user experience, and marketplace performance. In addition, the market surveillance includes a review of chatbot app features, digital phenotyping platforms, products from Help@Hand's recent Request for Statement of Qualification (RFSQ), and various learning briefs shared with the Help@Hand Collaborative in Year 2.

An **environmental scan** monitors public perceptions of mental health documented through key media events. It understands how international and local events (e.g. a celebrity opening up about their mental health struggles or a traumatic world event) may impact Help@Hand.

The **collaborative process evaluation** takes into consideration the processes, interactions, and collaboration across the Help@Hand counties/cities and stakeholder groups.

MARKET SURVEILLANCE

For the Help@Hand program, counties/cities must implement mental health technologies that meet the approved components shown in **Figure 1.1**. In Year 2, counties/cities considered three types of apps that met these criteria: meditation apps, chatbot apps, and peer support apps.

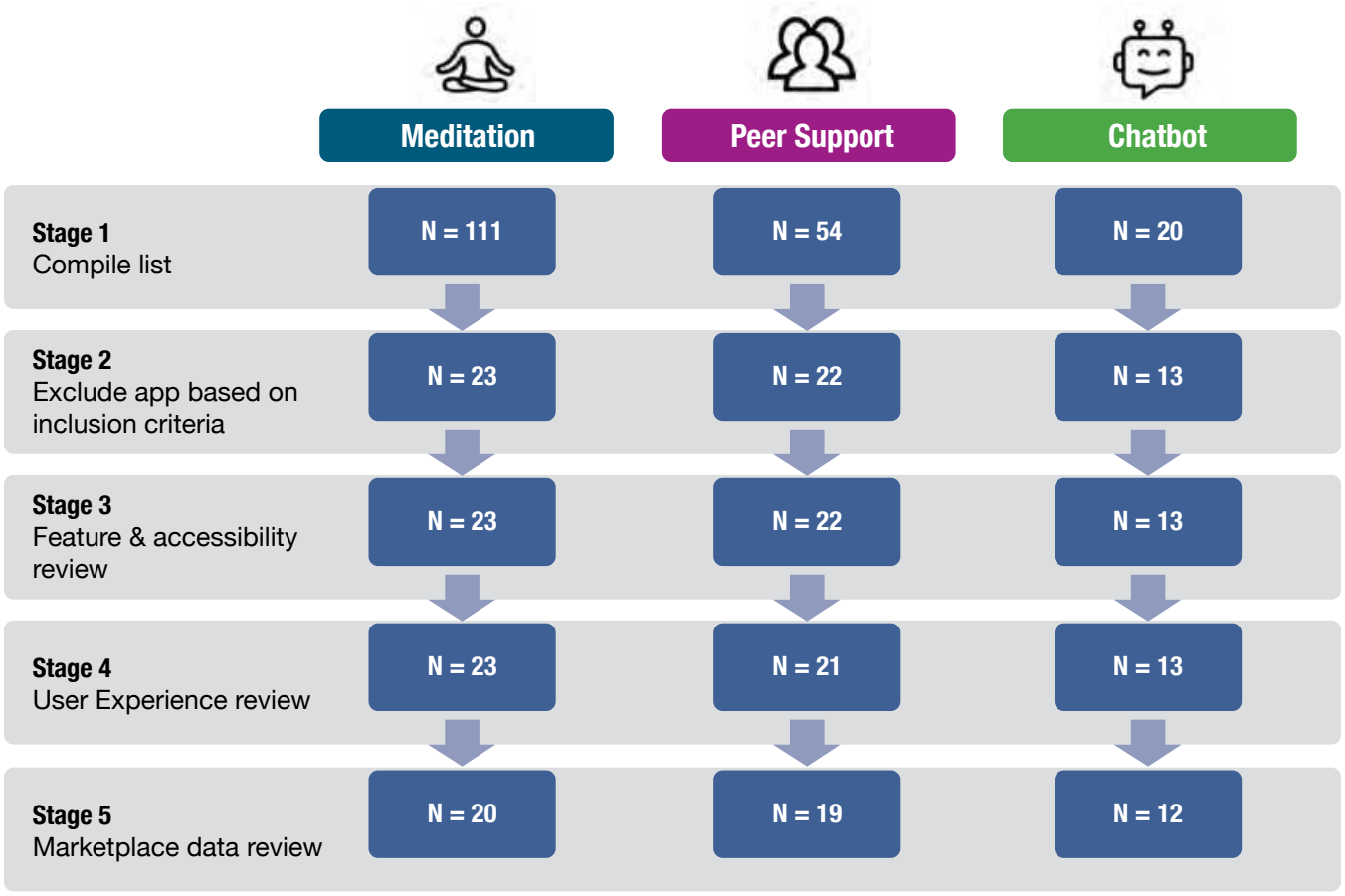
Figure 1.1. Approved Components of Help@Hand Technologies[4]

Peer Chat and Digital Therapeutics: Use techonology-based mental health solutions to intervene and offer support	**Virtual Evidence-Based Therapy Using an Avatar:** Use an avatar or other technologies for self-care	**Digital Phenotyping:** Use passive data for early detection and intervention

[4] Definitions of required components are from the RFSQ Vetting Process and Scoring Tool Criteria.

These apps were reviewed in the market surveillance in order to help counties/cities understand what the apps can offer, how they are being used, and to provide evaluation benchmarks. **Figure 1.2** illustrates the review process for these three types of apps.

Figure 1.2. Market Surveillance Review Process



Market Surveillance Review Process

- Stage 1- The evaluation team compiled a broad list of apps for each review based on app store searches and the team's expertise in digital mental health.
- Stage 2- The team excluded apps not meeting the inclusion criteria.[5] Fewer criteria were applied to the chatbot list since there were only a few chatbots available in the app marketplace.
- Stage 3- The team downloaded and explored the apps to determine the presence or absence of various features, including accessibility features (e.g., language, internet access, and assistive technology).
- Stage 4- The evaluation team had experts and consumers review the user experience of apps using the Mobile App Rating Scale (MARS), a well-known, validated, and standardized tool that assesses the engagement, functionality, aesthetics, and information quality of health apps (Stoyanov et al, 2015).
- Stage 5- The team gathered marketplace data (e.g., the number of monthly active users and downloads for each apps over the past year) from Apptopia, a third-party analytics platform.[6]

[5] The inclusion criteria for meditation and peer chat apps were: 1) available on both iOS and Android; 2) updated within the last 12 months; and 3) has either meditation or peer support as its primary feature. The inclusion criteria for chatbot apps was that it had a chatbot component as it's primary feature. Because there were fewer chatbot apps available in the marketplace to begin with, fewer criteria were applied to narrow down the chatbot app list.

[6] Apptopia, Marketplace data was not available for every app because apps needed to rank within the top 1500 apps for iOS and within the top 200 apps for Google Play in order to have marketplace data available on Apptopia. This explains why the number of apps reviewed in stage 5 differed from stage 3 and 4. In addition, the number of apps differed between the stages because apps are frequently added and removed from the marketplace.

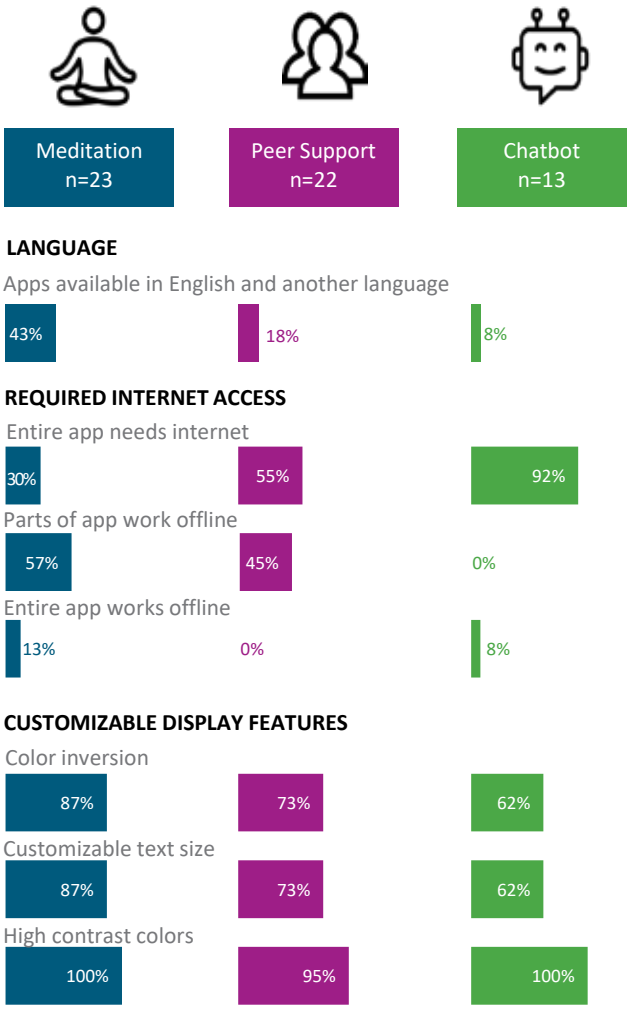
Accessibility, User Experience, and Marketplace Data Reviews:

ACCESSIBILITY

Accessibility means making apps easy to use for a broad range of people. If apps are only easy or possible to use for some people and not others, this can widen the gap in access to care. The accessibility of meditation, peer support, and chatbot apps was reviewed with respect to language, internet access, and customizable display features.

Figure 1.3 compares language availability, the need for internet connection for full or partial functionality, and customizable display features across all apps. Key learnings are presented below.

Figure 1.3. Accessibility Reviews of Meditation, Peer Support, and Chatbot Apps



App Accessibility Review - Key Points

Language: The majority of apps were available in English only. Note that even when different languages are available, this does not always mean that the app is culturally appropriate. It simply means that the text has been translated.

Required Internet Access: The majority of meditation, peer support, and chatbot apps reviewed need internet connectivity and could not be used without internet access. This can be a problem since some people may have inconsistent or limited internet access. Some meditation and peer support apps had parts that were available offline. For example, almost half (45%) of peer support apps had some content, such as assessments and journals available offline, but not the peer support forums or chatrooms themselves.

Customizable Display Features: For most apps, screen readers could only read some, but not all, of the app content. This means that users who need the text to be read aloud to them cannot use every part of the app. The ability to change text size, contrast, and colors can allow someone to read text on screen more easily.

USER EXPERIENCE REVIEWS

User experience means the overall experience one has when using an app. Questions to consider include:

- Is the app easy to use?
- Is the app interesting and fun to use?
- Is it interactive?
- Does the app work properly?
- How good does the app look?
- Is the content well-written and accurate?

User experience of mental health apps can be assessed through the Mobile App Ratings Scale (MARS; Stoyanov et al., 2015), which can be found in **Appendix B**. For each app reviewed in Year 2, two experts and one consumer used the MARS to assess the user experience of each app. Experts had extensive experience in user experience and mental health app reviews. Consumers were individuals who had lived experience with mental health challenges.

Figure 1.4 details both the expert and consumer scores for the chatbot apps reviewed. Note that while the MARS tool gives a total score out of 5.00, the developer of the tool states that a score of 4.00 can indicate high-quality apps. The majority of chatbot apps (77% expert rated, 62% consumer rated) scored higher than 4.00. **Appendix C** shows the expert and consumer user experience scores for meditation and peer support apps.

Figure 1.5 shows combined user experience scores across meditation, peer support, and chatbot apps to allow for comparisons. User experience was rated higher in chatbot apps than meditation and peer support apps. This suggests that chatbot apps have the best user experience. That said, there were fewer apps (N=13) in the chatbot group than the meditation and peer support group, so readers should be cautious when interpreting these results.

Figure 1.4. Expert and Consumer User Experience Reviews of Chatbot Apps

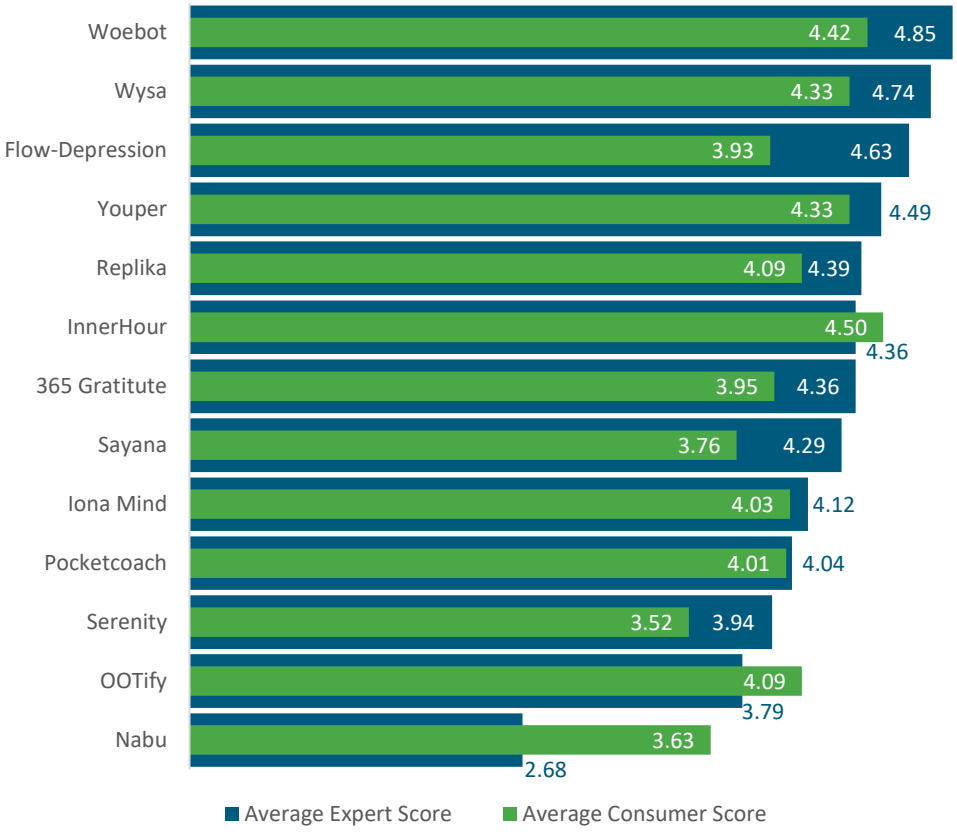
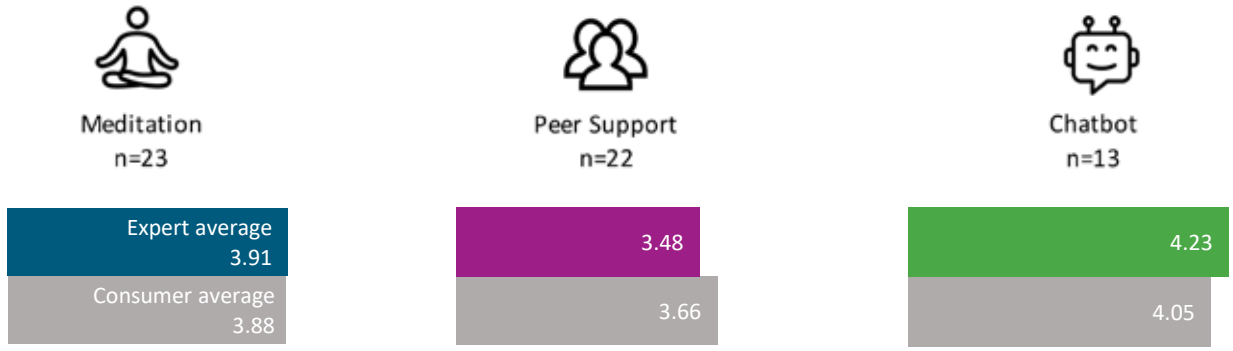


Figure 1.5. Average User Experience Reviews for Meditation, Peer Support, and Chatbot Apps



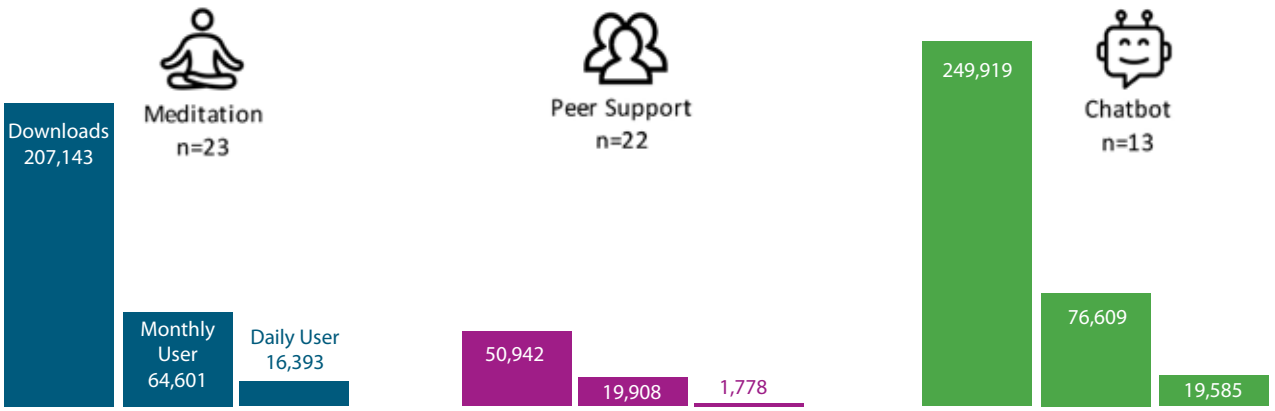
MARKETPLACE DATA REVIEW

Finally, marketplace data was reviewed to explore how people engage with and use these products. **Figure 1.6** compares the following metrics across meditation, peer support, and chatbot apps[7]:

- **Downloads:** The number of new users downloading the app for the first time.[8]
- **Monthly Active Users (MAU):** The number of users who opened the app at least once in a 30-day period
- **Daily Active Users (DAU):** The number of users who opened the app at least once in a day

Figure 1.6 shows that chatbot apps have higher median number of downloads and engagement (both MAU and DAU), compared to meditation and peer support apps. However, 1) there are fewer chatbot apps than meditation and peer support apps available in the marketplace, and 2) the highest performing apps in terms of downloads and engagement belong to the meditation category (Calm and Headspace). Meditation and peer support apps therefore have both very high and very low performing apps whereas chatbot apps tend to perform more consistently well.

Figure 1.6. Median Downloads, Monthly Users, and Daily Users of Meditation, Peer Support, and Chatbot Apps



[7] Ns noted in the figures represent the number of apps in each group with marketplace data available for both iOS and Android, which is why they are some differences between the Ns here and those reported elsewhere.
[8] If a user gets a new phone or re-downloads the app, it still counts as one download.

Feature Review: Chatbot Apps

What is a chatbot?
A chatbot is a software program designed to mimic a conversation with a human.

Meditation and peer support apps were reviewed in previous evaluation reports and can be found in **Appendix C**. This section provides a feature review of chatbot apps.

The goal of chatbots most often is not to make users think they are talking with a real person. Although they are sometimes called "virtual therapists," they are not a replacement for a therapist or other provider. Instead, chatbots may be helpful when used: 1) in addition to an existing professional care; 2) while someone waits for an appointment with a provider; and 3) to support overall wellness, rather than to treat mental health symptoms.

The evaluation team conducted a feature review of 13 chatbot apps as shown in **Table 1.1**. There are several key findings from the feature review of chatbots related to:

- **Chatbot Goals:** The primary purpose of chatbots may be to chat with the user about how they are feeling or to guide the user through the use of the app.
- **Response Options:** Interaction between a user and a chatbot varies from open-text to pre-set responses.
- **Chatbot Personalities:** Chatbot interface ranges from avatars with distinct "personalities" to simple text-based exchanges without an attached persona.
- **Crisis Response:** Chatbots varied drastically in their response to users indicating that they are experiencing a mental health crisis.

Table 1.1. Full Feature Reviews of Chatbot Apps

App name	Screen Reader Capabilities	Customizable Display Features	Internet required for use?	# Languages	Content for underserved groups	Features of chatbot			
	+++ All buttons spoken ++ Most buttons or features spoken + Some buttons or features spoken	A+ Text size T High contrast text Color inversion Animation reduction	Yes No			Is the primary goal to a) **chat** with the user about how they are feeling, or b) to **guide** them through using the app?	Can users respond via a) **pre-set responses only** or b) **both** open text and pre-set responses?	What is the personality of the chatbot avatar (if any)?	How does the chatbot respond to mental health crisis?[9]
365 Gratitude	++	◑ ▶	wifi	1	None	Guide	Pre-set only	Animated alpaca named Joy	N/A
Flow	+	A+ T ◑ ▶	wifi	2	None	Guide	Both	No clear avatar	N/A
InnerHour	++	A+ T ◑	wifi	1	None	Guide	Pre-set only	No clear avatar	N/A
Iona Mind	+	◑ ▶	wifi	1	None	Chat	Both	No clear avatar	Words of comfort. States the app is not designed to handle crisis. Advises user to contact emergency services.
Nabu	++	A+ ◑ ▶	wifi	1	None	Guide	Pre-set only	Animated owl	N/A
ometry	++	T ◑ ▶	wifi	1	None	Guide	Pre-set only	No clear avatar	N/A

[9] N/A means that users were not able to say that they were in crisis. Therefore, the response is not applicable.

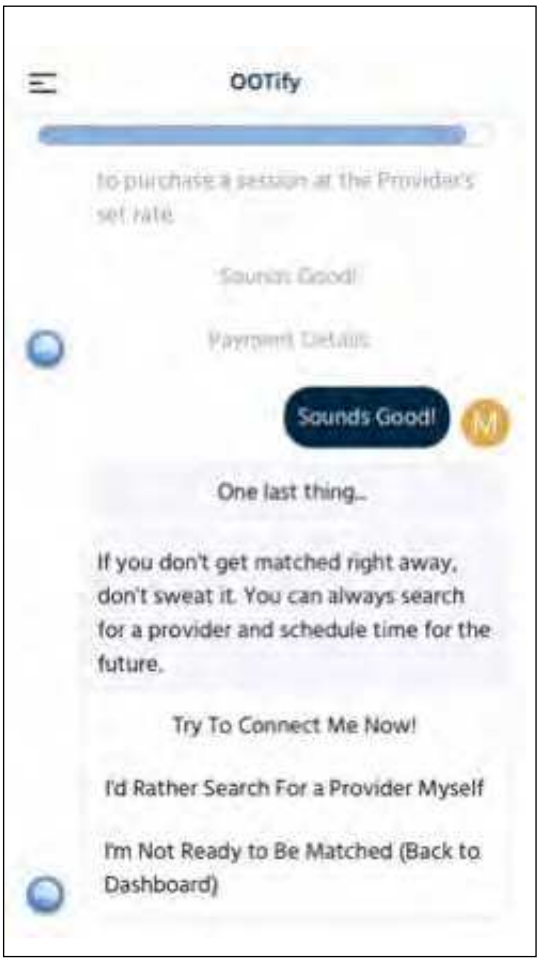
Pocketcoach	+	A+ 		1	None	Both	Both	No clear avatar	N/A
Replika	++	A+		1	None	Chat	Both	User can create/customize avatar	Crisis hotlines, offers tools to help manage panic attacks.
Sayana	+			1	None	Guide	Both	Human character	No crisis response
Serenity	++	A+ 		1	None	Chat	Both	Human character	Advises user to speak to "a human" in their life. Provides crisis hotline.
Woebot	+++	A+		1	None	Chat	Both	Animated robot	Words of comfort. States the app is not designed to handle crisis. Asks user's location and provides hotlines and text lines.
Wysa	+++			1	LGBTQ+ Community	Chat	Both	Animated penguin	Words of comfort, provides crisis line resources. SOS button also on home page with crisis resources.
Youper	+++	A+ 		1	None	Chat	Both	No clear avatar	Words of comfort. States the app is not designed to handle crisis. Asks user's location and provides hotlines and text lines.

CHATBOT GOALS

Figure 1.7 shows that the goals of chatbots vary from one mental health app to another. About half (n=7) of the 13 chatbot apps reviewed aimed to chat with the user about how they are feeling. The other half (n=6) aimed to guide the user through the app and help them find resources within the app. Furthermore, some chatbots were only available in the app at certain times. For example, the chatbot in 365 Gratitude only appeared during first use to introduce the user to the app—it was not available during later sessions.

Figure 1.7. Sample Goals of Chatbot Apps

Interactive Example: Wysa
Goal is to talk through how the user is feeling

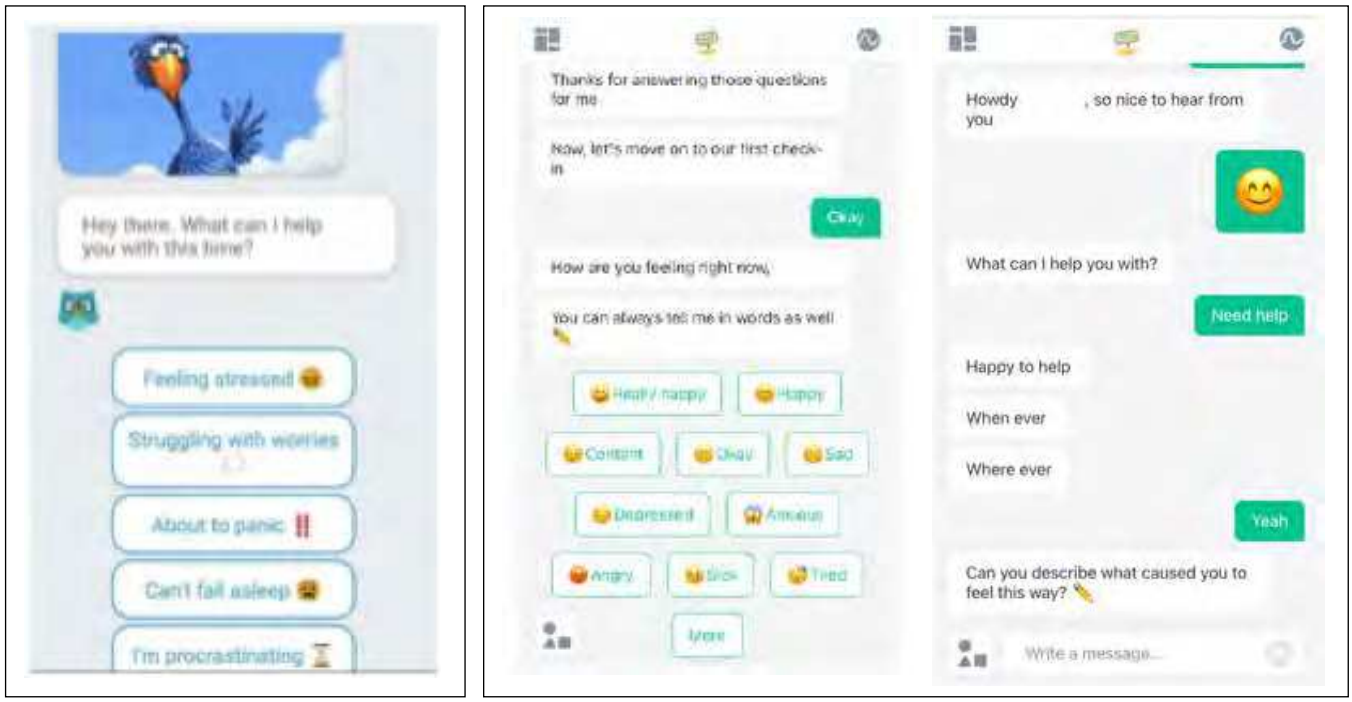


App Use Example: Ootify
Goal is to guide app use and match user with a provider

RESPONSE OPTIONS

Users may chat with the chatbot through pre-set responses or open-text responses. In a pre-set response model, users can only select options for response determined by the app. In an open-text response model, the user can type anything they like into the chat, as if they were sending a text message. Examples of both models are shown in **Figure 1.8**.

Figure 1.8. Sample Response Options of Chatbots Apps



Pre-Set Response Example: Nabu
Users choose from pre-set options only

Open-Text Response Example: Woebot
Users can use both open-text and pre-set response to chat

Of the apps reviewed, one-third (n=4) had only pre-set responses and two-thirds (n=9) had both open-text and pre-set options. A user cannot choose when they want to use a pre-set versus open-text response; the app determines that.

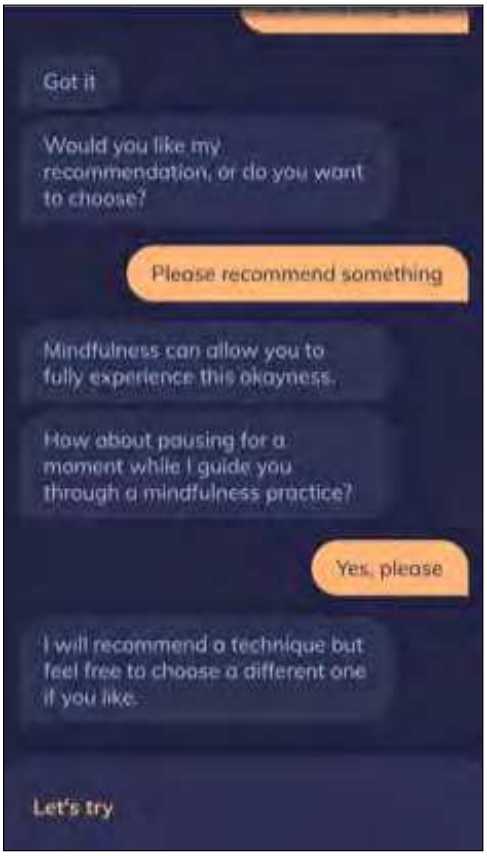
All apps whose primary goal was to chat with the user about their mental health allowed both open-text and pre-set options. While open text responses allow users to provide more personalized information and describe things in their own words, they may also pose challenges with monitoring. A chatbot may not necessarily know how to respond to an unlimited number of responses.

CHATBOT PERSONALITIES

Some chatbots have a distinct "personality" or avatar, while others are more simplistic and lack a clear avatar. Almost half (46%; n=6) of the apps reviewed had a distinct avatar personality, and 54% (n=7) did not. **Figure 1.9** provides examples of these chatbot styles.

Figure 1.9. Sample Personalities in Chatbot Apps

Avatar Example: 365 Gratitude
Chatbot is a cute alpaca named Joy



Non-Avatar Example: Youper
Chatbot does not have a clear or distinct personality

CRISIS RESPONSE

When talking to a chatbot, a user may disclose that they are in a mental health crisis and need immediate support. Research has shown that people view a conversation with a virtual therapist as more anonymous than a conversation with a human. They may then be more likely to disclose or describe something that they may not discuss with a human due to stigma (Lucas et al., 2017). Since users may disclose a mental health crisis to a chatbot, the evaluation team reviewed how each chatbot app responds to a crisis in order to help determine if the app responds sensitively and appropriately.

Not every app allowed a user an option to say that they were in crisis because some apps only allow for pre-set responses. Users were unable to say that they were in crisis through pre-set responses in 46% of the apps reviewed (n = 6). When users could say they were in crisis, one app did not acknowledge this or respond, and appeared to glitch. Of the apps that did respond, the most common response to crisis was providing hotline numbers where the user could get support. Details of crisis responses are in the last column of **Table 1.1**.

Review of Digital Phenotyping Platforms

Digital phenotyping platforms were also reviewed in Year 2. Digital phenotyping, one of the approved components of Help@Hand technologies, passively collects data to predict or monitor mental health and wellness. Passive data is collected "in the background," rather than being actively input into a device by a user (although users should always give permission for this data to be collected). Digital phenotyping models propose that how users interact with their devices can tell as much about their mental states as what they enter into their devices.

In Year 1, the market surveillance identified digital phenotyping platforms through app store searches and app descriptions. Mindstrong was the only platform found, since many digital phenotyping platforms were under development and not yet available on the app stores for download.[10] In Year 2, the evaluation team broadened the search to also include digital phenotyping platforms identified through expertise and knowledge of the digital mental health space, the published literature, and review papers and lists of digital phenotyping platforms in mental health. This resulted in a list of 11 digital phenotyping platforms. While this review was not meant to be exhaustive, it intended to identify some emerging digital phenotyping products and illustrate some of the variation in digital phenotyping platforms and available features.

Each platform was reviewed for the presence or absence of various features related to: 1) passive data collection (e.g., sensor-based data collection); 2) active data collection (e.g., surveys, cognitive tests, and voice recordings); and 3) types of interventions associated with the platform. **Table 1.2** displays the full information for each platform.

Table 1.2. Features of Digital Phenotyping Platforms

		Passive Data Collection Features						Active Data Collection				
	Operating System	Location Features	Interaction Features	Communi–cation Features	Movement Features	Physiology Features	Other Features	Surveys	Cognitive Tasks	Voice Recordings	Interventions	Intended for Research Purposes Only
Aware	Android, iOS	•	•	•	•		•	•			Tracking	•
BiAffect	iOS		•		•		•	•	•		No intervention	•
BeiWe	Android, iOS	•		•	•		•	•			No intervention	•
EARS	Android, iOS	•	•		•		•	•		•	No intervention	•
inSTIL	Android, iOS	•		•	•		•	•	•	•	No intervention	•
MindLAMP	Android, iOS	•		•	•			•	•		Mindfulness, Education tracking, interactive modules	
Mindstrong	Android, iOS	•	•	•				•			Linkage to care provider	
Monsenso	Android, iOS			•	•			•			Tracking	
MoodTriggers	Android	•		•	•	•	•	•			Tracking	•
MoviSensXS	Android				•	•	•	•			Triggered Interventions	•
Sensus	Android, iOS	•		•	•	•	•	•			No intervention	•

[10] This might be because they do not have a business-to-consumer model or are intended mostly for research purposes.

PASSIVE DATA COLLECTION

Six types of passive data collected via digital phenotyping platforms were identified:

Location Features	*Location Features* included Global Positioning System (GPS), or specific locations from other databases, such as Google Places location types. Location data was collected by 9 of 11 platforms (82%).
Interaction Features	*Interaction Features* refer to the way a person uses or interacts with their phone and include keystrokes, time and length of messages, typing movement, phone swipes, etc. Interaction data was collected by 4 of 11 platforms (36%).
Communication Features	*Communication Features* included call and text logs that provide information such as number, timing, and length of phone calls and text messages, and social media. Communication data was collected by 8 of 11 platforms (73%).
Movement Features	*Movement Features* included accelerometer data, step counts, exercise data, and metabolic equivalent of task. Movement data was collected by 10 of 11 platforms (91%).
Physiology Features	*Physiology Features* included galvanic skin response, heart rate, and heart rate variability. Physiological data was collected by 3 of 11 platforms (27%).
Other Features	*Other Features* included battery life, weather data, ambient light, facial expressions in "selfie" photos, and BlueTooth sensors triggers. Data from other features was collected by 8 of 11 platforms (73%).

ACTIVE DATA COLLECTION

Three types of active data collected via digital phenotyping platforms were identified:

Surveys	*Surveys* included both standard assessments and customizable assessments. Surveys could either be available for users to complete as desired, at fixed intervals, or triggered by passive data. Survey data was collected by 11 of 11 platforms (100%).
Cognitive Tasks	*Cognitive Tasks* are those that require a person to actively process information in order to assess cognitive processes, such as memory, attention, or learning. Data from cognitive tasks was collected by 3 of 11 platforms (27%).
Voice Recordings	*Voice Recordings* allowed users to record information through speech. Voice recording data was collected by 2 of 11 platforms (18%).

INTERVENTIONS

The digital phenotyping platforms reviewed included various interventions. About half of the platforms (n=6, 54%) included some form of intervention.

- **Tracking:** Tracking symptoms, mood, behaviors, and medication was most common.
- **Linkage to care provider:** Only *Mindstrong* included direct linkage to care providers, but *MindLAMP* could potentially facilitate this with a provider dashboard.
- **Triggered interventions:** *MoviSensXS* offered triggered interventions, or what are known as "ecological momentary interventions." These interventions could be triggered by different actions, including answers in a questionnaire or information from the sensor-based data collection. Interventions could take the form of text, audio, or video, but the content of these interventions would have to be created by the team deploying *MoviSensXS*.
- **Other:** *MindLAMP* included intervention modules such as mindfulness and psychoeducation. It also provided a dashboard that allows for information received by the *MindLAMP* platform to integrate with care providers.

Marketplace Data Review of Help@Hand RFSQ-Approved Apps

In addition to reviewing apps in the broader marketplace, the market surveillance reviewed apps in the Help@Hand Request For Statement of Qualifications (RFSQ).[11] The Help@Hand RFSQ-approved apps only included apps that met the project's required components: peer chat/digital therapeutics (N=75), therapy avatars (N=75), and digital phenotyping (N=41), where Ns represent the number of apps approved for inclusion in each category.

Figures 1.10 and 1.11 show the changes in downloads and monthly active users (MAU) across 2020 by component for each Help@Hand approved app where data is available (e.g., Ns in the graphs show the number of apps with marketplace data is available). Additional marketplace data is in **Appendix D**[12]. Although there is a general increasing trend for peer chat/digital therapeutic apps and decreasing trend for therapy avatar apps, significant variation exist in the month-to-month levels. Changes observed in downloads or use of the Help@Hand RFSQ-approved apps might be due to general changes in downloads and use in the broader app marketplace. Counties/cities should keep this in consideration when viewing app data obtained from vendors.

Figure 1.10. Median Downloads of Help@Hand RFSQ Apps in 2020

[11] Help@Hand released an RFSQ to vendors in September 2019 in response to a need for expanding the technology offerings within the project.

[12] Marketplace data was not available for every app in the RFSQ, because apps needed to rank within the top 1500 apps for iOS and within the top 200 apps for Google Play in order to have marketplace data available on Apptopia.

Figure 1.11. Median Monthly Active Users of Help@Hand RFSQ Apps in 2020

It is also worth noting the scale of downloads and monthly active users for the Help@Hand RFSQ apps versus the broader marketplace. The median download for Help@Hand RFSQ apps tended to be between 100-500 per month, whereas the meditation, peer support, and chatbot apps in the broader marketplace were approximately 17,000, 4,000, and 21,000 downloads per month, respectively. Similarly, the monthly active users for Help@Hand RFSQ apps were in the 10,000 to 40,000 range, and meditation, peer support, and chatbot apps in the broader marketplace were in the 20,000 to 76,000 range. As such, Help@Hand RFSQ-approved apps tended to be less downloaded and less used than the average app of similar categories in the marketplace. The maturity of products submitted to the Help@Hand RFSQ is a concern for their viability in the Help@Hand project.

Market Surveillance Learning Briefs

Learning briefs examining other aspects of the app marketplace were developed in Year 2 and can be found in **Appendix E**. These brief include.

- **Free Apps with COVID-19 Content Brief** reviews 10 free apps with COVID-19 content that could support the community during the pandemic.
- **Selected Mental Health App Performance during COVID-19 Brief** examines marketplace performance data of selected apps identified since the onset of COVID-19.
- **Mental Health Apps Provided or Recommended by Insurance Plans in California Brief** identifies mental health apps available for the community by major insurance companies in California.
- **myStrength and Apps Similar to myStrength Brief** summarizes features and research on RFSQ-approved apps that are similar to myStrength.

Learnings from the Market Surveillance

Learnings from reviews of apps considered by counties/cities and apps outside of Help@Hand found:

- **Language:** Many of these apps are not suitable for counties/cities targeting non-English speaking populations since they do not provide resources in languages other than English.
- **Internet Access:** Most apps need to be connected to the internet to work. People with limited access to the internet, such as geographically isolated populations or those with limited data plans, will not be able to get on-demand mental health support from these apps.
- **Assistive Technology:** Most apps allow the user to customize content display to some degree (e.g., a user could increase the text size to better view the content). However, if users need a screen reader to read content aloud to them, this was not widely available.
- **User Experience:** Chatbots had higher user experience scores than meditation and peer support apps from both experts and consumers.
- **Marketplace Data Review:** Marketplace data showed that peer support apps were far less popular than meditation or chatbot apps. They were downloaded less and had fewer monthly and daily active users. This suggests that people may be more likely to engage with meditation or chatbot apps.
- **Purpose of Chatbots:** Although an app may say that it provides a mental health chatbot, some apps simply guided the user through the app rather than providing mental health support or chatting with the user about how they are feeling. Chatbot apps also may not always respond appropriately when a user says that they are in crisis.
- **Digital Phenotyping Platforms:** Digital phenotyping platforms can collect a range of passive data but are more limited in the range of active data collection modes. Most digital phenotyping platforms are intended for research and assessment purposes with limited opportunities for clinical intervention.
  - **Passive Data:** The most common passive data features are location, communication, and movement.
  - **Active Data:** The most common active data collection method is surveys.
  - **Availability:** Most of the digital phenotyping platforms reviewed were available on both Android and iOS.
- **Help@Hand RFSQ-Approved Apps:** Marketplace data of the RFSQ app show considerable monthly changes in downloads and use. Comparisons between RFSQ apps with number of downloads and monthly active users from products in similar categories in the marketplace generally show fewer downloads and less use of RFSQ products.

ENVIRONMENTAL SCAN

An environmental scan monitors public perceptions of mental health documented through key media events. News stories based on keywords related to Help@Hand were collected, but analysis of these stories has not started due to limited staffing to support the environmental scan. This activity was on hold in Year 2.

COLLABORATIVE PROCESS EVALUATION

Help@Hand is also influenced by the processes, interactions, and collaboration across the Help@Hand counties/cities and stakeholder groups. The collaborative process evaluation examines how these factors affect Help@Hand at the system and organizational level.

The evaluation team developed an interview guide and survey for the collaborative process evaluation in Year 1 and updated the interview guide in Year 2 to reflect project changes. However, the Collaborative requested a pause on conducting interviews and surveys since October 2019. There are plans to re-launch the collaborative process evaluation in Year 3.

2 PEER EVALUATION

Key Points

- Peers play an active role in supporting the Help@Hand program across the Collaborative. There is overall enthusiasm for the contribution of the Peer component to Help@Hand.
- In response to the COVID-19 pandemic and the halting of in-person outreach activities, counties/cities created educational materials that could be delivered virtually to address digital literacy.
- Peers engaged in digital product testing throughout Year 2, and counties/cities plan to sustain this engagement into Year 3.
- Counties/cities reported a number of successes and challenges related to the Peer component of Help@Hand. Over time, more counties/cities reported successes with incorporating Peer input into Help@Hand decisions. However, challenges to program implementation were reported by an increasing number of counties/cities.

OVERVIEW

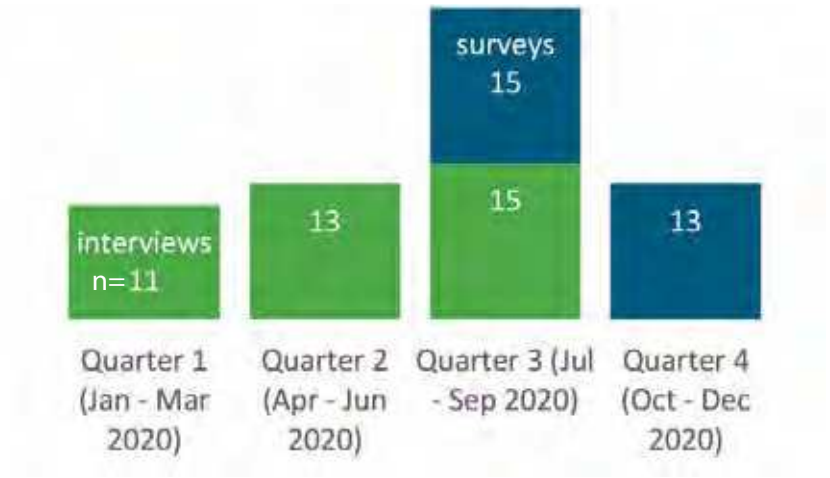
The evaluation of the Peer component of Help@Hand documents Peer activities, identifies successes and challenges to implementing the Peer component, and shares lessons learned across the Collaborative.

PEER EVALUATION

Surveys were developed from interviews conducted in quarters 1 and 2.[13] Surveys in quarter 3 (n=15) were completed by 14 Peers and 1 Tech Lead (from a county/city without a Peer Lead), while surveys in quarter 4 (n=13) were completed by 10 Peer Leads, 1 Tech Lead, and 2 Peer/Tech Leads.[14]

Figure 2.1 shows Peer evaluation activities conducted in each quarter of Year 2. **Appendix F** includes learning briefs summarizing findings from the quarter 2 interviews and quarter 3 surveys.

Figure 2.1. Peer Evaluation Interviews and Surveys Conducted in Year 2



Peer Activities in Year 2

Surveys asked about the activities that Help@Hand Peers engaged in within counties/cities during quarter 3 and quarter 4. **Figure 2.2** shows the survey results.

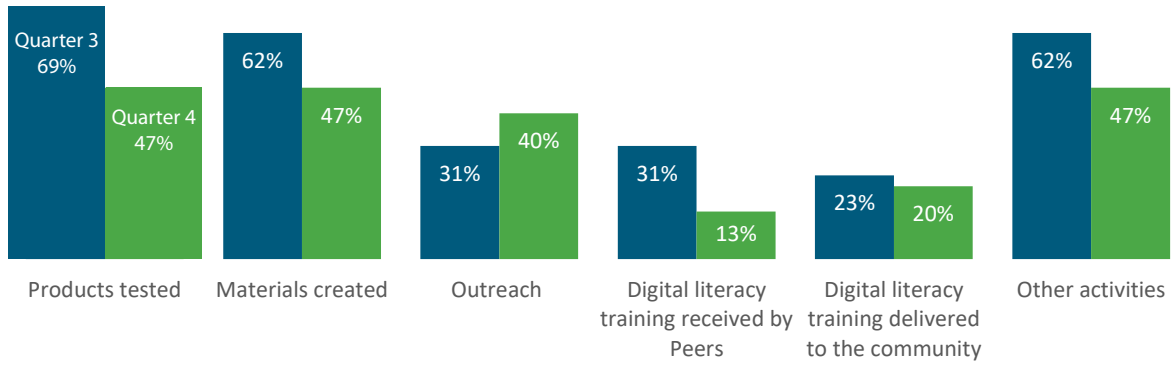
- **Product Testing and Material Creation.** The most common Peer activities in both quarters were testing products (e.g., potential digital mental health apps) and creating materials (e.g., developing educational presentations related to digital literacy) for target populations. Owing to social distancing mandates issued toward the end of quarter 1, collaboration among the Peers during quarters 3 and 4 occurred virtually and the materials developed were primarily intended for distribution through digital platforms. Using these platforms helped Peers learn new skills that would prepare them to carry out outreach virtually.

[13] Quarter 1 interviews (n=11) included ten Help@Hand Peer Leads and the Help@Hand Peer and Community Engagement Manager. Quarter 2 interviews (n=13) included 11 Peer Leads and two Tech Lead (from counties without a Peer Lead).

[14] Follow-up interviews were conducted in quarter 3 to elicit details on survey responses and were not conducted in quarter 4 due to the winter holiday.

- **"Other" Activities.** Peers were engaged in a variety of "other" activities during quarter 4. These included: 1) implementing the Mindstrong and Headspace apps; 2) becoming proficient in using virtual communication platforms; and 3) working with the Help@Hand evaluation team to refine surveys and focus group guides.

Figure 2.2. Peer Activities Reported in Peer Evaluation Surveys

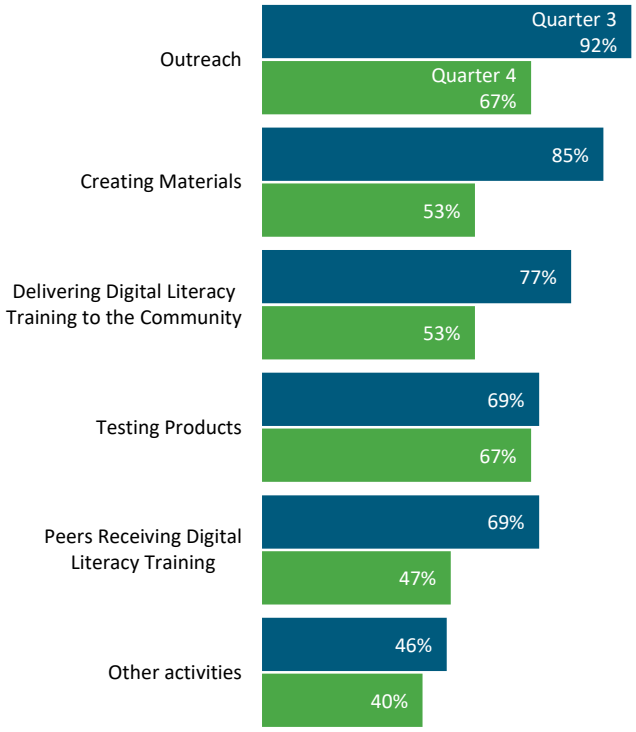


Planned Peer Activities

Surveys and interviews also asked about planned Peer activities for the following quarter. **Figure 2.3** shows the survey results. Together with the interviews, surveys reveal:

- **Changes in planned activities.** Outreach, creating materials, and delivering digital literacy training to the community were the most frequently identified planned Peer activities in the quarter 3 survey. Plans for all three of these activities were reduced in the quarter 4 survey, though over half of the respondents still indicated that these activities were planned. Plans to test products remained steady over both quarters at about two-thirds of respondents.
- **Optimism.** Interviews conducted in quarter 3 conveyed a general optimism about shifting from preparing for digital mental health literacy outreach and into implementing outreach in 2021.

Figure 2.3. Planned Peer Activities Reported in Peer Evaluation Surveys



Successes

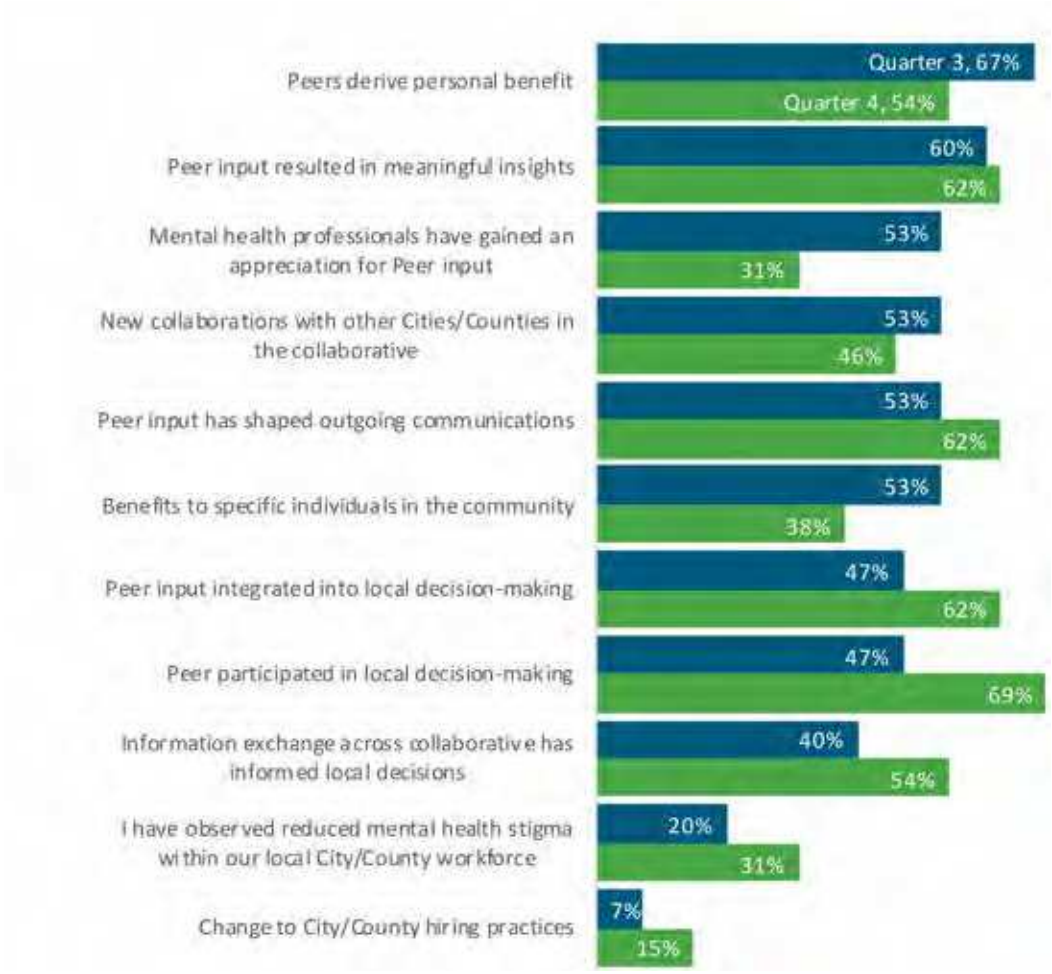
Early interviews (those conducted in quarters 1 and 2) found the following Peer successes:

- **Active Peer Engagement.** Peers were actively engaged in supporting Help@Hand by vetting potential technologies, developing digital literacy education materials, conducting outreach to the community, and delivering digital literacy workshops. In addition, Peers represented their counties/cities on Peer Leadership calls and participated in the digital mental health literacy (DMHL) train-the-trainer event held by CalMHSA.
- **Peers as Contributors and Collaborators.** Peers were recognized by Help@Hand as experts and partners in program development and delivery, which had a perceived impact on mental health stigma reduction within county organizations. Peer Leads attributed the reduced stigma both to the appreciation accorded to Peers by Help@Hand physicians and therapists, as well as the openness and transparency surrounding mental health issues that characterized the work between Peers and their colleagues. For Peers, openly addressing their mental health issues was a novel experience, which they felt brought about a cultural shift in the workplace, as colleagues responded with understanding and acceptance about mental health needs.
- **New Peer-related Personnel Policies.** Efforts to overcome hiring challenges led to changes in personnel policies in some counties/cities, such as creating a new job classification for peer employees.

Figure 2.4 shows successes identified in surveys from quarters 3 and 4. Interviews and surveys showed:

- **Quarter 3 Successes.** More than half of survey respondents noted the following successes since the beginning of the Help@Hand program:
  - Peer input was integrated into local decision-making.
  - Peer input yielded meaningful insights, such as focusing attention on the logistical issues of technology implementation (e.g., how much data would a cell phone plan need to use a given technology).
  - Peer input shaped outgoing communication, resulting in more effective messaging that was tailored for the intended audience.
  - New collaborations emerged across counties/cities, which was noted as unusual within the state since cross-county sharing is rare.
  - Help@Hand yielded benefits to specific individuals in the community. This includes the delivery of mental health services through telehealth, which was facilitated by digital literacy training given to the community by Peers. Another example is San Mateo and Youth Leadership Institute's anthology project, which is described in the **spotlight** on page 47.
  - Mental health professionals gained an appreciation for Peer input, which resulted in a reduction in the stigma around mental health within the county workforce. Peer Leads reported that this reduction in workplace stigma was a personal benefit for the Help@Hand Peers.
  - Peers derived personal benefit, including both gainful employment and a forum for discussing their mental health.
- **Changes in Successes from Quarter 3 to Quarter 4.** There was an increase in the proportion of counties/cities reporting that Peers were participating in local decision-making and that Peer input was integrated into local decision-making in the quarter 4 survey. There was also an increase in the proportion of respondents who indicated that information exchange across the Collaborative had informed local decisions.

Figure 2.4. Successes Reported in Peer Evaluation Surveys



DMHL Train-the-Trainer Workshop Attendees

Challenges

Early interviews found challenges with:

- **Recruiting, hiring, and retaining Peers.** It was challenging to recruit Peers who possessed the right constellation of skills and abilities for supporting Help@Hand (e.g., digital literacy, proficiency in a language other than English). Hiring has been complicated by county/city human resource policies that make some Peers ineligible. Attrition among the Peers was related to individuals being promoted, being in time-limited appointments, or being unable to meet the demands of the position over time.
- **Community outreach.** There was limited digital literacy among both the Peers and the members of the target populations. There were also challenges with meeting community needs. These challenges included: not having enough bilingual staff to reach non-English speaking communities; difficulty finding the right place and time to engage transition-age youth (TAY); and transportation and technology barriers for older adults and isolated communities.
- **Communication within and across counties/cities.** The departure of the Peer and Community Engagement Manager in March 2020 exacerbated delays in the flow of information across the Collaborative and highlighted limited information sharing mechanisms.
- **Decision-making and roles/responsibilities.** Interviews in the early part of Year 2 revealed that Peers were not completely integrated into decision-making processes within and across counties/cities during the start-up phases of Help@Hand. Also, there was a lack of clarity across the collaborative in terms of roles and responsibilities, causing Peers to be uncertain as to the decision-making processes.

- **COVID-19.** In quarter 1, counties/cities planned to mobilize outreach and digital literacy campaigns by hosting in-person "Appy Hours" and distributing paper DMHL materials. Plans also included disseminating information about digital mental health resources within the Peer workforce and to communities. Since COVID-19 restrictions hindered these plans, counties/cities generally responded by focusing their Peer efforts on technology testing and material development, much of it intended for virtual dissemination. The wide range of innovative responses illustrated the resilience of the Peer Leads in finding ways to continue to add value to the Help@Hand Collaborative and influence local decision-making through Peer input.

Figure 2.5 shows challenges identified in the latter half of Year 2. Surveys from quarters 3 and 4, as well as interviews from quarter 3, found:

- **Unclear Decision-Making Processes.** Lack of clarity regarding decision-making processes across the Collaborative was reported by about 40% of respondents in both surveys.
- **Challenges with hiring and internal information sharing (Quarter 3).** Difficulty with hiring and internal information sharing emerged as the most common challenges experienced by counties/cities since the beginning of Help@Hand in the quarter 3 survey. It is interesting to note that these challenges were reported by fewer counties/cities in the quarter 4 surveys.
  - **Difficulties in recruiting and hiring Peers.** There was difficulty in recruitment and hiring efforts due to employment structures (e.g., human resources and hiring policies) and personnel turnover.
  - **Insufficient flow of information within the county/city.** Two structural factors emerged as major contributing factors: 1) the use of subcontractors to carry out the Peer component, which added levels of authority and delayed transmission of information; and 2) the dual program management structure involving both Peer Leads and Tech Leads, which was viewed as creating silos of information that were not conducive to knowledge-sharing.

Figure 2.5. Challenges Reported in Peer Evaluation Surveys

Learnings from the Peer Evaluation

Interviews and surveys about the Peer component of Help@Hand reveal learnings on:

- **Product Testing and Material Creation.** Common Peer activities in Year 2 included testing potential technologies and creating outreach materials, particularly for virtual dissemination. Peer Leads expressed general optimism about implementing digital mental health literacy outreach in 2021.
- **Peer Successes.** There were several Peer successes in Year 2. These include:
  - **Local Decision-Making and Peer Input.** Peers were participating in local decision-making and their input was integrated in decision-making processes. Peer input offered meaningful insights for technology implementation and outgoing communication. It was also appreciated by mental health professionals and reduced mental health stigma within the county workforce.
  - **Collaborations across counties/cities.** This was a particularly noteworthy success since cross-county sharing is rare within the state. Information-sharing across the Collaborative helped inform some local decisions.
  - **Benefits for community members and Peers themselves.** Peers were involved in activities that helped the community. For example, Peers provided digital literacy trainings that helped community members access telehealth. In addition, Peers benefited from gainful employment and a forum for discussing their own mental health.
- **Peer Challenges and Opportunities.** Overall, interviews and surveys at the end of Year 2 revealed both enthusiasm and appreciation for the added value that Peers brought to the Help@Hand Collaborative. This was tempered, however, by frustration with the slow pace of technology implementations and the continued gap in the leadership structure resulting from the unfilled Peer and Community Engagement Manager position. Still, counties/cities appeared to engage an entrepreneurial spirit, especially in response to the challenges of the COVID-19 pandemic, and began to establish cross-collaborations to accelerate learnings.

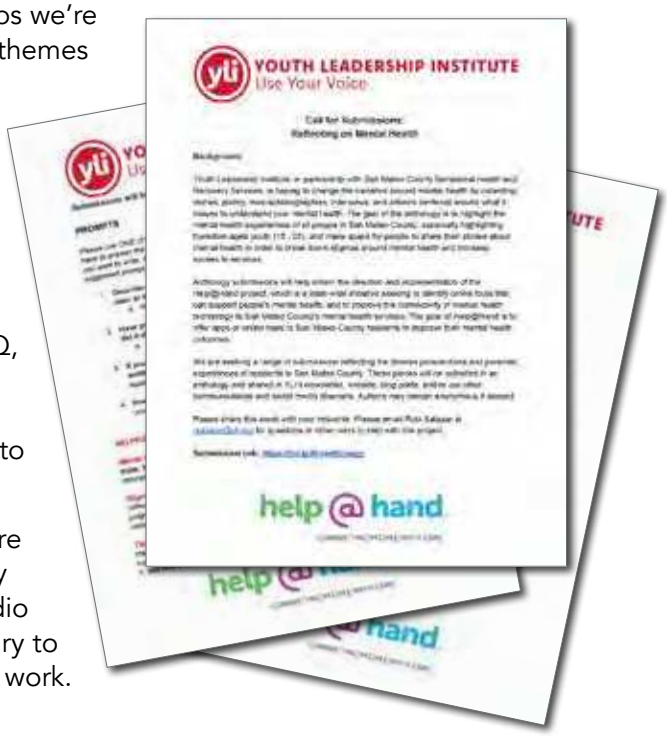
SPOTLIGHT
Anthology

Once the pandemic began, Youth Leadership Institute San Mateo (YLI) like other community organizations found themselves in need of novel ways to connect with the youth they served. Their shift to zoom meetings proved to be inaccessible for some and inadequate for others. Indeed, YLI's, Help@Hand Peer Leader, Adam Wilson, who was interviewed for this Spotlight, stated *We saw early on that having conversations and being on zoom, that not everyone was equipped to do it or wants to do it.* YLI, then, sought additional ways for young people to have a dialogue or outlet to deal with the pandemic. Inspired by one employee's recent experience with collecting stories from local community members, in partnership with San Mateo County Behavioral Health and Recovery Services, YLI created the anthology project.

Artist: Marcela Cordova

An anthology is a collection of selected literary pieces or passages or works of art or music (Merriam-Webster, n.d.). Anthologies can be centered around a certain theme, genre, culture, nation, or time period. With that in mind, the Youth Leadership Institute (YLI) San Mateo anthology project sought to gather a collection of writings, art, videos, etc. by individuals in San Mateo County. All pieces would center around the theme of mental health.

Specifically, in hopes of changing the narrative around mental health, the anthology project aimed to provide San Mateo County community members with an opportunity to express their experiences with mental health, emotional wellbeing, and COVID-19. The plan was to have individuals submit pieces that, together, would be turned into a collection of works. The anthology would highlight the mental health experiences of all people of San Mateo County especially transition-aged youth (15-25 years old). To break down stigmas around mental health as well as provide a space where the community could openly share their thoughts, and feelings about mental health, YLI planned to publish the anthology on their website. The project would, also, be used to inform the direction and implementation of the Help@Hand program. For instance, Wilson suggested it may inform YLI about what features the apps we're looking at for Help@Hand might need to include based on the themes we're seeing in the pieces.



Initially, YLI planned to invite only the youth that they worked with. It quickly shifted, however, to a community-wide project when YLI partnered with San Mateo County Behavioral Health and Recovery Services. This partnership expanded their reach to all adults – TAY through older adults. Likewise, to reflect the diversity of the community, YLI reached out to agencies and organizations that worked with such communities as Latinx, LGBTQ, and youth with mental health issues. They also made sure to include organizations in different economic areas and located throughout the county. Three organizations were subcontracted to assist with outreach and engagement for the anthology project.

Outreach began with a call for submissions. In it, individuals were invited to submit pieces using any medium and format that they chose. Suggestions included poetry, mini-autobiographies, audio and video, interviews, and artwork. Although it was not necessary to use them, four prompts were provided to inspire and guide the work.

Prompts included describing experiences with mental health, stigma around mental health, treatment for mental health and the impact of COVID-19 on mental health and emotional wellbeing. All prompts also included the role that technology had on one's mental health. Definitions were provided for the terms mental health, stigma, and technology too. Submissions could be in any language and everyone who submitted one or more pieces received a stipend. If YLI published a piece, that individual would receive an additional sum too.

As submissions were received, YLI was in awe of the depth of each piece. Using collage, prose, poetry, videos, and art created from various mediums, individuals described such feelings as isolation, loneliness, confinement, recovery, and self-affinity. Thus far, pieces from over 50 individuals between the ages of 15 -30 years-old and written in English or Spanish have been submitted. Wilson was unsure of the total number of pieces received because many individuals submitted several pieces.

Artist: Kai Doran

One challenge they faced was reaching older adults. Outreach efforts included texting, creating flyers, printing them, and personally distributing flyers to the community they worked with. Staff also tried slipping flyers under doors in older adult communities as well as emailing and calling them. Although these efforts were effective for younger adults, they were ineffective with older adults.

Nonetheless, the project grew to be larger and more time-consuming than expected. With a steady flow of pieces being submitted, YLI decided to start posting individual pieces on their Instagram. This, however, was more labor intensive than expected. Or, as Wilson stated, the capacity to meaningfully engage with all pieces is challenging. For instance, YLI needed to determine whether creators wanted to be anonymous. Also, because Instagram is a visual platform, pieces such as stories and poems that were text only needed to be designed in a visually appealing manner. Additionally, YLI staff chose hashtags and wrote captions for each piece; all of which needed to be approved by the creator before posting. Aware that they had followers who were Spanish-speaking, YLI also had captions written in both English and Spanish. As Wilson shared There's a lot of steps you want to take to assure that the youth's voice is being authentic and that it's also being anonymous if that's what they want.

Artist: Marcela Cordova

Unexpectedly, another benefit surfaced. Youth and parents shared that it positively impacted themselves and their families. Some parents shared that this was the first they were able to learn about their child's feelings about mental health and/or COVID-19. Wilson explained It has opened up some young people and their families to conversations that they might not have had. Secondly, for some young artists, having their work posted on Instagram was the first time they'd had a piece published. Indeed, Wilson stated that we had one young person submit five paintings and we've published a few of those. They've had a good amount of engagement and click throughs. That's been exciting to be able to give them a platform to show off their skills. Moreover, Wilson explained that the project gave youth an opportunity to express themselves in a way that they might not be able to do in their home, with their friends, or at school.

As stated above, submissions were to be used as way to learn about the mental health needs of the San Mateo Community. As of now, with submissions slowing down, the next steps for YLI include identifying the common themes in the anthology which will be used to inform what features the app should include and if there are specific mental health needs within their community. Wilson explained that we've seen some themes like isolation, depression and needing more mental health services. They haven't, however, been able to sit down and say what the biggest themes coming out of it are. YLI is also planning to include organizations that subcontracted with them in the Help@Hand pilot as well as create a space on their website to post the anthology.

Reference

(Merriam-Webster. (n.d.) Anthology. In Merriam-Webster.com dictionary. Retrieved January 22, 2021, from https://www.learnersdictionary.com/definition/anthology)

3 COUNTY/CITY TECHNOLOGY, USER EXPERIENCE, AND IMPLEMENTATION EVALUATION

Key Points

- Los Angeles and Riverside Counites conducted needs assessments with community college students and members of Riverside County's Deaf and Hard of Hearing Community, respectively. Orange County is planning a needs assessment of its clients. Needs assessments gather detailed information on perceptions of mental health among the target population, use of technology to support mental health, and resources desired to support mental health.
- Marin, Riverside, San Francisco, and San Mateo Counties, as well as City of Berkeley and Tri-City explored different technologies with target populations to select which technology to pilot or implement.
- Los Angeles, Marin, San Mateo, Santa Barbara, and Tehama Counties as well as Tri-City planned pilots that would test potential technologies with their target population on a small scale. Some pilots were paused or discontinued for various reasons.
- Los Angeles and Orange Counties implemented technologies, with the intention of scaling these across their target population or using them for the remainder of the project. Evaluation interviews and surveys with leadership, providers, and users were conducted in Year 2.
- Riverside County developed and launched a peer-chat app called Take my Hand in 2020, and San Francisco is planning to partner with Riverside on piloting this app as well in 2021.
- Los Angeles and San Mateo Counties began offering county residents Headspace in Year 2 in order address mental health needs in communities, particularly those impacted by COVID-19. San Francisco began planning their Headspace launch for 2021.
- Monterey and Los Angeles Counties released a Request for Information and created a Request for Proposal as part of their development of a tool that screens and refers consumers.
- Kern and Modoc Counties completed their projects and transitioned off of Help@Hand. Exit interviews were conducted with both counties.

OVERVIEW

This section presents county/city activities as of the end of Year 2, which are summarized in **Table 3.1**.

The progress made toward needs assessments, technology explorations and selections, pilot, and implementation phases is further detailed in this section. The COVID-19 Rapid Response, development of a Request for Information (RFI) and Request for Proposal (RFP), and project completion by some counties are also described.

Table 3.1. Overview of County/City Efforts at the End of Year 2

County/City	Activity	Target Audience(s)	Technology	Current Status
City of Berkeley	• Technology Exploration and Selection	• General population • Transitional age youth (TAY) • Isolated older adults	• Headspace • myStrength	• Active– planning underway
Kern	• Project Completion	• N/A	• N/A	• Completed
Los Angeles	• Needs Assessment	• Community college students	• N/A	• Completed
Los Angeles	• Pilot Planning	• Older Adults • Isolated populations at higher risk of serious complications from COVID–19 • Adult cognitive behavioral health clients • Individuals seeking Peer Resource Center support	• Uniper • CredibleMind • Headspace (pilot)	• Inactive– planned but not executed and no longer in progress
Los Angeles	• Implementation	• Dialectical behavior therapy (DBT) clients	• Mindstrong/ MindLAMP	• Active– transitioning from Mindstrong to MindLAMP
Los Angeles	• Rapid COVID–19 Response	• Los Angeles County residents	• Headspace	• Active– implementation underway
Marin	• Technology Exploration and Selection (completed) • Pilot Planning	• Older (isolated) adults	• myStrength • Uniper	• Active– pilot planning underway
Modoc	• Project Completion	• N/A	• N/A	• Active– participation in Help@Hand concludes April 2021
Mono	• Technology Exploration and Selection	• N/A	• Considering Headspace or myStrength	• Inactive– Will become active Spring 2021
Monterey	• Request for Information (RFI) (completed) • Request for Proposal	• Monterey County residents	• Screening and referral tool	• Active– planning underway
Orange	• Needs Assessment	• Behavioral Health Services clients • Parents of Behavioral Health Services clients	• N/A	• Active– planning underway
Orange	• Implementation	• Eligible clients at UCI Health Psychiatry Services	• Mindstrong	• Active– implementation underway

County/City	Activity	Target Audience(s)	Technology	Current Status
Riverside	• Needs Assessment	• Deaf and Hard of Hearing Community	• N/A	• Active– completed and planning expansion underway
Riverside	• Technology Exploration and Selection	• Full Service Partnership (FSP) consumers	• A4I or Focus	• Completed
Riverside	• Rapid COVID–19 Re–sponse	• Riverside County residents	• Take my Hand	• Active– implementation underway
San Francisco	• Technology Exploration and Selection	• TAY • Transgender youth and adults	• Take My Hand	• Completed
San Francisco	• Rapid COVID–19 Re–sponse	• San Francisco County resi–dents	• Headspace	• Active– planning underway
San Mateo	• Technology Exploration and Selection (complet–ed) • Pilot Planning	• Older adults • TAY	• Wysa	• Active– pilot planning un–derway
San Mateo	• Rapid COVID–19 Re–sponse	• San Mateo County residents	• Headspace	• Active– implementation underway
Santa Barbara	• Pilot Planning	• Clients recently discharged from inpatient psychiatric care • Geographically isolated individuals • TAY	• Headspace	• Paused
Tehama	• Pilot Planning	• Persons who are Homeless or at risk of Homelessness • Isolated Individuals • Tehama County Health Ser–vices Agency – Behavioral Health Consumers	• myStrength	• Active– planning underway
Tri-City	• Technology Exploration and Selection	• TAY • Older adults • Monolingual Spanish speakers	• Headspace • myStrength • Mindstrong	• Active– planning underway
Tri-City	• Pilot Planning	• TAY engaged at Tri–City's Wellness Center	• Wysa	• Inactive– planned but not executed

NEEDS ASSESSMENT (LOS ANGELES, ORANGE, RIVERSIDE)

In Year 2, needs assessments were conducted, planned, and expanded to engage members of target Help@Hand audiences regarding their mental health needs and their thoughts on how technology can help meet those needs. Specifically, Los Angeles, Orange, and Riverside Counties worked with the evaluation team to develop, conduct, and/or analyze data from their local needs assessments. These needs assessments identified: 1) current mental health needs and beliefs of the target population; 2) current apps, technologies, and resources used in the community; 3) factors likely to influence uptake of technologies; 4) initial measures of outcomes, such as stigma and social connectedness, and mental health literacy; and/or 5) insights for county/city recruitment strategies.

Los Angeles

Completed needs assessment

Los Angeles County partnered with El Camino College (a community college in Los Angeles County) and the Help@Hand evaluation team to conduct a needs assessment with students at El Camino College. A needs assessment survey was distributed electronically to a random sample[15] of 5,000 students from April 16 – June 30, 2020. A total of 500 participants completed the survey.[16]

Results from the needs assessment were shared with the Collaborative in past Help@Hand evaluation reports. A learning brief and comprehensive report were created and shared with Los Angeles County and El Camino College.

Orange

Planning needs assessment

Orange County began to use telehealth to deliver county behavioral health services during COVID-19. Anecdotally, some transitional aged youth (TAY) clients expressed a preference for in-person appointments. Orange County and the Help@Hand evaluation team tailored the needs assessment to learn: 1) whether all behavioral health clients had this preference; 2) what challenges clients may face in using telehealth services; and 3) what factors may contribute to dissatisfaction with telehealth services.

Two versions of the survey were created: one for clients over the age of 13, and another for parents or guardians of clients under the age of 13. The surveys were updated based on findings from a clinician telehealth study conducted by the county. The surveys are expected to be implemented in 2021.

Riverside

Expanding needs assessment

Riverside County partnered with the Center on Deafness Inland Empire (CODIE) and the Help@Hand evaluation team to conduct a needs assessment of the Deaf and Hard of Hearing Community. In September 2020, a focus group and survey were conducted with community advocates who identified as members of the Deaf and Hard of Hearing Community and were members of CODIE. Eleven people were invited to participate in the focus group and survey. Ten people participated in the focus group and nine people completed the survey.[17] Findings were shared in a learning brief with Riverside County and presented for the Collaborative in the quarter 3 report.

Results cannot be generalized to the larger Riverside Deaf and Hard of Hearing Community because of the small sample of the focus group and survey. As such, plans to expand the needs assessment survey to the larger Riverside Deaf and Hard of Hearing Community are underway. The survey is also anticipated to be implemented in 2021.

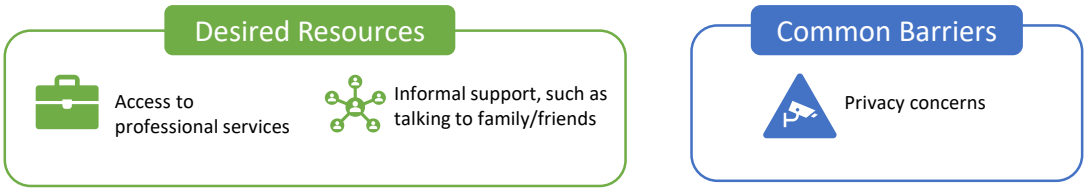
[15] Sampling was done proportionate to gender and race for California community colleges.
[16] Participants received a $10 Amazon gift card for completing the survey.
[17] Focus group participants received a $30 Amazon gift card, and survey participants received a $10 Amazon gift card.

LEARNINGS FOR THE HELP@HAND COLLABORATIVE: NEEDS ASSESSMENT (LOS ANGELES, RIVERSIDE)

While needs assessments are valuable for understanding the unique characteristics of a particular population, looking across needs assessments may also lead to broader insights. **Figure 3.1** shows common learnings from needs assessments with community college students in Los Angeles County and the Deaf and Hard of Hearing Community in Riverside County.

In particular, both target audiences expressed an interest in accessing professional services and informal support. Counties/cities should consider if their specific target audiences is also interested in such access and think about how technologies may support these needs. Privacy also emerged as a potential barrier for both community college students and the Deaf and Hard of Hearing Community who participated in the needs assessment. Ranging widely, privacy concerns included worries about vendors sharing personal data with third parties, potential data breaches, and being identified in peer chat apps. Counties/cities should consider privacy as a potential barrier in adopting and using mental health technologies for target populations.

Figure 3.1. Learnings from Needs Assessments with College Students and the Deaf and Hard of Hearing Community



TECHNOLOGY EXPLORATION AND SELECTION (BERKELEY, MARIN, RIVERSIDE, SAN FRANCISCO, SAN MATEO, TRI-CITY)

Technology exploration allows target audience members or those familiar with the target audience to explore technologies and give initial feedback on whether the technology fits the target audience. Those technologies that fit may be selected to pilot and/or implement with the target audience. In 2020, Marin, Riverside, San Francisco, and San Mateo Counties, as well as City of Berkeley and Tri-City, engaged in technology exploration and selection[18].

City of Berkeley

Exploring technologies

City of Berkeley reviewed four apps (Headspace, myStrength, HeyPeers, and Uniper) that may fit their TAY, isolated older adult, and general populations. In the wake of recent nationwide political upheaval surrounding the topic of racial justice, the city intends to make additional efforts to reach communities of color, including African American, Latinx, and Asian Pacific Islanders. City of Berkeley staff and Peers reviewed each app and determined myStrength and/or Headspace as likely technologies to implement, due especially to their widespread use with large numbers of people in various populations.[19] Staff will further review myStrength and Headspace in 2021.

[18] Mono County will conduct technology explorations in Spring 2021.

[19] Although a pilot was initially considered, City of Berkeley decided to proceed with a COVID-19 Rapid Response implementation.

Marin

Completed technology exploration and selection

Marin County examined myStrength and Uniper with its older adult population. With support from CalMHSA and the Help@Hand evaluation team, the county developed processes and tools to support virtual technology exploration that complied with COVID-19 social distancing requirements. Twelve older adults and community members explored myStrength and Uniper over seven days and then participated in focus groups and surveys.[20] Findings were shared in a learning brief with Marin County and in the quarter 3 Help@Hand evaluation report for the Collaborative.

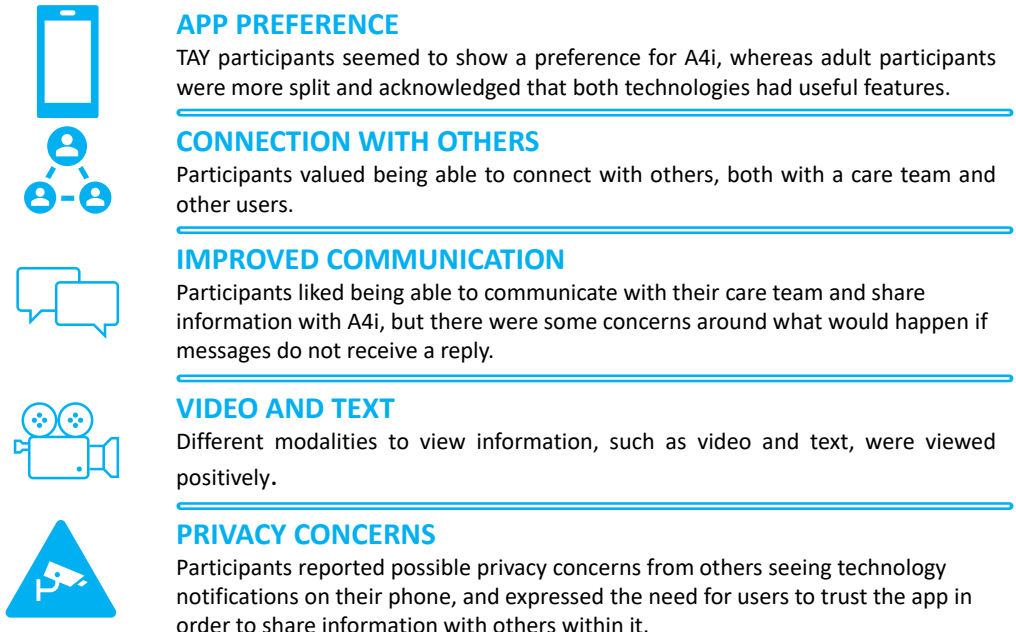
Riverside

Completed technology exploration and selection

In addition to conducting a needs assessment with the Deaf and Hard of Hearing Community (described above) and launching their own platform – Take my Hand (described below), Riverside County reviewed other apps to pilot with their various target populations.[21] Based on their review, Riverside County determined A4i and/or Focus may meet the needs of those in their Full Service Partnership (FSP) program, an intensive program offering mental health and support services for those experiencing and/or at-risk for institutionalization, homelessness, incarceration, or psychiatric in-patient services.

A total of 24 county clinic participants, including some FSP consumers, participated in focus groups and a survey. Eleven were aged 16-25 years and twelve were aged 26+ years.[22] Findings were shared in a learning brief with Riverside County. Key findings include:

Key Findings from Technology Exploration with FSP Consumers



San Francisco

Completed technology exploration and selection

At the beginning of 2020, San Francisco considered piloting Headspace with county staff. Toward the end of 2020, San Francisco decided to implement Headspace to anyone who lives or works in San Francisco County. San Francisco later used CalMHSA's Request for Statement of Qualification (RFSQ) product matrix[23] to review potential peer-chat apps for county residents, particularly transgender and TAY communities. The county considered 11 apps: HeyPeers, Ouchie, Pre Registry, SageSurfer, Sharpen Minds, Sober Grid, Support Groups Central, Supportiv, Uniper, Wysa, and Take my Hand (described below). Based on careful review and discussions, the county is considering to work with Riverside County to pilot Take my Hand in 2021.

[20] Participants received a gift card for their participation.

[21] Riverside County's priority target populations include: TAY; Deaf and Hard of Hearing; visually impaired; males aged 45+ years; high-risk populations (e.g., those who are re-entry, enrolled in the FSP Program, or with an eating disorder); Mid-County & Desert populations; adults aged 65+ years; and ethnic, cultural and LGBTQ+ communities.

[22] Participants received a gift basket for their participation.

[23] The RFSQ product matrix was created by CalMHSA to help counties/cities review the 93 RFSQ apps. The matrix has three components: (1) Ability to filter apps based on specific features; (2) Product profiles to compare across apps; and (3) Glossary of terms.

San Mateo

Completed technology exploration and selection

Figure 3.2 depicts the potential apps that San Mateo County primarily considered for its target audiences. For its technology exploration and selection, San Mateo County recruited older adults and TAY to engage with and review each app. They were then invited to complete a survey and discuss their experiences in focus groups.

Figure 3.2. Target Audiences and Technologies Considered for San Mateo County's Technology Exploration and Selection

TAY. Five TAY spent up to 6 hours exploring Headspace, myStrength, and Wysa. They then participated in both surveys and focus groups. Findings were shared in a learning brief with San Mateo County. Key findings include:

Key Findings from Technology Exploration with TAY

APP PREFERENCE
Participants seemed to show a preference for Headspace and Wysa over myStrength in terms of navigation, cultural sensitivity, meeting needs, and visual look.

NAVIGATION
It was important to easily navigate through the app to be able to engage with content. myStrength was perceived to be harder to navigate compared to the other two technologies due to the large amount of material, which was not organized in a user-friendly and aesthetically-pleasing manner.

CULTURAL SENSITIVITY
myStrength was perceived to be less culturally sensitive relative to Headspace and Wysa. Headspace had a relatively high rating and included content involving racial groups. Wysa also had a relatively high rating, though a participant acknowledged room for improvement.

RESOURCES REQUIRED
Most participants felt they had appropriate devices to access these technologies. However, it not only mattered whether participants had the resources required to use the app, but also to engage in various activities suggested by the app (e.g., cost of using therapist, need for equipment for workouts).

VISUAL LOOK AND VARIETY OF CONTENT
Participants were more engaged if they thought the app was visually pleasing, and a large variety of content prompted users to engage with the app.

Older Adults. Eight older adults spent 1-6 hours exploring myStrength and Wysa.[24] Seven of these older adults participated in surveys and six participated in a focus group. Findings were shared in a learning brief with San Mateo County and in the quarter 3 Help@Hand evaluation report for the Collaborative.

[24] Uniper was not explored because test accounts were not available.

Tri-City
Exploring technologies

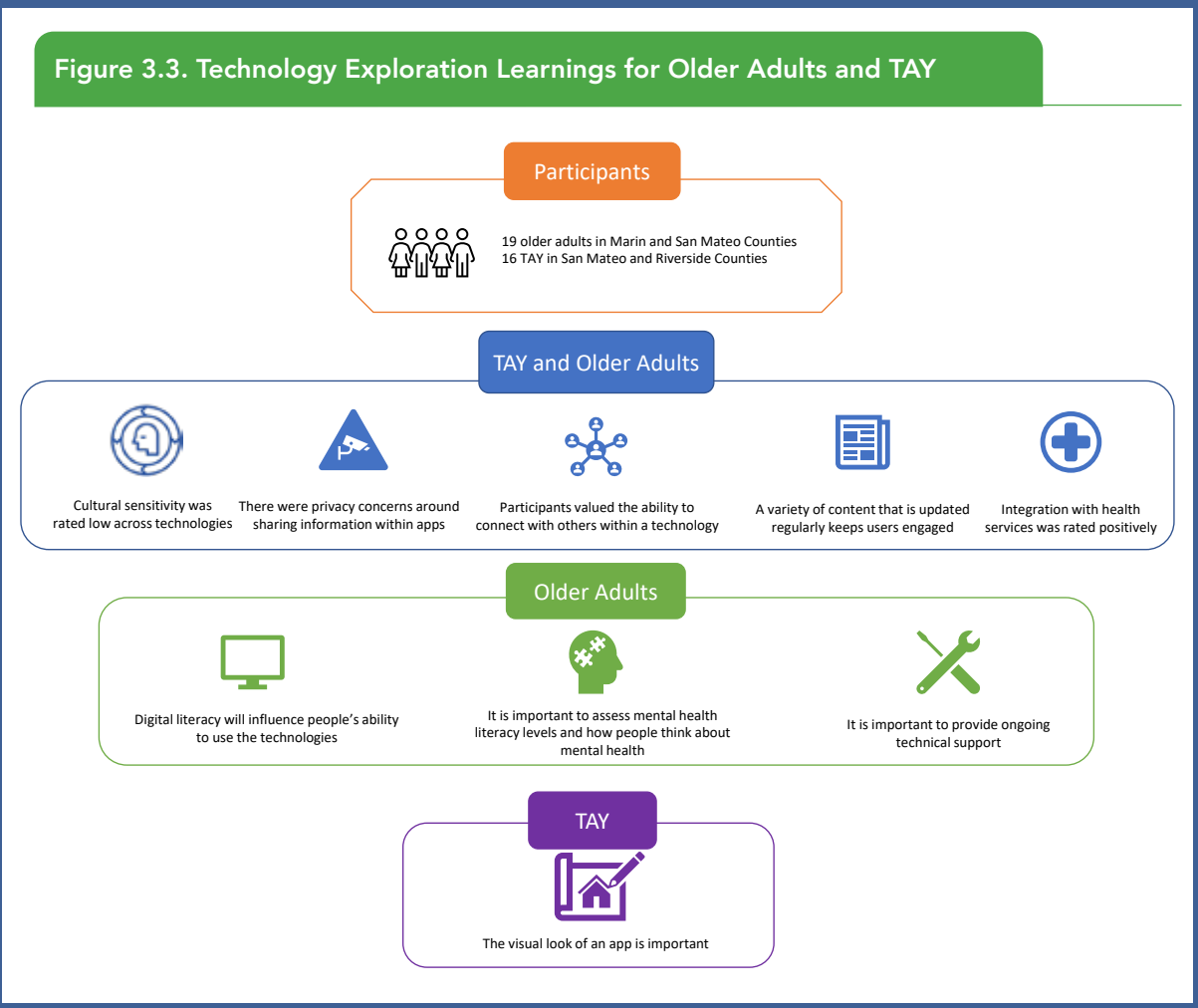
In late 2020, Tri-City began to shift from planning a pilot with Wysa to exploring Headspace and myStrength. Tri-City is also interested in a possible collaboration with Orange County to implement Mindstrong. In early 2021, Tri-City will conduct focus groups with Tri-City's clinical staff, Peers, and community members in order to determine which technologies best fit the needs and scope of their older adult, TAY, and monolingual Spanish-speaking populations.

LEARNINGS FOR THE HELP@HAND COLLABORATIVE: TECHNOLOGY EXPLORATION AND SELECTION (MARIN, RIVERSIDE, SAN MATEO)

Marin, Riverside, and San Mateo Counties worked with target audience members to explore technologies and provide feedback that would help select appropriate technologies to pilot and/or implement. Learnings from common target audiences (e.g., older adults and TAY) and technologies (e.g., myStrength) are presented below to help other counties/cities considering these audiences or technologies.

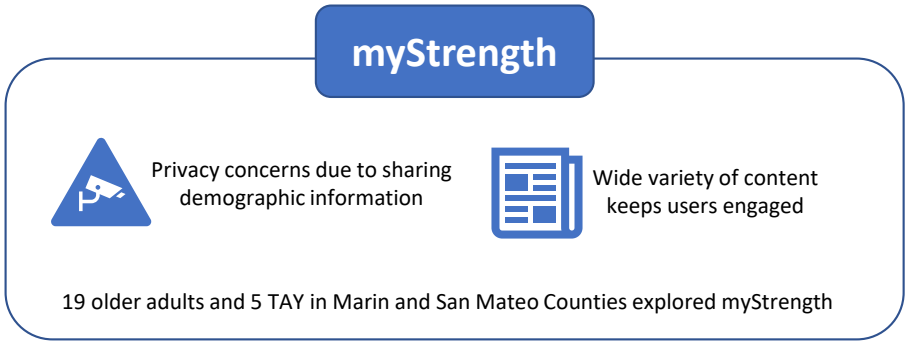
Figure 3.3 presents learnings from technology explorations with older adults and TAY in Marin, Riverside, and San Mateo Counties. Counties/cities across the Collaborative, particularly those targeting TAY or older adults, should consider these learnings when selecting technologies for their pilots or implementations.

Figure 3.3. Technology Exploration Learnings for Older Adults and TAY



myStrength was the only technology explored in multiple counties. **Figure 3.4** shows learnings from technology exploration with myStrength in Marin and San Mateo Counties. Participants enjoyed the variety of content that myStrength offers, such as information about mental health and the ability to track mood and sleep. However, they reported privacy concerns due to sharing demographic information within the app. These findings may be valuable to counties/cities planning to implement myStrength.

Figure 3.4. Technology Exploration Learnings for myStrength



PILOT (LOS ANGELES, MARIN, SAN MATEO, SANTA BARBARA, TEHAMA, TRI-CITY)

Los Angeles, Marin, San Mateo, Santa Barbara, and Tehama Counties as well as Tri-City planned pilots that would test potential technologies with their target population on a small scale. Pilots help to answer:

1) Should a county/city continue on a larger scale with the technology for their target population?
2) If a county/city continues with the technology, what can help inform a successful scale-up?
3) What learnings from the pilot can help other Help@Hand counties/cities?

Los Angeles

Pilot planned, but not executed

In March 2020, Los Angeles County presented three pilot proposals to Help@Hand Leadership for approval: Uniper for older adults; CredibleMind for isolated populations at higher risk of serious complications from COVID-19; and Headspace for adult cognitive behavioral health (CBT) clients and individuals seeking Peer Resource Center support. In April 2020, the three pilot proposals were approved, but Los Angeles County paused pilot launches in order to focus on their Headspace Rapid COVID-19 Response. In July 2020, the County decided not to move forward with these three pilots.

Marin

Planning pilot

Based on findings from their technology exploration of Uniper and myStrength with older adults and community members, Marin County's Advisory Committee decided to pilot both myStrength and Uniper with isolated older adults. The county worked with CalMHSA and the Help@Hand evaluation team to plan its pilots. In December 2020, Marin County presented its myStrength pilot to the Help@Hand Leadership and received approval to move forward.[25]

For their myStrength pilot, Marin County plans to recruit 30 English- and Spanish-speaking isolated older adults to engage with the technology. Tech4Life, a contractor hired by Marin County, will provide digital literacy training to all participants before engaging with myStrength. Marin County also secured a partnership with the Telehealth Equity Project, which will provide nurse interns to help recruit isolated older adults, offer them technical assistance, and conduct evaluation surveys. In addition to surveys with users, the evaluation will involve interviews with

[25] Marin County's pilot planning for Uniper is on hold until spring 2021 due to challenges planning two simultaneous pilots. In addition, Uniper was still finalizing the Spanish version of the app, which was a high priority for Marin County, whereas myStrength was ready to go.

users as well as surveys and interviews with the nurse interns (as shown in **Table 3.2**). The evaluation may also include interviews with the Marin County's Tech Lead and Peer. Marin plans to launch their pilot in early 2021.

Table 3.2. Evaluation Activities for Marin and Tehama Counties' Pilots

Evaluation Activity	Marin County	Tehama County
User Surveys	√ once before digital literacy training once after digital literacy training once at the end of the pilot	√ once at the beginning and once at the end of the pilot
User interviews	√ once 4–weeks after the pilot start	√ once 4–weeks after the pilot start and once at the end of the pilot
User Focus Groups		√ once 3 months after the pilot start and once 5 months after the pilot start
Staff Surveys	√ once at the end of the pilot	√ once no sooner than 2 months after the start of the pilot
Staff Interviews	√ once at the end of the pilot	√ once at the end of the pilot

San Mateo

Planning pilot

After reviewing technology exploration findings with older adults and TAY, San Mateo County selected to pilot Wysa with their older adult and TAY. Both target populations viewed Wysa as more culturally competent compared to the other technologies explored. San Mateo County also appreciated Wysa's flexibility to make changes to the app and add county-specific resources. A contract between Wysa and CalMHSA is expected in early 2021. San Mateo will also work with CalMHSA and the Help@Hand evaluation team to develop a pilot proposal.

Santa Barbara

Pilot planned, but not executed

In early 2020, Santa Barbara County collected input from community members and began planning to pilot Headspace with their target populations (e.g., TAY in colleges and universities; certain isolated adult clients; and adults discharged from psychiatric hospitals or who received crisis services). In May 2020, Santa Barbara County paused its pilot planning in order to focus on the impact of COVID-19 within the agency. Given feedback from community members that they needed digital literacy training and access to devices before launching an app, the county then shifted its efforts to developing and implementing their Digital Wellness Ambassador program. The program utilizes Peers to support those transitioning from inpatient to outpatient psychiatric care by sharing information on mental health resources and assisting with navigation to outpatient referrals. Santa Barbara County also partnered with other agencies to improve digital literacy among their target population. They subcontracted with Painted Brain to engage TAY in "listening sessions" that allows the county to hear from TAY about their mental health and technology needs. They also worked with a local community-based organization to host Appy Hours and plan digital literacy trainings for isolated older adults.

Tehama

Planning pilot

Tehama County initially considered piloting Happify, but Happify notified Help@Hand that they were not taking on new clients due to COVID-19. At that point, based on input and evaluation of other apps by their staff and Peers, Tehama decided to move forward with piloting myStrength. Target populations for the pilot include persons

who are Homeless or at risk of Homelessness, isolated individuals, and Tehama County Health Services Agency – Behavioral Health (TCHSA-BH) consumers. Their pilot will include Peer staff and wellness advocates recruiting and engaging 30 participants (10 from each target population) via a one-on-one approach.

In September 2020, Tehama County presented their pilot proposal to the Help@Hand Leadership and received approval to move forward. The county anticipates to finalize their contract with myStrength and launch their pilot in early 2021. **Table 3.2** summarizes how the pilot will be evaluated. The **spotlight** on page 61 highlights how Tehama County Peers helped shape and inform the pilot evaluation.

Tri-City

Pilot planned, but not executed

At the beginning of 2020, Tri-City decided to pilot Wysa with TAY engaged at Tri-City's Wellness Center based on insights from their wellness advocates. They actively worked with CalMHSA and the Help@Hand evaluation team to negotiate a contract with Wysa and plan their pilot. However, Tri-City paused their pilot planning in August 2020 due to personnel turnover and staff capacity concerns. In late 2020, Tri-City decided to no longer pursue a pilot with Wysa. Although Wysa met the needs of Tri-City's TAY population, it did not meet the needs of its other target populations (e.g., it would not work with their monolingual Spanish-speaking population). Thus, Tri-City shifted to exploring other technologies (as described above).

LEARNINGS FOR THE HELP@HAND COLLABORATIVE: PILOT (LOS ANGELES, MARIN, SAN MATEO, SANTA BARBARA, TEHAMA, TRI-CITY)

Los Angeles, Marin, San Mateo, Santa Barbara, and Tehama Counties as well as Tri-City planned different pilots to test potential technologies in Year 2. Key learnings from planning these pilots include:

- Structuring pilots: Pilots may be structured differently depending on the technology and target audience. For example, some target audiences may benefit from digital literacy and individualized support as part of a pilot. On the other hand, some technologies may be used on devices that target audiences are more familiar with, and may require less individualized support.
- New recruitment and engagement challenges: COVID-19 created new challenges for recruiting and engaging target audience members in pilots. Digital literacy levels influenced target audience members' ability to engage in remote data collection and redeem incentives distributed electronically. Careful planning and consideration was needed to address these challenges.
- Community-based partnerships: Partnering with organizations that serve the target audience can provide vital support with recruitment and staffing. For example, Marin County's partnership with the Telehealth Equity Project created a referral stream for their myStrength pilot and provided nurse interns to offer support.
- Easy to understand materials can support decision-making: Materials that use very little jargon helped people understand core concepts and make informed, insightful decisions. For example, materials with little jargon helped people easily understand statistics and inform decisions for the evaluation.
- Understand vendor data: It was important to know what data vendors were able to provide and whether vendors were open to taking new clients early in the pilot planning process.
- Involve Peers in evaluation: Peers offered valuable input when selecting appropriate evaluation items. Evaluation efforts must always find a balance between what is scientifically valid and what is feasible – a partnered Peer-driven approach was an effective strategy for striking this balance.

SPOTLIGHT

Engaging Peers in the Evaluation: A Model for Measurement

In the winter of 2019, the Help@Hand program completed the important work of defining and selecting the measurement constructs to assess mental health stigma.

A panel of five community Peers, individuals with lived experience and/or family member experience, and six academics with expertise in developing stigma measures was convened. The panel came to consensus on the dimensions of stigma that were important to measure as part of Help@Hand, specifically the following three areas:

1) **Internalized stigma:** one's own stigma toward their mental health condition;
2) **Resilience:** one's hope and positive attitude toward living with or recovering from one's mental health condition; and
3) **Mental health treatment stigma:** one's stigma toward seeking treatment for one's mental health condition.

The result of the effort was to identify 28 questions to be incorporated in the Help@Hand evaluation:

Background:

There are many measures of mental health stigma that focus on the broad perspectives of the stigmatizer versus the perspectives of the stigmatized. A community participatory approach was adopted in late 2019 to select the guiding instruments for the Help@Hand program. The effort ensured that the instruments:

1) were sensitive to the type of impact expected of Help@Hand apps;
2) met the stigma dimensions of interest of counties/cities; and
3) were scientifically valid.

DOMAIN / SCALE		SUBSCALE	ITEMS
Internalized Stigma	ISMI	Alienation	I feel out of place in the world because I have a mental illness Having a mental illness has spoiled my life People without mental illness could not possibly understand me I am embarrassed or ashamed that I have a mental illness I am disappointed in myself for having a mental illness I feel inferior to others who don't have a mental illness
		Social Withdrawal	I don't talk about myself much because I don't want to burden others with my mental illness I don't socialize as much as I used to because my mental illness might make me look or behave 'weird' Negative stereotypes about mental illness keep me isolated from the 'normal' World Stay away from social situations in order to protect my family or friends from embarrassment Being around people who don't have a mental illness makes me feel out of place or inadequate I avoid getting close to people who don't have a metal illness to avoid rejection
Resilience	RAS-R	Willingness to ask for help	I know when to ask for help I am willing to ask for help I ask for help when I need
		Not dominated by symptoms	Coping with my mental illness is no longer the main focus of my life My symptoms interfere less and less with my life My symptoms seem to be a problem for shorter periods of time each time they occur
Mental Health Treatment Stigma	SSOSH		I would feel inadequate if I went to a therapist for psychological help My self-confidence would NOT be threatened if I sought professional help Seeking psychological help would make me feel less intelligent My self-esteem would increase if I talked to a therapist My view of myself would not change just because I made the choice to see a therapist It would make me feel inferior to ask a therapist for help I would feel okay about myself if I made the choice to see professional help If I went to a therapist, I would be less satisfied with myself My self-confidence would remain the same if I sought professional help for a problem I could not solve I would feel worse about myself if I could not solve my own problems

Tehama County, in their pilot launch of myStrength, included the reduction of mental health stigma as an anticipated primary outcome of their technology implementation. The Tehama team turned to the work of tailoring their survey instruments to include items to measure mental health stigma in order to capture changes.

Led by Travis Lyon, Mental Health Services Act Coordinator, Behavioral Health, and in partnership with Ron Culver, Northern Valley Catholic Social Service (NVCSS) Supervisor, Tehama County Peer Programs, and a team of participating Peers, a workgroup was developed. This workgroup identified and commented on the limitations of the provided items that had been identified in the prior year.

Two primary limitations of the recommended survey items were identified by the workgroup. The first limitation was the overall length of the recommended items. Given the demographic questions that Tehama planned to include, surveys needed to be kept short to ensure that they could be reasonably completed. The second limitation was the lack of inclusivity and potential offensive wording of some of the items in the scales. For example, the surveys items were developed and guided by evidence-based practices to maximize the reliability and validity of the survey instruments. The Peers, however, were uncomfortable with some of the wording choices. Including questions with words like looking "weird" or "having one's life spoiled" were noted as potentially being stigmatizing themselves.

> *The reason the Peers and I wanted to include all three areas of internalized stigma, resilience, and mental health treatment seeking stigma is because they all go hand in hand. Internalized stigma, the belief that there is "something wrong with me," can lead to not seeking treatment; "there is something wrong with me because I need help," which in turn makes it very difficult to foster any sense of resilience, making it exceedingly challenging to break the cycle.*
>
> – **Ron Culver**, *Northern Valley Catholic Social Service (NVCSS) Supervisor, Tehama County Peer Programs*

With guidance from the Help@Hand evaluation team, the Peer workgroup sought to understand and respond to these limitations. Three areas were explored by the workgroup:

1. Which stigma topics/constructs, if any, were important to include in their evaluation?
   a) Internalized Stigma (subtopics: Alienation, Social Withdrawal)
   b) Resilience (subtopics: willingness to ask for help; not dominated by symptoms)
   c) Mental Health Treatment Seeking Stigma
2. How many questions did they want to include in their survey? What was feasible and appropriate when considering respondent burden?
3. What wording options seemed best for promoting cultural competency and inclusiveness?

The next step involved selecting the specific items to be used for each area of inquiry. To facilitate the discussion, the evaluation team shared data collected as part of the Help@Hand evaluation around survey wording and measurement with the Tehama workgroup. The workgroup reviewed the scree plot analysis for each construct to see how many unique groups of questions were present in each scale.

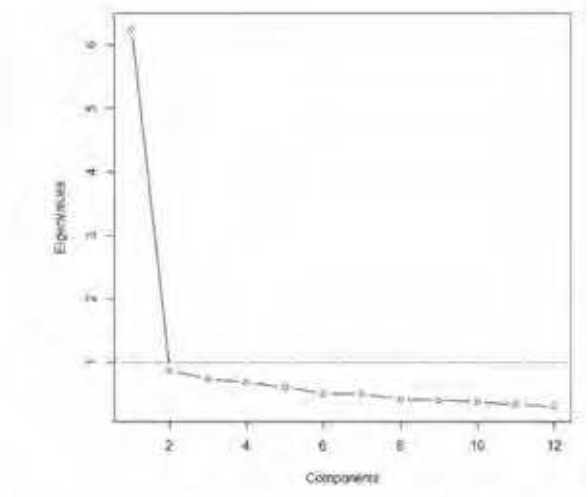


Figure 1: Scree plot for the 12 items of the ISMI section

Figure 1 shows the scree plot for the 12-items that are part of the ISMI scale. A scree plot displays how much variation each component captures from the data. The general rule, when using a scree plot, is to drop the components after the one starting the elbow. As shown in the figure, the scree plot indicated that there was one significant cluster (or group of items) and perhaps a second less meaningful cluster.

The workgroup then walked through different ways to consider the influence of each individual item on the total scale – or the item total correlation. For example, this was done by creating a total score for each scale, and then correlating each item's score with the total score (at the participant level).

Table 1 shows an example of Item I12 (which came from the social withdrawal subscale), which had the highest item total correlation with the ISMI scale (0.79), and that all the items had a relatively high total correlation (r >.5).

Table 1

7.1 The ISMI items

- I1: I feel out of place in the world because I have a mental illness.
- I2: Having a mental illness has spoiled my life.
- I3: People without mental illness could not possibly understand me.
- I4: I am embarrassed or ashamed that I have a mental illness.
- I5: I am disappointed in myself for having a mental illness.
- I6: I feel inferior to others who don't have a mental illness.
- I7: I don't talk about myself much because I don't want to burden others with my mental illness.
- I8: My mental illness might makes me look or behave "weird".
- I9: Negative stereotypes about mental illness keep me isolated from the 'normal' world.
- I10: I stay away from social situations in order to protect my family or friends from embarrassment.
- I11: Being around people who don't have a mental illness makes me feel out of place or inadequate.
- I12: I avoid getting close to people who don't have mental illness to avoid rejection.

Ranks	California dataset		Other States dataset	
	Item and category	Correlation with the ISMI total score	Item and Category	Correlation with the ISMI total score
1	I12(Social Withdrawal)	0.79	I12(Social Withdrawal)	0.80
2	I9 (Social Withdrawal)	0.77	I11 (Social Withdrawal)	0.77
3	I11(Social Withdrawal)	0.76	I9(Social Withdrawal)	0.77
4	I10(Social Withdrawal)	0.76	I10(Social Withdrawal)	0.76
5	I6 (Alienation)	0.76	I8 (Social Withdrawal)	0.74
6	I8 (Social Withdrawal)	0.75	I6 (Alienation)	0.74
7	I4 (Alienation)	0.73	I5 (Alienation)	0.74
8	I2 (Alienation)	0.73	I4 (Alienation)	0.72
9	I5 (Alienation)	0.71	I2 (Alienation)	0.70
10	I1 (Alienation)	0.68	I1 (Alienation)	0.67
11	I7 (Social Withdrawal)	0.62	I7 (Social Withdrawal)	0.64
12	I3 (Alienation)	0.60	I3 (Alienation)	0.59

In addition to considering the psychometric properties of each item, the Peer Workgroup also balanced their item selection by considering the language used in each item.

The final selection of items included the following:

Original Item Wording (Peer Selected)

1. Internalized Stigma (ISMI)
   A. Alienation
      1) I4: I am embarrassed or ashamed that I have a mental illness.
      2) I6: I feel inferior to others who don't have a mental illness.
      3) I2: Having a mental illness has spoiled my life.
   B. Social Withdrawal

1) I7: I don't talk about myself much because I don't want to burden others with my mental illness.
2) I11: Being around people who don't have a mental illness makes me feel out of place or inadequate.
3) I12: I avoid getting close to people who don't have mental illness to avoid rejection.

2. Resilience (RAS-R) - Willingness to ask for help and not dominated by symptoms
   1) R1: I know when to ask for help.
   2) R5: My symptoms interfere less and less with my life.
   3) R6: My symptoms seem to be a problem for shorter periods of time each time they occur.
3. Mental Health Treatment Stigma (SSOSH) - Self-Perception concerning Treatment
   1) S2: My self-confidence would NOT be threatened if I sought professional help.
   2) S4: My self-esteem would increase if I talked to a therapist.
   3) S9: My self-confidence would remain the same if I sought professional help for a problem I could not solve.

Peer Driven Item Reduction and Wording

1. Internalized Stigma (ISMI)
   A. Alienation
      1) I4: I am embarrassed or ashamed that I have mental health challenges.
      2) I6: I feel inferior to others who don't have mental health challenges.
      3) I2: Having mental health challenges has spoiled my life.
   B. Social Withdrawal
      1) I7: I don't talk about myself much because I don't want to burden others with my mental health challenges.
      2) I11: Being around people who don't have mental health challenges makes me feel out of place or inadequate.
      3) I12: I avoid getting close to people who don't have mental health challenges to avoid rejection.
2. Resilience (RAS-R) - Willingness to ask for help and not dominated by symptoms
   4) R1: I know when to ask for help.
   1) R5: My symptoms interfere less and less with my life.
   2) R6: My symptoms seem to be a problem for shorter periods of time each time they occur.
3. Mental Health Treatment Stigma (SSOSH) - Self-Perception concerning Treatment
   1) S2: My self-confidence would NOT be threatened if I sought professional help.
   2) S4: My self-esteem would increase if I talked to a therapist.
   3) S9: My self-confidence would remain the same if I sought professional help for a problem I could not solve.

In sum, there are several learnings that came out of this process:

- Including Peers in the decision-making process around measurement in evaluation is critical for selecting appropriate evaluation items.
- Developing the necessary understanding to make such decisions takes time.
- The availability of data gathered as part of the Help@ Hand evaluation was critical for using a data-driven approach for shortening the survey instruments.
- When presented with materials that are explained using minimal jargon, it is possible for people with limited training in statistics to understand the core issues and be able to make informed and insightful decisions.
- Evaluation efforts must always find a balance between what is scientifically valid and what is feasible – a partnered Peer-driven approach is an effective strategy for striking this balance.

> ***I believe it was an extremely worthwhile process. It was great to see how the Peers and the UCI team were willing to learn from each other, and how open the creative space was that allowed for a rich and meaningful dialogue. A genuinely enjoyable experience!***
>
> – **Ron Culver**, *Northern Valley Catholic Social Service (NVCSS) Supervisor, Tehama County Peer Programs*

The evaluation team wishes to extend a thanks to Travis for creating the time and space to do this work. We also wish to extend a special thanks to Ron and the Peers for so generously sharing their viewpoints and being open to learning about scale construction and item selection.

IMPLEMENTATION (LOS ANGELES, ORANGE)

An implementation is the launch of a single product with the focus on the county/city scaling it across their target population or using it for the remainder of the Help@Hand project. Los Angeles and Orange Counties implemented Mindstrong in different ways.

Los Angeles

Implementing

In 2020, Los Angeles County decided to discontinue the use of Mindstrong DBT diary cards, which are tools used as part of Dialectical Behavioral Therapy (DBT) to track symptoms and coping skills (Linehan, 1993), at their Harbor-UCLA DBT clinic. The decision was made for two reasons: 1) Mindstrong changed its business model to only support the full Mindstrong Care product line (not the DBT diary cards); and 2) Los Angeles County wanted a product that they could manage "in-house" in order to easily make customizations that meet client and county needs, such as having more active assessments. Los Angeles County also decided to work with MindLAMP to provide diary cards for their clients. A contract with MindLAMP was executed in October 2020 and the teams began transitioning patients from Mindstrong to MindLAMP into the new year.

COUNTY LEADERSHIP AND PROVIDER INTERVIEWS

The Help@Hand evaluation team interviewed Los Angeles County's leadership (n=2) and providers who used Mindstrong with their clients (n=2) in order to identify lessons learned and recommendations for counties/cities planning to or currently implementing Mindstrong. Interviewees identified **lessons learned**, including:

- **Lack of communication on client use:** Mindstrong was perceived as "a black box" in that providers had limited knowledge of client use (e.g., they did not know what information or services clients were offered, or which clients engaged with Mindstrong unless clients directly informed the providers). This was a significant challenge that helped inform the decision to discontinue Mindstrong.
- **Confusion on biomarker features:** Leadership, providers, and clients did not fully understand Mindstrong's biomarker function. This also informed the decision to discontinue Mindstrong.
- **Better alignment with county services:** LA County wanted a technology that they could use as part of the clinical services they offer. LA County was especially interested in alignment with other initiatives such as expansion of DBT across LA County. Examples of the features they thought would be beneficial to their clinical services include more directly incorporating the DBT diary card and providing real-time assessments, such as client self-report questionnaires.
- **Issues with accessing Mindstrong:** Use of Mindstrong's DBT diary card required consistent access to a smart phone or computer. Clients who did not have consistent access were unable to use Mindstrong.

Recommendations based on these lessons learned include:

- **Start planning implementation of Mindstrong early:** Early and ongoing planning with clinics and implementation settings is essential for collaborative problem-solving. Expected implementation challenges include smartphone and computer access, which should be anticipated early.
- **Request Mindstrong trainings:** For those counties/cities proceeding with Mindstrong implementations, Mindstrong can provide specific trainings to providers and other stakeholders within counties/cities on: 1) where to find information about client use and progress (e.g., what clients are doing in their sessions, what resources are offered to clients, and what progress clients are making in their recovery); 2) the biomarker feature and how Mindstrong is using biomarker data; and 3) how to discuss the use and value of biomarkers to clients.

Orange County

Implementing

Orange County launched Mindstrong at UCI Health Psychiatry Services in May 2020. The launch began with only two providers referring eligible clients to Mindstrong Care, but later included an additional 22 resident providers

referring eligible clients. After clients are offered a referral, Orange County's Peers connect with clients to answer questions and gain the consent of clients interested in participating. Mindstrong only contacts those clients interested in participating.

RESIDENT PROVIDER SURVEYS AND INTERVIEWS

In December 2020, 16 resident providers involved in the implementation completed a survey and four participated in interviews. The survey and interview aimed to identify early learnings from the initial few months of implementation, and also elicit strategies to improve the implementation. Findings included:

Survey Findings	Providers had positive impressions of Mindstrong including high acceptability, feasibility, and appropriateness. Providers felt that they had the necessary training, knowledge, resources, support, and leadership necessary to use Mindstrong. Providers felt that it would be important to have additional clarification on different aspects of the Mindstrong product and its care support to better understand who might be most appropriate to use it and why it could be useful to that client.
Interview Findings	Providers had a positive impression of Mindstrong, especially given potential for technology–delivered care during COVID–19. Some barriers identified were onboarding procedures (i.e., blocked numbers, research study framing), clinical and front desk staff having limited knowledge of the Mindstrong implementation, and a lower Mindstrong adoption rate among clients. Additional training could help support better familiarity with the Mindstrong platform. Additional incen–tives could be provided for referring clients to Mindstrong.

CLIENT SURVEYS AND INTERVIEWS

In addition to resident providers, adopters (e.g., clients who use Mindstrong) will be invited to complete surveys[26] and interviews on a regular basis to understand their experience with Mindstrong and to inform learnings and recommendations for the implementation. Non-adopters (e.g., clients referred to Mindstrong, but opt not to participate) will be asked to complete one survey and one interview to understand what factors influenced their decision to not use Mindstrong, and to further inform client outreach improvements.

All client surveys and interview guides were vetted by Orange County's Tech Leads and Peers as well as UCI Health Psychiatry Services' clinical champion. The evaluation team began surveying adopters and non-adopters in November 2020. Surveys will continue in 2021.

LEARNINGS FOR THE HELP@HAND COLLABORATIVE: IMPLEMENTATION (LOS ANGELES, ORANGE)

Learnings were identified from Los Angeles and Orange County's implementation of Mindstrong. The experience with Mindstrong in both counties, however, varied.

Los Angeles Implementation

Interviews with Los Angeles County on their Mindstrong implementation identified several lessons learned.

- Lack of communication on client use: Mindstrong was perceived as "a black box" in that providers had limited knowledge of client use (e.g., they did not know what information or services clients were offered, or which clients engaged with Mindstrong unless clients directly informed the providers).

[26] Most surveys are collected via phone in order to ensure as much relevant data is gathered in real time.

- Confusion on biomarker features: Mindstrong's biomarker function is not clear to the general consumer or their provider.
- Need for better alignment with county services: Los Angeles County wanted a technology that could be used as part of their clinical services they offer. Features that could not be incorporated with Mindstrong were more directly incorporating the DBT diary card and providing real-time assessments, such as client self-report questionnaires.
- Issues accessing Mindstrong: The use of the Mindstrong DBT diary card feature required consistent access to a smart phone or computer. Clients who did not have consistent access were unable to use Mindstrong.

Orange County Implementation

The implementation in Orange County of Mindstrong has focused on a wide-scale roll-out with full use of the Mindstrong product. Interviews conducted in Orange County identified several lessons learned:

- Positive impressions of Mindstrong: Providers had positive impressions of Mindstrong including high acceptability, feasibility, and appropriateness.
- Support and readiness for implementation: Providers felt that they had the necessary training, knowledge, resources, support, and leadership necessary to use Mindstrong.
- Areas for additional information: Providers felt that it would be important to have additional clarification on different aspects of the Mindstrong product and its care support to better understand who might be most appropriate to use it and why it could be useful to that client.
- Identification of early barriers: Some barriers identified were onboarding procedures (i.e., blocked numbers, research study framing), and clinical and front desk staff having limited knowledge of the Mindstrong implementation.

COVID-19 RAPID RESPONSE (LOS ANGELES, RIVERSIDE, SAN FRANCISCO, SAN MATEO)

The impact of COVID-19 required counties/cities to respond in new ways in order to rapidly support their communities. The Help@Hand project management team acknowledged this and developed the COVID-19 Rapid Response framework, which accelerates the process for counties/cities to implement technologies among community members—particularly those most disproportionately affected by COVID-19. In 2020, Riverside County used the framework to launch Take my Hand, while Los Angeles, San Francisco, and San Mateo used it to launch Headspace.

Riverside

Implementing Take my Hand

In April 2020, Riverside County developed and launched a peer-chat app called Take my Hand. Peer Support Specialists operated chats and on-call clinicians were available to support individuals whose chats indicated they were in crisis. **Figure 3.5** shows initial peer chat data collected by Riverside County. All figures were presented by Riverside County in their report summarizing Take my Hand's testing phase between April 17 - June 30, 2020.

Figure 3.5 includes:

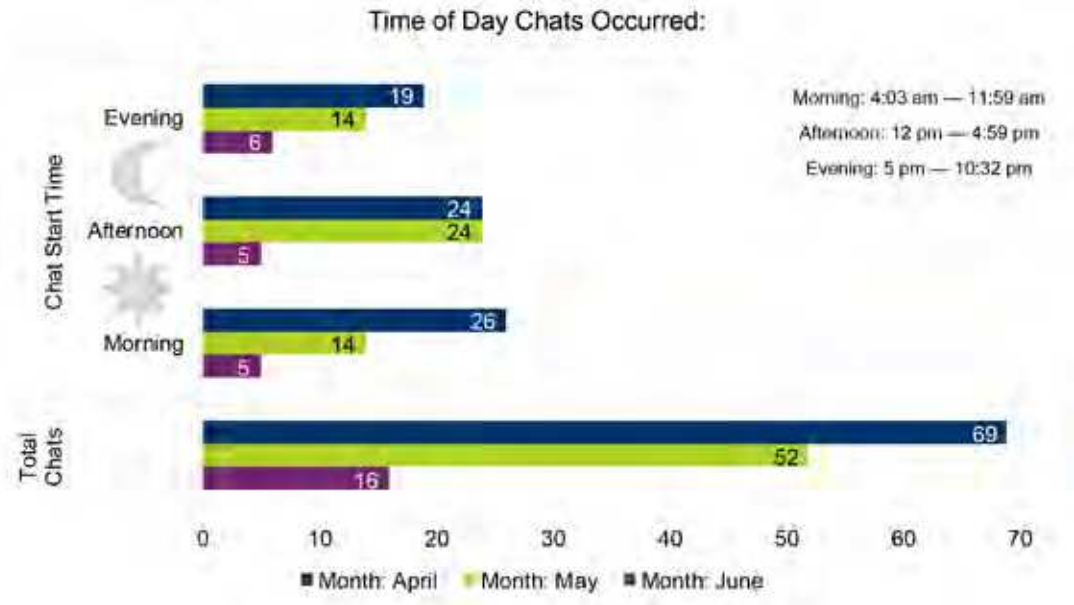
- **Chat frequencies:** Riverside County received 137 chats during the testing phase.
- **Time of day chats occured:** Chats occurred more commonly in the evening than the early morning or afternoon.

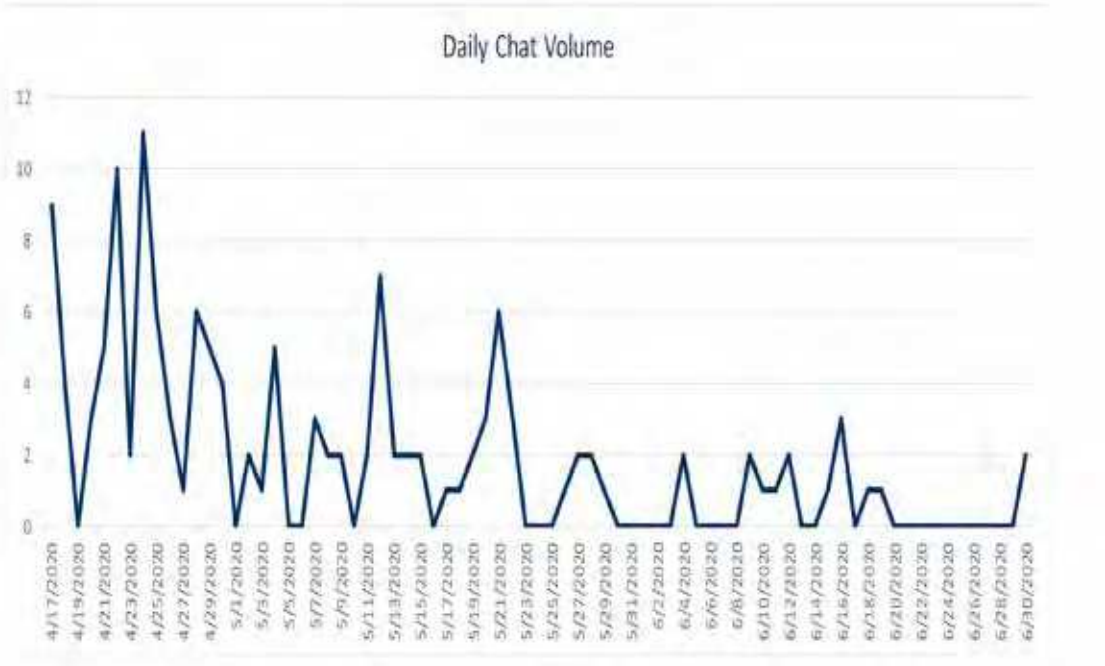
- **Daily chat volume:** Chat volume fluctuated. Most chats occurred early in the testing phase, but the overall volume was fairly low. One reason was due to limited advertising of Take my Hand in order to ensure enough staff capacity to respond to chat requests in the testing phase.
- **Average and sum of all chat duration:** The average chat duration was about 25 minutes.
- **Tags used during chats:**

  "Tags" flagged important topics arising in the chats, and helped Peers and clinicians assist consumers appropriately by informing them of the consumer's needs. Common tags are shown in the figure.
- **Customer demographic characteristic.** Gender, age, race/ethnicity, zip code, and other characteristics were collected.

Figure 3.5. Peer Chat Data Presented by Riverside County During Take my Hand Testing Phase

*One Spanish visitor, first timer


Time of Day Chats Occurred:
Morning: 4:03 am — 11:59 am
Afternoon: 12 pm — 4:59 pm
Evening: 5 pm — 10:32 pm
Chat Start Time
Evening
Afternoon
Morning
Total Chats
19
14
6
24
24
5
26
14
5
69
52
16
0
10
20
30
40
50
60
70
Month: April
Month: May
Month: June


Daily Chat Volume
12
10
8
6
4
2
0
4/17/2020
4/19/2020
4/21/2020
4/23/2020
4/25/2020
4/27/2020
4/29/2020
5/1/2020
5/3/2020
5/5/2020
5/7/2020
5/9/2020
5/11/2020
5/13/2020
5/15/2020
5/17/2020
5/19/2020
5/21/2020
5/23/2020
5/25/2020
5/27/2020
5/29/2020
5/31/2020
6/2/2020
6/4/2020
6/6/2020
6/8/2020
6/10/2020
6/12/2020
6/14/2020
6/16/2020
6/18/2020
6/20/2020
6/22/2020
6/24/2020
6/26/2020
6/28/2020
6/30/2020

Average Chat Duration (n=137):

25.05 min.

(min: 21s, max: 2hr. 40min.)

Average Waiting Time for a Peer to Pick-up a Chat:

31.01s

(min: 4s, max: 12min.)

Average Time for Consumer to Reply in the Chat:

67.73s

(min: 7s, max: 4.3min.)

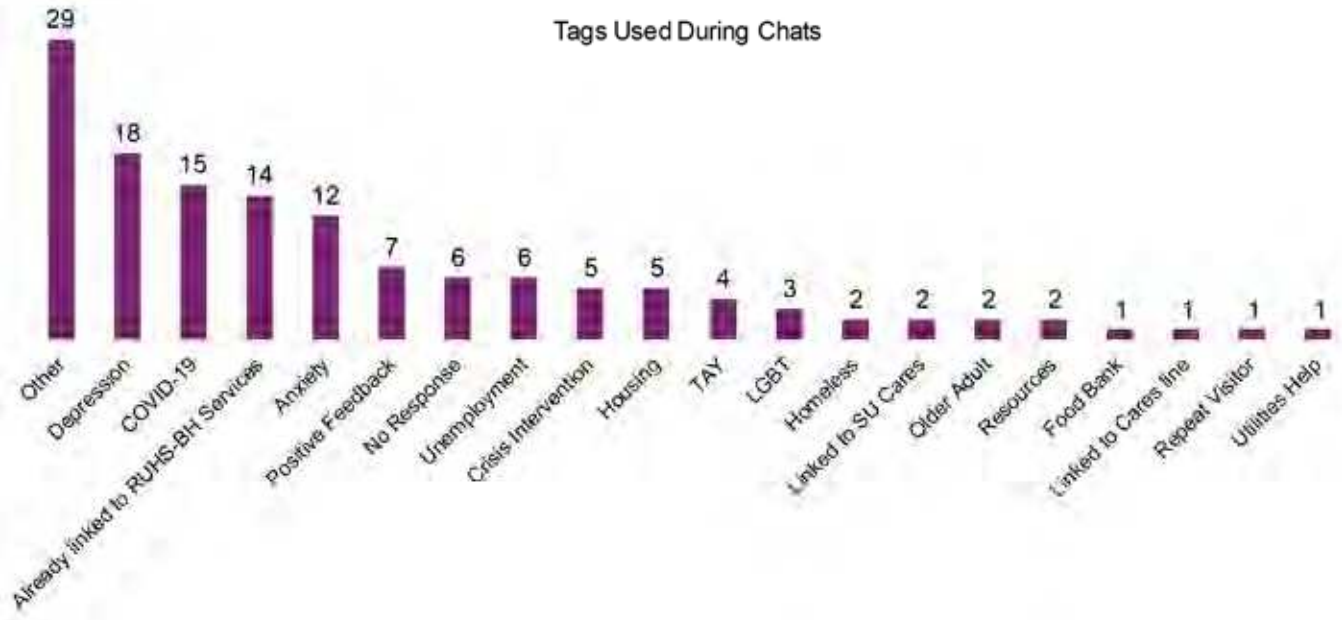
Crisis Transfers

Average Chat Duration (n=8):

35.03 min.

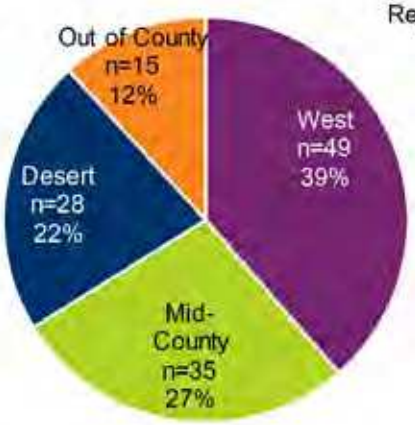
(min: 3min, max: 1hr. 57min.)

Sum of All Chat Durations per Month (n=137)



Demographic Characteristics

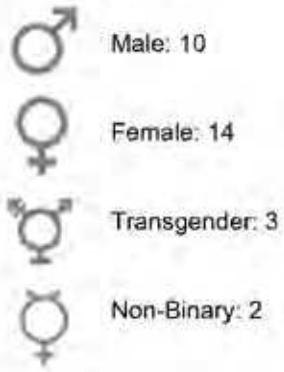
Region (n=127)



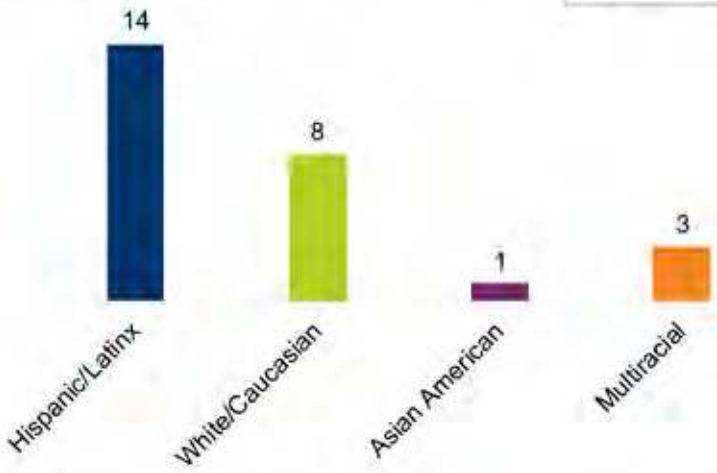
Top 5 Customer Reported Zip codes			
Zip code	City	Region	Count
92507	Riverside	West	n=11
92503	Riverside	West	n=7
92879	Corona	West	n=6
92585	Menifee	Mid-County	n=5
92201	Indio	Desert	n=4

Age Group:
TAY:6
Adult: 13
Older Adult: 5

Gender (n=26)



Race/Ethnicity (n=26)



LGBQ+ Community (Yes=8)

	Veteran	Deaf or Hard of Hearing	Disabling Condition
Yes	3	1	4
No	23	25	22

Riverside County developed Take my Hand as a web-based live chat application that provides one-on-one support from a credentialed Peer Support Specialist. It was initially developed for the Help@Hand project but was rapidly deployed as additional support to the community after the 211 and 911 crisis call centers became overwhelmed following the COVID-19 pandemic. Take my Hand entered it's public testing phase April 17th, 2020 to June 30th, 2020. Take my Hand was offered 24/7 to the Riverside community and utilized Riverside University Health System-Behavioral Health's (RUHS-BH) Peer workforce, in addition to clinical therapists in the event of a crisis situation. An evaluation plan was developed for Take my Hand's trial phase.

Information was synthesized from the rapid deployment of Take my Hand led by RUHS-BH and their Peer team for the purposes of the formative evaluation (see Appendix G). This includes identifying lessons learned and providing recommendations from the Help@Hand evaluation team. Sources of data used for this synthesis included: 1) "RUHS-BH Take my Hand Live Peer Chat COVID-19 Rapid Deployment-Test Phase Report" developed by the Help@Hand Team in Riverside County; 2) "Take My Hand Test Phase Report" developed by Riverside County's local evaluators; and 3) Riverside County meeting notes from the Help@Hand evaluation team. This synthesis may provide generalizable insights as to how other counties/cities might successfully implement and sustain Take my Hand and/or apply learnings from Riverside's experience to their own implementations of other technologies.

Los Angeles, San Francisco, San Mateo

Planning and/or implementing Headspace

Los Angeles County used the COVID-19 Rapid Response framework to launch free Headspace subscriptions for all county residents in April 2020. San Mateo Headspace is available to all county residents. The San Mateo team chose to focus their outreach on a small, targeted audience first. They will begin a broader outreach in 2021. Meanwhile, San Francisco County plans to provide free Headspace subscriptions to all county residents in 2021.

HEADSPACE IN LOS ANGELES AND SAN MATEO COUNTIES

Below is data from the Headspace roll-out in Los Angeles and San Mateo Counties. Data includes monthly active users, monthly engagement rate, and engagement by content type.[30]

METRIC	DEFINITION
Monthly Active Users (MAU)	Number of enrolled Headspace members who have engaged with at least 1 piece of content in Headspace in a given month
Monthly Engagement Rate	Percent of total enrolled Headspace members who have engaged with at least 1 piece of content in Headspace in a given month (e.g., number of members who have engaged in a given month / total number of enrolled members)
Engagement by Content Type	The number of users engaging with each section in the app (e.g. focus, med–itation, sleep, etc.)

[30] Data was from the Headspace Enrollment Report for Los Angeles and San Mateo Counties. This report is available on each counties' Headspace dashboard.

Monthly Active Users and Monthly Engagement Rate

Figure 3.6 shows monthly active users and monthly engagement rate change from month-to-month, which is typical. This may be due to a number of reasons, including: marketing/advertising from the county and/or Headspace, current events, the time of the year, and more. For example, Netflix released a series on Headspace that may cue people to use the app after watching the show, or make them less likely to use the app and watch the show instead. Note that there are considerable differences between the monthly active users in Los Angeles County compared to San Mateo County because Los Angeles County made Headspace available to the entire county, while San Mateo conducted outreach to a small, targeted population.

The figure also shows that overall users in Los Angeles and San Mateo Counties may have an initial burst of interest in the technology and then later lose interest and be less engaged. These declines in use and engagement over time are common. In fact, use and engagement of Headspace by users across the United States declines over time. Studies have corroborated this pattern and found that nearly 1 in 4 people abandon apps after only one use (Perez, 2016). This suggests that the first few days of use may be when someone is a "motivated audience" and most interested in using a technology, and it is therefore critical for counties/cities to support and encourage people to use the app within the first few days of access.

Figure 3.6. Monthly Active Users for Los Angeles and San Mateo Headspace

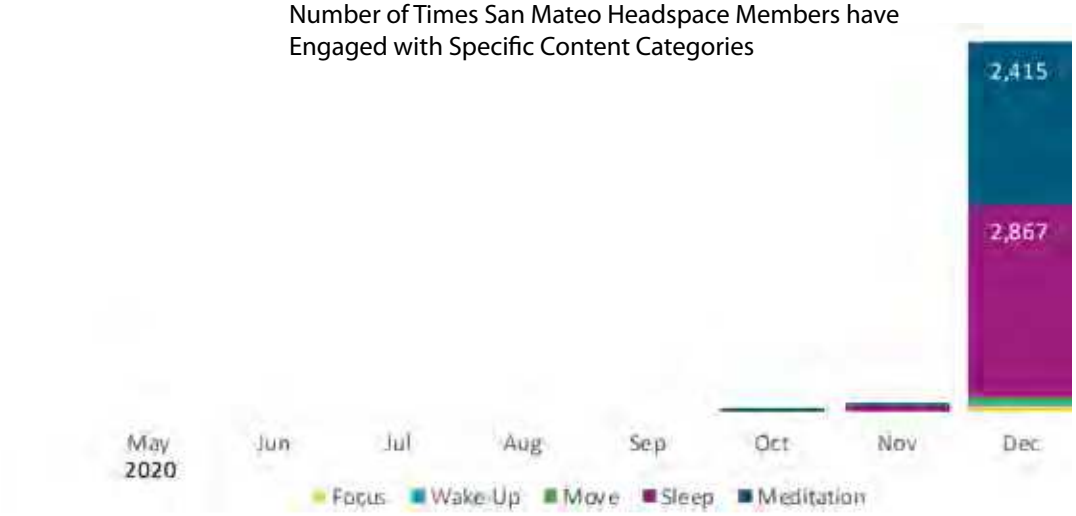
Engagement by Content Type

Metrics such as monthly active users do not tell the full story. Engagement data within the app is crucial to understanding what people are using, and potentially benefiting from, in the app. This information might be useful to drive marketing and messaging. For example, the figures below show the types of content people are most engaged with in Los Angeles and San Mateo Counties.

In Los Angeles County, Headspace's meditation content was most popular from May-August 2020. Content related to sleep then became more popular beginning in September 2020.

Figure 3.7. Los Angeles Headspace – Engagement by Content Type

Figure 3.8. San Mateo Headspace – Engagement by Content Type



LEARNINGS FOR THE HELP@HAND COLLABORATIVE: COVID-19 RAPID RESPONSE (LOS ANGELES, RIVERSIDE, SAN FRANCISCO, SAN MATEO)

Various lessons were learned from Los Angeles, Riverside, San Francisco, and San Mateo Counties who used a framework developed by Help@Hand's project management team to accelerate the process of implementing technologies in communities. Riverside County implemented their Take my Hand platform, whereas the other counties implemented Headspace.

Riverside County's Take my Hand

- Importance of a live virtual platform: Riverside County identified a public health need to find a safe alternative to alleviate the growing strain being placed on 911 and 211 crisis call centers at the onset of the COVID-19 pandemic. Offering a support service via a live virtual platform may expand accessibility, support, and mental health services to those within and outside of Riverside County's behavioral health system.
- Training needs: Training varied across Peer Support Specialists, which highlighted the need to identify and define core competencies required for Peer Operators.
- Effective resources: Resources on the Take my Hand platform with Helpline information and "canned responses" to connect users with crisis-related resources were effective ways to help clients until a warm hand-off with clinical staff could be made.

Headspace Rapid Response

- Initial user engagement: The first few days after a client downloads an app may be the most likely time for them to become engaged with the app. Thus, it is critical for counties/cities to support and encourage people to use the app within the first few days of access.
- Value of app-level, county-specific data: App-level, county-specific data provided by app developers can help increase project learnings (for example, data on Headspace Engagement in Los Angeles and San Mateo), and is more valuable to evaluative efforts than looking at marketplace trends overall.

RFI AND RFP DEVELOPMENT (MONTEREY, LOS ANGELES)

Monterey County plans to develop a tool for all county residents that screens for various behavioral health issues and refers users to care. In early 2020, Monterey County developed and released a Request for Information (RFI) that gathered feedback from the vendor community on matters related to the development of the tool. Based on the RFI results, Monterey County developed a Request for Proposals (RFP) to solicit proposals from vendors interested in developing the app. The RFP will be released in 2021. This effort was done in partnership with Los Angeles County. The **spotlight** on page 81 shares more information about Monterey County's RFI and RFP process.

PROJECT COMPLETION (KERN, MODOC)

In 2020, Kern and Modoc Counties announced they completed their projects and would transition off Help@Hand. Exit interviews were conducted with each county's project lead (e.g., Tech Lead) to:

1. **Evaluate their experiences** as part of Help@Hand.
2. **Document lessons learned** from these experiences.
3. **Gather recommendations** for other counties and cities in Help@Hand.

LEARNINGS FOR THE HELP@HAND COLLABORATIVE: PROJECT COMPLETION (KERN, MODOC)

Exit interviews with Kern and Modoc Counties identified collaborative accomplishments from their Help@Hand experience, including:

- New collaborations: Counties/Cities forged new partnerships with each other as a result of the Help@Hand program. For example:
  - Kern County was the first to curate an app guide—a list of apps that may benefit its community. Kern collaborated with other counties/cities to adapt and distribute the app guide for various communities.
  - Through opportunities such as Kern County's Peer Summit, Peers strengthened relationships with and learned from Peers in other counties/cities.
- Awareness of mental health resources and needs: Overall, the Tech Leads observed increased awareness of mental health resources and of the need for tailored, innovative, and easy to access mental health services.
- Importance of Peers: The Help@Hand program highlighted the significant value and contributions of Peers, identifying and providing opportunities to increase Peer visibility and in activities led by counties/cities. Modoc and Kern Counties also identified lessons learned:
- Peer training and supervision: Peers are an important workforce within Help@Hand; however, Kern and Modoc Counties struggled to provide sufficient Peer training and supervision that would allow Peers to consistently contribute their skills to needed areas of the project.
- Private (vendor) and public (county/city) misalignment: County Tech Leads perceived a misalignment of project goals between private (vendor) and public (county/city) entities. For example, counties/cities prioritize ensuring access to services for those most at need, but vendors prioritize growing their market potential. Also, vendors are generally more experienced in developing novel service delivery methods than in working within existing service systems. This tension has brought about challenges with developing and interpreting contracts between vendors and counties/cities.
- Balancing implementation needs: Challenges persisted in counties balancing the necessary resources for implementing within their counties and completing required deliverables for Collaborative-wide project management. These challenges were often perceived to slow progress in implementation and create administrative burden, especially among smaller counties/cities with fewer resources.

Recommendations based on these lessons learned include:

- Facilitate more cross-collaborations: CalMHSA could offer flexible use of supplemental funds to counties/ cities in order to develop and support cross-collaborative subprojects within Help@Hand that may extend beyond technology implementations. CalMHSA may offer operational and project management support for these subprojects.
- Facilitate "communities of practice": CalMHSA would be instrumental in facilitating the communities of practice due to their unique role as the project manager of the overall Help@Hand project. CalMHSA would not be expected to lead the communities of practice, but to provide the structure in which they could be facilitated. CalMHSA is able to facilitate these communities of practice because they have knowledge of each county/city's interests and where shared interests might lie.

  CalMHSA could facilitate communities of practice or affinity networks within the Help@Hand project to: 1) increase collaborative problem-solving through sharing of resources, experiences, tools, and best practices; 2) increase support to Peers and capitalize on strengthening Peer relations across counties/cities; and 3) speed translation of learnings into practice. Communities of practice may include:

  - Subgroups focused on specific technologies (e.g., Headspace or myStrength) and/or populations (e.g., TAY or isolated older adults). These topics arise in different meetings, but not enough time is available for them. The subgroups would convene in a way that allows time for in-depth learning.
  - Regular topical meetings or interactive web tools that allow for easy sharing and access to resources or plans, which could be particularly beneficial to Peers.[31]
  - Subject matter experts train or facilitate on topics of interest, such as a presentation or case study about a successful implementation of myStrength, along with lessons learned.
- Hire staff to support the Peer component of Help@Hand: Given the need for Peer training and supervision resources, CalMHSA should accelerate efforts to fill the position of Peer Engagement and Community Manager and supplement this position with a second Peer for administrative support, Peer support, and continuity in the event of personnel turnover.

[31] An example of an online community practice would be the Implementation Science Coordination, Consultation & Collaboration Initiative for HIV/AIDS research, which provides various resources for project planning and implementation in their resource hub: https://isc3i.isgmh.northwestern.edu/resource-hub/

SPOTLIGHT
Monterey County's Model for Building a Web-Based Screening Tool

Mental health screenings are often the first step in getting help. However, Monterey County identified an important need faced by many county behavioral health systems -- walk-in clinics and other behavioral health services surpassed the county's capacity to screen clients and refer them to appropriate care and services. In response, Monterey County chose to focus their Help@Hand efforts toward creating a web-based screening tool that would screen for various behavioral health issues and refer people to care.

Wes Schweikhard, Monterey County's Tech Lead, referred to the tool as a *"way to minimize the time spent between someone experiencing symptoms and accessing services. We hope this will be a powerful tool that the public can use without any prior experience with mental health issues or services, providing them with useful information regarding their (or someone else's) symptoms and connect them to care. We also hope this will prove to be an aid to our clinical environments by providing a meaningful and accurate precursory assessment, which may allow for more clinical staff time to be devoted to therapy services."*

The goal is for the web-based screening tool to be available to all residents from Monterey County, Los Angeles County, and potential other participating California municipalities. This tool is not intended to provide a clinical diagnosis, but rather to guide a person through a series of questions with the purpose of helping them to understand potential symptoms, to give educational information, and to provide an option for referrals to available support resources. Furthermore, those who receive a referral will have their assessment results made available to appropriate care resources in order to expedite intake processes.

Request for Information (RFI) and Request for Proposal (RFP)

As noted in their approved MHSA Innovation Plan Proposal, the tool will be developed around the following core criteria:

Tool to be Developed around Following Core Criteria

- Being able to screen for a broad range of disorders, from low-risk with mild need to severe with urgent need.
- Being easily accessible for use by community-based providers to help individuals acquire treatment.
- Maintaining confidentially standards.
- Interfacing with MCBH's Avatar electronic health record system to provide more seamless transitions into care.
- Working fluently in Spanish.
- Build upon current evidence-based screening tools with proven validity, and utilize item response theory to minimize the number of questions involved in the assessment.

Monterey County decided to custom build this screening tool, rather than procure and adapt another product. This decision was largely based on a noted absence in the marketplace of a product that offered both a robust assessment functionality and also delivered referrals within the local county environment. Given that Monterey County had no prior experience developing a technology product, they joined the Help@Hand Collaborative to leverage the resources of the project, particularly CalMHSA's procurement processes and expertise in the technology space.

As part of the Collaborative, Monterey County has received extensive support and guidance from CalMHSA and formed a partnership with Los Angeles County Department of Mental Health. To start the work, Monterey County and CalMHSA initially began to develop a Request for Proposal (RFP) to design and build the tool. However, several questions arose while developing the RFP, such as: What are the required vendor qualifications? What does it actually take to develop an app? and, How much should this cost?

Given the number of outstanding questions that needed to be answered prior to selecting a vendor, CalMHSA and Monterey County made an incremental decision to release a Request for Information (RFI) prior to developing the final RFP. Wes described the RFI as a "rough draft" of the county's vision and needs, meant to solicit responses from vendors with information on the vendors' potential approach. In particular, the RFI was designed to help Monterey County gather information that will be used to define the scope of their product by filling in important details that were previously missing, like the market rate to develop the app and technical approaches. Vendors also raised important questions about the county's current technology infrastructure and data storage requirements, highlighting the need to include the county's information technology team on this project.

The RFI was released on 04/20/20 and concluded on 05/29/20, there were 17 respondents. This foundational work was important as it generated a number of key learnings:

1. **Confirmed the feasibility of the general approach.** The quality and quantity of the received responses provided evidence of feasibility that the technology vendor community could submit proposals based on the identified requirements within the proposed budget framework.
2. **Indicated that the clinical and technical requirements of the tool could be addressed by a single vendor.** Prior to the RFI, there was some thought that two or more vendors might be needed to address the design requirements separately of the technical requirements. Responses to the RFI clearly suggested that this work could be accomplished by a single vendor, thus simplifying the overall process.
3. **Informed licensing.** Technology vendors raised the issue of the complex licensing requirements that might burden counties/cities when trying to make changes to the product and/or raise concerns around ownership of the product in the future. As a result of the RFI, Monterey County identified the need to own the product in partnership with CalMHSA and Los Angeles County.
4. **Highlighted the value of using the RFI mechanism to test assumptions around technology requirements.**

Monterey County is anticipating that building a digital mental health product will require a team with diverse skillsets with technical and clinical backgrounds. Wes, who has a background in data management and analytics, has been the primary Monterey County employee working on Help@Hand. Jon Drake, the Assistance Bureau Chief of MCBH, has joined the project in recent months to provide additional guidance and support with his extensive procurement experience. It is anticipated that additional county staff, specifically clinical and IT subject-matter experts, will become engaged once development of the tool begins.

Wes Schweikhard, Monterey County's Tech Lead

Wes recommended that other counties considering a similar route ***"have robust discussions, buy-in, and participation with clinical, IT and peer representatives in your county early on, to identify the specific goals, consumer experience and integrations your tech project will have. This will help articulate your scope in more tangible terms and also help set realistic expectations regarding staff involvement, to ultimately make the RFP and implementation processes go more smoothly."***

Monterey County, Los Angeles County, and CalMHSA are pleased to announce that the RFP was released on January 8, 2021.

Learnings from the Technology, User Experience, and Implementation Evaluation

The Help@Hand evaluation team worked closely with the Help@Hand Collaborative to support several counties/cities' activities this year. Key learnings include:

- **Engagement Challenges.** Several counties/cities have noted the challenges of engaging with stakeholders remotely given COVID-19 and stakeholders' digital literacy levels, which will influence their ability to engage in a remote process. Additional planning, follow-up with participants, and organization/structure, as well as leveraging partnerships to reach community members, may be needed.
- **Needs Assessment.** As noted by the counties/cities, it is important to engage community stakeholders throughout the project. A needs assessment is one opportunity to engage stakeholders and gather feedback early in the process to better match users' needs with potential technologies.
  - o Through needs assessments with two target audiences—community college students in Los Angeles County and members of the Deaf and Hard of Hearing Community in Riverside County—both accessing professional services and informal support resources for managing their own mental health emerged as desired resources.
- **Technology Exploration and Selection.** Technology explorations in Marin, San Mateo, and Riverside Counties revealed similarities across target audiences in terms of perceptions of technologies.
  - o Both older adults and TAY emphasized the importance of cultural competency in technologies, the value of being able to connect with others within the technologies, the potential of integrating technologies with health services, and the usefulness of a variety of content that is updated regularly.
  - o Consistently across both needs assessments and technology explorations, privacy concerns—in terms of what information is collected and how it is used—has been discussed as a potential barrier to using technologies to support mental health.
  - o Differences across target audiences also emerged through technology explorations in Marin, San Mateo, and Riverside Counties. For older adults, digital literacy, how mental health is perceived, and on-going technical support are key; whereas, for TAY, the visual aesthetic of the technology is an important factor that would influence use.
  - o Through technology explorations of myStrength in Marin and San Mateo Counties, participants consistently reported the variety of content within myStrength positively, but had some concerns about the demographic information that users are required to share within the app in order to use it.
- **Los Angeles Implementation.** It should be noted that the Mindstrong implementation in Los Angeles was limited to a small number of clients with limited access to the full product. As such, interviews with Los Angeles County on their Mindstrong implementation identified several lessons learned.
  - o **Lack of communication on client use:** Mindstrong was perceived as "a black box" in that providers had limited knowledge of client use (e.g., they did not know what information or services clients were offered, or which clients engaged with Mindstrong unless clients directly informed the providers).
  - o **Confusion on biomarker features:** Mindstrong's biomarker function is not clear to the general consumer or their provider.
  - o **The need for better alignment with county services:** Los Angeles County wanted a technology that could be used as part of their clinical services they offer. Features that could not be incorporated with Mindstrong were more directly incorporating the DBT diary card and providing real-time assessments, such as client self-report questionnaires.
  - o **Issues accessing Mindstrong:** The use of the Mindstrong DBT diary card feature required consistent access to a smart phone or computer. Clients who did not have consistent access were unable to use Mindstrong.

- **Orange County Implementation.** The implementation in Orange County of Mindstrong has focused on a wide-scale roll-out with full use of the Mindstrong product. Interviews conducted in Orange County with provides identified several lessons learned:
  - o **Positive impressions of Mindstrong**. Providers had positive impressions of Mindstrong including high acceptability, feasibility, and appropriateness.
  - o **Support and readiness for implementation.** Providers felt that they had the necessary training, knowledge, resources, support, and leadership necessary to use Mindstrong.
  - o **Areas for additional information:** Providers felt that it would be important to have additional clarification on different aspects of the Mindstrong product and its care support to better understand who might be most appropriate to use it and why it could be useful to that client.
  - o **Identification of early barriers:** Some barriers identified were onboarding procedures (i.e., blocked numbers, research study framing), and clinical and front desk staff having limited knowledge of the Mindstrong implementation.
- **COVID-19 Rapid Response.** Various lessons were learned across different Counties implementing technologies as a rapid response to COVID-19 (i.e., Riverside, Los Angeles, San Francisco, and San Mateo).

  Riverside-Take my Hand for COVID-19
  - o Riverside County identified a public health need to find a safe alternative to alleviate the growing strain being placed on 911 and 211 crisis call centers at the onset of the COVID-19 pandemic. Offering a support service via a live virtual platform may expand accessibility, support, and mental health services to those within and outside of Riverside County's behavioral health system.
  - o Depth of nature and training varied across Peer Support Programs, thus recognizing a need to identify and define core competencies required for Peer Operators.
  - o Accessing resources (on the Take my Hand platform) with Helpline information available and using "canned responses" around connecting the user with crisis-related resources was an effective alternative until a warm hand off with clinical staff could be made.

  Headspace Rapid Response for COVID-19
  - o The first few days after a client downloads an app may be the most likely time for them to become engaged with the app. Thus, it is critical for counties/cities to support and encourage people to use the app within the first few days of access.
  - o App-level, county-specific data provided by app developers can help increase project learnings (for example, data on Headspace Engagement in Los Angeles and San Mateo), and is more valuable to evaluative efforts than looking at marketplace trends overall.
- **Project Completion.** As part of Kern and Modoc County's experience completing the Help@Hand project, various lessons were learned.
  - o **Peer training and supervision:** Peers are an important workforce within Help@Hand; however, Kern and Modoc Counties struggled to provide sufficient Peer training and supervision that would allow Peers to consistently contribute their skills to needed areas of the project.
  - o **Private (vendor) and public (county/city) misalignment:** County Tech Leads perceived a misalignment of project goals between private (vendor) and public (county/city) entities. For example, counties/cities prioritize ensuring access to services for those most at need, but vendors prioritize growing their market potential. Also, vendors are generally more experienced in developing novel service delivery methods than in working within existing service systems. This tension has brought about challenges with developing and interpreting contracts between vendors and counties/cities.
  - o **Balancing implementation needs:** Challenges persisted in counties balancing the necessary resources for implementing within their counties and completing required deliverables for Collaborative-wide project management. These challenges were often perceived to slow progress in implementation and create administrative burden, especially among smaller counties/cities with fewer resources.

4 OUTCOMES EVALUATION AND DATA DASHBOARDS

Key Points

- The evaluation team worked with experts to identify mental health stigma measures. A report that describes and recommends different mental health stigma measures to be included in the Help@Hand evaluation was developed in Year 2.
- The California Health Interview Survey (CHIS) included questions specifically tailored for the Help@Hand program on the use of online mental health resources. An important finding was both teens and adults with high distress levels compared to those with lower distress levels were more likely to have used online tools to connect with others with similar mental health or alcohol/drug concerns.
- Statewide vital statistics data on suicides and drug and alcohol overdoses in California between 2015-2019 were analyzed. Prior to launching technologies in Help@Hand counties, general rates of suicide and overdose are slightly higher in non-Help@Hand counties (those California counties not participating in Help@Hand) than in Help@Hand counties.

OVERVIEW

This section focuses on evaluating the impact of Help@Hand at a statewide level. It presents the following activities and learnings:

- **Outcomes Evaluation**
  - o Measuring Mental Health Stigma
  - o Data from Different Sources
  - o Learnings from the Outcome Evaluation
- **Data Dashboards**

OUTCOMES EVALUATION

The outcomes evaluation assesses Help@Hand's impact in California related to its five shared learning objectives:

1. **Detect and acknowledge mental health symptoms sooner;**
2. **Reduce stigma associated with mental illness by promoting mental wellness;**
3. **Increase access to the appropriate level of support and care;**
4. **Increase purpose, belonging, and social connectedness of individuals served;**
5. **Analyze and collect data to improve mental health needs assessment and service delivery.**

Measuring Mental Health Stigma

The evaluation team was able to identify measures for each of the learning objectives, except mental health stigma. In Year 1, the Help@Hand evaluation team performed a literature search of stigma measures and identified a large number of measures (over 400). A community participatory approach was used to ensure that the stigma measures used for this program: 1) capture the type of impact expected of Help@Hand technologies to be implemented; 2) meet the dimensions of stigma of interest to the participating Help@Hand counties/cities; and 3) are scientifically valid.

In Year 1, a panel of five Peers and individuals with lived experience and/or family member experience, as well as six academics with expertise in developing stigma measures, was convened. A report that described the process of identifying and recommending mental health stigma measures to be included in the Help@Hand evaluation was developed in Year 2.

Data from Diverse Sources

Counties/cities and technology vendors collected important data that can help reveal the full impact of Help@Hand in communities and in the state. This work included discussing how to access data from county/city and technology vendor systems.

In addition, the Help@Hand evaluation team worked with stakeholders to collect data from the California Health Interview Survey (CHIS) and California Health and Human Services (CHHS).

CHIS

CHIS is the largest state health survey in the nation. It asks questions on a wide range of health topics to a random sample of teens and adults throughout the state of California. In addition to collecting data from CHIS' routinely asked survey, the Help@Hand evaluation team and CalMHSA worked with CHIS to include additional questions related to Help@Hand. **Appendix H** includes these additional questions.

CHIS fielded their survey with the additional questions from September 2019-December 2019 for adult surveys and from September 2019-January 2020 for teen surveys. Data from the CHIS survey provided insights on the use of mental health technologies in California.[32] Overall, Help@Hand counties and non-Help@Hand counties had similar trends. **Appendix I** includes a table of the following data for specific counties.

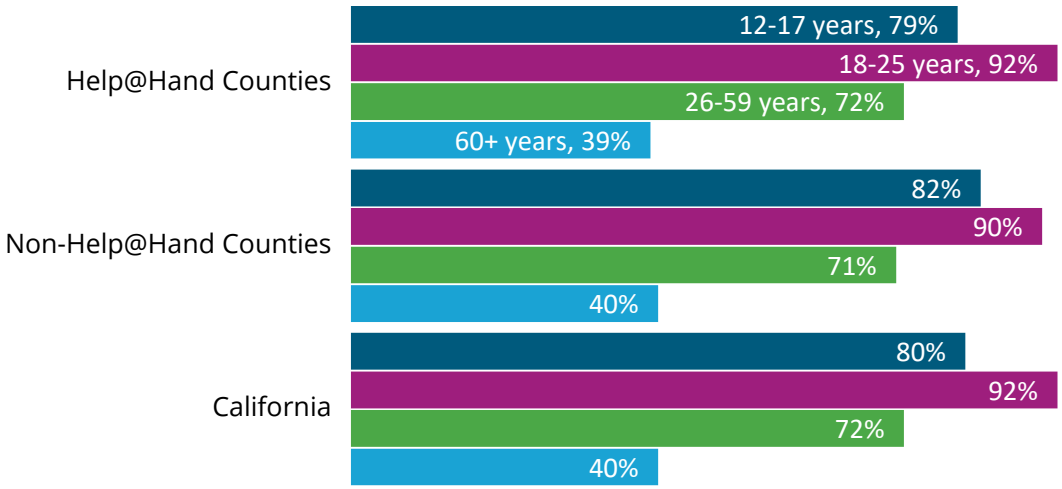
Age

Figure 4.1 shows the percent of people who use the internet and social media almost constantly or many times a day by age group for the Help@Hand counties, the comparison counties, and the State of California. The highest levels of use were among those age 18-25, followed by those age 12-17, and 26-59. People over the age of 60 had the lowest rates of intensive daily use; however, nearly 40% reported accessing the internet constantly or many times per day.

[32] The teen analytical sample was restricted to individuals between the ages of 12 to 17 and included 847 participants. The adult analytical sample was restricted to individuals of age 18 and older and included 22,160 individuals.

Figure 4.1. Internet and Social Media Use by Age

Participants who on a daily basis use the internet almost constantly or many times a day



Participants who on a daily basis use a computer or mobile device for social media almost constantly or many times a day

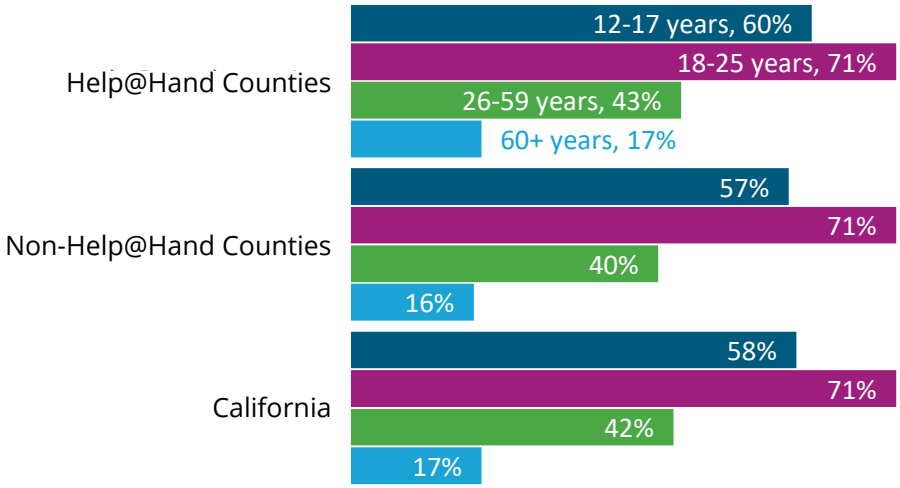
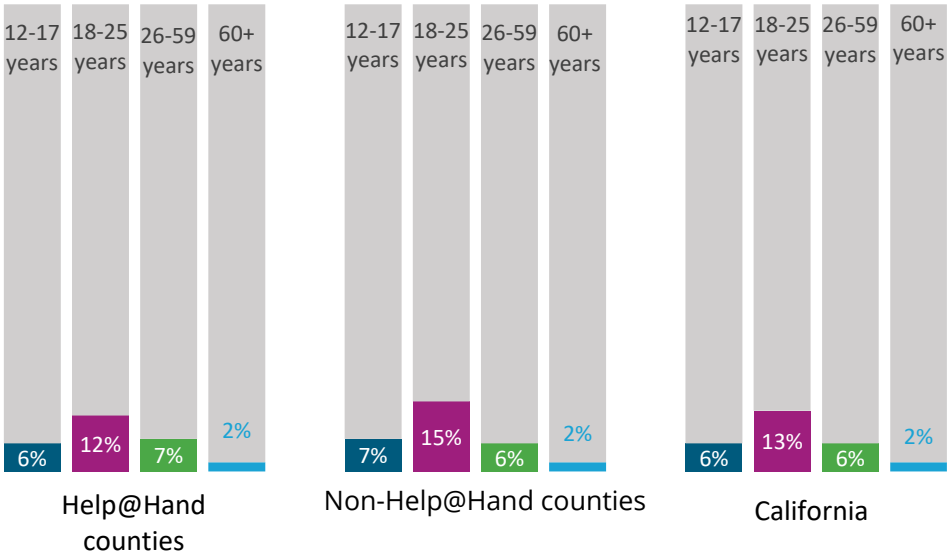


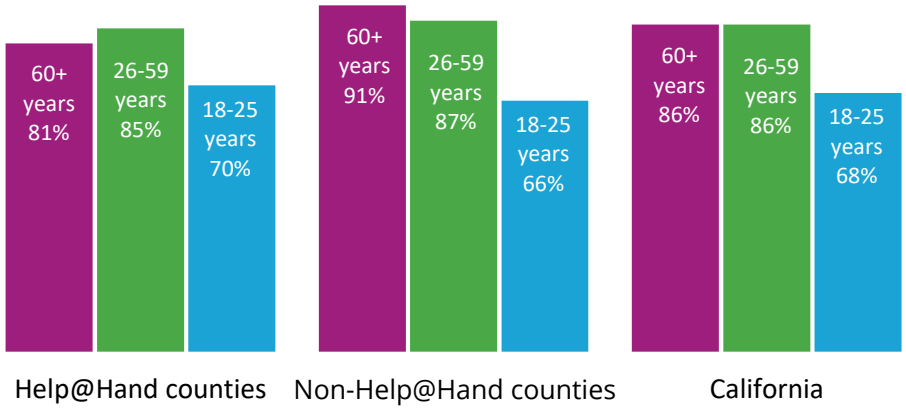
Figure 4.2 shows that 18-25 year olds (13% of them for all counties in California) also reported using online tools for mental health or addiction support more than other age groups in the past year. However, the individuals from age groups 26-59 and 60+ years found these tools more useful than the 18-25 year olds. This may suggest that TAY may be more likely to use online tools. Interestingly, there were generally high levels of usefulness among all people who tried these products, suggesting that understanding the various factors that impede access may be a fruitful area for exploration.

Figure 4.2. Use of Online Tools by Age

Participants who in the past 12 months tried to get help from an online tool for problems with their mental health, emotions, nerves, or use of alcohol or drugs



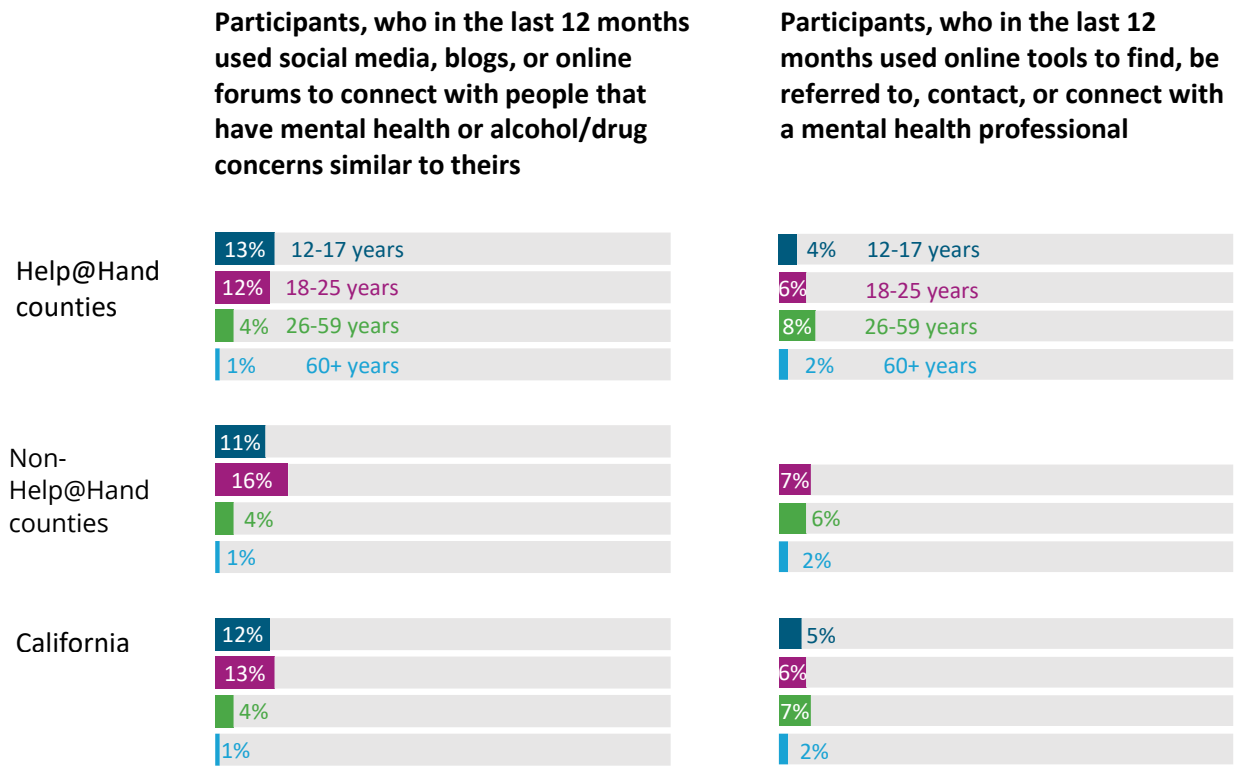
Adults who rated the online tool they used as somewhat or very useful



As shown in **Figure 4.3**, less than 15% of individuals surveyed used social media, blogs, and/or other online tools to connect with people with similar mental health or alcohol/drug concerns and/or connect with a professional. Taken with the findings from **Figure 4.2** above, perhaps people might be more likely to use an online tool to address their emotional needs, rather than using tools to connect to others.

Distress Level

Figure 4.3. Use of Online Tools to Connect with Others by Age



Similar data was analyzed for teens and adults by distress level. For teens, the use of the internet and social media is relatively high for all distress levels (as shown in **Figure 4.4**). For adults, however, there are more notable differences in internet and social media use depending on the distress level. In particular, adults who have no to low distress levels use the internet and social media much less than adults with medium or high distress levels.

Figure 4.4. Internet and Social Media Use by Distress Level

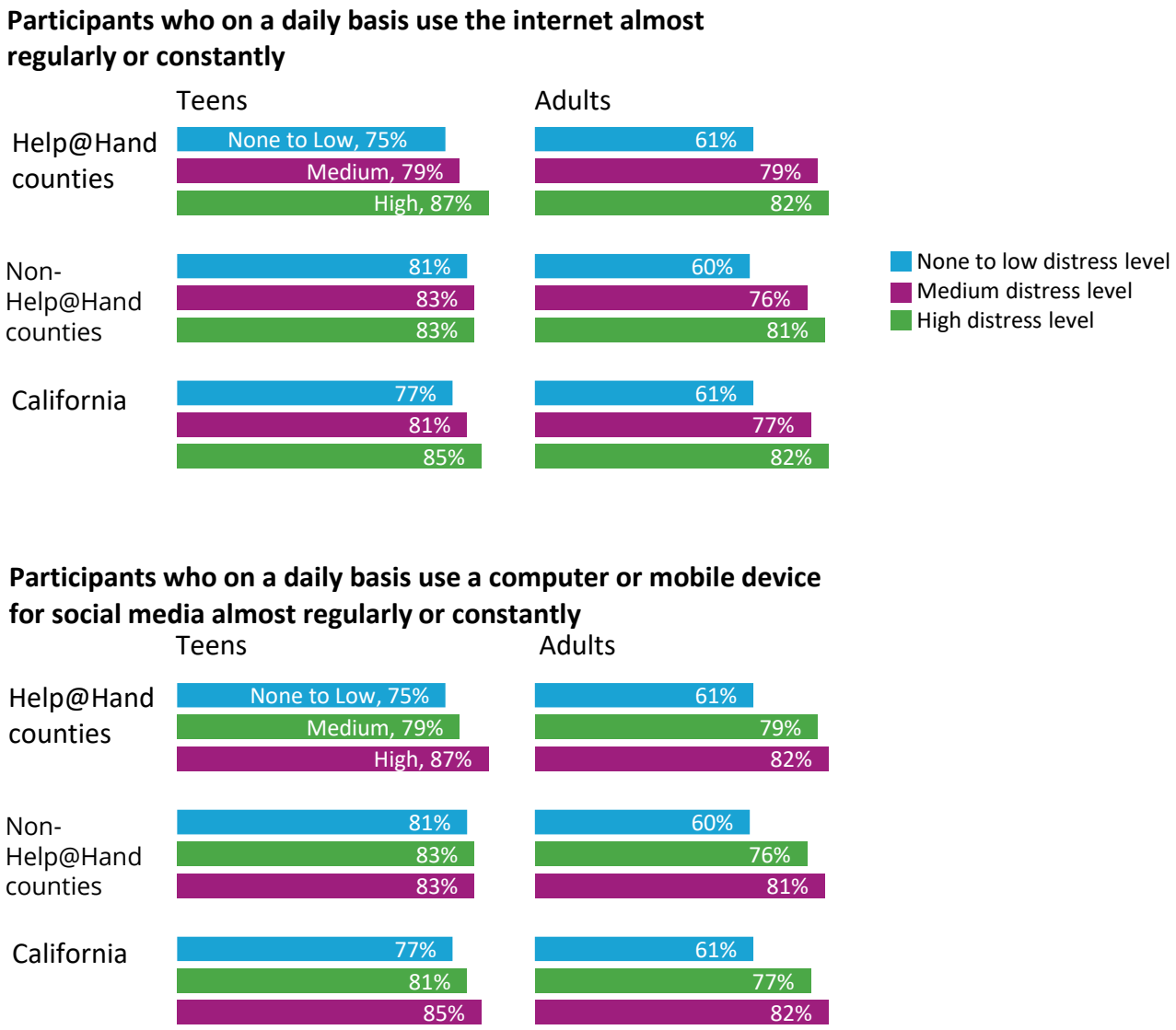


Figure 4.5 shows the percentage of adults that reported using online tools for mental health or alcohol/drug support in the past year increased significantly as the distress level increased. When asked about how useful the online support tools were, adults with high levels of distress reported the lowest levels of usefulness. This suggests that online tools may be more useful among people will low to medium distress levels. There is limited information available for teens due to the small number of participants and the very targeted subject of this survey.

Figure 4.5. Use of Online Tools by Distress Level

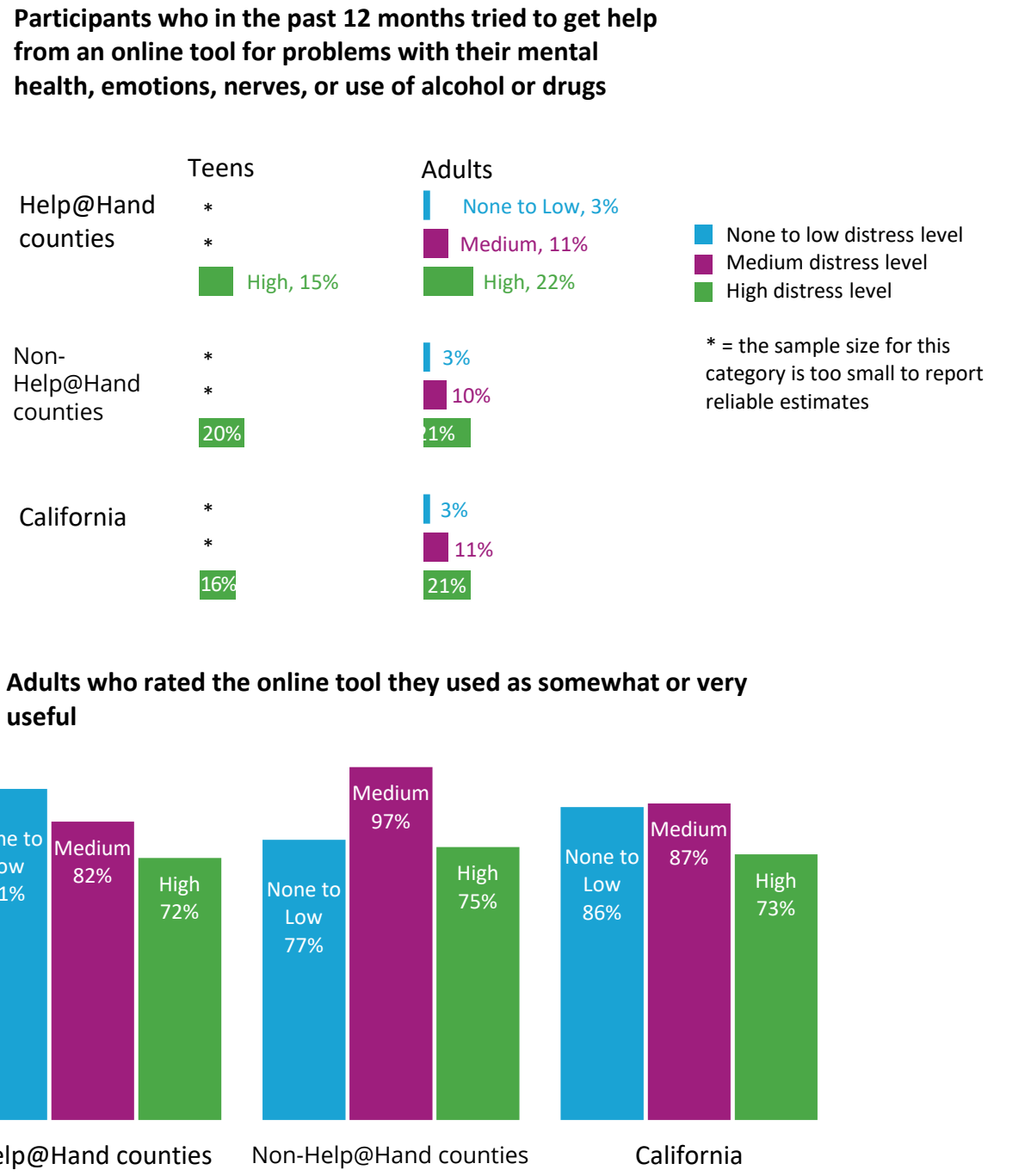
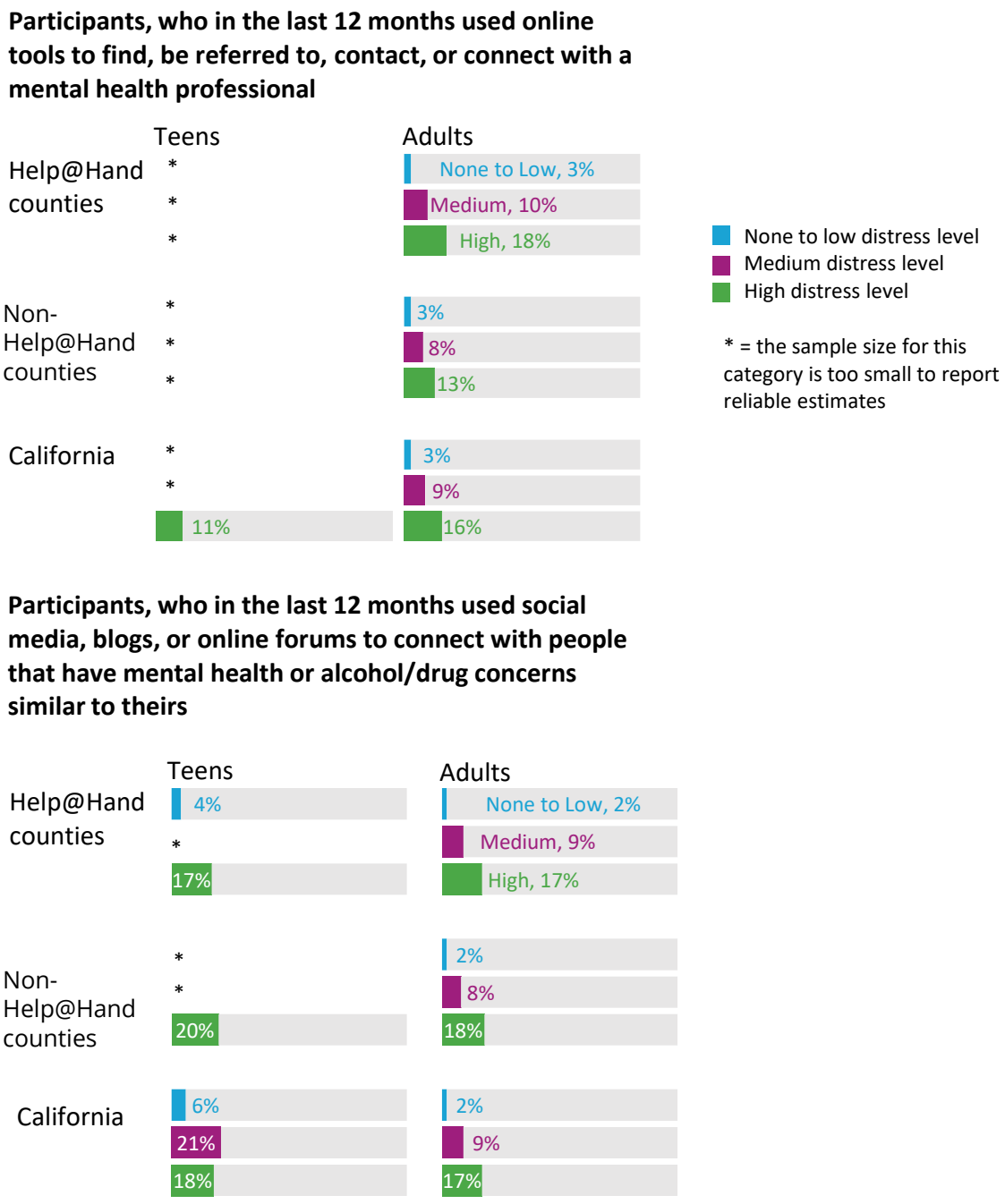


Figure 4.6 reveals that both teens and adults with higher distress levels were more likely to have used social media, blogs, or online forums to connect with people with similar mental health or alcohol/drug concerns: statewide, 18% of teens with high distress and 17% of adults with high distress. The same pattern was observed for adults who used online tools to connect with a mental health professional: 16% of adults with high distress, compared to 3% of adults with no to low distress. Due to the small number of teen participants and the nature of the survey, data is limited for some variables.

Figure 4.6. Use of Online Tools to Connect with Others by Distress Levels



VITAL STATISTICS

CHHS and its IRB approved the Help@Hand evaluation team to analyze: 1) Office of Statewide Health Planning and Development (OSHPD) inpatient and emergency department data; and 2) vital statistics. Analysis of inpatient, emergency department, and vital statistics data can compare access to care, access to appropriate levels of care, and outcomes across Help@Hand counties/cities. It can also draw comparisons with non-Help@Hand counties.

The following is a presentation of suicides and overdoses in California from vital statistics data between 2015-2019. Suicide and drug and alcohol overdoses claim thousands of lives each year in California. Underlying causes that lead to these deaths include depression, loneliness, bullying, histories of mental illness, and post-traumatic stress disorder (PTSD). This data serves to inform the Help@Hand counties/cities about the prevalence of deaths due to these causes in their respective area relative to the rest of the state.

It also establishes a baseline. The Help@Hand program aims to address such deaths by improving access to mental health resources and reducing mental health stigma. As a result, suicides and drug and alcohol overdoses may decrease as counties/cities participating in Help@Hand implement mental health technologies in the years to come.[33]

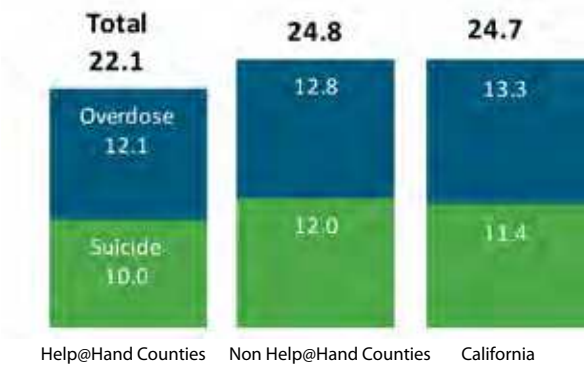
Because it is difficult to establish in cases of overdose whether death was accidental or intentional, determination of final cause of death as suicide by medical examiners is imprecise and varies substantially across counties. Therefore, the analysis considered a lower bound, defined as those reported by the medical examiners as suicides, and an upper bound, defined as those reported as suicide plus those reported as overdose.[34]

General Trends

Figure 4.7 shows that the average annual suicide rate between 2015-2019 was 11.4 deaths per 100,000 residents, and the annual average overdose rate was 13.3 in California. These averages were slightly smaller for the Help@Hand counties than for non-Help@Hand counties. For Help@Hand counties, the average annual suicide rate and overdose rate were 10.0 and 12.2 per 100,000 Californians, respectively. For non-Help@Hand counties, the average annual suicide rate and overdose rate were 12.0 and 12.8 per 100,000 Californians, respectively.

It is important to keep in mind that these rates are for the period prior to the implementation of mental health apps in the Help@Hand counties/cities. As Help@Hand implements technologies in future years, the analysis of this data may reflect differences in the baseline rates of Help@Hand and non-Help@Hand counties as a result.

Figure 4.7. Suicide and Overdose Death Rates per 100,000 Residents



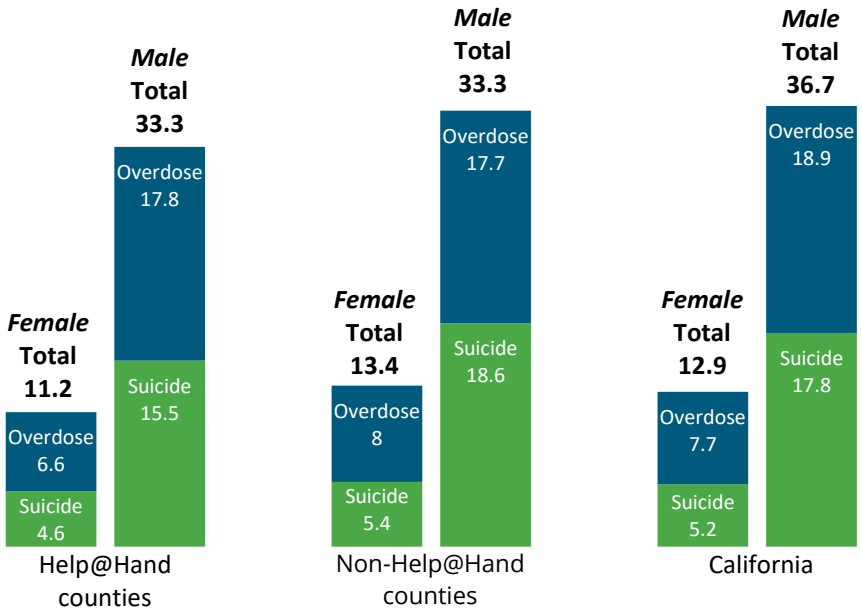
Gender

As shown in **Figure 4.8,** men are at a substantially higher risk for suicide and overdose than women. Men in California had an average annual suicide rate of 17.8 deaths per 100,000 residents and an average annual overdose rate of 18.9 per 100,000 residents.

[33] Data was aggregated to the county level and merged with population data from the United States Census Bureau to calculate population based rates for each year and for population subgroups. The annual rates were averaged over the 5-year period (e.g., 2015-2019)and are shown per 100,000 residents.

[34] Because it is difficult to establish in cases of overdose whether death was accidental or intentional, determination of final cause of death as suicide by medical examiners is imprecise and varies substantially across counties. Therefore, the analysis considered a lower bound, defined as those reported by the medical examiners as suicides, and an upper bound, defined as those reported as suicide plus those reported as overdose. Death with a final cause of suicide have ICD-10 codes X60-X84. Deaths with a final cause of overdose by drugs or alcohol have ICD-10 codes of X40-X45 (accidental poisoning) and Y10-Y15 (poisoning with undetermined intent).

Figure 4.8. Suicide and Overdose Death Rates per 100,000 Residents by Gender

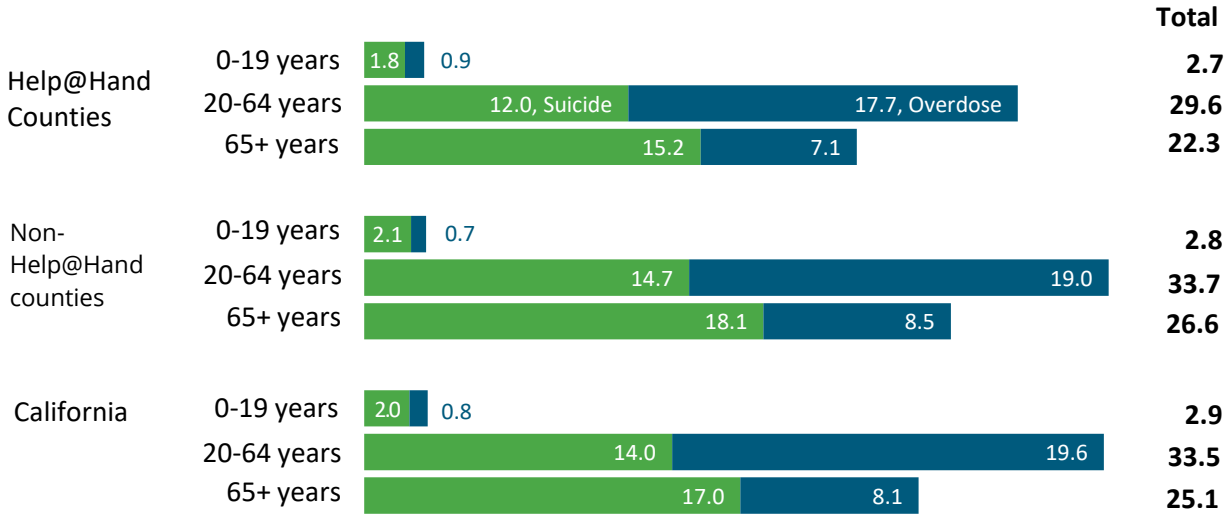


Age

Figure 4.9 shows that the age group in California with the highest rate of suicides was 65 and over, with an average annual rate of suicide of 17.0 deaths per 100,000 residents. The group with the second highest rate was the 20-64 year olds. In terms of drug and alcohol overdoses, 20-64 year olds had the highest rates by far.

Although deaths by overdose had small differences between counties, there were larger differences between counties for suicide. In particular, adults 65 and over had an average annual suicide rate in Help@Hand counties of 15.3 deaths per 100,000 residents, compared to 19.0 in non-Help@Hand counties.

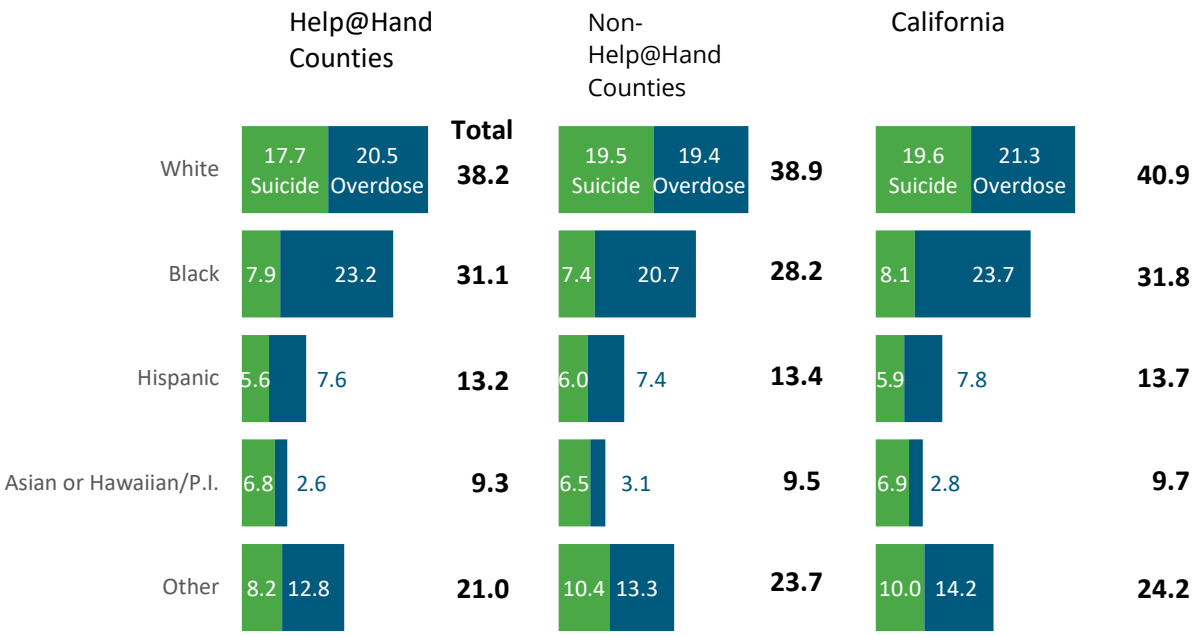
Figure 4.9. Suicide and Overdose Deaths Per 100,000 by Age



Race

Non-Hispanic Whites had the highest suicide rate, but non-Hispanic Blacks or African-Americans had the highest overdose rate in California during the period (as shown in **Figure 4.10**). Non-Hispanic Whites also had high rates of overdose. Overall, the suicide and overdose rates by race were generally similar in the Help@Hand counties and the non-Help@Hand counties.

Figure 4.10. Suicide and Overdose Deaths Per 100,000 by Race



Learnings from the Outcomes Evaluation

The Help@Hand evaluation team examined statewide data and learned:

- **Recent CHIS data shows:**
  - o **Technology Use by Age.** People of all ages used the internet many times a day or almost constantly, which means that they could access online support when needed. However, few people reported using online tools, particularly to connect with others.
  - o **Technology Use by Distress Level.** Both teens and adults with high distress reported using social media, blogs, or online forums to connect with people with similar mental health or alcohol/drug concerns.
- **Vital statistics data from California between 2015-2019 reveals trends in suicide and drug and alcohol overdose:**
  - o **Suicide and Overdose Trends.** Suicide and drug and alcohol overdoses rates in California are shown between 2015 and 2019. Help@Hand counties may want to consider technologies specifically targeting high risk communities.
  - o **Demographics of Suicide and Overdose Trends.** Men had a higher risk of suicide and overdose than women. Older adults over 65 years had higher rates of suicide, while younger adults between 20-64 years had higher rates of overdose.

DATA DASHBOARDS

Orange County and the Help@Hand evaluation team planned to pilot decision support dashboards that would be shared with other counties/cities. This work is paused to allow Orange County to focus on other project priorities and activities.

5 HELP@HAND EVALUATION ADVISORY BOARD

The Help@Hand evaluation received guidance and consultation from a team of state-wide experts and representatives across a broad spectrum of fields, stakeholder groups, and target populations. In particular, the Help@Hand Evaluation Advisory Board ensured that the evaluation:

- Considered key target audiences and addressed county/city-level variability
- Included measures of both process outcomes (implementation) and behavioral/health status outcomes (changes in participants) relevant to Help@Hand's goals
- Used methods appropriate to the project, especially with respect to scope and data collection
- Served as a vehicle for program improvement and program accountability that informed potential replication of the project
- Aligned with promising best practices, and
- Contributed to the existing knowledge base.

In Year 2, the Board met in three virtual meetings, during which the evaluation team provided updates on the Help@Hand evaluation and elicited the Board's feedback and guidance.

The Evaluation Advisory Board is comprised of a diverse group and includes:

- Experts with experience in mental health and/or technology evaluation
- Experts with experience in implementation science and evaluation
- Philanthropic and/or non-profit representatives
- Community mental health advocates
- County/City-level Help@Hand leaders
- Individuals with lived experience of a mental health/co-occurring issue accompanied by the experience of recovery, and
- Mental Health Services Oversight and Accountability Commission representatives

Help@Hand Evaluation Advisory Board Members

- Chair, Sergio Aguilar-Gaxiola, MD, PhD
  Director, UC Davis Center for Reducing Health Disparities
  Professor of Clinical Internal Medicine, UC Davis
- Ron Culver, BA[35]
  Supervisor II Tehama County Peer and Workforce Programs, Northern Valley Catholic Social Service
- Alex Elliott, MSW[36]
  Psychiatric Social Worker, Los Angeles County Department of Mental Health
- Doris Estremera, MPH
  Mental Health Services Act (MHSA) Manager, San Mateo County Health - Behavioral Health & Recovery Services
- Sharon Ishikawa, PhD
  MHSA Coordinator, Orange County Health Care Agency – Behavioral Health Services
- Karen D. Lincoln, PhD, MSW
  Associate Professor, School of Social Work, University of Southern California
  Director, USC Hartford Center of Excellence in Geriatric Social Work
- Brian S. Mittman, PhD
  Research Scientist, Health Services Research and Implementation Science, Kaiser Permanente Southern California
- Maria Martha Moreno, MS
  Administrative Services Manager, Riverside University Health System- Behavioral Health
- Keris Myrick, MS, MBA
  Co-Director, Mental Health Strategic Impact Initiative (S2i)
- Theresa Nguyen, LCSW
  Chief Program Officer and Vice President of Research and Innovation, Mental Health America
- David W. Oslin, MD
  Chief of Behavioral Health, Professor of Psychiatry, University of Pennsylvania
- Lawrence A. Palinkas, PhD
  Professor of Social Work, Anthropology and Preventive Medicine, University of Southern California
- Brian R. Sala, PhD
  Deputy Director, Evaluation and Program Operations, Mental Health Services Oversight and Accountability Commission
- Danielle A. Schlosser, PhD
  Lead Clinical Scientist, Mental Health, Verily
  Assistant Professor of Psychiatry, Department of Psychiatry, UCSF
- Brandon Staglin, MS
  President, One Mind
- Lindsay Walter, JD
  Deputy Director Admin and Operations, MHSA Chief – Santa Barbara County Department of Behavioral Wellness

[35] Joined the Help@Hand Evaluation Advisory Board in December 2020
[36] Joined the Help@Hand Evaluation Advisory Board in December 2020

RECOMMENDATIONS

Recommendations have been shared in each of the Year 2 quarter reports. Recommendations for the Help@Hand Collaborative have been consolidated, and in some cases repeated here, with learnings presented in this report according to the diverse themes reflected in the project. These recommendations are not meant to be interpreted as exhaustive or complete, but rather reflect knowledge that has been gleaned from some of the major opportunities and challenges of the past year. Furthermore, learnings and recommendations from the Evaluation Advisory Board are also reflected in themes below.

As such, the Help@Hand evaluation team recommends the following for the overall Help@Hand Collaborative and the individual Help@Hand counties/cities.

RECOMMENDATIONS FOR THE HELP@HAND COLLABORATIVE

CONTINUE TO BUILD A COLLABORATIVE AND COOPERATIVE CULTURE THAT FOSTERS RELATIONSHIPS, TRUST, AND RESPECT ACROSS THE COLLABORATIVE:

- **Facilitate more cross-collaborations:** Counties/cities are integrating Collaborative feedback into the work that they do (e.g., Santa Barbara utilizing Riverside's Poster; Kern widely sharing app guide; Los Angeles' recommendations around resources for LifeLine phones). The Help@Hand project management team may want to consider offering flexible use of supplemental funds to counties/cities in order to develop and support cross-collaborative subprojects within Help@Hand that may extend beyond technology implementations. The Help@Hand project management team may offer operational and project management support for these subprojects.
- **Facilitate "communities of practice":** CalMHSA would be instrumental in facilitating the communities of practice due to their unique role as the project manager of the overall Help@Hand project. CalMHSA would not be expected to lead the communities of practice, but to provide the structure in which they could be facilitated. CalMHSA is able to facilitate these communities of practice because they have knowledge of each county/city's interests and where shared interests might lie. CalMHSA could facilitate affinity networks, or communities of practice,[37,38] within the Help@Hand project to: 1) increase collaborative problem-solving through sharing of resources, experiences, tools, and best practices; 2) increase support to Peers and capitalize on strengthening Peer relations across counties/cities; and 3) speed translation of learnings into practice. Communities of practice may include:
    - Subgroups focused on specific technologies (e.g., Headspace or myStrength) and/or populations (e.g., TAY or isolated older adults). These topics arise in different meetings, but not enough time is available for them. The subgroups would convene in a way that allows time for in-depth learning.
    - Regular topical meetings or interactive web tools that allow for easy sharing and access to recourses or plans (which could be particularly beneficial to Peers).
    - Subject matter experts providing trainings or facilitation on topics of interest, such as a presentation or case study about a successful implementation of myStrength, along with lessons learned.
- **Facilitate use of SharePoint as a resource.** SharePoint improvements are appreciated by the Collaborative. Locating and accessing information (e.g. navigation) continues to be a challenge. Consider creating a workgroup to develop a model for organization that would be intuitive and useful for counties/cities staff accessing the site.

[37] Communities of practice are groups of people who have a similar and strong interest for a specific topic. They engage in joint activities/discussions, help each other, and share information (Centers for Disease Control and Prevention, 2019). Free resources may be found at: https://www.cdc.gov/phcommunities/resourcekit/resources.html

[38] An example of an online community practice would be the Implementation Science Coordination, Consultation & Collaboration Initiative for HIV/AIDS research, which provides various resources for project planning and implementation in their resource hub: https://isc3i.isgmh.northwestern.edu/resource-hub/

CONTINUE TO REFINE AND STREAMLINE PROJECT PROCESSES:

- **Leverage streamlined processes.** Urgency around responding to the COVID-19 pandemic compelled processes to streamline and quickly problem-solve barriers. Identifying and leveraging these streamlined processes will be important for future implementations. The COVID-rapid response technology implementation was a great example of a streamlined process.
- **Adapt project management support and documentation materials** (e.g. implementation meeting agendas or OCM plan templates) with an effort to simplify and make more efficient. These materials will be useful and important for future technology implementations both within Help@Hand and across other similar projects undertaken within counties/cities.
- **Continue to understand and document what information counties/cities value and need from the Technology vendor when selecting technologies.** For example, information about a product's available languages continues to be a common request. The 2019-2020 RFSQ process, Monterey RFI/RFP, and recent contract negotiations, for example, may offer important insights into county/city specific needs and requirements vis-à-vis general customer needs.

CONTINUE TO MEANINGFULLY ENGAGE PEERS IN HELP@HAND'S GOVERNANCE, PLANNING, IMPLEMENTATION, AND EVALUATION:

- **Hire staff to support the Peer component of Help@Hand.** Given the need for Peer training and supervision resources, CalMHSA should accelerate efforts to fill the position of Peer Engagement and Community Manager and supplement this position with a second Peer for administrative support, Peer support, and continuity in the event of personnel turnover.
- **Hire and retain qualified Peers.** Consider creating a workgroup to address barriers and facilitators that have emerged in the Help@Hand project for hiring and retaining qualified Peers (e.g. Human resources (HR)) policies around prior criminal records; need for ongoing support for Peers in recovery; HR limits on type of employment (e.g. extra work); Career pathways for success; High turnover).
- **Facilitate the development of formal pathways for increasing Peer engagement.** Counties/cities can incorporate Peers at different levels of the project (e.g., marketing, social media, video production). Counties/cities should consider how best to include Peers and what additional training can be useful to supporting the Peer workforce. See additional recommendations above pertaining to Communities of Practice.
- **Include Peers in the decision-making process around measurement in evaluation.** When presented with materials that are explained using minimal jargon, it is possible for people with limited training in statistics to understand the core issues and be able to make informed and insightful decisions. However, these efforts often require additional time and resources to support. Nonetheless, evaluation efforts must always find a balance between what is scientifically valid and what is feasible--a partnered Peer-driven approach is an effective strategy for striking this balance.

CONTINUE TO INTEGRATE DIGITAL MENTAL HEALTH LITERACY (DHML) TRAINING INTO COUNTY/CITY IMPLEMENTATIONS:

- **Analyze available data.** DMHL resources, consisting of 10 videos as well as an Instructor led curriculum which includes the 'Managing your digital presence curriculum' and 'Cyberbullying Curriculum', has been made available on the https://helpathandca.org/dmhl/ website. Use data available from website analytics and surveys to understand frequency of current use of materials and satisfaction with content. This information will be important for planning efforts around further dissemination.
- **Consider planned expansions and/or efforts to disseminate DMHL videos.** Consider a strategy to expand the use of the DMHL curriculum across the Collaborative – perhaps include link to site in marketing efforts. Providing much needed digital mental health literacy training to appropriate target populations may improve uptake of technology implementations.
- **Consider integration into tech implementations.** Consider additional efforts to integrate DMHL program in county/city pilot projects and implementations.

CONTINUE TO WORK TO STRUCTURE THE RELATIONSHIP BETWEEN TECHNOLOGY VENDORS AND COUNTIES/CITIES IN WAYS THAT PROMOTE A WIN-WIN FOR THE PRIVATE-PUBLIC PARTNERSHIP:

- **Incorporate data collection and sharing plans when contracting with technology vendors.** Because the availability of marketplace data via a third-party analytics platform changes over a relatively short period of time, it is crucial for vendors to directly provide these metrics. Detailed data provided directly from the app developer will yield more consistently available data points to help understand product performance. This data will also allow counties/cities to determine the real-world engagement and effectiveness of the apps and help achieve learning objectives. The Collaborative should negotiate contracts on behalf of counties/cities that ensure the apps provide detailed, individual-level data, including data on adoption, engagement, abandonment, and outcomes.
- **Understand the available resources offered by the vendor.** Consider using the following questions as a guide. These questions are not intended to be comprehensive, but rather used to facilitate a guided conversation:
    - *Marketing:* What marketing materials are available and have been used to support adoption of product and maintenance of use over time? Who are the target audiences for these materials? Describe any efforts to test the efficacy/usefulness of potential marketing approaches?
    - *Implementation:* Describe some of the settings for which the product has been successfully implemented? What has been some of the most successful implementation contexts (including target audiences)?
    - *Data Availability:* Will data be shared at individual level or the aggregate? Identified or de-identified? Is the vendor willing to provide a data dictionary for data to be shared with the county/city? How are data constructs operationalized (including what is the denominator that is used)?
    - *Dashboard Construction:* How often will data on the dashboard be refreshed? Will archival data be made available? Will the data be exportable?
- **Consider ownership issues, intellectual property, and/or licensing of products when deciding how best to move forward with custom builds.** There are important implications of these early decisions for future customizations of the product and expansions of the product to other markets.

CONTINUE ADOPTING A PERSON-CENTERED APPROACH, MATCHING THE NEEDS OF DIVERSE TARGET AUDIENCE MEMBERS TO APPROPRIATE AVAILABLE TECHNOLOGIES:

- **Consider language and culture.** Assess how the language and content of potential technologies fits the needs of diverse target audience members. Making a technology available to diverse ethnic, language, or cultural groups involves more than just translation.
- **Develop set of questions to assess cultural competency of the technology itself.** Data collection with technology consumers found that cultural competency is important across target audiences. Counties/cities have echoed the need for culturally competent technologies, but technologies explored have been rated low in cultural competency. Developing a set of questions to assess cultural competency of a technology itself early on, as well as evaluate to what extent vendors are able to meet counties/cities' needs regarding cultural competency for a particular target audience.
- **Consider assistive technologies:** Many technology products do not have sufficient assistive technologies. General-use apps which are available on the app stores are unlikely to be a good fit for people with disabilities. Discuss as a Collaborative how to vet potential technologies to meet such criteria. Discuss with chosen vendors their capabilities and capacity to expand accessibility features. Speak with members of the target group to understand what assistive technologies are most relevant across the Collaborative. Discuss as a Collaborative how to vet potential technologies to meet such criteria and discuss with chosen vendors their accessibility capabilities.

INCLUDE IMPORTANT STAKEHOLDERS FOR CONDUCTING CULTURAL TAILORING AND DISSEMINATION:

- **Include Peers and stakeholders in dissemination efforts.** Efforts are currently underway to translate materials for dissemination to key target audiences. As recommended as part of best practices, consider including

Peers and stakeholders in all dissemination efforts to ensure appropriate translation, cultural tailoring, and dissemination of documents and products.

- **Consider the materials to be selected for translation and dissemination.** There are a number of strategies for success, including selecting a medium for dissemination that suits the message (e.g. consider use of video or infographic). Identify the audience and tailor the message – it is important not to overlook the intended audience and consider specifically tailoring each message to that audience.

CONTINUE CONVERSATIONS AND PLANNING AROUND THE EQUITABLE DISTRIBUTION OF DEVICES:

- **Consider forming a Collaborative level workgroup to develop a recommendation or guideline, rather than a prescription.** Counties/cities are seeking a lot of guidance around equitable distribution of devices. Most counties/cities don't have guidelines for providing equitable distribution of technologies. There are concerns around making the program truly equitable, while balancing limited budgets, concerns around how the devices will be used, and liability.
- **Recognize a one size fits all model may not work.** Counties/cities might want to try different methods of distribution (e.g., loan, free devices, etc.) based on specific population needs. It is important for counties/cities to consider what the criteria are for those who will be receiving devices from county/city-specific programs.
- **Consider use of existing or prior programs to model distribution methods after and/or to leverage available resources** (e.g., state of California's distribution of Chromebooks for education, library device loan models, etc.). As noted during Tech Lead (9/8/2020), California Broadband and Digital Literacy office has work that might intersect with or support work being done by the Help@Hand project. California Broadband and Digital Literacy office work focuses on providing broadband internet access (not devices) to stakeholders across California.

RECOMMENDATIONS FOR INDIVIDUAL HELP@HAND COUNTIES/CITIES

Recommendations for individual Help@Hand counties/cities also come from across the quarter reports, as well as include learnings and recommendations from this report.

LOCAL IMPLEMENTATION:

- **Define goals and learning objectives for each technology implementation early in the process**. Participants rate the usefulness of technologies differently, depending on what goals a technology is expected to meet. Counties/cities should clearly define their goals and learning objectives to select and evaluate a technology.
- **Customize implementations for local context.** Implementations will be more likely to succeed when counties/cities deeply understand the problem or need they are trying to solve or address locally - both from the data and input from the community and from understanding the existing work and coalitions that may be working on similar issues.
- **Develop structured processes for eliciting stakeholder engagement.** Counties/cities who wish to engage community members throughout the project should develop structured plans for stakeholder engagement , find and leverage meaningful partnerships to reach and engage stakeholders, especially when utilizing remote processes during COVID-19. Counties/cities have found that working with local agencies that serve their target population can help with outreach and marketing for the project.
- **Remember the 5 key takeaways when engaging people (e.g. in a focus group):**
  1) Establish a win-win-win; show benefits to potential participants.
  2) "Your ego is not your amigo"[39]; research team should be humble and know that they might not be the only expert in what is being studied.
  3) Be intentional / know target audience for recruitment.

[39] Direct quote shared by one of the Help@Hand counties/cities on Tech Lead Call, 11/17/2020.

4) Luck is the residue of hard work – there is a lot of work that must go into the planning of any effort to engage stakeholders and community members.

5) One-size does not fit all when it comes to interventions and when it comes to research and/or evaluation.

- **Understand the underlying needs of your target audiences.** Needs assessments can provide important insights in the mental health needs of a target population. If counties/cities do not have a detailed understanding of their target audience yet, a needs assessment is recommended to uncover needs that can inform technology selection. In addition, these needs may inform strategies for marketing and outreach that is appropriate for the target population.
- **Understand and address barriers to accessing digital technologies.** As many apps do not function offline, work with county/city informational technology to explore potential options, consider workflow integration, and discuss client's internet access to find suitable workarounds. For example, if an app only has downloadable content, where can the client go to download the content? Digital literacy training and resources can also help users better understand connectivity to WiFi and internet data to avoid unexpected charges.
- **Recognize and plan for the challenge of working remotely.** Providing remote technical support is more challenging than in-person support. When gathering feedback remotely, counties/cities should be prepared to provide additional support and set aside time to collect target audience feedback.
- **Consider how the communication of informed consent and/or terms of services facilitates transparency among your counties/cities' consumers.** Because privacy concerns were a commonly identified barrier to technology use, maintaining communication and transparency on how app data is collected, stored, and used can help mitigate privacy concerns. As noted by counties/cities, an informed consent process that communicates a technology's terms and conditions in lay terms can also help technology users understand how their information will be used.
- **Test crisis response within apps.** Many of the apps reviewed did not include a crisis response. Counties/cities are encouraged to test crisis responses within the app to ensure that they meet expectations and respond appropriately. A crisis response plan outside of the app is also essential. If apps do not provide a crisis response, ensure that clients are aware of this and know who they should contact if they are in crisis.
- **Engage leadership and identify local champions.** Having strong leadership and champions can be crucial to seeing the project move forward. Resilience and stamina are keys to sustaining the project. Also, be sure to identify partners who are ready to be involved and participatory in the process -- "It takes a village."
- **Align terms.** It is important to ensure a shared understanding of commonly used terms for involved parties. For example, make sure that the technology vendor, participating clinics, county/city, and any other involved partners have a shared understanding of the definition of "Serious Mental Illness (SMI)". Counties/cities, vendors, and clinicians make not use this term in the same way.
- **Marketing efforts and materials must be on-going to promote continued uptake of products.** Recruitment of consumers and/or clinicians/ and/or other stakeholders must be viewed as being continuous -- not a one-time event if counties/cities want to see sustained growth in technology uptake.
- **Aim to recruit users in pilot efforts that reflect the target population.** Users can perceive the usefulness of technologies differently when they consider a technology for themselves, versus when considering it for a particular population. For the exploration phase, counties/cities should aim to recruit participants that are as representative as possible of the target audience.

PRODUCT FIT AND ENGAGEMENT:

- **Compare the features of similar products (e.g. myStrength, SilverCloud) during the app selection process.** Many of the products reviewed during the RFSQ process have features that overlap, but have important differences that make some apps a better fit for a particular target audience than other apps.
- **Consider products that connect people together.** Counties/cities should consider whether or not technologies allow users to connect with others, whether professional services or informal support, to receive mental

health support, and to what extent their target audience(s) would like to utilize these types of features, as this was valued by multiple target audiences in both needs assessments and technology explorations.

- **Consider products that connect people to existing systems of care.** Because participants also valued when technologies were integrated into existing systems of care, counties/cities should work with vendors to understand how a technology may work within existing health services but also to what extent the vendor is willing to add customization for connections to local resources and support to be embedded within the technology.
- **Engage early to enhance uptake.** The first few days after a client downloads an app may be the most likely time for them to become engaged with the app. Considering what other active approaches to enhance uptake and engagement may help people use the app within the first few days. For example, if they have technical difficulties or other questions during their first use, is there someone they can reach out to or a resource they can visit to help resolve them?
- **Continually check in with consumers who use a product over time.** Technology explorations indicated that participants valued having a variety of content that is consistently updated. In order to understand user engagement, counties/cities should consider not only capturing users' early impressions of a technology, but also checking in at later time points to evaluate whether the content meets users' long-term needs. Counties/cities can also engage with the vendors to determine if and how often content is updated.

CLINICAL INTEGRATION:

- **Create materials to help provide more training and orientation to residents and other clinic staff.** Perhaps the vendor has materials that are already available that could be disseminated. However, consider if these require adaptations and tailoring for appropriate groups.
- **Support early clinical champions.** Focusing support on "early adopters" might be more beneficial than changing the views of less enthusiastic providers.
- **Address barriers early and share with clinic staff changes made to address their concerns.** Generally, when a product is first introduced into a system, there is an overall positive view of the product. Addressing barriers to implementation early is important to supporting and sustaining early enthusiasm and excitement.

DATA USE:

- **Use data to continuously learn, adapt, and improve.** Design implementation and evaluation plans concurrently to support the collection of important data necessary for informing programmatic decisions.
- **Initiate vendor calls earlier in planning process to allow for better alignment with program and evaluation planning.**

DISSEMINATION AND SUSTAINABILITY:

- **Leverage local resources.** When marketing county/city efforts, it can be useful to work with other divisions within the department (e.g., TAY groups, Substance Use/Addiction recovery, Cultural Competency) to not only reach a wider audience but also to assist with messaging. Relatedly, it is useful to collaborate with local mental health organizations.
- **Be deliberate in where and how you market.** When marketing on digital media/online, it is important to consider the pros and cons of each platform as well as which audiences visit which social media platforms.
- **Start preparing for project end right now.** Consider the vision for what your county/city actually wants to achieve during the remaining time in the Help@Hand program, balancing Help@Hand objectives with project feasibility.
- **Develop long term roadmap.** Developing a long-term roadmap is a critical tool for ensuring sustainability for the programs counties/cities are building. Having a project plan align with a long-term roadmap also provides the opportunity to get input and buy-in from program staff and external stakeholders. Consider the opportunities for counties/cities to build sustainable infrastructures and roadmaps to support long-term technology integrations.

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APPENDIX A: COUNTY/CITY PROGRAM INFORMATION

Each Help@Hand county/city completed the following tables describing their program information, accomplishments, lessons learned, and recommendations.

City of Berkeley	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	• Andrea Bates	• Kirsten White • Karen Klatt	• Kirsten White • Karen Klatt	• Kirsten White • Karen Klatt
Implementation Site	• TBD	• TBD	• TBD	• TBD
Team Composition	• Tech Lead, Behavioral Health Director, MHSA Coordinator, Peer, Project Coordinator	• Steven, BH Director • Karen, MHSA Coordinator • Jaime, Peer Lead • Kirsten, RDA Consultant • Nicole, RDA Consultant	• Steven, BH Director • Karen, MHSA Coordinator • Jaime, Peer Lead • Kirsten, RDA Consultant • Nicole, RDA Consultant • Jeff Buell, Clinical Coordinator	• Steven, BH Director • Karen, MHSA Coordinator • Jaime, Peer Lead • Kirsten, RDA Consultant • Nicole, RDA Consultant • Jeff Buell, Clinical Coordinator
Target Audience	• TBD	• TAY; isolated seniors; communities of color, including African Americans, Latina, etc.; general population of Berkeley	• TAY; isolated seniors; communities of color, including African Americans, Latinx, and API community members; general population of Berkeley	• TAY; isolated seniors; communities of color, including African Americans, Latinx, and API community members; general population of Berkeley
Products in Use/Planned	• TBD	• Under review	• Selection in progress	• Berkeley staff completing validation of Headspace and myStrength
Implementation Approach	• TBD	• TBD	• TBD	• Rapid Response
Other Unique Qualities (of target audience, implementation, or other program aspect)	• TBD	• Prefer to engage minority-owned vendors	• Prefer to engage minority-owned vendors	• Following a review of the vendors qualified through the RSFQ process, no vendor was clearly minority-owned and no product was made specifically for BIPOC consumers.
Milestones	• Not applicable	• Peer Lead allocated to project • Local consultants contracted and onboarded to support app selection and developed plans for implementation	• The City Mental Health Team Partners are engaged in the App Technology selection	• Products selected for exploration (Headspace, myStrength) • Internal staff validation to prepare for product launch underway • Developing Peer engagement plans
Lessons Learned	• Regular brainstorm and Q&A opportunities, particularly Tech Lead Collaboration meetings, with fellow Help@Hand jurisdictions are valuable for supporting such a dynamic project implementation process • A shared understanding of project objectives is key • Objectives should be revisited with stakeholders on an ongoing basis			
Recommendations	• Regularly reteach and reinforce expectations regarding the required implementation documentation, both as a best practice and also to support counties/cities experiencing staff turnover or project pauses; • Consider offering support to connect smaller cohorts of similarly-sized/similarly-resourced jurisdictions on a quarterly or biannual basis, as progress of a very large county might be presented as a watershed project milestone but very inappropriate for a small jurisdiction to aspire to; • Increase transparency of product take-up (and perhaps other metrics) across pilots. It would be helpful to have better access to this data across pilots in order to inform realistic goal-setting at the local level.			

Kern County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	• Lamar K. Brandysky, LMFT	• Lamar K. Brandysky, LMFT	• Lamar K. Brandysky, LMFT	• Lamar K. Brandysky, LMFT
Implementation Site	• Self-Empowerment Team	• Self-Empowerment Team	• Self-Empowerment Team	• N/A
Team Composition	• Project Lead, Peer Lead, 2 Peers, PIO, Marketing Associate	• Project Lead, Peer Lead, 1 Peer, PIO, Marketing Associate	• Project Lead, Peer Lead, 1 Peer, PIO, Marketing Associate	• N/A
Target Audience	• Clients with serious mental illness • Kern County Residents	• Clients with serious mental illness • Kern County Residents	• Clients with serious mental illness • Kern County Residents	• N/A
Products in Use/Planned	• App guide, 2nd Edition – English and Spanish versions • App guide, 3rd Edition (planned)	• App guide, 2nd Edition – English and Spanish versions • App guide, 3rd Edition (planned)	• App guide, 2nd Edition – English and Spanish versions • App guide, 3rd Edition (planned)	• N/A
Implementation Approach	• Wide distribution of the app guide	• Wide distribution of the app guide	• Wide distribution of the app guide	• N/A
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Offer clinician education on app guide (planned) • Support other Help@Hand Counties/Cities (Mono, Modoc, and Santa Barbara) develop their own tailored app guide • Adapt app guide for Nevada, Fresno, San Bernardino, and Inyo Counties to publish their own app guide	• Offered clinician education on app guide (planned) • Supported other Help@Hand Counties/Cities (Mono, Modoc, and Santa Barbara) develop their own tailored app guide • Adapted app guide for Nevada, Fresno, San Bernardino, and Inyo Counties to publish their own app Guide	• The state-wide medical emergency declared by the governor has resulted in a pause on all Help@ Hand activities	• N/A
Milestones	• Published the 2nd Edition of *"The Peers' Guide to Behavioral Health Apps"* app guide in English and Spanish • Created a version of the app guide for Modoc, Mono, and Santa Barbara Counties that included content modifications and printing set-up • Prepared and Implemented a four-hour Peer Workshop on empowerment training for Kern BHRS and contracted Peers • Empowered Peers though the app guide development and dissemination • Prepared and hosted two-day digital mental health literacy training for Help@Hand Peers • Presented app guide to County Board of Supervisors in January • Presented to the Kern BHRS Management and to the Kern BHRS contract CEOs • Started systemic distribution to other Kern County agencies	• The state-wide medical emergency declared by the governor has resulted in a pause on all Help@ Hand activities.		• Kern County has completed their participation in the Help@Hand project.
Lessons Learned	• The proposed apps need to be thoroughly vetted prior to piloting with clients. A prime role of County mental health is to assure the provision of safe products to their vulnerable population. • Digital literacy takes one-on-one coaching which is time consuming and labor intensive. • Consumers benefit from basic digital literacy training. • Collaborating with fellow counties is fruitful and productive. • Working with County agencies requires an abundance of patience and perseverance. • It is vital that the peer employees not only have lived experience, but that they will have progressed sufficiently in their recovery that they feel free to share details of their journey. This sharing of surviving and thriving in their recovery is a prime issue to benefit our consumers and members.			
Recommendations	• Focus on producing a product. Time and energy can be spent on process and procedures with no resulting product			

Los Angeles County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	• Katherine Steinberg, MPP, MBA • Alex Elliott, MSW • Ivy Levin, LCSW	• Katherine Steinberg, MPP, MBA – Reassigned mid May 2020 • Alex Elliott, MSW – Served as a liaison for Painted Brain/ Peer contributions	• Alex Elliott, MSW- Served as a liaison for Painted Brain/Peer contributions	• Alex Elliott, MSW- Served as member of Evaluation State-Wide Advisory Board
Implementation Site	• Harbor UCLA DBT program • Peer Resource Center (planned) • Geriatric Evaluation Networks Encompassing Services Intervention Services (GENESIS) outpatient program for older adults (projected for pilot) • Telecare Los Angeles Older Adults (LAOA) Full Service Partnership (FSP) program (projected for pilot)	• Harbor UCLA DBT program • Peer Resource Center (planned) All pilots were placed on hold due to COVID	• Harbor UCLA DBT program • Peer Resource Center (planned) All pilots were placed on hold due to COVID	• Harbor UCLA DBT program • LAC DMH DBT Programs • LAC DMH will be moving forward with contracting with Prevail for a full LA community roll out to commence February 2021.
Team Composition	• Program Lead/Project Manager, Chief Medical Officer (Executive Sponsor), Behavioral Health Director, 2 Tech Leads, Chief Information Officer, IT Project POC, Chief of Peer Services, Evaluation Lead, Privacy SME, IT Security SME, Harbor UCLA Clinical Champion, Public Information Officer	• Program Lead/Project Manager, Chief Medical Officer (Executive Sponsor), Behavioral Health Director, 2 Tech Leads, Chief Information Officer, IT Project POC, Chief of Peer Services, Evaluation Lead, Privacy SME, IT Security SME, Harbor UCLA Clinical Champion, Public Information Officer	• Program Lead/Project Manager, Chief Medical Officer (Executive Sponsor), Behavioral Health Director, Chief Information Officer, IT Project POC, Chief of Peer Services, Evaluation Lead, Privacy SME, IT Security SME, Harbor UCLA Clinical Champion, Public Information Officer, Additional DMH staff/SMEs, as needed	All other pilots were placed on hold due to COVID • MindLAMP: Chief Information Officer, IT Project POC, Harbor UCLA Clinical Champions, DBT Project Liaison, Evaluation Advisory Board Member
Target Audience	• Transitional age youth and college students • County employees • Complex needs individuals (i.e., those with multiple and repeated hospitalizations) • Individuals and family members uncomfortable accessing community mental health services seeking de-stigmatized care and supports for well-being • Existing mental health clients seeking additional support or seeking care/support in a non-traditional mental health setting	• All Los Angeles County residents in need of support due to COVID • County employees • Existing mental health clients seeking additional support or seeking care/support in a non-traditional mental health setting	• All Los Angeles County residents in need of support due to COVID • County employees • Existing mental health clients seeking additional support or seeking care/support in a non-traditional mental health setting	• All Los Angeles County residents in need of support due to COVID • County employees • Existing mental health clients seeking additional support or seeking care/support in a non-traditional mental health setting
Products in Use/Planned	• Headspace (planned) • Modified Mindstrong Health App • CredibleMind (projected for pilot) • Uniper (projected for pilot) • MindLAMP (projected for pilot)	• Headspace for COVID-19 response made available • Modified Mindstrong Health App	• Headspace for COVID-19 response continued • Began transition from Mindstrong Health App to MindLAMP (diary cards)	• Headspace for COVID-19 response continued • Continued transition from Mindstrong Health App to MindLAMP (diary cards)
Implementation Approach	• Headspace for current DBT clients (possible COVID-19 response) • Headspace for individuals visiting the DMH Peer Resource Center • CredibleMind for isolated populations at higher risk for more serious complications from COVID-19 • Uniper for current DMH clients in the GENESIS outpatient program for older adults • Uniper for current older adult clients with internet access enrolled in the Telecare Los Angeles Older Adults (LAOA) Full Service Partnership (FSP) program • MindLAMP for clients in Harbor UCLA DBT program	• Headspace for COVID-19 response made available to all county residents • MindLAMP for clients in Harbor UCLA DBT program • Headspace for individuals visiting the DMH Peer Resource Center	• Headspace for COVID-19 response, available for all LA County residents • MindLAMP for clients in DBT programs in LA County, in development	• Headspace for COVID-19 response, available for all LA County residents • MindLAMP for clients in DBT programs in LA County, in development

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Los Angeles County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Other Unique Qualities (of target audience, implementation, or other program aspect)	• LAC DMH is exploring how to use apps and platforms that have already gone through internal review to meet the increased needs of those impacted by COVID-19 (COVID-19 response)	• Rapid deployment, without pilot process, of Headspace to meet the increased needs of the community due to COVID-19 • Streamlined all DMH communications to ensure community is aware of resources available	• Transition in progress to use MindLAMP to meet the increased needs of clients receiving DBT • MindLAMP is a unique open source solution • MindLAMP is developing a Digital Diary Card for LACDMH • DMH is developing the technical infrastructure to host MindLAMP within LACDMH's IT ecosystem via Microsoft Azure	• Transition in progress to use MindLAMP to meet the increased needs of clients receiving DBT • MindLAMP is a unique open source solution • MindLAMP is developing a Digital Diary Card for LACDMH • MindLAMP is translated into Spanish • DMH is developing the technical infrastructure to host MindLAMP within LACDMH's IT ecosystem via Microsoft Azure
Milestones	• Continued development and refinement of pilot proposal documents • Coordinated calls between vendors, LAC IT security, LAC program leads, and CalMHSA to get questions answered • Began evaluation planning and proposal refinement with UCI and CalMHSA • Learning collaborative at PRC: Discussion for the Development of a Guide to Wellbeing app guide • Development of Painted Brain App Evaluation Matrix • Finalized Guide to Wellbeing app guide and shared with the Help@Hand Collaborative • Gathered free resources offered in response to COVID-19 and shared with the Help@Hand Collaborative • Created a dynamic QR code for app guide • Presented pilot plans to Help@Hand leadership group (all pilots approved by Collaborative) • Development of Digital Health Literacy Modules by Painted Brain and associated DMH review • Headspace presentation at Countywide Supervisors Forum • Headspace on-site meeting: Getting started with Headspace with Tom Freeman, Engagement Manager • Development of request for information (RFI) Screening Tool w/ Monterey County • Participated in Help@Hand Language/Monolingual Working Group • Clinical Peer Review Presentation for the Quality, Outcomes and Training Division: Resources to help Deaf, Hard of Hearing, Blind and Physically Disabled Populations access and use Assistive Technology • Updated Help@Hand LA Charter and committee structure • Collaborated with UCI to develop the Community College students digital mental health baseline needs assessment	• The Leadership Committee reviewed and approved three pilot proposals from LA County on April 9th, 2020 • Headspace Plus subscription made available to all Los Angeles County residents as part of COVID rapid response in early May • Updated Peer-developed Digital Mental Health Literacy Modules to adapt for virtual training sessions • Engaged in the development of specific modules of digital health literacy curriculum and training to include telehealth etiquette and use of selected DMH telehealth platform (Vsee) by Peers • Held Digital Mental Health Literacy virtual trainings for Service extenders, Community Health Workers, and Peers champion • Translated Guide to Wellbeing app guide to Spanish and disseminated to the Help@Hand Collaborative • Various outreach and communication efforts to increase awareness and engagement with Headspace and the Guide to Wellbeing Apps • LACDMH LE provider completed interview on Apps to Support Wellbeing at Compton Pride	• Held Digital Mental Health Literacy virtual trainings for Service extenders, Community Health Workers, and Peers champion. Virtual trainings included Telehealth connection and support training for the peer champions • Held office hours to provide support and technical assistance for Service extenders, Community Health Workers, Peer Resource Center staff, and Peer champions • Presentation at 8/20 Peer Lead Collaboration meeting: Painted Brain: Peer roles in Telehealth	
Lessons Learned				
Recommendations				

Marin County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	• Chandrika Zager, LCSW MPH • Lorraine Wilson, MSW	• Chandrika Zager, LCSW MPH • Lorraine Wilson, MSW	• Chandrika Zager, LCSW MPH	• Chandrika Zager, LCSW MPH • Lorraine Wilson, MSW
Implementation Site	• Not applicable	• Not applicable	• Not applicable – working through partner CBOs	• Not applicable – working through partner CBOs
Team Composition	• Behavioral Health Director, Peer, MHSA Coordinator, Tech Lead	• Behavioral Health Director, Peer, MHSA Coordinator, Tech Lead	• Behavioral Health Director, MHSA Coordinator, Tech Lead, Peer Lead	• Behavioral Health Director, MHSA Coordinator, Tech Lead, Peer Lead
Target Audience	• Older Adults (particularly those who are isolated)	• Older Adults (particularly those who are isolated)	• Older Adults (particularly those who are isolated)	• Older Adults (particularly those who are isolated)
Products in Use/Planned	• Uniper (Testing) • myStrength (Testing) • Happify (Testing) • Wysa (Testing)	• Uniper • myStrength	• Uniper • myStrength	• myStrength
Implementation Approach	• TBD	• TBD	• In development	• Coordinated partnership with Telehealth Nurse Interns – blend of home visiting and virtual support
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Builds an intergenerational component (planned) • Obtain stakeholder feedback through online venues (COVID-19 response); will require both group and individual coaching and a much more drawn out process	• Virtual Focus Groups (200 hours, 12 participants) • All data gathered remotely – Zoom, Doodle, Online Surveys, DocuSign	• Concurrent dual pilots planned • Piloting both apps with monolingual Spanish-speaking population	• Piloting myStrength with English and monolingual Spanish-speaking population. Digital literacy is a major focus of the pre-pilot launch.
Milestones	• Business Advisory Committee established and will hold first meeting 4/16 • Identified two groups of stakeholder testers (congregation of older adults and peers) • Request for proposal issued to identify a trainer experienced with older adults to assist with digital literacy training • Recruitment is underway to hire a Peer for the project	• Advisory Committee met 4 times and helped recruit focus group members, outline outreach plan, and shared additional considerations for local evaluation • Tech4Life hired – contractor experienced in remote coaching in use of tech for older adults • Peer recruitment – Anticipated start mid-late August	• Peer Lead hired and onboarded • Dual pilot proposal approved by compliance, county counsel, and IT	• Telehealth Equity Partnership formalized which bring in university nurse interns to provide intergenerational in-home and virtual support • Training plans for partners developed and digital literacy curriculum and training formalized • Pilot preparation completed and approved • Intern training manual developed • Established online system for enrolling community members through CBOs
Lessons Learned	• Increasing digital literacy during a pandemic with a target population where more than 50% do not have devices and many require internet requires a significant investment of staff resources and logistical coordination to overcome. IT direct tech support would have dramatically enhanced efficiency of Help@Hand staff, allowing them to focus on program logistics rather than technical aspects of the project, such as configuring devices and establishing G-mail accounts. • Establishing tech accounts on behalf of participants requires careful consideration and legal agreements that would be enhanced/ simplified with coordinated tech support – Google Work Space • County systems are not accustomed to flexibly responding to technology needs of residents – how do we design systems from an equity lens when it involves purchasing equipment for residents or supporting internet? Payment systems don't align with program needs. • Partnerships are key to add capacity needed to reach isolated populations • Outreach for individuals who are isolated and monolingual speakers require targeted strategies – finding the partners who know where they are in the community; for Spanish Speaking population, despite multiple outreach strategies, the only one that led to participants enrolling were through Promotores who are out talking to people (YouTube, texts with IHSS and other strategies did not yield results). For English Speakers, 2 CBOs identified all participants in a very short period of time. Knowing the target audience was critical. • Defining "Isolation" is a complex concept to define in a pandemic and cultural considerations need to be considered • Use of University interns to work in small County is key to providing a labor force to engage isolate populations where Peer workforce is part time – if population had tech experience, project would be tremendously simplified (majority of resource intensity is onboarding participants to tech so that they can use an app/device) • Balancing varying system requirements of multiple partners is time intensive (e.g., onboarding interns, compliance, legal, training). Being clear on where decision making resides up front is important. • Collaborating across multiple agencies (7 County Departments-- IT, Compliance, HR Volunteer Coord., County Counsel, Aging and Adult Services, BHRS, Fiscal; two CBOs- Tech4Life and West Marin Senior Services; Two Universities, CalMHSA and UCI as well as Promotores requires lots of planning, coordination and communication; deadlines need to factor in the needs of multiple partners and approval processes. • Multiple legal agreements were required to onboard participants, involving remote acceptance of Google Terms and Privacy Policies, Help@Hand Participation Agreements and Device Use Agreements, all of which needed combinations of IT, Compliance and County Counsel approval. • Using data to find out where your population resides (Census and other key agencies like IHSS was key).			

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Marin County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Lessons Learned	• The field of digital behavioral health appears to not have experience responding in depth to issues of language and culture. Products are rolled out to Spanish Speakers are lacking in some critical areas. • Flexibility and creativity of research team were instrumental in influencing project design and in supporting data gathering for populations that are unable to access technology on the front -end. • New limitations of Spanish functionality of myStrength identified (no privacy practices or terms of service in Spanish) • Logistics of reaching older adults in Covid are complex – how to get sign off on release of information for those with no digital literacy? • Reaching the Spanish Speaking population requires more individualized approach – traditional flyers are not enough; one-on-one communication and outreach is necessary • County system not experienced/designed to administratively do things like pay for internet (limited-term for pilot) Processes need to be memorialized. • Only two nurse interns speak Spanish, leaving staffing challenges to work with those participants who need assistance in Spanish			
Recommendations	• Since additional IT support is necessary, establishing a technical support agreement with HHS IT and/or budgeting for and bringing on contracted IT support would help to accommodate project support needs. • Design future project timelines and goals to align better with staffing structure.			

Modoc County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	• Rhonda Bandy, PhD	• Rhonda Bandy, PhD	• Rhonda Bandy, PhD	• Rhonda Bandy, PhD
Implementation Site	• Modoc County Behavioral Health (MCBH)	• Modoc County Behavioral Health (MCBH)	• Modoc County Behavioral Health (MCBH)	• Modoc County Behavioral Health (MCBH)
Team Composition	• MCBH Branch Director, MCBH MHSA Coordinator, Behavioral Health Specialist	• MCBH Branch Director, MCBH MHSA Coordinator, Behavioral Health Specialist	• MCBH Branch Director, MCBH MHSA Coordinator, Behavioral Health Specialist, Peers, Health Services IT	• MCBH Branch Director, MCBH MHSA Coordinator, Behavioral Health Specialist, Peers, Health Services IT
Target Audience	• Current clients • County residents	• Current clients • County residents	• Current clients • County residents	• Current clients • County residents
Products in Use/Planned	• DBT Diary Cards from Mindstrong (tentative) • Apps vetted by other Counties that Modoc chooses off the bench (planned)	• Apps vetted by other Counties that Modoc chooses off the bench (planned)	• Waiting for apps vetted by other Counties that Modoc will choose off the bench • Appy Hours training is beginning to be translated into Spanish by local peer due to process taking too long through H@H administrative coordination. If the translation arrives before we are finished, we'll be happy to use it, especially since we are paying money through the collaborative for the translation	• None
Implementation Approach	• None until apps available on bench • Starting up Appy Hours for Digital Literacy Training in preparation for app implementation	• None until apps available on bench • Appy Hours for Digital Literacy Training on hold due to COVID-19 in preparation for app implementation	• None, stakeholders expressing impatience • Appy Hours for Digital Literacy Training on hold due to COVID-19	• None
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Phones not offered until apps are implemented	• Phones not offered until apps are implemented	• None	• None
Milestones	• Developed Appy Hours	• None this quarter due to COVID-19	• None, can't move forward until all paperwork is completed by other counties and approved by CalMHSA and H@H Leadership	• Gave notice to exit from H@H April 7, 2021.
Lessons Learned	• Stakeholder's patience has limits, especially when they view an INN as an expensive endeavor and are not seeing any tangible benefits.			
Recommendations	• Unencumber the app pilot processes so change can happen. Address leadership issues at CalMHSA. Finalize contracts around budgetary items, such as evaluation, etc.			

Mono County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	• Amanda Greenberg, MPH • Stephany Valadez	• Amanda Greenberg, MPH • Stephany Valadez	• Amanda Greenberg, MPH • Stephany Valadez	• Amanda Greenberg, MPH • Stephany Valadez
Implementation Site	• TBD	• TBD	• TBD	• TBD
Team Composition	• Behavioral Health Program Manager, Behavioral Health Services Coordinator	• Behavioral Health Program Manager, Behavioral Health Services Coordinator	• Behavioral Health Program Manager, Behavioral Health Services Coordinator	• Behavioral Health Program Manager, Behavioral Health Services Coordinator
Target Audience	• Individuals in remote, isolated areas of the County who have less access to social support and mental health services • Students attending Cerro Coso Community College in Mammoth Lakes	• Individuals in remote, isolated areas of the County who have less access to social support and mental health services • Students attending Cerro Coso Community College in Mammoth Lakes	• Individuals in remote, isolated areas of the County who have less access to social support and mental health services • Students attending Cerro Coso Community College in Mammoth Lakes	• Individuals in remote, isolated areas of the County who have less access to social support and mental health services • Students attending Cerro Coso Community College in Mammoth Lakes
Products in Use/Planned	• TBD (awaiting larger County/City pilots to be completed)	• TBD (awaiting larger county/city pilots to be completed)	• TBD (awaiting larger county/city pilots to be completed)	• TBD (awaiting larger county/city pilots to be completed)
Implementation Approach	• TBD (awaiting larger County/City pilots to be completed)	• TBD (awaiting larger county/city pilots to be completed)	• TBD (awaiting larger county/city pilots to be completed)	• TBD – considering "ready-made", out of the box, implementation specific products
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Mono County is very small, remote and rural, so we will have some challenges around implementation in our outlying areas	• Mono County is very small, remote and rural, so we will have some challenges around implementation in our outlying areas	• Mono County is very small, remote and rural, so we will have some challenges around implementation in our outlying areas	• Mono County is very small, remote and rural, so we will have some challenges around implementation in our outlying areas
Milestones	• Awaiting pilots	• Awaiting pilots	• Awaiting pilots • Peer Lead assigned to Project	• Awaiting pilots
Lessons Learned	• As a small county, MCBH asks staff to wear many different hats. One of the lessons learned from being part of this collaborative and other Innovation projects is that MCBH needs to ensure that staff assigned to lead certain projects have the capacity to do so. If they do not, then MCBH needs to consider what other staffing/consultants may be needed to take the project forward			
Recommendations	• We appreciate the move toward "ready made" apps.			

Monterey County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	• Wesley Schweikhard	• Same as Q1	• Same as Q1	• Same as Q1
Implementation Site	• Family Member / Friend of an Individual that Experiences a Mental Health Disorder • Individual entering Mental Health Clinic • Community Service Provider conducting outreach activities	• Same as Q1	• Same as Q1	• Same as Q1
Team Composition	• Behavioral Health Director, Tech Lead, Subject Matter Experts (Legal, IT)	• Same as Q1	• New Interim Behavioral Health Director (Lucero Robles)	• Jon Drake, Asst Bureau Chief assisting with procurement process
Target Audience	• Adults • Monolingual Spanish adults	• Same as Q1	• Same as Q1	• Same as Q1
Products in Use/Planned	• Custom build behavioral health screening tool (planned)	• Same as Q1	• Same as Q1	• Same as Q1
Implementation Approach	• Not Applicable	• Not applicable; Focus is on custom development vendor procurement	• Not applicable; Focus is on custom development vendor procurement	• Not applicable; Focus is on custom development vendor procurement
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Developing a custom build product instead of an existing product	• Same as Q1	• Same as Q1	• Same as Q1
Milestones	• Developed and release Request for Information (RFI) requesting feedback from vendor community on development of peer chat screening tool • Began to analyze RFI results	• Completed analysis of RFI results • Began to develop Request for Proposals (RFP), which was informed by RFI results • Began recruiting RFP review panel to include peers/stakeholders, clinical experts, and technology experts	• Same as Q2. RFP release stalled as CalMHSA identifies new county partners to join project. Additional steps also need to be taken to clarify roles and responsibilities of the county, CalMHSA, and vendors during the design/build and implementation phases of the project.	• RFP Released!
Lessons Learned	• County behavioral health staff are generally not familiar with development of technology products. Could have used education on the iterative process from the onset, as the county lacks staff support to monitor/approve the breadth and frequency of deliverables involved.			
Recommendations				

Orange County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	• Sharon Ishikawa, PhD • Flor Yousefian Tehrani, PsyD, LMFT	• Sharon Ishikawa, PhD • Flor Yousefian Tehrani, PsyD, LMFT	• Sharon Ishikawa, PhD • Flor Yousefian Tehrani, PsyD, LMFT	• Sharon Ishikawa, PhD • Flor Yousefian Tehrani, PsyD, LMFT
Implementation Site	• UCI Medical Center • OC Community Colleges (initial communications begun to explore interest and feasibility of being implementation sites)	• UCI Medical Center • Community Colleges implementation delayed • Re-started conversations with County-operated programs (PACT, esp. CYBH) about MS implementation	• UCI Medical Center • Continued conversations with County-operated programs (Adult Mental Health) about feasibility of MS implementation • Explored opportunities for MS expansion	• UCI Medical Center • Determined County-operated programs (Adult Mental Health) may not be feasible at this time • Re-started internal discussions about feasibility of MS implementation in Community Colleges • Explored opportunities for MS expansion
Team Composition	• Peer Lead, 2 Peers, Compliance, PIO, AQIS, Cambria (3.5 FTE) to support Mindstrong Launch	• Peer Lead, 2 Peers, Compliance, PIO, AQIS, Cambria (2.5 FTE) to support Mindstrong Launch; 2 HCA INN Staff to support Informed Consent process; re-initiation of discussions with County managers to determine interest in MS (modified model) for their programs	• Peer Lead, 2 Peers, Compliance, Cambria (2.5 FTE) to support Mindstrong implementation; 2 HCA INN Staff to support Informed Consent process • Engaged new vendor, Charitable Ventures for marketing collateral and website	• Peer Lead, 2 Peers, Compliance, Cambria (2.5 FTE) to support Mindstrong implementation; 2 HCA INN Staff to support Informed Consent process, Charitable Ventures to support marketing collateral and website updates
Target Audience	Mindstrong • Adults 18+ • English fluency • Resident of Orange County • Diagnosis of Major Depressive Disorder, Bipolar Disorder, Schizophrenia, or Schizoaffective Disorder • Anxiety disorders, substance use disorders or other co-occurring diagnoses are ok • May have a history of psychiatric hospitalization and/or 1+ crisis evaluations within last 12 months • Device eligibility: owns a smartphone with unlimited data, talk and text • May be expanded depending on research on Lifeline phones and Mindstrong data usage	Mindstrong • Adults 18+ • English fluency • Resident of Orange County • Diagnosis of Major Depressive Disorder, Bipolar Disorder, Schizophrenia, or Schizoaffective Disorder • Anxiety disorders, substance use disorders or other co-occurring diagnoses are ok • May have a history of psychiatric hospitalization and/or 1+ crisis evaluations within last 12 months • Device eligibility: owns a smartphone with unlimited data, talk and text • May be expanded depending on research on Lifeline phones and Mindstrong data usage	Mindstrong • Adults 18+ • English fluency • Resident of Orange County • Diagnosis of Major Depressive Disorder, Bipolar Disorder, Schizophrenia, or Schizoaffective Disorder • Co-occurring anxiety disorders, substance use disorders or other secondary diagnoses are ok as long as a qualifying diagnosis is present • Use of a smartphone (Android 6/iOS 11 or newer) • Internet access: Wi-Fi at home, work, school and/or cellular data plan • Primary user of their smartphone device • Does not currently have a psychotherapist Exclusion Criteria: • Consistent attendance at scheduled psychotherapy sessions provided by a licensed MFT/LCSW/LPCC or intern, or license-waivered clinician • Client only receiving non-clinical ancillary supports (i.e., case management, peer support, housing support, etc.) is **NOT** excluded from this program May be expanded depending on research on Lifeline phones and Mindstrong data usage	Mindstrong • Adults 18+ • English fluency • Resident of Orange County • Diagnosis of Major Depressive Disorder, Bipolar Disorder, Schizophrenia, or Schizoaffective Disorder, Post Traumatic Stress Disorder (PTSD), Obsessive Compulsive Disorder (OCD) • Co-occurring anxiety disorders, substance use disorders or other secondary diagnoses are ok as long as a qualifying diagnosis is present • Use of a smartphone (Android 6/iOS 11 or newer) • Internet access: Wi-Fi at home, work, school and/or cellular data plan • Primary user of their smartphone device Exclusion Criteria: • Does not currently have a psychotherapist • Consistent attendance at scheduled psychotherapy sessions provided by a licensed MFT/LCSW/LPCC or intern, or license-waivered clinician • Client only receiving non-clinical ancillary supports (i.e., case management, peer support, housing support, etc.) is NOT excluded from this program Mindstrong is continuing to explore the expansion of qualifying diagnoses
Products in Use/Planned	• Mindstrong Crisis Prevention Services (Planned)	• Mindstrong Crisis Prevention Services (In Use as part of soft launch)	• Mindstrong Crisis Prevention Services (In Use as part of soft launch)	• Mindstrong Health
Implementation Approach	• Mindstrong (Not in use yet)	• Mindstrong launched May 14, 2020	• Expanded Mindstrong referring providers at UCI Medical Outpatient Psychiatry to include residents • Revisited Mindstrong eligibility criteria to ensure appropriate referrals (i.e., clarified qualifying diagnoses; defined psychotherapist/psychotherapy)	• Started discussions on how to move to a broader marketing approach rather than a case by case referral • Developed digital consent videos to automate HCA informed consent process

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Orange County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
			• Updated HCA Informed Consent document to address Apple/Android privacy alerts • Continued discussions on clarity of continuity of care • Increased emphasis on sustainability planning • UCI Evaluation initiated interviews with referring providers and shared results recommendations with HCA • Several provider recommendations were implemented to improve and streamline the referral process • Established necessary activities to allow Peers to conduct outreach to complete consumer informed consent (smartphone, BAA's, secure emails, FTP site) • Conducted provider training to support full deployment to UCI Psychiatry • OC Peer developed Mindstrong consumer information sheet	• Created an eligibility and referral guide to help providers with referral process • Created physical outreach materials (postcard) to be used when referring providers want to share Mindstrong information with consumers • UCI Evaluation conducted interviews with referring providers and consumers to gather their feedback and perspectives on the referral process and to identify potential areas for improvement • Increased Peer involvement through participation in tech lead calls and development of outreach materials (brochures, flyers, MS video, FAQs)
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Serving individuals regardless of insurance type/status • Creating plan to pilot/test Lifeline phones • Extensive conversations and iterative refinement around informed consent process involving project team, compliance, Peers, UCI Medical, Mindstrong and video production company; including digitization of consent form and creating companion video/audio	• Proposal for Mobile Innovation and Lifeline Testing going through community planning	• Continuous assessment and adjustment of the rapid deployment response	• Evaluated referral flow and numbers and adjusted the process for improvements • Started discussions on feasibility of expanding Mindstrong to different target populations and programs
Milestones	Mindstrong: • Tentative pilot launch at UCI Medical Center in Spring 2020 (depending on impact of COVID-19 public health emergency response) • Implementation planning for Community Colleges, with preliminary soft pilot launch in Fall 2020 (possibly sooner in response to increased need for telehealth support due to impact of COVID-19 on school closures)	• Launched Mindstrong with UCI Medical Outpatient Psychiatry on 5/14/2020 • As of June 30, 2020 (end of Q2) UCI MC/Psychiatry referral statistics indicate: o 2 Referring providers o 16 consumers referred o 10 completed Mindstrong enrollments o 4 consumers could not be contacted by HCA-INN to complete Informed consent. o 2 consumers in-process	• Fully launched at UCI Psychiatry on 9/16/2020 • Streamlined Mindstrong training referral process using an Epic referral order • Contracted with marketing vendor (through CalMHSA) to convert informed consent into video format, convert trifold brochures into webpages and update OC Help@Hand webpages • Referral Statistics provided below table	• Trained Peers in referral/consent process • Began process for converting informed consent into digital format
Lessons Learned	• Communication with vendors, checking in to ensure information, terminology, messaging, and shared vision is accurate and determine appropriate data sharing is transparent • Risk, liability, legal counsel, and crisis response protocols are critical elements to the project and must remain an ongoing priority throughout implementation • Consumers and providers need easy access to County-specific and Help@Hand project information to learn about the product and what to expect • Identify and maintain strategies for effective, transparent communication and decision-making throughout implementation			
Recommendations	• Collaborate and prepare early with key stakeholders to support alignment in approaches, definitions, terminology, etc. and continuously revisit throughout implementation or when considering program expansion • Involve various subject matter experts (compliance, legal, fiscal, contracts, etc.) to support all stages of project implementation • Develop a streamlined process for training providers and project staff about the product to support consistency in communication about the product and with eligible consumers • Maintain ongoing and transparent communication between all project partners • Determine data access and ownership prior to execution of contracts • Actively engage Peers in all project activities • Maintain adaptable strategies and workplans; anticipate shifts and be flexible and prepared for changes • To the extent possible, maintain consistency in project staff for historical knowledge and continuity • Utilize parallel workstreams to more efficiently accomplish project activities			

Riverside County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	Maria Martha Moreno, MS CIS	Maria Martha Moreno, MS CIS	Maria Martha Moreno, MS CIS	Maria Martha Moreno, MS CIS
Implementation Site	• Transitional Age Youth Drop-In Centers (in Mid-County, Desert and Western Regions)	• Riverside County Community, Transitional Age Youth Drop-In Centers (in Mid-County, Desert and Western Regions)	• TakemyHand Live Peer Chat: Riverside County Community Transitional Age Youth (TAY) Drop-In Centers (in Mid-County, Desert and Western Regions), Deaf and Hard of Hearing • A4i or FOCUS: TAY, Adult and Older Adult SMI/ FSP Focus Participants from Western, Desert and Mid-County • Custom App or Existing App (TBD): Deaf and Hard of Hearing.	• TakemyHand Live Peer Chat: Riverside County Community Transitional Age Youth (TAY) Drop-In Centers (in Mid-County, Desert and Western Regions), Deaf and Hard of Hearing • A4i or FOCUS: TAY, Adult and Older Adult SMI/ FSP Focus Participants from Western, Desert and Mid-County • Custom App or Existing App (TBD): Deaf and Hard of Hearing. CODIE Representative team
Team Composition	• Peer Manager, Senior Peer, Peers, Clinical Supervisor, CODIE Representative, crisis intervention Clinicians, Application Developer, Technology Lead	• Peer Manager, Senior Peer, Peers, CODIE Representative, crisis intervention Clinicians, Application Developer, Technology Lead	**Leadership** Mathew Chang, Director Amy McCann, Assistant Director Brandon Jacobs, Deputy Director Research & Quality David Schoelen, MHSA Administrator **IT** Tura Morice, Chief Information Officer Jimmy Tran, Chief Information Security Officer Robert Watson, IT System Administrator **Compliance Officer** Ashley Trevino-Kwong, Compliance Officer **Senior Public Information Specialist** Thomas Peterson **Consumer Affairs Manager** Shannon McCleerey-Hooper **Senior Peer:** Pamela Norton **Peers:** Dakota Brown, Melissa Vasquez, Peter Kiriakos, Rhonda Taiwo, Carmela Gonzalez-Soto. **Social Media:** Dylan Colt Robert Youssef **Senior Clinical Therapist II** Amenze Ogbebor - In recruitment process Evaluation: Suzanna Juarez-Williamson, Supervisor Christy Mota, Research Specialist II.	**Leadership** Mathew Chang, Director Amy McCann, Assistant Director Brandon Jacobs, Deputy Director Research & Quality David Schoelen, MHSA Administrator **IT** Tura Morice, Chief Information Officer Jimmy Tran, Chief Information Security Officer Robert Watson, IT System Administrator **Compliance Officer** Ashley Trevino-Kwong, Compliance Officer **Senior Public Information Specialist** Thomas Peterson **Consumer Affairs Manager** Shannon McCleerey-Hooper **Senior Peer:** Pamela Norton **Peers:** Dakota Brown, Melissa Vasquez, Peter Kiriakos, Rhonda Taiwo, Carmela Gonzalez-Soto. **Social Media:** Dylan Colt Robert Youssef **Senior Clinical Therapist II** Amenze Ogbebor - In recruitment process Evaluation: Suzanna Juarez-Williamson, Supervisor Christy Mota, Research Specialist II.

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Riverside County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
			Application Developer: Rick Wright **Administrative Svc Analyst:** Ursula Lewis **CODIE Representatives:** Gloria Moriarty Lisa Price **Cultural Competency** Tonica Robinson, Manager Consulting Cultural Outreach & Education Workforce	**Application Developer:** Rick Wright **Administrative Svc Analyst:** Ursula Lewis **CODIE Representatives:** Gloria Moriarty Lisa Price **Cultural Competency** Tonica Robinson, Manager Consulting Cultural Outreach & Education Workforce
Target Audience	• Higher Risk Populations (i.e., first onset, re-entry, FSP consumers, eating disorders, suicide prevention) • Traditionally Underserved Communities (i.e., Hispanic/Latino, American Indian, African American, Asian-Pacific Islander, LGBTQ, deaf and hard of hearing) • Geographic service barriers to rural and frontier communities • Hearing and visually impaired communities	**Early Detection:** TAY Suicide Prevention: Men over the age of 45, Adults over the age of 65, TAY **Improve Outcomes for High Risk Populations:** Re-entry Consumers, FSP Consumers, Eating Disorder Consumers **Improve Service Access to Underserved Communities and for Rural Regions:** Deaf and Hard of Hearing, Visually Impaired, Mid-County & Desert Regions, Ethnic Cultural & LGBT communities.	**Early Detection:** TAY ***Suicide Prevention:*** Men over the age of 45, Adults over the age of 65, TAY Improve Outcomes for High Risk Populations: Re-entry Consumers, FSP Consumers, Eating Disorder Consumers ***Improve Service Access to Underserved Communities and for Rural Regions:*** Deaf and Hard of Hearing, Visually Impaired, Mid-County & Desert Regions, Ethnic Cultural & LGBT communities.	**Early Detection:** TAY ***Suicide Prevention:*** Men over the age of 45, Adults over the age of 65, TAY Improve Outcomes for High Risk Populations: Re-entry Consumers, FSP Consumers, Eating Disorder Consumers ***Improve Service Access to Underserved Communities and for Rural Regions:*** Deaf and Hard of Hearing, Visually Impaired, Mid-County & Desert Regions, Ethnic Cultural & LGBT communities.
Products in Use/Planned	• Take My Hand Peer Chat	TakemyHand Peer Chat, A4i, Focus, SageSurfer ManTherapy, FEEL Wearable, custom development for the Deaf and Hard of Hearing community.	TakemyHand Peer Chat, A4i, Focus, Custom development or existing app for the Deaf and Hard of Hearing community, SageSurfer ManTherapy, FEEL Wearable.	TakemyHand Peer Chat, A4i, Custom development or existing app for the Deaf and Hard of Hearing community, SageSurfer ManTherapy, FEEL Wearable, myStrength.
Implementation Approach	• The Take My Hand site will be live during set hours and managed by trained/certified Peer Operators (COVID-19 response)	• Takemyhand Peer chat is available to the Riverside community and promoted within the department via county emails, committees, social media, newsletters, etc. • Currently planning for focus groups with stakeholders, recruitment of consumers in app pilot selection process with three different Full-Service Partnership clinics (Desert, West and Mid-County regions).	• Takemyhand Peer chat is available to the Riverside community and promoted within the department via county emails, committees, social media, newsletters, etc. • Currently planning for focus groups with stakeholders, to guide the selection of additional apps for piloting. The stakeholders are under recruitment among consumers in three different Full-Service Partnership programs (Desert, West and Mid-County regions) and may include youth at the TAY centers.	• Takemyhand Peer chat is available to the Riverside community and promoted within the department via county emails, committees, social media, newsletters, etc. • Pilot A4i - Consumers in Full-Service Partnership programs (Desert, West and Mid-County regions) • Phase 1 Takemyhand Peer chat Transitional Age Youth. • DMHL – Painted Brain, Senior Peer Support Specialists and regional ambassadors' department-wide.
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Piloting own in-house product • Make Peers available on the app 24/7 (Planned) • The peer chat is based on the peer model and people will communicate with a real person; not Artificial Intelligence • Chat is anonymous and does not collect and/or store PII or PHI	Outreach and Education/Training provided by Peer Manager, Senior Peer, Peers, Supervising CT and Tech Lead. Regular collaboration feedback/updates to stakeholders committees/Meetings: Adult System of Care Committee, Behavioral Health Commission, Housing Committee, Cultural Competency Reducing Disparities, Committee, Older Adults System of Care Committee, Riverside Resilience	Outreach and Education/Training provided by Peer Manager, Senior Peer, Peers, Tech Lead. Regular collaboration feedback/updates to stakeholders Committees/Meetings: • FSP Committee – Melissa, Dakota, Martha • Adult System of Care Committee – Melissa • Behavioral Health Commission – Martha, Pamela, Melissa • Center on Deafness Inland Empire – Dakota	Outreach and Education/Training provided by Peer Manager, Senior Peer, Peers, Tech Lead. Regular collaboration feedback/updates to stakeholders Committees/Meetings: • FSP Committee – Melissa, Dakota, Martha • Adult System of Care Committee – Melissa • Behavioral Health Commission – Martha, Pamela, Melissa • Center on Deafness Inland Empire – Dakota

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Riverside County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
		community, TAY Collaborative– Desert, Mid, and Western, IEHP **Plan to collaborate:** Children's Committee meetings Criminal Justice Committee Desert Regional Board Eating Disorder Collaborative Inland Empire Kindness Campaign Mid County Regional Board Model Deaf Community Committee NAMI San Jacinto Promotores Asian American Task Force LGBT PEI Specialized Ethnic Community Initiatives programs	• Children's Committee – Melissa • Cultural Competency Reducing Disparities Committee – Martha, Pamela Melissa • Desert Regional Board meetings – Dakota • Eating Disorder Collaborative meetings – Dakota • Legislative Committee – Melissa • Mid County Regional Board meetings – Melissa • Model Deaf Community Committee – Dakota, Pamela, Martha, Shannon • NAMI San Jacinto meetings – Martha • Older Adults System of Care Committee – Dakota • TAY Collaborative meetings: Desert, Mid, and Western – Melissa, Dakota • Housing Committee – Dakota • Veterans Committee – Dakota • Riverside Resilience community meetings – TBD • May is Mental Health Month Fairs- Western & Mid County – TBD • Criminal Justice Committee – TBD • Inland Empire Kindness Campaign meetings – TBD	• Children's Committee – Melissa • Cultural Competency Reducing Disparities Committee – Martha, Pamela Melissa • Desert Regional Board meetings – Dakota • Eating Disorder Collaborative meetings – Dakota • Legislative Committee – Melissa • Mid County Regional Board meetings – Melissa • Model Deaf Community Committee – Dakota, Pamela, Martha, Shannon • NAMI San Jacinto meetings – Martha • Older Adults System of Care Committee – Dakota • TAY Collaborative meetings: Desert, Mid, and Western – Melissa, Dakota • Housing Committee – Dakota • Veterans Committee – Dakota • Riverside Resilience community meetings – TBD • May is Mental Health Month Fairs- Western & Mid County – TBD • Criminal Justice Committee – TBD • Inland Empire Kindness Campaign meetings – TBD
Milestones	**Compliance:** • Terms of Service – Approved by Riverside Help@Hand team (Technical lead, Clinical lead, Peer lead, Senior Peer, Evaluation Supervisor), HIPAA Compliance Officer and County Counsel • Chat engine software (LiveChatInc) approved by County IT, Department IT, HIPAA Compliance Officer, and Executive Team **Technical:** • Completed chat platform • Accomplished user testing for prototype on two different occasions and feedback was provided • Developed app to be able to identify a crisis situation and transfer chat to CT (a professional with specialized training) • Defined and set useful chat tags for reporting purposes (in various operators groups) • Made site searchable by Google • Made Live Chat Security HIPAA-compliant by disabling the ability to email a chat transcript, the ability to send files (Peer Opera- tor/Visitors), hiding chat history from visitors, inactivity timeouts, etc. • Made Operator passwords are managed by Take my Hand site administrators • Made authentication via LiveChat (no IP restriction) • Chat routing manual (visitors are picked from the queue) • Useful Links on Take my Hand website (i.e., Resources, Terms of Service)	**Technical:** • Defined and set useful chat tags for reporting purposes (in various Peer Operators groups) • Made TMH website searchable by Google • Management of Peer Operator user accounts and passwords • Authentication via LiveChat (no IP restriction) • Configuration of chat routing manual (visitors are picked from the queue) • Multiple Changes in Pre-Post, crisis and 1st time visitors (English/Spanish) Chat online surveys • Peer Operators TMH groups (Riverside, Riverside Crisis, Riverside 1st time visitors, Riverside Spanish, Riverside Spanish 1st time visitors) setup and configuration • April 27 through May 27, 2020- Website Visits 94,861, Unique TMH Website Visitors: 2,867 • June 5th through July 5th - Website Visits 63,355, Unique TMH Website Visitors: 2,963. • Website Metrics – need to license the software to be able to report on entire testing period. • Identified technical functionality to tag "trolls", inappropriate language chat users, and ability to ban users via the Ban User button • Complexity of the data files Structure of chats statistics files • Create and post Cookie Policy ((English/Spanish) • Notice of Privacy Practices (posted) • Frequently Asked questions webpage • Images management	**Pilot Needs Assessment Planning/Implementation Activities:** Deaf and Hard of Hearing Needs Assessment session 1 completed. Deaf and Hard of Hearing Community Survey planning initiated. **Personnel:** • Peer Recruitment - 3 new Peer trainees - Completed • Sr. CT Recruitment - 1 - Completed **Technical:** • TakemyHand Website Content Management system (FAQs, Resources, widgets, etc.) – WIP • TakemyHand Sandbox website/Chat engine. Successful tested video, language translator, chatbot and rich language chat content • TechSuite Electronic Health Records new service codes for staff time accounting **Marketing:** TakemyHand Promotional videos • TakemyHand Quick Info: https://www.youtube.com/watch?v=kweG5pZBndA • Dakota: https://www.youtube.com/watch?v=TJD-j4YuoKM&feature=youtu.be • Melissa: https://www.youtube.com/watch?v=Hqjf8sHaYq8&feature=youtu.be	**Target Area:** Improve Service Access to Underserved Communities Population: Deaf and Hard of Hearing • Focus Group - CODIE Members • Needs Community Assessment Survey • Contract Justification Completed with Sorenson for Services (Adaptation of the 10 DMHL Videos, Curriculum, Community Survey, TMH Peer Operator training, TMH Terms of Service) • Deaf and Hard of Hearing (Focus Group) Needs Assessment Learning Update Report (UCI) **Technology**: • Mobile Devices/Kiosks - Contract Justification Completed • Procurement of 400 devices (100 iPads, 100 iPhones, 100 Galaxy Tab A, 100 Android Phones) - completed • IT Services and Support - Contract Justification Completed • SOW Jaguar Computer Systems -Reviewed/Completed • Contract IT Services & Support -Jaguar - Initiated • GIM - Kiosk procurement Process- 32 small kiosks, 7 (55") Large kiosks - Initiated • Kiosk Uses/Features Summary **Take my Hand Peer Chat** **Target Area:** Improve Service Access to Underserved Communities

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Riverside County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
	• Website content is 90 percent complete in English • Website loads testing reports (test 3 response times TakeMyHand.com, test 3 transaction throughout TakeMyHand.com) • Creating website content in Spanish (in process) • Cookie Policy (in process) **Training:** • Developed training materials for Peer Operators (Peer Operator training checklist, training for COVID-19, facilitator's manual for COVID-19, Peer Operator, training PPT script only, print-up manual for Peer Operator COVID-19). This includes a module on strategies to deal with "trolls", inappropriate language and situational challenges from malicious participants. • Scenario role-plays and a brainstorming solution session is included • Provided protocols for risk assessment and crisis protocols (Risk assessment, Questions-to-Assess-Suicide-Risk Handout, Essential Workers Support Line Protocol and Procedure) • Consumer resources; Riverside Free App guides (English/Spanish), County Resources (Resources Quick Link on Take my Hand website). • Quick list of crisis phone numbers, MS Teams, email, phone, etc. for internal communications among chat operators • Chat coverage work schedules • Identified protocols for tagging "trolls", inappropriate language chat users, and ability to ban users via the Ban User button • Canned responses • Established work hours • Developed strategy to deal with trolls and visitors using inappropriate language by banning them • Developed pre chat survey, post chat survey, post crisis chat survey, and first time visitors post chat survey **Marketing:** • Done by word of mouth, via a banner on the department website, and video presentation of product on departments' Facebook, YouTube page, etc. • Have internal department and stakeholders' newsletter (in process) **Evaluation:** • Developed internal evaluation plan (Evaluation Plan Tech Suite; Surveys (User Survey – post chat survey for participants in English/Spanish, After X number of chats – User Survey (Usability) in English/Spanish, Peer User Operator Survey, Clinician Operator Survey, Innovation Demographics in English/Spanish)	• Website design, development and content management took place as we implemented the test phase. • Website Spanish translations and design of the TakemyHand was implemented three weeks into the testing phase • Define useful Links on Take my Hand website (i.e., Resources, FAQs, Privacy Practices, Terms of Service, About Us, etc.) • Manage website content (English/Spanish) • Design of dynamic widgets (English/Spanish) • Design of content management website tool • TMH Website Load Testing Reports -Response times/Transaction throughout • TMH Capacity Framing –Full scale testing- scales automatically based on volume, performance improved to 1,000 entries requests per second. • 2-Tiers – Chat features in LiveChat engine –AWS/Web hosted Whois. • ELMR setup/training: special population /scheduling calendar site, service codes, staff member hours and exceptions • Export of chat data files: Total chats, Peer Operators Performance, chat duration, chat rating, chat availability, chat engagement, chat response time, missed chats, tags usage, chat waiting time, chat abandonment, pre and post chat surveys for all groups (English/Spanish, 1st time visitors, & crisis) **Marketing:** • All Hands on Deck Newsletters • ChatVox Weekly Bulletin for Operators • TakemyHand One Page Conversation Handouts for Clinics/Consumers • YouTube TakemyHand Promotional videos o Shannon McCleerey-Hooper: https://youtu.be/UZXfnqoX-2E o Shannon McCleerey-Hooper: https://youtu.be/tb9ilc26oPg o Maria Martha Moreno: https://youtu.be/9Ht94xAPNdc o Pamela Norton: https://losangeles.cbslocal.com/video/program/1430/4540496-website-provides-mental-health-support/ **Training:** Training Materials were adjusted/improved as the needed. **Peer Operators:** • One-on-One Virtual Peer Chat: A Training Manual for Peer Operators	• Alex: https://www.youtube.com/watch?v=G5e0MnRJLxs&feature=youtu.be **Training Materials:** TakemyHand Peer Chat • Getting up to speed on Rise & Storyline (trainings) and training Peers in other departments • Brainstorming out-of-the-box engagement strategies and "how to make recovery irresistible" • Create & deliver Storyline TakemyHand A.I. Waiting Room presentation "Waiting for a Peer Chat Operator: The Consumer Experience" • Update promotional materials to reflect new, shorter, TakemyHand Operator Hours • Resources Materials (Peter) *Deaf and Hard of Hearing* • Create & deliver Storyline Deaf/HOH app presentation, "Gloria Possibilities" • Resources Information Gathering (Carmela) *Digital Mental Health Literacy* • Digital FootPrints: https://360.articulate.com/review/content/d9535ce9-49c6-4c67-a07d-17ea85f8cca7/review • Adapting DMHL to virtual presentation (part 1 approaching completion; part 2 will be next quarter) • Create QR Code narrated PowerPoint module for DMHL *Other Training* • Testing out the Focus & A4i apps via test accounts • Continuing to crawl the internet for new MH apps and setting up test accounts with likely candidates • Update Free app guide to delete Freemium apps and insert new free ones, like "UCLA Mindful" • A4i vs. FOCUS in preparation for focus group PowerPoint presentation: https://rise.articulate.com/share/lddMB6DGaUkNb0E69oH9gTB3Z-kF5ZB3K#/lessons/t7aUhQftE6UKROMRfiZX-g9y_W__Wwf1S **Peer Manager Report finalized and shared.** The report shares the key players, the steps taken and the lessons learned as Riverside University Health System-Behavioral Health (RUHS-BH) worked to rapidly deploy the test phase of the first, ever, live, one-on-one Peer Support web-based chat platform, in response to the COVID-19 pandemic. **EVALUATION:** *Evaluation of TakemyHand testing phase report finalized and shared.*	**Population:** Deaf and Hard of Hearing, Mid-County & Desert Regions, Ethnic Cultural and LGBT • Take my Hand Peer Chat Operation 8 am to 5 pm Monday through Friday • Fulfilled and Implemented Crisis CT Role for Take my Hand • Resources Document List • Take my Hand Peer Operator Online USER GUIDE • Take my Hand INFOGRAPHICS • Take my Hand INFOGRAPHICS - LGBT • Take my Hand WIREFRAME • Take my Hand Security Questions (TMH Website & LIVECHAT Inc.) • Initiated TMH Service Mark (Trademark process) - Initiated process • Peer Operator Training completed for 4 new Peer Support Specialists/One Clinical Therapist • TechSuite Electronic Health Records new service codes for staff time accounting.- add new as needed • IEHP County Programs Liaison I Behavioral Health and Care Management Department- Arlene Ferrer • Take my Hand Newsletter No. 3 December 2020 • Convo Take My Hand flier - English • Convo Take My Hand flier - Spanish • RUHS Social Media - Facebook/Instagram • Peer Staff Development (ongoing) • Coping skills Resource Binder per Topic (WIP) • Articulate tool training to create presentations • Searchable spreadsheet for our resource list (WIP) • Identified need to create fuller Peer/CT Operator Training for TMH. (WIP) • Identified need to train Peer Team regarding emotional response and effective communication in text (WIP) • Help@Hand Learning Brief Riverside County Take My Hand **A4i/FOCUS** **Target Area:** Improve Outcomes for High Risk Populations. **Population:** FSP Consumers" A4i and FOCUS -Four Focus Groups (FSP, TAY, Adult, Older Adult) - 22 consumer participants • Tested & Explored A4i and FOCUS apps • Focus Group -fliers • Focus Group Recruitment Activities • Apps Focus Groups Presentation - Distributed and presented Executive Team/Managers/Supervisors • A4i vs FOCUS Articulate online presentation • Recruit and Assist with Focus Group Registration Process

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Riverside County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
		• Creating a Conversation: Addressing Distress in Peer Support • Open-ended Questions Quick Reference Handout • TMH Facilitator's Manual for Peer Ops COVID • TMH Peer Operator CheckList • Crisis Clinical Staff • Crisis SoC Protocols - Community Response Triage TMH • Essential Workers Support Line Protocol and Procedure TMH **Peer Manager Report:** The report will share the key players, the steps taken and the lessons learned as Riverside University Health System-Behavioral Health (RUHS-BH) worked to rapidly deploy the test phase of the first, ever, live, one-on-one Peer Support web-based chat platform, in response to the COVID-19 pandemic. **Evaluation:** A multi-tiered approach to examine various level of functionality, user experience and impact. The testing phase evaluation will focus on the following goals: 1). Test product acceptance and usability with real chat participants; 2). Gather information on Chat participant experience; 3). Gather information on Peer and CT Operator's Experience and Training • Chat Statistics • Total chats, • Peer Operators Performance • Chat duration • Chat rating • Chat availability • Chat engagement • Chat response time • Missed chats • Tags usage • Chat waiting time • Chat abandonment • Chat Surveys: pre and post chat surveys (English, Spanish, 1st time visitors, & crisis) • Peer Operators Interviews	A multi-tiered approach to examine various levels of functionality, user experience and impact. The testing phase evaluation focused on the following goals: 1). Test product acceptance and usability with real chat participants; 2). Gather information on Chat participant experience; 3). Gather information on Peer and CT Operator's Experience and Training • Chat Statistics: Total chats; Peer Operators Performance; Chat duration; Chat rating; Chat availability; Chat engagement; Chat response time; Missed chats; Tags usage; Chat waiting time; Chat abandonment • Chat Surveys: Region of County, zip code, acceptance of Terms of Service, post chat satisfaction survey, and demographics collection from first time visitors. • Testing phase report also included qualitative data from UCI focused interviews with peer chat operators • Deaf and Hard of Hearing (DHH) Needs Assessment began including a focus group and survey with community advocates. A broader DHH community survey is under development in collaboration with a lead DHH community advocate, UCI and County Evaluation staff. • Recruitment began for stakeholders to participate in focus groups to assist with app selection for piloting • Draft materials for app selection focus groups were developed including participation agreement, demographics, and tech use survey and focus group questions. Focus Groups Materials • A4i vs. FOCUS • PowerPoint presentation under development to use in focus group presentations to stakeholders • Demographics and tech use survey developed for focus group participants, focus questions for A4i and FOCUS app developed	• A4i vs FOCUS Power Point Presentation • Facilitate Focus Group • Design of Focus Group Registration Google Form • Tracking of final list of Focus Group Participants • Configure 4 iPad Devices to loan to focus group participants • Focus Groups gift baskets for participants - completed • Help@Hand Learning Brief_Riverside County APP Exploration Report (A4i and FOCUS) - Focus Groups (FSP, TAY, Adult, Older Adult) • Data Analysis on Education Level for current FSP TAY Consumers **Digital Mental Health Literacy Training** • Completed Section 1 of DMHL Self-Guided Online Platform version • Started -Section 1 of DMHL facilitator-guided online platform **Reduce stigma associated with mental illness by promoting mental wellness Educate/Outreach/Reduce Stigma/Partnership/ Resources** • Operation Uplift - Medical Center - offering the Take my Hand Peer Chat Resource • LGBT Medical Center -offering the Take my Hand Peer Chat Resource • Suicide Prevention Coalition • Cultural Competency Reducing Disparities Committee • FSP Committee • Behavioral Health Commission • Eating Disorder Collaborative • Tested & Explored free Apps • Riverside Free app guide - English • Riverside Free app guide -Spanish • Rural Communities (Facebook live panel to learn about approaches to reach rural communities in California) • Map -Unincorporated Riverside Communities • Attempted contact and build rapport in order to incorporate Model Deaf Community Committee's perspective in DHoH survey for a fuller community view. • Collecting app information (Android & iOS) from the team to maintain information on free-freemium apps to keep Free App guide up-to-date. • Exploring free to freemium apps (during downtown time)

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Riverside County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Lessons Learned	• **Focus Groups** • **How did you recruit participants for your focus groups, and what were your strategies to communicate with them?** You Voice Counts Fliers, and A4i/Focus PowerPoint Presentations during managers and Quality Improvement Committee meetings, emails to the executive team, department Peer Workforce, Managers and Clinic Supervisors were sent to announce and get help with stakeholders' recruitment. • **What worked well in terms of communicating?** Meetings and A4i and Focus Video presentations. • **What did not work well?** Short timeline in recruiting stakeholders' participants, an extended timeline can allow for verbal promotion via telephone with clinic supervisors and clinic staff meetings. • **What would you do differently next time?** Extend the recruitment timeline and better preparation for the logistics in general (presentation, devices, support staff, incentives, etc.) • **What were your goals and were they clearly defined going into these focus groups?** The goal was for stakeholders to share their thoughts about the two app features (A4i and FOCUS). Main theme was around "Do they find the app feature helpful" and "Does it not interest you at all?" • **Did the focus group achieve those?** Yes. Findings are in the Help@Hand Learning Brief_Riverside County APP Exploration.v5 (UCI Report). • **If they did, what worked well?** Our Peer team participated in providing feedback on the content of the presentation as to ensure recovery language is in use throughout the presentation, survey and one-on-one communication. Peer team was very proactive in working with the focus participant one-on-one to assist with the completion of the pre-focus group survey and in explaining the participation consent. Email and test reminders were sent to participants a day prior and on the day of the focus group. This was key to ensure participants remember their focus group event. In addition, we had a good number of TAY participants that were well informed about existing wellness apps and they were already using some of these apps. • **TakemyHand Live Peer Chat** • Identified need to create fuller Peer/CT Operator Training for TMH. • Identified need to train Peer Team regarding emotional response and effective communication in text. • Coping skills Resource Binder per Topic. • Closing the gap of available mental health Peers for the DHoH population -"Building Peer Leaders" Peer Support Training to a few Gloria-identified CODIE members. Coordinate with CODIE (Gloria) to develop a Peer Training Plan. • **Deaf and Hard of Hearing** • Findings from the first stakeholders meeting were very useful and are a baseline to start drafting user case stories. • To be able to gather more stakeholder representation data, there is the need to implement a DHoH Community needs assessment survey distributed along with an ASL video adaptation featured with Deaf talent that is representative of the Riverside demographic breakdown.			
Recommendations	• **Next steps:** • **Target Area:** Improve Service Access to Underserved Communities • **Population:** Deaf and Hard of Hearing" • Work with Sorenson for the adaptation of the DHoH Community Needs Assessment Survey • Deaf & Hard of Hearing App (custom or existing app) -Continue with identifying needs • "Building Peer Leaders" Peer Support Training to a few Gloria-identified CODIE members. Coordinate with CODIE (Gloria) to develop a Peer Training Plan. • Facilitator's Guide and Student Workbook in preparation to meet with Gloria to discuss the materials, and how we augment them for the DMHL learning. • Coordinate with CODIE (Gloria) to TakemyHand Peer Operators Training Plan -after hired/contracted. • Global transformational advocacy • **Technology** • Deliver devices • Kiosks distribution/install process • Draft policy and procedures for sanitizing the kiosk • Draft policy and procedures for addressing vandalism on kiosks • Research Text to Speech Apps for our Blind Community • **Take my Hand Peer Chat** • **Target Area:** Improve Service Access to Underserved Communities • **Population:** Deaf and Hard of Hearing, Mid-County & Desert Regions, Ethnic Cultural and LGBT" • Take my Hand Peer Chat Terms of Service VIDEO (English/Spanish) • Take my Hand Peer Chat Terms of Service VIDEO (Deaf and Hard of Hearing) -Sorenson • LGBT Take my Hand Riverside Spotlight Report • Peer Staff Development (Ongoing) • Addition of Family Advocate services on TakemyHand Website • Take my Hand Chat Language Translator • Take my Hand Video functionality (DHoH) • TakemyHand Grievance/ End-User Experience feedback form available independently from automated survey after chat close. • Chatbot Functionality for visitors in the queue - (HIPPA compliance)			

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Riverside County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Recommendations	• TakemyHand Mobile app version • Contract RTA/Metrolink - Take my Hand - marketing skin for buses -digital advertising • Service Mark • URL link to California Consumer Privacy Act • IIS Server set up - to store chats data - get approval • Word cloud chat analysis • Dashboard reports configuration • Video stories webpage - marketing/ • Link to Help@Hand website • Automate chat data exports for evaluation • TMH changes/improvements based on stakeholder feedback • Create TakemyHand Product Profile - for Pilot Proposal? • TakemyHand vetting process from other counties - San Francisco • Secure timeline for pilot phase (Riverside Only) - do we need to have a Pilot? • Secure timeline for pilot phase (additional Counties – added in after initial Riverside pilot)- San Francisco • TakemyHand Landing Page- Other Counties - San Francisco county • Coping skills Resource Binder per Topic (WIP) • Articulate tool training to create presentations (ongoing) • Searchable spreadsheet for our resource list (WIP) • Identified need to create fuller Peer/CT Operator Training for TMH. (WIP) • Identified need to train Peer Team regarding emotional response and effective communication in text (WIP) • Press Release - marketing • **A4i** • **Target Area:** Improve Outcomes for High Risk Populations • **Population:** FSP Consumers" • Aim to start A4i App Pilot during this Quarter • Pilot Proposal (see CalMHSA Template) • User Agreement - Consumer - review by county counsel -compliance officer • Informed Consent -Consumer - review by county counsel -compliance officer • Evaluation Planning • App customizations • Trainings • **Marketing** • Digital Mental Health Literacy Training • Start DMHL training with peers who are going in to the hospitals to engage consumers. • Start normalizing DMHL and telehealth services, as well as introduce free wellness applications as a tool for self-support as they transition services. • Started -Section 1 of DMHL facilitator-guided online platform • Painted Brain contract to assist with DMHL training throughout the Department • **Reduce stigma associated with mental illness by promoting mental wellness** • **Educate/Outreach/Reduce Stigma/Partnership/Resources** • Riverside free app guide 123 Approval Process • Work with the Peer Support Specialists doing Navigation to get them primed for the opportunity to do that kind of introduction of apps. FSP Peers/consumers. • Model Deaf Community Committee (MDCC)- (promote community survey, DMHL videos, etc.) • Establish our consulting cultural outreach workforce to reach out to targeted populations about Help@Hand, education, resources and reduction of Mental Health Stigma. (SOW) • Riverside Help@Hand Story Map - prioritize and support Activities in Rural Areas • **Quarter 2 (Apr-May-Jun)** • myStrength • Target Area: LGBT, FSP, Older Adults, TAY, • Population: • Select Apps for other Pilots • Focus Groups: SageSurfer, ManTherapy, FEEL Wearable • **Quarter 3 (Jul-Aug-Sep)** • Distribution of devices acquired through government program.			

Santa Barbara County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	• Lindsay Walter, JD- MHSA • Maria Arteaga, JD- Peer & Ethnic Services • Vanessa Ramos- Help@Hand Project Manager	• Lindsay Walter, JD- MHSA • Maria Arteaga, JD- Peer & Ethnic Services • Vanessa Ramos- Help@Hand Project Manager	• Lindsay Walter, JD- MHSA • Maria Arteaga, JD- Peer & Ethnic Services • Vanessa Ramos- Help@Hand Project Manager	• Lindsay Walter, JD- MHSA • Maria Arteaga, JD- Peer & Ethnic Services • Vanessa Ramos- Help@Hand Project Manager
Implementation Site	• TBD	• On-line for Q2	• TBD	• TBD
Team Composition	• MHSA Chief, Department Peer and Equity Services Manager, Assistant Director, County IT staff, Project Manager, Division Chief of IT, MHSA Coordinator, Regional Tech Ambassadors, Tech-Testers	• Assistant Director; Ethnic Services and Peer Manager; MHSA Chief; Health Care Coordinator- Tech/Peer lead; IT; Help@ Hand peer team; Project Contractor	• Assistant Director; Peer and Ethnic Services Manager; MHSA Chief; Health Care Coordinator-Tech/Peer lead; Help@ Hand peer team; Project Contractor- Painted Brain	• Assistant Director; Peer and Ethnic Services Manager; MHSA Chief; Health Care Coordinator-Tech/Peer lead; Help@ Hand peer team; Project Contractor- Painted Brain
Target Audience	• Individuals age 16 and over living in geographically isolated communities of diverse backgrounds • Transitional aged youth who are students at colleges and universities • Adults discharged from psychiatric hospitals and/or recipients of crisis services	• Individuals age 16 and over living in geographically isolated communities of diverse backgrounds • Transitional aged youth who are students at colleges and universities • Adults discharged from psychiatric hospitals and/or recipients of crisis services	• Individuals age 18 and over living in geographically isolated communities of diverse backgrounds • Transitional aged youth who are students at colleges and universities- 18 and older • Adults discharged from psychiatric hospitals and/or recipients of crisis services	• Individuals age 18 and over living in geographically isolated communities of diverse backgrounds • Transitional aged youth who are students at colleges and universities- 18 and older • Adults discharged from psychiatric hospitals and/or recipients of crisis services
Products in Use/Planned	• Headspace (planned) • Digital Literacy - Needs and Responses from Stakeholder Sessions (planned) • Digital Mental Health Literacy Course from CalMHSA (planned)	• Digital Wellness Ambassadors curriculum- combined digital literacy (Help@Hand/Painted Brain/CalMHSA) • Zoom platform • App guide-mobile application in the brochure	• Digital Wellness Ambassadors curriculum- combined digital literacy (Help@Hand/Painted Brain/CalMHSA) • Zoom platform • Outreach materials created by local Help@Hand team • Mindfulness sessions with Dr. Brock Travis	• Zoom platform • App guides • Appy Hour Templates • Peer Support Group PPTs • Headspace
Implementation Approach	• Headspace with up to 45 people which will include Dept. Clinical Staff/IT Staff/Peer Staff/Tech Testers within each target population/CBO that work with target populations/ MHSA Chief/Peer and Equity Manager/Help@Hand Project Manager/if hired by then Help@Hand Project Outreach Coordinator	• Combine digital literacy to create Digital Wellness Ambassadors materials • Disseminate by providing literacy curriculum throughout clinics; community centers; community-based organizations; adult housing; recovery learning centers; on-line; tbd • Share and provide linkage to low cost laptops/phone and WIFI	• Combine digital literacy to create Digital Wellness Ambassadors materials • Disseminate by providing literacy curriculum throughout clinics; community centers; community-based organizations; adult housing; recovery learning centers; on-line; TBD • Share and provide linkage to low-cost laptops/phone and WiFi	• Increase access to technology devices through sharing acquisition resources • Increase digital literacy through hosting Appy Hours throughout the county through collaboration with community partners • Create normalcy in using wellness apps to support mental wellness such as Headspace through peer led support groups
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Foster diversity within target populations including Spanish/Mixteco speakers and individuals from communities marginalized including LGBTQ+ • Goals for the pilot include adoption of digital wellness tools within the target populations, reduce isolation and loneliness within target populations, reduce negative life events among members of each target population, implementation of digital literacy and men- tal health literacy facilitated through peer employment opportunities and measuring the success of wellness through employment	• Peer driven curriculum is created to meet specific needs of peer community within SB target populations • COVID highlighted the need for technology access within target populations; project will begin to explore low cost laptop within target populations; • The group coordinated a digital Mental Health COVID-19 Campaign to compliment the May Mental Health Awareness including daily motivations and resources for all MH Staff, daily peer groups for community and disclosed peers, and targeted age groups by postcard mailings and chalk art. This was then extended by local peer support partners coordinating zoom daily peer groups whose monthly calendar is sent out digitally by our PIO.	• Digital Wellness Ambassador's will provide warm hand off through engaging BWELL Adult Recipients of Crisis Services/Discharged from PHF in peer-led digital literacy groups at the PHF; connecting clients to Lifeline cell phone; providing warm hand offs after the client discharges while awaiting outpatient services • Digital Wellness Ambassadors will work with Painted Brain to engage TAY enrolled in colleges/universities in hosting Appy Hours Sessions to build Digital Wellness and Digital Empowerment Toolboxes • Digital Wellness Ambassadors will work with Promotoras community to enhance digital literacy for use with mental health education as created by the local promotoras	• Digital Wellness Ambassador engage BeWell Adult Recipients of Crisis Services/Discharged from PHF in peer-led digital literacy groups at the PHF; share resources to the Lifeline cell phone program; provide introduction to the clinic peers who may be working with clients after discharge from the PHF • Digital Wellness Ambassadors will work with Painted Brain to engage TAY enrolled in colleges/universities in developing curriculum supporting using digital tools to support mental wellness • Digital Wellness Ambassadors will work with community to enhance digital literacy of current county application available such as Octopus- the benefits platform created by Social Services
Milestones	• Employment of peers	• Help@Hand peers are now hired through county	• Digital Wellness Ambassadors are working on the	• Help@Hand is facilitating peer-led groups at the

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Santa Barbara County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
	• Engagement with peer agencies • Development of strategies for upcoming pilot • Solidified the need for Digital Literacy and Digital Mental Health Literacy throughout the community • Explored digital wellness tools within the Psychiatric Health Facility connecting to the ongoing Wellness and Recovery Peer-run groups • Identified the need for target population of baseline data	extra-help vs temp agency • Contracted with Painted Brain • Began on-line learning collaboratives with painted brain and Help@Hand peers	creation of the Digital Wellness Handbook where the Digital Wellness Ambassador role is defined and supported through the development of peer-run groups; agendas to be led at the PHF and throughout the target populations including MHSA Housing and Senior Facilities • A guide to Zoom basics is being formulated to ensure that clients at the PHF understand the basics to connecting to tele-health via Zoom platform • Project Manager/Healthcare Coordinator is working through OCM Plan with implementation team • Monthly Action Items are being documented to ensure project's continued progress- see attached	in-patient Psychiatric Health Facility • More than 50 community members have received digital literacy training • Help@Hand project is highlighted quarterly in the Consumer and Family Member Newsletter • Community stakeholders are given updates monthly at different department hosting action team meetings • Help@Hand is working with local research and evaluation team on a Process Improvement Project approved by EQRO that measures the success of clients discharged from the PHF and client's first appointment • Help@Hand has gained community feedback through presentations given at BeWell Action Team meetings and with community-based organizations
Lessons Learned	• Lessons learned- The realization regarding the digital divide that exist within the community. Basic technology needs must be addressed prior to the adaptation of digital tools intended to support mental health needs. The three basic needs we learned about are: 1. Lack of access to digital technology tools 2. Lack of access to WIFI; internet; data plans 3. Lack of digital literacy such as how to download an app, how to update an app for best practices surrounding security • An additional lesson learned we discovered is the resiliency of mental health consumers in Santa Barbara County. For example, Help@Hand project hosted over 100 support groups on ZOOM and several Appy Hours with contracted vendor Painted Brain. The community rallied together and worked amongst each other to help one another learn how to use the call-in feature on ZOOM. Little by little the comfortability of using the ZOOM platform lessoned. Help@Hand collaborated with a local Lifeline vendor to provide smartphones to local community members that qualified. Once the qualifying consumers received phones, consumers then worked with local community-based organization to learn about digital basics.			
Recommendations	• Recommendations are: 1) a robust stakeholder feedback at the beginning of project implementation to continue to better understand and meet the basic needs of the community 2) to respect and honor the learnings found. For example, CalMHSA's Peer Manager visited several counties and met with community stakeholders to better learn about the community needs. The information that was gathered was that the community needed phones, WIFI and to increase digital literacy. Unfortunately, the project was already moving ahead with selection of mobile apps which left a fragmented system of who had access to digital technology, understanding of digital tools and who did not. If the project would have visited counties before beginning the process of the application selection there may have been better programming or focus in connecting consumers with technology devices, WIFI and increasing digital literacy. 3) to utilize peer staff from different counties to support the development and vet the language of materials being created for the larger project such as the website, stakeholder reports etc. This may help the project ensure that the project is peer-led as it was intended.			

San Francisco County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	• Teresa Yu, LMFT	• Teresa Yu, LMFT	• Teresa Yu, LMFT • Meaghan O'Brien, MA	• Teresa Yu, LMFT • Meaghan O'Brien, MA
Implementation Site	• TBD	• TBD	• TBD- currently narrowed down 9 apps (using Product Matrix developed by Help@Hand). Plan to have 10 apps to review and narrow down if Riverside's Peer Chat becomes available for the collaborative to use	• Headspace SOW approved for 10,000 licenses for Jan 1- Dec 1. • Have identified Take my Hand as the app of preference for TAY and Trans-Identified Adults.
Team Composition	• MHSA Director, Peer, MHSA Coordinator, Tech Lead, 2 Finance	• MHSA Interim Director (Tech Lead), Peer/MHSA Peer Services Manager, Finance, BHS • Consultant, Staff and Director from MHASF	• MHSA Interim Director (Tech Lead), Peer/MHSA Peer Services Manager, Finance, BHS • Consultant, Staff and Director from MHASF	• MHSA Interim Director (Tech Lead), Peer/MHSA Peer Services Manager, Finance, BHS Consultant, Staff and Director from MHASF. MHSA Director, SOCs, MHSA Peer Services Manager.
Target Audience	• TBD	• TBD	• App being researched: Community and Mental Health Consumers/family members with a specific focus on TAY and Trans-identified individuals • Headspace: MHA SF clients, mental health system clients • including SRO residents	• App being researched: Community and Mental Health Consumers/family members with a specific focus on TAY and Trans-identified individuals • Headspace: MHA SF clients, mental health system clients including SRO residents and Children, Youth and Families Department.
Products in Use/Planned	• TBD (waiting on approved apps by the Collaborative) • Headspace (the City/County of SF is exploring to possibly pilot for staff. This would add to the populations included in this project	• TBD (waiting on approved apps by the Collaborative and conducting app exploration)	• 9 apps have been narrowed down for continued app exploration • Headspace: 10,000 licenses planned to be added to MHA SF contract for this fiscal year	• Take my Hand • Headspace: 10,000 licenses planned to be added to MHA SF contract for this fiscal year
Implementation Approach	• TBD	• TBD	• TBD	
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Interested in Peer Chat apps available to all, but with a focus on the Transgender and Transitional Age Youth communities	• Interested in Peer Chat apps available to all, but with a focus on the Transgender and Transitional Age Youth communities	• Interested in Peer Chat apps available to all, but with a focus on the Transgender and Transitional Age Youth Communities (TAY) • Peers are concerned with PHI/data consumption while using app	• Exploring Headspace use with CYF (Children, Youth and Families) who are wanting to integrate it with clinical services
Milestones	• Started the City/County's collaboration with Mental Health Association of San Francisco	• Mental Health Association (MHA) has started to participate in Tech Lead and Implementation calls. They are conducting app exploration.	• Establishing a biweekly meeting between SF DPH and MHA SF • MHA SF hiring a Programs Coordinator to heavily support project (10/1 start date) • Developed a Product Matrix of apps that fit SF city/county needs, completed Needs Assessment • Exploring Headspace for SF city/county consumers	• Working on a hiring plan to hire two Peer Navigators to support Programs Coordinator at MHASF • Developing 12-part Digital Literacy Education training series for SF residents to begin 2/2021 • Moving forward with Headspace implementation with SF city and county
Lessons Learned	• Frequent and regular communication between County and CBO and adequate staffing devoted to the project has been key • More involved County/CBO collaboration than other Innovation projects due to complexity and changes with projects • Getting all parties together and more communication: such as between City Attorney and CalMHSA helped ensure clarity with complex County BOS/contracting process			
Recommendations	• Communication and collaboration: see above and also meeting with other counties who are implementing similar projects is very helpful for planning and learning about best practices for implementation			

San Mateo County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	• Doris Estremera, MPH	• Doris Estremera, MPH	• Doris Estremera, MPH	• Doris Estremera, MPH
Implementation Site	• Peninsula Family Service (PFS) • Youth Leadership Institute (YLI)		• Community-based agencies, BHRS clinics, online	• Community-based agencies, BHRS clinics, online
Team Composition	• MHSA Coordinator, Peer Specialist/Peer Support, Contracted Agencies: 1)Youth Leadership Institute (TAY Contractor): Peer Lead/ Program Coordinator, Bilingual-bicultural TAY Peer Lead (Spanish), 2) Peninsula Family Services (PFS): Peer Lead/Program Coordinator, bilingual-bicultural Peer (Spanish/Chinese)	• MHSA Coordinator, Peer Specialist/Peer Support, Contracted Agencies: 1) Youth Leadership Institute (TAY Contractor): Peer Lead/ Program Coordinator, Bilingual-bicultural TAY Peer Lead (Spanish), 2) Peninsula Family Services (PFS): Peer Lead/ Program Coordi- nator, bilingual-bicultural Peer (Spanish/ Chinese)	• MHSA Coordinator • Office of Consumer and Family Affairs: Peer Specialist/Peer Support • Contracted Agencies: 1. Youth Leadership Institute (TAY Contractor): Peer Lead/ Program Coordinator, Bilingual-bicultural TAY Peer Lead (Spanish) 2. Peninsula Family Service (Older Adult Contractor): Peer Lead/ Program Coordinator, bilingual-bicultural Peer (Spanish/ Chinese) 3. California Clubhouse and Heart and Soul: Help@Hand Peer Ambassadors	• MHSA Coordinator • Office of Consumer and Family Affairs: Peer Specialist/Peer Support • Contracted Agencies: 1. Youth Leadership Institute (TAY Contractor): Peer Lead/ Program Coordinator, Bilingual-bicultural TAY Peer Lead (Spanish) 2. Peninsula Family Service (Older Adult Contractor): Peer Lead/ Program Coordinator, .5FTE bilingual-bicultural Peer (Spanish) 3. California Clubhouse and Heart and Soul: Help@Hand Peer Ambassadors 4. Painted Brain: Peers providing digital mental health literacy train-the-trainer for peers and “tech hours” for community at large
Target Audience	• Transitional age youth • Older adults	• Transitional age youth • Older adults	• Transitional age youth (TAY) • Older adults	• Transitional age youth (TAY) • Older adults
Products in Use/Planned	• Happify with older adults (planned) • Remente with transitional age youth (planned)	• Headspace for COVID rapid response, plan to release August/ September 2020 • Selecting new products, considering: o Unipercare, myStrength, Wysa for older adults o Headspace, myStrength, Wysa for transitional age youth	• Headspace for COVID Rapid Response released September 2020 • Selecting new products for pilot, considering: o myStrength, Wysa for older adults o Headspace, myStrength, Wysa for TAY • Painted Brain digital mental health training for peers	• Headspace for COVID Rapid Response released September 2020 • Older Adults and TAY selected Wysa for pilot to launch in February/March 2021
Implementation Approach	• Remente for transitional age youth, YLI Peer Leads and youth ambassadors plan, promote and support the use of the app • Happify for older adults, PFS Peer Leads and older adult ambassadors plan, promote and support use of the app	• Phase 1 – Help@Hand Peer Ambassadors from YLI, PFS and Advisory Committee to promote and support use of all apps (Headspace and additional selections). Peer ambassadors supporting outreach and engagement efforts through appy hours, direct community outreach and additional strategies to be developed. • Phase 2 – California Clubhouse and Heart and Soul (peer-led organizations) Peer Ambassadors to support integration of apps into Behavioral Health and Recovery Services. Strategies to be developed.	• Help@Hand Advisory Committee of local stakeholders continues to meet monthly and provides feedback on appropriate technology to meet the needs of older adults and transition-age youth, consults on the strategies for outreach and engagement, informs project evaluation, supports recruitment of older adults and youth to participate in the exploration and pilot phase of app selection, and serve as ambassadors of Help@Hand • Phase 1 – Help@Hand Peer Ambassadors from YLI, PFS and Advisory Committee promote and support use of all apps (Headspace and additional selections). Peer Ambassadors support outreach and engagement efforts through ‘Appy Hours,’ recruitment of participants in selection of apps and digital mental health literacy • Phase 2 – California Clubhouse and Heart and Soul (peer-led organizations) and BHRS Peer Ambassadors will support integration of apps into Behavioral Health and Recovery Services including	• Help@Hand Advisory Committee of local stakeholders continues to meet monthly and provides feedback on appropriate technology to meet the needs of older adults and transition-age youth, consults on the strategies for outreach and engagement, informs project evaluation, supports recruitment of older adults and youth to participate in the exploration and pilot phase of app selection, and serve as ambassadors of Help@Hand • Phase 1 – Help@Hand Peer Ambassadors from YLI, PFS and Advisory Committee promote and support use of all apps (Headspace and additional selections). Peer Ambassadors support outreach and engagement efforts through ‘Get Appy’ workshops, recruitment of participants in selection of apps and digital mental health literacy. o Further marketing and outreach plans for Headspace response under development. o Pilot proposal for Wysa app under development • Phase 2 –BHRS Peer Ambassadors will support integration of apps into Behavioral Health and

Continued on next page

San Mateo County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
			digital mental health training of clients by peers • Painted Brain is supporting a train-the-trainer for peers and clients will receive devices (cell phone/ tablets) along with digital mental health supports. • Further marketing and outreach plans for Headspace response under development	Recovery Services including digital mental health training of clients by peers o Painted Brain is supporting a train-the-trainer for peers and clients will receive devices (cell phone/ tablets) along with digital mental health supports.
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Help@Hand Advisory Committee of local stakeholders meet monthly since inception (provides feedback on technology features, enhancements and customization to meet the needs of older adults and transition age youth, consults on the strategies for outreach and engagement, informs project evaluation questions and outcomes)	• Using T-Mobile Gov L1 Plan to procure devices for clients. • Using Headspace as a broader response to the San Mateo County community at-large to support for one-year due to COVID	• Leveraged $408,000 of MHSA and CARES Act funding to procure additional federally subsidized devices for clients to use for both Help@Hand and broader telehealth and recovery-oriented services for clients • Using Headspace as a broader response to the San Mateo County community at-large to support for one year due to COVID	• Contracted with Painted Brain to support additional "tech hours" for both Help@Hand implementation and broader racial equity actions due to COVID shelter-in-place • Leveraged $408,000 of MHSA and CARES Act funding to procure additional federally subsidized devices for clients to use for both Help@Hand and broader telehealth and recovery-oriented services for clients • Using Headspace as a broader response to the San Mateo County community at-large to support for one year due to COVID
Milestones	• Conducted focus groups with older adults and youth to learn needs and select the most appropriate apps • Focus groups to support development of digital mental health literacy curriculum • Hosted NorCal Peer Summit • PFS hosting AppyHours, engaging older adults in using technology • YLI developed a Help@Hand specific Youth Advisory Group • Advisory Committee received training on app exploration process to provide more in-depth input on selected apps • Ambassadors and peers participated in Digital Mental Health Literacy Train-the-trainer	• PFS shifted to over-the-phone and online Appy-Hours to continue engaging older adults in using technology. • YLI kicked off online Youth Advisory Group • Successfully procured and distributed 40 free phones to clients and tablets for peer workers to support during COVID • In negotiations with Headspace to provide access to the app for one-year to San Mateo County residents as a response to COVID • Re-started app selection process due to Happify unavailability during COVID and youth needs shifting now that interactions are primarily online. • Worked with UCI to tailor the app selection survey and make it available online	• Engaged 20+ BHRS and community-based agencies' Peer Partners and Family Partners in the distribution of phones to clients, which will include digital mental health literacy training for the clients • Contracted with Painted Brain to provide digital mental health literacy train-the-trainer for Peer/ Family Partners • Launched Headspace access for one-year to San Mateo County residents as a response to COVID	• Selected apps • Expanded "tech hours" to community at large and partnering community-based agency staff • Partnering with other counties on Headspace license sharing, evaluation and marketing
Lessons Learned	• Addressing the digital divide by providing digital literacy supports are needed prior to engagement in any behavioral health technology solution and at various levels including; peer support workers, behavioral health staff across the network of providers, community and clients. • Having explicit communication with stakeholders of "non-negotiables" should be part of the selection of an app. For example, including cultural and language vetting as part of the early focus groups to inform selection of an app.			
Recommendations	• Implement an advisory committee of stakeholders early in the process to vet, consult with, create buy-in and provide direction • Include evaluation lens as part of project planning and process development for all aspects of the project including procurement, selection, piloting and implementation • Include devices and digital literacy as part of the overall solution; including train-the-trainer for peer support workers, and various opportunities for ongoing digital literacy support for clients ("tech hours") and providers (intermediate tech training, e.g. equitable facilitation of groups, telehealth, etc.) • Include opportunities for collaboration with other Help@Hand Counties while honoring local diversity and needs			

Tehama County	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	• Michelle Brousseau • Avery Vilche	• Travis Lyon • Avery Vilche	• Travis Lyon • Avery Vilche	• Travis Lyon • Avery Vilche
Implementation Site	• TBD	• Tehama County	• Tehama County	• Tehama County
Team Composition	• MHSA Coordinator, Tech Leads, Peer, Behavioral Health Director, Staff	• Behavioral Health Director, MHSA Coordinator, Tech Leads, Peer Supervisor, Staff, Peer Advocates	• Behavioral Health Director, MHSA Coordinator, Clinician, Case Manager, 2 Health Educators, Peer Supervisor, 2 Peer Advocates, Health Services Analyst	• Behavioral Health Director, MHSA Coordinator, Clinician, Case Manager, 2 Health Educators, Peer Supervisor, 2 Peer Advocates, Health Services Analyst
Target Audience	• TBD	• Persons who are Homeless or at risk of Homelessness, Geographically Isolated Adults, and TCHSA-BH Consumers	• Persons who are Homeless or at risk of Homelessness • Isolated Individuals • Tehama County Health Services Agency – Behavioral Health (TCHSA-BH) Consumers	• Persons who are Homeless or at risk of Homelessness • Isolated Individuals • Tehama County Health Services Agency – Behavioral Health (TCHSA-BH) Consumers
Products in Use/Planned	• TBD	• myStrength	• myStrength	• myStrength
Implementation Approach	• TBD	• Pilot with 30 people (10 from each Target Audience), Track Progress	• Pilot with 30 people (10 from each Target Audience), Track Progress	• Pilot with 30 people (10 from each Target Audience), Track Progress
Other Unique Qualities (of target audience, implementation, or other program aspect)	• TBD	• TBD	• Using a one-on-one individualized approach with participants linked to Peer Staff and Wellness Advocates	• Using a one-on-one individualized approach with participants linked to Peer Staff and Wellness Advocates
Milestones	• Not applicable	• Not applicable	• Pilot Proposal received budget approval from Collaborative Leadership • Organizational change management (OCM) Plan completed and initiated • Evaluation Plan completed • Vendor Engagement Plan completed	• Evaluation instruments completed • Statement of Work drafted
Lessons Learned	• Time required for processes and approvals • Project requires dedicated resources • OCM is as important as the technology • Strong ad hoc communication between implementation meetings facilitates progress			
Recommendations				

Tri-City	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
Tech Lead	• Toni Robinson • Dana Barford	• Toni Robinson • Dana Barford	• Dana Barford	• Amanda Colt • Dana Barford
Implementation Site	• Transitional Age Youth Wellness Center	• Tri-City Wellness Center	• Tri-City Wellness Center	• Virtual due to COVID-19
Team Composition	• MHSA Coordinator, MHSA Manager, Peer Lead, MHSA Director	• MHSA Manager, MHSA Coordinator, Wellness Advocate Supervisor, Wellness Advocates, Wellness Center Supervisor, Clinicians, MHSA Director, Clinical Director	• MHSA Manager, MHSA Coordinator, Wellness Advocate Supervisor, Wellness Advocates, Wellness Center Supervisor, Clinicians, MHSA Director, Clinical Director	• MHSA Manager, MHSA-Inn Program Coordinator, MHSA Director, Cambria Consultant, Painted Brain Peer Consultant
Target Audience	• Transitional age youth • Older adults • Monolingual Spanish speakers	• For the potential pilot, our target audience has been updated to include: TAY; Older adults; Wellness advocates (peers); FSP clients being monitored by their clinicians	• For the potential pilot, our target audience has been updated to include: TAY; Older adults; Wellness advocates (peers); FSP clients being monitored by their clinicians	• For Implementation, our target populations will be TAY, Older adults, and Monolingual Spanish Speakers
Products in Use/Planned	• Wysa with transitional age youth	• Wysa	• Wysa	• Mindstrong collaboration with Orange County • Headspace or myStrength with CalMHSA
Implementation Approach	• Have a small focus group for pilot to obtain valuable feedback on a biweekly basis	• Twenty users will be recruited to use Wysa for 3 months and will participate in 7 focus groups held biweekly to evaluate Wysa's usability and effectiveness.	• Due to the loss of key staff, the pilot project and related focus groups were placed on temporary hold. However, Tri-City continues to actively participate in all other aspects and activities of this project and the Collaborative	• Due to COVID-19 and turnover of Program Coordinators we have continued to participate in all activities of the collaborative, but implementation of project has been delayed • Currently in discussion with Orange County to join them in the implementation of Mindstrong • Working with CalMHSA to implement either HeadSpace or myStrength with our target populations
Other Unique Qualities (of target audience, implementation, or other program aspect)	• Having input from a focus group of peers to select the app to be piloted	• A group of 4 clinicians will also be recruited to determine the feasibility and appropriateness of using Wysa in support of the services they provide.	• Due to COVID-19, the 4 clinicians originally anticipated to determine the feasibility and appropriateness of using Wysa were not available to support this project due to the increased need for client services. The goal is to reevaluate this component in January 2021	• We will be holding a workgroup in January to present to them our ideas for moving forward with Mindstrong and either Headspace or myStrength
Milestones	• Focus group selected the app for pilot	April • A focus group comprised of Wellness Advocates, MHSA staff, and the IT consultant, participated in a product testing of the Wysa application • Product testing resulted in Tri-City moving forward with the app, with adjustments to the emergency contact function May • Wysa agreed to making adjustments to the emergency contact function of the app • CalMHSA began contract negotiations with Wysa • Tri-City started drafting the pilot proposal • Through the collaboration, various wellness apps have made accessing their apps free for participating counties/agencies and Tri-City has been taking advantage of the opportunity by providing the resources to staff and clients	August • Innovation Coordinator/Tech Lead left Tri-City in August. As a result, the Wysa pilot project was placed on temporary hold until a replacement is hired • Tri-City continues to actively participate in all other aspects and activities of this project and the Collaborative	December • Hired new Innovation Program Coordinator • Speaking with Orange County to possibly collaborate with them in order to implement Mindstrong in Tri-City • In discussion with CalMHSA about implementing either HeadSpace or myStrength with our Target Populations

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Tri-City	Quarter 1 (Jan–Mar 2020)	Quarter 2 (Apr – Jun 2020)	Quarter 3 (Jul – Sept 2020)	Quarter 4 (Oct – Dec 2020)
		• CalMHSA created Digital Mental Health Literacy training videos and Tri-City will be utilizing the videos for clients and community members • Tri-City met with UCI to develop an evaluation plan for the pilot process June • CalMHSA and Wysa reached an agreement in contract negotiations and Tri-City was given the green light to move forward with the pilot proposal and pilot evaluation plan • Tri-City continued to send useful wellness app information to our staff for self-care (and some client resources) • Tri-City Wellness Advocates started planning for a Community Connections webinar to teach our clients and community members how to be safe online. They will be using the skills and information they acquired during the train-the-trainer session of the February Help@Hand Peer Summit • Tri-City was trained to use Smartsheet for project management		
Lessons Learned	• We learned that we did not have the adequate internal staff to support implementation of project. We are reaching out to Painted Brain and Cambria to assist with support during implementation of future projects in order to ensure we can have a successful launch.			
Recommendations	• Collaborate with Orange County to take over some of their licenses for Mindstrong in order to roll out Mindstrong to our Target Populations. Work with CalMHSA to implement either Headspace or myStrength.			

Mobile Application Rating Scale (MARS)

App Quality Ratings

The Rating scale assesses app quality on four dimensions. All items are rated on a 5-point scale from "1.Inadequate" to "5.Excellent". Circle the number that most accurately represents the quality of the app component you are rating. Please use the descriptors provided for each response category.

SECTION A

Engagement – fun, interesting, customisable, interactive (e.g. sends alerts, messages, reminders, feedback, enables sharing), well-targeted to audience

1. **Entertainment: Is the app fun/entertaining to use? Does it use any strategies to increase engagement through entertainment (e.g. through gamification)?**
   - 1 Dull, not fun or entertaining at all
   - 2 Mostly boring
   - 3 OK, fun enough to entertain user for a brief time (< 5 minutes)
   - 4 Moderately fun and entertaining, would entertain user for some time (5-10 minutes total)
   - 5 Highly entertaining and fun, would stimulate repeat use

2. **Interest: Is the app interesting to use? Does it use any strategies to increase engagement by presenting its content in an interesting way?**
   - 1 Not interesting at all
   - 2 Mostly uninteresting
   - 3 OK, neither interesting nor uninteresting; would engage user for a brief time (< 5 minutes)
   - 4 Moderately interesting; would engage user for some time (5-10 minutes total)
   - 5 Very interesting, would engage user in repeat use

3. **Customisation: Does it provide/retain all necessary settings/preferences for apps features (e.g. sound, content, notifications, etc.)?**
   - 1 Does not allow any customisation or requires setting to be input every time
   - 2 Allows insufficient customisation limiting functions
   - 3 Allows basic customisation to function adequately
   - 4 Allows numerous options for customisation
   - 5 Allows complete tailoring to the individual's characteristics/preferences, retains all settings

4. **Interactivity: Does it allow user input, provide feedback, contain prompts (reminders, sharing options, notifications, etc.)? Note: these functions need to be customisable and not overwhelming in order to be perfect.**
   - 1 No interactive features and/or no response to user interaction
   - 2 Insufficient interactivity, or feedback, or user input options, limiting functions
   - 3 Basic interactive features to function adequately
   - 4 Offers a variety of interactive features/feedback/user input options
   - 5 Very high level of responsiveness through interactive features/feedback/user input options

5. **Target group: Is the app content (visual information, language, design) appropriate for your target audience?**
   - 1 Completely inappropriate/unclear/confusing
   - 2 Mostly inappropriate/unclear/confusing
   - 3 Acceptable but not targeted. May be inappropriate/unclear/confusing
   - 4 Well-targeted, with negligible issues
   - 5 Perfectly targeted, no issues found

A. Engagement mean score = _____

SECTION B

Functionality – app functioning, easy to learn, navigation, flow logic, and gestural design of app

6. **Performance: How accurately/fast do the app features (functions) and components (buttons/menus) work?**

    1 App is broken; no/insufficient/inaccurate response (e.g. crashes/bugs/broken features, etc.)
    2 Some functions work, but lagging or contains major technical problems
    3 App works overall. Some technical problems need fixing/Slow at times
    4 Mostly functional with minor/negligible problems
    5 Perfect/timely response; no technical bugs found/contains a 'loading time left' indicator

7. **Ease of use: How easy is it to learn how to use the app; how clear are the menu labels/icons and instructions?**

    1 No/limited instructions; menu labels/icons are confusing; complicated
    2 Useable after a lot of time/effort
    3 Useable after some time/effort
    4 Easy to learn how to use the app (or has clear instructions)
    5 Able to use app immediately; intuitive; simple

8. **Navigation: Is moving between screens logical/accurate/appropriate/ uninterrupted; are all necessary screen links present?**

    1 Different sections within the app seem logically disconnected and random/confusing/navigation is difficult
    2 Usable after a lot of time/effort
    3 Usable after some time/effort
    4 Easy to use or missing a negligible link
    5 Perfectly logical, easy, clear and intuitive screen flow throughout, or offers shortcuts

9. **Gestural design: Are interactions (taps/swipes/pinches/scrolls) consistent and intuitive across all components/screens?**

    1 Completely inconsistent/confusing
    2 Often inconsistent/confusing
    3 OK with some inconsistencies/confusing elements
    4 Mostly consistent/intuitive with negligible problems
    5 Perfectly consistent and intuitive

B. Functionality mean score = _____

SECTION C

Aesthetics – graphic design, overall visual appeal, colour scheme, and stylistic consistency

10. **Layout: Is arrangement and size of buttons/icons/menus/content on the screen appropriate or zoomable if needed?**

    1 Very bad design, cluttered, some options impossible to select/locate/see/read device display not optimised
    2 Bad design, random, unclear, some options difficult to select/locate/see/read
    3 Satisfactory, few problems with selecting/locating/seeing/reading items or with minor screen-size problems
    4 Mostly clear, able to select/locate/see/read items
    5 Professional, simple, clear, orderly, logically organised, device display optimised. Every design component has a purpose

11. Graphics: How high is the quality/resolution of graphics used for buttons/icons/menus/content?

1 Graphics appear amateur, very poor visual design - disproportionate, completely stylistically inconsistent
2 Low quality/low resolution graphics; low quality visual design – disproportionate, stylistically inconsistent
3 Moderate quality graphics and visual design (generally consistent in style)
4 High quality/resolution graphics and visual design – mostly proportionate, stylistically consistent
5 Very high quality/resolution graphics and visual design - proportionate, stylistically consistent throughout

12. Visual appeal: How good does the app look?

1 No visual appeal, unpleasant to look at, poorly designed, clashing/mismatched colours
2 Little visual appeal – poorly designed, bad use of colour, visually boring
3 Some visual appeal – average, neither pleasant, nor unpleasant
4 High level of visual appeal – seamless graphics – consistent and professionally designed
5 As above + very attractive, memorable, stands out; use of colour enhances app features/menus

C. Aesthetics mean score = _____

SECTION D

Information – Contains high quality information (e.g. text, feedback, measures, references) from a credible source. Select N/A if the app component is irrelevant.

13. Accuracy of app description (in app store): Does app contain what is described?

1 Misleading. App does not contain the described components/functions. Or has no description
2 Inaccurate. App contains very few of the described components/functions
3 OK. App contains some of the described components/functions
4 Accurate. App contains most of the described components/functions
5 Highly accurate description of the app components/functions

14. Goals: Does app have specific, measurable and achievable goals (specified in app store description or within the app itself)?

N/A Description does not list goals, or app goals are irrelevant to research goal (e.g. using a game for educational purposes)
1 App has no chance of achieving its stated goals
2 Description lists some goals, but app has very little chance of achieving them
3 OK. App has clear goals, which may be achievable.
4 App has clearly specified goals, which are measurable and achievable
5 App has specific and measurable goals, which are highly likely to be achieved

15. Quality of information: Is app content correct, well written, and relevant to the goal/topic of the app?

N/A There is no information within the app
1 Irrelevant/inappropriate/incoherent/incorrect
2 Poor. Barely relevant/appropriate/coherent/may be incorrect
3 Moderately relevant/appropriate/coherent/and appears correct
4 Relevant/appropriate/coherent/correct
5 Highly relevant, appropriate, coherent, and correct

16. **Quantity of information: Is the extent coverage within the scope of the app; and comprehensive but concise?**

N/A There is no information within the app
1 Minimal or overwhelming
2 Insufficient or possibly overwhelming
3 OK but not comprehensive or concise
4 Offers a broad range of information, has some gaps or unnecessary detail; or has no links to more information and resources
5 Comprehensive and concise; contains links to more information and resources

17. **Visual information: Is visual explanation of concepts – through charts/graphs/images/videos, etc. – clear, logical, correct?**

N/A There is no visual information within the app (e.g. it only contains audio, or text)
1 Completely unclear/confusing/wrong or necessary but missing
2 Mostly unclear/confusing/wrong
3 OK but often unclear/confusing/wrong
4 Mostly clear/logical/correct with negligible issues
5 Perfectly clear/logical/correct

18. **Credibility: Does the app come from a legitimate source (specified in app store description or within the app itself)?**

1 Source identified but legitimacy/trustworthiness of source is questionable (e.g. commercial business with vested interest)
2 Appears to come from a legitimate source, but it cannot be verified (e.g. has no webpage)
3 Developed by small NGO/institution (hospital/centre, etc.) /specialised commercial business, funding body
4 Developed by government, university or as above but larger in scale
5 Developed using nationally competitive government or research funding (e.g. Australian Research Council, NHMRC)

19. **Evidence base: Has the app been trialled/tested; must be verified by evidence (in published scientific literature)?**

N/A The app has not been trialled/tested
1 The evidence suggests the app does not work
2 App has been trialled (e.g., acceptability, usability, satisfaction ratings) and has partially positive outcomes in studies that are not randomised controlled trials (RCTs), or there is little or no contradictory evidence.
3 App has been trialled (e.g., acceptability, usability, satisfaction ratings) and has positive outcomes in studies that are not RCTs, and there is no contradictory evidence.
4 App has been trialled and outcome tested in 1-2 RCTs indicating positive results
5 App has been trialled and outcome tested in $\geq$ 3 high quality RCTs indicating positive results

D. Information mean score = _____ *

* Exclude questions rated as "N/A" from the mean score calculation.

App subjective quality

SECTION E

20. Would you recommend this app to people who might benefit from it?

1	**Not at all**	I would not recommend this app to anyone
2		There are very few people I would recommend this app to
3	**Maybe**	There are several people whom I would recommend it to
4		There are many people I would recommend this app to
5	**Definitely**	I would recommend this app to everyone

21. How many times do you think you would use this app in the next 12 months if it was relevant to you?

1	**None**
2	1-2
3	3-10
4	10-50
5	>50

22. Would you pay for this app?

1	No
3	Maybe
5	Yes

23. What is your overall star rating of the app?

1	★	One of the worst apps I've used
2	★★	
3	★★★	Average
4	★★★★	
5	★★★★★	One of the best apps I've used

Scoring

App quality scores for

SECTION

A: Engagement Mean Score = _____

B: Functionality Mean Score = _____

C: Aesthetics Mean Score = _____

D: Information Mean Score = _____

App quality mean Score = _____

App subjective quality Score = _____

App-specific

These added items can be adjusted and used to assess the perceived impact of the app on the user's knowledge, attitudes, intentions to change as well as the likelihood of actual change in the target health behaviour.

SECTION F

1. **Awareness: This app is likely to increase awareness of the importance of addressing [insert target health behaviour]**

Strongly disagree				Strongly Agree
1	2	3	4	5

2. **Knowledge: This app is likely to increase knowledge/understanding of [insert target health behaviour]**

Strongly disagree				Strongly Agree
1	2	3	4	5

3. **Attitudes: This app is likely to change attitudes toward improving [insert target health behaviour]**

Strongly disagree				Strongly Agree
1	2	3	4	5

4. **Intention to change: This app is likely to increase intentions/motivation to address [insert target health behaviour]**

Strongly disagree				Strongly Agree
1	2	3	4	5

5. **Help seeking: Use of this app is likely to encourage further help seeking for [insert target health behaviour] (if it's required)**

Strongly disagree				Strongly Agree
1	2	3	4	5

6. **Behaviour change: Use of this app is likely increase/decrease [insert target health behaviour]**

Strongly disagree				Strongly Agree
1	2	3	4	5

APPENDIX C: REVIEWS OF MEDITATION AND PEER SUPPORT APPS

Selected Feature and User Experience Reviews of Meditation Apps

App name	Screen Reader Capabilities	Customizable Display Features	Offline Availability	Number of Languages Available in App	Content for Selected Target Groups	Peer Connection in-app	User Experience Score (Max: 5)	
	+++ All buttons spoken ++ Most buttons or features spoken, some exceptions + Some buttons or features spoken, many exceptions	A+ Text size T High contrast text ◑ Color inversion ▶ Animation reduction	Internet needed Offline Access $ Offline access, paid version only Downloadable content $ Downloadable content, paid version only				Expert	Consumer
10% Happier	+	A+ T ◑	↓	1	None	No	4.57	4.39
Aura	+	A+ T ◑	↓	1	None	Yes	4.52	4.65
Black Lotus	++	A+ T ◑	↓	2	None	Yes	4.19	3.82
Breathe	+	A+ T ◑ ▶	((·))	1	"Dealing with injustice" content in paid version	No	4.76	4.00
Buddhify	+	T ◑	((·))	1	None	Yes	4.21	2.99
Calm	+++	A+ T ◑ ▶	↓	9	None	No	4.69	4.11
Headspace	++	A+ T ◑ ▶	↓	5	None	Yes	4.95	5.00
HelloMind	+	A+ T ◑ ▶	((·))	1	None	No	3.67	4.09
Human.ly	+	A+ ◑	((·))	1	None	No	4.31	3.80
Insight Timer	+	A+ T ◑	↓$	35+	None	Yes	4.38	4.39
Liberate Meditation	++	A+ ◑	((·))	1	Black, Indigenous, and POC community	No	3.23	3.21
21-Day Meditation Experience	++	A+ T ◑	((·))	1	None	No	3.61	3.83
Meditopia	++	T ◑	↓$	9	None	No	4.77	3.98
Mind the Bump	++	A+ T ◑	((·))	1	LGBTQ+ community, single parents (app designed for expectant parents)	No	3.81	3.58
Omvana	++	A+ T ◑	((·))	3	None	No	3.39	3.95
Prekha Meditation	+++	A+ T ◑	↓	2	None	No	1.09	2.67
Relax Melodies	+	A+ T ◑ ▶	↓	3	None	No	4.65	3.73
Simple Habit	+	A+ T ◑ ▶	↓$	1	None	No	3.43	4.02

Simply Being	++	A+ 		1	None	No	2.82	3.22
Smiling Mind	++	A+ 		4	None	No	4.88	4.79
Take a Breat	++	A+ 		1	None	No	3.84	3.17
The Mindfulness App	++	A+ 		13	None	No	3.94	3.96
Waking Up	+			1	None	Yes	4.04	3.98

Selected Feature and User Experience Reviews of Peer Support Apps

App Name	Screen Reader Capabilities	Customizable Display Features			Offline Access	Number of Languages Available in App	Content for Selected Target Groups	In–App Peer Support							User Experience Scores (MARS)	
Screen Reader Capabilities +++ All buttons spoken ++ Most buttons or features spoken, some exceptions + Some buttons or features spoken, some exceptions **Customizable Display Features** A- Text size T High contrast text ◑ Color inversion		**Is app content available offline?** Internet needed, no content available online Internet needed for chats, other content available offline						Moderated chatroom	Unmoderated chatroom	Moderated forum	Unmoderated forum	1–on–1 peer messaging	Connect in–app with therapist	Referral available	Expert	User
365 Gratitude Journal	+	A-		◑		1	None			•					4.36	3.95
7 Cups	++			◑		34	LGBTQ+	•		•		•	•		3.44	2.75
DBT Coach	++	A-	T	◑		1	None		•	•					3.85	4.09
Habitica	++	A-				19	None	•		•		•			3.88	3.65
iPrevail	++	A-	T	◑		1	None			•		•			4.16	3.56
iRel8	++		T	◑		1	None				•	•		•	2.88	3.47
LGBT+ Amino	+	A-	T	◑		1*	LGBTQ+	•		•		•			3.51	3.7
OOTify	++	A-	T	◑		1	None			•			•	•	3.79	4.09
Pocket Rehab	++	A-	T	◑		1	None			•		•		•	4.07	3.28
rTribe	++	A-	T	◑		1	None	•				•	•		4.05	4.24
Sanvello	+++		T	◑		1	None			•			•		4.8	4.79
Sober Grid	++			◑		1	None			•		•			3.51	3.4
SoberTool	++	A-	T	◑		1	None			•					2.71	3.41
Solace	++	A-	T	◑		1	None	•		•					1.28	2.53
TalkLife	+	A-	T	◑		1	None			•		•			n/a	n/a
Therapeer	++		T	◑		1	None	•							4.23	3.9
Trill Project	+	A-	T	◑		1	LGBTQ+			•		•		•	3.44	3.64
Unmasked Mental Health	++	A-	T	◑		1	None					•			2.74	3.15
Wakie	++	A-	T	◑		1*	None	•		•		•			3.08	3.45
We Are More	++	A-		◑		1	People living with chronic disease			•		•		•	3.15	3.79
What's Up				◑		1	None			•					2.67	3.83
Wisdo	+++	A-	T	◑		1	None			•		•			3.38	4.25

*More languages available in iOS (see Appendix C)

APPENDIX D: MARKETPLACE REVIEWS OF HELP@HAND RFSQ APPROVED APPS

All numbers shown are medians since averages were not available for these metrics on the third-party analytics platform used. Top performing apps are apps with the highest number of downloads. Some apps were included in more than one OAC RFSQ component, which is why some top performing apps are repeated (e.g. Headspace & Ouchie).

OAC RFSQ Component	# apps in this RFSQ category	Data type	# apps with this data available	Metric	Top performing app	Jan 10 - Feb 10	Feb 11 - Mar 10	Mar 11 - Apr 10	Apr 11 - May 10	May 11 - Jun 10	Jun 11 - Jul 10	Jul 11 - Aug 10	Aug 11 - Sep 10	Sep 11 - Oct 10	Oct 11 - Nov 10	Nov 11 - Dec 10
Peer Chat/Digital Therapeutic	75	iOS & Android	23	DAU		6022	6353	5100	2619	1286	6513	5505	5608	8792	7010	6746
				MAU		16165	16828	15838	3981	6193	19525	19646	25830	25519	27647	37102
				Downloads	Spruce	237	263	228	186	198	349	357	415	419	423	428
		iOS only	4	DAU		--	256	1281	1340	1053	2219	2195	2043	1453	1506	1220
				MAU		20715	23753	31562	33978	35959	38640	40659	42031	41948	42005	45984
				Downloads	UpLift	--	98	81	32	99	100	92	73	60	55	38
		Android only	3	DAU		--	--	--	278	662	--	--	--	--	--	--
				MAU		--	110	109	813	8315	15080	18438	21066	28449	31247	29882
				Downloads	Ouchie	--	--	--	92	126	--	--	--	--	--	--
Therapy AVATAR	32	iOS & Android	5	DAU		6308	6081	5013	4440	6693	5321	4410	3738	3559	3211	2941
				MAU		39803	38245	34987	33137	35732	33582	30092	26994	25115	22267	17844
				Downloads	Headspace	263	260	204	198	285	158	172	151	159	110	103
		iOS only	4	DAU		--	225	1240	1340	1037	2215	2195	2043	1453	1506	1220
				MAU		--	352	2418	3894	4150	7075	8653	9202	8624	8306	7937
				Downloads	UpLift	--	98	80	32	92	100	92	73	60	55	38
		Android only	3	DAU		--	--	--	278	662	--	--	--	--	--	--
				MAU		--	--	--	745	3809	--	--	--	--	--	--
				Downloads	Ouchie	--	--	--	92	126	--	--	--	--	--	--
Passive Data	41	iOS & Android	8	DAU		883	799	169	386	780	131	373	486	359	429	5873
				MAU		11557	10850	979	1728	4494	2182	1225	3610	3890	4035	30883
				Downloads	Azova	83	83	84	87	151	11	60	85	83	99	371
		iOS only	2	DAU		--	--	--	--	--	--	--	--	--	--	--
				MAU		--	--	--	--	--	--	--	--	--	--	--
				Downloads	CaptureProof	--	--	9	--	--	7	--	--	--	--	--
		Android only	2	DAU		--	--	--	--	14	--	--	--	--	--	--
				MAU		--	--	--	--	115	--	--	--	--	--	--
				Downloads	Melon	--	--	--	4	4	--	--	--	--	--	--

FREE APPS TO HELP PEOPLE COPE WITH COVID-19 June 2020

This review highlights well-established and popular free apps to help people cope with COVID-19. These apps have either made existing content available for free during the pandemic, or added new content to address issues arising from COVID-19.

App Name / Developer	Platform: iOS	Platform: Android	Platform: Web	Cost: Completely Free	Cost: Free, with additional features available in paid version	Intervention Components: CBT	Intervention Components: Positive Psychology	Intervention Components: Mindfulness	Intervention Components: Chatbot/AI	Intervention Components: Symptom Tracking	Intervention Components: Psychoeducation	Available Languages	Population-Specific Tailored Content	Available COVID-19 Specific Content	Year Launched	# of Downloads (in past 90 days): iOS	# of Downloads (in past 90 days): Android	Published Research Evidence	Vetted in Help@Hand RFSQ?
Calm Calm, Inc.	•	•	•		•		•	•				English, German, Spanish, French, Korean, Portuguese	Children	Free resource hub online: https://www.calm.com/blog/take-a-deep-breath	2013	2,279,000	2,272,000	Yes	No
COVID Coach National Center for PTSD	•	•		•		•	•	•		•	•	English	Some resources for military personnel & parents/caregivers	App created for COVID-19 & draws from another app by same developers	2020	16,920	9,412	No	No
Happify Happify, Inc.	•	•	•		•	•	•	•		•	•	English, Chinese, French, German, Japanese, Portuguese, Spanish, Traditional Chinese	None	Has content such as “Managing Stress in Uncertain Times”	2013	30,290	9,125	Yes	Yes
Headspace* Headspace Inc.	•	•	•		•		•	•				English, French, German, Portuguese, Spanish	Children	COVID-19 “Weathering the storm” content pack free for everyone. Premium access is free to the unemployed, health professionals, & educators during pandemic	2012	860,200	851,200	Yes	Yes
NOD Grit Digital Health	•	•		•		•	•	•				English	College students & young people	App redesigned for COVID-19 & has activities for social distancing	2019	1,108	738	No**	Yes
Sanvello* Sanvello Health Inc.	•	•	•		•	•		•		•	•	English, text translations in Spanish & French	None	Has community discussion groups specific to the pandemic. Premium access is free during pandemic	2012	63,020	254,800	Yes	No
SuperBetter SuperBetter, LLC	•	•	•	•		•	•				•	English	None	Two new COVID-19 specific content (“Stay Strong in a Pandemic” & “Stay-at-Home Scavenger Hunt”)	2012	10,030	3514	Yes	No
This Way Up St Vincent’s Hospital Sydney			•	•		•				•	•	English	Teenagers, young adults, & adults	Guided downloadable workbooks & resources (“Staying on Track During the Pandemic”)	2012	N/A – Web app	N/A – Web app	Yes	No
Woebot Woebot Labs, Inc.	•	•		•		•			•	•	•	English	Young adults	Additional COVID-19 lesson (“Perspective”)	2018	23,760	115,800	Yes	No
Wysa * Wysa Ltd.	•	•			•	•		•	•	•	•	English	None	Has health anxiety & isolation content free to anyone during pandemic	2016	30,450	45,770	Yes	Yes

* Apps included in Catalyst toolkit located at: https://georgehills.SharePoint.com/sites/helpathand/_layouts/15/Doc.aspx?sourcedoc=%7B0CC8FF8F-DF56-46D2-8718-4D0A452F3AAA%7D&file=COVID%2019%20Resources.docx&action=default&mobileredirect=true

** Randomized control trial completed, but not yet published

help @ hand™ Evaluation

Learning Brief: Marketplace Performance of Mental Health Apps during COVID-19

September 2020

Multiple sources have reported increases in mental health needs since the outbreak of COVID-19, as shown by increasing rates of anxiety, depression, stress, sleep disturbance, and substance use.[1,2,3,4] Increased rates of mental health symptoms are especially prevalent among those most directly impacted, such as frontline medical workers[5] and children.[6] Given unique barriers to care that currently exist (e.g. physical distancing measures that may limit contact with providers), people are looking to digital tools to help them manage these stressors. This may potentially lead to an important opportunity for digital mental health. [7,8] Indeed, many digital mental health companies have reported that they have received record numbers of users during the pandemic. [9,10,11]

As such, Tri-City expressed interest in learning about the traffic and use of the following apps since the onset of COVID-19 in March 2020:

- Calm
- Headspace
- iChill
- myStrength
- Sanvello
- Wysa

This learning update presents marketplace performance data on the number of downloads and daily active users (DAU) to examine traffic and use. The data reflects users in the United States during the time period of March – September 2020. The data is combined across iOS and Android apps stores. Data separated for iOS and Android is available on request.

METRIC	DEFINITION
Number of Downloads	Number of new users downloading the app for the first time over a defined time period.[a]
Daily Active Users (DAU)	Number of unique devices that created at least one session (e.g., opened the app) in a 24-hour period.[b]
Average Daily Active Users (DAU)	The average DAU over a period of time.[c]

Overall Number of Downloads and Daily Active Users by Month

Below are the number of downloads and daily active users over two-month periods for each app.

Number of Downloads

	Jan-Feb	Mar-Apr	% change	May-Jun	% change	Jul-Aug	% change
Calm	2,469,074	2,767,405	+12%	3,128,669	+13%	2,796,824	-11%
Headspace	1,282,453	1,279,537	-0.2%	1,100,017	-14%	741,374	-33%
iChill	80	72	-10%	961	+1,235% [d]	327	-66%
myStrength	7,859	15,157	+93%	34,662	+129%	26,941	-22%
Sanvello	48,824	175,191	+259%	234,537	+34%	264,983	+13%
Wysa	68,533	47,883	-30%	58,350	+22%	66,051	+13%

*NOTE: Percent change represents change from previous two-month period

[a] This metric only captures overall new users. Re-downloads do not count toward this metric (i.e., if you break your phone, get a new phone, re-download the same app again – the re-download will not count). App updates also do not count toward this metric.
[b] This means that a user who opened the app once and a user who opened the app 10 times in the last 24-hours are both only counted as one DAU.
[c] Any time that you are looking at DAU over an aggregated period of time (e.g., a week, month, quarter, year, etc.) you are looking at the Average DAU. For example, if you look at the DAU for April 2018, then you are looking at the average of the 30 daily DAU values in that month.
[d] Please note this app had small number of total downloads and DAUs.

Average DAU

	Jan-Feb	Mar-Apr	% change	May-Jun	% change	Jul-Aug	% change
Calm	1,954,907	1,975,848	+1%	2,234,581	+13%	2,246,286	+1%
Headspace	939,467	1,055,420	+12%	960,340	-9%	847,818	-12%
iChill	17	15	-15%	78	+423%	40	-49%
myStrength	984	2,184	+122%	5,800	+166%	5,271	-9%
Sanvello	24,684	60,908	+147%	117,792	+93%	156,249	+33%
Wysa	37,471	26,538	-29%	29,023	+9%	29,442	+1%

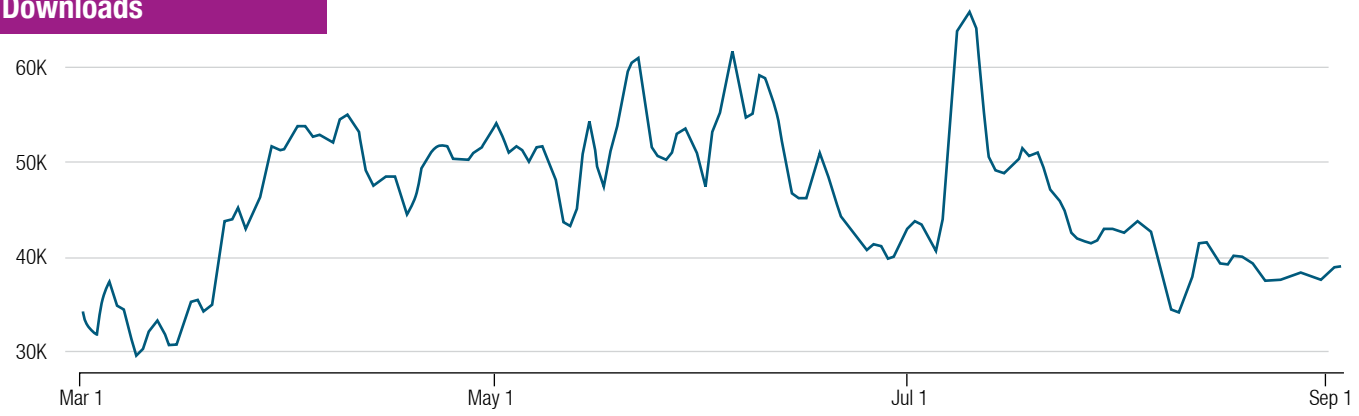
*NOTE: Percent change represents change from previous two-month period

Detailed Number of Downloads and Daily Active Users by App

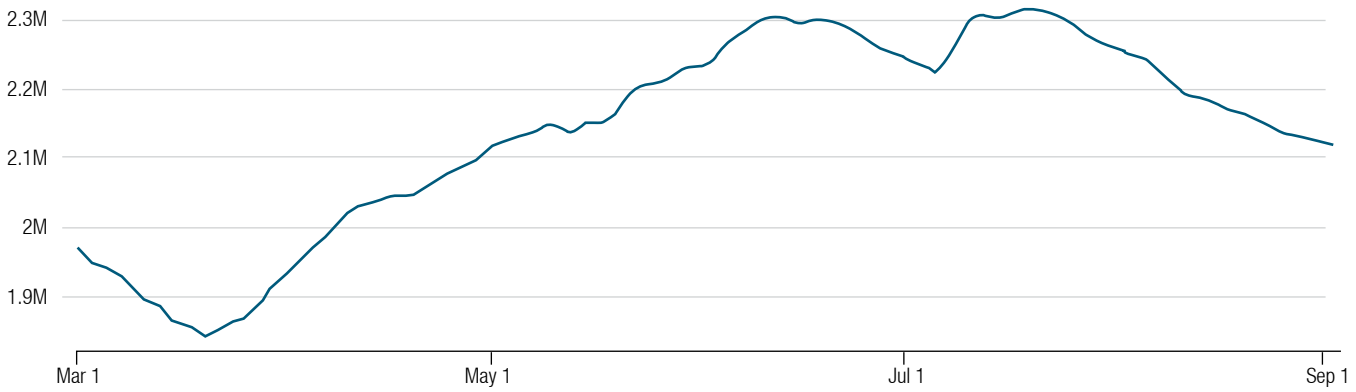
Below are the number of downloads and daily active users for each app between March 1-September 3, 2020.

Calm

Downloads

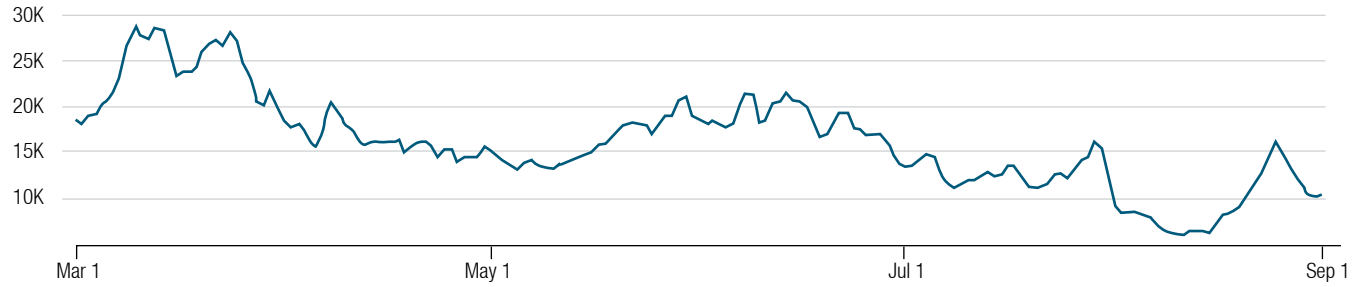


Daily Active Users

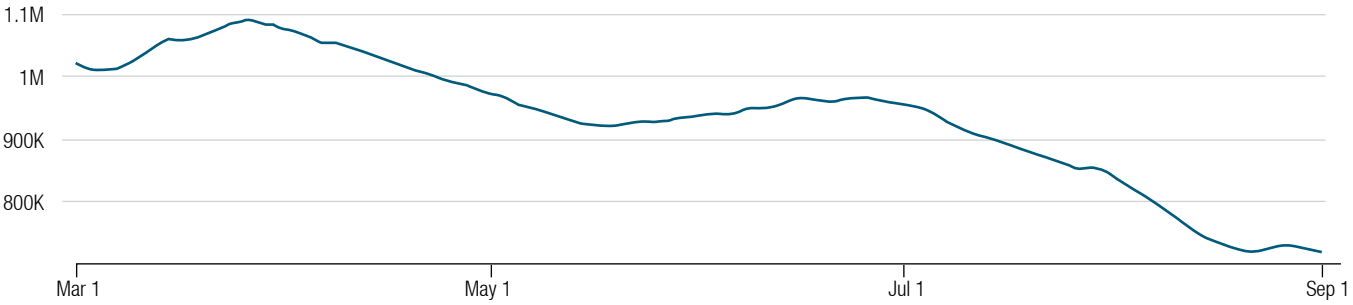


Headspace

Downloads

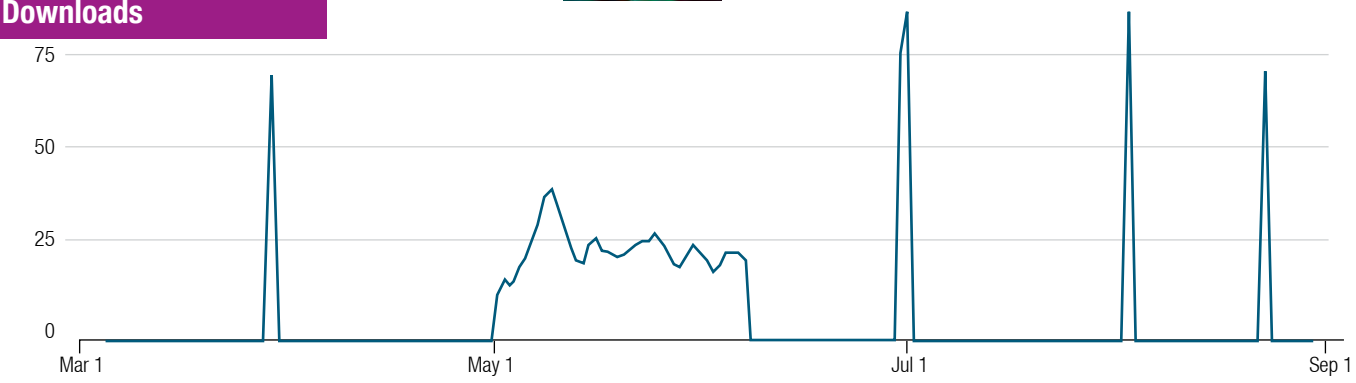


Daily Active Users

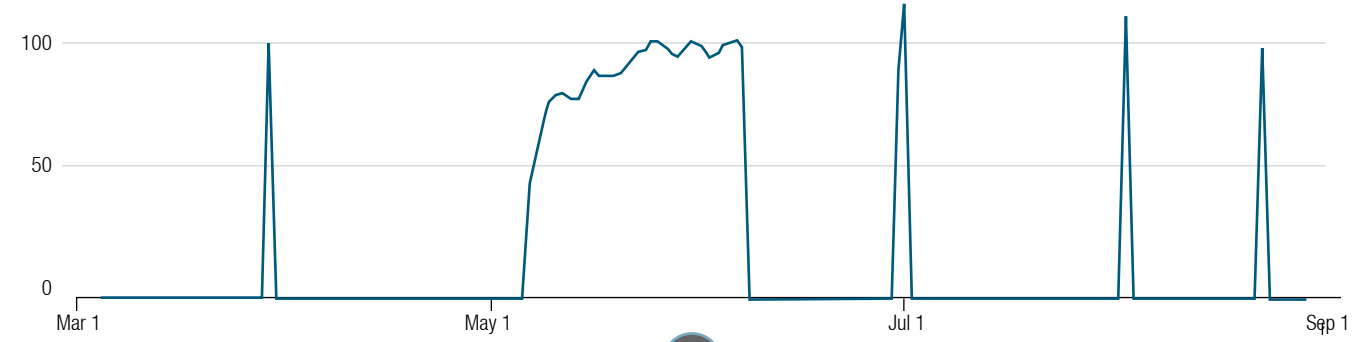


iChill

Downloads

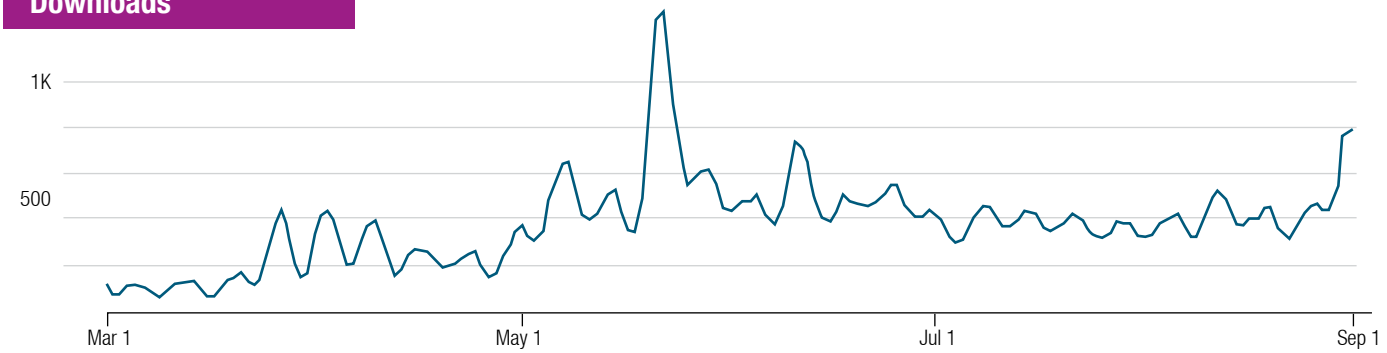


Daily Active Users

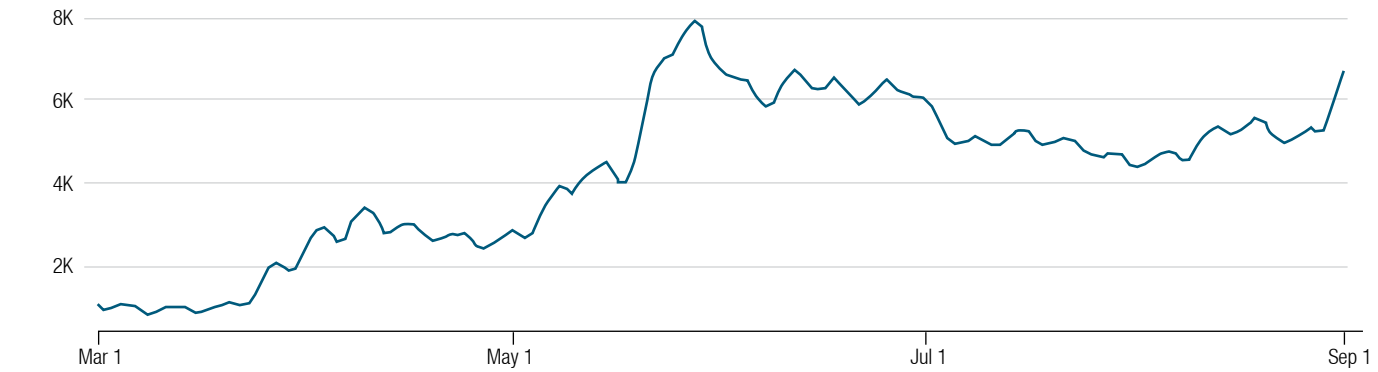


myStrength

Downloads

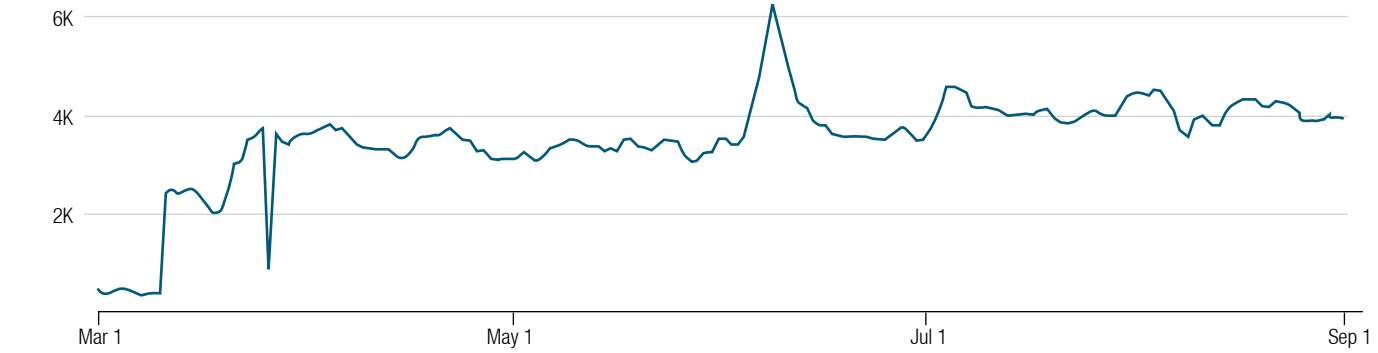


Daily Active Users

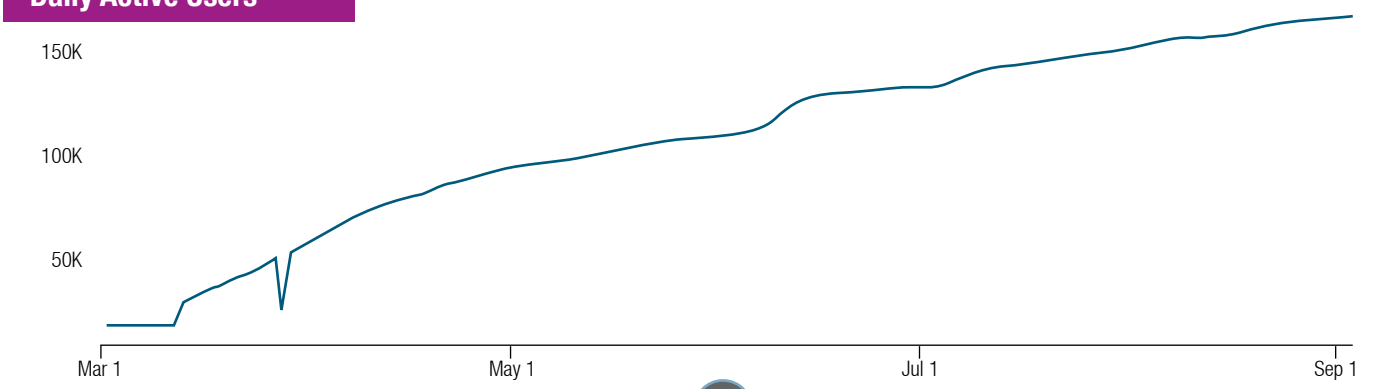


Sanvello

Downloads

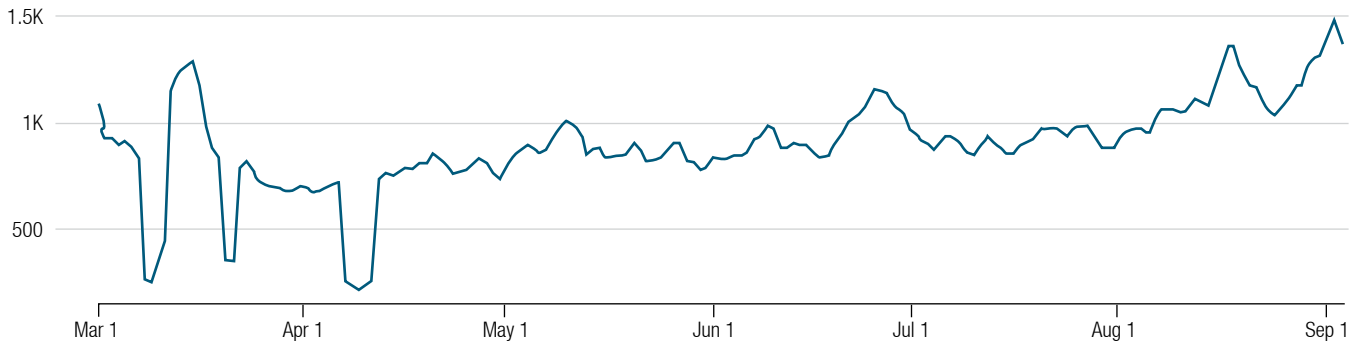


Daily Active Users

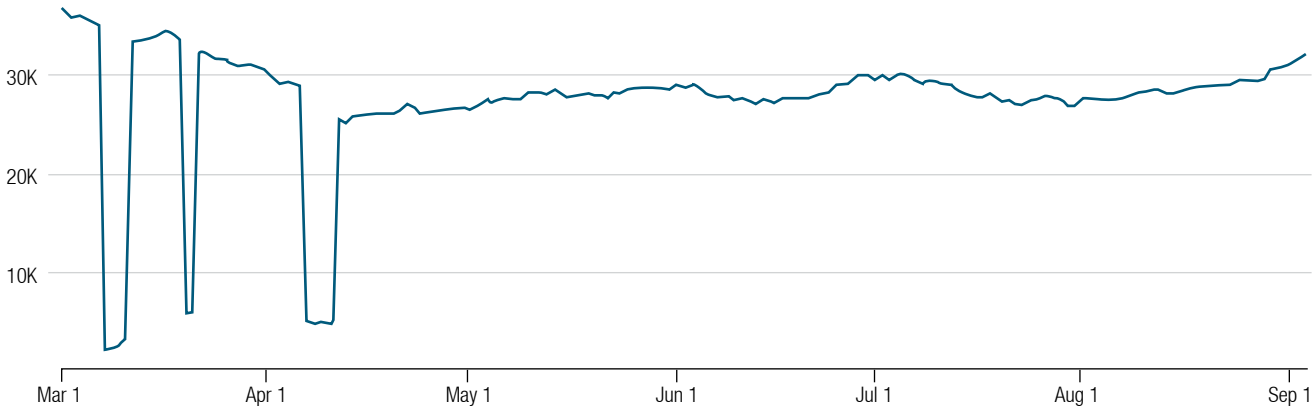


Wysa

Downloads



Daily Active Users



Notable Partnerships

Below are links to articles describing notable partnerships for each app that may have affected market performance.

Calm membership included on American Express cards [May 18, 2020]

Calm available to Kaiser Permanente members [May 19, 2020

Headspace free for healthcare professionals [March 16, 2020]

Headspace available to NY state residents [Apr 6, 2020]

Headspace available to all LA County Residents [Apr 28, 2020]

Headspace made available for free for people who are unemployed [May 14, 2020]

myStrength available to Kaiser Permanente members[April 2, 2020]

Sanvello announced free premium access for anyone [March 20, 2020]

Sanvello releases free clinician dashboard to mental health professionals [Apr 16, 2020]

Aetna International announces partnership with Wysa [May 18, 2020]

Wysa being offered for free at Cincinnati Children's Hospital [Aug 8, 2020]

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[5] Pappa, S., Ntella, V., Giannakas, T., Giannakoulis, V. G., Papoutsi, E., & Katsaounou, P. (2020). Prevalence of depression, anxiety, and insomnia among healthcare workers during the COVID-19 pandemic: A systematic review and meta-analysis. *Brain, behavior, and immunity*.

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[7] Torous, J., Myrick, K. J., Rauseo-Ricupero, N., & Firth, J. (2020). Digital mental health and COVID-19: Using technology today to accelerate the curve on access and quality tomorrow. *JMIR mental health*, 7(3), e18848.

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[10] *Healthcare Apps: A Boon, Today And Tomorrow.* (n.d.). Retrieved September 10, 2020, from https://www.forbes.com/sites/eladnatanson/2020/07/21/healthcare-apps-a-boon-today-and-tomorrow/#5700a6101bb9

[11] *Telemedicine, Once a Hard Sell, Can't Keep Up With Demand - WSJ*. (n.d.). Retrieved September 10, 2020, from https://www.wsj.com/articles/telemedicine-once-a-hard-sell-cant-keep-up-with-demand-11585734425

help @ hand™ Evaluation

Learning Brief: Mental Health Apps Provided and Recommended By California Insurance Plans

September 2020

The table below summarizes a selection of mental health apps that are provided or recommended by insurance plans across California. The information provided was gathered in Summer 2020.

App	Description	Provided by[1]	Recommended By[2]
	Calm is a mindfulness apps with content for music, meditation, and sleep.	Oscar Kaiser Permanente	Blue of California Anthem Blue Cross
	Headspace is a mindfulness meditation app, which includes content to help users focus, sleep, meditate, and be more physically active.	--	Blue of California
	MyLife Meditation (formerly Stop, Breathe & Think) allows users to check in with how they are feeling, and recommends short guided meditations and mindfulness activities based on current mood.	--	Anthem Blue Cross
	myStrength allows users to track their mood over time, join supportive online communities, and access other educational and coping resources to help with the management of depression, anxiety, stress, etc.	Kaiser Permanente	--
	Recovery Record is designed to aid recovery from eating disorders using techniques rooted in cognitive behavioral therapy (CBT).	--	Cigna
	Sanvello uses principles of CBT to help users with symptoms of anxiety, depression, or stress.	United Healthcare	--
	Teladoc connects users with medical and behavioral health professional through phone or video.	Tufts Health Plan Molina	--
	Virtual Hope Box contains simple tools to help users with coping, relaxation, distraction, and positive thinking. It also allows users to upload photos and other files to create a “hope box.”	--	Anthem Blue Cross
	Wysa is an artificially intelligent (AI) chatbot who can coach users to cope with issues like stress, depression, anxiety, sleep, etc.	Aetna	--

[1] App is included in membership with free or discounted access for insurance plan members.
[2] App is listed on insurance plan’s website as a recommended resource, but no free or discounted access benefits for insurance plan members.

MYSTRENGTH AND SIMILAR APPS

September 2020

PRODUCT MATRIX SUMMARY

Below is a summary of information from the Help@Hand product matrix for myStrength and apps similar to myStrength. It also identifies those apps with published research evidence. Please note that the Help@Hand product matrix did not have information related to "Specialized Target Populations," "Improving Communication with Isolated Individuals," and "Utilization of Peers" for these apps.

App Name	OAC Component	Additional Product Features	Physical or Behavioral Health	Referral	Monolingual Support	Wearable/ Additional Tech	Published Research Evidence
myStrength	Digital Therapeutics	Addiction Recovery + Goal Setting Mood Tracker + Meditation + Journal + Assessments	Behavioral	Needs Referral	Spanish	None listed on product matrix	No
Happify	Digital Therapeutics	Community / Group Involvement + Goal Setting + Mood Tracker + Meditation + Journal + Assess-ments + Games	Behavioral	No Referral Necessary	Chinese, French, German, Japanese, Portuguese, Spanish, Traditional Chinese	None listed on product matrix	Yes
Meru	Chat (Therapist or Non-Peer) + Digital Therapeutics	Care Coordination + Virtual Appointments / Telehealth + Meditation + Assessments	Physical & Behavioral	Needs Referral	None listed on product matrix	Wearable/ Additional Tech	Yes
SilverCloud	Chat (Therapist or Non-Peer) + Digital Therapeutics	Addiction Recovery + Virtual Appointments / Telehealth + WRAP or Action Planning + Goal Setting + Mood Tracker + Journal + Assessments	None listed on product matrix	No Referral Necessary	None listed on product matrix	None listed on product matrix	Yes

SELECTIONS FROM PUBLISHED RESEARCH EVIDENCE

Below is a selection of the published literature of Happify, Meru, and SilverCloud. Studies related to the feasibility and acceptability of these apps among users and/or studies that had strong research design are shown since they may help inform decisions of Help@Hand Counties/Cities.

Happify

Article Name: "Seeing the 'Big' Picture: Big Data Methods for Exploring Relationships Between Usage, Language, and Outcome in Internet Intervention Data."

Publication year: 2016

What did the study look at? Does greater usage of Happify predict higher well–being?

How did they collect the data? 152,747 users within the app were sampled. The research team used a proprietary measure called the Happify Scale to measure positive emotion and satisfaction with life.

What did they learn? It is challenging to infer data without a control group. The goal of the study was more to understand how to leverage big datasets to understand the effects of using Happify without inferring its effectiveness. Analyzing data within each user led the team to conclude that those who used the app saw greater well–being during periods of time when they used Happify more frequently.

Citation: Carpenter, J., Crutchley, P., Zilca, R. D., Schwartz, H. A., Smith, L. K., Cobb, A. M., & Parks, A. C. (2016). Seeing the "Big" Picture: Big Data Methods for Exploring Relationships Between Usage, Language, and Outcome in Internet Intervention Data. Journal of Medical Internet Research, 18(8), e241. https://doi.org/10.2196/jmir.5725

Article Name: Effect of Brief Biofeedback via a Smartphone App on Stress Recovery: Randomized Experimental Study

Publication year: 2019

What did the study look at? Does using Happify lead to physiological and psychological effects that indicate stress reduction?

How did they collect the data? They sampled 140 participants who were randomized to recover from a stressful situation in one of three ways: with no phone; with a phone (no Happify); and with Happify. The research team measured stress through a self–report measure and by measuring two salivary biomarkers (Salivary cortisol and sAA [salivary alpha amylase]).

What did they learn? The study found significantly lower levels of sAA for those in the Happify group, with no significant differences for the conditions of levels of salivary cortisol and self–reported stress.

Citation: Hunter, J. F., Olah, M. S., Williams, A. L., Parks, A. C., & Pressman, S. D. (2019). Effect of Brief Biofeedback via a Smartphone App on Stress Recovery: Randomized Experimental Study. JMIR Serious Games, 7(4), e15974. https://doi.org/10.2196/15974

Article Name: Testing a scalable web and smartphone based intervention to improve depression, anxiety, and resilience: A randomized controlled trial

Publication year: 2018

What did the study look at? Does use of Happify reduce depression and anxiety symptoms and increase resilience?

How did they collect the data? Final data was taken from 1,051 total users who were randomized into conditions of using Happify or receiving psychoeducation–only. Users were further split into subgroups of recommended usage or low usage of both conditions. The researchers used the PHQ–9, GAD–7, and a proprietary scale to measure depression, anxiety, and resilience, respectively.

What did they learn? Participants who used Happify at recommended levels reported fewer depressive and anxiety symptoms and greater resilience.

Citation: Parks, A. C., Williams, A. L., Tugade, M. M., Hokes, K. E., Honomichl, R. D., & Zilca, R. D. (2018). Testing a scalable web and smartphone based intervention to improve depression, anxiety, and resilience: A randomized controlled trial. International Journal of Wellbeing, 8(2), 22–67. https://doi.org/10.5502/ijw.v8i2.745

Meru

Article Name: Feasibility and Efficacy of the Addition of Heart Rate Variability Biofeedback to a Remote Digital Health Intervention for Depression

Publication year: 2020

What did the study look at? How feasible is it to use Meru with Heartrate Variability Biofeedback and did this treatment show changes in symptoms of depression?

How did they collect the data? An enhanced group (N = 48) where patients received heartrate variability–biofeedback (HRV–B) along with using Meru, was compared to a standard group (N = 48) which only used Meru (no HRV–B). The study took historical outcome data from a group of patients. Researchers used the PHQ–9 to measure changes in symptoms and also used the number of completed exercises and other usage statistics such as hours spent in practice and the number of messages sent between therapist and client to measure engagement.

What did they learn? Patients in the enhanced group were more likely to report a clinically significant improvement in depressive symptom score post–intervention.

Citation: Economides, M., Lehrer, P., Ranta, K., Nazander, A., Hilgert, O., Raevuori, A., … Forman–Hoffman, V. L. (2020). Feasibility and Efficacy of the Addition of Heart Rate Variability Biofeedback to a Remote Digital Health Intervention for Depression. Applied Psychophysiology and Biofeedback, 45(2), 75–86. https://doi.org/10.1007/s10484–020–09458–z

Article Name: Feasibility of a Therapist–Supported, Mobile Phone–Delivered Online Intervention for Depression: Longitudinal Observational Study

Publication year: 2019

What did the study look at? How feasible is it to integrate the Ascend intervention from Meru Health?

How did they collect the data? Researchers conducted 2 pilot studies with a total of 117 Finnish adults with elevated depression symptoms were prescribed a specific intervention within Meru. Researchers examined dropout rates and daily practice with Meru. They also looked at weekly group chat use and changes in depression symptoms using the BDI–II for study 1 and the PHQ–9 for study 2.

What did they learn? Dropout rates were 27% for study 1 and 15% for study 2. Daily practice and group chat use decreased from the beginning of the intervention to 4–weeks after the interven–tion. Depression rates decreased as well during the period. More daily practice and chat group use predicted occurrence of fewer depressive symptoms at 4–weeks after the intervention.

Citation: Goldin, P. R., Lindholm, R., Ranta, K., Hilgert, O., Helteenvuori, T., & Raevuori, A. (2019). Feasibility of a Therapist–Supported, Mobile Phone–Delivered Online Intervention for De–pression: Longitudinal Observational Study. JMIR Formative Research, 3(1), e11509. https://doi.org/10.2196/11509

Article Name: Long–Term Outcomes of a Therapist–Supported, Smartphone–Based Intervention for Elevated Symptoms of Depression and Anxiety: Quasiexperimental, Pre–Postintervention Study

Publication year: 2019

What did the study look at? Does the Ascend intervention in Meru maintain a reduction in symptoms of anxiety and depression up to 12–months post–treatment?

How did they collect the data? The study involved 102 adult participants who were a part of a previous study and who showed a reduction in symptoms of anxiety and depression. Researchers measured change with the GAD–7 and PHQ–9.

What did they learn? The intervention was associated with reductions in symptoms of depression maintained 12–months after the program and symptoms of anxiety maintained 6–months after the program.

Citation: Economides, M., Ranta, K., Nazander, A., Hilgert, O., Goldin, P. R., Raevuori, A., & Forman–Hoffman, V. (2019). Long–Term Outcomes of a Therapist–Supported, Smartphone–Based Intervention for Elevated Symptoms of Depression and Anxiety: Quasiexperimental, Pre–Postintervention Study. JMIR MHealth and UHealth, 7(8), e14284. https://doi.org/10.2196/14284

Article Name: Smartphone–Delivered, Therapist–Supported Digital Health Intervention for Physicians with Burnout

Publication year: 2020

What did the study look at? Is it feasible to use Meru to support physicians experiencing burnout?

How did they collect the data? 36 physicians who were showing elevated signs of work–related stress based on a burnout measure were administered the Meru Health app. Data was available for 33 of the physicians. Researchers used a single–item burnout measure and the PHQ–9. Intervention engagement was measured by user interaction with Meru via the smartphone app (e.g., total number of seconds of completed mindfulness meditation practices).

What did they learn? There was significant decrease in burnout and depressive symptoms. Engagement metrics were not significantly associated with the outcomes.

Citation: Raevuori, A., Forman–Hoffman, V., Goldin, P., Gillung, E., Connolly, S., Dillon, E., ... & Huang, F. Smartphone–Delivered, Therapist–Supported Digital Health Intervention for Physicians with Burnout. https://static1.squarespace.com/static/5cc948f6348cd94004675d2a/t/5f3a2e6362c23339b595ce66/1597648525041/PAMF_PhysicianBurnout_MeruHealth.pdf

SilverCloud Health

Article Name: Supported Internet–Delivered Cognitive Behavioral Therapy Programs for Depression, Anxiety, and Stress in University Students: Open, Non–Randomised Trial of Acceptability, Effectiveness, and Satisfaction

Publication date: 2018

What did the study look at? How feasible is the use of SilverCloud developed platforms?

How did they collect the data? 102 participants were recruited from counseling centers at a U.S. University. The PHQ–9, GAD–7, and DASS–21 were used to assess changes in symptoms. A Satisfaction with Treatment questionnaire was also used to understand acceptability of SilverCloud.

What did they learn? There was a significant decrease in symptoms of depression, anxiety, and stress. Most participants found the programs helpful or very helpful and liked the convenience and flexibility of the intervention.

Citation: Palacios, J. E., Richards, D., Palmer, R., Coudray, C., Hofmann, S. G., Palmieri, P. A., & Frazier, P. (2018). Supported Internet–Delivered Cognitive Behavioral Therapy Programs for Depression, Anxiety, and Stress in University Students: Open, Non–Randomised Trial of Acceptability, Effectiveness, and Satisfaction. JMIR Mental Health, 5(4), e11467. https://doi.org/10.2196/11467

Article Name: An internetdelivered selfmanagement programme for bipolar disorder in mental health services in Ireland: Results and learnings from a feasibility trial

Publication date: 2020

What did the study look at? How feasible is it to use SilverCloud in a treatment facility?

How did they collect the data? 15 patients in a mental health treatment facility in Ireland used SilverCloud for 10–weeks. Feasibility was assessed from the perspective of patients and clinicians, with patient feasibility being measured through engagement with the intervention, and clinician feasibility being measured through metrics like number of patients supported and if the clinicians were active supporters of the product. Researchers also used the Satisfaction with Treatment questionnaire, Bipolar Recovery Questionnaire (BRQ), Quality of Life in Bipolar Scale (QOL.BD), Brief Illness Perception Questionnaire (BIPQ), Internal State Scale (ISS), as well as semi–structured interviews.

What did they learn? There was a high frequency of tool usage. Patients found the intervention acceptable and easy–to–use, but it was noted that there were several barriers to implementation, such as patient access to technology and low numbers of clinicians who became active supporters of the intervention.

Citation: Enrique, A., Duffy, D., Lawler, K., Richards, D., & Jones, S. (2020). An internetdelivered selfmanagement programme for bipolar disorder in mental health services in Ireland: Results and learnings from a feasibility trial. Clinical Psychology & Psychotherapy. https://doi.org/10.1002/cpp.2480

Article Name: A pragmatic randomized waitlist–controlled effectiveness and cost–effectiveness trial of digital interventions for depression and anxiety

Publication date: 2020

What did the study look at? How cost–effective is it to use SilverCloud in stepped–care settings and is it effective in reducing symptoms?

How did they collect the data? The study looked at PHQ–9, GAD–7, and WSAS to measure effectiveness among participants in a stepped–care setting. Calculated quality–adjusted life year (QALY) and a modified–Client Service Receipt Inventory (care resource–use) was also used.

What did they learn? SilverCloud users showed improvements in symptoms of depression and anxiety. The probability of cost–effectiveness was 46.6% over a 6–month period, which increased to 91.2% over a 12–month period.

Citation: Richards, D., Enrique, A., Eilert, N., Franklin, M., Palacios, J., Duffy, D., … Timulak, L. (2020). A pragmatic randomized waitlist–controlled effectiveness and cost–effectiveness trial of digital interventions for depression and anxiety. Npj Digital Medicine, 3(1). https://doi.org/10.1038/s41746–020–0293–8

Article Name: Adapting an internet–delivered intervention for depression for a Colombian college student population: An illustration of an integrative empirical approach

Publication date: 2019

What did the study look at? How can SilverCloud be adapted for different cultures?

How did they collect the data? Researchers used qualitative and quantitative methods to adapt the Space from Depression program from SilverCloud. Researchers adapted the Space from Depression program by including Colombian actors in the videos they used, common phrases used in Colombia, and relevant scenarios. Researchers developed their own measure, the Cultural Relevance Questionnaire (CRQ), which they administered to reviewers of the adapted product to help rate cultural validity.

What did they learn? Researchers found that the changes made to the adapted product was positive, and feedback was used to further improve the product.

Citation: Salamanca–Sanabria, A., Richards, D., & Timulak, L. (2019). Adapting an internet–delivered intervention for depression for a Colombian college student population: An illustration of an integrative empirical approach. Internet Interventions, 15, 76–86. https://doi.org/10.1016/j.invent.2018.11.005

help@hand™ Evaluation

Peer Evaluation Learnings

September 2020

EXECUTIVE SUMMARY

Between April and June 2020, the Help@Hand Evaluation Team conducted one-on-one telephone interviews with Peer Leads (N = 11) and Tech Leads (from Counties/Cities without Peer Leads; N = 2) from the following regions participating in the Help@Hand Collaborative: City of Berkeley; Kern County; Los Angeles County; Marin County; Modoc County; Monterey County; Orange County; Riverside County; San Mateo County; Santa Barbara County; Tehama County; and Tri-City. Interview transcripts were analyzed using Atlas.ti. Results are summarized in **Table 1**. More detailed results will be reported in the Y2Q3 Evaluation Report.

Major Learnings

- **Peer involvement in the Help@Hand Collaborative is overwhelmingly seen as a value-added component**, with Peers offering a unique and critical perspective on product selection, development, and delivery.
- The size and employment models of the Peer workforce are both quite variable across Help@Hand counties/cities, and a number of counties/cities have engaged subcontractors to access Peers and facilitate program management.
- In Year 2 Quarter 1, **Peers were involved in a variety of activities**, including creating materials, outreach, product testing, and being trained in digital literacy.
- In Year 2 Quarter 3, **Counties/Cities plan to involve Peers in virtual outreach, digital literacy training, and reviewing apps**.
- **Integrating Peer input into Help@Hand continues to be an essential element of the project's mission and vision**. A number of counties/cities reported very positive experiences with Peers providing input locally. Perceptions of Peer input at the Collaborative-level was mixed, with some respondents noting room for improvement.
- **Leveraging the power of the Collaborative to enhance the effectiveness of Help@Hand also continues to be critical for project success**. Although a couple of respondents gave very positive and specific examples of assistance they received from other counties/cities in the Collaborative, a majority of respondents expressed an interest in clarifying the decision-making process across the Collaborative.
- Respondents reported a range of challenges to integrating Peers into the Help@Hand Collaborative. **Client-level challenges** included: lack of digital literacy among clients; lack of access to the internet or cell phones among clients; need for bilingual staff and materials; and restrictions on face-to-face contact related to the COVID-19 pandemic. **County/City-level challenges** related to: the COVID-19 pandemic (i.e., re-allocation of county/city resources and work-from-home requirements); limited Peer staffing capacity since many Peers wear multiple hats within their agencies and do not have enough time to spend on Help@Hand; need for better internal communication within and among county/city staff; and difficulty recruiting, hiring and retaining Peers.

Major Recommendations

The learnings indicate that there are potential gains by facilitating greater flow of information across the Collaborative. The impact has been considerable when counties/cities have made personal contact with their counterparts at other counties/cities, particularly given that each county/city has pioneered unique strategies for overcoming challenges that might well be translatable to additional counties/cities. The current structure, in which Peers exchange information with one another in a Peer-only call, limits the potential degree to which counties/cities can learn from one another and rapidly adopt innovations. Recommendations based on this synthesis are:

1. The **Peer Engagement Manager** has a central role in providing strong leadership for the Help@Hand Peer component. Therefore, it is important for Help@Hand to immediately hire a strong Peer candidate for this position. This individual will be able to accelerate the flow of Peer-related information across the Collaborative.
2. The size and complexity of the Help@Hand Collaborative Peer component requires **administrative support for the Peer Engagement Manager** in order to fully support the development and implementation of Peer activities throughout the 14 counties/cities of the Collaborative. Additional personnel may also help facilitate dissemination of information from the Collaborative to the Peers.

Table 1. Themes identified from interviews.

◔ = theme present in 25-50% of interviews. ◕ = theme present in greater than 50% of interviews. Selected quotes provided as examples.

Peer Contribution	
◕	Peers add value to Help@Hand *"You need the culturally-appropriate strategies for each community. You have Peer people who have lived experience who wear that badge and can be an example to people."*
Peer Workforce Models	
◕	Use of Subcontractors *"We are able to make this happen with the support of a peer-trusted and peer-run [subcontractor who has] an incredible wealth of knowledge when it comes to supporting peer employment and peer tech questions."*
◔	Variable Peer workforce size *"As of now, there are no Peers assigned to work on this project." "We have 8 total peers – 7 plus myself.""*
Past Peer Activities	
◔	Creation of Help@Hand materials Outreach Product Testing Peers trained in digital mental health literacy
Planned Peer Activities	
◕	Outreach Peers to deliver digital mental health literacy training
◔	App reviewing and testing
Peer Input (County/City-level)	
◕	Positive assessment of Peer input *"Our leadership team really seems to support and appreciate the skills abilities and work of the peer workforce."*
◔	Room for improvement *"People are making decisions without having peers involved."*
Peer input (Collaborative-level)	
◔	Peers well integrated *"What I have seen I feel like we have a really strong voice. I feel like we have a lot of input."*
◔	Room for improvement *"I get the sense that the Peers feel like they are not heard."*
Horizontal Communication (County/City to County/City)	
◔	Productive collaborations
Vertical Communication (Collaborative to County/City)	
◕	Lack of clarity on roles and responsibilities, particularly related to decision making *"It is still unclear where decision making power lies in all of this. Is it the collaborative, or the county? Who from the county is part of the collaborative in terms of decision-making power?"*
Challenges (Client-level)	
◔	Limited digital literacy Lack of access to technology Language barriers COVID-19-related restrictions on face-to-face outreach
Challenges (County/City- level)	
◕	COVID-19-related work-from-home and physical distancing requirements COVID-19-related resource redirection Limited time on the project given that Peers and Peer Leads fulfill multiple roles within the county/city Miscommunication between and among county/city staff
◔	Difficulty finding, recruiting, and retaining qualified Peers *"That has been a challenge: to hire people specifically for Help@Hand and our program."*

help@hand™ Evaluation

Peer Evaluation Learnings

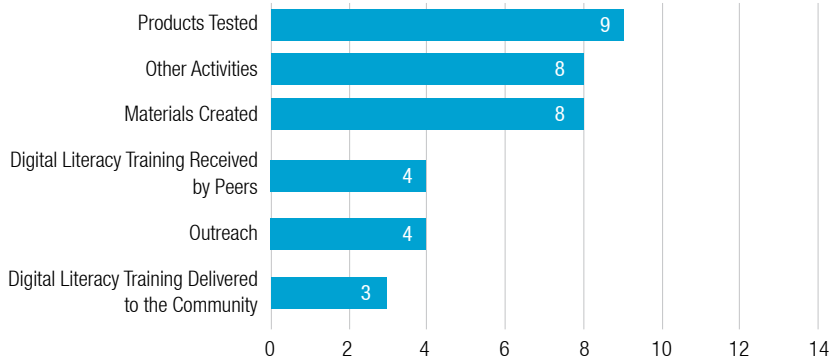
Year 2, Quarter 3 (July - September 2020)

A brief survey was completed by 14 Peer Leads and 1 Tech Lead at the end of Q3.[1] Participating Counties/Cities included: City of Berkeley, Kern County, Los Angeles County, Marin County, Modoc County, Mono County, Monterey County, Orange County, Riverside County, San Francisco County, San Mateo County[2], Santa Barbara County, Tehama County, and Tri-City. The surveys were followed with an interview to collect additional details, and the interview findings will be summarized in the upcoming Year 2 Evaluation Report. This preliminary learning brief summarizes data from the survey in order to provide rapid feedback on the implementation of the Help@Hand Peer component.

Characteristics of Help@Hand Peer Programs

Number of Peers Employed Across Counties/Cities		Use of Subcontracts
Number of Peers	**Number of Cities/Counties**	
0	1	6 Help@Hand Peer Leads are subcontractors
1	3	8 Counties/Cities employ Help@Hand Peer outreach workers using a subcontract
2-4	4	
5-8	4	
9 or more	2	

Peer Activities Reported during Year 2 Quarter 3



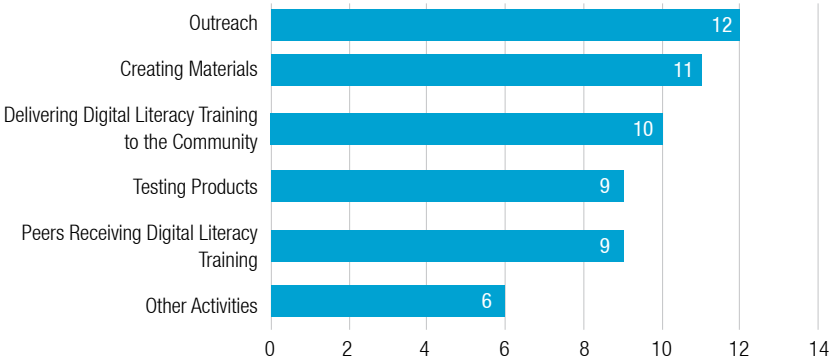
Question wording:

The following questions ask about the activities that Help@Hand Peers engaged in within your city/county during the third quarter of 2020 (July, August, September). Please choose the appropriate answer for each potential activity.

(Response options: Peers did this during 3rd Quarter or Peers did not do this during 3rd Quarter).

** The figure to the left shows the number of interviewees who responded Peers did the activity in the 3rd quarter.*

Peer Activities Planned for Year 2 Quarter 4



Question wording:

The following questions ask about PLANNED Peer activities for the fourth quarter of 2020 (October, November, December). Please indicate which of the following activities are currently planned for Peers to engage in in support of Help@Hand for the fourth quarter of 2020.

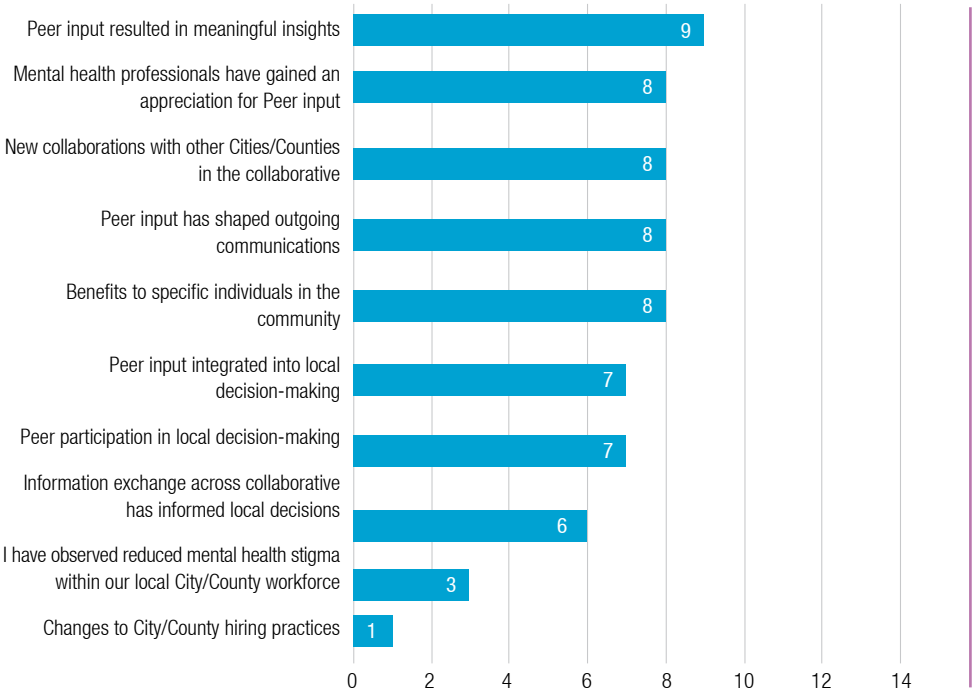
(Response options: We plan for Peers to do this in the 4th Quarter or We do not plan for Peers to do this in the 4th Quarter).

** The figure to the left shows the number of interviewees who responded Peers are planned to do the activity in the 4th quarter.*

[1] The survey was developed based on themes emerging from interviews conducted with county/city Peer and Tech Leads in Year 2, Quarter 2. The survey conducted in Year 2, Quarter 3 had a response rate of 100%. One survey was omitted from the summary of challenges and successes owing to missing data.

[2] Two Peer Leads from San Mateo County were surveyed.

Year 2 Quarter 3 Successes

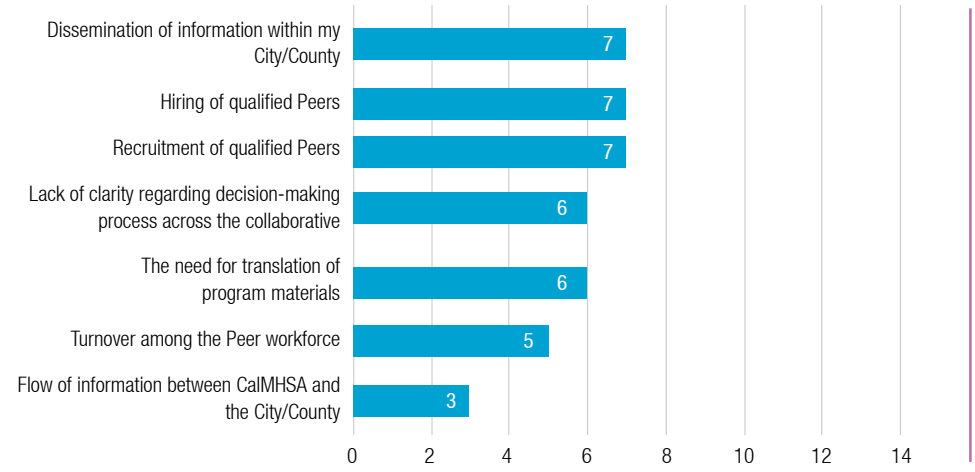


Question wording:

Successes: To help us estimate how widespread specific are across the Help@Hand collaborative, please indicate whether your City/County has experienced any of the following as a consequence of participation in Help@Hand. For this question, you can think about all experiences since the start of the project. Please choose yes or no for each option.

** The figure to the left shows the number of interviewees who identified the specific success.*

Year 2 Quarter 3 Challenges



Question wording:

Challenges: To help us estimate how widespread the following challenges are, please indicate which of the following has hindered your progress as you implemented the Peer component of the Help@Hand project. For this question, you can think of all experiences since the start of the project. Please choose yes or no for each option.

** The figure to the left shows the number of interviewees who identified the specific challenge.*

APPENDIX G: TAKE MY HAND

Summary

Lessons Learned

Lessons learned are organized within each EPIS phase. Within each phase, learnings are further characterized by the key people/process as follows:

- RUHS-BH Leadership
- Peers (Senior Peer Support Specialists and Peer Operators)
- Technology/Take my Hand Features
- Users
- Service Delivery

Recommendations

To facilitate generalizable knowledge across the Help@Hand Collaborative, recommendations are organized in the following categories: Implementation, Organizational Change Management, Technology, and Evaluation.

The Help@Hand evaluation team acknowledges that some of the recommended actions are currently underway. These recommendations are documented, nonetheless, for the benefit of the Collaborative.

Background

Information was synthesized from the rapid deployment of Take my Hand led by Riverside University Health System-Behavioral Health (RUHS-BH) and their Peer team for the purposes of the formative evaluation. This includes identifying lessons learned and providing recommendations from the Help@Hand evaluation team. Sources of data used for this synthesis included: 1) "RUHS-BH Take my Hand Live Peer Chat COVID-19 Rapid Deployment-Test Phase Report" developed by the Help@Hand Team in Riverside County; 2) "Take My Hand Test Phase Report" developed by Riverside County's local evaluators; and 3) Riverside County meeting notes from the Help@Hand evaluation team. This synthesis may provide generalizable insights as to how other counties/cities might successfully implement and sustain Take my Hand and/or apply learnings from Riverside's experience to their own implementations of other technologies.

Thank you to the entire TakemyHand project team for sharing your materials and learnings. Special thanks to Pamela, Shannon, Dakota, Maria Martha, Suzanna, and Christy.

Exploration, Preparation, Implementation, and Sustainment Framework

The Exploration, Preparation, Implementation, and Sustainment (EPIS) framework[27] was used to organize the lessons learned and recommendations for this synthesis. The EPIS framework highlights factors across the four phases that occur when implementing a new intervention or practice.

Exploration Phase

Identifying a Need and Exploring Possible Solutions

Riverside County experienced a high volume of COVID-19 cases early in the pandemic and anticipated an associated rise in mental health needs.

Lessons Learned

<u>RUHS–BH Leadership:</u>

1. Identified a public health need to find a safe alternative to alleviate the growing strain being placed on 911 and 211 crisis call centers at the onset of the COVID-19 pandemic.

<u>Peers:</u>

1. Determined that a Peer chat app would address the public and mental health needs in their community.

[27] See https://episframework.com/ for more information on the EPIS Framework.

2. Recognized that it was important to leverage RUHS-BH's established Peer workforce, incorporating their skills and service delivery into the Take my Hand platform.

Technology:

1. Discovered through exploration that current digital mental health therapeutics (aka apps) were limited due to absence of a trained Peer Support Specialist. Specifically, someone who could address and respond to multiple needs of their community (e.g.; access to behavioral health resources, taking a non-medical approach that is recovery-oriented, multi-language capabilities, an interface that reduces mental health stigma and is multicultural, etc.).
2. Discovered through exploration that current apps did not identify core competencies of Peer support. These core competencies are defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) as "the concepts and practices of 'Power Sharing', 'Recovery Coaching', 'Recovery Environment – High Expectation', 'Mutuality' and 'Role Modeling'".
3. Recognized that Take my Hand supplements already existing crisis services, and offers alternatives to these crisis services – by increasing access to Peer support, educating individuals about systems & services within Riverside County, and creating positive repute for the RUHS-BH System.
4. Ventured that Take my Hand might offer cost savings to the County by: lessening the demand on clinical and crisis services through Peer support; reducing translation service costs with its chat function; and promoting efficient use of the behavioral health services that RUHS-BH offers.

Users:

No lessons learned were identified for users during the Exploration Phase.

Service Delivery:

1. Recognized the importance of supporting community members' ability to access support with a Peer Support Specialist at any time without an appointment.
2. Identified that shifting the service location to a live virtual platform might increase accessibility to individuals within and outside of Riverside County's behavioral health system.
3. Identified the importance of Take my Hand expanding the target audience to include new people not currently engaged by RUHS-BH, at any stage of wellness (including prevention and early intervention), with no triaging required.

Recommendations

Implementation

1. Identify current offerings, limitations, and opportunities of the existing service delivery system to support a virtual platform like Take my Hand.

Organizational Change Management

Peer Support Specialists: Training, Oversight, Experience

1. Define the roles and activities of a "Peer".
2. Define the need to be met (e.g., provide non-medical support).
3. Define the target audience.

Technology

1. Identify, develop answers for and integrate into the app Frequently Asked Questions (FAQs).

Evaluation (Local Evaluators and/or Help@Hand Evaluators)

1. Document a timeline of the various assessment time-points.
2. Attempt to systematically capture information obtained during exploration that informed subsequent decision-making.

Preparation Phase

Preparing for Implementation

To prepare for the Implementation of Take my Hand, RUHS-BH began gathering information and identifying factors that would be key to successful implementation, including but not limited to, the following: completing requirements for information technology and security, testing the technology's capacity to handle large volumes of users, mitigating potential risks or harm to users, developing strategic marketing, vetting materials for cultural appropriateness, projecting how the operation of Take my Hand might impact the prioritization of other duties at RUHS-BH, identifying key administrative stakeholders to successful deployment and implementation, identifying fiscal administrative barriers, and further developing the Peer Operator role.

Lessons Learned

RUHS–BH Leadership

1. Recognized that dedicated pre-implementation time is needed to vet and review terms of service by multiple key County employees (i.e., the Director, Information Security office, County Counsel etc.).

Peers

Senior Peer Support Specialist

1. Learned that the depth and nature of training varied across Peer Support Programs. Recognized need to identify core competencies required for Peer Operators.
2. Identified training gaps among Peer Operators (e.g. how Peer Operators could respond to emergent or unanticipated topics).

Peer Operator

3. Recognized that Peer Operators working remotely allowed for chat services to be provided 24/7
4. Identified the need for advanced training around the following topics: crisis transfers, how to use the Take my Hand platform, how to handle "trolls"[28] and controversial topics, and basic Peer support was necessary.

Technology

1. Recognized and corrected limitations of landing page.
2. Identified need to development 'back-end' of product for data collection.
3. Worked with Vendor to facilitate ease of use for consumer, Peer Operator, and Clinical Support[29]

Users

1. Determined it was important to create scripted responses in preparation for frequently asked questions/topics.

Recommendations

Implementation

1. Develop an implementation plan grounded in the exploration and preparation activities completed. This plan can include:
    a. Providing guidance on training Peer Operators (i.e., when the training will take place, who will be involved in the training, what content will be included in the training, defining timepoints of assessing the fidelity of the training, and determining a follow-up plan for assessing the adequacy of that training in terms of continued skill use or needs identified post-training).
        i. Training is a good initial step, and it is important to identify training gaps to assess whether training is sufficient.
    b. Defining the steps needed to obtain leadership approvals for implementation in the clinic.
    c. Identifying when to collect specific website metrics and how those data will be used.
2. Disseminate the implementation plan to relevant clinic leadership, key stakeholders, and local evaluators.
3. Consider areas of potential adaptation to Take my Hand in the event that a nimble response is needed to respond to changes in delivery platforms or implementation processes. These areas of potential adaptation include training materials, training processes, tags and canned responses used, and Take my Hand's accessibility and functionality.

[28] Definition of Troll: "An Internet slang, a troll is a person who starts flame wars or intentionally upsets people on the Internet by posting inflammatory and digressive, extraneous, or off-topic messages in an online community (such as a newsgroup, forum, chat room, or blog) with the intent of provoking readers into displaying emotional responses…." (see https://en.wikipedia.org/wiki/Internet_troll, accessed on 10/22/2020).

[29] There were many changes requested and made to the Vendor during this time to develop the website. Additional details are available upon request to the County or CalMHSA.

4. Develop an implementation plan prior to implementing practice change. Due to the goal of rapidly deploying Take my Hand in response to COVID, development of an implementation plan was not at the forefront of RUHS-BH's deployment efforts. However, an implementation plan may be developed based on the information gathered from the 10- week test phase as RUHS-BH moves forward with piloting Take my Hand in Riverside County.

Organizational Change Management

General

1. Regularly review and update Organizational Change Management plan to reflect changes in leadership, stakeholder engagement, readiness and sustainability.
2. Consider barriers and facilitators to sustainment even in early stages of planning. Create processes that support sustainment (e.g. creating opportunities for continual training, revisiting assigned responsibilities to updated changes).

Peer Support Specialists: Training, Oversight, and Experience

1. Create a structured Peer Operator training curriculum that can be adapted or modified if needed.
2. Review trainings and work collaboratively with Peers to identify any gaps in the curriculum. This might also be useful as an ongoing process as gaps might become more apparent overtime.
3. Review chats to determine how often to offer refresher courses or adapt the training curriculum.
4. Consider County limitations to hiring or contracting Peer Operators and develop a plan to address any challenges to onboarding the Peer Operators (e.g., hold a meeting with the Human Resources department and County leadership to develop a streamlined way to onboard Peers).
5. Define hours of operation for Take my Hand. If Take my Hand is operating 24/7, then a safe and secure place with stable internet connection should be identified (especially those for those individuals working the late night and early morning shifts).
6. Develop a plan to safely handle crisis events with step-by-step instructions on how to do a warm hand-off to a clinician.
7. Develop procedures to address submitted grievances by consumers.
8. Assign tasks and timing in the OCM plan to ensure Peers are allocated to specific tasks and review and training is conducted as regular times.

Technology

1. Identify the best way to integrate the approved terms of service into the Take my Hand platform.
2. Establish and define Take my Hand's cookie policy.
3. Identify the best way to convey the terms of service and cookie policy to consumers.
4. Establish a feature and procedure for consumers to submit grievances.

Evaluation

1. Define an evaluation plan that will guide how to determine whether the questions posed in the implementation effort will be answered. For example, if the question is about the optimal number of Peer Operators to support 10 unique chats per hour, then data about the user volume, length of chats, and perceived Peer Operator efficacy to respond to chats is needed.
2. Identify the most important website metrics (i.e., what RUHS-BH is trying to change or understand) and prioritize them when exporting data.
3. Develop procedures for prioritizing and exporting chat data files (i.e., total chats, Peer Operator performance measures, chat duration, chat rating, chat availability, chat engagement, chat response time, missed chats, tag usage, chat waiting time, chat abandonment etc.)
4. Identify how chat data files will be utilized within a specific County.

Implementation Phase

Pilot Implementation of Take my Hand

RUHS-BH launched Take my Hand on April 17, 2020. The testing phase lasted about 10-weeks and was completed on June 30, 2020. RUHS-BH gathered information from this testing phase and incorporated it into two COVID-19 rapid deployment reports: 1) one cataloging information developed by the RUHS-BH team, and 2) the other synthesizing data from user surveys and Peer Operator interviews. These reports were intended to help inform the Help@Hand Collaborative and document the processes that took place in the planning, development and implementation of Take my Hand. They identified key findings from the testing phase, including areas of growth, challenges experienced, and suggestions for moving forward with Take my Hand in Riverside County.

Lessons Learned

RUHS–BH Leadership

Peers

Senior Peer Support Specialists

Peer Operators

1. Identified that user volume was low and therefore manageable (chats ranged from 0-12 per day with an average number of chats being 1.85). Concerns were voiced that a higher volume of users might lead to consumers not receiving the necessary support or limit the peer support process.
2. Peer Operators recognized the value of being mindful of individual clients' needs. Standardized 'canned' responses were viewed as being less useful due to some clients reporting their responses were unhelpful.
3. Peer Operator's reported that reviewing past chats and observing chats helped to reduce their own anxiety around supporting users through a chat platform.

Technology

1. Learned that call volume fluctuates significantly. Early on in the testing phase, chat volume was its highest. Chats became less frequent as the testing phase went on over time.
2. Identified that accessing resources (on the Take my Hand platform) with Helpline information available and using "canned responses" (term used by RUHS-BH) around connecting the user with crisis-related resources was an effective alternative until a warm hand off with clinical staff could be made.
3. Recognized need to examine use and functionality of tags. Most tags fell under the "other" category due to the chat topic not fitting any of the pre-existing tags.
    a. Other chat topics included: "depression", "COVID-19", "Already linked to RUHS-BH services", "anxiety", "positive feedback", "no response", "unemployment, "crisis intervention", "housing", "TAY"(Transitioned Aged Youth), "LGBT", "homeless", linked to SU Cares", "older adult", "resources", "food bank", "linked to Cares line", "repeat visitor", and "utilities help".

Users

1. Recognized need to continue to describe and address technical challenges. Most technical challenges reported were in regards to WiFi connectivity from both Peer Operators and clients.
2. Recognized need to continue to evaluate the visitor experience. It was noted that visitors to the Take my Hand website left the website when asked to answer questions at the start of a chat.
3. Concerns were expressed around the anonymity of users, especially if they reveal information that required mandated reporting.

Recommendations

Implementation

1. Keep a log of the various technical difficulties and how they were addressed.
2. Develop a short list of open-ended questions that Peer Operators can use at the start of chats to engage Users and retain them on the chatline (e.g., who is important in your life?).

3. Add new tags to capture life-stressors, such as relationship issues, stress, and parenting.
4. Identify strategies for supporting callers during crisis transfers.

Organizational Change Management

1. Designate payroll codes for Peer Operators to properly account for time spent working the chat.
2. Ensure clinical staff are trained on the purpose, development, and operations of Take my Hand.
3. Define what would constitute a crisis transfer from a Peer Operator to a clinician.
4. Develop a protocol for clinical staff and Peer Operators on how to engage in crisis related services over a chat or phone.
5. Train clinical staff and Peer Operators in engaging in crisis related services over a chat or phone.
6. Develop a streamlined way for Peer Operators, clinicians, and Senior Peer Support Specialists to communicate with one another.

Peer Support Specialists: Training, Oversight, and Experience

1. Train Peer Operators in exploring a user's expression of harm ideation to determine passive thoughts vs. active harm.
2. Develop and regularly review a safety protocol for assessing and managing crisis situations.
3. Develop a peer consultation and training protocol that includes reviewing and observing chats.

Technology

1. Create a feature that can be included in the website metrics data pull that captures technical difficulties on both the Peer Operator and User sides.
2. Define activities that constitute "trolling" (e.g., inappropriate use or behavior on platform(and create a protocol for how to address, de-escalate, and disengage with a "troll."
3. Post the Cookie Policy and Privacy Practices in both English and Spanish on the Take My Hand website.
4. Develop a Frequently Asked Questions page for the Take my Hand website.

Evaluation

1. Establish a technical difficulty monitoring protocol that determines the frequency of assessing and addressing technical difficulties.
2. Establish a fidelity monitoring protocol to assess the quality of support being provided through Take my Hand.
3. Monitor fidelity to the training protocol and determine the frequency of refresher training on the crisis transfer process, the ASIST model, and basics of Peer support.
4. Create a weekly or monthly Take my Hand Peer Operator consultation group to check in on issues that have come up during shifts, exploring solutions to challenges faced by users, and establish a support network for the Peer Operators.
5. Develop a safety protocol that is able to incorporate anonymous users if they disclose information that requires mandated reporting.
6. Identify relevant factors likely to influence call volume (e.g. marketing, PR, local and national events).

Sustainment Phase

Continued Delivery of Take my Hand at Scale

During the Sustainment Phase, it is recognized that the Outer Context (e.g., the OAC, CalMHSA, Statewide policies etc.) and Inner Context structures (e.g., RUHS-BH leadership, Peers, and Clients) and supports are ongoing so that Take my Hand continues to be delivered, with adaptation as necessary, to realize its public mental health impact. Take my Hand is currently preparing to expand within Riverside (to the Transition Aged Youth (TAY) population) and/or to other Counties. Because of this, there are yet no key findings, Lessons Learned, or Recommendations pertaining to the Sustainment Phase. However, the lessons learned and recommendations from the Exploration, Preparation and Implementation phases suggest the importance of returning to past phases to refine processes and apply recommendations in order to facilitate incremental growth and movement towards a sustained implementation system for Take my Hand.

Web Version:

"Mental Health and Technology" [Mental Health and Technology] -

"AG44" [AG44] -
The next questions are about your use of technology.

People may use the internet for streaming video/music, playing games, checking social media, using apps, browsing the web, etc, on a computer or on a phone or mobile device.

On a typical day, how often do you use the internet?

❍ 01 Almost constantly
❍ 02 Many times a day
❍ 03 A few times a day
❍ 04 Less than a few times a day

"AG45" [AG45] - On a typical day, how often do you use a computer or mobile device for social media?

Social media may include Facebook, Instagram, Twitter, Snapchat, YouTube, etc

❍ 01 Almost constantly
❍ 02 Many times a day
❍ 03 A few times a day
❍ 04 Less than a few times a day

"AG46" [AG46] - In the past 12 months, have you tried to get help from an on-line tool, including mobile apps or texting services for problems with your mental health, emotions, nerves, or your use of alcohol or drugs?
❍ 01 Yes
❍ 02 No
If = 2, -3 go to AG48

"AG47" [AG47] - How useful was this?
❍ 01 Very
❍ 02 Somewhat
❍ 03 Not at all

"PN_AG48" [PN_AG48] -

PROGRAMMING NOTE AG48: IF AG46 =2 AND AF81 = 1 THEN CONTINUE WITH AG48
ELSE SKIP TOAG49

"AG48" [AG48] - What is the MAIN REASON you did not try to get help from an on-line tool, including mobile apps, or texting services?

❑ ❍ 1 Got better/ no longer needed
❑ ❍ 2 Wanted to handle problem myself
❑ ❍ 3 Don't own a smartphone or computer or don't have enough space to download new apps
❑ ❍ 4 Didn't know about these apps
❑ ❍ 5 Don't trust mobile apps
❑ ❍ 6 Concerns about privacy and security of data
❑ ❍ 7 Don't think it would be helpful or work
❑ ❍ 8 Cost
❑ ❍ 9 Don't have time
❑ ❍ 10 Received traditional/ face-to-face services
❑ ❍ 11 Don't think I needed it
❑ ❍ 12 Don't have enough space to download new apps
❑ ❍ 91 Other (Specify: _____)

"AG49" [AG49] - In the past 12 months, have you connected online with people that have mental health or alcohol/drug concerns similar to yours through methods such as social media, blogs, and online forums?

Include online forums or closed social media groups on specific issues, doing hashtag searches on social media, or following people with similar health conditions

❑ ❍ 01 Yes
❑ ❍ 02 No

"AG50" [AG50] - In the past 12-months, have you used online tools to find, be referred to, contact, or connect with a mental health professional?

For example, by texting, on-line messaging, video chat, or a mental health or health-related mobile app

❑ ❍ 01 Yes
❑ ❍ 02 No

CATI Version:

"Mental Health and Technology" [Mental Health and Technology] -

"AG44" [AG44] - The next questions are about your use of technology.

People may use the internet for streaming video/music, playing games, checking social media, using apps, browsing the web, etc, on a computer or on a phone or mobile device.

On a typical day, how often do you use the internet?

Would you say...

❑❑ ❍❑ 01 Almost constantly,
❑❑ ❍❑ 02 Many times a day,
❑❑ ❍❑ 03 A few times a day, or
❑❑ ❍❑ 04 Less than daily?
❑❑ ❍❑ -7 REFUSED
❑❑ ❍❑ -8 DON'T KNOW

"AG45" [AG45] - On a typical day, how often do you use a computer or mobile device for social media? Would you say…
[IF NEEDED: "Social media may include Facebook, Instagram, Twitter, Snapchat, YouTube, etc.]
❑❑ ❍❑ 01 Almost constantly,
❑❑ ❍❑ 02 Many times a day,
❑❑ ❍❑ 03 A few times a day, or
❑❑ ❍❑ 04 Less than a few times a day?
❑❑ ❍❑ -7 REFUSED
❑❑ ❍❑ -8 DON'T KNOW

"AG46" [AG46] - In the past 12 months, have you tried to get help from an on-line tool, including mobile apps or texting services for problems with your mental health, emotions, nerves, or your use of alcohol or drugs?
❑❑ ❍❑ 01 YES
❑❑ ❍❑ 02 NO
❑❑ ❍❑ -7 REFUSED
❑❑ ❍❑ -8 DON'T KNOW
If = 2,-7,-8 goto AG48

"AG47" [AG47] - How useful was this?
❑❑ ❍❑ 01 VERY
❑❑ ❍❑ 02 SOMEHWAT
❑❑ ❍❑ 03 NOT AT ALL
❑❑ ❍❑ -7 REFUSED
❑❑ ❍❑ -8 DON'T KNOW

"PN_AG48" [PN_AG48] -

PROGRAMMING NOTE AG48: IF AG46 =2 AND AF81 = 1, THEN CONTINUE WITH AG48 ELSE SKIP TOAG49

"AG48" [AG48] - What is the main reason you did not try to get help from an on-line tool, including mobile apps, or texting services?
❑❑ ❍❑ 1 GOT BETTER/NO LONGER NEEDED
❑❑ ❍❑ 2 WANTED TO HANDLE PROBLEM ON OWN
❑❑ ❍❑ 3 DON'T OWN A SMARTPHONE OR COMPUTER OR DON'T HAVE ENOUGH SPACE TO DOWNLOAD NEW APPS
❑❑ ❍❑ 4 DIDN'T KNOW ABOUT THESE APPS
❑❑ ❍❑ 5 DON'T TRUST MOBILE APPS
❑❑ ❍❑ 6 CONCERNS ABOUT PRIVACY AND SECURITY OF THE DATA

☐ ○ 7 DON'T THINK IT WOULD BE HELPFUL OR WORK
☐ ○ 8 COST
☐ ○ 9 DON'T HAVE TIME
☐ ○ 10 RECEIVED TRADITIONAL/FACE-TO-FACE SERVICES
☐ ○ 91 DON'T THINK I NEEDED IT
☐ ○ 12 DON'T HAVE ENOUGH SPACE TO DOWNLOAD NEW APPS
☐ ○ 13 Other (Specify: _____)
☐ ○ -7 REFUSED
☐ ○ -8 DON'T KNOW

"AG49" [AG49] - In the past 12 months, have you connected online with people online that have mental health or alcohol/drug concerns similar to yours through methods such as social media, blogs, and online forums?

[IF NEEDED: "Examples include online forums or closed social media groups on specific issues, doing hashtag searches on social media, or following people with similar health conditions."]

☐ ○ 01 YES
☐ ○ 02 NO
☐ ○ -7 REFUSED
☐ ○ -8 DON'T KNOW

"AG50" [AG50] - In the past 12-months, have you used online tools to find, be referred to, contact, or connect with a mental health professional?

[IF NEEDED: "Examples of online tools include texting, on-line messaging, video chat, or a mental health or health-related mobile app."]

☐ ○ 01 YES
☐ ○ 02 NO
☐ ○ -7 REFUSED
☐ ○ -8 DON'T KNOW

APPENDIX I: CHIS DATA BY COUNTY

MENTAL HEALTH TECHNOLOGY QUESTIONS	AGE	COUNTIES												
		LOS ANGELES	SAN DIEGO	ORANGE	RIVERSIDE	ALAMEDA	SAN FRANCISCO	SAN MATEO	KERN	SANTA BARBARA	MARIN	MONTEREY	TEHAMA, ETC.	DEL NORTE, ETC.
On a typical day, how often do you use the internet? (The numbers correspond to the percentage of participants who selected "Almost constantly" or "Many times a day")	12-17 y. o.	79.9 [72.0 ; 87.8]	75.2 [60.1 ; 90.3]	87.5 [77.8 ; 97.3]	81.3 [68.4 ; 94.3]	90.3 [78.1 ; 100]	88.5 [68.2 ; 100]	82.9 [56.4 ; 100]	68.0 [35.8 ; 100]	*	*	*	92.9 [79.2 ; 100]	75.8 [52.6 ; 100]
	18-25 y. o.	90.7 [86.8 ; 94.6]	92.0 [86.5 ; 97.6]	93.1 [86.3 ; 99.9]	95.1 [87.5 ; 100]	*	93.6 [84.4 ; 100]	*	84.0 [67.3 ; 100]	95.8 [87.5 ; 100]	*	96.1 [87.9 ; 100]	81.2 [52.5 ; 100]	*
	26-59 y. o.	68.7 [66.0 ; 71.5]	75.4 [71.0 ; 79.8]	70.4 [64.9 ; 75.9]	72.7 [67.6 ; 77.8]	76.2 [68.4 ; 84.0]	87.7 [81.9 ; 93.5]	85.3 [76.8 ; 93.8]	55.7 [44.4 ; 67.1]	71.3 [54.5 ; 88.0]	82.4 [74.9 ; 90.0]	76.1 [62.7 ; 89.4]	61.6 [46.7 ; 76.6]	67.8 [56.2 ; 79.3]
	60+ y. o.	36.1 [32.8 ; 39.4]	41.7 [37.0 ; 46.4]	39.6 [33.5 ; 45.6]	39.7 [33.5 ; 45.8]	40.9 [31.6 ; 50.1]	34.9 [23.3 ; 46.5]	60.4 [47.1 ; 73.7]	30.9 [19.7 ; 42.0]	38.9 [27.9 ; 49.9]	52.7 [42.7 ; 62.8]	50.1 [37.3 ; 62.9]	28.0 [20.6 ; 35.3]	34.8 [25.2 ; 44.4]
On a typical day, how often do you use a computer or mobile device for social media? (The numbers correspond to the percentage of participants who selected "Almost constantly" or "Many times a day")	12-17 y. o.	51.0 [42.0 ; 59.9]	66.9 [50.9 ; 82.9]	60.3 [45.8 ; 74.8]	77.8 [64.3 ; 91.3]	*	63.0 [32.6 ; 93.4]	82.0 [55.1 ; 100]	90.1 [73.8 ; 100]	*	*	77.5 [39.8 ; 100]	89.7 [74.0 ; 100]	*
	18-25 y. o.	70.9 [65.2 ; 76.7]	69.7 [60.4 ; 79.1]	64.0 [50.7 ; 77.4]	73.1 [60.5 ; 85.8]	94.1 [85.9 ; 100]	49.2 [26.8 ; 71.7]	*	75.7 [59.4 ; 92.0]	91.5 [80.5 ; 100]	94.8 [82.5 ; 100]	*	73.2 [38.3 ; 100]	*
	26-59 y. o.	43.9 [41.3 ; 46.5]	44.6 [40.4 ; 48.8]	41.2 [35.6 ; 46.8]	46.9 [39.6 ; 54.2]	42.8 [35.3 ; 50.3]	50.5 [43.5 ; 57.5]	29.9 [20.6 ; 39.2]	31.7 [21.5 ; 41.8]	51.9 [35.3 ; 68.5]	28.5 [15.0 ; 42.0]	52.7 [36.4 ; 71.0]	34.6 [22.4 ; 46.7]	35.4 [24.4 ; 46.5]
	60+ y. o.	17.4 [14.6 ; 20.2]	15.6 [12.6 ; 18.5]	13.9 [10.5 ; 17.2]	20.4 [15.4 ; 25.4]	17.9 [10.0 ; 25.9]	16.2 [7.6 ; 24.8]	19.7 [10.9 ; 28.4]	14.8 [6.6 ; 23.0]	20.3 [8.4 ; 32.2]	18.0 [7.6 ; 28.3]	14.4 [7.4 ; 21.4]	15.3 [10.1 ; 20.4]	13.9 [7.5 ; 20.3]
MENTAL HEALTH TECHNOLOGY QUESTIONS (ADULTS ONLY)	DISTRESS LEVEL	COUNTIES												
		LOS ANGELES	SAN DIEGO	ORANGE	RIVERSIDE	ALAMEDA	SAN FRANCISCO	SAN MATEO	KERN	SANTA BARBARA	MARIN	MONTEREY	TEHAMA, ETC.	DEL NORTE, ETC.
On a typical day, how often do you use the internet? (The numbers correspond to the percentage of participants who selected "Almost constantly" or "Many times a day")	None to low	57.8 [55.2 ; 60.4]	65.9 [62.7 ; 69.2]	60.8 [56.7 ; 64.8]	58.5 [52.6 ; 64.4]	65.1 [58.6 ; 71.6]	77.3 [70.5 ; 84.1]	77.1 [67.8 ; 86.3]	54.9 [45.5 ; 64.4]	58.1 [46.1 ; 70.0]	73.9 [64.8 ; 82.9]	68.6 [57.0 ; 80.2]	55.0 [43.6 ; 66.4]	49.3 [38.7 ; 59.9]
	Medium	77.3 [72.3 ; 82.4]	73.5 [64.9 ; 82.1]	81.1 [73.2 ; 88.9]	83.2 [73.2 ; 93.1]	82.2 [73.0 ; 91.4]	95.7 [90.7 ; 100]	88.8 [76.0 ; 100]	58.7 [33.6 ; 83.9]	84.4 [68.6 ; 100]	57.3 [25.3 ; 89.3]	85.4 [61.8 ; 100]	58.2 [32.0 ; 84.4]	57.5 [34.4 ; 80.5]
	High	82.5 [77.5 ; 87.5]	88.3 [81.6 ; 95.1]	85.1 [75.0 ; 95.2]	87.6 [81.1 ; 94.2]	77.9 [61.3 ; 94.5]	68.6 [48.0 ; 89.1]	93.2 [84.8 ; 100]	47.6 [24.1 ; 71.0]	95.3 [89.7 ; 100]	93.7 [85.6 ; 100]	95.3 [87.3 ; 100]	47.6 [19.7 ; 75.4]	69.6 [45.7 ; 93.6]
On a typical day, how often do you use a computer or mobile device for social media? (The numbers correspond to the percentage of participants who selected "Almost constantly" or "Many times a day")	None to low	35.0 [32.7 ; 37.4]	38.0 [34.7 ; 41.3]	32.2 [27.5 ; 36.9]	34.2 [28.3 ; 40.0]	36.9 [30.6 ; 43.1]	42.6 [35.8 ; 49.4]	24.3 [15.6 ; 33.0]	31.2 [23.5 ; 38.9]	47.2 [35.1 ; 59.3]	36.0 [19.5 ; 52.5]	45.7 [32.2 ; 59.1]	34.7 [22.2 ; 47.2]	22.9 [15.5 ; 30.3]
	Medium	57.1 [51.3 ; 62.8]	43.4 [33.0 ; 53.8]	58.5 [45.4 ; 71.5]	66.7 [53.6 ; 79.8]	59.2 [48.7 ; 69.8]	46.3 [24.2 ; 68.4]	55.8 [31.8 ; 79.8]	43.6 [23.6 ; 67.6]	*	*	*	*	*
	High	59.6 [53.8 ; 65.4]	59.8 [49.8 ; 69.7]	52.9 [38.3 ; 67.6]	60.4 [48.2 ; 72.6]	54.2 [35.0 ; 73.5]	45.2 [24.5 ; 65.8]	*	46.4 [23.9 ; 68.9]	61.0 [62.0 ; 100]	*	68.4 [32.5 ; 100]	*	*
MENTAL HEALTH TECHNOLOGY QUESTIONS (TEENS ONLY)	DISTRESS LEVEL	COUNTIES												
		LOS ANGELES	SAN DIEGO	ORANGE	RIVERSIDE	ALAMEDA	SAN FRANCISCO	SAN MATEO	KERN	SANTA BARBARA	MARIN	MONTEREY	TEHAMA, ETC.	DEL NORTE, ETC.
On a typical day, how often do you use the internet? (The numbers correspond to the percentage of participants who selected "Almost constantly" or "Many times a day")	None to low	76.8 [65.2 ; 88.3]	62.9 [36.5 ; 89.2]	87.2 [74.6 ; 99.9]	80.6 [60.4 ; 100]	78.3 [56.1 ; 100]	*	94.4 [81.8 ; 100]	*	*	*	*	82.8 [48.2 ; 100]	91.5 [73.3 ; 100]
	Medium	77.6 [44.7 ; 100]	70.4 [37.8 ; 100]	80.7 [42.3 ; 100]	72.8 [38.0 ; 100]	95.1 [86.2 ; 100]	*	*	*	*	*	*	*	*
	High	84.9 [72.3 ; 97.6]	*	94.1 [85.3 ; 100]	90.5 [78.0 ; 100]	*	81.5 [49.8 ; 100]	*	*	*	*	*	*	*
On a typical day, how often do you use a computer or mobile device for social media? (The numbers correspond to the percentage of participants who selected "Almost constantly" or "Many times a day")	None to low	42.5 [30.2 ; 54.9]	57.8 [31.7 ; 83.8]	60.9 [41.5 ; 80.4]	72.3 [48.2 ; 96.5]	*	*	91.1 [74.9 ; 100]	86.2 [62.7 ; 100]	*	*	81.8 [36.4 ; 100]	74.9 [34.1 ; 100]	*
	Medium	78.0 [56.9 ; 99.2]	79.0 [50.5 ; 100]	72.1 [33.9 ; 100]	81.6 [49.4 ; 100]	*	*	*	*	*	*	*	*	*
	High	53.2 [37.0 ; 69.5]	71.6 [44.6 ; 98.7]	*	83.0 [64.2 ; 100]	*	81.5 [49.8 ; 100]	*	*	*	*	*	*	*

The numbers indicated within brackets represent the 95% confidence interval of these estimates.

The "*" are used for the cross-tabs for which the sample was too small, no respondents were in that category, or the estimates were unstable.

help @ hand™ Evaluation

For questions or feedback, please contact:
evalHelpatHand@hs.uci.edu

Innovation Project: Restorative Practices for Improving Mental Health (RPIMH)

TRI·CITY
Mental Health

Restorative Practices for Improving Mental Health (RPIMH)

Breathe ~ Heal ~ Restore

MHSOAC
Mental Health Services
Oversight & Accountability Commission

MENTAL HEALTH SERVICES ACT
PROPOSITION 63
CALIFORNIA

INNOVATIVE PROJECT PLAN
RECOMMENDED TEMPLATE

COMPLETE APPLICATION CHECKLIST
Innovation (INN) Project Application Packets submitted for approval by the MHSOAC should include the following prior to being scheduled before the Commission:
☒ Final INN Project Plan with any relevant supplemental documents and examples: program flow-chart or logic model. Budget should be consistent with what has (or will be) presented to Board of Supervisors. *(Refer to CCR Title9, Sections 3910-3935 for Innovation Regulations and Requirements)*
☒ Local Mental Health Board approval Approval Date: 5/19/2021
☒ Completed 30 day public comment period Comment Period: 4/9/21-5/10/21
☒ BOS approval date Approval Date: 5/19/2021 If County has not presented before BOS, please indicate date when presentation to BOS will be scheduled: *Note: For those Counties that require INN approval from MHSOAC prior to their county's BOS approval, the MHSOAC may issue contingency approvals for INN projects pending BOS approval on a case-by-case basis.*
Desired Presentation Date for Commission: ***As soon as possible. Funds are subject to reversion effective June 30, 2021*** ***Note: Date requested above is not guaranteed until MHSOAC staff verifies all requirements have been met.***

County Name: Tri-City Mental Health Authority

Date submitted: May 25, 2021

Project Title: Restorative Practices for Improving Mental Health (RPIMH)

Total amount requested: $949,957

Duration of project: Three Years July 1, 2021-June 30, 2024

Purpose of Document: The purpose of this template is to assist County staff in preparing materials that will introduce the purpose, need, design, implementation plan, evaluation plan, and sustainability plan of an Innovation Project proposal to key stakeholders. *This document is a technical assistance tool that is recommended, not required.*

Innovation Project Defined: As stated in California Code of Regulations, Title 9, Section 3200.184, an Innovation project is defined as a project that "the County designs and implements for a defined time period and evaluates to develop new best practices in mental health services and supports". As such, an Innovation project should provide new knowledge to inform current and future mental health practices and approaches, and not merely replicate the practices/approaches of another community.

Section 1: Innovations Regulations Requirement Categories

CHOOSE A GENERAL REQUIREMENT:

An Innovative Project must be defined by one of the following general criteria. The proposed project:

- ☐ Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention
- ☐ Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- ☒ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- ☐ Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

CHOOSE A PRIMARY PURPOSE:

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

- ☐ Increases access to mental health services to underserved groups
- ☒ Increases the quality of mental health services, including measured outcomes
- ☒ Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- ☐ Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Section 2: Project Overview

PRIMARY PROBLEM

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community. Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.

Tri-City Mental Health Authority (Tri-City) provides services to a community comprised of three very distinct cities – Claremont, La Verne, and Pomona. Not only do these cities vary by size and population, they also vary financially, by their views on mental health, and by their overall community cultures. However, since March 2020, the residents of these three cities have shared one common concern that has led to an increase in anxiety, depression, fear and overall stress: COVID-19.

According to Ginger.com, the leader in on-demand mental healthcare, prior to the onset of COVID-19 in 2020, 60% of workers reported that stress impacted them at work to the point of tears, which is a 23% increase from 2019 (Ginger, 2020). Those surveyed following the outbreak of COVID-19 indicated even significantly higher levels of stress including claims that this was the “most stressful time of their entire professional career.” Additional survey data indicates that although workers agree that their employers have increased its focus on employee mental health as a result of COVID-19, more can be done. Tri-City agrees with this statement and hopes to address this commitment to staff through this plan.

In addition to the stress and burnout experienced by mental health professionals, Transition Age Youth (TAY) ages 18-25, continues to be both a priority population and yet acknowledged, "difficult to engage" group for Tri-City Mental Health. Although the pandemic has impacted all age groups within the Tri-City area, studies have shown that it seems especially damaging to these vulnerable individuals including youth in foster care.

According to the American Psychological Association, "the potential long-term consequences of the persistent stress and trauma created by the pandemic are particularly serious for our country's youngest individuals, known as Generation Z (Gen Z). Our 2020 survey shows that Gen Z teens (ages 13-17) and Gen Z adults (ages 18-23) are facing unprecedented uncertainty, are experiencing elevated stress and are already reporting symptoms of depression." (Harris Poll, 2020)

Transition Age Youth, including those residing in foster care, or who identify as LGBTQ, experience an even greater impact on their lives including living conditions and basic standards of health, education, employment and well-being since the start of this pandemic.

This year-long exposure to elevated stress in mental health service providers compounded with the persistent anxiety and trauma found in the youth of our cities, has launched this mental and emotional health focused project to provide staff and youth in our communities with a menu of independent and self-selected trainings which are easily accessible online and available in a group venue or independent study.

PROPOSED PROJECT

Describe the INN Project you are proposing. Include sufficient details that ensures the identified problem and potential solutions are clear. In this section, you may wish to identify how you plan to implement the project, the relevant participants/roles within the project, what participants will typically experience, and any other key activities associated with development and implementation.

A) Provide a brief narrative overview description of the proposed project.

Community engagement and collaboration have long been the driving forces behind the success of the projects and programs implemented by Tri-City Mental Health under the Mental Health Services Act. By engaging individuals who live and work within the three cities of Claremont, La Verne, and Pomona, Tri-City staff are able to create projects that reflect both the desire and needs of the communities we serve.

This long-standing alliance is the undertone of the **Restorative Practices for Improving Mental Health (RPIMH)** project which is comprised of a combination of three evidence-based practices, SKY Breathing, Trauma Informed Yoga, and Restorative Practice Circles. These three practices are typically delivered independently and address distinct elements related to physical health and emotional health of participants. Each of these practices are normally offered separately for a fee and as such, may not meet the individual needs of the participants. In addition, the cost is often times prohibitive for the disadvantaged youth we serve.

This project is proposing to combine these three practices into a single course of treatment or healing aimed at addressing the deficits in mental and emotional support currently available in this area. Three target populations are identified and will be engaged for this project: 1) Tri-City clinical and non-clinical staff who are experiencing the effects of COVID 19 leading to elevated stress and potential burnout; and 2) Transition Age Youth (TAY) ages 18-25, who reside within the Tri-City catchment area, including TAY who are at risk due to COVID-19, those who are residing in foster care, or identify as LGBTQ, and 3) the youth staff that support them.

The three practices selected by the workgroup participants include:

SKY Breathing: an evidence-based practice that can help individuals reduce stress and clear their minds through a breath meditation. Improvements noted by researchers and participants include the areas of depression, stress, mental health, mindfulness, positive affect, and social connectedness in addition to better quality of sleep. Researchers have shown that each emotion is linked to a breathing pattern and when you change the way you breathe you can change how you feel.

Trauma Informed Yoga: which emphasizes the impact of trauma on the entire mind-body system and provides an approach to creating a safe and supportive space where participants can learn emotional regulation skills through connection with the breath and increased body awareness. Trauma-informed yoga will increase access to mental health services to underserved groups and help participants develop positive copying mechanisms and increase the quality of mental health services while decreasing the symptoms of depression, anxiety, and stress.

Restorative Practice Circles: used to bring together both offenders and victims in an attempt to repair damaged relationships through a process of accountability and forgiveness. The reasoning behind this concept is that when someone offends or hurts someone else, the offender can reflect on their harm to the victim and work towards reconciliation while taking a restorative approach to heal the transgression. Restorative circles have proven to be

effective in a variety of educational and community settings. Circles are facilitated by individuals who hold credentials including LCSW, MFT, retired educators, college students, community members and individuals with lived experience.

Through the combined application of these three evidence-based practices, this project hopes to address the issues of retention and burnout for Tri-City staff in addition to improving the overall wellbeing of transition age youth and their support staff residing in the cities of Claremont, Pomona and La Verne.

Training Process:

This project is designed to augment existing support services or provide self-help wellness practices for those who are not currently receiving services. The trainings are designed to be accessed virtually through webinars offering three distinct wellbeing practices: SKY Breathing, Trauma Informed Yoga, and Restorative Practice Circles.

Each quarter will train a cohort of 10 individuals from each target populations, for a total of 30 participants, which allows for smaller groups and more individualized attention.

Each cohort will be offered the option to participant in one or more of the three practices (SKY Breathing, Trauma Informed Yoga, Restorative Practice Circles) depending on their schedule, preference and interest by selecting from a menu of predetermined days and times similar to classes offered at a gym or community center.

Tri-City staff will have the option to register for trainings based on their schedule. Tri-City staff will be allowed to use agency time to attend these trainings and their salary will be allocated to the RPIMH project.

Transition Age Youth (Impacted by COVID 19/Foster Care/LGBTQ) will have the option to register for trainings based on their schedule. TAY will be offered a stipend to participant in this project and will be paid per training.

Youth support staff for the TAY indicated above will have the option to register for trainings based on their schedule. Youth support staff will be offered a stipend to participant in this project and will be paid per training.

Outreach and Engagement:

Tri-City Staff: Outreach will take place internally and self-referrals will be made in conjunction with schedules and workload. The evaluation for this group will be focused on reducing staff burnout and staff retention. In addition, the evaluations will measure the impact on client outcomes when working with a staff member who is participating in this project.

Transition Age Youth (Impacted by COVID 19/Foster Care/LGBTQ): Outreach will focus on TAY who have a connection to support services or identified groups. The referral can be self-referral or through community organizations and other partners. Trainings will be specific to the TAY population and evaluation will focus on increase access to mental health services and decrease symptoms of PTSD, depression, anxiety and stress due to COVID-19.

Youth Support Staff: Outreach efforts will consist of contacting identified community partners who work with high risk youth. Trainings will be consistent with the TC staff trainings. The evaluation process will be focused on reducing youth support staff burnout.

Access to Trainings:

A subpage to Tri-City's website has been created for the purpose of showcasing the Restorative Practices for Improving Mental Health (RPIMH) project. This webpage will house updates on this project, calendar of trainings available, as well as links for registration for upcoming trainings. This page will also house the recorded trainings for future review by participants. In order to access and view the recorded webinars, participants are required to complete a registration form which will ensure tracking of participation. These videos will become available to community members upon the completion of this project.

Trainings will be offered on a quarterly basis. The training times will vary depending on the practice. This allows the participants to choose which of the practices would be most convenient for their schedule.

Examples include:
SKY Breathing: 7.5 hours delivered over three days
Trauma Informed Yoga: 8 hours delivered over 4 weeks
Restorative Practice Circles: 2 hours over 1 day

For participants who elect to join the Train-the Trainer cohort:
SKY Breathing: 8 hours delivered over four days
Trauma Informed Yoga: 15 hours over four days
Restorative Practice Circles: 2 hours over 25 weeks

B) Identify which of the three project general requirements specified above [per CCR, Title 9, Sect. 3910(a)] the project will implement.

This project applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system.

C) Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply an approach from outside the mental health field, briefly describe how the practice has been historically applied.

Each of the three trainings, SKY Breathing, Trauma Informed Yoga, and Restorative Practice Circles, have been implemented in a variety of settings but not as a "training package" used to address burnout in mental health professionals or to address trauma, depression, and anxiety in youth, including those who identify as LGBTQ, or reside in foster care.

SKY Breathing is typically taught either during an in-person training (pre COVID) or virtually. The length of time varies for each training but is typically delivered in a three-day timeframe. It can be longer for specific populations who may require additional time and support. This training is usually offered as a single method with instructors who are specifically trained in this practice.

Trauma Informed Yoga is also a specialty training that is offered in-person (pre COVID) or virtually. Instructors are also specifically trained in this practice which addresses and supports individuals who have experienced some form of trauma. Although there is a breathing component to this practice, the breath training is not as extensive or specific as SKY Breathing.

Restorative Practice Circles, also known as Restorative Justice, has historically been implement in the justice system and primarily focused on bringing together criminal offenders and their victims in an effort to encourage accountability and restitution or attempt to repair the damage done by the crime. This practice seeks to make a cultural shift from a punitive model to a restorative model. Restorative circles have also proven to be successful in educational settings as well where these skills are useful in helping student to build positive relationships and learn to support one another.

This project is proposing to combine these three practices into a single course of treatment or healing aimed at addressing the deficits in mental and emotional support currently available in this area.

D) **Estimate the number of individuals expected to be served annually and how you arrived at this number.**

This project intends to serve approximately 360 individuals over a three-year period. The following represents a projection of the number served and trained over the life of the project. However, these numbers are subject to change based on current and future COVID-19 restrictions and participation.

Tri-City Clinical and Non-Clinical Staff: We estimate serving 120 Tri-City staff over a three-year period. This will include both clinical and non-clinical staff. These trainings will be offered

both virtually, where staff will have access to them on-demand or in organized groups, and in person (year two-three), based on updated COVID -19 restrictions.

TAY/LGBTQ/Foster Youth and Youth Support Staff: This project anticipates serving a total of 240 transition age youth who are at risk due to COVID-19, LGBTQ, and/or foster youth and the staff that support them. Trainings will be offered virtually for those who have access to mobile devices, and in-person when COVID-19 restrictions allow. Each of the components will be offered but we anticipate one of more will be more popular or practical for specific populations. TAY and youth support staff participants will receive stipends as an incentive to participate in the trainings.

These numbers were arrived at based on current Tri-City staff employment numbers as well as local demographics. Tri-City currently employs 212 individuals, agency-wide and this project is intended to be offered to both clinical and non-clinical staff. Current demographic information for the combined cities of Pomona, Claremont and La Verne estimated the number of youths to average about 20% of the total population[1]. However, this project will serve a sample size of 240 TAY and support staff and then expanded if proven to be successful.

E) **Describe the population to be served, including relevant demographic information (age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate).**

Three target populations are identified and will be engaged for this project 1) Tri-City clinical and non-clinical staff who are experiencing the effects of COVID-19 leading to elevated stress and potential burnout; and 2) Transition Age Youth (TAY) ages 18-25, who reside within the Tri-City catchment area, including individuals who are at risk due to COVID-19, residing in foster care, identify as LGBTQ, and 3) the youth staff that support them.

All trainings and support services will be delivered in both English and Spanish, Tri-City's primary threshold languages.

RESEARCH ON INN COMPONENT

A) What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

Research conducted for this project indicates that traditionally, each of these practices are offered as a separate component and outcomes are measured based on the individual impact for each. Although yoga may incorporate breathing as a component, it does not

[1] US Census Bureau

include the specific approach of SKY Breathing which is one of the featured practices in the project.

SKY Breathing teaches breathing techniques and meditation which have been demonstrated to help de-stress both the mind and the body, thus bringing emotional well-being and balance to life. This practice is provided in a variety of community and professional settings but typically as a stand-alone program, although with variations depending on the audience.

Trauma Informed Yoga is a practice that focuses on creating a safe and supportive space where participants, through a connection of breath and increase body awareness, can learn emotional regulation skills. This practice is also provided in a variety of settings including yoga studios or other locations.

Restorative Practice Circles is typically utilized in the judicial and school-based systems. There are some community-based trainings also available. However, these trainings focus only on accountability and relationship repair and do not include the breathing or yoga components.

Currently Tri-City staff who are enrolled in employer-provided insurance have access to myStrength and Calm mobile apps. However, staff who do not have insurance through Tri-City do not have this added wellness benefit. This also includes the youth support staff who may not have these same benefits through their organizations. In addition, these apps are utilized at staff discretion and Tri-City is not able to track the use or impact of this benefit on staff burnout or retention.

By incorporating all three of these evidence-based practices, Tri-City will attempt to offer an array of support practices that will increase the quality of mental health wellbeing as well as promoting interagency and community collaboration related to mental health services and supports and/or outcomes.

Through this project, we hope to introduce three completely different approaches to wellbeing though instructor led sessions for breathing, yoga and restorative circles where staff are given paid time during their workday to take a break and participate in one or more of these wellness practices. Through pre and post surveys we hope to measure the impact of these wellness interventions on the personal and professional performance of both Tri-City staff and youth support staff.

In addition, SKY Breathing and Trauma Informed Yoga have a mobile app that can be accessed by participants. Prerecorded trainings will also available.

B) Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.

In order to determine the innovative approach of this project, research was conducted on the topics of SKY Breathing, Trauma Informed Yoga, and Restorative Practice Circles, as well as similar projects in general. The research indicated that there is no evidence or example of a public mental health agency implementing a program that involves utilizing a combination of these practices for the benefit of both agency staff and transition age youth, using evidence-based trainings to both support and attempt to mitigate the impact of COVID-19.

In addition, by utilizing the MHSA Program Search Tool located on the Mental Health Services Oversight and Accountability website, Tri-City staff reviewed all Innovation projects listed beginning in FY 2012-13 to date and found no projects that appeared to have the components, SKY Breathing, Trauma Informed Yoga, or Restorative Practice Circles listed. In addition, none of the current or previous projects implemented by other counties appear to address staff retention and burnout.

Citations and links to specific articles are located in the Appendix on page 28.

LEARNING GOALS/PROJECT AIMS

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the expansion of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the expansion of effective practices.

A) What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?

The **Restorative Practices for Improving Mental Health (RPIMH)** project hopes to determine if offering a set of self-help practices, used in combination, can help mental health staff to improve their own mental and physical health while serving clients in both an existing and post COVID-19 world. This project seeks to understand if providing a series of evidence-based training that can be accessed on-demand, will help to reduce stress and improve retention in community mental health.

In addition, will these same set of practices help transition age youth (ages 18-25) to improve their resiliency and emotional regulation while decreasing symptoms of trauma, depression, anxiety, and stress as well as the youth staff that support them. These goals were determined

by both Tri-City staff and community members as a result of engagement in surveys, workgroups, and outside research.

Goals for this project include:

1. Reduce the rate of burnout in Tri-City staff and increase retention rate
2. Reduce the rate of burnout in community support staff that work with TAY
3. Develop an online menu of wellbeing practices that staff can access on-demand
4. Increase client outcomes when incorporating one or more of these practices
5. Increase access to mental health services for Transition Age Youth (TAY)
6. Decreased symptoms of trauma, depression, anxiety, and stress in the TAY population
7. Increase the number of TAY who are reunited with family members through restorative dialogue

B) How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

Each of these learning goals reflect Tri-City's desire to evaluate, through pre and post evaluations, and ultimately improve the overall mental wellbeing for these critical populations. Through the combination of these evidence-based practices, this project hopes to address the issues of retention and burnout for Tri-City staff in addition to improving the overall wellbeing of transition age youth at risk due to COVID-19, including those who identify as LGBTQ, and foster care youth, in addition to the staff that support them.

EVALUATION OR LEARNING PLAN

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. Specifically, please identify how each goal will be measured and the proposed data you intend on using.

All surveys and evaluations for this project will be conducted by Tri-City's Best Practices (BP) staff. In addition, all outcomes and reports will be generated by BP staff including those utilized in the INN Annual Reports and RPIMH Final Project Report.

Each of these learning goals/questions will be evaluated by the method indicated below. Pre and post tests will be administered before and after each training. Results will be compiled and presented to participants and stakeholders on a quarterly basis. Any necessary changes or course corrections will be made at that time.

In addition, performance measure will be developed based on a data collection method platform called Results Based Accountability (RBA). RBA uses a data-driven, decision-

making process to help communities to improve the effectiveness of their programs. This method starts with the end in mind and works forward with an emphasis on the target population vs performance of the program.

EVALUATION OR LEARNING PLAN

- Reduce the rate of burnout in Tri-City staff and increase retention rate

Learning Goal	Evaluation Method
Is RPIMH effective in reducing burnout among clinical and non-clinical mental health professionals? Is RPIMH effective in engaging TC staff in a sustained well-being practice? Does the knowledge gained through the combination of RPIMH frameworks help staff to integrate these practices in their scope of work?	1. Staff data that includes: Number of people trained in RPIMH and by job position. 2. Pre and post survey of participants that includes questions related to burnout and stress. Burnout is measured with the Maslach Burnout Inventory and the Perceived Stress Scale. Open-Ended questions will also be included to gather information specific to what they find stressful or difficult about their jobs. 3. Post survey of their use of these practices, how often, and their experiences. Open-Ended questions will also be included to learn more about their experiences and comments on what worked well and what could be improved. 4. Follow up survey in six months to learn how they have used these practices including open-ended questions. 5. Pre and Post measures of retention rate by position/clinical and non-clinical.

- Reduce the rate of burnout in community support staff that work with TAY

Learning Goal	Evaluation Method
Is RPIMH effective in improving well-being among youth workers? Does RPIMH reduce stress among youth workers?	1. Pre and post survey of participants that includes questions related to burnout and stress. Burnout is measured with the Maslach Burnout Inventory and the Perceived Stress Scale. Open-Ended questions will also be included to gather

	information specific to what they find stressful or difficult about their jobs. 2. Survey on how they have used these practices (post survey only). Open-Ended questions will also be included to learn more about their experiences and their use of these practices and comments on what worked well and what could be improved.

- Develop an online menu of wellbeing practices that staff can access on-demand

Learning Goal	Evaluation Method
Does providing an access on-demand menu of wellbeing practices contribute to retention?	1. Number of practices offered 2. Number of practices accessed 3. Number of people who accessed the practices 4. Post survey of those who accessed these practices and how they used them to help themselves and others. Open-Ended questions will also be included to learn more about whether the on-demand menu is effective and their use of these practices and comments on what worked well and what could be improved.

- Increase client outcomes when incorporating one or more of these practices

Learning Goal	Evaluation Method
Does the practice of RPIMH by clinicians improve client outcomes?	1. Post survey of staff to see how often they connect clients with these practices and the number of clients they have connected with. Open-ended questions asking how they felt their clients benefitted and how it improved their rapport with clients. 2. Add questions to the client survey (MHSIPs) that address the use and experience of clients when using these

	practices (post survey only). Open-ended questions about how the clients benefitted, what worked well for them, and what could be improved or changed.

- Increase access to mental health services for Transition Age Youth (TAY)

Learning Goal	Evaluation Method
Does RPIMH promote interagency and community collaboration related to mental health services by providing an entry point to seeking additional support services?	1. Number of service requests for Access to Care from community agencies that are involved in this project. 2. Number of referrals into Tri-City programs (MHSA, IOET, etc.) from community agencies that are involved in this project. 3. Focus group with community agencies on their experiences with this project, their likelihood of reaching out to Tri-City for assistance or to refer someone for services, and how this project could be improved.

- Decreased symptoms of PTSD, depression, anxiety, and stress *in the TAY population*

Learning Goal	*Evaluation Method*
Is RPIMH effective in reducing symptoms of trauma, *PTSD, depression, anxiety, and stress* in youth?	1. Pre and post surveys of Tri-City Mental Health TAY clients (18 years and older) that includes: a. Measures of depression, anxiety, and stress using the PHQ-9 to measure depression, the GAD-7 to measure anxiety and the Perceived Stress Scale. b. The use and experience of clients when using these practices, including open-ended comments. c. Measures of resiliency emotional regulation, and ability to manage stress.
Is RPIMH effective in increasing resiliency among youth?	
Is RPIMH effective in increasing emotional regulation among youth?	

- Increase the number of TAY who are reunited with family members through restorative dialogue

Learning Goal	Evaluation Method
Is RPIMH effective in reuniting families who are estranged or experiencing relationship challenges?	1. Number of TAY families who participate in RPIMH who are not unified or are experiencing challenges. 2. Pre and post surveys measuring communication and interaction. Post survey will also include how often they use these practices and their experiences when using them. Open-Ended questions will also be included to learn more about their experiences and what specifically did and did not improve. Comments will also be gathered on their ideas on how this project could be improved.

Historically Tri-City has not tracked "burn-out" rates specifically among staff members. However, with the onset of COVID-19 and the resulting increase in clinical caseloads as well as concern for health and safety when delivering services, anecdotal stories and comments from staff have indicated that the role of a community mental health clinician acting in a COVID -19 environment, had become increasingly stressful during 2020.

Although the pandemic is subsiding, the long-term impact of COVID-19 on both staff and clients has yet to be determined. Recruiting and retaining community mental health workers has long been a concern for Counties. Tri-City has worked diligently to develop incentives that have value for staff and help to increase retention. These benefits include WET student loan repayment plans, administrative leave time, and several trainings designed to improve staff skills. However, we are looking to do more to address these issues on a personal as well as professional level.

When first considering this project, these are the statistics we reviewed at the time of this project's development:

Current # of Clinical Therapist on staff 42

<u>2020</u>
2020 # of Clinical Therapist Hires: 19
2020 # of Clinical Therapist Separations: 12

2021-January - April
2021 # of Clinical Therapist Hires: 3
2021 # of Clinical Therapist Separations: 3

Although the numbers for 2021 only reflect the first few months, the trend seems to continue; significant decrease in the number of therapist hired and the separations continue at a steady pace.

Our hope is that, with this project, staff will take advantage of these wellness practices that will be available via webinars, recordings and, when possible, in person, to support their own mental wellbeing and the stressors that lead to burn-out and staff turnover.

Section 3: Additional Information for Regulatory Requirements

CONTRACTING

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

Tri-City expects to contract with outside trainers for SKY Breathing, Trauma Informed Yoga, and Restorative Practice Circle trainings. In addition, if possible, this project will utilize trainers that practice within the Tri-City area and are current stakeholders and community members. Funding for these trainers/trainings will be provided through the RPIMH project budget.

The trainings will be coordinated and supervised by the Innovation Coordinator in collaboration with the training representatives. Each of these evidence-based trainings will be evaluated by Tri-City's Best Practices Department and outcomes will be shared with stakeholders via quarterly and annual Innovation project reports as well as through presentations in community stakeholder meetings.

COMMUNITY PROGRAM PLANNING

Please describe the County's Community Program Planning process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community.

Since the onset of COVID-19, in-person stakeholder meetings are prohibited which makes frequent communication with stakeholders via email and virtual meetings even more critical to ensure they are aware of resources and support services that are available to them and the community at large. Stakeholder meetings and workgroups were transitioned to a virtual platform in March of 2020 in addition to emails sent with links to online trainings and virtual webinars as well as service updates.

To begin this Innovation planning process, stakeholders were informed and invited during the September 2020 stakeholder meeting to participate in the development of a new Innovation project. Participants who expressed an interest in this process were informed of

the workgroup information. In addition, an online survey was distributed to stakeholders to request new ideas to be submitted. From this survey three ideas were submitted which were presented to the Innovation workgroup.

In an ongoing effort to collect additional stakeholder input, stakeholders and community members were emailed and encouraged to complete Tri-City's MHSA Planning Process Survey to share their thoughts and concerns regarding the availability of support services, priority populations and unmet needs within the Tri-City care. This annual community planning survey is available in both English and Spanish and is used to identify the needs and priorities of the three cities. These results are then presented to the Innovation workgroups who were able to incorporate these needs and concerns in the creation of new Innovation projects.

In the most recent planning survey, when asked to identify priority populations, respondents indicated their concern for Transition Age Youth (18-25), including those who reside in foster care or identify as LGBTQ. These results were the impetus that sparked further conversations in the Innovation workgroups where participants addressed the numerous issues encountered by this critical population while developing this project proposal.

The demographics for those completing the Community Planning Survey included:
Gender: 82% Female and 18% Male
Age: Ages 26-59 64% and 60+ 36%
Primary Language English 91% and Spanish 9%
Race/Ethnicity: Hispanic/Latino 27%, White/Caucasian 55%, Other 18%
Other: LGBTQ 9%

In January of 2021, community members and Tri-City staff came together to begin the process of identifying a new Innovation project. Innovation workgroup participants consisted of fifteen members who reflect a diverse group of individuals. These individuals represented Tri-City staff, faith-based leaders, community members involved in juvenile justice, LGBTQ, and transition age youth. Two project ideas were presented by community members; one did not meet the criteria for an Innovation project and the other project was voted to move forward and is presented here. A third option was considered a duplicate of a previous idea.

The following is a list of the public meetings, postings and approvals:
Stakeholder Meetings: 9/30/20, 3/4/21
Innovation Workgroups: 1/21/21, 2/4/21, 2/9/21, 2/10/21, 2/11/21
Plan Posting Date for 30-Day Comment Period: April 9, 2021 to May 10, 2021
Mental Health Commission Approval: May 19, 2021
Tri-City Governing Board Approval: May 19, 2021

MHSA GENERAL STANDARDS

Using specific examples, briefly describe how your INN Project reflects, and is consistent with, all potentially applicable MHSA General Standards listed below as set forth in Title 9 California Code of Regulations, Section 3320 (Please refer to the MHSOAC Innovation Review Tool for definitions of and references for each of the General Standards.) If one or more general standards could not be applied to your INN Project, please explain why.

A) Community Collaboration

The overall focus of this project is to create community collaboration around mental health and wellbeing. Tri-City will work with various local organizations representing the target populations as well as the trainers who have been identified to participate in this project. These organizations include faith-based groups, youth organizations, foster care group homes, local LGBTQ Pride Center, and Tri-City Wellness Center.

B) Cultural Competency

Cultural competence and inclusion are vital to creating projects that are accessible to community members residing within the Tri-City area. Each of the practices included in this project proposal are available in both English and Spanish. Tri-City will collaborate with each organization to identify the best cultural approach for working with each of these populations. This information will be incorporated in the training approaches utilized in this project.

C) Client-Driven

This project was selected after an extensive stakeholder process which included clients, community members and individuals with lived experience. The methods of feedback incorporated were collected through stakeholder meetings, Innovation workgroups and a community planning survey.

D) Family-Driven

Family members have provided valuable insight and feedback as to ways Tri-City can continue to support their needs and approach obstacles they may be facing when seeking services for themselves and their children. This feedback has been incorporated in the planning of this project.

Although the SKY Breathing and Trauma Informed Yoga are person-specific and will be offered on an individual basis to participants, the Restorative Practice Circles are designed to engage family members and other who were “wronged” due to the behaviors of the participant. This training will educate the participant in

the principals of Restorative Practices and then encourage family members, foster parents, and others to join in the circles to begin the process of restoring the relationships.

E) Wellness, Recovery, and Resilience-Focused

All three components of this project are wellness, recovery, and resilience-focused. When used in combination, these practices will build on the strengths of each practice and participant to support people-in-recovery and those who may have experienced trauma, to live meaningful lives guided by their own choices.

F) Integrated Service Experience for Clients and Families

Through this project, Tri-City staff will have access to all three practices and able to share these skills with their clients. Clients will then be able to share their experiences with family members and extend these practices/skills to others. In addition, these practices, Restorative Circles in particular, will provide an opportunity for clients and their family members to use this new skill of communication and accountability to heal their broken relationships.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

Explain how you plan to ensure that the Project evaluation is culturally competent and includes meaningful stakeholder participation.

Tri-City Mental Health is committed to the advancement of quality mental health services that are culturally compatible and respectful of the diverse healthcare beliefs of the people served. It is the mission of this Agency to guide and support the staff of Tri-City to ensure cultural and linguistically appropriate programs and services are available for community members residing in the cities of Claremont, Pomona and La Verne by building strong and collaborative relationships through partnerships and community engagement. Tri-City has a robust stakeholder engagement process which includes open communication, pre and post surveys, workgroups, community stakeholder meetings, and continuous feedback. Materials are offered in both English and Spanish as well as interpreters for non-English speaking participants. Tri-City understands that Innovation projects are ever-evolving and it is necessary to have continuous check-ins with stakeholders to know if there is a pivot that needs to occur.

In addition, Tri-City hosts four community groups where participants are able to provide feedback regarding new and ongoing projects. These groups include ¡Adelante! Latino and Hispanic Wellness Advisory Council, whose primary goal is to instill hope and wellness by empowering community members within the Latino and Hispanic community to advocate and

share their experience, knowledge and feedback. The LGBTQ+ Wellness Advisory Council was established to give a voice to LGBTQ+ communities by empowering members to advocate and share their experience, knowledge and feedback. The African American Family Wellness Advisory Council (AAFWAC) whose primary goal is to nurture hope and wellness within the African American community through mental health advocacy and treatment referral. The final group, dedicated to the Asian American Pacific Islander population, is currently in the formation phase and will be serving our AAPI community members in the same capacity as the groups mentioned about.

During the course of this learning project, there will be quarterly evaluations and discussions impacting the project activities based on outcomes. Participants of the project advisory committee will work closely with Tri-City staff in identifying performance and outcome measures that will provide the most credible and timely data for this project.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

Briefly describe how the County will decide whether it will continue with the INN project in its entirety, or keep particular elements of the INN project without utilizing INN Funds following project completion.

Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals upon project completion.

This project is not intended to provide direct services for individuals with severe emotional disturbance (SED)/serious mental illness (SMI). However, this project will provide support for providers in an effort to reduce burnout which directly impacts availability, consistency and continuity of care for person with severe emotional disturbance/serious mental illness.

This project will be evaluated based on participant/stakeholder feedback and various outcomes and performance measures. If determined to be successful, this project may be assumed under the Prevention and Early Intervention plan, as funding allows.

In addition, both the Tri-City staff, TAY, and TAY support staff who are trained in each of these practices will have the opportunity to continue to train other individuals in the community including clients, peers, family members and other service partners.

COMMUNICATION AND DISSEMINATION PLAN

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

A) How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties? How will program participants or other stakeholders be involved in communication efforts?

This project will be promoted on Tri-City's website as well as all Tri-City social media platforms. Announcements have been made during stakeholder meetings and through direct emails. Tri-City staff will also be included in the launch process once the appropriate approvals have been received. In addition, local community partners who are offering these trainings will be promoting this project internally to their members.

Tri-City will provide stakeholders with periodic status reports during MHSA presentations and through Annual Updates and Three-Year Integrated plans. Tri-City will also seek opportunities to provide information on shared learnings during conferences, community meetings and collaborations with county partners. Program participants will be invited to share their personal experiences during these gatherings and other stakeholders will be able to share this project directly with their community organization, agency or department. The project and all subsequent reports will be posted on Tri-City's website as well as promoted through social media.

B) KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

Breathing Trauma Restorative Stress Burnout

TIMELINE

A) Specify the expected start date and end date of your INN Project
July 1, 2021 to June 30, 2024

B) Specify the total timeframe (duration) of the INN Project
Three Years

C) Include a project timeline that specifies key activities, milestones, and deliverables—by quarter.

The following represents a projection of anticipated activities along with the corresponding dates. However, these projections are only estimates and may be adjusted throughout the life of the project based on actual project performance and any unforeseen impact due to COVID-19 restrictions.

<u>Year 1, Quarter 1 July – Sept 2021</u>

- Create outreach and engagement strategy with training consultants
- Prepare outreach and engagement marketing materials

- Determine required documents such as Release of Information and/or HIPAA
- Confirm project participants and related organizations
- Advise and promote trainings to Tri-City staff
- Develop outcome and performance measures to support data collection
- Administer pre-training surveys to both Tri-City staff and TAY/TAY support staff
- Begin onboarding process for both Tri-City staff and TAY/TAY support staff
- Begin training on SKY Breathing for Tri-City staff and TAY/TAY support staff
- Begin training on Trauma Informed Yoga for Tri-City staff and TAY/TAY support staff
- Begin training on Restorative Practice Circles for TC staff and community members
- Administer post-training surveys to both Tri-City staff and TAY/TAY support staff

Year 1, Quarter 2 Oct – Dec 2021

- Administer pre-training surveys to both Tri-City staff and TAY/TAY support staff
- Begin onboarding process for both Tri-City staff and TAY/TAY support staff
- Begin training on SKY Breathing for Tri-City staff and TAY/TAY support staff
- Begin training on Trauma Informed Yoga for Tri-City staff and TAY/TAY support staff
- Begin training on Restorative Practices/Circles for Tri-City staff and TAY/TAY support staff
- Administer post-training surveys to both Tri-City staff and TAY/TAY support staff
- Review learning questions and performance measures to ensure accurate tracking
- Prepare quarterly report-post on Tri-City website and share with stakeholders

Year 1, Quarter 3 Jan – Mar 2022

- Administer pre-training surveys to both Tri-City staff and TAY/TAY support staff
- Continue training on SKY Breathing for Tri-City staff and TAY/TAY support staff
- Continue training on Trauma Informed Yoga for Tri-City staff and TAY/TAY support staff
- Continue training on Restorative Practice Circles for Tri-City staff and TAY/TAY support staff
- Administer post-training surveys to both Tri-City staff and TAY/TAY support staff
- Review learning questions and performance measures to ensure accurate tracking
- Prepare quarterly report-post on Tri-City website and share with stakeholders

Year 1, Quarter 4 Apr – June 2022

- Administer pre-training surveys to both Tri-City staff and TAY/TAY support staff
- Continue training on SKY Breathing for Tri-City staff and TAY/TAY support staff

- Continue training on Trauma Informed Yoga for Tri-City staff and TAY/TAY support staff
- Continue training on Restorative Practices/Circles for Tri-City staff and TAY/TAY support staff
- Begin train-the-trainer on SKY Breathing for Tri-City staff and TAY/TAY support staff
- Begin train-the-trainer on Trauma Informed Yoga for Tri-City staff and TAY/TAY support staff
- Begin train-the-trainer on Restorative Practice Circles for Tri-City staff and TAY/TAY support staff
- Administer post-training surveys to both Tri-City staff and TAY/TAY support staff
- Review learning questions and performance measures to ensure accurate tracking
- Prepare quarterly report-post on Tri-City website and share with stakeholders

Year 2, Quarter 1 July – Sept 2022

- Create annual Innovation Project Report for FY 2021-22
- Review learning questions and performance measures to ensure accurate tracking
- Identify participants to become trainers for FY 2022-23
- Begin onboarding process for community trainers and staff trainers
- Administer pre-training surveys to both Tri-City staff and TAY/TAY support staff
- Continue training on SKY Breathing for Tri-City staff and TAY/TAY support staff
- Continue training on Trauma Informed Yoga for Tri-City staff and TAY/TAY support staff
- Continue training on Restorative Practice Circles for Tri-City staff and TAY/TAY support staff

Year 2, Quarter 2 Oct – Dec 2022

- Administer pre-training surveys to both Tri-City staff and TAY/TAY support staff
- Continue training on SKY Breathing for Tri-City staff and TAY/TAY support staff
- Continue training on Trauma Informed Yoga for Tri-City staff and TAY/TAY support staff
- Continue training on Restorative Practice Circles for Tri-City staff and TAY/TAY support staff
- Administer post-training surveys to both Tri-City staff and TAY/TAY support staff
- Review learning questions and performance measures to ensure accurate tracking
- Prepare quarterly report-post on Tri-City website and share with stakeholders

Year 2, Quarter 3 Jan – Mar 2023

- Administer pre-training surveys to both Tri-City staff and TAY/TAY support staff
- Continue training on SKY Breathing for Tri-City staff and TAY/TAY support staff
- Continue training on Trauma Informed Yoga for Tri-City staff and TAY/TAY support staff
- Continue training on Restorative Practice Circles for Tri-City staff and TAY/TAY support staff
- Administer post-training surveys to both Tri-City staff and TAY/TAY support staff
- Review learning questions and performance measures to ensure accurate tracking
- Prepare quarterly report-post on Tri-City website and share with stakeholders

Year 2, Quarter4 Apr – June 2023

- Administer pre-training surveys to both Tri-City staff and TAY/TAY support staff
- Continue training on SKY Breathing for Tri-City staff and TAY/TAY support staff
- Continue training on Trauma Informed Yoga for Tri-City staff and TAY/TAY support staff
- Continue training on Restorative Practice Circles for Tri-City staff and TAY/TAY support staff
- Begin train-the-trainer on SKY Breathing for Tri-City staff and TAY/TAY support staff
- Begin train-the-trainer on Trauma Informed Yoga for Tri-City staff and TAY/TAY support staff
- Begin train-the-trainer on Restorative Practice Circles for Tri-City staff and TAY/TAY support staff
- Administer post-training surveys to both Tri-City staff and TAY/TAY support staff
- Review learning questions and performance measures to ensure accurate tracking

Year 3, Quarter 1 July – Sept 2023

- Create annual Innovation Project Report for FY 2022-23
- Review learning questions and performance measures to ensure accurate tracking
- Begin onboarding process for community trainers and staff trainers
- Administer pre-training surveys to both Tri-City staff and TAY/TAY support staff
- Continue training on SKY Breathing for Tri-City staff and TAY/TAY support staff
- Continue training on Trauma Informed Yoga for Tri-City staff and TAY/TAY support staff
- Continue training on Restorative Practice Circles for Tri-City staff and TAY/TAY support staff

Year 3, Quarter 2 Oct – Dec 2023

- Administer pre-training surveys to both Tri-City staff and TAY/TAY support staff
- Continue training on SKY Breathing for Tri-City staff and TAY/TAY support staff
- Continue training on Trauma Informed Yoga for Tri-City staff and TAY/TAY support staff
- Continue training on Restorative Practice Circles for Tri-City staff and TAY/TAY support staff
- Administer post-training surveys to both Tri-City staff and TAY/TAY support staff
- Review learning questions and performance measures to ensure accurate tracking
- Prepare quarterly report-post on Tri-City website and share with stakeholders

Year 3, Quarter 3 Jan – Mar 2024

- Administer pre-training surveys to both Tri-City staff and TAY/TAY support staff
- Continue training on SKY Breathing for Tri-City staff and TAY/TAY support staff
- Continue training on Trauma Informed Yoga for Tri-City staff and TAY/TAY support staff
- Continue training on Restorative Practice Circles for Tri-City staff and TAY/TAY support staff
- Administer post-training surveys to both Tri-City staff and TAY/TAY support staff
- Review learning questions and performance measures to ensure accurate tracking
- Prepare quarterly report-post on Tri-City website and share with stakeholders

Year 3, Quarter4 Apr – June 2024

- Administer pre-training surveys to both Tri-City staff and TAY/TAY support staff
- Continue training on SKY Breathing for Tri-City staff and TAY/TAY support staff
- Continue training on Trauma Informed Yoga for Tri-City staff and TAY/TAY support staff
- Continue training on Restorative Practices/Circles for Tri-City staff and TAY/TAY support staff
- Administer post-training surveys to both Tri-City staff and TAY/TAY support staff
- Review learning questions and performance measures to ensure accurate tracking

Year 3, July – Dec 2024

- Process final outcome survey results
- Create final Innovation Project Report
- Assess project for incorporation under Prevention and Early Intervention (PEI)

Section 4: INN Project Budget and Source of Expenditures

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

The next three sections identify how the MHSA funds are being utilized:

A) BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)
B) BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal year)
C) BUDGET CONTEXT (if MHSA funds are being leveraged with other funding sources)

BUDGET NARRATIVE

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Ideally, the narrative would include an explanation of amounts budgeted to ensure/support stakeholder involvement (For example, "$5000 for annual involvement stipends for stakeholder representatives, for 3 years: Total $15,000") and identify the key personnel and contracted roles and responsibilities that will be involved in the project (For example, "Project coordinator, full-time; Statistical consultant, part-time; 2 Research assistants, part-time…"). Please include a discussion of administration expenses (direct and indirect) and evaluation expenses associated with this project. Please consider amounts associated with developing, refining, piloting and evaluating the proposed project and the dissemination of the Innovative project results.

Section 4: INN Project Budget and Source of Expenditures

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

BUDGET NARRATIVE

Tri-City Mental Health Authority (TCMHA) has allocated $949,957 in Innovation funds for the following project: Restorative Practices for Improving Mental Health (RPIMH). This three-year project is expected to commence in July 2021, pending approval from the MHSOAC, and conclude in June 2024.

All cost elements included in this budget are estimated and subject to revision based on final determination of contracts, costs of training, evaluations, and additional services as required.

The amounts included in this budget cover personnel costs, operating costs, costs for consultants, other expenditures.

Personnel Costs:
The salaries and benefits included within this budget are estimated based on the total number of hours of training/participation that is being proposed for Tri-City staff engagement. Approximately 2,300 hours of training/participation for approximately 145 staff over the three-year project period. In addition, a portion of salaries and benefits for Tri-City's INN Program Coordinator and Tri-City's MHSA Projects Manager have also been included. (2.0 FTE) 68% of total project budget for staff salary and benefits

INN Program Coordinator: The Coordinator will oversee the implementation of the RPIMH project including the planning, organizing, training and directing of activities as they relate to this project.

MHSA Projects Manager: The Manager will monitor the implementation of the RPIMH project and will directly supervise the Coordinator to ensure appropriate progress is being made throughout the project period.

Evaluation/Quality Improvement Staff: Tri-City data analysts will support this program through processing of evaluations, and analysis of data that is gathered throughout the project period.

Operating Costs:
Indirect operating costs are calculated at approximately 15% and would be used to cover the general and indirect operating costs to support this program.

Consultant/Training Costs:
The Consultants Costs will be used to pay for the facilitators which will provide the instruction and training for the three evidence-based practices proposed which include Sky Breathing, Trauma Informed Yoga, and Restorative Practice Circles. Each training module will be conducted by a separate organization who has been vetted and able to provide each training in both English and Spanish. In addition, these training will be provided by qualified individuals who are embedded in the Tri-City area. Finally, these organizations have an affiliation with each of the community populations stated in this project and will assist with the recruiting and onboarding process.

Other Expenditures:
Other expenditures anticipated include the payment of stipends to participants as well as the purchase of tablets and/or smart phone. Also, in addition to the estimated purchase of evaluation tools, Tri-City anticipates the need to purchase licenses for virtual meeting platforms such as Zoom.

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 21/22**	**FY 22/23**	**FY 23/24**			**TOTAL**
1.	Salaries	$169,518	$177,994	$146,537			$494,049
2.	Direct Costs						
3.	Indirect Costs						
4.	**Total Personnel Costs**	**$169,518**	**$177,994**	**$146,537**			**$494,049**
OPERATING COSTS		**FY 21/22**	**FY 22/23**	**FY 23/24**			**TOTAL**
5.	Direct Costs						
6.	Indirect Costs	$45,903	$47,099	$30,906			$123,908
7.	**Total Operating Costs**	**$45,903**	**$47,099**	**$30,906**			**$123,908**
NON RECURRING COSTS (equipment, technology)		**FY 21/22**	**FY 22/23**	**FY 23/24**			**TOTAL**
8.							
9.							
10.	**Total Non-recurring costs**						
CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)		**FY 21/22**	**FY 22/23**	**FY 23/24**			**TOTAL**
11.	SKY Breathing	$42,000	$42,000	$16,000			$100,000
12.	Trauma Informed Yoga	$42,000	$42,000	$16,000			$100,000
13.	Restorative Practices	$42,000	$42,000	$16,000			$100,000
14.	**Total Consultant Costs**	**$126,000**	**$126,000**	**$48,000**			**$300,000**
OTHER EXPENDITURES (please explain in budget narrative)		**FY 21/22**	**FY 22/23**	**FY 23/24**			**TOTAL**
15.	Stipends for TAY & Community Participants	$8,000	$8,000	$8,000			$24,000
16.	Other-Supplies, Materials, Tablets	$3,500	$3,000	$1,500			$8,000
17.	**Total Other Expenditures**	**$11,500**	**$11,000**	**$9,500**			**$32,000**
BUDGET TOTALS		**FY 21/22**	**FY 22/23**	**FY 23/24**			**TOTAL**
Personnel (line 1)		**$169,518**	**$177,994**	**$146,537**			**$494,049**
Direct Costs (add lines 2, 5, 11, 12 and 13 from above)		**$126,000**	**$126,000**	**$48,000**			**$300,000**
Indirect Costs (add lines 3, and 6 from above)		**$45,903**	**$47,099**	**$30,906**			**$123,908**
Non-recurring costs (line 10)		**-**	**-**	**-**			**-**
Other Expenditures (line 17)		**$11,500**	**$11,000**	**$9,500**			**32,000**
TOTAL INNOVATION BUDGET		**$351,921**	**$361,093**	**$236,943**			**$949,957**

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION:							
A.	**Estimated total mental health expenditures <u>for ADMINISTRATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 23/24**			**TOTAL**
1.	Innovative MHSA Funds	$330,490	$338,591	$221,192			$890,273
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Administration**	**$330,490**	**$338,591**	**$221,192**			**$890,273**
EVALUATION:							
B.	**Estimated total mental health expenditures <u>for EVALUATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 23/24**			**TOTAL**
1.	Innovative MHSA Funds	21,431	$22,502	$15,751			$59,684
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Evaluation**	**$21,431**	**$22,502**	**$15,751**			**$59,684**
TOTAL:							
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21/22**	**FY 22/23**	**FY 23/24**			**TOTAL**
1.	Innovative MHSA Funds	**351,921**	**$361,093**	**$236,943**			**$949,957**
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Expenditures**	**$351,921**	**$361,093**	**$236,943**			**$949,957**
*If "Other funding" is included, please explain.							

Use of Workforce Education and Training (WET) Funds:
Although Tri-City staff considered the use of Workforce Education and Training (WET) funds to support these trainings, it became clear that due to the uncertainty of how these training would best support both staff and community members, and how well these practices would integrate into one approach to wellness, this proposal would be better suited as an Innovation project.

However, when considering sustainability, if proven to be successful, and based on lessons learned and adaptation made, WET funds will be considered for funding of future staff trainings. Prevention and Early Intervention (PEI) funds are anticipated to fund any further community trainings for TAY and TAY support staff. This determination was made based on the PEI criteria for serving ages 0-25 as well as increasing access to services.

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Capital Facilities and Technological Needs
Project Proposal

Component Exhibit 1

Capital Facilities and Technological Needs Face Sheet

MENTAL HEALTH SERVICES ACT (MHSA)
CAPITAL FACILITIES and TECHNOLOGICAL NEEDS
FY 2021-22

County: Tri-City Mental Health Authority Date: May 19, 2021

County Mental Health Director:

Antonette (Toni) Navarro, LMFT
Printed Name

Signature

Date: 05/27/2021

Mailing Address: Tri-City Mental Health Authority
1717 N. Indian Hill Blvd, Suite B
Claremont, CA 91711

Phone Number: 909-623-6131 Fax: 909-623-4073

E-mail: anavarro@tricitymhs.org

Contact Person: Rimmi Hundal
Phone: 909-623-6131
Fax
E-mail:

Component Exhibit 1 (continued)

COUNTY CERTIFICATION

I hereby certify that I am the official responsible for the administration of Community Mental Health Services in and for Tri-City Mental Health Authority (TCMHA) and that the following are true and correct:

This Component Proposal is consistent with the Mental Health Services Act.

This Capital Facilities and Technological Needs FY 2021-2022 Component Proposal Update is consistent with and supportive of the standards set forth in Title 9, California Code of Regulations (CCR) Section 3320.

The County certifies that if proposing technological needs project(s), the Technological Needs Assessment, including the Roadmap for moving toward an Integrated Information Systems Infrastructure, will be submitted with the first Technological Needs Project Proposal.

This Component Proposal has been developed with the participation of stakeholders, in accordance with Title 9, CCR Sections 3300, 3310, and 3315, and with the participation of the public and our contract service providers. The draft local Capital Facilities and Technological Needs Component Proposal was circulated for 30 days to stakeholders for review and comment and a public hearing was held by the local mental health board. All input has been considered, with adjustments made, as appropriate.

Mental Health Services Act funds are and will be used in compliance with Title 9, CCR Section 3410, Non-Supplant.

All documents in the attached Component Proposal for Capital Facilities and Technological Needs are true and correct.

Date: 05/27/2021 Signature: _____

County Mental Health Director

Executed at: Claremont, CA

Component Exhibit 2

COMPONENT PROPOSAL NARRATIVE

1. Framework and Goal Support

Briefly describe: 1) how the County plans to use Capital Facilities and/or Technological Needs Component funds to support the programs, services and goals implemented through the MHSA, and 2) how you derived the proposed distribution of funds below.

Proposed distribution of funds:

Capital Facilities	$ N/A	or	%
Technological Needs	$ 300,436	or	100%

Breakdown:

1) Cerner Electronic Health Record (EHR) system implementation costs at $270,436
2) Unite Us referral management platform costs at $30,000.

Summary:

Tri-City Mental Health (TCMH) intends to expend existing MHSA funds assigned to Capital Facilities and Technological Needs to implement a new Electronic Health Record system and client referral management platform.

The Office of the National Coordinator for Health Information Technology's (ONC) Cures Act Final Rule passed in 2020 is designed to empower patients with their health record in the modern health IT world. It supports seamless and secure access, exchange, and use of electronic health information. The rule is designed to give patients and their healthcare providers secure access to health information. It also aims to increase innovation and competition by fostering an ecosystem of new applications to provide patients with more choices in their healthcare. It calls on the healthcare industry to adopt standardized application programming interfaces (APIs), which will help allow individuals to securely and easily access structured electronic health information using smartphone applications. The rule includes a provision requiring that patients can electronically access all of their electronic health information (EHI), structured and/or unstructured, at no cost.

To meet the needs of the ONC rule, TCMH intends to migrate its current EHR platform from Welligent to the Cerner Electronic Health record platform. TCMH is seeking stakeholder approval for a portion of the implementation costs of the Cerner EHR platform.

Additionally, TCMH does not currently have a centralized referral management platform. Such a system would allow TCMH to ensure the quality of referrals delivered by TCMH, as well as allow for both increased transparency and follow-up

from both the TCMH clinical and Community Navigator staff as well as the participants.

Background:

1) TCMH has being using Welligent as its primary client information system since 2011. The platform also handles client scheduling, call center, client check-in and payment collection, individual and group progress notes, clinical features including medication management, billing and reporting. Due to the extensive requirements of the ONC rule regarding interoperability, Welligent is no longer sufficient to meet the Agency's responsibilities.

Beginning January of 2020, the TCMH executive team has undergone an extensive request for proposal process to determine the best EHR platform to meet both the needs of the agency, as well as the regulatory requirements. The request for proposal process solicited bids from four platforms, with an extensive review conducted by a committee of clinical, MHSA, and operations staff resulting in Cerner as the best fit to meet all requirements.

In February 2021, Cerner produced a project quote and timeline that will result in a full transition of services to the Cerner platform by July of 2022.

2) Unite Us will be implemented as a pilot over the next 3 years within two departments of Tri-City that are primary access points to care and services: Access to Care and Community Navigators. Both of these teams are responsible to receive referrals for requests for treatment services and/or requests for basic needs necessary for well-being.

Tri-City's philosophy is that all referrals for services and needs outside of its system of care require review and diligence on the part of the staff in order to ensure that the referrals being given out are currently available and easily accessible to the person requesting assistance. At this time, that process is done manually by Tri-City's staff, which limits not only the resources staff is able to access in real time, but also may be inefficient in terms of the growing numbers of referrals as a result of the pandemic. The Unite Us platform will be piloted to see if the use of this electronic organized community network system not only increases the number and of persons served in regards to referrals and resources for care to support over well-being, but whether or not use of the platform serves to create a more comprehensive and connected network of community partners that results in quicker and more responsive services for persons in need throughout the three cities.

Component Exhibit 2

2. Stakeholder Involvement

Provide a description of stakeholder involvement in identification of the County's Capital Facilities and/or Technological Needs Component priorities along with a

short summary of the Community Program Planning Process and any substantive recommendations and/or changes as a result of the stakeholder process.

On April 8, 2021, community members and staff gathered in a virtual stakeholder meeting to review this proposed Capital Facilities and Technological Needs project proposal. During this meeting, the Interim Chief Information Officer presented a comprehensive overview of each project, including the design and estimated costs for each component. At the completion of the presentation, all participants were asked to vote on this new project via an online poll resulting in full stakeholder approval.

30-Day Public Notification:

This plan was posted on Tri-City's website on April 9, 2021 through May 10, 2021 for a 30-day public comment period. Copies of this proposal were also distributed to local venues including city government locations, libraries and community centers located throughout the cities of Claremont, Pomona, and La Verne.

This plan was presented to the local Mental Health Commission and Tri-City Governing Board on May 19, 2021. The Mental Health Commission endorsed this plan and the Tri-City Governing Board approved and adopted it at that time.

Component Exhibit 3

COMPONENT PROPOSAL: CAPITAL FACILITIES NEEDS LISTING

Please list Capital Facility needs (ex: types and numbers of facilities needed, possible County locations for needed facilities, MHSA programs and services to be provided, and target populations to be served, etc.)

Capital Technological Needs Listing:

Technological Platform	Projected Funding
Cerner Electronic Health Record System Implementation	$270,436
Unite Us Platform Implementation	$30,000

Component Exhibit 4

COMPONENT PROPOSAL: TECHNOLOGICAL NEEDS

Please check-off one or more of the technological needs which meet your goals of modernization/transformation or client/family empowerment as your county

moves toward an Integrated Information Systems Infrastructure. Examples are listed below and described in further detail in Enclosure 3. If no technological needs are identified, please write “None” in the box below and include the related rationale in Exhibit 1.

Electronic Health Record (EHR) System Projects (check all that apply)

X Infrastructure, Security, Privacy
Practice Management

X Clinical Data Management

Computerized Provider Order Entry

X Full EHR with Interoperability Components (for example, standard data exchanges with other counties, contract providers, labs, pharmacies)

Client and Family Empowerment Projects

Client/Family Access to Computing Resources Projects

Personal Health Record (PHR) System Projects

X Online Information Resource Projects (Expansion / Leveraging information sharing services)

Other Technology Projects That Support MHSA Operations

Telemedicine and other rural/underserved service access methods

Pilot projects to monitor new programs and service outcome improvement

Data Warehousing Projects / Decision Support

Imaging / Paper Conversion Projects

Other (Briefly Describe)

Mental Health Services Act
Capital Facilities and Technological Needs Project Proposal

Subject:

Approval for the expenditure of funds in the amount of $300,436 as follows:

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2) Unite Us referral management platform costs at $30,000.

Summary:

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