NAPA COUNTY

Health & Human Services Agency

Napa County Mental Health Division FY 22-23 Annual Update to the Mental Health Services Act (MHSA) Three-Year Plan for FY 20-21 to FY 22-23

A Tradition of Stewardship
A Commitment to Service

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MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: Napa

☐ Three-Year Plan for FY 20-21 to FY 22-23
☑ FY 22-23 Annual Update to Three-Year Plan for FY 20-21 to FY 22-23

Local Mental Health Director	Program Lead
Name: Cassandra Eslami, LMFT Telephone Number: (707) 299-2102 E-mail: Cassandra.Eslami@countyofnapa.org	Name: Felix A. Bedolla, Project Manager Telephone Number: (707) 299-1759 E-mail: Felix.Bedolla@countyofnapa.org
Local Mental Health Mailing Address : Napa County Mental Health Division 2751 Napa Valley Corporate Drive, Bldg. A Napa, CA 94559	

I hereby certify that I am the official responsible for the administration of county mental health services in and for said county/city and that the County has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this FY 22-23 Annual Update to the MHSA Three-Year Program and Expenditure Plan for FY 20-21 to FY 22-23 (hereafter MHSA FY 22-23 Annual Update) including stakeholder participation and non-supplantation requirements.

This MHSA FY 22-23 Annual Update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The MHSA FY 21-22 Annual Update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate.

This MHSA FY 22-23 Annual Update, attached hereto, was adopted by the Napa County Board of Supervisors on TBD.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Codesection 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.
All documents in the attached annual update are true and correct.

Cassandra Eslami, LMFT	final will be signed	
Local Mental Health Director (PRINT)	Signature	Date

INTRODUCTION

Napa County Mental Health Plan (NCMHP) is committed to provide culturally competent mental health services that promote individual strengths, inspire hope, and improve the quality of life for people within Napa County. The Mental Health Services Act (MHSA) is essential to providing preventative, effective mental health service and promotes access to care throughout Napa County.

The FY 22-23 Annual Update is the final update to the MHSA Three Year Plan for FY 20-21 to FY 22-23. The purpose of the FY 22-23 Annual Update is the following:

1. Inform the community and local stakeholders of the implementation of MHSA programs in the Napa County community;
2. Provide local stakeholders an opportunity to offer input, feedback, and commentary on MHSA programs and services;
3. Provide an update on the implementation of MHSA programs and services and any changes to the Napa County Board of Supervisors;
4. Submit an update of the implementation of Napa County MHSA programs and services and any changes to the California Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission (MHSOAC).

The FY 22-23 Annual Update includes a summary of changes of MHSA programs, outcome data from FY 20-21 and year to date data for FY 21-22. Program updates are organized by existing MHSA components of Prevention and Early Intervention (PEI), Community Services and Supports (CSS), CSS Housing, Innovations (INN), Workforce Education and Training (WET) and Capital Facilities/Technological Needs (CF/TN).

Components are further broken down by program and include the following information: program summary, program cost, total number served, projected service targets and outcomes as well as anticipated changes as a result of any identified challenges. Clearly, the most significant challenge experienced by all MHSA programs, in FY 20-21, was the COVID-19 Pandemic, which forced programs to adapt their service delivery models to meet the changing needs of the populations they serve.

MHSA REVENUE PROJECTIONS

The Mental Health Services Act (MHSA) passed as Proposition 63 in 2004, became effective January 1, 2005, and established the Mental Health Services Fund (MHSF). Revenue generated from a one percent tax on personal income in excess of $1 million is deposited into the MHSF and then distributed by the State Controller to all Counties.

Counties are required to rely on the revenue forecast provided by the Dept of Finance (DOF) and the MHSA fund is highly volatile. Over the years, the MHSA revenue source has fluctuated substantially, from swings as low as 40% less during the great recession to a 63% increase in 2020-21 due to funds carried over from 2020 into 2021 due to the pandemic-related tax payment deferral and the healthier than anticipated economy.

MHSA revenue was anticipated to increase modestly by approximately 5% in FY 21-22 and was then expected to decrease by approximately 16% in FY 22-23 due to the Covid-19 Pandemic. However, MHSA revenues instead increased in FY 21-22 in part due to deferred tax payments mentioned previously and the upward trend in revenue is expected to continue into FY 22-23. As a result, the NCMHP currently has unexpended, unallocated funds and will be exploring opportunities to expand and create new CSS and PEI programs based on stakeholder input as well as fully fund the NCMHP's MHSA Prudent Reserve at 33% of the annual CSS Component budget. With inflation and the possibility of a Recession in the coming months, however, the NCMHP will carefully monitor revenue and expenditures to determine if funding and program adjustments will need to be made.

HIGHLIGHTS, UPCOMING CHANGES, AND OPPORTUNITIES FOR FY 22-23

Prevention and Early Intervention (PEI) Component

Initial PEI Request For Proposals (RFP)

In December 2021, NCMHP posted an RFP for proposals to serve specific target populations previously identified by local stakeholders. The RFP process provided an opportunity for the community-based organizations to rethink their programs and services to meet the community's current needs. The PEI RFP application aligned with the State's PEI strategies, regulations, locally identified target populations, and local needs as well as COVID-19 service adaptations. NCMHP awarded eight programs, listed below. Some previously funded PEI programs were awarded funding and new programs were funded as well with a requested start date of July 1, 2022.

Target Populations and Available MHSA PEI Funding	**Amount Awarded**
Children (0-15)/Transition Age Youth (15-24) Prevention/Early Intervention - $160,000	
Napa County Office of Education (NCOE) - Court and Community Schools Student Assistance Program	$80,000
Mentis #1 - Safety Net for Youth Mental Wellness Program	$80,000
Latinx Youth Prevention/Early Intervention - $80,000	

UpValley Family Resource Centers – CLARO (Challenging Latinos to Access Resources and Opportunities)/CLARA (Challenging Latinas through Action, Resources and Awareness) Youth Mentoring Program	$80,000
Families at Risk Prevention/Early Intervention - $90,000	
Cope Family Resource Center – Strengthening Families At-Risk	$90,000
Older Adults Prevention/Early Intervention - $90,000	
Mentis #2 – Healthy Minds, Healthy Aging Program for Older Adults	$90,000
LGBTQ Stigma and Discrimination Reduction - $50,000	
On the Move - LGBTQ Connection Program	$50,0000
Geographically Isolated Communities Access and Linkage to Treatment - $160,000	
Napa Valley Education Foundation - American Canyon Mental Health Access Program	$160,000
Suicide Prevention Proposals - $40,000	
Mentis #3 - Suicide Prevention	$40,000
Total PEI Funding To Be Awarded	**$670,000**

Community Services and Support (CSS) Component

Mobile Response Team (MRT)

The NCMHP utilized CSS System Development funding to implement a new program, the Mobile Response Team (MRT). MRT provides professional, same-day intervention for adults and children who are experiencing mental health crises. The MRT prioritizes community response for all individuals regardless of insurance status. Trained licensed mental health clinicians and mental health workers respond and deploy within Napa County to provide community support with care and utilization of de-escalation skills, risk assessment, and linkage to the Crisis Stabilization Services (CSS), County and community based mental health services, community-based organizations as well as other supportive services. MRT visits community members, consumers, families and/or significant support persons to prevent acute psychiatric crises resulting in involuntary hospitalizations and connect our community members to resources that can provide applicable supportive services.

Crisis Stabilization Services (CSS, also known as CSU)

After an extensive request for proposal (RFP) process, the contract for the Napa County Crisis Stabilization Services (CSS) program was awarded to Crestwood Behavioral Health and they began to offer services on June 1, 2021. During the RFP process, NCMHP decided that MHSA

funds would no longer be needed to operate the Crisis Stabilization Unit effective June 1, 2021, however, FY 20-21 program outcomes, demographics, etc. are included in this Annual Update.

Innovations (INN) Component

Innovation Round 2

The NCMHP has requested an extension for the Addressing the Mental Health Needs of the American Canyon Community Innovation Round 2 Project, which is now known as the Filipino Life and Generational Groups (FLAGG) program, so that it can complete the final phase of the program and disseminate the project's learnings. Please see page 44 and Appendix 5 for specific details regarding this request for an extension and additional funding.

Innovation Round 4 Project

The NCMHP intends to participate in the Mental Health Oversight and Accountability Commission's (MHSOAC) Multi-County Full Service Partnership (FSP) Innovation Project designed to improve the FSP programs and increase our capacity to use FSP data to drive decision-making. In California, FSPs provide intensive, comprehensive mental health and social assistance services for approximately 60,000 individuals living with serious mental illness each year. As a result of the project, counties will design and implement improvements to their FSP data and services that have the potential to increase the consistency, quality, and effectiveness of care for individuals with the most serious mental health needs. The total funding for Napa Count to participate in this project is $844,750. Please see Appendix 4 for more details regarding Napa County's proposed participation in the MHSOAC's FSP Collaborative Project.

New Opportunities – PEI Funding

2nd PEI Request For Proposals (RFP)

With the opportunity provided by these PEI funds, the NCMHP will be releasing a 2nd RFP in FY 22-23 for the following target populations and services.

Population Focus	**PEI Program Category and Program Description**	**Contract Maximum**
Children	Prevention: Infant-Parent/Maternal Mental Health Support	$120,000
Older Adults	Prevention: Social Connectedness and Wellness	$160,000
Black, Indigenous, and People of Color	Access and Linkage to Treatment: Mental Health Equity Outreach, Education, and Engagement	$160,000
General Population	Access and Linkage to Treatment: Co-Occurring Substance Abuse and Mental Health	$330,000
	Total Available Funding	**$770,000**

New Opportunities – CSS Funding

The NCMHP plans to expand existing CSS programs and to explore development of new CSS programs including:

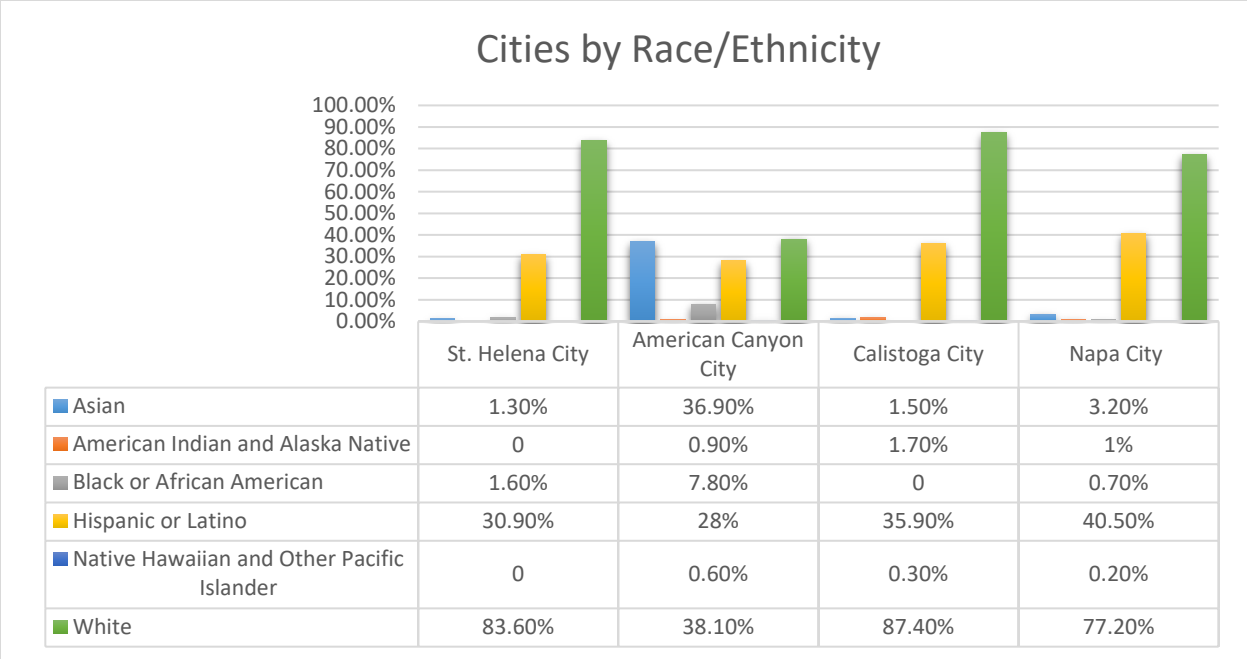
- Creation of an Adult Therapy program
- Expansion of the Children's FSP Expansion to include wraparound/FSP services for Child Welfare Services and Juvenile Probation clients using MHSA CSS funds as a match to EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) funds.
- Expansion of the Crisis Stabilization Unit to build out additional space for youth crisis stabilization services and treatment; will be exploring the feasibility of transferring CSS funds to the Capital Facilities Component using the 20% Rule (i.e., 20% of the average of the last 5 years of CSS allocations)
- Additional CSS funds may be needed to cover the costs to expand Crisis Stabilization Unit Services for additional youth
- Payment for the MH Division's share of costs for a new electronic health record using CSS Administration funds
- Expansion of the System Navigators program to provide transportation case management to individuals for whom transportation is a significant barrier to access services.
- NCMHP may also be exploring expansion of other stakeholder approved CSS programs

Overview of Napa County

With its world-renowned wines, restaurants and resorts, the Napa Valley has given its name to an idyllic lifestyle of laid-back sophistication. Napa County is also home to 138,019 residents who share a strong sense of community and a legacy of preserving and protecting their rich agricultural heritage. Located in the heart of California's pre-eminent wine region, Napa County is also part of the dynamic San Francisco Bay metropolitan area. The County's strategic location, sunny Mediterranean climate, and abundant natural and cultural resources, provides a mix of small town living and city amenities. With its tradition of stewardship and responsible land use planning, Napa County has maintained a strong rural character.

Demographics

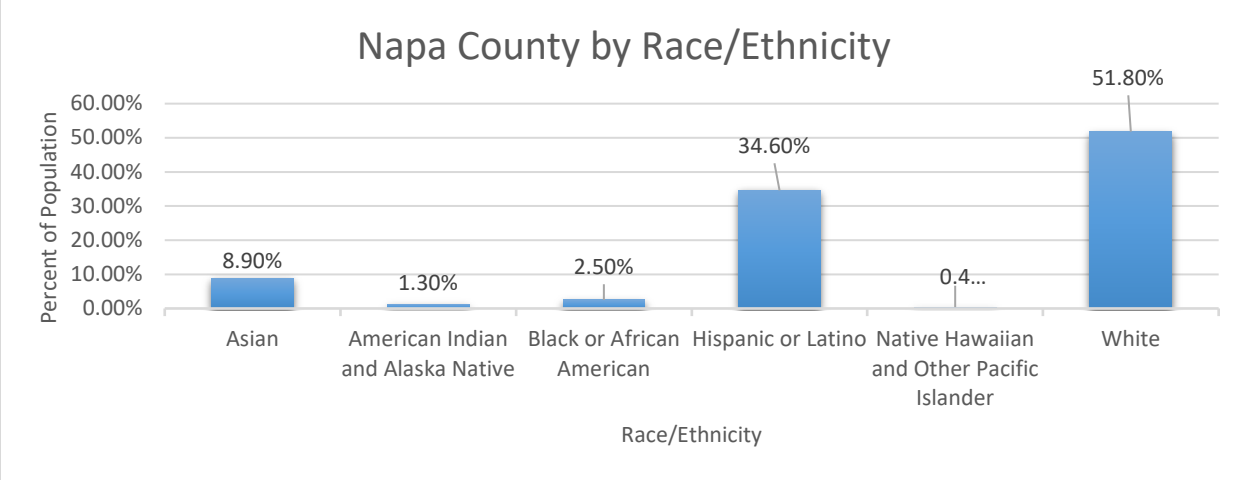
The graph below shows Napa County's population by city and race/ethnicity. The City of American Canyon remains the most diverse City in the County, while the Cities of Calistoga and St. Helena remain the least diverse.



	St. Helena City	American Canyon City	Calistoga City	Napa City
Asian	1.30%	36.90%	1.50%	3.20%
American Indian and Alaska Native	0	0.90%	1.70%	1%
Black or African American	1.60%	7.80%	0	0.70%
Hispanic or Latino	30.90%	28%	35.90%	40.50%
Native Hawaiian and Other Pacific Islander	0	0.60%	0.30%	0.20%
White	83.60%	38.10%	87.40%	77.20%

* The percentages in the graph may not add to 100% because individuals can identify as more than one race and/or ethnicity

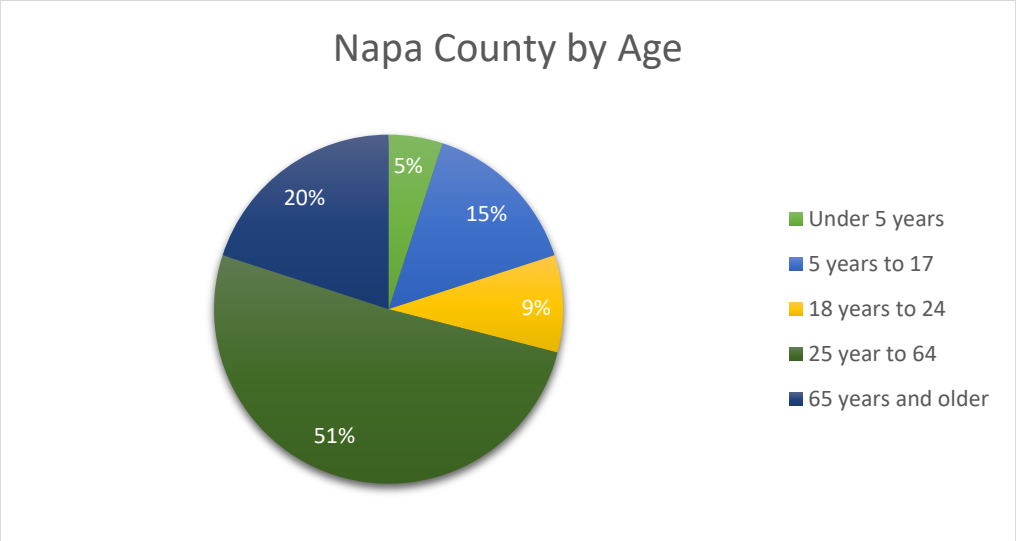
The largest race/ethnicity group in Napa County is White, 51.8% of residents identify as White. Latinos are the second largest ethnic group in Napa County, 34.6% of residents identify as Hispanic or Latino. Almost 9% of residents identify as Asian, making it the third largest racial group in Napa County.[1]



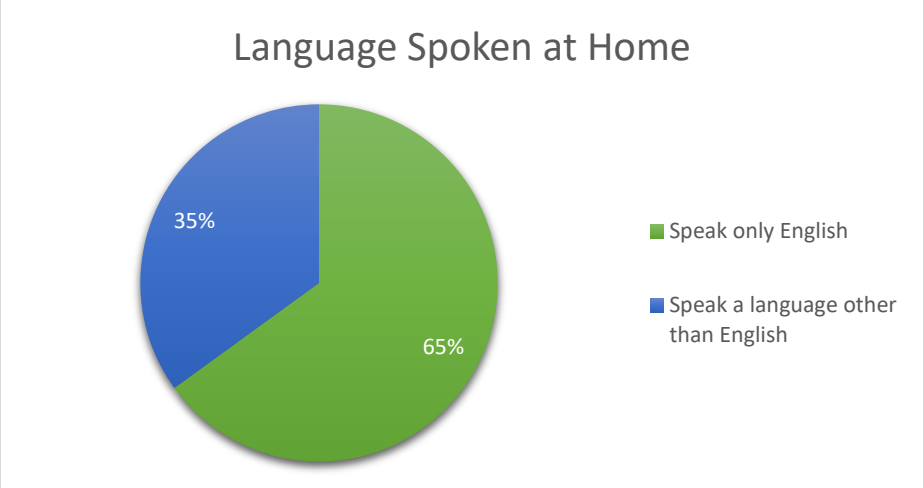
Fifty-one percent of all residents range from 25 years old to 64 years old; this age group accounts for over half of Napa County residents. The second largest age group is 65 years and older, making up 20% of the County's population. The third largest age group is youth, ranging

[1] U.S. Census Bureau QuickFacts: United States

from 5 years old to 17 years old, accounting for 15% of the population. The smallest age group is children ranging from 0 years old to 5 years old making up 5% of Napa County's population.[2]



In Napa County, 35% of residents speak a language other than English. About 28% of residents are Spanish speakers. Currently, Spanish is Napa County's only threshold language.



NAPA COUNTY MHSA COMMUNITY PLANNING PROCESS

[2]Napa County 2019 US Census Data

Napa County Mental Health Stakeholder Participation

The Napa County Mental Health Stakeholder Advisory Committee (SAC) is the primary stakeholder body that is involved in the NCMHP's MHSA Community Program Planning Process. The committee participates in all stages of the planning process throughout the fiscal year. Updated State information and MHSA changes and significant program changes are related to the SAC participants during the monthly meeting. Participants work with the NCMHP to ensure that their constituencies receive the information necessary to be able to give input and participate in the planning process. SAC meetings take place every first Wednesday of the month and are open to the public.

Although the SAC participants are the most involved in the MHSA planning process, other groups also receive MHSA information and have the opportunity to provide input and participate in the MHSA planning process. MHSA information is distributed to Mental Health Division staff, the NCMHP Board, MHSA Contractors, Community Mental Health providers and the Behavioral Health Cultural Competence Committee.

The SAC is composed of:

- Health Representative - Director of Behavioral Health/Ole Health
- LGBTQ Representative - LGBTQ Connection Director, On the Move, Inc.
- Public Health Services - Nursing Supervisor, Health & Human Services
- Family Member of an Adult Consumer Representative - ParentsCAN
- Sheriff's Department - Law Enforcement Representative
- Education Representative - NCOE Associate Superintendent
- Parent Partner Representative - Family and Youth Partnership, Nexus Program, Stanford Sierra Youth & Families
- Family Center Representative - Program Director, Cope Family Center
- Student Mental Health Representative - Director of Napa Valley College Student Health Center
- Consumer/Family Member Representative - Innovations Community Center, On The Move
- Consumer Representative - Mental Health Board
- Native American Representative - Director, Suscol Intertribal Council
- Consumer/Family Member Representative- Innovations Community Center, On The Move
- Behavioral Health Representative - Executive Director, Mentis

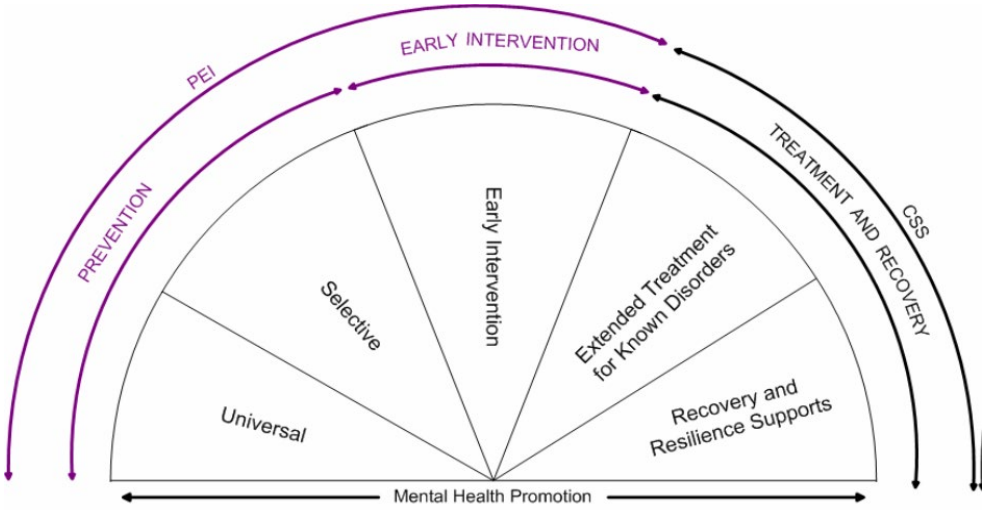
Public review and public hearing

The 30-day Public Review and Comment Period for the FY 22-23 Annual Update to the MHSA Three Year Plan will take place from Friday, July 8th to Monday, August 8th, 2022. A public hearing will be held via Zoom at a publicly noticed meeting of the Napa County Mental Health Board on Monday, August 8th at 4pm.

Component: Prevention and Early Intervention

Prevention and Early Intervention (PEI) is one of five components that make up the Mental Health Services Act (MHSA). The scope of prevention and early intervention services intended to be funded using PEI is described in the figure below.

Mental Health Intervention Spectrum Diagram[3]



The community planning for the current Prevention and Early Intervention (PEI) programs took place in 2007 and was updated in 2020. The regulations that describe the parameters of the funding and the reporting are updated periodically by the Mental Health Services Oversight and Accountability Commission (MHSOAC). In July 2018, the MHSOAC updated the PEI regulations to define services and describe the intended outcomes for PEI programs.

The PEI Program Evaluation Report reflects significant shifts in how the Napa County PEI programs reported demographics, program activities and outcomes. FY 19-20 was the first year that all nine programs were able to report in alignment with the updated regulations.[4] The Prevention and Early Intervention programs provide services and supports within three categories: Stigma and Discrimination Reduction, Prevention, and Early Intervention.

Report Organization

Section One: Summary of Activities and Outcomes across Programs

The report begins with a summary of the activities and outcomes across all of the programs. Because programs use varied approaches to prevention and early intervention, this section is

[3] Source: Adapted from Mrazek and Haggerty (1994) and Commonwealth of Australia (2000), From the MHSA Proposed Guidelines Prevention and Early Intervention Component of the Three-Year Expenditure Plan, September 2007., page 6.

[4] The updated Prevention and Early Intervention Regulations as of July 1, 2018 can be found here: https://mhsoac.ca.gov/sites/default/files/documents/2018-08/PEI%20Regulations_As_Of_July%202018.pdf

to aid in understanding the overall scale and impact of the funding. The sections include: Partnerships, Outreach, Demographics, Screenings, Outcomes, Referrals as well as a summary of the Program Changes Due to COVID-19.

Section Two: Summary of FY 19-20 and FY 20-21 Activities and Outcomes by Program

Next, each of the program's activities and outcomes are summarized by funding area: Stigma and Discrimination Reduction, Prevention, or Early Intervention. Each program summary includes information about the community needs addressed by the program, the program's activities and outcomes, and the changes the program made due to COVID-19.

Section Three: Summary of FY 18-19 Activities and Outcomes by Program

The FY 18-19 data was collected and reported prior to the updated logic models and evaluation plans being developed. This section includes a summary of the activity and outcome data available from this fiscal year.

Napa County Mental Health Services Act Prevention and Early Intervention Programs by Funding Area

PEI Funding Area	Agency and Program Name
Stigma and Discrimination Reduction	On The Move: LGBTQ Connection
Prevention	Suscol Council: Native American PEI Project
	UpValley Family Centers: UpValley Mentoring Program PEI Project (CLARO/CLARA)
	Napa Valley Education Foundation: American Canyon Student Assistance Program
	Cope Family Center: Home Visitation
	Cope Family Center: Strengthening Families
	NEWS: Kids Exposed to Domestic Violence (KEDS)
Early Intervention	Napa County Office of Education (NCOE): Court and Community Schools Student Assistance Program
	Mentis: Healthy Minds, Healthy Aging (HMHA)

To view the MHSA PEI Program Evaluation Report, please see Appendix 1.

Component: Community Services and Supports (CSS) Summary

NCMHP's Community Services and Supports (CSS) Component consists of a variety of programs that provide FSP wraparound services, mobile response services, a peer-operated adult self-help center, system navigators, and a variety of outreach and engagement services to the community. These programs include Full Service Partnerships (FSP), System Development - Mobile Response Team (MRT), Family Urgent Response System (FURS), and Outreach and Engagement - Project Access Programs.

Full Service Partnerships (FSP) Overview and Outcomes

FSP programs are in-house programs and are most succinctly described as a "whatever it takes" program approach for consumers. This implies a broad range of services and supports not typically associated the traditional mental health model. Such supports include assistance in meetings daily leaving needs, paying for health care, and providing respite services when needed (UCLA Center for Healthier Children, Youth and Families, pg. 26)[5]. The FSP programs consists of five units including, Children's FSP (CFSP), Transitional Age Youth FSP (TAY), Adult FSP (AFSP), Adult Treatment Team (ATT) and Older Adult FSP (OA FSP).

Children's Full Service Partnership (CFSP)

Program Summary

The Children's Full Service Partnership (CFSP) assists underserved, at-risk children with a serious emotional disturbance who demonstrate problems with functioning in at least two of the following areas: school, home, community, or peer relationships, or are either at risk for hospitalization, incarceration, suicide, homicide, removal from the home, or the mental disorder impairments are likely to continue for more than a year without treatment.

Key aspects of the CFSP program:

- Children aged 0 to 15.
- CFSP staff provides a holistic approach to address the mental health and emotional issues limiting the child and the family's capacity for success.
- Wraparound efforts are based in the community and encourage the family's use of their natural supports and resources.
- CFSP collaborates with the family and their external support network or helps them create one.

[5] UCLA Center for Healthier Children, Youth and Families. (2013). *Full Service Partnerships: California's Investment to Support Children and Transition-Age Youth with Serious Emotional Disturbance and Adults and Older Adults with Severe Mental Illness Contextual Factors and the Relationship to Expenditures and Cost Offsets*. http://archive.mhsoac.ca.gov/Evaluations/docs/MHSA_CostOffset%20Report_FSP_byCounty_201304.pdf

- This process of working with the child, family and the CFSP team occurs through periodic and frequent contact at home, at school, or in the community to address the child's emotional, social, academic, and familial needs.

Covid-19 Adaptations

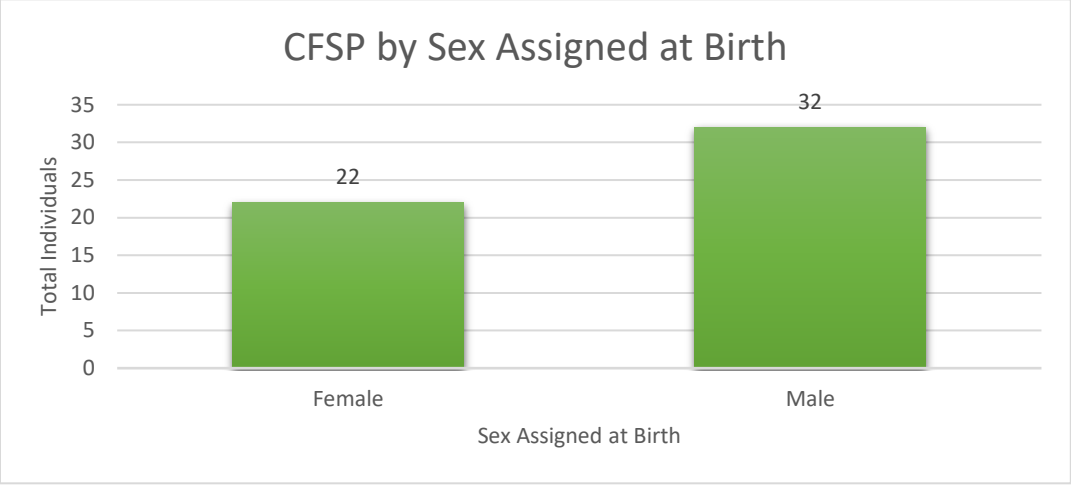
- CFSP staff provided face-to-face services for individuals as needed and where individuals felt most comfortable.
- CFSP staff also provided telehealth services as needed

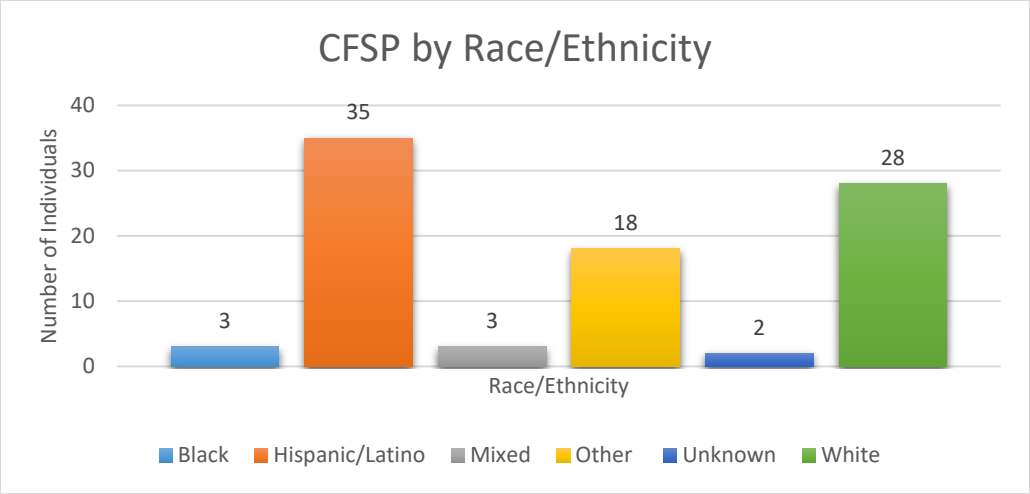
Services and Funding

Total Individuals Served FY 20-21	54
Funding	$721,234
Cost Per Individual	$13,356
Total Individuals Served FY 21-22	55
Projected Consumers FY 22-23	56

Demographics

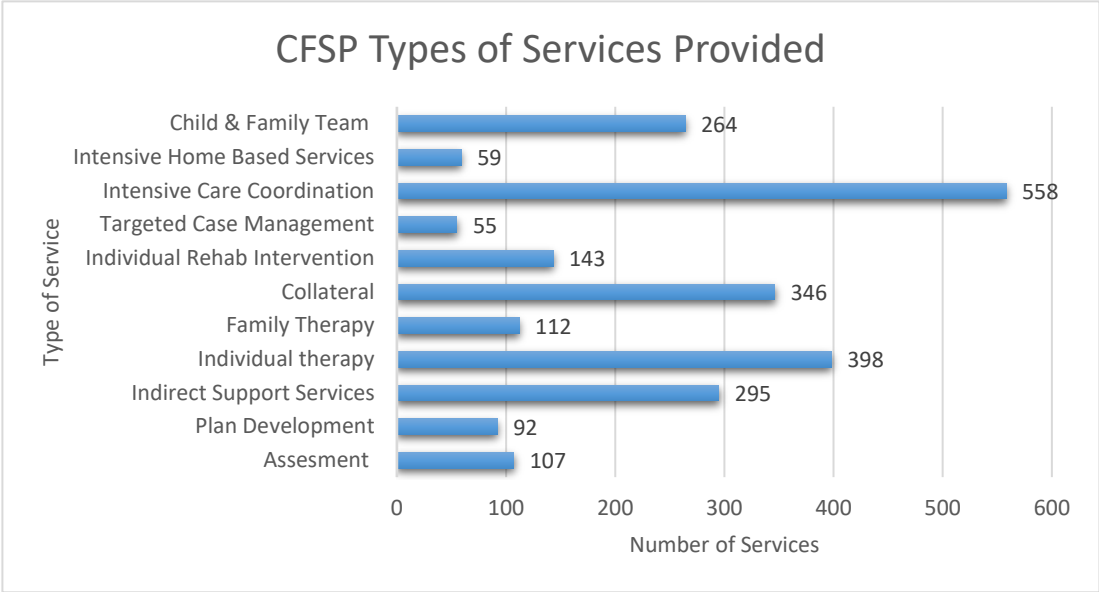
In FY 20-21, CFSP served 54 individuals. Regarding sex assigned at birth, of the 54 individuals, 32 identified as male and 22 as female. About 65% of individuals identified as Latino/Hispanic, just over 50% identified as White and one third identified as Other.





Services

CFSP provided 2,409 services in FY 20-21. The most common services provided by the CFSP team was intensive care coordination (23%) and individual therapy (16%). The least common service was targeted case management (2.3%) and intensive home-based services (2.4%).



Transitional Age Youth Full Service Partnership (TAY)

Program Summary

The Transitional Age Youth Full-Service Partnership (TAY) Program provides a comprehensive range of support services for youth. Services specifically address the unique issues of youth who must manage their mental health challenges while moving toward independence.

TAY staff assist individuals in identifying their strengths, concerns, needs and motivations to develop an individualized service plan. Youth and their families will have a multitude of services to choose from to assist them in attaining the goals they have identified in their individualized services plan. The goal is that when participants leave the program, they will have the skills and stability to make choices that will maximize their chances of success, sense of normalcy, and self-efficacy.

Key aspects of the TAY program:

- Youth ages 16 to 24.
- Setting and pursuing goals, identifying barriers, and implementing wellness strategies.
- Housing assistance and learning independent living skills.
- Engaging or re-engaging in continuing their education.
- Mental health and substance abuse treatment.
- Accessing needed health and dental care, as well as family planning services.
- Social linkages to natural supports and community resources.

Covid-19 Adaptations

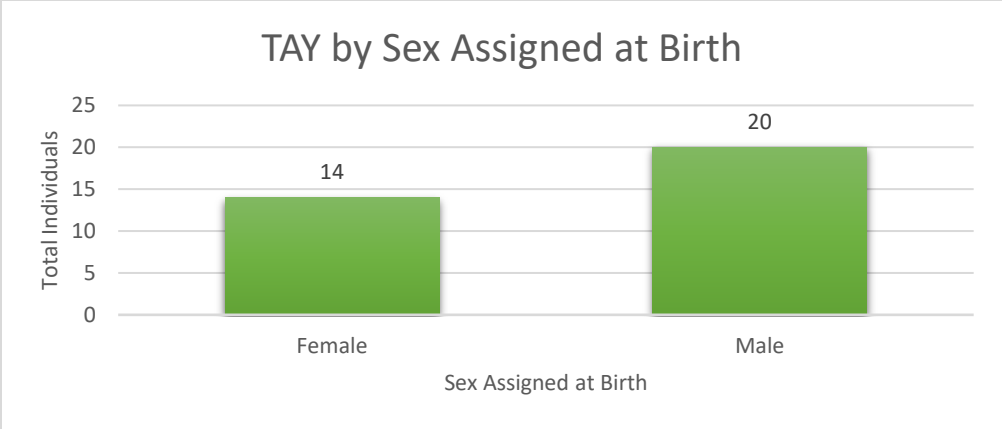
- TAY FSP staff offered face-to-face services for individuals where they felt most comfortable.
- TAY FSP staff provided telehealth services as needed

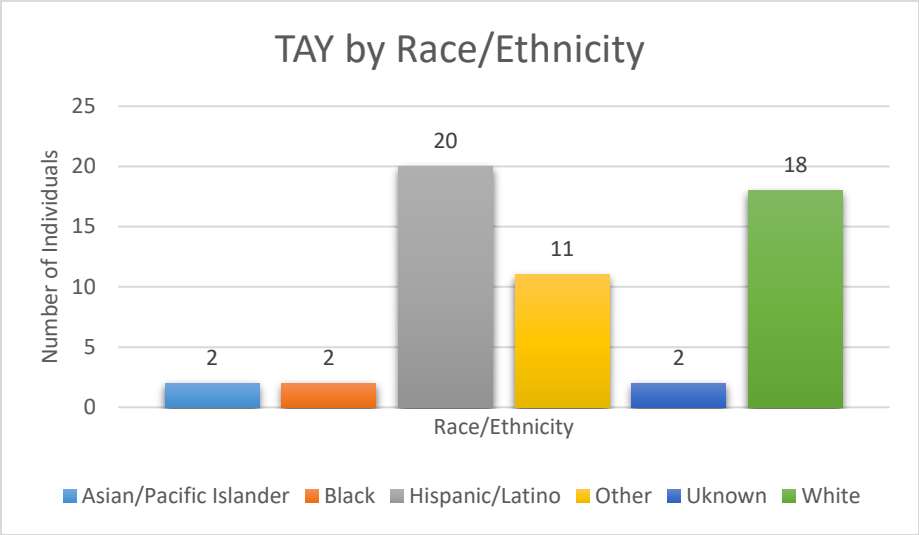
Services and Funding

Total Individuals Served FY 20-21	35
Funding	$424,278
Cost Per Individual	$12,122
Total Individuals Served FY 21-22	35
Projected Consumers FY 22-23	36

Demographics

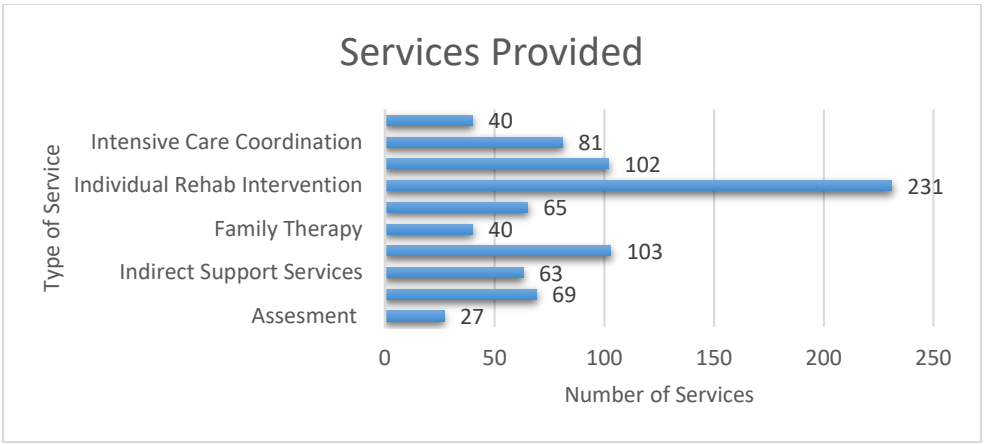
During FY 20-21, TAY served 35 individuals. Of the 35 individuals, 20 individuals identified as male and 14 as female. Regarding race and ethnicity, about 57% of individuals identified as Latino/Hispanic, just over 50% identified as White and 31% identified as Other.





Services

The TAY team provides 821 services in FY 20-21. The most common types of services provided were individual rehab intervention (28%) and individual therapy (13%). The least common services were assessments (3%), child and family team (5%) and family therapy (5%).



Adult Full Service Partnership (AFSP)

Program Summary

The Adult Full Service Partnership (AFSP) program provides intensive wrap around services to adults, between the ages of 26-59, who are diagnosed with a serious and persistent mental illness and are homeless, at risk of homelessness, or at risk of placement outside of the County. The program incorporates a dynamic team of licensed and non-licensed bilingual case managers, peer staff who also provides complementary work as a mental health worker aide, and a program supervisor. The program focuses on providing strengths based therapeutic case management services. Services are tailored to assist individuals in reaching their specific wellness and recovery goals while honoring and respecting all cultural backgrounds.

Key Aspects of the Program

- Strength-based program focusing on the individual's goals for recovery in their lives.
- Centered on individual needs.
- Focused on engaging individuals in their own care.
- Meeting individuals "where they are."
- Fostering hope and building on human resilience.

Covid-19 Adaptations

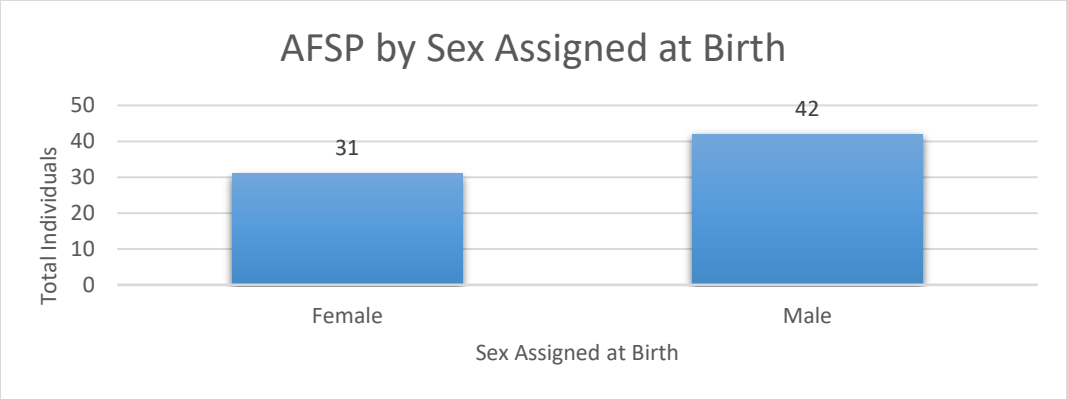
- Amidst the pandemic, the AFSP team continued to provide face-to-face services for individuals meeting them where they are at – shelters, encampments, parks, library, and anywhere in the community that client identified to be a preferred meeting space.
- Team members pivoted to telehealth services where this could be done successfully given the oftentimes limited access to technology that participants have.
- Collaborated with partner agencies to meet our consumers' needs and support in meeting goals and creating a life that they want to live and enjoy.

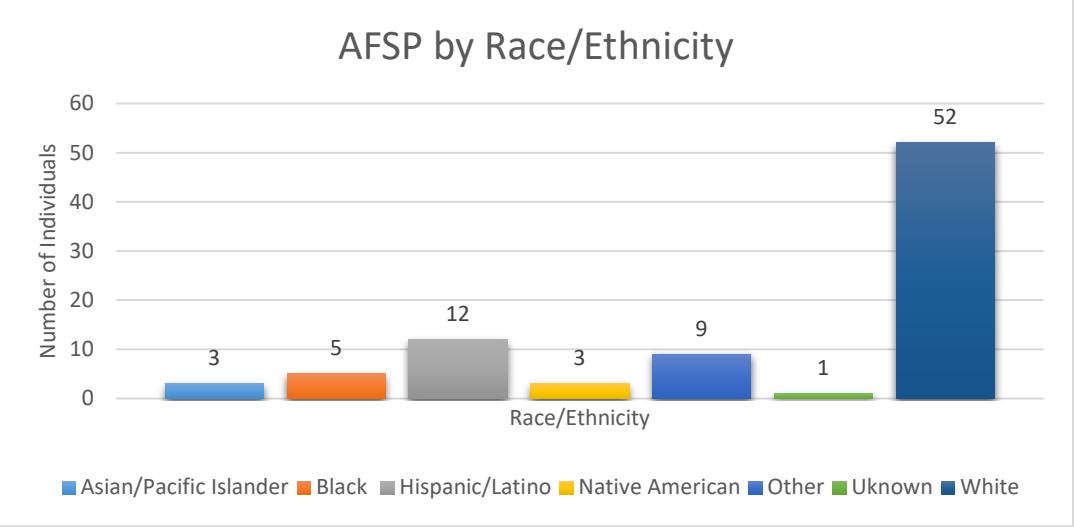
Services and Funding

Total Individuals Served FY 20-21	73
Funding	$1,116,810
Total Cost Per individual	$15,299
Total Individuals Served FY 21-22	68
Projected Consumers FY 22-23	69

Demographics

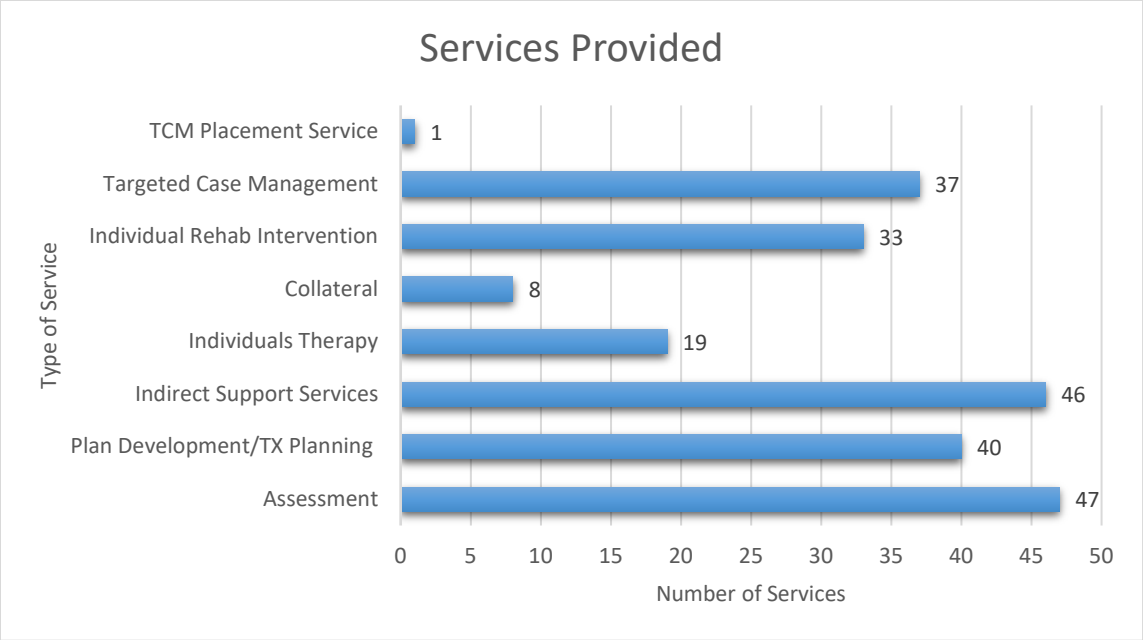
In FY 20-21, AFSP served 73 individuals. Regarding sex assigned at birth, of the 73 individuals, 42 identified as male and 31 as female. Of the individuals served, 71% identified as White, 16% identified as Latino/Hispanic, 12% identified as other and about 1.5% identified as Black.





Services

AFSP provided a total of 231 services. The most common services provided by AFSP were assessments (20%) and indirect support services (20%). The least common services were collateral and targeted case management placement services.



Adult Treatment Team (ATT)

Program Summary

The Adult Treatment Team (ATT) serves adults with severe mental illness. Individuals are often referred following inpatient psychiatric hospitalization, incarceration, or at significant risk for hospitalization and incarceration, resulting in long-term or higher care due to mental health symptoms.

Key aspects of program:

- Services are designed to enhance social well-being and behavioral and physical health.
- Assist individuals in the enhancement of recovery skills.

Covid-19 Adaptations

- ATT FSP staff provided face-to-face services for individuals meeting them where in their preferred meeting spaces.
- ATT FSP staff also provided telehealth services as needed

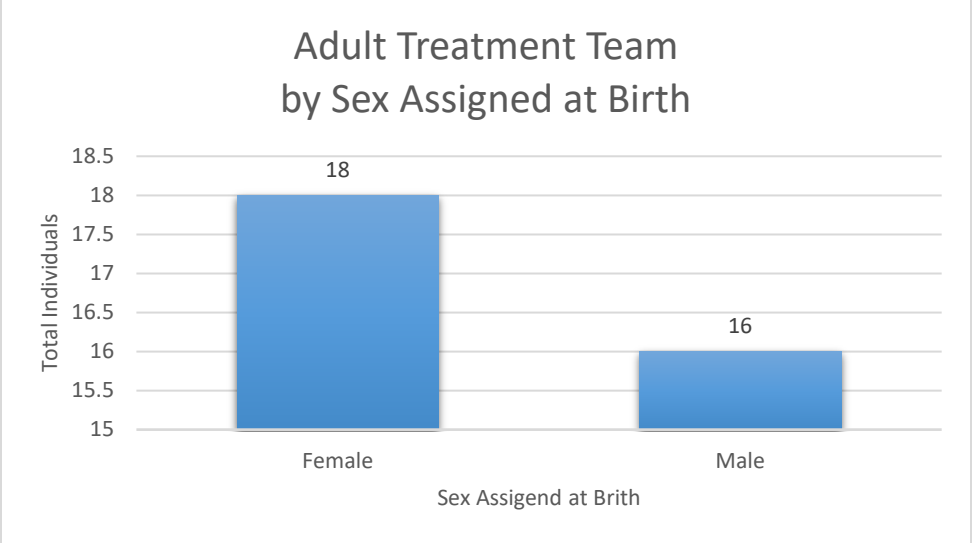
Services and Funding

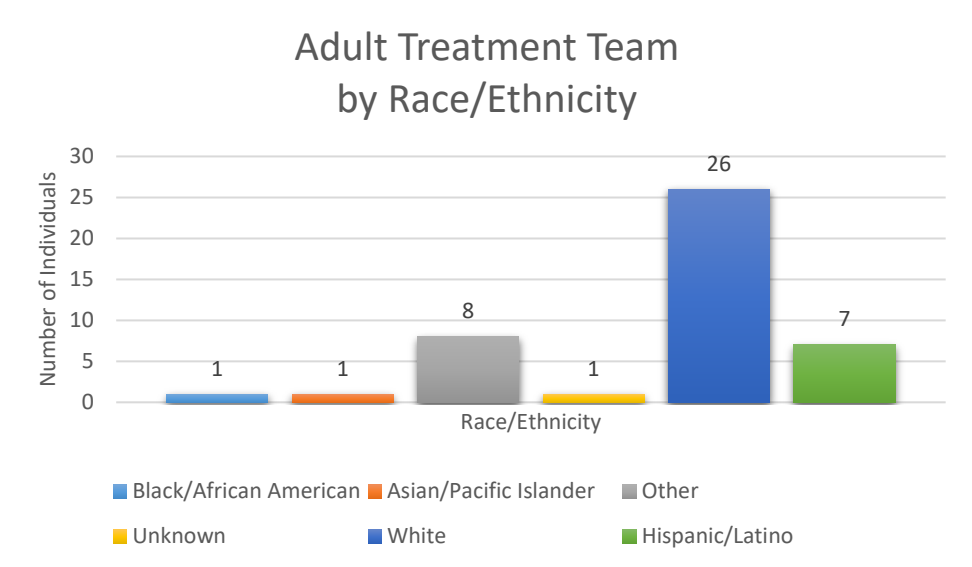
Total Individuals Served FY 20-21	34
Funding	$757,158
Cost Per Individual	$22,269

Total Individuals Served FY 21-22	33
Projected Consumers FY 22-23	34

Demographics

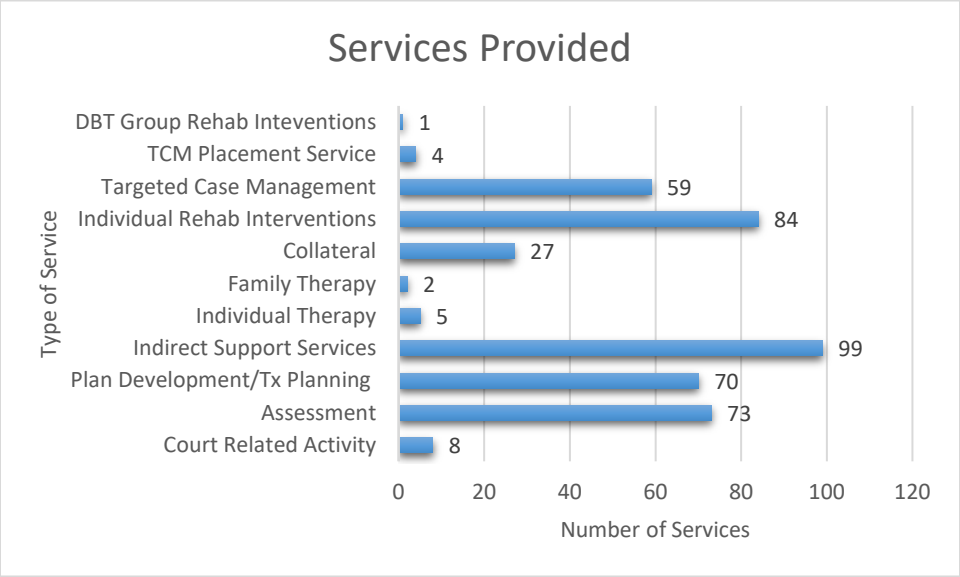
In FY 20-21, ATT served 34 individuals. Of the 34 individuals, 16 identified as male and 22 as female. Regarding race and ethnicity, just under half identified as White, 15% identified as Other and 13% identified as Hispanic/Latino.





Services

In FY 20-21 ATT provided 407 services. The most common services provided by the ATT team was indirect support services (24%) and individual rehab interventions (21%). The least common services were DBT group rehab interventions (>1%).



Older Adult Full Service Partnership (OA FSP)

Program Summary

The Older Adult Full Service Partnership (OA FSP) was designed for underserved, at-risk adults of age 60 years and older. Staff in the OA FSP program works with older adults who are often medically fragile. Because of this, many individuals are at-risk of placement in Skilled Nursing Facilities (SNF). Individuals often also have co-occurring medical or substance abuse disorders and are unable to participate in traditional mental health clinic programs. Many of the individuals served are living with personality disorders and staff works with them to support their unique bio/psycho/social needs. OA FSP staff provide assistance to address older adults' physical emotional, and living situation needs.

Key aspects of program

- Counseling to address physical, emotional needs
- Individualized goals
- Referral and Linkage services for appointments
- Assistance arranging transportation to and from appointments
- Medication support and assistance
- Housing assistance
- Financial/health benefit assistance

Covid-19 Adaptations

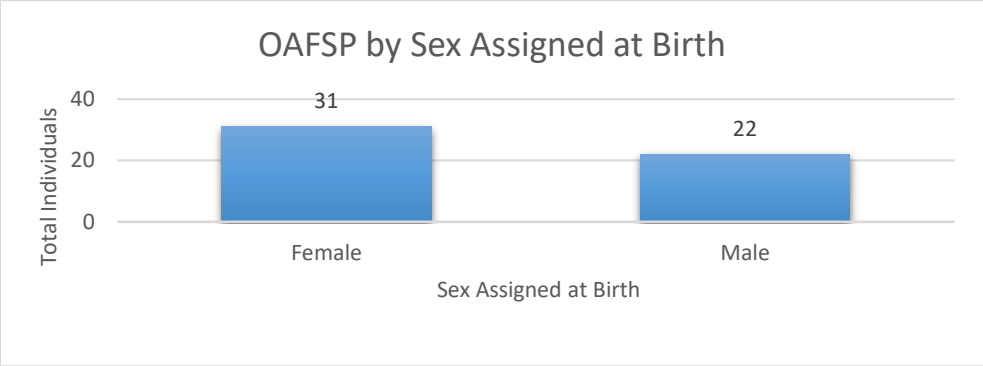
- OA FSP found nontraditional ways to reach the older adult population. Some of these ways include, talking through windows, dropped off self-care packets and spent extra time reading mail for seniors.
- OA FSP connected seniors to other providers and services.
- Connected seniors to support pets.
- For seniors in facilities the OA FSP team, sat outside facilities and accompanied seniors, called to check-in, set up zoom for seniors and with seniors.

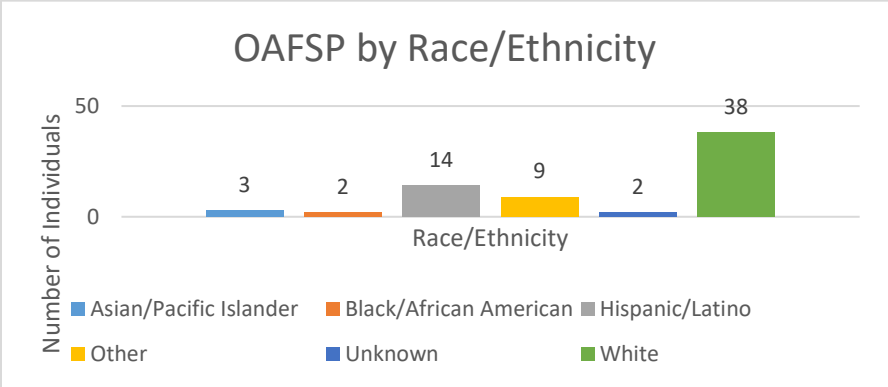
Services and Funding

Total Individuals Served FY 20-21	53
Funding	$575,287
Cost Per Individual	$10,854
Total Individuals Served FY 21-22	39
Projected Consumers FY 22-23	50

Demographics

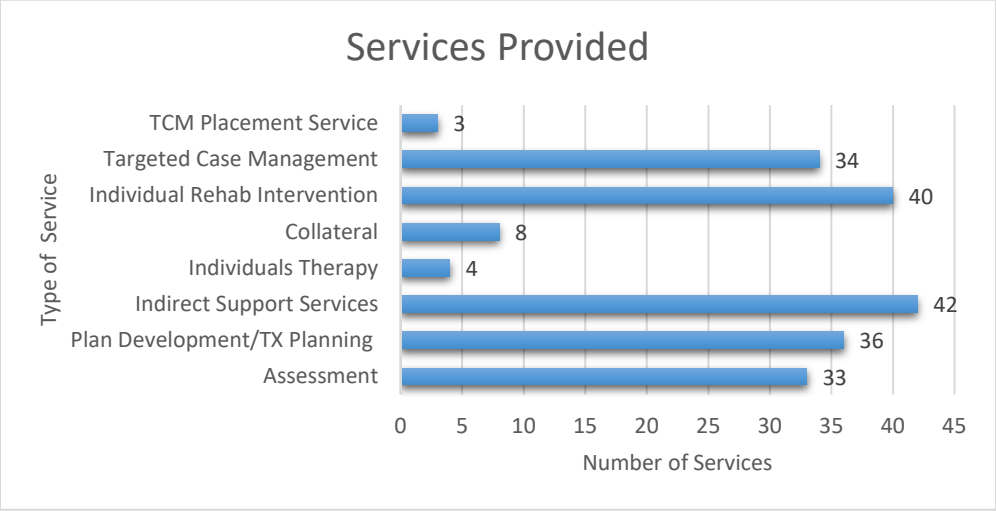
In FY 20-21, OA FSP served 53 individuals. Regarding sex assigned at birth, of the 53 individuals, 22 identified as male and 31 as female. About 72% of individuals served identified as White, 26% identified as Latino/Hispanic and 17% identified as Other.





Services

In FY 20-21, OA FSP provided 200 services. The most common services provided were indirect support services (21%) and individual rehab intervention (20%). The least common services were individual therapy (>1%) and TCM placement service (>1%).



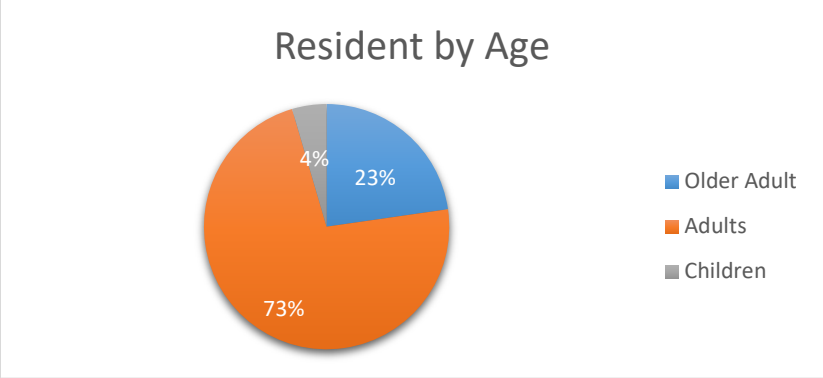
Community Services and Support: Housing

Program Summary

The Progress Foundation Hartle Court Housing Apartment Complex is comprised of 21 one-bedroom units of MHSA permanent supportive housing for adults with mental illness who are homeless or at risk of homelessness. There are an additional three non-MHSA bedroom units.

In FY 20-21, five older adults, 16 adults, and one child were living in the units. Housing status for all individuals, at initial rent up was homeless. During that period, there was one eviction, which resulted in one permanent departure. Of the 21 older adults/adult residents, two residents were enrolled in one of the NCMHP MHSA FSP programs.

Demographics



Supportive Services and Resources

Services and resources are available to eligible residents. The services are both on-site and off-site, these services include:

- Service coordination
- Case management/crisis intervention
- Substance abuse services
- Innovations
- Medication education/support
- Life skills
- Employment/vocational services
- Tenant association/council
- Benefits counseling
- Social/recreational activities
- AA/NA groups
- Primary care: health screening, assessment, education
- Domestic violence services

Community Services and Supports: Project Access

Program Summary

Project Access is a program that includes CSS Outreach and Engagement strategies designed to increase access to mental health services and supports individuals and families with serious emotional disorders and severe mental illness throughout Napa County. Project Access programs include System Navigator Outreach and Engagement, Innovations Community Center (ICC) and ParentsCAN (PCAN). Strategies align with the following major guiding principles and goals of MHSA:

- Outreach to and expansion of services to consumer population to more adequately reflect the prevalence estimates and the race and ethnic diversity within Napa County.
- Increases in consumer-operated services such as drop-in centers, peer support programs, warm lines, crisis services, case management programs, self-help groups, family partnerships, parent/family education, and consumer provided training and advocacy services.
- Elimination of service policies and practices that are not effective in helping clients achieve their goals.
- Integrated treatment for persons with dual diagnoses, particularly serious mental illness and serious substance use disorders, through a single individualized plan, and integrated screening and assessment at all points of entry into the service system.
- Implementation of specific strategies to achieve more meaningful collaboration with local resources to promote creative and innovative ways to provide integrated services with the goals of adequate health care, independent living, and self-sufficiency.
- Reductions in the negative effects of untreated mental illness including reductions in institutionalization, homelessness, incarceration, suicide, and unemployment.

Project Access: System Navigator Outreach and Engagement

Program Summary

System Navigators provide mental health outreach, service connection, transportation, resources, support groups and referrals to individuals and families throughout Napa County. System Navigators are bilingual and bicultural to support the needs of the Latino community. They educate the community and service providers about available mental health services and provide support and guidance in connecting with mainstream resources such as healthcare, MediCal, CalFresh and housing services.

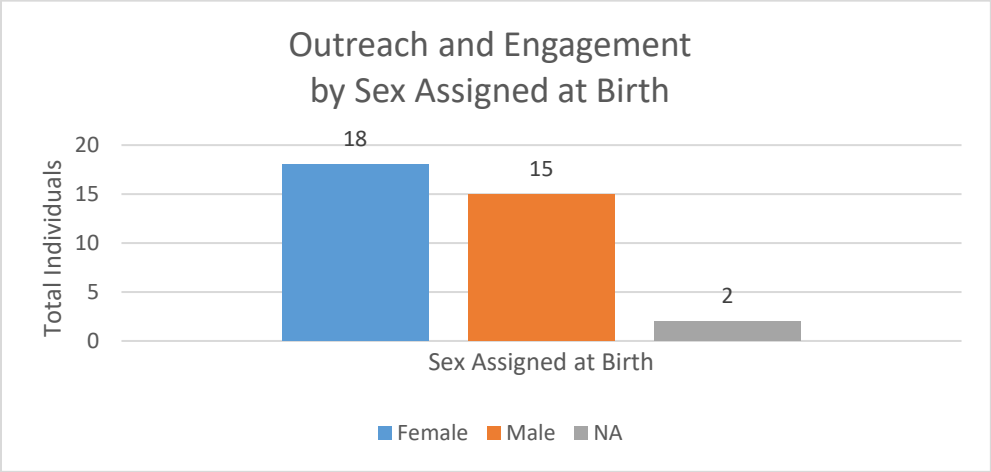
System Navigators also provide limited case management to individuals who need extra support. Usually, these individuals connect with System Navigators at resource fairs or outreach events and request assistance with some intractable issues. The System Navigators work closely with the individual and provide limited case management for up to 60 days with the goal to connect the individual to the appropriate resources and agencies.

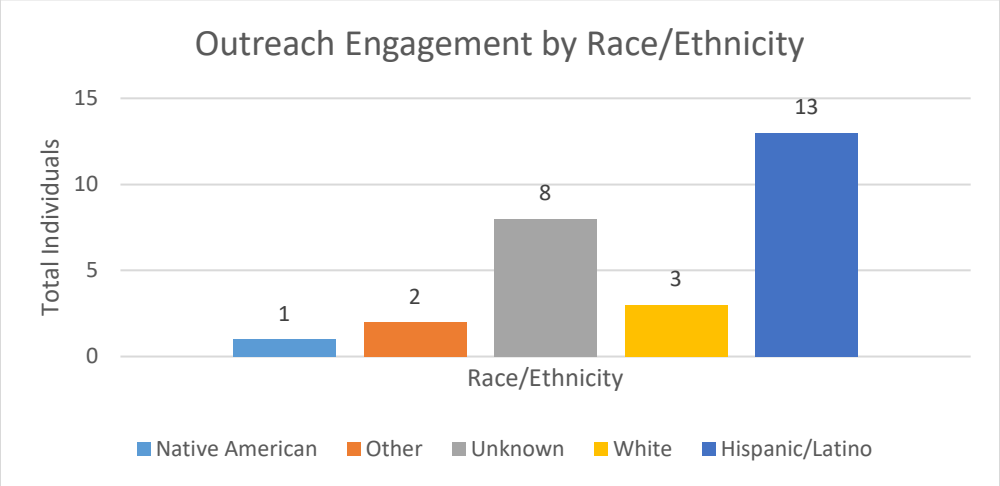
Services – Case management

Total Individuals Served FY 20-21	35
Total Individuals Served FY 21-22	48
Projected Individuals to be served in FY 22-23	20

Demographics

In FY 20-21, System Navigators provided 35 individuals with case management services. Of the 35 individuals, 15 identified as male, 22 as female and 2 individuals chose NA for sex assigned at birth. About 37% of individuals served identified as Latino/Hispanic, about 23% were Unknown and 9% identified as White.





Services

Outreach and Engagement solely provides indirect support services to individuals. They connect people to the appropriate resources and other services, and help the individuals navigate the process.

System Navigator Outreach

Due to the Covid-19 pandemic, System Navigators adapted to new and changing outreach ways. Outreach events mostly happened via Zoom, radio, and television. The table below lists the different presentations and innovative ways System Navigators outreached to the community during the pandemic. It is difficult to quantify people reached through broadcasted events, such as TV shows and radio shows, this are approximate numbers.

AFSP, the umbrella unit for System Navigators, is currently working on improving their outreach tracking to better capture all their outreach activities.

Outreach Event	Date	Number of attendees
ESL Immigration NVUSD Class- Zoom	10/24/20	14
PCAN Staff - Zoom	12/3/20	6
Mentis Staff - Zoom	1/27/21	6
Charlando con Teresa Foster- Local TV Show	2/19/21	8,200
Continuum of Care Meeting - Zoom	3/4/21	25
PCAN Spanish Support Group - Zoom	3/5/21	8
Domingo con Nico- Local Radio Station	3/7/21	8,200
PCAN English Support Group - Zoom	3/10/21	4
City of Napa Housing Division Meeting- Zoom	3/35/21	12
PCAN Spanish Support Group - Zoom	4/2/21	3
ICC Spanish Support Group - in person	4/19/21	11
ICC Spanish Support Group – in person	6/21/21	15

Project Access: Innovation Community Center

Program Summary

Innovations Community Center (ICC), a program of On The Move, is a consumer-staffed mental health program that supports individuals from underserved communities. Providers and participants work together to foster healing through storytelling, artistic expression, healthy living, spiritual practice, and social connections. The ICC program uses an interwoven approach to wellness that involves a collection of "strands":

Art Expression - Visual art, dance, music, theater and writing which allows for non-verbal articulation of feelings.

Healthy Living - Enhancing the mind and body experience with the natural benefits of gardening, exercise, healthy cooking and eating together.

Spiritual Healing - Quieting the mind, body and soul through meditation, yoga, Tai Chi, and other forms of spirituality.

Social Connections - Building relationships by participating in daily check-ins, support groups, and celebrations.

Community Engagement - Building confidence and agency through volunteerism and leadership opportunities.

Within these strands, ICC offers a broad range of ongoing and stand-alone activities. Activities are led by a combination of professionals, peer staff and program participants, with the support of community partners, including a team of professional volunteers made up of a nurse, a social worker, a mental health therapist; wellness and employment coaches, accredited somatic, Reiki and sound healing practitioners, WRAP and PSYCH-K certified facilitators. Members participate in support groups, one-on-one peer coaching, hands-on activities, social gatherings, and educational workshops. Peer leadership is developed through volunteerism, internships, paid employment and involvement in the Work for Wellness leadership cohort, and ongoing staff training and coaching.

COVID-19 Program Changes

In March 2020, ICC transitioned to a modified program in response to the Covid-19 pandemic and since Summer 2021 has offered a range of in-person and virtual services. ICC modified its programs to meet the unique health and safety needs of its participants, many of whom reported increased mental health challenges and social isolation due to the pandemic.

Key program changes included:

- *Morning Community Activities:* ICC has remained open in the morning to provide a familiar and resourceful space in a time of great uncertainty. While practicing physical-distancing, participants sharea light breakfast, listen to relaxing music, check-in with staff and peers, practice meditation and gardening, receive public

health and resource updates, and develop a daily wellness/safety plan. All activities are also streamed over Zoom for those who to prefer to join virtually.

- *Virtual Activities:* For the first half of the year, each afternoon, ICC provided online opportunities using Facebook Live and Zoom to offer workshops, support groups, community gatherings and virtual arts andhumanities field trips. In the second half of the year, most activities returned to in-person gatherings, although the Center continued to offer a weekly Talking Circle over Zoom to ensure that all members were able to participate.

- *Workshops & Support Groups:* In the second half of the year, ICC was able to host in-person workshops and support groups, including classes on nutrition and coping skills, hands-on art classes, community gardening, spiritual practices and support groups around mental health and substance abuse. There were several seasonal events hosted in the garden that gave participants a chance to socialize and engage in enriching learning in a hospitable environment. One of these events was, “A Celebration of Water”. At this event, attendees learned about the healing properties of water, plants that represent water, and howto make crafts that they could take home as talismans to remind them to include water in their everyday self-care practices.

- *Community Meetings*: Staff and participants met weekly to discuss programming, community engagement and outreach, facility protocols as related to the pandemic, participant suggestions and level of satisfactionwith Center programming and operations, and leadership opportunities in the areas of peer mentorship, peer governance, peer led-activities and volunteering

- *Daily Phone Calls*: ICC staff and interns provide peer-to-peer check-ins and wellness coaching by telephone to participants who are isolated and especially vulnerable to anxiety and depression.

- *Basic Needs:* ICC coordinates the receipt and distribution of essentials including meals, groceries, clothing and gas vouchers, hygiene materials and hand sanitizer to participants with identified needs.

- *May is Mental Health Month event*: ICC modified its annual May is Mental Health event to an online format, which highlighted essential workers and their life experiences during the pandemic

- *Technology and Communication:* ICC is helping participants access free and reduced-cost internet and providing one-on-one coaching to help participants to access remote platforms and resources as needed.

Program Evaluation and Development Activities

To assess its progress towards its stated goals and objectives, ICC staff gather multiple data points withthe support of On The Move's evaluation consultant, including:

- Demographics, including name, age, gender, income, race, language
- Participation, including attendance, volunteer/leadership hours
- Satisfaction, including measures of participants' perceptions of program delivery and impact
- Attitudinal and Behavior Change, including participants' perceptions of personal change and growth in wellness and/or leadership skills

Peer staff gather data through registration forms, sign-in sheets, service logs surveys and community meetings. The program's evaluator works alongside staff to analyze data quarterly and to planprogram improvement activities.

ICC's evaluation of its peer support program is based on the mental health recovery framework developed by the US Substance Abuse and Mental Health Services Administration. Specifically, ICC has selected five participant-level indicators to measure the impact of its model:

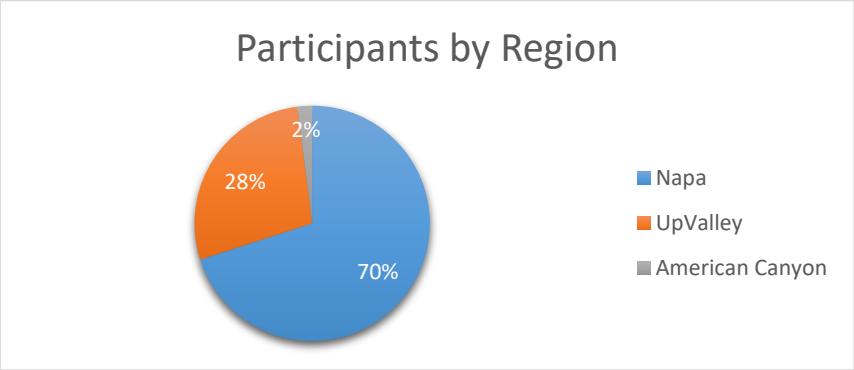
- Increased sense of control and ability to bring about change in their lives
- Increased self-esteem and confidence
- Increased sense of hope and inspiration
- Increased social support and social functioning
- Increased engagement in self-care and wellness

Through the center's feedback loop survey, participants are asked to reflect on a series of questions related to these five indicators of mental health recovery. The program evaluator summarizes and analyzes the survey data annually.

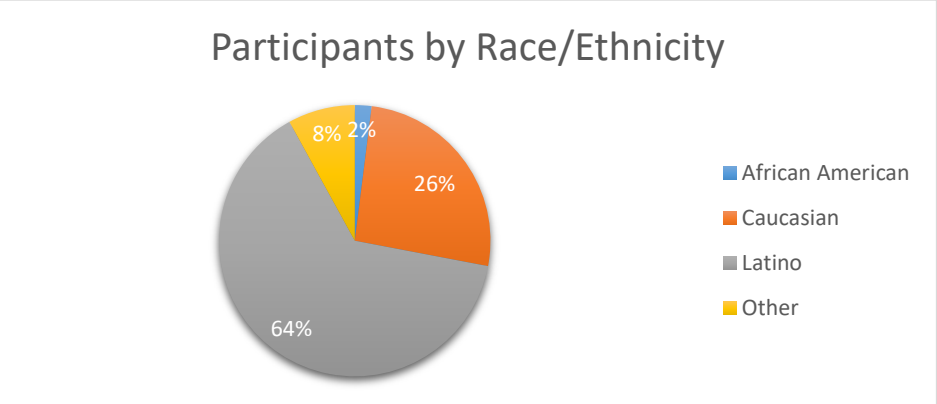
Demographics

The figures below detail the general demographics of the individuals who participated in ICC programs and activities between July 2020 and June 2021. A comparison of program records from FY 19-20 with FY 20-21 shows the following trends:

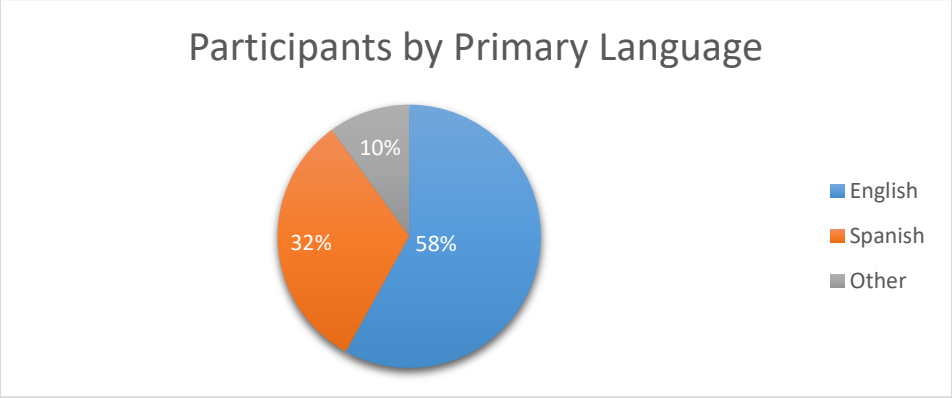
The percentage of participants from UpValley communities of Calistoga, St. Helena and Yountvilleincreased significantly, with UpValley residents now accounting for 28% of participants, compared to 2% in FY 19-20.



The percentage of Latinos participants increased by 23%, from 41% to 64%.

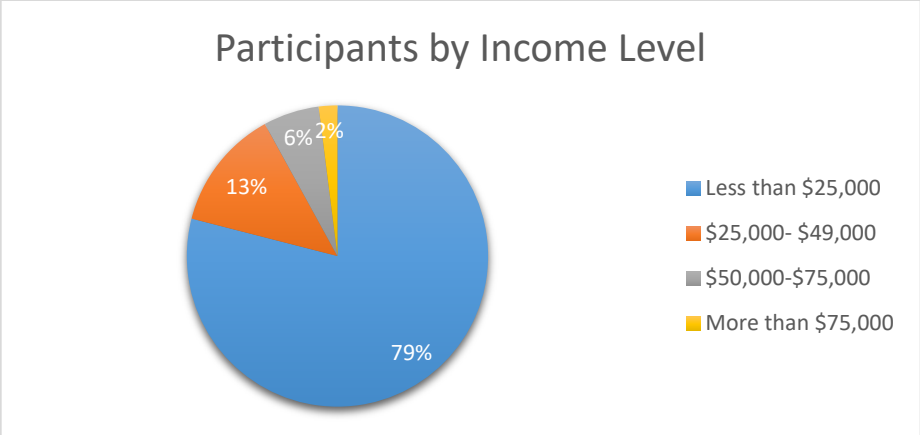


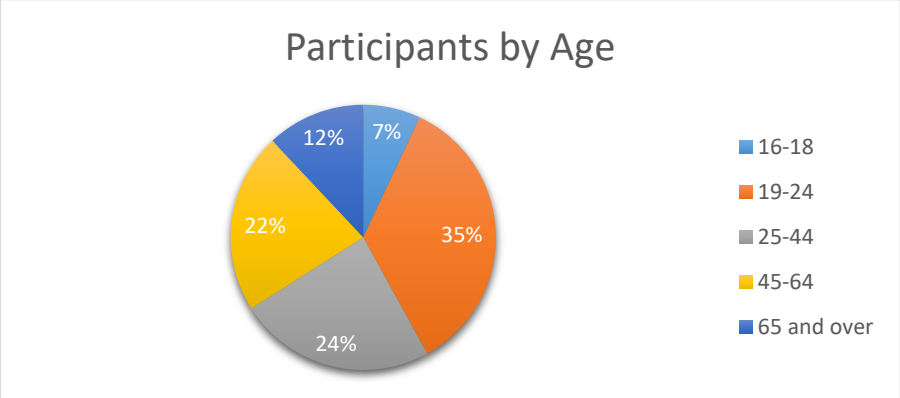
The percentage of Spanish speakers increased by 2%, up from 30% to 32%.



The percentage of very low-income participants grew from 73% to 79%. In terms of participant age, ICC's participant population shifted significantly, with:

- Participants 19-24 years old increasing from 4% to 35% of the total population
- Participants 45-64 years old increasing from 0% to 22% of the total population
- Participants 65 or more year old decreasing from 69% to 12% of the total population.

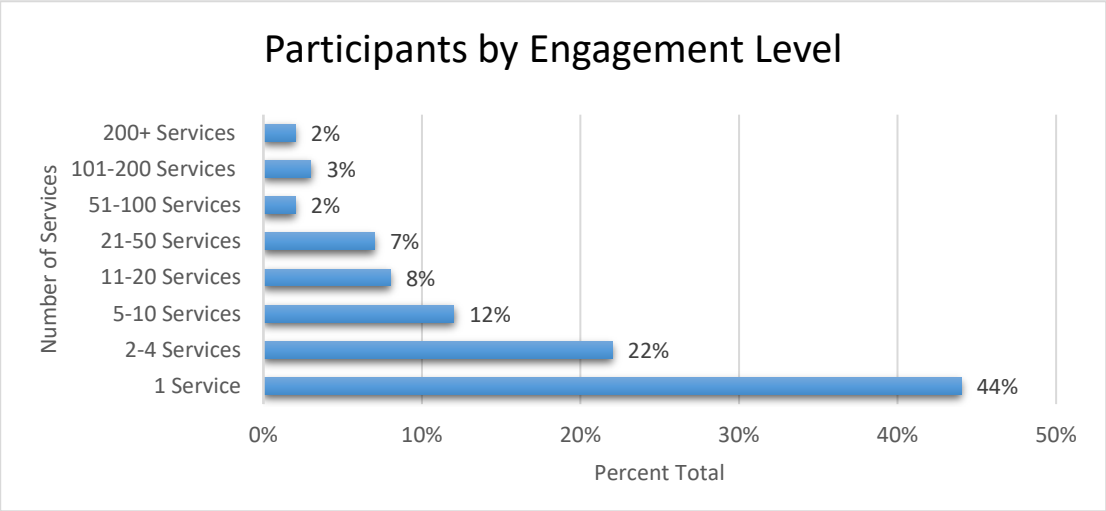




Participation Data

Participation Rate: More than half, 56% of ICC'S 293 unduplicated participants engaged in at least two services or activities in FY 20-21, a key measure of participants' ability to maintain emotional and/or physical health on a short-term basis. An additional 97 community members connected with ICC to seek out Covid-19, immigrant, and other resources, including referrals or Ole Health, the Napa Valley Food Bank, the Napa County Recovery Center and Napa County Health and Human Services.

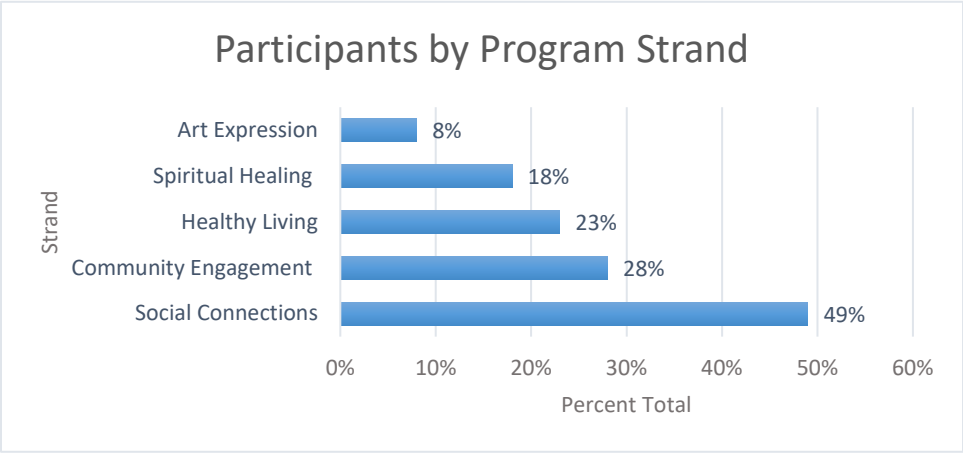
102 or 34% of ICC's members were very active at the Center, participating in at least five activities during the program year, which increases social connection and supports healthy, nurturing relationships with other participants.



Seventeen members participated in 100+ services over the course of the year. Program staff reportthat these community members have come to see ICC as their home base and contact point with a network of other service providers. While interacting with ICC, these participants receive peer support around their recovery work, including help to do “homework” for other programs, groups, and appointments, and to connect with others. Recently, one of these individuals said the new motto for ICCshould be, “Come and get your love.” According to program staff, all these people give and receive love at the Center, which is a foundational experience that helps them be successful in their own way in other areas of their lives.

Participation by Wellness Strand

49% of clients participated in Social Connections including morning check-ins, community meetings, support groups, special events, talking circles and coffee hours, morning check-ins, community meetings, support groups, special events, talking circles and coffee hours.



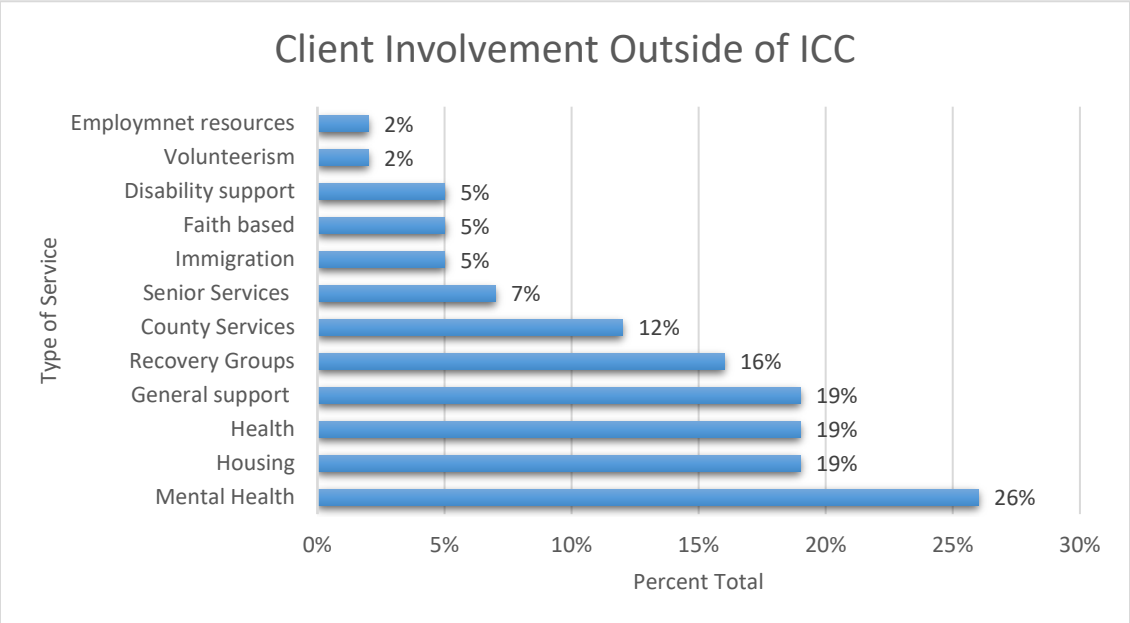
Leadership and Volunteerism

As a peer-led program, ICC actively works to engage its participants as peer staff, interns, and volunteers. In FY 20-21, ICC set a goal of involving 75 individuals as volunteers. Over the course of the year, 84 participants, or 29% of all participants, served as volunteer class facilitators, offered support during classes and special events and supported operations of the Center with housekeeping and as peer mentors, program interns and/or peer leaders in the Work for Wellness program. Participants take on active leadership roles around outreach, community education on disaster preparedness and creating new opportunities for supporting their peers' physical wellness.

The five ICC participants employed as peer staff received numerous opportunities to grow their leadership and work skills through regular training and coaching. Peer staff completed 23 different training modules including topics such as Covid-19 safety protocols, harassment, and mandated reporter, intake for Adult Protective Services, immigration, trauma, stress management, and peer employment. Staff also participated in an ongoing coaching circle, adult reflection, and clinical supervision. With support of their coaches, peer staff shared their learnings through trainings they hosted for 10 community members who included participants, family members, community service providers and volunteers.

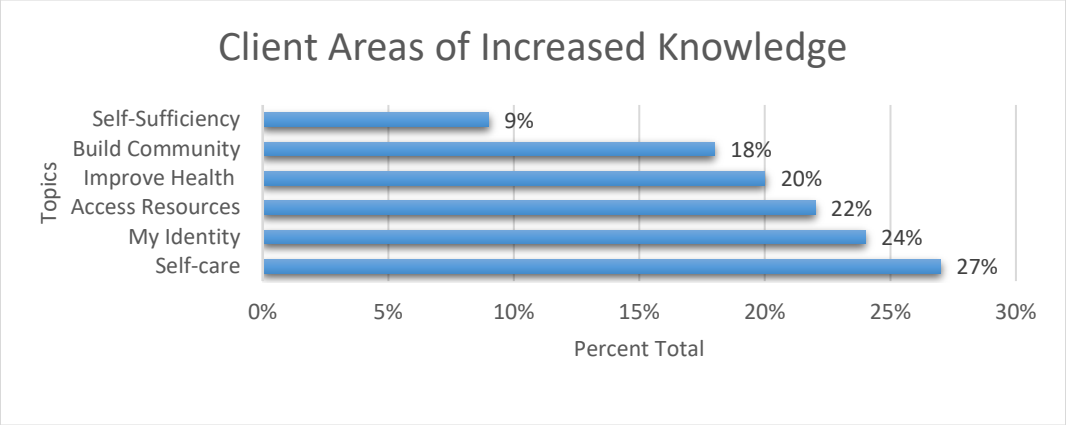
Impact Summary

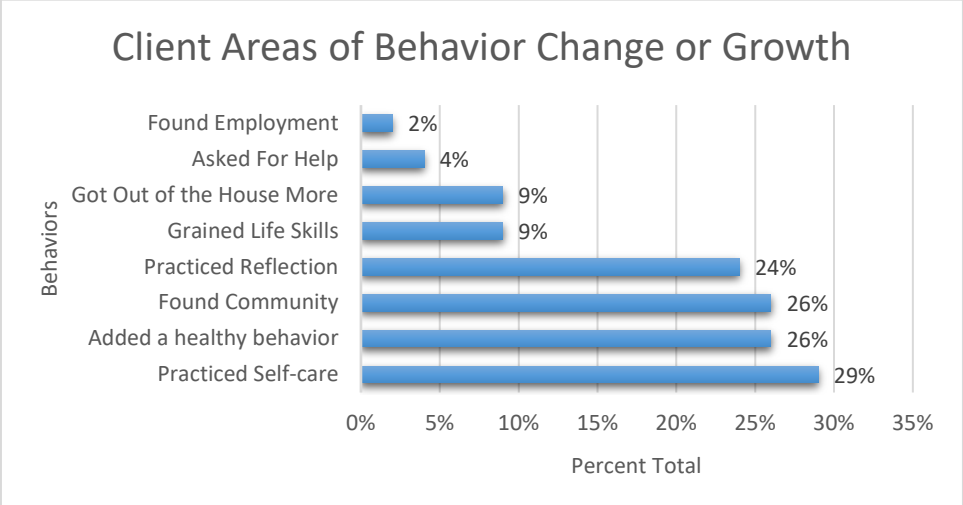
In July 2021, ICC's peer staff gathered information from members regarding their experiences in FY 20-21. Fifty ICC participants completed the survey, the majority of whom interacted with the Center every week. Staff used the data to recommend program improvements. Findings from the survey, recommendations and program plans were communicated back to ICC participants.



Key Findings

- 76% of ICC members were connected to and participated in community services and programs in addition to ICC services.
- 90% of survey respondents could identify one thing they learned over the last year. Participants reported learning more about self-care, identity and how to access resources, improve health, build community and become more self-sufficient.
- 92% of survey respondents could identify at least one change they made because of what they learned at ICC.





Crisis Stabilization Unit (CSU)

Program Summary

With funding from the California Health Facilities Finance Authority's (CHFFA) Investment in Mental Health Wellness Act Grant, NCMHP developed the first Crisis Stabilization Unit (CSU) in Napa County. The CSU began offering services on May 3, 2017, through a contract with Exodus to provide CSU services. The CSU has 6 Adult and 2 Adolescent beds and was designed to

address gaps in the county's continuum of care by providing access to emergency psychiatric services complementary to current resources.

- Offers the first emergency psychiatric crisis services available in Napa County;
- Expands access to early intervention and treatment services to improve the consumer experience, and helps them to achieve recovery and wellness;
- Diverts mental health consumers from hospitalization and other institutional care to more appropriate, less restrictive levels of care;
- Reduces the negative impacts of extended hospital emergency room stays upon consumers and local hospital emergency departments; and

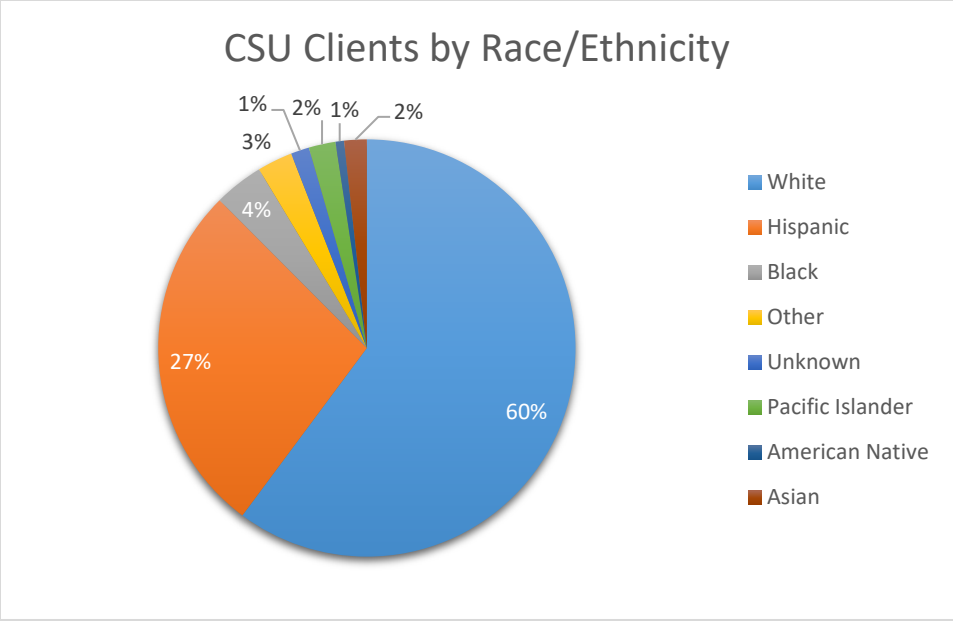
MHSA funded the CSU from May 2017 through May 2021. The NCMHP released an RFP for CSU Services and after a review of all the proposals received awarded the CSU Contract to Crestwood, which began providing services effective June 1, 2021. MHSA funds were no longer needed to support the CSU as the County identified other sources of funding.

Services

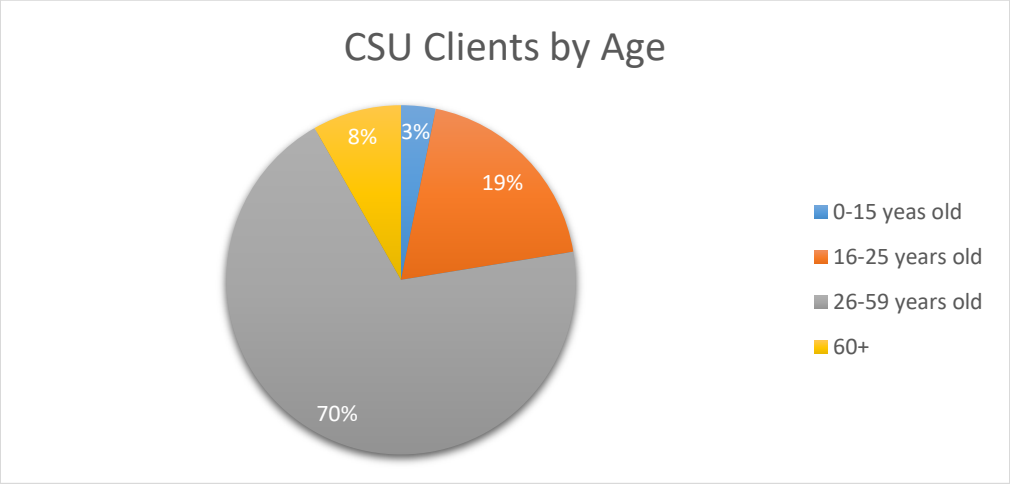
In FY 20-21, from July 2020 through May 2021, the CSU served 538 unduplicated individuals and had 914 visits; this is a 27% decrease from the previous year. Of the 538 clients, 238 identified as homeless and 128 had co-occurring disorders. The average length of stay was 36.9 hours, and the average daily admissions was 2.7 a day.

Demographics

Of the individuals admitted to the CSU over 60% identified as White, just over 27% identified as Hispanic/Latino and close to 4% identified as Black.



Of the individuals served, about 66% were in the age group of 26-59, about 18% were in the age group of 16-25, just under 8% were under the age group of 60 plus, and about 7.5% were in the age group of 0-15.



Referrals

The table below shows the four places with the highest number of referrals, in FY 20-21, 13 places referred individuals to the CSU. Law enforcement, Self/Family, Hospital ER and Napa County Mental Health were the places with the most referrals to the CSU.

Referred From	Total
Law Enforcement	295
Self/Family	284
Hospital ER	197
Napa County Mental Health	37

ParentsCAN (PCAN) - Outreach and Support Groups

Due to Covid-19 pandemic limitations, PCAN provide 1 on 1 outreach by contacting families, that they had previously worked with, to assess current needs and refer them to appropriate programs. PCAN outreached through community events, calls, newsletters and via Zoom.

Community Events Outreach

Community events outreach was mostly around fire emergency response and distributing personal protective equipment to families. PCAN reached 2,702 duplicated families through community events in Napa County.

Campaign Name	Start Date	Total Family Attendees	Demographic	Location
Emergency Response-Glass Fire 2020	9/28/20 - 10/1/20	906	Parents; Local Community	UpValley
Food Distribution	4/27/21	40	Parents; Local Community; Seniors	Napa City
PPE Distribution PCAN Families	7/1/20-6/30/21	100	Parents; Local Community; Professional Partners	Napa County
PPE Distribution Fire Evacuees	7/1/20-6/30/21	50	Parents; Local Community; Professional Partners	Napa County
PPE Distribution Farmworkers	7/15/20	15	Parents; Local Community; Professional Partners; Other	UpValley
PPE Distribution AC Mobile Home/Senior Living	8/11/20	96	Parents; Local Community; Professional Partners; Other	American Canyon, Napa County
PPE Distribution American Canyon	8/11/20	325	Parents; Local Community; Professional Partners	American Canyon, Napa County
PPE Distribution Calistoga	8/12/20	120	Parents; Local Community; Professional Partners	Calistoga, Napa County
PPE Distribution Napa High 10/17/20 Vol	10/17/20	1000	Parents; Local Community; Professional Partners	Napa High School
PPE Distribution CSOA	10/30/20	50	Local Community; Professional Partners; Other	Napa county

Disaster Outreach

Beginning August 2020, the outreach focus shifted from pandemic to fire outreach. The Lightning Complex Fires and Glass Fires occurred in August 2020 and again in September 2020. PCAN targeted families in UpValley and families in rural Napa, 964 families were reached.

Quarter	Contacts	Duplicated Families Reached
1	1,217	333
2	1,258	319
3	1,661	325
4	1,190	287

Outreach calls included check-ins and follow-ups with families regarding the following topics:

- Census
- Childcare
- Education (Distance Learning and Special Education)
- Employment
- Financial Assistance
- Food
- Housing
- Internet/Computer
- Medi-Cal
- Mental Health
- Respite/Personal Care
- Triple P Parenting Classes

Depending on the identified needs, staff explained available resources, referring families to the resources for direct help, assisting with applications and offering 1:1 Triple P Parenting assistance. Families reported needing assistance with the following: (one family may have reported needing assistance in more than on area).

Type of need	Number of households needing type of assistance
Mental Health	183
Financial Assistance	90
Triple P	114
Food	27
Respite/ Personal Care	73
Housing	19
Technology (internet/computer)	9
Employment	12
Medi-Cal	14
Childcare	2

Newsletter

PCAN distributed three newsletters during the first and third quarter of FY 20-21, and 3,891 duplicated families received the newsletter. Newsletters were distributed via mail and e-mail.

Quarter	Number of Newsletters	Months of Distribution	Topics	Number of families receiving newsletter
1	1	July	Census, voting, emergency preparedness and PCAN services.	1,000
3	1	April	Autism Awareness and new PCAN youth resource website page.	1,698
3	1	May	Stress tips, national hotlines and local mental health crisis hotlines, PPE distribution events and PCAN services.	1,193
Number of families receiving newsletter (e-mail and mail)				3,891

Challenging Behaviors Spanish Groups

PCAN provided 10 Spanish support groups via Zoom, 72 individuals participated in groups.

Quarter	Number of groups	Number of participants
1	3	23
2	3	28
3	2	13
4	2	8
Total	10	72

Respite Services

There were 15 respite services requests and a total of $1,200 was expended.

Quarter	Number of requests	Dollar amount paid
1	4	$600
2	6	$400
3	2	$200
4	3	0
Total	15	$1,200

Mobile Response Team (MRT)

Program Summary

The Mobile Crisis Response Team (MRT) provides professional, same-day intervention for adults and children who are experiencing mental health crises. The MCRT prioritizes community response for all individuals regardless of insurance status. Licensed mental health clinicians and mental health workers are trained to respond and deploy within Napa County to provide community support with care and utilization of de-escalation skills, risk assessment, and linkage to the County Crisis Stabilization Unit, can initiate a 5150 hold in the community and provides follow-up and post crisis support while linking to long term services.

Recruitment for the program staff began Fall 2020. Since then, three new staff members were hired, one licensed mental health counselor, one registered mental health counselor and one senior mental health worker. Staff is expected to respond within 30 minutes of receiving a call and will provide services in private residences, hospitals, parking lots, streets, and schools.

The roll out timeline of the program is as follows:

Phase One

- February 14, 2022
- Operating Hours: 8am-5pm, Monday-Friday

Phase Two

- Goal May 1, 2022
- Operating Hours: 8am-6pm, 7 days per week

Phase Three

- Goal based on all positions being filled: August 1, 2022
- Operating Hours: 8am-9pm, 7 days per week

The MRT began operation on February 15, 2022. From February 15th through May 15th, the response number received 85 calls. Of the 85 calls, 48% were made by community partners and 24% by family members, these were the most common reporting parties. The nature of crisis for 38% of the calls was DTS, being the most common crisis call. 29% of calls were identified as Erratic BX, making this type of crisis was the second most common nature of crisis call. The NCMHP and law enforcement partnered and jointly responded 9 times during this time period.

Reporting Party Type	Total	%
Community Partner	41	48%
Family	20	24%
School	11	13%
Other	8	9%
NSO	1	1%
Friend	2	2%
Shelter	1	1%
Total	85	100%

Nature of Crisis	Total	%
DTS	32	38%
Erratic BX	25	29%
Other	18	21%
GD	7	8%
DTO	3	4%
Total	85	100%

Family Urgent Response System (FURS)

Program Summary

The MRT will also cover responses for the Family Urgent Response System (FURS), which is a 24/7 mandated program. FURS is a coordinated statewide, regional, and county-level system designed to provide collaborative and timely state-level phone-based response and county level in-home, in-person mobile response during situations of instability, for purposes of preserving the relationship of the caregiver and the child or youth. FURS builds upon the Continuum of Care Reform and the state's recent System of Care development, to provide current and former foster youth and their caregivers with immediate, trauma-informed support when they need it. FURS provides 24/7 immediate, in-person support during situations of instability, closing the gap for families experiencing conflict that previously had nowhere to turn and providing a trauma-informed alternative for families who previously resorted to calling 911 or law enforcement.

Napa County's Health and Human Services Child Welfare Services (CWS) and the MH Division collaborate with Juvenile Probation to ensure FURS implementation and service delivery goals are successfully met. FURS went live Spring of 2021 and has not received any calls to date.

Component: Innovation (INN)

Innovation Round 2 Projects

All four of the Innovation Round 2 projects (Adverse Childhood Experiences, Native American Historical Trauma and Traditional Healing, and Work for Wellness) were terminated or no longer funded by MHSA at the end of FY 20-21. The Addressing the Mental Health Needs of the American Canyon Filipino Community Project, which is now known as the Filipino Life and Generational Groups (FLAGG) project, continued with limited funding from the Napa Valley Unified School District, however, the FLAFF project has requested a one year extension of time and additional $138,425 of Innovation funding to complete Phase 3 and dissemination of information, which has been complicated and delayed by the COVID Pandemic.

The goal of FLAGG was to create an intergenerational approach to support the mental health needs of Filipino youth in American Canyon. American Canyon middle and high school students self-reported (CA Healthy Kids Survey) higher levels of anxiety and depression than their peers. The project focuses on listening, learning, and addressing the root causes of their anxiety and

depression and developing meaningful intergenerational (i.e., parents, caregivers, and grandparents) interventions to support Filipino youth.

The project is divided into three phases. Phase 1 focused on building trust, recruiting community, parents, and students, and developing listening sessions to learn about the specific needs and issues that Filipino adolescents were facing. Phase 2 builds on the first phase and develops intergenerational FLAGG (Filipino Life And Generational Groups) working groups to support student mental health within the group itself and within the school community. Peer leadership, training regarding mental health and resilience, and learning about Filipino culture are highlights of Phase 2 activities. Phase 3 has students taking their voice and their learnings forward to the school and community to educate others and influence systems change.

Justification for Extension

The project is currently in Phase 2. Because of the pandemic and school closures, most of Phase 2 has been conducted virtually, making it difficult for the project staff to quickly make gains and progress in group cohesion, learning goals and output. As the funding stands, the project must wrap up Phase 2 soon, to provide adequate time for the final phase. Preferably, the project could be extended for another year to provide additional Phase 2 time in-person and on-site to deepen the project impact and provide students with the opportunity to conduct Phase 3 activities in a way that may change systems and deepen community knowledge.

Please see Appendix 5 for more details and budget regarding the request for an extension of the FLAGG project.

Innovation Round 2 Project Learnings

Below are summaries of each Innovation Round 2 Project's learning questions and summaries of learning. See Appendix 2 for a complete evaluation report for Innovation Round 2 Projects.

Filipino Life and Generational Groups (FLAGG)

Overview

The Filipino Life and Generational Groups Innovation Round 2 Project was funded to address the disparity in reported mental health risk and mental health service use by Filipino youth. The disparity in needs was uncovered using the California Healthy Kids survey data and the service use was reviewed using school records.

Learning Questions

Innovation projects are developed to address learning questions. The following learning questions guided the activities and the evaluation of the Filipino Life and Generational Groups (FLAGG).

1. Does an intergenerational approach to mental health support change?

- Intergenerational empathy and understanding about wellness needs of parents and students?
- Willingness of Filipino youth and families to use supports to promote and maintain wellness?

2. Do the ideas generated by the intergenerational approach change how the district and mental health providers support changes to?
    - Screening process to identify mental health risks of all students, not just those with external behaviors.
    - Supports available to promote and maintain wellness for all students?

Summary of Learning

Data was collected and reviewed throughout the project to inform the program planning. The findings are organized by learning question.

Does an intergenerational approach to mental health support change intergenerational empathy and understanding about wellness needs of parents and students?

- In the surveys and in the interviews, there was evidence that the intergenerational approach increased empathy around how stress is experienced by adults and youth.

Does an intergenerational approach to mental health support change willingness of Filipino youth and families to use supports to promote and maintain wellness?

- The participants spoke clearly about the need for groups like FLAGG that combine the discussion of mental health with the discussion of culture. Though they noted the importance of more intensive supports like therapy and counseling, they were clear that it was very difficult to suggest to Filipino adults.
- Because of the resistance to therapy and counseling, youth were cautious about discussing their own mental health needs with adults. Several youth noted the mandated reporting guidelines inhibited them from using supports themselves and/or offering supports to other youth.

Do the ideas generated by the intergenerational approach change how the *district and mental health providers* support changes to screening process to identify mental health risks of all students, not just those with external behaviors?

- The participants were asked about their ideas for how to identify stress and mental health concern among Filipino youth and adults. They shared that stress is most likely to appear as anger/irritability in adults and as behavior changes in youth. In some cases, individuals may share that they are stressed, but this was not a common response from participants.
- Participants used described mental health concerns as changes in Feelings/Emotions, Behaviors, and risks of Harm/Danger. They were more likely to indicate that youth will Tell Someone when they have a mental health concern or show a change in behaviors. Mental health concerns in adults were more likely to be described as resulting in Isolation/Withdraw.

- Suggestions about how to identify students with mental health concerns in schools included establishing relationships with students, so you know when there is a change in their behavior, integrating mental health discussions into classrooms, providing anonymous ways to express themselves and hear that the experiences are common, consider peer programs and address the stigma of mental health directly. They agreed that academic indicators alone will not identify the needs.
- These ideas have not yet been shared widely with district and mental health providers but are being reviewed and implemented by American Canyon High School Wellness staff.

Do the ideas generated by the intergenerational approach change how the *district and mental health providers* support changes to supports available to promote and maintain wellness for all students?

- When participants were asked for suggestions on how to promote and maintain wellness for Filipino students, they described Discreet/Safe Spaces, Changes in the Classrooms, and Support for Adults.
- When asked what they would change about the current supports in schools, they talked about the need to address confidentiality, consider the impact of academic pressures, and offer breaks, incorporate more clubs and cultural supports, and extend school year supports through the summer.

Adverse Childhood Experiences (ACEs)

Overview

Paraprofessionals, who are individuals' first contact with services, are often best positioned to intervene in the prevention and treatment of ACEs yet have the least professional support to address ACEs in their own lives. In contrast, licensed professionals receive training and often ongoing supervision to address their own trauma history and the impact it has in their work. The Adverse Childhood Experiences (ACEs) Innovation Project was designed to explore whether identifying and discussing the role of ACEs and Resiliency in the lives of paraprofessionals improves how individuals understand ACEs and Resiliency in the lives of the individuals they serve and/or improves how individuals manage workplace stress.

Learning Questions

The project was guided by three learning questions:

1. How does a paraprofessional's personal history with ACEs and Resiliency impact how they address ACEs with their clients?
2. How does a paraprofessional's personal history with ACEs and Resiliency impact their workplace stress?

3. Which supports do paraprofessionals find the most effective in changing how they address ACEs and Resiliency with individuals and/or how they manage workplace stress?

Summary of Learning

How does a paraprofessional's personal history with ACEs and Resiliency impact how they address ACEs with their clients?

- Most participants reported that understanding their own ACES has helped them to be more compassionate with their clients, to listen more, and to be more open to possible underlying causes or explanations for client behavior.
- When asked to describe the specific changes they made, the most common reports were: having more compassion; having more empathy; having more curiosity, making time and space to listen more; having a better understanding of trauma and being open to discussing candidly, or asking questions, that may have been uncomfortable for them previously; being aware of their own triggers and not responding emotionally, not mirroring a client's emotions; and, not taking things their clients do or say personally.
- Participants who said "yes" to making changes in the way they address ACES and Resiliency with their clients also reported that they'd observed changes in their clients as a result.
- Changes in RAISE training program participant survey responses over time indicate an increased awareness of the impact that that a paraprofessional's personal experience with past adverse experiences has on their ability to serve their clients.

How does a paraprofessional's personal history with ACEs and Resiliency impact their workplace stress?

Responses over time indicate an increased awareness among most RAISE participants of the impact that a paraprofessional's personal history with past adverse experiences on their workplace stress.

Most RAISE participants interviewed at the end of the project acknowledged the impact that unaddressed ACEs can have on how a person manages their workplace stress.

Most referenced the need to take care of themselves, to take time out for things they enjoy, and to have a toolbox of self-care strategies that can be used in the moment

Which supports do paraprofessionals find the most effective in changing how they address ACEs and Resiliency with individuals and/or how they manage workplace stress?

Addressing ACEs

As noted previously, one of the main supports in changing how paraprofessionals address ACEs with clients was an improved understanding of how their personal experience with trauma informs their reactions to client situations.

When asked about the types of supports paraprofessionals find the most effective in changing how they address ACEs and Resiliency with individuals, most RAISE participants reported the need to view behavior in the context of ACEs and past trauma, providing understanding and compassion, and making no assumptions about why individuals behave the way they do.

Sharing the Learning

During the project implementation, participants reported that sharing the information with the participants' coworkers, managers and/or supervisors helped them to use the information at work. The additional support of co-workers made the application of the learning more effective.

About one third of those who shared the learning with co-workers (4 of 11) reported changes about how ACEs and Resiliency was addressed in their organization.

A manager training component was added to the project as participant identified the need for more support from within their organization.

Managing Workplace Stress

Participants reported the need to find what works for "you" to address workplace stress. Most reported that they didn't think about self-care before RAISE, and they remind themselves to stay focused on consciously engaging in self-care activities. Many noted the need to focus on taking care of themselves, so they can take care of others.

Preferences for managing workplace stress varied by individual and included: being physically active, using strategies that could be done in the moment (e.g., breathing) and practicing the self-reflection they learned in the training.

Work for Wellness

Overview

The Work for Wellness project was funded to address the disparate definitions of successful employment for individuals with Serious Mental Illness. The project convened stakeholders and worked to increase commitment of the various stakeholders to each other to create common frameworks for describing and promoting success.

Organization

This program report begins with a review of data on underemployment for individuals with mental health needs despite the evidence based practices designed to promote successful employment. The next section is a discussion of the program planning and implementation and the learning that resulted from convening stakeholders and developing shared measures of success. The report continues with an overview of the Work For Wellness project and the findings from participant and staff interviews.

Learning Questions

1. How to create shared measures of success among all participants in the system?
2. How to increase commitment of all system participants to each other?
3. How to implement common measures of success?

In addition to the original learning questions, MSHA staff asked project staff to include learning about how mental health providers can support employment as an option for wellness and recovery.

Summary of Learning

How to create shared measures of success among all participants in the system?

The first Phase of the project focused on the experiences of individuals with Serious Mental Illness and employment. The resulting measures of success reflected these perspectives but did not include the supported employment and employer points of view. Though this approach was good for building trust and promoting engagement from the employee group, the resulting model describing success was not clear to all participants.

The second Phase of the project prioritized hearing from the supported employment and employer point of view and resulted in a shifted definition of success. Previously the focus had been on the individual and their needs, this changed to a focus on the work and what an individual needs to have in place for themselves outside of work to do the work successfully.

How to increase commitment of all system participants to each other?

Phase One brought a disparate group of individuals with varied experiences and roles with employment and with mental health. The monthly meetings and group activities helped individuals learn about themselves and each other. Participants shared that the experiences in the first phase changed how they interacted with each other and how they thought about the challenges facing others. Several noted that they felt a sense of accomplishment and hoped the work would have an impact.

Despite disappointing engagement by employers and decision makers, at the end of Phase One individuals reported that the support they gave each other was a benefit to them. They felt the process of listening to each other was valuable and connected them.

How to implement common measures of success?

Plans to implement the common measures of success began at the end of Phase One as the project staff prepared for Phase Two. The initial plan was to test the STAFF model and share it with employers. After reviewing staff and participant feedback, it became apparent that there needed to be more stakeholder input.

Staff created a new plan for Phase Two to collect and incorporate the missing perspectives from supported employment, employers, and mental health providers. This resulted in a shift from

focusing on the individual and their needs to the work and what the individual needs to have in place (outside of work) to do the work effectively.

At the end of Phase Two, project staff were planning to begin a life skills group at the ICC to support individuals who have been diagnosed with a Serious Mental Illness and want to prepare to work. Staff also noted that the shift to centering the work instead of the individual has been helpful in supporting individuals in other systems that sustain the vulnerable (transportation, housing, etc.)

Most of the participants who completed Phase Two indicated that they hoped to be involved in the upcoming Work for Wellness life skills groups.

How can mental health providers support employment as part of wellness and recovery?

Participants indicated that mental health providers should understand the types of supports available. They also reflected on the potential role of providers in addressing the stigma of mental illness that individuals encounter with supported employment and with employers.

Staff noted the main role of mental health providers is in keeping individuals with a Serious Mental Illness stable and able to use supported employment or to be employed. They also encouraged providers to avoid referring individuals to supported employment who are not stable or ready to be employed.

Native American Historical Trauma and Healing Workshop Series

Overview

The Suscol Council Intertribal Council's Innovation Project was funded to respond to the lack of information about Native history and experience and to respond to the community's curiosity about the use of the healing methods demonstrated in Suscol's community education. The project was designed specifically for mental health providers to expand understanding, compassion, and resources available to the Native individuals seeking mental health supports.

Learning Questions

Innovation projects are developed to address learning questions. The following learning questions guided the activities and the evaluation of the Native American Historical Trauma and Healing Workshop Series.

1. Does the workshop series change mental health providers' understanding and compassion for Native American individuals with mental health concerns and a traditional view of trauma?
2. Do providers integrate the learning into their own self-care? Why or why not?

3. Do providers use their knowledge of Native American culture and history and their experiences with traditional wellness and healing methods6 to change their professional practice? How? Why?

Summary of Learning

Data was collected and reviewed throughout the project to inform the workshop series and to understand how individuals were using the information. The findings are organized by learning question.

Does the workshop series change mental health providers' understanding and compassion for Native American individuals with mental health concerns and a traditional view of trauma?

Yes, the participants reported changes in their understanding of the Native history and experience and reported feeling both inspired and overwhelmed by the information. The participants talked about the emotional impact of the learning and reported changes in knowledge, attitudes, and behaviors as a result of participating. A community wide survey done at the end of the project also showed increased familiarity with regional Tribes, and more information about historical trauma among the community mental health providers.

Do providers integrate the learning into their own self-care? Why or why not?

The participants reported positive changes after experiencing the healing elements at the end of the workshops and most of the providers were comfortable integrating the learning into their own self-care. A few were concerned about cultural appropriation and did not feel as comfortable.

Do providers use their knowledge of Native American culture and history and their experiences with traditional wellness and healing methods to change their professional practice? How? Why?

Yes, after the workshops about 40% of the participants indicated they planned to use at least one of the methods with clients. Several providers shared the elements with co-workers to promote using the elements with clients served by their agency. Among the providers who did not plan to use the elements, some indicated it felt inappropriate for them because it wasn't their tradition, other talked about referring individuals to Suscol or other agencies and/or community members who can provide the elements for Native individuals.

6 In this report, "healing methods," "healing traditions," and "healing elements" are used interchangeably. These terms are all meant to describe a process of healing.

Innovation Round 3 Project

Learning Health Care Network for Early Psychosis

The NCMHP and other California counties in collaboration with the UC Davis Behavioral Health Center of Excellence received approval to use Innovation or other Prop 63 funds to develop infrastructure for a sustainable Learning Health Care Network (LHCN) for Early Psychosis (EP) programs. Of those counties with approved funding, the following counties have processed and executed contracts between their behavioral health services departments and UC Davis: San Diego, Solano, Sonoma, Los Angeles, Orange, Stanislaus, and Napa. The One Mind Foundation, based in Rutherford, CA, has also contributed $1.5 million in funding to support the project.

This Innovation project seeks to demonstrate the utility of the network via a collaborative statewide evaluation to assess the impact of the network and these programs on the consumers and communities that they serve. This project, led by UC Davis in partnership with UC San Francisco, UC San Diego, University of Calgary, and multiple California counties, will bring consumer-level data to the providers' fingertips for real-time sharing with consumers, and allow programs to learn from each other through a training and technical assistance collaborative. This Statewide EP Evaluation and LHCN propose to 1) increase the quality of mental health services, including measurable outcomes, and 2) introduce a mental health practice or approach that is new to the overall mental health system. The project must comply with the regulatory and funding guidelines for evaluation as stipulated by the applicable Mental Health Services Act (MHSA) funding regulations, contract deliverables, and best practices. There are three components to the data collected for the LHCN: County Level, Program Level, and Qualitative data (Figure 1). The protocol for collecting each component has been reviewed by an Institutional Review Board (IRB) and approved before commencement of data collection. Further, aspects of the data design will be shaped by the input of community partners, including mental health consumers, family members, and providers.

For more details on this project, please see Appendix 3.

Innovation Round 4 Proposed Project

DESCRIPTION OF LOCAL NEED

FSP Program Overview: Napa County has five Full Service Partnership (FSP) programs. During FY 2020-2021, these programs served a total of 249 consumers served including 54 children served by Children's FSP, 35 youth served by Transition Age Youth (TAY) FSP, 73 adults served by Adult FSP, 34 adults served by the Adult Treatment Team (ATT) FSP, and 53 older adults served by Older Adult (OA) FSP. Individuals who identified as White, 46%, were the highest represented group. Hispanic/Latinos were the second largest group receiving services, 27% of individuals identified as Hispanic/Latino. Only 1% of individuals identified as Native American and under 1% identified as Mixed, making both groups the least represented. Napa county FSP

programs provided 4,105 aggregate services in FY20-21. The service provided most frequently was intensive care coordination and individual therapy. The services least provided were DBT group rehab intervention, TCM placement service and court related activity.

FSP Challenges: Local stakeholders have identified several challenges that could be addressed through the Multi-County FSP Innovation Project.

- **Telling the Story of Napa's FSP's Impact:** Local stakeholders have asked the MH Division to provide evaluation data to demonstrate the effectiveness of FSP services. They point out that the MH Division requires contractors to evaluate their own programs and they have expressed strong interest in reviewing FSP evaluation data, however, the following issues have made it difficult to paint an accurate picture of the impact of the FSP services provided by Napa County staff.
- **Data collection, reporting, and training challenges:** Napa County has reported outcomes for the individuals served by the previously mentioned FSPs in the California Department of Health Care Services Data Collection and Reporting (DCR) System. In the early years of MHSA implementation, staff were able to extract meaningful data from the system and generate accurate FSP outcome reports, however, as time went on unresolved DCR issues made it difficult to impossible to extract useful and meaningful data from the DCR System. Additionally, limited training opportunities for FSP staff have contributed to lack of understanding around how to make best use of the DCR system. FSP staff are committed to providing high quality care for their FSP partners and focus on completing progress notes for our Electronic Health Record (EHR). Unfortunately, staff are not as consistent entering data into the DCR and neglect to complete Key Event Tracking or 3M Quarterly Forms because it is separate data entry process and their priorities are focused on documentation of the services, they provide to ensure they are maintaining productivity standards.
- **Lack of Clear Definitions of Discharge Reasons:** When compiling FSP outcomes to report in the FY 21-22 Annual Update, staff determined that FSP programs each have their own understandings and reasons for selecting "Administrative and NA" as the reason for discharge. A significant number of cases were closed under these discharge reasons; however, it is difficult to identify or track a standard for this discharge. Through participation in the FSP Collaborative, staff hope to work with FSP staff to create shared definitions for discharge reasons and identify cases and scenarios when these reasons are applicable and share best practices.
- **Staff Turnover and Outliers:** The MH Division has experienced significant staff turnover throughout the years and some staff have left abruptly without reassigning partners to other staff or closing partners who are no longer receiving services. As a result of this situation, there are outliers in the DCR that skew the outcome results and don't present an accurate picture of the true outcomes of the FSP programs. Efforts to resolve these outliers with DCR Technical Assistance have been unsuccessful and so these outliers continue to skew outcomes and invalidate outcome reports.

Response to Local Need

Through this Innovation proposal, NCMHP seeks to participate in the statewide initiative to increase counties' collective capacity to gather and use data to better design, implement, and manage FSP services. The total cost for Napa County to participate in the FSP Collaborative is $844,750. The key priorities outlined in the Innovation Plan will allow Napa County Behavioral Health Services to address current challenges and center FSP programs and services around meaningful outcomes for participants. More specifically, participating in this project and aligning with the identified priorities will enable the department to:

1. Develop a clear strategy for how outcome goals and performance metrics can best be tracked using existing state and/or county-required tools to support meaningful comparison, learning, and evaluation.
2. Develop training materials for staff and supervisors to support increased accuracy in the completion of DCR Outcome reports and forms.
3. Develop FSP Outcome and Audit reports that accurately reflect the impact FSP services are having on FSP partners
4. Create a model of best practices that is relevant for the current needs of FSP partners in the age of Covid, housing challenges, etc.
5. Incorporate learnings for other cohorts participating in the Multi-County FSP Collaborative to improve services and practices in Napa County FSPs
6. Improve existing FSP performance management practices (i.e., when, and how often program data and progress towards goals are discussed, what data is included and in what format, and how next steps and program modifications are identified).

In addition, this project will provide the NCMHP with the opportunity to share and exchange knowledge with other counties participating in this project and through the statewide learning community. For more details on this project, please see Appendix 4.

Component: Workforce Education and Training (WET)

NCMHP has expended all the WET funding. Currently, there are no plans to allocate any additional funds to this component. It is possible to receive reallocated WET funds from the State, but the amount is usually small. Plans will be developed if additional funds are received from the State.

Bay Area Regional Partnership Workforce Education and Training

Program Summary

The Department of Healthcare Access and Information (HCAI), formerly known as the Office of Statewide Health Planning and Development (OSHPD), is statutorily required to coordinate with California Behavioral Health Planning Council (CBHPC) for the planning and oversight of the

2020-2025 Workforce Education and Training (WET) Five-Year Plan. The 2020-2025 WET Plan includes funding for five Regional Partnerships (RP) to administer programs that oversee training and support to the PMHS workforce in their region.

The Regional Partnerships, created by the MHSA, administer the series of programs supporting individuals to promote the leveraging of resources to best serve local jurisdictions. HCAI contracts with each of the Regional Partnerships for activities supporting individuals. HCAI assists with the administrative execution of educational scholarships, clinical graduate student stipends, and educational loan repayments.

The strategy is two-fold. First, identify individuals in the early stages of considering and deciding on their career trajectory. Once an individual decides on a Public Mental Health System (PMHS) career in the mental health field, the WET Plan envisions that the full range of programs would support them over the course of their education in exchange for working in the PMHS. Selecting candidates from underserved communities and local jurisdictions also support "grow-your-own" workforce development strategies.

In the span of three years, the Napa County MHSA will transfer $45,486 in CSS Component funding to the WET Component to provide funding for the WET Regional Partnership. In return, Napa County MHSA will receive a total of $137,834, with a 3-1 match from the State. If eligible, anyone employed by the Napa County Mental Health Plan can apply to the program.

The Greater Bay Area Region ("GBA") - consists of Alameda, Contra Costa, Marin, Monterey, Napa, San Francisco, San Mateo, San Benito, Santa Clara, Solano, Santa Cruz Counties, and the City of Berkeley. The following categories are included in Napa County's Scope of Work.

1. Loan Repayment Program
   Eligible individuals include mental health professionals who provide services in the Napa County publicly-funded Mental Health Plan ("MHP") that the Napa County Mental Health Division identifies as high priority, considering applicants who previously received scholarships. Considerations may be made in the following factors when determining award amounts: applicants who previously received scholarships, educational attainment, the level of unmet need in the community served, and years of service in the Napa County MHP. GBA shall determine the amount they award and length of volunteer or paid work commitment.

2. Undergraduate College and University Scholarships – Applicant eligibility criteria and terms of the agreement are in development. Napa County will implement a scholarship program to provide scholarships to undergraduate and graduate students interested in pursuing an education in the mental health field. The scholarship level would depend on the student's academic aspirations including certificate, associate degree, bachelor's degree, or master's degree.

3. Pipeline Development for middle school, high school, and community college students –
   Napa County will introduce the Public Mental Health System (PMHS) to middle school, high school, and community college students to encourage them to consider a career in the mental health field.

Possible strategies include support for peer counseling programs in middle and high schools, student conferences, and presentations to middle school, high school and community college students in peer counseling, psychology, Human Services, and other mental health related courses.

4. Retention Activities
   The aim of retention activities is for counties to promote developing and implementing systemic changes and opportunities that increase the likelihood of staff retention in the PMHS workforce. Napa County will utilize funds to provide clinical, cultural competency, and other trainings for County and community providers who comprise the Napa County MHP.

Component: Capital Facilities/Technological Needs (CF/TN)

The NCMHP will be exploring the feasibility of transferring CSS funds to the Capital Facilities Component using the 20% Rule (i.e., 20% of the average of the last 5 years of CSS allocations). Funds will potentially be used to expand the Crisis Stabilization Unit facility to build out additional space for youth crisis stabilization services and treatment.

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Napa

✓ FY 22-23 Annual Update to the MHSA Three-Year Plan for FY 20-21 to FY 22-23

☐ MHSA Three-Year Plan for FY 20-21 to FY 22-23

Local Mental Health Director	**County Auditor-Controller/City Financial Officer**
Name: Cassandra Eslami, LMFT Telephone: (707) 299-2102 Number E-mail: Cassandra.Eslami@countyofnapa.org	Name: Tracy A. Schulze Telephone: (707) 253-4551 Number E-mail: Tracy.Schulze@countyofnapa.org
Local Mental Health Mailing Address: Napa County Mental Health Division 2751 Napa Valley Corporate Drive, Bldg. A Napa, CA 94559	

I hereby certify that this Mental Health Service Act FY 22-23 Annual Update to the MHSA Three-Year Program and Expenditure Plan for FY 20-21 to FY 22-23 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 Annual 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 other 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.

Cassandra Eslami — final will be signed

Local Mental Health Director (PRINT) — Signature — Date

I hereby certify that for the fiscal year ended **June 30, 2021** , the County has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's financial statements are audited annually by an independent auditor and the most recent audit report is dated **December 29, 2021** for the fiscal year **ended June 30, 2021**. I further certify that for the fiscal year ended **June 30, 2021**, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County 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.

Tracy A. Schulze — final will be signed

County Auditor Controller (PRINT) — Signature — Date

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

FY 21-22 MHSA Funding Summary

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

County: Napa Date: 3/16/22

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2021/22 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	8,716,551	1,567,932	1,290,976	4,191	0	
2. Estimated Prior Year Reversion				0		
3. Estimated New FY 2021/22 Funding*	7,231,120	1,865,353	492,625	39	0	
4. Transfer in FY 2020/21[a/]	0			0	0	0
5. Access Local Prudent Reserve in FY 2021/22	0	0				0
6. Re-distributed Reversion Funds						
7. Estimated Available Funding for FY 2021/22	15,947,671	3,433,285	1,783,601	4,230	0	
B. Estimated FY 2021/22 MHSA Expenditures	4,308,895	1,033,600	77,000	4,230	0	
G. Estimated FY 2021/22 Unspent Fund Balance	11,638,776	2,399,685	1,706,601	0	0	

**Includes the planned No Place Like Home Initiative reduction estimate of $313,672 for CSS and $137,847 for PEI*

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2021	764,402
2. Contributions to the Local Prudent Reserve in FY 2021/22	0
3. Distributions from the Local Prudent Reserve in FY 2021/22	0
4. Estimated Local Prudent Reserve Balance on June 30, 2022	764,402

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 21-22 PEI Funding

Mental Health Services Act (MHSA) Three Year Plan
Prevention and Early Intervention (PEI) Funding

County: Napa

Initial Date: 1/20/2020
Revision Date: 3/16/22

	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. LGBTQ PEI Project	43,500	43,500				
2. Native American PEI Project	94,878	94,878				
3. Upvalley Mentoring Program PEI Project	76,150	76,150				
4. American Canyon SAP PEI Project	159,807	159,807				
5. Domestic Violence PEI Project	109,400	109,400				
6. Home Visitation PEI Project	50,000	50,000				
7. Strengthening Families PEI Project	98,000	98,000				
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Court and Community Schools SAP PEI Project	81,600	81,600				
12. Mentis Healthy Minds Healthy Aging	91,350	91,350				
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	180,915	180,915				
PEI Assigned Funds - CalMHSA	48,000	48,000				
Total PEI Program Estimated Expenditures	1,033,600	1,033,600	0	0	0	0

FY 21-22 CSS Funding

Mental Health Services Act (MHSA) Three Year Plan
Community Services and Supports (CSS) Funding

County: Napa

Initial Date: 1/20/2020
Revision Date: 3/16/22

	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. Children's FSP	721,234	249,271	461,403			10,560
2. TAY FSP	424,278	177,393	246,885			
3. Adult FSP	1,116,810	630,768	426,482			59,560
4. Adult Treatment Team FSP	757,158	437,285	314,173			5,700
5. Older Adult FSP	575,287	341,037	229,250			5,000
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
Non-FSP Programs						
1. Mobile Crisis Response Team	260,000	84,997	50,003			125,000
2. Project Access	453,618	444,458				9,160
3. Admin	415,625	379,285	0			36,340
4.						
5.						
6.						
7.						
8.						
9.						
10.						
CSS Administration	1,564,401	1,564,401				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	6,288,411	4,308,895	1,728,196	0	0	251,320
FSP Programs as Percent of Total	83.4%					

FY 21-22 INN Funding

Mental Health Services Act (MHSA) Three Year Plan
Innovations (INN) Funding

County: Napa

Initial Date: 6/30/2017
Revision Date: 3/16/22

	Fiscal Year 2021-2022					
	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. Allen & Shea Consulting Services	42,806	42,806				
2. Aldea	20,000	20,000				
3. UC Davis	7,194	7,194				
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
INN Administration	7,000	7,000				
Total INN Program Estimated Expenditures	77,000	77,000	0	0	0	0

FY 21-22 WET Funding

Mental Health Services Act (MHSA) Three Year Plan
Workforce, Education and Training (WET) Funding

County: Napa

Initial Date: 1/20/2020
Revision Date: 3/16/22

	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. Residency/ Internship	3,615	3,615				
2. Staff Development	0	0				
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
WET Administration	615	615				
Total WET Program Estimated Expenditures	4,230	4,230	0	0	0	0

FY 21-22 CFTN Funding

Mental Health Services Act (MHSA) Three Year Plan
Capital Facilities/Technological Needs (CFTN) Funding

County: Napa

Initial Date: 1/20/2020
Revision Date: 3/16/22

	Fiscal Year 2022-23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Electronic Health Record	0	0				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11.						
12.	0					
13.	0					
14.	0					
15.	0					
CFTN Administration	0	0				
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0

FY 22-23 MHSA Funding Summary

FY 2022/23 Mental Health Services Act Annual Update
Funding Summary

County: Napa Date: 7/5/22

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2022/23 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	11,638,776	2,399,685	1,706,601	0	0	
2. Estimated Prior Year Reversion				0		
3. Estimated New FY 2022/23 Funding*	7,127,064	1,835,353	487,625	45,486	0	
4. Transfer in FY 2021/22[a/]	0			0	0	0
5. Access Local Prudent Reserve in FY 2022/23	0	0				0
6. Re-distributed Reversion Funds						
7. Estimated Available Funding for FY 2022/23	18,765,840	4,235,038	2,194,226	45,486	0	
B. Estimated FY 2022/23 MHSA Expenditures	5,251,564	1,024,486	599,401	45,486	0	
G. Estimated FY 2022/23 Unspent Fund Balance	13,514,276	3,210,552	1,594,825	0	0	

**Includes the planned No Place Like Home Initiative reduction estimate of $313,672 for CSS and $137,847 for PEI*

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2022	764,402
2. Contributions to the Local Prudent Reserve in FY 2022/23	605,268
3. Distributions from the Local Prudent Reserve in FY 2022/23	0
4. Estimated Local Prudent Reserve Balance on June 30, 2023	1,369,670

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 22-23 PEI Funding

Mental Health Services Act (MHSA) Three Year Plan
Prevention and Early Intervention (PEI) Funding

Initial Date: 1/20/2020
County: Napa Revision Date: 7/5/22

	Fiscal Year 2022-23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. LGBTQ Connection PEI Program	50,000	50,000				
2. CLARO/CLARA Youth Mentoring Program	80,000	80,000				
3. American Canyon MH Access Program	160,000	160,000				
4. Strengthening Families PEI Program	90,000	90,000				
5. Safety Net for Youth Mental Wellness Program	80,000	80,000				
6. Suicide Prevention Program	40,000	40,000				
7.						
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Court and Community Schools SAP PEI Program	80,000	80,000				
12. Mentis Healthy Minds, Healthy Aging Program	90,000	90,000				
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	306,486	306,486				
PEI Assigned Funds - CalMHSA	48,000	48,000				
Total PEI Program Estimated Expenditures	1,024,486	1,024,486	0	0	0	0

FY 22-23 CSS Funding

Mental Health Services Act (MHSA) Three Year Plan
Community Services and Supports (CSS) Funding

Initial Date: 1/20/2020
County: Napa Revision Date: 7/5/22

	Fiscal Year 2022-23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Children's FSP	858,931	386,968	461,403			10,560
2. TAY FSP	614,139	367,254	246,885			
3. Adult FSP	1,310,675	831,030	420,085			59,560
4. Adult Treatment Team FSP	384,794	58,524	320,570			5,700
5. Older Adult FSP	662,309	428,059	229,250			5,000
6.	0					
7.	0					
8.	0					
9.	0					
Non-FSP Programs						
1. Mobile Crisis Response Team	646,100	471,097	50,003			125,000
2. Project Access	634,267	625,107				9,160
3. Admin	645,898	609,558				36,340
4. Realocation to WET for Regional Partnership	45,486	45,486				
5.						
6.						
7.						
8.						
CSS Administration	1,428,481	1,428,481				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	7,231,080	5,251,564	1,728,196	0	0	251,320
FSP Programs as Percent of Total	72.9%					

FY 22-23 INN Funding

Mental Health Services Act (MHSA) Three Year Plan
Innovations (INN) Funding

Initial Date: 1/20/2020
County: Napa Revision Date: 7/5/22

	Fiscal Year 2022-2023					
	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. Allen & Shea Consulting Services	44,095	44,095				
2. LHCN - Aldea	48,857	48,857				
3. LHCN - UC Davis	28,924	28,924				
4. MHSOAC FSP Collaborative Project	332,450	332,450				
5. FLAGG - Innovation Round 2 Extension	138,425	138,425				
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
INN Administration	6,650	6,650				
Total INN Program Estimated Expenditures	599,401	599,401	0	0	0	0

FY 22-23 WET Funding

Mental Health Services Act (MHSA) Three Year Plan
Workforce, Education and Training (WET) Funding

Initial Date: 1/20/2020
County: Napa Revision Date: 7/5/22

	Fiscal Year 2022-23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Regional Partnership	45,486	45,486	0			0
2.	0	0				
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
WET Administration	0	0				
Total WET Program Estimated Expenditures	45,486	45,486	0	0	0	0

FY 22-23 CFTN Funding

Mental Health Services Act (MHSA) Three Year Plan
Capital Facilities/Technological Needs (CFTN) Funding

Initial Date: 1/20/2020
County: Napa Revision Date: 7/5/22

	Fiscal Year 2022-23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0	0				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
CFTN Programs - Technological Needs Projects						
8.						
9.	0					
10.	0					
CFTN Administration	0	0				
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0

Mental Health Board
Zoom Meeting Minutes

August 8, 2022, 4:00 to 6:00 pm

Chair:	Rob Palmer **Vice Chair:** Kristine Haataja
Minutes:	LuAnn Pufford, Sr. Office Assistant

---- Agenda Topics ----

1. Call to Order

The Zoom meeting was called to order at approximately 4:00 p.m. by Vice-Chair Kristine Haataja.

2. Roll Call/Introductions

The Napa County Mental Health Board (MHB) met in regular session on Monday, August 8, 2022, with the following members present: Vice-Chair Kristine Haataja and members Keri Akemi-Hernandez, Kathleen Chance, Neil D'Silva, Zachariah Geyer, Kristyn Miles, Beth Nelsen, Ed Ortiz, Patricia Sullivan, Orion Taraban and Heidi Van De Ryt. Chair Rob Palmer and members Tiffany Iverson and Rowena Korobkin arrived late. Member Supervisor Ryan Gregory was excused.

Napa County Mental Health Division Staff present: Cassandra Eslami, Behavioral Health Director, LuAnn Pufford, Sr. Office Assistant, Felix Bedolla, MHSA Project Manager, and Liset Esqueda, MHSA Staff Services Analyst II.

The Guest presenter was Felix Bedolla, MHSA Project Manager.

3. Public Comment

None

4 . Board Member Comment or Announcements

Beth Nelsen announced that she may be resigning from the Mental Health Board (MHB) soon, due to other commitments.

Vice-Chair Kristine Haataja reminded the MHB members that it is time to begin working on the MHB Annual Report to the Board of Supervisors. She asked for volunteers to assist with this annual project.

5. Approval of Minutes and Consent Items

One correction to the July 11th meeting Minutes was requested. With this correction noted, a motion to approve the July 11, 2022 Minutes was made by member Keri Akemi-Hernandez and was seconded by member Zachariah Geyer. The motion passed with 10 Ayes and 1 abstention from member Orion Taraban; no *members were opposed.

**See list of members under item 2 Roll Call/Introductions.*

6. Old Business

None

7. New Business

A. The Public Hearing for Mental Health Services Act (MHSA) FY 22-23 Annual Update to the MHSA Three Year Plan opened at approximately 4:12 pm. Felix Bedolla, MHSA Project Manager, began with an overview of the Highlights, Upcoming Changes, and Opportunities for FY 22-23 within the Prevention and Early Intervention (PEI) Component, Community Services and Supports (CSS) Component and Innovation Component. Next the purpose of the FY 22-23 Annual Update was reviewed, followed by MHSA Revenue Projections, funding awarded for new programs, and new opportunities for PEI and CSS funding. The final item reviewed was the FY 21-22 MHSA Funding Summary.

Vice-Chair Kristine Haataja made a request to have MHB member input at the stakeholder meetings for the next MHSA Three Year Plan. The Public Hearing was closed at approximately 4:49 pm.

B. The floor was opened to nominations for the Executive Committee Members-At-Large, with Vice-Chair Kristine Haataja nominating members Orion Taraban, Patricia Sullivan and Heidi Van De Ryt. No other nominations were proposed. A motion to accept the slate of Executive Committee Members-At-Large was made by Chair Rob Palmer and was seconded by member Kristyn Miles. The motion passed with all Ayes; no *members were opposed.

**See list of members under item 2 Roll Call/Introductions.*

C. Behavioral Health Director's Report included the following updates:

- Mental Health Division is applying for a Grant to fund two new youth "beds" at the Crisis Stabilization Unit (CSU)
- Community planning process for the next MHSA Three Year Plan will have a lot of advertising and broadcasting by various media platforms. More information on this to come
- Two new Request For Proposal (RFP) being released soon. One for the psychiatric medication clinic and one for MHSA PEI programs
- Chair of the Suicide Prevention Council is changing from staff at Aldea Children & Family Services to Mentis. The Council is working on plans to advertise the new 9-8-8 Suicide and Crisis Lifeline as September is National Suicide Prevention month
- There continues to be a high vacancy rate of staff in the Mental Health Division. Efforts are underway for recruitment of both permanent staff and interns
- Mental Health is monitoring and waiting on current legislation for the proposed Care Court

D. Committee and Work Group reports:

Quality Improvement Committee (QIC): Kristine Haataja – Results of the Triennial Audit were reviewed. There were 219 requirements for the Audit. The compliance rate was 94%.

Work Group: Promoting Integrated Care, An Opportunity Assessment – Ed Ortiz mentioned that he hoped to close out this Work Group after a meeting with the Behavioral Health Director scheduled for tomorrow.

Suicide Prevention Council: Kristyn Miles – There is no update this month, as the July meeting was cancelled.

Veterans Commission: Kathleen Chance – The Veterans Commission meeting for July was cancelled; there is no update as this time.

Work Group: Mental Health Services for Victims of Domestic Violence – Keri Akemi-Hernandez and Kristine Haataja. Kristine is scheduling meetings to work on this topic.

E. CALBHB/C is providing support for two new items of legislation; expanding access to medication for mental health consumers and workforce development of mental health professionals to serve children and youth, due to a shortage of clinicians in California.

8. Announcements & Informational Items

A. Speaker Schedule Plan for FY2020-2021
   1. PATH Grant & SAMHSA Grant – September
   2. DHCS Triennial Audit Presentation – October
   3. Yountville Veterans Home & San Francisco Veterans Administration Mental Health Services/Programs - TBD
   4. Mental Health Division Strategic Plan – TBD
   5. Update on CalAIM Initiatives – TBD

B. Napa County **Mental Health Board web page** includes Executive Committee and Board meeting agendas, minutes & supporting documents: http://www.countyofnapa.org/HHSA/MentalHealthBoard/

C. Next **MH Board Meeting,** September 12, 2022, 4:00 to 6:00 pm

D. Next **Executive Committee Meeting**, August 24, 2022, 3:30 to 4:30

9. Adjournment

A motion to adjourn the meeting was made by member Keri Akemi-Hernandez and was seconded by member Rowena Korobkin. The meeting adjourned at approximately 5:17 pm.

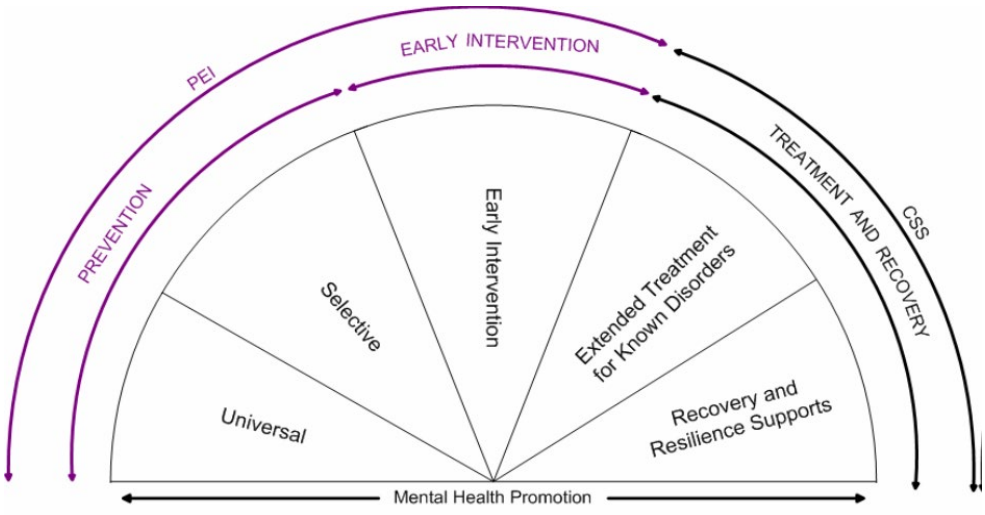
Napa County Mental Health Division Mental Health Services Act Prevention and Early Intervention

THREE YEAR EVALUATION REPORT FY 18-19 TO FY 20-21

Introduction

Prevention and Early Intervention (PEI) is one of five components that make up the Mental Health Services Act (MHSA). The Act, also known as Proposition 63, was passed by voters in 2004, and is intended to support mental health services in California. The funding is distributed by each county based on the local needs identified in community planning processes.[1] The scope of prevention and early intervention services intended to be funded using PEI is described in the figure below. *Note that CSS refers to Community Services and Supports and includes treatment for individuals who have been diagnosed with a Serious Mental Illness. CSS funds are separate from PEI funds.*

Mental Health Intervention Spectrum Diagram[2]



The community planning for the current Prevention and Early Intervention (PEI) programs took place in 2007 and was updated in 2020. The regulations that describe the parameters of the funding and the reporting are updated periodically by the Mental Health Services Oversight and Accountability Commission (MHSOAC). In July 2018, the MHSOAC updated the PEI regulations to define services and describe the intended outcomes for PEI programs.

This program summary report reflects significant shifts in how the Napa County PEI programs reported demographics, program activities and outcomes. FY 19-20 was the first year that all nine programs were able to report in alignment with the updated regulations.[3] The Prevention and Early Intervention

[1] In addition to Prevention and Early Intervention, the five components also include Community Services and Supports, Innovation, Capital Facilities and Technology and Workforce Education and Training. More information about the five components of MHSA can be found here: https://mhsoac.ca.gov/sites/default/files/documents/2016-02/FactSheet_FiveComponents_121912.pdf

[2] Source: Adapted from Mrazek and Haggerty (1994) and Commonwealth of Australia (2000), From the MHSA Proposed Guidelines Prevention and Early Intervention Component of the Three-Year Expenditure Plan, September 2007., page 6.

[3] The updated Prevention and Early Intervention Regulations as of July 1, 2018 can be found here: https://mhsoac.ca.gov/sites/default/files/documents/2018-08/PEI%20Regulations_As_Of_July%202018.pdf

programs provide services and supports within three categories: Stigma and Discrimination Reduction, Prevention, and Early Intervention.

Report Organization

Section One: Summary of Activities and Outcomes across Programs

The report begins with a summary of the activities and outcomes across all of the programs. Because programs use varied approaches to prevention and early intervention, this section is to aid in understanding the overall scale and impact of the funding. The sections include: Partnerships, Outreach, Demographics, Screenings, Outcomes, Referrals as well as a summary of the Program Changes Due to COVID-19.

Section Two: Summary of FY 19-20 and FY 20-21 Activities and Outcomes by Program

Next, each of the program's activities and outcomes are summarized by funding area: Stigma and Discrimination Reduction, Prevention, or Early Intervention. Each program summary includes information about the community needs addressed by the program, the program's activities and outcomes, and the changes the program made due to COVID-19.

Section Three: Summary of FY 18-19 Activities and Outcomes by Program

The FY 18-19 data was collected and reported prior to the updated logic models and evaluation plans being developed. This section includes a summary of the activity and outcome data available from this fiscal year.

Napa County Mental Health Services Act Prevention and Early Intervention Programs by Funding Area

PEI Funding Area	Agency and Program Name
Stigma and Discrimination Reduction	On The Move: LGBTQ Connection
Prevention	Suscol Council: Native American PEI Project
	UpValley Family Centers: UpValley Mentoring Program PEI Project (CLARO/CLARA)
	Napa Valley Education Foundation: American Canyon Student Assistance Program
	Cope Family Center: Home Visitation
	Cope Family Center: Strengthening Families
	NEWS: Kids Exposed to Domestic Violence (KEDS)
Early Intervention	Napa County Office of Education (NCOE): Court and Community Schools Student Assistance Program
	Mentis: Healthy Minds, Healthy Aging (HMHA)

Appendices

At the request of Mental Health Division staff, the report concludes with Appendices summarizing the partnership and outreach activities by month.

Section One: Summary of Activities and Outcomes across Programs

Overview

To understand how the nine programs collectively address how mental health prevention and early intervention is discussed and how services are provided in Napa County, this section aggregates the activities and outcomes for FY 18-19, FY 19-20, and FY 20-21.

Each of the nine programs used different approaches to access community members. Some of the programs focused on partnerships and outreach, others focused on providing direct services. The following table is provided to illustrate the various ways programs put the services together and to clarify which programs are included in the aggregated summaries.

MHSA: Prevention and Early Intervention
Overview of Activities and Mental Health Outcomes Across Programs

Agency: Program	Partnerships	Outreach	Demographics	Screenings	Mental Health Outcomes	Referrals	COVID-19 Changes
Stigma and Discrimination Reduction							
On The Move: LGBTQ Connection	X	X	X				X
Prevention							
Suscol Intertribal Council: Native American PEI Project	X	X	X			X	X
UpValley Family Centers: UpValley Mentoring Program PEI Project (CLARO/CLARA)	X	X	X	X		X	X
Napa Valley Education Foundation: American Canyon Student Assistance Program	X		X	X	X	X	X
Cope Family Center: Home Visitation	X		X	X	X	X	X
Cope Family Center: Strengthening Families	X	X	X	X	X	X	X
NEWS: Kids Exposed to Domestic Violence (KEDS)	X	X	X			X	X
Early Intervention							
Napa County Office of Education (NCOE): Court and Community Schools Student Assistance Program			X	X	X	X	X
Mentis: Healthy Minds, Healthy Aging (HMHA)		X	X	X	X	X	X

Partnerships

The Prevention and Early Intervention programs are intended to extend the reach of Napa County Mental Health Division into the community. In FY 19-20 and FY 20-21, seven of the nine funded programs used MHSA funds to develop and maintain partnerships with agencies in Napa County.[4] In some cases these were partnerships that were initiated by the program to strengthen the mental health supports they provide for individuals, in other cases, program staff went to agencies to bring a mental health perspective to discussions about how to care for people in Napa County.

The seven agencies worked with 90 individuals and/or organizations in 498 meetings during FY 19-20 and FY 20-21. The partners included schools, faith communities, established public agencies, and community coalitions.

The individuals and organizations that partnered with PEI funded programs are listed on the next page alphabetically.

[4] Though the funded programs worked to establish partnerships during FY 18-19, it was not tracked in the evaluation until FY 19-20.

- 2020 Census Napa County
- Abode
- Aldea
- Amber Manfree, Napa Board of Supervisors Candidate
- American Canyon High School Staff
- American Canyon Middle School Staff
- Arts Council Napa Valley
- Art Association Napa Valley
- Boys and Girls Clubs of Napa Valley
- Burnett Therapeutic Services, Inc.
- Calistoga Joint Unified School District
- Cakebread Cellars
- CareerPoint North Bay
- Child Start
- City of Napa
- City of Napa Housing Authority
- City of St. Helena
- Collabria
- Cope
- Courage Center
- Community Resources for Children
- Crosswalk Church
- Donaldson Way Elementary
- Equality California Institute (EQCAI)
- Fair Housing Napa Valley
- Fellowship of Episcopalian Churches of the Napa Valley: Napa, St. Helena, Calistoga
- First 5 Napa County
- GEO Reentry Services
- Harvest Middle School
- Harvest Pediatrics
- Immigration Institute of the Bay Area (IIBA)
- Innovations Community Center
- JGS Distributing
- Jeffrey Durham, Yountville Councilmember
- Jill Hernandez, RN
- Kaiser Permanente, Napa
- LGBT Veterans of the North Bay
- Live Healthy Napa County
- MCE Community Choice Energy
- Mentis
- Migrant Education Program
- Multidisciplinary Team (14 agencies)
- Napa County Board of Supervisors
- Napa County Child Welfare Services
- Napa County District Attorney's Office
- Napa County Health & Human Services Agency (HHSA)
- Napa County Library
- Napa County Office of Education (NCOE)
- Napa County Office of Education (NCOE) Camille Creek
- Napa County Probation
- Napa County Public Health
- Napa County Suicide Prevention Council
- Napa Creek Manor
- Napa Junction Elementary School Staff
- Napa Police Department
- Napa Solano Medical Society
- Napa State Hospital
- Napa Valley College Cadet Program
- Napa Valley Community Organizations Active in Disaster (COAD)
- Napa Valley Language Academy
- Napa Valley Unified School District (NVUSD)
- NEWS
- North Bay Regional Center
- OLE Health
- Open Space
- ParentsCAN
- People’s Collective for Change
- Providence St Joseph Health System
- Puertas Abiertas
- Queen of the Valley Care Network
- Queen of the Valley Community Benefit Committee
- Queen of the Valley Hospital
- Queen Of the Valley-Community Outreach
- Rainbow Action Network (RAN)
- Reverend Linda Sue Powers
- Resource Conservation District
- Rohlff’s Manor
- Rotary Club of North Napa
- St Helena Women Stand Up
- St Helena Unified School District
- Summer Search
- Sunrise Montessori of Napa Valley
- Teens Connect
- Touro University
- Travis Credit Union
- Unitarian Universalists, Napa
- UpValley Family Centers, St. Helena and Calistoga
- Vintage High School
- Women's Intercultural Network
- Yountville Veteran's Home

Outreach

Prevention and Early Intervention funds are used to bring information about the signs and symptoms of mental health concerns, as well as resources for mental health supports to Napa County communities. Six of the nine programs provided outreach in the community using MHSA funds. These efforts resulted in 183 events reaching 20,859 participants.

Additionally, two programs provided outreach through social media. In FY 20-21, they reported reaching 21,531 users/month.

Location

Over two-thirds of the outreach events took place in the City of Napa (70%), 17% took place in UpValley communities and 6% took place online. One event was held in American Canyon.

During the pandemic, the location reporting varied by agency. Some programs indicated the event was in a city if all of those attending were in that city, and others reported all virtual events as online events. When a city was noted, it was included in the city location, rather than in the online category.

Napa County Mental Health Services Act Prevention and Early Intervention Programs:
Outreach Event Location, FY 18-19, FY 19-20, and FY 20-21

	FY 18-19		FY 19-20		FY 20-21		Total	
Event Location	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
American Canyon	14	5%	1	1%	0	0%	15	3%
Calistoga	9	3%	7	5%	1	2%	17	4%
Napa	220	75%	83	65%	28	51%	331	70%
St. Helena	30	10%	20	16%	7	13%	57	12%
Yountville	1	0%	5	4%	0	0%	6	1%
Unincorporated Area of Napa County	8	3%	1	1%	1	2%	10	2%
Online/Telephone	0	0%	11	9%	18	33%	29	6%
Unknown	10	3%	0	0%	0	0%	10	2%
Total Outreach Events	**292**		**128**		**55**		**475**	

Setting

The six agencies who used PEI funds to provide outreach moved a lot of the events online over the past two years, particularly in FY 20-21. Other frequently reported settings were cultural organizations, schools and universities, recreational settings, and senior centers. These settings accounted for 54% of the events.

Napa County Mental Health Services Act Prevention and Early Intervention Programs:
Outreach Events by Setting, FY 18-19, 19-20 and FY 20-21

	FY 18-19		FY 19-20		FY 20-21		Totals	
Event Setting	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Cultural organizations	64	22%	30	23%	13	24%	107	23%
Schools/Universities	40	14%	17	13%	6	11%	63	13%
Recreational settings	2	1%	18	14%	0	0%	20	4%
Senior centers	0	0%	15	12%	0	0%	15	3%
Family resource centers	0	0%	4	3%	4	7%	8	2%
Residences	0	0%	7	5%	0	0%	7	1%
Support groups	0	0%	5	4%	1	2%	6	1%
Churches or faith-based organizations	0	0%	3	2%	2	4%	5	1%
Primary health care or health clinics	1	0%	3	2%	0	0%	4	1%
Libraries	0	0%	2	2%	0	0%	2	0%
Other (online, other social service agency, community settings)	33	11%	24	19%	29	53%	86	18%
Setting not reported[5]	152	52%	0	0%	0	0%	152	32%
Total Events	**292**		**128**		**55**		**475**	

[5] In FY 18-19, the outreach setting was not collected or reported consistently. In FY 19-20 it was added as a part of all program evaluations.

Participants

The general public was the most commonly reported participant type. The COVID 19 Shelter in Place order impacted the size and the reach of the events in FY 19-20 and FY 20-21.

Napa County Mental Health Services Act Prevention and Early Intervention Programs:
Outreach Event Attendance by Participant Description: FY 18-19, FY 19-20, and FY 20-21

	FY 18-19		FY 19-20		FY 20-21		Totals	
Participant Description	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
General Public	10,173	18%	6,227	72%	11,733	96%	28,133	36%
Other Social Service Providers	206	0%	474	5%	161	1%	841	1%
Students	205	0%	568	7%	44	0%	817	1%
Seniors	0	0%	186	2%	166	1%	352	0%
Faith leaders	0	0%	251	3%	41	0%	292	0%
Other	0	0%	238	3%	5	0%	243	0%
K-12 educators	7	0%	210	2%	22	0%	239	0%
Consumers and/or family members	58	0%	153	2%	0	0%	211	0%
Parents	170	0%	82	1%	43	0%	295	0%
Medical Providers	0	0%	75	1%	6	0%	81	0%
Behavioral Health Providers	45	0%	45	1%	14	0%	104	0%
College and university educators	0	0%	51	1%	2	0%	53	0%
Active Military or Veteran	0	0%	38	0%	0	0%	38	0%
Politicians	0	0%	3	0%	21	0%	24	0%
Participant type not reported[6]	47,086	81%	0	0%	0	0%	47,086	60%
Total Outreach Participants Reached	**57,950**		**8,601**		**12,258**		**78,809**	

[6] In FY 18-19, the participant type was not collected or reported consistently. In FY 19-20 it was added as a part of all program evaluations.

Demographics

The Napa County Mental Health Division funds Prevention and Early Intervention programs to reach communities, populations and individuals who are not as likely to seek out or use existing mental health supports. To understand how the programs are able to access these groups, demographics were collected for all individuals who participated in a service. Services included workshops, classes, support groups, individual visits with support providers as well as therapeutic services.

MHSOAC requests demographics in several areas that are more specific than the demographics generally collected by the programs. In particular, the data to describe Race and Ethnicity, Gender Identity, Sexual Orientation and Disability are often outside of the typical data collection that programs have in place for the individuals they serve. Programs were encouraged to collect what they were able to and to reach out to MHSA staff for additional resources as indicated.

Overall

The overall demographics of the individuals served have been aggregated for this report to protect the identities of individuals in smaller PEI programs. Programs collected demographic forms for the majority of the individuals served. Some programs were able to report some demographics based on their knowledge of the individuals without a full demographic form, particularly for the age, language, and primary residence categories. There were several areas where the demographic data collection was tricky.

- Race: In several programs, staff reported that individuals who identify as Hispanic or Latino did not want to indicate they were “White” when asked about race. In one program, individuals chose “American Indian” as they felt that most reflected their indigenous Mexican and Central American heritage. In other programs, the individuals chose “Other,” “Decline,” or did not respond to this question.
- Ethnicity: The ethnicity categories ask for individuals to choose a more detailed category within the broader Hispanic or Latino or Non-Hispanic groupings. Many programs collected information about whether participants identify as Hispanic/Latino but did not collect more specific information.
- Gender Identity and Sexual Orientation: Many of the programs reported difficulty collecting information about gender identity and sexual orientation. In some cases the programs noted that they don’t see individuals long enough to build the rapport and trust they felt was needed to request this information. In other cases, programs indicated they were unsure of how to bring these areas into the conversations with individuals. A few programs described the need for staff training for these two areas. Programs who used a clinician to do the intake with individuals were more likely to collect this information consistently. Some programs reported that staff may be completing this section without directly asking individuals. In FY 20-21, gender identity information was collected for 65% of participants and sexual orientation information was collected for 64% of participants.
- Disability: The questions about disabilities were generally reported by school-based programs that screen for disabilities to assist students in learning. Other programs did not collect this information as consistently. At several agencies, there was confusion about the definition of disability, particularly when clients completed the demographic form themselves. In FY 20-21, disability information was collected for 64% of participants.

Referrals

Demographics are also collected for individuals who were referred to mental health services. [7]

Summary Table

The demographics are summarized in the following table to illustrate the reach of the PEI programs into the Napa County communities and describe who received referrals for mental health services and supports.

Napa County Mental Health Services Act Prevention and Early Intervention Programs:
Summary of Participant Demographics for Services and Referrals (FY 19-20 and FY 20-21)

	PROGRAM SERVICES						REFERRALS	
	FY 18-19		FY 19-20		FY 20-21		FY	FY
	n	%	n	%	n	%	19-20	20-21
Total Number of participants (unduplicated)	**1,361**	**--**	**1,110**	--	**1,546**		**298**	**287**
Demographic forms collected	--	--	942	85%	1,047	68%	74%	61%
Race	**n**	**%**	**n**	**%**	**n**	**%**	**%**	**%**
American Indian or Alaska Native	136	10%	140	13%	118	8%	9%	3%
Asian	20	1%	82	7%	110	7%	5%	2%
Black of African American	61	4%	56	5%	71	5%	1%	1%
Native Hawaiian or Pacific Islander	68	5%	5	0%	9	1%	0%	1%
White	539	40%	529	48%	581	38%	31%	30%
Other	113	8%	133	12%	228	15%	16%	4%
More than one race	129	9%	54	5%	88	6%	6%	2%
Decline to answer	43	3%	37	3%	157	10%	17%	7%
Ethnicity	**n**	**%**	**n**	**%**	**n**	**%**	**%**	**%**
Hispanic or Latino as follows:	654	48%	303	27%	276	18%	--	16%
Caribbean	0	0%	0	0%	0	0%	0%	0%
Central America	0	0%	13	1%	19	1%	1%	1%
Mexican/Mexican-American	1	0%	395	36%	325	21%	25%	20%
Puerto Rican	0	0%	2	0%	1	0%	0%	0%
South American	0	0%	3	0%	3	0%	0%	0%
Other	0	0%	84	8%	2	0%	3%	0%
Non-Hispanic as follows:	295	22%	--	--	--	--	--	5%
African	6	0%	30	3%	53	3%	0%	0%
Asian Indian/South Asian	0	0%	6	1%	7	0%	0%	0%
Cambodian	0	0%	1	0%	0	0%	0%	0%
Chinese	0	0%	5	0%	12	1%	0%	0%
Eastern European	0	0%	6	1%	12	1%	0%	0%
European	198	15%	113	10%	178	12%	4%	2%
Filipino	0	0%	36	3%	103	7%	3%	0%

[7] In FY 18-19 Referral Demographics were not collected or reported.

	PROGRAM SERVICES						REFERRALS	
	FY 18-19		FY 19-20		FY 20-21		FY	FY
Ethnicity (cont'd)	**n**	**%**	**n**	**%**	**n**	**%**	**19-20**	**20-21**
Japanese	0	0%	1	0%	5	0%	0%	0%
Korean	0	0%	0	0%	1	0%	0%	0%
Middle Eastern	0	0%	4	0%	6	0%	0%	0%
Vietnamese	0	0%	0	0%	8	1%	0%	0%
Other	1	0%	49	4%	59	4%	2%	0%
More than one ethnicity	122	9%	36	3%	48	3%	0%	1%
Decline to answer	17	1%	104	9%	136	9%	20%	3%
Age	**n**	**%**	**n**	**%**	**n**	**%**	**%**	**%**
0-15 Children/Youth	236	17%	500	45%	566	37%	49%	0%
16-25 TAY	384	28%	262	24%	413	27%	19%	0%
26-59 Adult	335	25%	166	15%	317	21%	28%	0%
60+ Older Adult	255	19%	123	11%	14	1%	1%	0%
Decline to answer	20	1%	10	1%	12	1%	3%	0%
Veteran Status (age 18 and older only)	**n**	**%**	**n**	**%**	**n**	**%**	**%**	**%**
Yes	8	1%	17	2%	39	3%	0%	0%
No	125	9%	169	15%	5	0%	21%	7%
Decline to answer	0	0%	73	7%	231	15%	0%	0%
Sex Assigned at Birth	**n**	**%**	**n**	**%**	**n**	**%**	**%**	**%**
Male	522	38%	397	36%	456	29%	12%	20%
Female	817	60%	597	54%	663	43%	39%	24%
Decline to answer	3	0%	83	7%	81	5%	0%	0%
Current Gender Identity	**n**	**%**	**n**	**%**	**n**	**%**	**%**	**%**
Male	312	23%	304	27%	230	15%	14%	11%
Female	497	37%	506	46%	436	28%	46%	22%
Transgender	3	0%	0	0%	0	0%	0%	0%
Genderqueer	5	0%	1	0%	1	0%	0%	0%
Questioning or unsure of gender identity	1	0%	17	2%	0	0%	0%	0%
Another gender identity	1	0%	9	1%	1	0%	0%	0%
Decline to answer	15	1%	104	9%	15	1%	5%	0%
Sexual Orientation	**n**	**%**	**n**	**%**	**n**	**%**	**%**	**%**
Gay or Lesbian	14	1%	13	1%	10	1%	0%	0%
Heterosexual or Straight	561	41%	472	43%	507	33%	44%	20%
Bisexual	36	3%	106	10%	17	1%	3%	2%
Questioning or unsure of sexual orientation	36	3%	12	1%	1	0%	0%	0%
Queer	0	0%	3	0%	3	0%	0%	0%
Another sexual orientation	8	1%	7	1%	13	1%	0%	0%
Decline to answer	47	3%	194	17%	78	5%	17%	11%

Disability *Mental or physical impairment lasting more than 6 months and limiting major life activity that is not the result of a severe mental illness*	**PROGRAM SERVICES**						**REFERRALS**	
	FY 18-19		**FY 19-20**		**FY 20-21**		**FY 19-20**	**FY 20-21**
	n	**%**	**n**	**%**	**n**	**%**		
Mental (excluding: Mental Illness)	0	0%	69	6%	65	4%	0%	2%
Physical/mobility	47	3%	44	4%	22	1%	0%	2%
Chronic health condition (including chronic pain)	47	3%	80	7%	61	4%	0%	2%
Difficulty seeing	111	8%	25	2%	19	1%	0%	0%
Difficulty hearing	1	0%	16	1%	10	1%	0%	1%
Other	32	2%	18	2%	22	1%	0%	4%
No disability	2	0%	325	29%	748	48%	48%	39%
Decline to answer	190	14%	71	6%	43	3%	0%	2%
Primary Language	**n**	**%**	**n**	**%**	**n**	**%**	**%**	**%**
English	809	59%	562	51%	722	47%	66%	5%
Spanish	414	30%	353	32%	419	27%	28%	37%
Other	40	3%	42	4%	74	5%	6%	5%
Decline to answer	11	1%	11	1%	11	1%	0%	5%
Primary Residence	**n**	**%**	**n**	**%**	**n**	**%**	**%**	**%**
American Canyon	23	2%	368	33%	540	35%	21%	17%
Napa	162	12%	354	32%	348	23%	48%	29%
Yountville	1	0%	12	1%	14	1%	0%	0%
St Helena	17	1%	85	8%	54	3%	1%	1%
Angwin	0	0%	2	0%	11	1%	0%	0%
Calistoga	14	1%	113	10%	46	3%	2%	1%
Unincorporated Area of Napa County	0	0%	5	0%	2	0%	0%	0%
Other	1	0%	18	2%	28	2%	1%	1%
Decline to answer	0	0%	9	1%	9	1%	1%	0%

Screenings

Six of the nine programs screened individuals for mental health concerns in FY 19-20 and FY 20-21.[8] Some programs used a single screener, others used several. Overall, 25% of the screenings indicated some risk for a mental health concern.

Napa County Mental Health Services Act Prevention and Early Intervention Programs:
Summary of Screenings Completed Prior to Services, by Screener, FY 19-20 and FY 20-21 Combined

Screener Used	Group Screened	Number of Individuals Screened	Percentage in Risk Category		
			No Risk	Mild to Moderate Risk	High Risk
Edinburgh Post-Natal Depression Scale	Parents of Children 0-5	138	93	43	2
Ages and Stages (ASQ)	Children 0-5	328	248	51	29
Ages and Stages Social Emotional (ASQ-SE)	Children 0-5	196	163	15	18
Strengths and Difficulties Questionnaire (SDQ)	Students K-12	4,163	3,358	445	360
Depression Severity (DASS-21 Scores)	Parents of Children 0-18	85	47	23	15
Anxiety Severity (DASS-21 Scores)		85	41	17	27
Stress Severity (DASS-21 Scores)		85	41	22	22
PHQ-9	Students, Grade 9-12	250	102	72	15
	Parents of Children 0-18	52	5	28	19
	Older Adults	140	27	59	15
Overall/All Screenings		**5,314**	**78%**	**15%**	**10%**

[8] In FY 18-19 Screening data was not collected and reported consistently.

Outcomes

Five of the nine programs were able to rescreen individuals after they received mental health services and supports. Some individuals were screened with more than one screener. Overall, 730 individuals completed a pre and post screening, and 64% reported fewer symptoms and/or lower risks on at least one of the tools used. The collection of the post screening information was hindered by the COVID-19 Shelter in Place order for several programs.

Napa County Mental Health Services Act Prevention and Early Intervention Programs:
Summary of Screenings Completed After Services, by Screener, FY 19-20 and FY 20-21 Combined

Screener Used	Group Screened	Number of Individuals Screened Before and After Services	Percentage of Individuals who Reported Fewer Symptoms/ Lower Risks After Services
Edinburgh Post-Natal Depression Scale	Parents of Children 0-5	90	65%
Healthy Families Parenting Inventory (HFPI): Depression		104	62%
Healthy Families Parenting Inventory (HFPI): Social Connections		106	63%
Depression Severity (DASS-21 Scores)	Parents of Children 0-18	35	57%
Anxiety Severity (DASS-21 Scores)		38	57%
Stress Severity (DASS-21 Scores)		39	59%
Emotional Rating Scale		41	85%
PHQ-9		37	70%
	Students 9th to 12th grade	16	94%
	Older Adults	71	85%
SF-12v2TM		32	75%
SDQ	Students K-12	121	41%
Overall/All Screenings		**730**	**64%**

Referrals

Seven of the nine programs provided referrals to mental health services and supports for individuals they served. Overall, 585 referrals were given representing 22% of all participants in FY 19-20 and FY 20-21.[9]

Location

The most common referrals were to Mentis programs and to Napa County Mental Health's ACCESS program. These two agencies accounted for 75% of all referrals.

Napa County Mental Health Services Act Prevention and Early Intervention Programs:
Referrals by Location, FY 19-20 and FY 20-21

	FY 19-20		FY 20-21		Total	
Referral Location	**n**	**%**	**n**	**%**	**n**	**%**
Mentis	124	42%	71	25%	195	33%
Napa County Mental Health: ACCESS	99	33%	54	19%	153	26%
Aldea	18	6%	16	6%	34	6%
Exodus	11	4%	7	2%	18	3%
Kaiser	3	1%	7	2%	10	2%
Napa Infant Preschool Program	4	1%	6	2%	10	2%
Burnett Therapeutic Services, Inc.	6	2%	3	1%	9	2%
Stanford Youth Solutions	5	2%	3	1%	8	1%
Alternatives For A Better Living	5	2%	1	0%	6	1%
Innovations Community Center	5	2%	0	0%	5	1%
Other	3	1%	2	1%	5	1%
Therapeutic Child Care Center	4	1%	0	0%	4	1%
Private Therapist	3	1%	0	0%	3	1%
Napa County Alcohol and Drug Services & NA	1	0%	1	0%	2	0%
Napa Mom Squad	2	1%	0	0%	2	0%
North Bay Regional Center	0	0%	2	1%	2	0%
Ole Health	2	1%	0	0%	2	0%
Alcoholics Anonymous	0	0%	1	0%	1	0%
Care Solace	0	0%	1	0%	1	0%
Cope	1	0%	0	0%	1	0%
National Suicide Prevention Hotline	1	0%	0	0%	1	0%
ParentsCAN	1	0%	0	0%	1	0%
Total Referrals	**298**		**287**		**585**	

[9] In FY 18-19, referrals were not tracked consistently.

Timeliness

One fifth of the mental health referrals (20%) occurred within the first three months that an individual experienced symptoms. An additional 21% occurred within the first year. Twelve individuals (2%) reported untreated symptoms for over ten years with a range from "10+" to 36 years.

Napa County Mental Health Services Act Prevention and Early Intervention Programs:
Timeliness of Referrals for Mental Health Concerns, FY 19-20, FY 20-21

Length of Time from Mental Health Symptoms to Referral	FY 19-20		FY 20-21		Total	
Months	**n**	**%**	**n**	**%**	**n**	**%**
0 Months	60	20%	2	1%	62	11%
1 Month	8	3%	3	1%	11	2%
2 Months	17	6%	7	2%	24	4%
3 Months	10	3%	6	2%	16	3%
4 Months	8	3%	1	0%	9	2%
5 Months	4	1%	3	1%	7	1%
6 Months	26	9%	6	2%	32	5%
7 Months	7	2%	2	1%	9	2%
8 Months	6	2%	3	1%	9	2%
9 Months	1	0%	1	0%	2	0%
10 Months	0	0%	0	0%	0	0%
11 Months	0	0%	0	0%	0	0%
Years						
1 Year	19	6%	34	12%	53	9%
2 Years	7	2%	17	6%	24	4%
3 Years	6	2%	8	3%	14	2%
4 Years	3	1%	4	1%	7	1%
5 Years	4	1%	2	1%	6	1%
6 Years	3	1%	2	1%	5	1%
7 Years	2	1%	0	0%	2	0%
8 Years	0	0%	0	0%	0	0%
9 Years	1	0%	1	0%	2	0%
10 Years	1	0%	2	1%	3	1%
More than 10 years	9	3%	3	1%	12	2%
Unknown	96	32%	180	63%	276	47%
Total Referrals	**298**		**287**		**585**	

COVID-19 Shelter-in-Place

As the COVID-19 Shelter-in-Place Order took effect in March 2020, Napa County MHSA staff reached out to the nine PEI programs to understand the program changes that were occurring in response to the restrictions. These conversations continued as the programs adapted and as they completed the program reports for FY 19-20. The program staff's comments are summarized at the end of each program summary report and are aggregated in this section to provide an overview of the various shifts made in services, outreach, and evaluation in order to continue to serve participants during the pandemic. The changes continued into FY 20-21 while the pandemic precautions restricted in person meetings and events.

Changed Format of Services

All of the programs reported moving their services to an online/virtual format and most reported using phone services as well to reach individuals they previously served in person. As they described this shift, most also noted that services were paused for a bit to pivot to the new formats and to address/accommodate participants' technology needs. Two programs noted that the virtual format made parts of their services more accessible, and more people were able to participate after the changes were made.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
COVID-19 Shelter-in-Place Changes, FY 19-20
Changed Format of Services (n=9)

	PEI Funded Programs Reporting Changes	
Changed Format of Services	**Frequency**	**Percent**
Shifted Services to Virtual Format	9	100%
Shifted Services to Phone Format	8	89%
Addressed/Accommodated Technology Needs of Participants	5	56%
Program Paused Services to Pivot to Virtual Format	6	67%
Virtual Format Made Services More Accessible to Participants	2	22%

Changed Type of Services

Two thirds of the programs reported contacting clients to check on their wellbeing and needs after the Shelter-in-Place Order took effect. These check-ins informed the programs' understanding of the participants' changing needs and resulted in programs reducing some services and in one case, adding new services. Generally, the programs reported an increase in the need for one-on-one supports and decreased interest in (as well as feasibility of) group supports. A few programs also noted that they reduced screening and referrals during this time due to lack of access to individuals and temporarily unclear protocols about how to access referral services.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
COVID-19 Shelter-in-Place Changes, FY 19-20
Changed Type of Services (n=9)

	PEI Funded Programs Reporting Changes	
Changed Type of Services	**Frequency**	**Percent**
Increased Contacts with Participants/Wellbeing Checks	7	78%
Participants Reported Increased/Changed Needs	6	67%
Reduced Some Services	7	78%
Added New Services	1	11%
Reduced Screening/Referrals	2	22%

Changed Outreach

Programs that had events and/or meetings planned cancelled these activities with the Shelter-in-Place Order. In response to the shift, three of the programs put increased efforts into posting on social media platforms to continue to connect with individuals in the community and to provide information and support.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
COVID-19 Shelter-in-Place Changes, FY 19-20
Changed Outreach (n=9)

	PEI Funded Programs Reporting Changes	
Changed Outreach	**Frequency**	**Percent**
Increased Social Media	3	33%
Cancelled Outreach Events and/or Meetings	4	44%

Changed Evaluation

In a few cases, programs reported that they were unable to collect data as effectively after the Shelter-in-Place Order. This primarily impacted the collection of post assessments and surveys that would typically take place in the fourth quarter. In one instance, the program changed how they collected data in response to the changed services and access to participants.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
COVID-19 Shelter-in-Place Changes, FY 19-20
Changed Evaluation (n=9)

	PEI Funded Programs Reporting Changes	
Changed Evaluation	**Frequency**	**Percent**
Less Data Collected	3	33%
Changed Data Collection	1	11%

Section Two: Summary of Activities and Outcomes by Program

Stigma and Discrimination Reduction

The Napa County Mental Health Division supports one Stigma and Discrimination Reduction Program using PEI funds. The program focuses on reducing stigma and promoting inclusive services that screen, support, and refer individuals who identify as LGBTQ for mental health concerns. The services of stigma and discrimination reduction programs fall into three categories: Outreach, Mental Health Screening and Referrals, and Trainings.

Overview

For the ease of quickly reviewing the population served and the program activities, an overview is provided in the following table. The program is nested within a larger organization and used other funding to screen and refer individuals with mental health concerns. In FY 20-21, PEI funding was used to pilot a process for screening older adults who identify as LGBT.

MHSA: Stigma and Discrimination Reduction
Overview of Stigma and Discrimination Reduction Program: Population Served and Activities

Agency: Program	Population Served	Outreach	Mental Health Screenings and Referrals	Trainings
On The Move: LGBTQ Connection	Individuals who identify as LGBTQ Providers who serve LGBTQ individuals in Napa County	Outreach to individuals who identify as LGBTQ to promote awareness about when to seek mental health support and how to access affirming services.	Pilot a process for screening older adults for mental health concerns (FY 20-21)	Provide LGBTQ Best Practice Trainings to providers and offer technical assistance to individual organizations

Outcomes

The outcomes below are a summary to demonstrate how the Stigma and Discrimination Reduction program promotes awareness and inclusive services for individuals who identify as LGBTQ.

- Improved understanding, compassion and confidence among the providers who attended the LGBTQ Best Practice Trainings.
- The providers who attended the trainings reported making changes in their workplace to make mental health services more affirming and to improve access for LGBTQ individuals.

On The Move: LGBTQ Connection

Community Needs Addressed by Program

- Lack of LGBTQ competent and/or specialized community resources & services in Napa County
- Mental health needs of LGBTQ individuals are not being met (LGBTQ people are not accessing current services and/or not bringing full self)

FY 20-21: Activities and Outcomes

Outreach: Outreached to the Napa County LGBTQ community to promote understanding of when to seek mental health support and how to access affirming mental health services.

- **Increased Social Media Presence:** On average, the program provided almost daily social media outreach (23 times/month) on three platforms (Facebook, Instagram and Twitter). Compared to FY 19-20, this was a 22% increase.
- **Focus on Mental Health Topics and Strategies:** The most frequent topics of the posts included: Support Group Outreach (66%), Mental Health Resources (17%), LGBTQ Affirming Resources (7%), and Crime Victim/Mental Health Services (4%).
- **Reach an average of over 22,000 users each month:** Across all three social media platforms, the program reached an average of 22,079 users and engaged with an average of 1,576 users each month.

Napa County Mental Health Services Act Prevention and Early Intervention Programs:
LGBTQ Connection: Number of Followers, Estimated Reach and Engagement
Social Media Outreach, FY 20-21

	Facebook	Instagram	Twitter[10]
Number of Followers	8,192	3,848	2,011
Estimated Reach	142,723	122,225	n/a
Engagement	8,021	10,887	n/a

[10] Twitter stopped providing demographic data analytics tool in January 2020.

Provider Trainings: Provided LGBTQ Best Practice trainings to service providers to address how to screen, refer, and/or support LGBTQ individuals with mental health concerns.

- **Improved Understanding, Compassion and Confidence:** In FY 20-21, 324 individuals attended the provider trainings. Of these, 173 responded to a survey about their learning as a result of the workshop. They reported the following changes:
    - 95% Improved understanding of LGBTQ identities.
    - 89% More compassion for LGBTQ people and their experiences.
    - 92% More awareness of issues that affect the mental health of LGBTQ youth and seniors
    - 93% More confidence in their ability to support LGBTQ people,
    - 92% Gained knowledge of resource and referral information for LGBTQ people, and
    - 82% Can identify specific mental health resources accessible for LGBTQ people.

- **Providers Made Changes in their Workplace:** Of the 355 individuals who attended the provider trainings, 145 responded to questions about the types of changes they intended to make when returning to their workplace in order to make mental health services more affirming and to improve access for LGBTQ individuals. An online survey was sent out 3 months after the trainings to providers to ask what they have actually implemented; 77 individuals responded.
    - Providers were most likely to indicate that they intended to and actually did shift language in their workplaces.
    - Displaying support for LGBTQ clients and sharing inclusive resources was also frequently noted.
    - Making concrete changes to outreach, programs and or the organization was less frequently reported by respondents, although over a quarter of respondents reported making changes to their forms to be more LGBTQ inclusive within 3 months after the training.

Napa County Mental Health Services Act Prevention and Early Intervention Programs:
LGBTQ Connection: Intended and Actual Changes made to Workplace,
Provider Workshop Survey and Three Month Survey, FY 20-21

Workplace Changes	Intended Changes (n=145)	Actual Changes (n=77)
Using gender neutral language	25%	82%
Asking and respecting preferred names and pronouns	39%	64%
Showing visible displays of support for LGBTQ clients (Rainbow stickers, flags, etc.)	23%	43%
Sharing LGBTQ-inclusive resources	9%	36%
Attending more trainings or looking for more resources	7%	35%
Making forms more inclusive	8%	28%
Doing LGBTQ-inclusive outreach	0%	13%
Made a change to organizational policy or practice guidelines	13%	11%
Created or updated a program offering to be LGBTQ specific or LGBTQ inclusive	0%	11%
Other changes	29%	17%

Technical Assistance for Organizations: LGBTQ Connection provided technical assistance visits to 46 organizations representing a variety of service sectors. Two of the agencies served also received MHSA PEI Funding.

- 23%: Schools/Universities
- 18%: Primary healthcare or health clinics
- 11%: Local Government agency/representatives
- 7%: Law Enforcement
- 7%: Behavioral Healthcare Provider
- 2%: Cultural Organizations
- 2%: Family Resource Center
- 2%: Recreational settings
- 2%: Support Groups
- 15%: Other

LGBTQ Connection met with agencies an average of 1.5 times, and up to six times, during the fiscal year to support their efforts to **improve their outreach to be inclusive**, provide training to the organization as

the **staff adjust services to support LGBTQ individuals**, and offered technical assistance about **inclusive language, celebrating PRIDE, best practices, strategic planning, and evaluation.** LGBTQ Connection also provided assistance on how to best **reach out to LGBT older adults and LGBTQ youth.**

Screenings (Pilot): In FY 20-21, staff worked with the agency's older adult LGBT group to discuss how to best screen LGBT older adults for mental health concerns. This process began with staff researching promising practices from LGBT elder-serving organizations and professionals. After researching several options, the discussion was brought to the group participants at their regular monthly meeting. The following list describes the process and the findings about using a mental health screener with older adults who identify as LGBT:

- Formal tools were not a good fit for the group's format.
- Staff worked with the agency's clinical director to develop a flexible screener to assess for pertinent concerns and allow for access to referrals.
- Staff partnered with the monthly attendees to test and discuss conversation starting points they felt were appropriate for the topic. The following questions were used to understand the participants' views:
    - What do you think of this topic?
    - How do you/did you know when you needed to ask for support?
    - What has been the biggest change(s) in your life as a result of COVID?
    - What stops you from seeking medical (health or mental health) care?
    - What has been most helpful in seeking and participating in care?
    - What does connection look like for you now?
- Follow up questions for deeper exploration included:
    - How has isolation impacted your mental health?
    - How have you adapted your (social) life?
    - What questions landed for you and what questions didn't feel as relevant?
    - What other questions might we ask?
- Overall, the group gave positive feedback about the conversation.
- Prior to the actual meeting, one of the group facilitators was unsure about how the process would feel compared to the typical meetings. After the meeting had ended, the group AND that same facilitator gave feedback that the conversation was very useful and would like it to happen more regularly.

FY 19-20: Activities and Outcomes

Outreach: Outreached to the Napa County LGBTQ community about understanding when to seek mental health support, and how to access affirming mental health services.

- **Increased Social Media Presence during Shelter-in-Place:** On average, the program provided social media outreach six times/month on three platforms (Facebook, Instagram and Twitter). Once the COVID Shelter-In-Place order took effect, the program increased postings to an average of 19 times/month.
- **Focus on Mental Health Topics and Strategies:** The most frequent topics of the posts included: Self Care (35%), Mental Health Resources (26%), Coping Strategies (22%), COVID related concerns and/or Resources (20%), and LGBTQ Affirming Resources (19%).
- **Reach an average of over 27,000 users each month:** Across all three social media platforms, the program reached an average of 27,832 users each month and engaged with an average of 1,691 users.

Napa County Mental Health Services Act Prevention and Early Intervention Programs:
LGBTQ Connection: Number of Followers, Estimated Reach and Engagement
Social Media Outreach, FY 19-20

	Facebook	Instagram	Twitter
Number of Followers	4,268	1,638	923
Estimated Reach (Peak Month)	20,070	n/a	10,500
Estimated Reach (Average Month)	15,245	3,192	9,395
Engagement (Peak Month)	2,550	n/a	104
Engagement (Average Month)	1,183	412	96

Provider Trainings: Provided LGBTQ Best Practice trainings to service providers to address how to screen, refer, and/or support LGBTQ individuals with mental health concerns.

- **Improved Understanding, Compassion and Confidence:** In FY 19-20, 251 individuals attended the provider trainings. Of these, 134 responded to a survey about their learning as a result of the workshop. They reported the following changes:
    - 97% Improved understanding of LGBTQ identities.
    - 96% More compassion for LGBTQ people and their experiences.
    - 96% More awareness of issues that affect the mental health of LGBTQ individuals.
    - 99% More confidence in their ability to support LGBTQ people, and
    - 95% Gained understanding of affirming mental health resources for LGBTQ people, and
    - 86% Can identify specific mental health resources accessible for LGBTQ people.

- **Providers Made Changes in their Workplace:** Of the 251 individuals who attended the provider trainings, 67 responded to questions about the types of changes they intended to make when returning to their workplace in order to make mental health services more affirming and to improve access for LGBTQ individuals. An online survey was sent out twice to providers to ask what they have actually implemented.
    - Providers were most likely to indicate that they intended to and actually did **shift language in their workplaces**.
    - **Displaying support for LGBTQ clients and sharing inclusive resources** was also frequently noted.
    - Making concrete changes to outreach, programs and or the organization was less frequently reported by respondents.

Napa County Mental Health Services Act Prevention and Early Intervention Programs:
LGBTQ Connection: Intended and Actual Changes made to Workplace,
Provider Workshop Survey and Three Month Survey, FY 19-20

Workplace Changes	Intended Changes (n=67)	Actual Changes (n=19)
Using gender neutral language	15%	63%
Asking and respecting preferred names and pronouns	34%	58%
Sharing LGBTQ-inclusive resources	1%	42%
Showing visible displays of support for LGBTQ clients (Rainbow stickers, flags, etc.)	16%	31%
Making forms more inclusive	1%	15%
Attending more trainings or looking for more resources	3%	5%
Doing LGBTQ-inclusive outreach	3%	5%
Made a change to organizational policy or practice guidelines	3%	5%
Created or updated a program offering to be LGBTQ specific or LGBTQ inclusive	0%	5%
Other	28%	37%

Technical Assistance for Organizations: LGBTQ Connection provided technical assistance to 30 organizations representing a variety of service sectors. Five of the agencies served also received MHSA PEI Funding.

- 13%: Behavioral Health Care Providers
- 11%: Law Enforcement
- 11%: Schools/Universities
- 8%: Primary health care or health clinics
- 5%: Libraries
- 5%: Residences
- 3%: Churches or faith-based organizations
- 3%: Cultural organizations
- 3%: Senior centers
- 3%: Support groups
- 37%: Other

LGBTQ Connection met with agencies an average of 1.9 times, and up to seven times, during the fiscal year to support their efforts to improve their outreach to be inclusive, provide training to the organization as the staff adjust services to support LGBTQ individuals, and offered technical assistance about inclusive language, celebrating PRIDE, best practices, strategic planning, and evaluation.

FY 19-20: Program Changes due to COVID

- **Outreach:** Once the COVID Shelter-In-Place order took effect, the program increased social media postings to an average of 19 times/month compared to an average of six times/month pre-COVID.
- **Outreach:** The program began monthly "COVID check-ins" with participants to ask about well-being and mental health and to offer supports, services and referrals.
- **Provider Trainings:** In April, the Provider Trainings were moved to a virtual format using Zoom. To be sure it was dynamic, interactive and engaging, staff use the whiteboard features and the breakout rooms. They piloted the training with their own agency staff in May and began offering it to providers in June 2020.
- **Technical Assistance for Organizations**: The staff noted there was less interest from organizations for technical assistance in March and April as agencies adjusted their services to accommodate the new guidelines. Organizations began to reach out again in June as they considered how to incorporate PRIDE month celebrations into their services.

Prevention

Napa County Mental Health Division funded six Prevention programs serving individuals of all ages with a focus on children, youth, and their families. The work of these programs fell into four categories: Partnerships, Outreach, Screenings/Referrals and Services/Supports. The section that follows provides a summary of each Prevention program's activities and outcomes.

Overview

For the ease of quickly reviewing the programs, the population served, and the program activities, general information is summarized in the following table. Some of the programs operate within a larger organization or program and thus have other funding or support to address an area, others rely on partners to provide services in a specific category.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Overview of Prevention Programs: Population Served and Activities

		PEI Funded Program Activities			
Agency: Program	**Population Served**	**Partnerships**	**Outreach**	**Mental Health Screenings and Referrals**	**Mental Health Services and Supports**
Suscol Intertribal Council: Native American PEI Project	Individuals in Napa County who identify as Native American and community members with an interest in Native American history, culture, and traditions.	Partnerships with a variety of community organizations to promote access to services for Native individuals	Community outreach to promote familiarity with Native history and experiences	Informal conversation with individual	Monthly workshops to share/teach norms of indigenous culture
UpValley Family Centers: UpValley Mentoring Project (CLARO/CLARA)	Latinx and Latinx middle school and high school students in St Helena and Calistoga	Partnerships with school administration in St Helena and Calistoga	*(not provided with PEI funding)*	Strengths and Difficulties Questionnaire	Individual and group support
Napa Valley Education Foundation: American Canyon Student Assistance Program	American Canyon students in kindergarten to 12th Grade	Partnerships with school administration in American Canyon	*(not provided with PEI funding)*	Strengths and Difficulties Questionnaire	Individual and group support

		PEI Funded Program Activities			
Agency: Program	**Population Served**	**Partnerships**	**Outreach**	**Mental Health Screenings and Referrals**	**Mental Health Services and Supports**
Cope: Home Visitation	Children 0-5 and their families	Participate in a Multidisciplinary Team, partner with mental health providers and disaster organizations.	Parent events to promote social connections	Edinburgh Scale for Post-Partum Depression, Healthy Families Parenting Inventory (HFPI), Ages and Stages Questionnaire (ASQ and ASQ-SE)	Home visitors support individuals to connect to referrals and supports
Cope: Strengthening Families	Parents of Children 0-18 Individuals in UpValley communities	*(not pursued with PEI funding)*	General outreach to families in Napa County about mental health supports and other resources	Informal conversation with parent to refer to groups PHQ-9, Emotional Rating Scale, and/or the DASS-21 for parents in groups	Group and Individual support for parents in Napa, St Helena, and Calistoga
NEWS: Kids Exposed to Domestic Violence	Children 0-18 who have been exposed to domestic violence	KEDS Collaborative: Meet with agencies serving children to educate about trauma informed responses	Parent and community outreach to educate about impact of domestic violence on mental health	Informal conversation with parent	Weekly support groups for children to teach coping skills

Outcomes

The programs receiving funds to provide prevention services do the work in a variety of ways. The outcomes listed demonstrate how the programs promote prevention of mental health concerns in Napa County.

- Maintained and developed partnerships to increase access to mental health services and supports for individuals who identify as Native American.
- Improved familiarity with the norms of indigenous cultures.
- Improved familiarity with the signs and symptoms of mental health concerns and the resources available in Napa County.
- Improved understanding of cultural identity among Latinx youth. These youth also reported more positive relationships.
- Supported parents of children aged 0-5 to improve depression symptoms and to improve their social connections.
- Reduced depression, anxiety, and stress for parents of children aged 0-18. Parents also reported fewer mental health symptoms.
- Children learned coping strategies to reduce stress and anxiety. Children reported using the strategies and sharing them with their family.

Suscol Intertribal Council: Native American PEI Project

Community Needs Addressed by Program

- Lack of information about Native history and experiences in Napa County
- Lack of enculturation[11] for Native people in Napa County
- Need to improve access to mental health services for Native people in Napa County.

FY 20-21: Activities and Outcomes

Organizational Partnerships: In FY 20-21, Suscol Intertribal Council worked with **Live Healthy Napa County** to reduce stigma and discrimination. Staff joined the coalition to improve diversity and inclusion in the school system by increasing visibility and understanding of students of color, in particular Native American students. The effort is working to "increase feelings of Respect and Social Inclusion for students of color in Napa County." To accomplish this goal, the group "partner[s] with students, schools, and community cultural bearers to co-create K-12 inclusive history curriculum…" to address historical inaccuracies.

Outreach (Information): Outreach was provided to share information and increase the community's familiarity with Native history and experiences in Napa County. General outreach also included information about ongoing classes for Native American individuals and for community allies who are interested in attending or could refer others to the resources.

In FY 20-21, Suscol Intertribal staff reported 29 outreach events and/or activities reaching an estimated 11,750 individuals. The outreach is designed to highlight Native history and experiences in Napa County, and to encourage individuals to join the ongoing workshops available for Native individuals and allies in Napa County. The majority of the outreach was done in the City of Napa (72%), followed by St Helena (24%) and the Unincorporated Areas of Napa County (3%).[12]

Because Suscol is working to bring mental health prevention information to Native Americans in Napa County, much of the outreach work was intertwined with the work they do for the Native community. Most of the outreach was provided at Suscol's offices or at the Suskol House in rural Napa County (57%). In FY 20-21, three of the outreach events that were held at the Suscol office included talks on history, the experiences of Native individuals living in Napa County, and a panel discussion with Native youth.

[11] enculturation: the process whereby individuals learn their group's culture, through experience, observation and instruction.

[12] Some outreach occurs in Sonoma and Lake counties to reach the Native individuals and their descendants who are from Napa County and have been displaced. In each instance, Napa residents attended the presentation. These presentations were not included in this report in order to adhere to MHSA guidelines about providing services within the boundaries of Napa County.

The remaining outreach took place in schools/universities (19%), churches (10%), a family resource center, and at the St Helena Rotary Club. Many of the meetings happened virtually (33%) using Zoom. One talk took place on the local radio station and reached an estimated 10,000 individuals.

The PEI Regulations ask about specific groups who are contacted through the outreach. Using the categories provided, Suscol reported reaching the following groups.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Native American PEI Project: Outreach Contacts by PEI Population Group, FY 20-21

PEI Population Group	Frequency	Percent
General Public	11,627	99%
Faith leaders	29	<1%
Students	44	<1%
Other: *Native individuals and elders*	5	<1%
Politicians	21	<1%
K-12 educators	22	<1%
College and university educators	2	<1%
Total Outreach Contacts	**11,750**	

Ongoing Workshops (Information, Enculturation): Suscol provides focused workshops to share the norms of indigenous cultures, information about the signs and symptoms of mental health concerns and information about community resources for mental health concerns. In FY 20-21, they offered 185 workshop sessions on 4 different topics. Demographic forms were collected for 35 of the 108 individuals who participated. 29% of the 35 individuals (n=10) indicated they identified as American Indian or Alaska Native, compared to 8% of the total PEI participants for all programs. All workshops were provided on Zoom.

The workshops in brief:

- **Talking Circle:** Held twice a month virtually to foster an environment for discussion of daily stress and traumatic experiences. Promoted emotional and mental health by talking through problems and connecting with the others in the group. Encourages culturally relevant activities while educating the public.
- **Meditation:** This class was held virtually in FY 20-21. Classes were held twice each week, once for the general public and for the ICC participants. Meditation gives participants the tools to deal with the stress of daily life and environmental tragedies in a healthy way.
- **Drum and Singing:** Held online once a week. A place to teach and learn culturally significant songs with the voice, drum, rattle, or other item. Children and adults participate.
- **Historical Trauma & Traditional Healing, Cohort 5 and 6:** Developed with MSHA Innovation funding in 2018, each cohort receives a five-workshop series. The workshops educate participants on the history of Napa Valley's first peoples. The series takes place via Zoom using a

slideshow presentation and a culturally relevant healing element at the end. Each class runs two hours or more. These classes create a space for the public to have an open discussion and learn about the history of the region, atrocities done unto the first peoples, and the subsequent trauma associated with this that continues to affect the mental health of Native individuals. These workshops are necessary to create a space for healing of colonizers and oppressed peoples alike.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Native American PEI Project: Workshop Topics, Attendees and Number of Sessions, FY 20-21

		Number of Sessions				
Topic	**Number of Attendees (duplicated)**	**Q1**	**Q2**	**Q3**	**Q4**	**Total Sessions FY 20-21**
Talking Circle for ICC	72	4	2	6	6	18
Talking Circle	63	5	5	6	6	22
Meditation for ICC	152	11	7	10	13	41
Meditation	230	10	12	11	13	46
Drum and Singing	333	13	10	12	12	47
Historical Trauma and Healing, Cohort 5	144	3	2			5
Historical Trauma and Healing, Cohort 6	97			3	2	5
Total Unduplicated Attendees	**108**					
Total Workshop Sessions		**46**	**38**	**48**	**52**	

Workshop participants are asked to complete a pre and post-workshop survey. Many participants attended more than one workshop. To avoid duplicated surveys, the pre-survey was given to all participants the first time they attended a workshop in the fiscal year, and the post-survey sent to all participants in April 2021 to capture learning that had occurred. Due to the COVID limitations, all surveys were completed online. Staff noted that the online format impacted the response rate. Less than one third of all attendees completed a pre-survey (n=33, 31%).

- Thirty-three pre surveys were collected in FY 20-21. 20 respondents (31%) indicated this was their first workshop with Suscol Council.
- The pre-surveys were analyzed to see if there were differences in the responses based on whether or not the respondent had attended a workshop previously. For all three measures, those who had attended previously rated their familiarity higher on average.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Native American PEI Project: Average Familiarity Rating, Workshop Participants Pre-Workshop Survey, FY 20-21

	Familiarity Rating (*Scale of 0: NOT Familiar to 5: VERY Familiar)*							
	Overall		Respondents who have NOT attended a previous Suscol workshop		Respondents who have attended a previous workshop		Respondents who have attended 10 or more previous workshops	
Survey Question	**n**	**Average**	**n**	**Average**	**n**	**Average**	**n**	**Average**
My understanding of the norms of indigenous cultures	34	2.7	23	2.3	11	3.5	34	2.7
My understanding of the signs and symptoms of mental health concerns	34	3.2	23	3.0	11	3.7	34	3.2
My understanding of the mental health resources in Napa County	34	2.4	23	2.0	11	3.3	34	2.4

The post-workshop surveys were completed by 20 participants. 85% indicated they had attended the Historical Trauma & Traditional Healing workshop. Three respondents indicated they had attended 10 or more Suscol workshops, and two indicated it was their first workshop. For the rest, the responses ranged from one to five workshops. On average, respondents indicated they had more familiarity with each of the three areas after participating in the workshop(s).

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Native American PEI Project: Average Familiarity Rating,
Workshop Participants Post Workshop Survey (n=20), FY 20-21

	Familiarity Rating (*Scale of 0: NOT Familiar to 5: VERY Familiar)*[13]		Percentage Increase from Average Pre to Post Familiarity Ratings
Survey Question	**PRIOR to taking the Suscol Workshop(s)**	**AFTER taking the Suscol Workshops**	
My understanding of the norms of indigenous cultures	3.3	4.4	33%
My understanding of the signs and symptoms of mental health concerns	3.7	4.2	12%
My understanding of the mental health resources in Napa County	2.8	4.1	44%

[13] Note the familiarity scale was altered to adjust to the format of the online survey. The pre workshop survey used a scale of 0 to 10, the post workshop survey was abbreviated to use a scale from 0 to 5.

Screening and Referrals: Native individuals were screened for mental health concerns and referred as indicated. Staff talked with attendees informally after workshops and events to assess signs and symptoms of mental health concerns and to offer referrals.

FY 19-20: Activities and Outcomes

Organizational Partnerships: In FY 19-20, Suscol Intertribal Council maintained organizational partnerships and began several new partnerships to increase access to mental health services for Native individuals.

Maintained Partnerships

- **Innovations Community Center (ICC):** The agencies partnered to bring Suscol's PEI workshops to participants. Once the Shelter-in-Place was put into effect, the agencies worked together to provide workshops over Zoom.
- **Yountville Veterans Home:** Suscol Council collaborated with the Yountville Veterans Home to begin teaching workshops to the Native American residents. The workshops were not held due to Shelter-in-Place.
- **Courage Center:** Suscol Council and Courage Center staff developed a Memorandum of Understanding for referrals between the programs. As a result of this partnership, Courage Center staff attended further training about Native American experience in Napa County.
- **Napa Valley Unitarian Universalists (NVUU):** The NVUU provided meetings space for Suscol Council and is a partner in promoting cultural outreach and education about the Native people in Napa Valley. NVUU's Native minister disseminates the correct history of the region. This partnership encouraged better mental health by making local Native people feel visible and understood.
- **Napa County Resource Conservation District:** Suscol Council partnered with the Napa County Resource Conservation District to promote outdoor activities that enhance the wellness of Native people and connect them with their traditional lands. This was particularly important during the Shelter-in-Place Order that kept many people indoors.

Developed New Partnerships

- **Fellowship of Episcopalian Churches of the Napa Valley:** Suscol Council partnered with the Episcopalian churches in Napa Valley (Napa, St. Helena and Calistoga) to support the work of anti-racism to unpack the systemic racism present in the Napa Valley, including the experiences of Native individuals. The coalition's work promoted the understanding and inclusion of non-white perspective and experience within the predominantly white community of Napa County.
- **Napa County Regional Park and Open Space District:** Suscol Council partnered with the Open Space District to incorporate Native American perspective in local land management. Participating in this partnership promoted the relevancy and value of the Native and Indigenous people and ceremony and encouraged Native wellness.
- **2020 Census Napa County:** Suscol Council staff worked with the 2020 Census outreach efforts to teach those planning for and doing outreach for the Census about the unique issues facing unrecognized, urbanized Native Americans and their descendants. Suscol Council also contacted Native American people to complete the Census and promoted the outreach efforts. This partnership was established to increase the resources allocated to Native people in Napa County (including relevant mental health resources).

Outreach (Information): Outreach was provided to share information and increase the community's familiarity with Native history and experiences in Napa County. General outreach also included information about ongoing classes for Native American individuals and for community allies who are interested in attending or could refer others to the resources.

In FY 19-20, Suscol Intertribal staff reported 52 instances of outreach to individuals and organizations in Napa County, reaching 3,153 individuals. The outreach is intended to raise awareness about Native history and experiences in Napa County, and to encourage individuals to join the ongoing workshops available for Native individuals and allies in Napa County. The majority of the outreach was done in the City of Napa (79%), followed by Yountville and St Helena (19%) and the Unincorporated Areas of Napa County (2%).[14]

Because Suscol is working to bring mental health prevention information to Native Americans in Napa County, much of the outreach work was intertwined with the work they do for the Native community. Most of the outreach was provided at Suscol's offices or at the Suskol House in rural Napa County (62%). At Suscol's offices, the outreach was generally done with individuals who dropped in for information. At the Suskol House the outreach was done as part of gatherings, drum blessings, ceremony, and work days. The remaining outreach took place in schools/universities (15%), recreational settings (12%), senior centers (6%), churches (4%) and libraries (2%). At these venues, the outreach included tabling at community events, presenting Native History in classrooms, and meeting with decision-makers to address policies.

The PEI Regulations ask about specific groups who are contacted through the outreach. Using the categories provided, Suscol reported reaching the following groups.

[14] Some outreach occurs in Sonoma and Lake counties to reach the Native individuals and their descendants who are from Napa County and have been displaced. In each instance, Napa residents attended the presentation. These presentations were not included in this report in order to adhere to MHSA guidelines about providing services within the boundaries of Napa County.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Native American PEI Project: Outreach Contacts by PEI Population Group, FY 19-20

PEI Population Group	Frequency	Percent
General Public	2,593	82%
Faith leaders	251	8%
Students	209	7%
Other: *Native individuals and elders*	44	1%
Active Military or Veteran	38	1%
Other social service providers	8	0%
Behavioral Health Providers	4	0%
Politicians	3	0%
K-12 educators	2	0%
College and university educators	1	0%
Total Outreach Contacts	**3,153**	

Ongoing Workshops (Information, Enculturation): Suscol provides longer workshops to share the norms of indigenous cultures, information about the signs and symptoms of mental health concerns and information about community resources for mental health concerns. In FY 19-20, they offered 105 workshop sessions on 11 different topics. Demographic forms were collected for 92 individuals. 20% of the individuals indicated they identified as American Indian or Alaska Native, compared to 14% of the total PEI participants for all programs. Workshops are provided in community venues, at the Suscol offices, and at the Innovations Community Center (ICC). After the Shelter-in-Place order in March 2020, workshops were moved to Zoom.

The workshops in brief:

- **Talking Circle:** Group support to discuss the ways of a healthy lifestyle, mental wellness, and cultural awareness. Located at the ICC and Suscol office
- **Craft Class:** A different traditional craft taught each class to share Native cultures and traditions while fostering a social and supportive setting. Located at the ICC and Suscol office.
- **Sewing Class:** Teaching the importance and fun of sewing traditional and non-traditional projects. Located at Suscol office.
- **Meditation:** A virtual class developed in March and launched in April 2020 after the Shelter-in-Place Order; this class allowed people to reconnect from the safety of their homes. Meditation allowed for better mental health and stamina during stressful times and gave participants the resources they needed to handle the crisis. Classes were once a week for the general public and for the ICC participants. Classes ran 45 minutes to an hour and a half.
- **Drum Circle:** Way to learn about traditional drumming. Located at Suscol office. This workshop was moved to Zoom in April 2020.

- **Native American Family Summer Camp:** Weekend of fun for children and their parents at the Suskol property promoting traditional Native American crafts and games. Guests camped out for two nights.
- **Historical Trauma & Traditional Healing, Cohort 4:** Developed with MHSA Innovations funds in 2018 and provided through PEI funding once the Innovation project concluded. A five-workshop series educating participants on the history of Napa Valley's first peoples, including the trauma that Native populations experience and the healing methods they use to address the mental health impacts. In FY 19-20, the workshop began in-person at Grace Episcopal Church in St. Helena and moved onto Zoom during the Shelter-in-Place Order. Workshops were once a month with a slideshow presentation and healing element at the end. Each session ran two hours or more.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Native American PEI Project: Workshop Topics, Attendees and Number of Sessions, FY 19-20

		Number of Sessions				
Topic	**Number of Attendees (duplicated)**	**Q1**	**Q2**	**Q3**	**Q4**	**Total FY 19-20**
Talking Circle @ ICC	133	6	5	5	0	16
Talking Circle @ Suscol	13	2	3	2	0	7
Craft Class @ ICC	68	2	3	2	0	7
Craft Class @ Suscol	19	3	2	3	0	8
Sewing Circle	14	3	3	2	0	8
Meditation (Zoom)	64	0	0	0	13	13
Meditation ICC (Zoom)	38	0	0	0	13	13
Drum Circle	30	5	4	5	0	14
Drum Circle (Zoom)	84	0	0	0	13	13
Native American Family Summer Camp	15	1	0	0	0	1
Historical Trauma and Healing, Cohort 4	115	0	0	2	3	5
Total Attendees	**593**					
Total Workshop Sessions		**22**	**20**	**21**	**42**	**105**

Workshop participants are asked to complete a pre and post-workshop survey. Many participants attended more than one workshop. To avoid duplicated surveys, the pre-survey was given to all participants the first time they attended a workshop in the fiscal year, and the post-survey was planned for the fourth quarter to capture learning that had occurred. Due to the Shelter-in-Place Order, post-surveys were sent out online in May 2020.

- Eighty-eight pre surveys were collected in FY 19-20. 49 respondents (56%) indicated this was their first workshop with Suscol Council. Respondents were asked how many workshops they had attended, and responses ranged from one to 30.
- The pre-surveys were analyzed to see if there were differences in the responses based on the number of workshops previously attended. The findings show that those who have attended 10 or more workshops are most likely to indicate they were familiar with indigenous cultures, the signs and symptoms of mental health concerns, and the mental health resources available in Napa County.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Native American PEI Project: Average Familiarity Rating, Workshop Participants Pre-Workshop Survey, FY 19-20

	Familiarity Rating (*Scale of 0: NOT Familiar to 10: VERY Familiar)*							
	Overall		Respondents who have NOT attended a previous Suscol workshop		Respondents who have attended 1-9 previous workshops		Respondents who have attended 10 or more previous workshops	
Survey Question	**n**	**Average**	**n**	**Average**	**n**	**Average**	**n**	**Average**
My understanding of the norms of indigenous cultures	86	4.7	49	3.7	20	5.6	9	7.2
My understanding of the signs and symptoms of mental health concerns	85	6.8	48	6.7	20	6.4	9	8.1
My understanding of the mental health resources in Napa County	84	5.4	48	5.0	20	5.5	9	7.6

The post-workshop surveys were moved online to accommodate the Shelter-in-Place Order. Suscol staff sent surveys to all workshop participants with a known email address. The need for an email address limited the staff's ability to contact previous workshop attendees and responses.

The post-workshop surveys were completed by 28 participants. Over half (57%) indicated they had attended the Historical Trauma & Traditional Healing workshop. Three respondents indicated they had attended 10 or more workshops, and three indicated it was their first workshop. For the rest, the responses ranged from one to seven workshops. On average, respondents indicated they had more familiarity with each of the three areas after participating in the workshop(s).

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Native American PEI Project: Average Familiarity Rating,
Workshop Participants Post Workshop Survey (n=28), FY 19-20

	Familiarity Rating (*Scale of 0: NOT Familiar to 5: VERY Familiar)*[15]		Percentage Increase from Average Pre to Post Familiarity Ratings
Survey Question	PRIOR to taking the Suscol Workshop(s)	AFTER taking the Suscol Workshops	
My understanding of the norms of indigenous cultures	2.6	3.8	46%
My understanding of the signs and symptoms of mental health concerns	3.3	4.0	21%
My understanding of the mental health resources in Napa County	3.1	3.9	26%

Screening and Referrals: Native individuals were screened for mental health concerns and referred as indicated. Staff talked with attendees informally after workshops and events to assess signs and symptoms of mental health concerns and to offer referrals.

FY 19-20: Changes due to COVID

- Workshops were moved online in April 2020 to accommodate the Shelter-in-Place Order. The talking circles were moved first, and staff worked in FY 19-20 to adapt the craft classes for FY 20-21.
- Suscol Council doubled the number of workshops they provided and increased outreach on social media during the fourth quarter to respond to the need for social connection.
- The post-workshop survey was moved online (usually done on paper during in person workshops) and was limited by the availability of participant emails. Generally, emails were available for those participants who attended a virtual workshop, but not for those who attended in-person workshops in the previous three quarters.
- Workshops at the Veterans Home were postponed due to Shelter-in-Place.
- Screenings and referrals were done over Zoom after the workshops had ended. Participants stayed on the call with Suscol Council staff to discuss concerns. This was particularly true once the wildfires began. Many Native individuals live in the rural unincorporated areas of Napa County, the areas particularly impacted by the fires. Suscol Council staff used the agency's social media to share information about wildfire resources and to communicate during the evacuations.

[15] Note the familiarity scale was altered to adjust to the format of the online survey. The pre workshop survey used a scale of 0 to 10, the post workshop survey was abbreviated to use a scale from 0 to 5.

UpValley Family Centers: UpValley Mentoring Program PEI Project (CLARO/CLARA)

Community Needs Addressed by Program

- Lack of mental health supports for youth in UpValley communities
- Lack of cultural supports for youth in UpValley communities

FY 20-21: Activities and Outcomes

Activities

Develop and Maintain Partnerships

- Calistoga Joint Unified School District: Program staff attend the Core Team meetings to identify students at risk and to plan referrals and interventions.
- St Helena Unified School District: Program staff attend the Student Support Services meeting.

Meetings Attended: Staff attended 33 Core Team meetings at CJUSD and 6 Student Support Services at SHUSD.

Train Facilitators

- Train facilitators to use the Strengths and Difficulties Questionnaire (SDQ).

Facilitators Trained: Two facilitators were trained to use the Strengths and Difficulties Questionnaire (SDQ).

Support Youth

- Weekly meetings addressing mental health topics through the units of CLAR@ curriculum.
- One on one mentoring with facilitators.

Weekly Meetings: The UVFC Mentoring program facilitators met with students weekly in both Calistoga and St Helena. They used the CLAR@ curriculum[16] that has been adapted for local use. The material focused on building cultural identity, addressed stress and anxiety, and encouraged students to recognize stigma and seek connections and support.

- In FY 20-21, the program served 70 youth overall. Thirty-nine (55%) students participated in 9 groups in St Helena and Calistoga. Groups were provided for both middle and high school students. At two of the four school sites, groups were available in both Spanish and English.

[16] The CLARO/A curriculum was developed by Martin Flores in Los Angeles. It is based on the work of Dr. Manuel Ramirez III (Multicultural/Multiracial Psychology: Mestizo Perspectives in Personality and Mental Health: Ramirez III, Manuel: 9780765700735: Amazon.com: Books) and the work of Jerry Tello (http://www.jerrytello.com/about.html).

Napa County Mental Health Services Act Prevention and Early Intervention Programs
UpValley Mentoring Program: CLAR@ Groups by Language, Gender and Students, FY 20-21

	Number of Groups by Language		Number of Groups by Gender		Total Groups	Number of Students by Gender		Total Students
School District/School	**English**	**Spanish**	**Girls**	**Boys**		**Girls**	**Boys**	
Calistoga Joint Unified School District								
High School	2	2	2	2	**4**	18	3	**21**
Middle School	0	0	0	0	**0**	0	0	**0**
Totals	**2**	**2**	**2**	**2**	**4**	**18**	**3**	**21**
St Helena Unified School District								
High School	2	1	1	2	**3**	4	6	**10**
Middle School	2	0	1	1	**2**	2	6	**8**
Totals	**4**	**1**	**2**	**3**	**5**	**6**	**12**	**18**
Totals Both Districts	**6**	**3**	**4**	**5**	**9**	**24**	**15**	**39**

One-on-One Mentoring: One-on-one mentoring was provided for participating students who needed more frequent or more personalized support. In FY 20-21, 31 (44%) students were part of the one-on-one mentoring program only, and 7 (10%) were part of both the group and one-on-one mentoring programs.

Outcomes: Forty-five (64%) students completed a survey about their attitudes towards self, friends, family, and others regarding mental health. Brief findings are included below.

- Cultural Identity: Respondents indicated **positive changes in their understanding of their cultural identity.** Many participated in the program in previous years, building on their existing knowledge.
- Stress and Anxiety: All respondents, including students who completed a follow-up survey,[17] reported significant increases in knowledge about stress and anxiety. All respondents could name at least one strategy for self-care.
- Connections: The students gave generally positive responses to the questions on connections. On a scale of 0-4, respondents indicated that they felt most comfortable talking about mental health **with other students.**
- Mental Health Warning Signs and Resources: On average, **respondents named at least 2 warning signs** of mental distress **and at least 2 mental health resources** to seek mental health support.

[17] Eighteen students were able to complete and return a follow-up survey at the end of the school year. (25% of all participants)

Screen and Refer Youth

- Participating youth are screened using the SDQ and referred to mental health supports as indicated
- Youth who are referred receive support

Outcomes:

- Four out of five of the students who completed an initial screening using the SDQ reported an average number of difficulties (80%)
- Students with a higher than average number of difficulties were referred to the Wellness Teams for supports (20%).

Napa County Mental Health Services Act Prevention and Early Intervention Programs
UpValley Mentoring Program: Youth Screened by Level of Risk, FY 20-21

SDQ Score Category	Frequency	Percent
Close to Average Number of Difficulties (0-15)	20	80%
Slightly Raised to High Number of Difficulties (16-19)	2	8%
Very High Number of Difficulties (20-40)	3	12%
Total Students Screened	**25**	

FY 19-20 Activities and Outcomes

Support Youth

Group Meetings: The UVFC Mentoring program facilitators met with students weekly in both Calistoga and St Helena. They used curriculum[18] that has been adapted for local use, CLAR@, that focused on building cultural identity, addressed stress and anxiety, and encouraged students to address stigma and seek connections and support.

- In FY 19-20, the program served 132 youth in 12 groups in St Helena and Calistoga. Groups were provided for both middle and high school students. At three of the four school sites, groups were available in both Spanish and English.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
UpValley Mentoring Program: CLAR@ Groups by Language, Gender and Students, FY 19-20

	Number of Groups by Language		Number of Groups by Gender		Total Groups	Number of Students by Gender		Total Students
School District/School	**English**	**Spanish**	**Girls**	**Boys**		**Girls**	**Boys**	
Calistoga Joint Unified School District								
High School	3	2	3	2	**5**	38	11	**49**
Middle School	2	0	1	1	**2**	17	14	**31**
Totals	**5**	**2**	**4**	**3**	**7**	**55**	**25**	**80**
St Helena Unified School District								
High School	2	1	1	2	**3**	12	15	**27**
Middle School	1	1	1	1	**2**	15	10	**25**
Totals	**3**	**2**	**2**	**3**	**5**	**27**	**25**	**52**
Totals Both Districts	**8**	**4**	**6**	**6**	**12**	**82**	**50**	**132**

[18] The CLARO/A curriculum was developed by Martin Flores in Los Angeles. It is based on the work of Dr. Manuel Ramirez III (Multicultural/Multiracial Psychology: Mestizo Perspectives in Personality and Mental Health: Ramirez III, Manuel: 9780765700735: Amazon.com: Books) and the work of Jerry Tello (http://www.jerrytello.com/about.html).

One-on-One Mentoring: One-on-one mentoring was provided for participating students who needed more frequent or more personalized support.

- Staff was able to support 14 students (11% of the total 132 students) in the first two quarters of the year and 21 students (16%) in the second half of the year.

Outcomes: At the end of the program, students completed a questionnaire asking about changes they have experienced in three areas. Brief findings are included below.

- Cultural Identity: The students[19] who completed a post-test indicated **very positive changes in their understanding of their cultural identity.**
- Stress and Anxiety: The respondents reported more moderately positive scores for the stress and anxiety questions. Though all of the students *agreed* that they **felt comfortable sharing thoughts in a group**, just two of the sixteen *strongly* agreed.
- Connections: The students gave generally positive responses to the questions on connections. They were particularly in agreement with the statement that they had **more positive relationships with other students.**

FY 19-20: Changes due to COVID

- The facilitator who had been working with the girls' groups left just before the Shelter-in-Place Order took effect. The program was unable to replace her before the end of the school year. When the schools closed in March, another staff person reached out to the girls. As she was known in Calistoga, some girls there participated. None of the St Helena girls continued in the program after the staff change. In the second half of the year, four of the 55 girls in Calistoga participated in a group and none of the girls in St Helena participated.
- The facilitator working with the boys' groups continued meeting with the students throughout the shutdown. Thirty of the original 75 continued with the program after the Shelter-in-Place Order took effect.
- Student surveys were distributed to students as the schools closed in March. Very few were returned due to the Shelter-in-Place Order. (n=16, 12%)
- Staff used one on one mentoring with more students and more frequently due to the changes in the meeting format (moving from in-person to online).
- Staff had planned to choose a tool to screen for mental health concerns and to train the facilitators to use the tool in Q4 of FY 19-20. This task was postponed until FY 20-21 as staff and facilitators moved services online and adjusted to the changes due to the Shelter-in-Place order.

[19] Sixteen students were able to complete and return a post- test in March 2020. (12% of all participants)

Napa Valley Education Foundation: American Canyon Student Assistance Program

Community Needs Addressed by Program

- Social emotional needs of youth are not addressed in traditional academic curriculum
- Student success relies on students feeling safe and having the social emotional skills to learn
- Schools are a common place where students' social emotional needs are identified but often have few resources to serve these needs

FY 20-21: Activities and Outcomes

Wellness Team: In FY 20-21, the school and wellness center staff reviewed available attendance, grade, and behavior data as well as the students' responses to the Strengths and Difficulties Questionnaire (SDQ) to identify students who may need mental health supports. The frequency of the meetings and the meeting attendance varied by school location. The teams began meeting after the first month of school when student data was available to review.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
American Canyon Student Assistance Program: Wellness Team Meetings by School, FY 20-21

	Napa Junction Elementary School	American Canyon Middle School	American Canyon High School
Meeting Frequency	Weekly	Weekly+	Weekly
Total Meetings	30	52	31
Average Attendees	7	6	8

Screenings: The screenings at the elementary school were done with children when a concern was identified. The Wellness Center staff worked with the middle school and high school sites to screen all eligible students using the Strengths and Difficulties Questionnaire (SDQ). In FY 20-21, 73% of the eligible students at the middle and high school sites completed an SDQ. At Napa Junction Elementary, 53 parents completed an SDQ for students in grades K-3. The staff anticipate being able to increase the number of students screened in each fiscal year.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
American Canyon Student Assistance Program: Mental Health Screening Participation
Napa Junction Elementary, American Canyon Middle School and American Canyon High School, FY 20-21

School Site	Eligible for Screening[20]	Completed a Strengths and Difficulties Questionnaire (SDQ)	
	Number of Students	Number of Students	Percent of Students
Napa Junction Elementary	420	182	43%
American Canyon Middle School	1,011	789	78%
American Canyon High School	1,707	1,188	70%
Total Students	**3,138**	**2,159**	**69%**

The Strengths and Difficulties Questionnaire (SDQ) is a 25-item screening tool.[21] For youth in 4th through 12th grade, NVUSD used the version that is self-administered and appropriate for youth ages 4-17. For students in kindergarten through third grade, the parent completed the screening. Respondents used a three point scale to indicate whether each item applied to them (Not True, Somewhat True and Certainly True). Scores range from 0 to 40 depending on the responses. To protect the confidentiality of the students at each site, the scores are aggregated below for review.

Some of the students who receive services are referred based on attendance, behavior, or grade data. Others are referred solely on the SDQ score.

- Of the students served by the Wellness Centers in 2020-2021, half reported an average number of difficulties (51%).
- One quarter of the students reported a Very High Number of Difficulties (25%).

Napa County Mental Health Services Act Prevention and Early Intervention Programs
American Canyon Student Assistance Program:
Aggregated Strengths and Difficulties Questionnaire Scores (Initial Screening):
Napa Junction Elementary, American Canyon Middle School and American Canyon High School, FY 20-21

	Fall 2020 Screening		Spring 2021 Screening	
SDQ Score Category	Frequency	Percent	Frequency	Percent
Close to Average Number of Difficulties (0-15)	138	51%	84	46%
Slightly Raised to High Number of Difficulties (16-19)	62	23%	51	28%
Very High Number of Difficulties (20-40)	68	25%	47	26%
Total Students	**268**		**182**	

[20] Based on enrollment at each site in the 20-21 school year. All data from http://www.ed-data.org/district/Napa/Napa-Valley-Unified, accessed 03 18 22.
[21] More information about the SDQ can be found here: https://www.sdqinfo.org/a0.html

Across all three sites, 122 students completed both screenings. The scores were matched to understand the impact of the interventions. Aggregated results are reported for the middle and high school students.[22]

- At both sites, about half of the students reported fewer difficulties at the spring screening.
- There was very little change in the average number of difficulties at either site.
- High school students were more likely than middle school students to report an increase in difficulties from the beginning to the end of the school year.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
American Canyon Student Assistance Program:
Changes in Strengths and Difficulties Questionnaire Scores (Fall 2020 and Spring 2021 Screening, n=122):
American Canyon Middle School and American Canyon High School, FY 20-21

		Percentage		
School	**Average Change in Difficulties**	**Decreased Number of Difficulties**	**No Change in Difficulties**	**Increased Number of Difficulties**
American Canyon Middle School	0.0	49%	7%	40%
American Canyon High School	0.5	47%	1%	50%

Mental Health Services and Supports:

Students with identified mental health risks and/or needs were offered services and supports. In FY 20-21, student data was reviewed by the Wellness Teams at each site. The review included academic indicators as well as the SDQ scores. Typically, the academic data and the mental health screening data both showed risks and areas of concern. In some cases, the student's academic data was not a concern, and the student was only identified using the mental health screening scores. Students who were identified as in need of services were offered group support and/or individual support at the school site. Those with higher needs were also referred to additional mental health resources in the community.

Students used group and individual supports at the campus Wellness Centers. Group support at each school site was offered based on the mental health and developmental needs of the students. The elementary school offered support around social skills and grief & loss, the middle school groups addressed self-esteem, grief & loss, and life skills/empowerment. The high school groups provided counseling for newcomers and life skills/empowerment for Latina youth. Groups are run by Wellness Center staff, interns supervised by the staff, and community mental health providers.

[22] The sample size of students who completed both screenings was less than 10 for the elementary school students. To protect student privacy the changes are not reported.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
American Canyon Student Assistance Program: Group Support Description and Average Student Attendance
Napa Junction Elementary, American Canyon Middle School and American Canyon High School, FY 20-21

School	Topic	Number of Groups	Number of Sessions	Average Attendance
Napa Junction Elementary	Social Skills	1	8	4
	Grief and Loss	1	8	5
American Canyon Middle School	Self Esteem (virtual)	1	5	3
	Grief and Loss (virtual)	1	12	3
	Mariposa (virtual)	1	27	3
American Canyon High School	Newcomer Counseling	1	10	5
	Mariposa	1	13	2

The Wellness Center social workers provided individual supports on campus to students who were identified. This included brief one on one interventions where the social workers checked in regularly with students, case management services to address more significant needs and crisis assessments when students needed immediate mental health supports. Staff also supported students who were on waiting lists for additional mental health services and worked with families to connect students to outside resources. This included working through the complexities of consents and insurance coverage.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
American Canyon Student Assistance Program: Wellness Center Services by Site[23]
Napa Junction Elementary, American Canyon Middle School and American Canyon High School, FY 20-21

School	Number of Students Offered Support	Number of Students who Received Brief One on One Interventions	Number of Students Who Received Case Management	Number of Students who Received a Crisis Assessment
Napa Junction Elementary School	70	n/a	70	n/a
American Canyon Middle School	178	60	148	10
American Canyon High School	250	n/a	250	66
Total	**498**	**60**	**468**	**76**

[23] Students may have received more than one type of service, therefore the counts in this table may be duplicated.

Students were referred for additional mental health services as indicated. In FY 20-21, 47 students from across the school sites were referred for additional mental health services. Referrals included behavioral health and counseling services, as well as crisis mental health supports.

FY 19-20: Activities and Outcomes

Wellness Team: In FY 19-20, the school and wellness center staff reviewed available attendance, grade and behavior data as well as the students' responses to the Strengths and Difficulties Questionnaire (SDQ), to identify students who may need mental health interventions. The frequency of the meetings and the meeting attendance varied by school location. The teams began meeting after the first month of school when student data was available to review.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
American Canyon Student Assistance Program: Wellness Team Meetings by School, FY 19-20

	Napa Junction Elementary School	American Canyon Middle School	American Canyon High School
Meeting Frequency	Bi-Weekly	Variable	Weekly
Total Meetings	20	15	27
Average Attendees	5	5	7

Screenings: The screenings at the elementary school were done with children when a concern was identified. FY 19-20 was the first year the Wellness Center staff worked with the middle school and high school sites to screen all eligible students using the Strengths and Difficulties Questionnaire (SDQ). In FY 19-20, 71% of the eligible students at all three sites completed an SDQ. The staff anticipate being able to increase the number of students screened in each fiscal year.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
American Canyon Student Assistance Program: Mental Health Screening Participation
Napa Junction Elementary, American Canyon Middle School and American Canyon High School, FY 19-20

	Eligible for Screening	Completed a Strengths and Difficulties Questionnaire (SDQ)	
School Site	Number of Students	Number of Students	Percent of Students
Napa Junction Elementary	39	14	36%
American Canyon Middle School	1,025[24]	930	91%
American Canyon High School	1,670[25]	1,007	60%
Total Students	**2,734**	**1,951**	**71%**

The Strengths and Difficulties Questionnaire (SDQ) is 25 item screening tool.[26] For youth in 4th through 12th grade, NVUSD used the version that is self-administered and appropriate for youth age 4-17. For students in kindergarten through third grade, the teacher completed the screening. Respondents used a three point scale to indicate whether each item applied to them (Not True, Somewhat True and

[24] Enrollment data is from the Census Day Count for FY 19-20, www.eddata.org, accessed 01/20/21
[25] Ibid.
[26] More information about the SDQ can be found here: https://www.sdqinfo.org/a0.html

Certainly True). Scores range from 0 to 40 depending on the responses. To protect the confidentiality of the students at each site, the scores are aggregated below for review.

- Two-thirds of the students who completed an initial screening using the SDQ reported an average number of difficulties (67%)
- Students with a higher number than average number of difficulties were referred to the Wellness Teams for supports (33%).

Napa County Mental Health Services Act Prevention and Early Intervention Programs
American Canyon Student Assistance Program:
Aggregated Strengths and Difficulties Questionnaire Scores (Initial Screening):
Napa Junction Elementary, American Canyon Middle School and American Canyon High School, FY 19-20

SDQ Score Category	Frequency	Percent
Close to Average Number of Difficulties (0-15)	1,199	67%
Slightly Raised to High Number of Difficulties (16-19)	306	19%
Very High Number of Difficulties (20-40)	278	14%
Total Students	**1,951**	

Mental Health Services and Supports:

Students with identified mental health risks and/or needs were offered services and supports. In FY 19-20, student data was reviewed by the Wellness Teams at each site. The review included academic indicators as well as the SDQ scores. Typically the academic data and the mental health screening data both showed risks and areas of concern. In some cases, the student's academic data was not a concern, and the student was only identified using the mental health screening scores. Students who were identified as in need of services were offered group support and/or individual support at the school site. Those with higher needs were also referred to additional mental health resources in the community.

Students used group and individual supports at the campus Wellness Centers. Group support at each school site was offered based on the mental health and developmental needs of the students. The elementary school offered social skills supports, the middle school groups addressed substance use, anxiety and self-esteem and the high school groups addressed substance use and grief. Groups are run by Wellness Center staff, interns supervised by the staff and community mental health providers.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
American Canyon Student Assistance Program: Group Support Description and Average Student Attendance
Napa Junction Elementary, American Canyon Middle School and American Canyon High School, FY 19-20

School	Topic	Number of Groups	Number of Sessions[27]	Average Attendance
Napa Junction Elementary	Social Skills	2	12	5
American Canyon Middle School	Substance Use	1	8	5
	Anxiety	1	6	5
	Self Esteem	1	4	5
American Canyon High School	Substance Use	3	3	4
	Grief Support	1	8	3

The Wellness Center social workers provided individual supports on campus to students who were identified. This included brief one on one interventions where the social workers checked in regularly with students, case management services to address more significant needs and crisis assessments when students needed immediate mental health supports. Staff also supported students who were on waiting lists for additional mental health services and worked with families to connect students to outside resources. This included working through the complexities of consents and insurance coverage.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
American Canyon Student Assistance Program: Wellness Center Services by Site[28]
Napa Junction Elementary, American Canyon Middle School and American Canyon High School, FY 19-20

School	Number of Students Offered Support	Number of Students who Received Brief One on One Interventions	Number of Students Who Received Case Management	Number of Students who Received a Crisis Assessment
Napa Junction Elementary School	41	12	27	7
American Canyon Middle School	n/a	23	31	7
American Canyon High School	199	85	68	33

[27] The number of sessions reflects the typical number of sessions for a full group. Groups that were in progress in March 2020 were halted due to COVID and individual support was offered by Wellness Center staff online.
[28] Students may have received more than one type of service, therefore the counts in this table may be duplicated.

Students were referred for additional mental health services as indicated. In FY 19-20, 52 students from across the school sites were referred for additional mental health services. Referrals included behavioral health and counseling services, as well as crisis mental health supports.

FY 19-20: Changes due to COVID

- Due to COVID, the schools moved to virtual instruction in March 2020. Students and staff were not allowed on campus to provide or receive Wellness Center services. There was significant uncertainty about when and how school would reopen. The first closure was for two weeks, it was then extended to six weeks, and ultimately schools did not reopen for the FY 19-20 school year.
- During the transition and amidst the uncertainty, Wellness Center staff created the "NVUSD Wellness Playbook for Distance Learning." The plan outlined how to continue Wellness Team Meetings online and continue to screen and triage students at risk. It also included guidance on how to provide services by phone or online and information about additional training for staff and teachers to respond to students' needs during the pandemic.
- Meetings with staff continued during COVID, and at two school sites, the average attendance at these meetings increased. The virtual format of the meeting allowed more of the part time staff to attend the weekly meetings and led to higher attendance.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
American Canyon Student Assistance Program
Wellness Team Meeting Attendance by School, FY 19-20

	Average Attendance		
School Site	**All meetings**	**Meetings prior to COVID**	**Meetings during COVID**
Napa Junction Elementary School	5	3	7
American Canyon Middle School	5	5	6
American Canyon High School	7	7	7

- Wellness teams were not able to track the typical academic data. Attendance, grading and classroom behavior indicators all shifted in the online environment.
- Wellness Center staff coordinated with school staff to check in with families and students that were not participating in online learning and students that had previously been served by the Wellness Center. In some cases, students needed technology (laptops, hot spots) or food, and in others they needed phone or online mental health supports.
- In person support (including individual support and support groups) ended in March 2020. Wellness Center staff continued to offer students supports by phone or online.
- Staff were not able to collect the SDQ at the end of the year due to the changes in how students were supported and how services were delivered.

Cope Family Center: Home Visitation

Community Needs Addressed by Program

- Parents of young children are at risk of perinatal depression.
- Young children may have mental health and developmental concerns that can lead to more serious mental health needs.
- Parents can use support to sustain family functioning while parenting young children.

FY 20-21 Activities and Outcomes

Cope's Parents as Teachers Home Visiting Program supports families in Napa County with a myriad of services. PEI funding supports mental health screenings and referrals.

Activities

Advocacy Work (Coordinate with Mental Health Supports): Home visitor staff work directly with mental health providers to better understand how mental health services are delivered and to educate providers about needs of young families. Major coordinating activities include:

- Multidisciplinary Team Meetings: The team continued to meet virtually throughout 20-21. Meetings included representatives from a variety of behavioral health and social service agencies, such as: Child Welfare Services, Family Preservation, Public Health, Puertas Abiertas, Exodus/Crisis Services, Napa County Mental Health, Aldea, CalWORKs, NEWS, Employment Development, North Bay Regional Center, Napa Infant Program, Therapeutic Child Care Center and ParentsCAN as well as mental health providers in private practice.
- Community Organizations Active in Disaster (COAD) Mental Health Subcommittee: Staff from the program support the subcommittee in planning for responses that support the mental health needs of families in disasters.
- Community Organizations Active in Disaster (COAD) Housing Subcommittee: Home Visiting staff have attended these meetings to educate providers and decisions makers about the mental health impact of housing insecurity and how to address it with families. Staff encourage providers to assist families in the processes needed to protect them in retaining their housing and help to reduce families' stress.

Outcomes

Family Centered Assessment and Goal Setting (Screen/Identify Parents): In FY 20-21, 36 parents of children 0-5 were screened for mental health needs using the Edinburgh Post Natal Depression Scale.[29] The scale has 10 questions that are scored from 0 to 3. Individuals with a score of 10 or greater are considered to have possible depression. The scale also includes a screening question for suicidal

[29] More information about the Edinburgh Postnatal Depression Scale can be found here: https://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf

ideation. Though over half of the parents screened were at minimal risk (56%), 12% reported moderate risk and one parent (3%) reported high risk for post-natal depression.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Home Visitation Program: Parent Screening Scores: Edinburgh Post-Natal Depression Scale, FY 20-21

Edinburgh Scale Score Range and Risk for Post-Partum Depression	Number of Screenings	Percentage of Screenings
0-9: Minimal Risk	20	56%
10-19: Moderate Risk	15	42%
20 or higher: Highest Risk	1	3%
Total Parent Screenings	**36**	

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Home Visitation Program: Mental Health Screenings and Referrals Overall, FY 19-20 and FY 20-21

	Overall FY 19-20	Overall FY 20-21
Average Number of Screenings/Month		
Adults	5	3
Children	19	6
Average Number of Referrals/Month		
Adult	3	2
Children	1	1

The Home Visitation program uses the Healthy Families Parenting Inventory (HFPI)[30] to understand families' needs and how they change over time. Of the nine domains that are assessed, the social support and depression areas are tracked for PEI purposes. In FY 20-21, data was available for 31 parents to understand whether they improved or maintained in the two categories.

- **Depression Improved**: In FY 20-21, 14 of the 31 parents improved in the domain related to depression (45%). An additional 3 parents maintained their score in this domain (10%).
- **Social Connections Improved:** In FY 20-21, 15 of the 31 parents improved in the domain related to social connections (48%). An additional 8 parents maintained their score in this domain (26%).

Child Screening (Screen/Identify Children): In FY 20-21, 122 children were screened using the Ages and Stages Questionnaire (ASQ).[31] Of these, 10% (n=12) had concerns in more than one developmental domain and 17% (n=21) were referred for health and developmental services.

[30] Brief information about the proprietary HFPI is available here: https://www.lecroymilligan.com/product-page/hfpi-manual.
[31] More information about the Ages and Stages Questionnaires can be found here: https://agesandstages.com/

Fifty children were screened using the Ages & Stages Questionnaire: Social-Emotional (ASQ:SE). Eight of children screened for social-emotional concerns were referred for mental health supports (16%).

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Home Visitation Program: Child Screening
Ages and Stages (ASQ) and Ages and Stages Social Emotional (ASQ-SE) Results, FY 20-21

	ASQ		ASQ-SE	
Result	**Number of Screenings**	**Percent of Screenings**	**Number of Screenings**	**Percent of Screenings**
Development On Schedule (Above Cutoff)	60	54%	39	78%
Monitor Development (Close to the Cutoff)	34	30%	3	6%
Refer for Further Assessment (Below Cutoff)	18	16%	8	16%
Total Child Screenings	**112**		**50**	

Group Connections (Support Parents): In FY 20-21, the Home Visitation program offered 13 events for parents to connect with each other and with community resources. Each event was offered twice on the same date. One of the sessions was in Spanish and one was in English. On average, 16 parents attended one session of each event. All events were virtual and/or drive-by due to the ongoing pandemic.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Home Visitation Program: Group Connection Topics and Content, FY 20-21

Topics	Activities/Content
Family Fun	Fall Into Crafting Eat, Craft and Give Graduation Celebrations Music and Movement We Love Animals Walk with Us Holiday Cookie Decorating
Family Support	Dream it. Believe it. Do it. Vision Boards Mothers' Day Gifts Special Needs Families' Parent Support Group Family Connections

FY 19-20 Activities and Outcomes

Cope's Parents as Teachers Home Visiting Program supports families in Napa County with a myriad of services. The Prevention and Early Intervention funds support portions of the program related to mental health screenings and referrals and comprise 6% of the total program budget.

Advocacy Work (Coordinate with Mental Health Supports): Work directly with mental health providers to better understand how mental health services are delivered and to educate providers about needs of young families.

- Multidisciplinary Team Meetings: These weekly meetings took place at Cope's offices in FY 19-20 until the Shelter-in-Place order. The team began meeting virtually in April. On average, 14 providers attended to coordinate care for families. Representatives attended from Child Welfare Services, Family Preservation, Public Health, CalWORKs, NEWS, Employment Development, Therapeutic Child Care Center and ParentsCAN as well as mental health providers in private practice.
- Community Organizations Active in Disaster (COAD) Mental Health Subcommittee: The COAD subcommittee meets as indicated depending on the disaster that is being addressed. In FY 19-20, this ranged from weekly to monthly. There are typically 15 providers that attend. The attendees coordinate disaster response to support families and adjust services as indicated to accommodate the mental health needs of families in disasters.
- Community Organizations Active in Disaster (COAD) Housing Subcommittee: Home Visiting staff attend this meetings to educate providers and decisions makers about the mental health impact of housing insecurity and how to address it with families. Staff encourage providers to assist families in the processes needed protect them in retaining their housing and help to reduce families' stress.

Outcomes

Family Centered Assessment and Goal Setting (Screen/Identify Parents):

In FY 19-20, 102 parents of children 0-5 were screened for mental health needs using the Edinburgh Post Natal Depression Scale (EPDS).[32] The EPDS has 10 questions that are scored from 0 to 3. Individuals with a score of 10 or greater are considered to have possible depression. The scale also includes a screening question for suicidal ideation.

[32] More information about the Edinburgh Postnatal Depression Scale can be found here: https://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Home Visitation Program: Parent Screening Scores: Edinburgh Post-Natal Depression Scale, FY 19-20

Edinburgh Scale Score Range and Risk for Post-Partum Depression	Number of Parents	Percentage of Parents
0-9: Minimal Risk	73	72%
10-19: Moderate Risk	28	27%
20 or higher: Highest Risk	1	1%
Total Parent Screenings	**102**	

Child Screening (Screen/Identify Children): In FY 19-20, 216 children were screened using the Ages and Stages Questionnaire (ASQ) and 146 children were screened using the Ages & Stages Questionnaire: Social-Emotional (ASQ:SE)[33]. Of these, 5% were referred for health and developmental services and 7% were referred for mental health supports.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Home Visitation Program: Child Screening
Ages and Stages (ASQ) and Ages and Stages Social Emotional (ASQ-SE) Results, FY 19-20

	ASQ		ASQ-SE	
Result	Number of Children	Percentage of Children	Number of Children	Percentage of Children
Development On Schedule (Above Cutoff)	188	87%	124	85%
Monitor Development (Close to the Cutoff)	18	8%	12	8%
Refer for Further Assessment (Below Cutoff)	10	5%	10	7%
Total Child Screenings	**216**		**146**	

Group Connections (Support Parents): In FY 19-20, the Home Visitation program offered 11 events for parents to connect with each other and with community resources. On average, 16 parents attended each event. The topics address Family Fun, Family Support, Cultural Traditions and Wellness. The events were paused with the Shelter-in-Place Order and resumed virtually in May 2020.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Home Visitation Program: Group Connection Topics and Content, FY 19-20

[33] More information about the Ages and Stages Questionnaires can be found here: https://agesandstages.com/

Topics	Activities/Content
Family Fun	Summer Safety Literacy Pumpkin Patch Field Trip Holiday Celebration Graduation Celebrations
Family Support	Budgeting and Saving Building Resiliency through Self Care Virtual Parent Connections
Cultural Traditions	Traditional Family Recipes
Wellness	Yoga in the Park

These events bring parents together and are one part of supporting families' mental health. The Home Visitation program uses the Healthy Families Parenting Inventory (HFPI)[34] to understand families' needs and how they change over time. Of the nine domains that are assessed, the social support and depression areas are tracked for PEI purposes.

- **Depression Improved**: In FY 19-20, 65% of the 90 parents who completed the depression subscale improved their scores (n=59), and
- **Social Connections Improved:** Of the 91 parents who completed the social connections subscale, 66% improved their scores (n=60).

[34] Brief information about the proprietary HFPI is available here: https://www.lecroymilligan.com/product-page/hfpi-manual.

FY 19-20: Changes due to COVID

- All services were moved to phone and virtual formats. Assessments that would typically be done in person were done over Zoom. For some families this meant everything was being done on their phones.
- The number of contacts that staff had with families after the Shelter-in-Place Order increased. Staff primarily provided emotional support and helped to reduce families' isolation. The number of screenings and referrals for mental health services decreased from March to June 2020 when compared to the average for the first eight months of the fiscal year. Staff reflected on the changed needs of families during this time as families focused on their immediate needs (food, diapers, housing, childcare, school, employment, etc.).

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Home Visitation Program: Mental Health Screenings and Referrals
Prior to COVID, During COVID and Overall, FY 19-20

	Pre COVID (July 19-Feb 20)	During COVID (Mar 20-Jun 20)	Overall FY 19-20
Average Number of Screenings/Month			
Adults	7	3	5
Children	21	14	19
Average Number of Referrals/Month			
Adult	4	2	3
Children	2	0	1

- The Shelter-in-Place Order and the restrictions on gatherings resulted in several parent events being cancelled. Two parent connection meetings were developed for Zoom and offered in May 2020. Offered in English and Spanish, the two meetings hosted an average of seven parents at each event.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Home Visitation Program: Number of Group Connection Events and Attendance
Prior to COVID, During COVID and Overall, FY 19-20

	Pre COVID (July 19-Feb 20)	During COVID (Mar 20-Jun 20)	Overall FY 19-20
Number of Group Connection Events	9	2	11
Average Parent Attendance	18	7	16

Cope Family Center: Strengthening Families

Community Needs Addressed by Program

- Need for mild to moderate mental health supports for parents
- Lack of mental health supports in UpValley communities (from MHSA community planning processes)

FY 20-21: Activities and Outcomes

Outreach: General outreach to families in Napa County that includes mental health resources in addition to other supports (e.g. CalFresh, employment, rent assistance, etc.)

Outreach Activities: In FY 20-21, Cope provided 9 outreach activities online via Zoom due to COVID-19. Participants were primarily the general public and social service providers.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Strengthening Families: Outreach Participants, FY 20-21

Participants	Frequency	Percent
General Public	95	46%
Medical Providers	6	3%
Other Social Service Providers	99	48%
Behavioral Health Providers	8	4%
Total Participants	**208**	

Partnerships: Partnerships with family resources centers in Napa County to identify parents in need of mild to moderate mental health supports.

- Mentis partnered with family resource centers to provide outreach and referral: Cope, Calistoga Family Resource Center, and St. Helena Family Resource Center.
- Mentis had 24 total referrals for the Strengthening Families Groups. Of these referrals, 12 participants engaged for at least one contact.

Screen Parents: Parents are screened for mental health needs by a Resource Specialist.

Parents Screened and Referred: The Resource Specialists at Cope screened families to determine needs. Families were referred to the Triple P Level 4 and Level 5 interventions, the Transitions groups, and/or mental health services in the community based on identified mental health needs.

In FY 20-21, 88 of the parents screened were referred for mental health supports and services including the Level 4 Group (n=36) and the Triple P Family Transitions Program Level 5 (n=24). Referrals to Cope Family Services came from Child Welfare Services (18%), community agencies (16%), the county (10%), family law (9%), online searches/social media (9%), friends (8%) and schools (2%).

Support Parents: In FY 20-21, support was provided to strengthen parenting skills and to address mental health concerns. The Triple P parenting groups were offered by COPE in English and the Healthy Relationships groups were offered in Spanish by Mentis

Cope Family Center offered multiple support program options for parents. In FY 20-21, all parents who were referred to a support program attended at least one session.

Triple P Family Transitions Group (Level 5), Level 4 Group, and Level 4 Standard: *Triple P Family Transitions* support is designed "for parents whose family situation is complicated by problems such as partner conflict, stress or mental health issues."[35] In FY 20-21, four Family Transitions Groups were offered in Napa County using PEI funding; 34 parents participated. Each group was five sessions.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Strengthening Families: Triple P Level 5 Transitions Groups Attendance, FY 20-21

Group Type	Number Enrolled	Average Attendance	Maximum Attendance	Duration
Triple P Level 5 Transitions Group	13	12	13	August to September 2020
Triple P Level 5 Transitions Group	8	8	10	October to December 2020
Triple P Level 5 Transitions Group	5	5	6	January to March 2021
Triple P Level 5 Transitions Group	8	6	7	April to May 2021
Total Participants	**34**			

In FY 20-21, Cope Family Center also supported parents through *Level 4 Groups* in English and Spanish which typically included 5 group sessions and 3 individual sessions. *Level 4 Standard* offered individual support, typically 10 sessions. Five Level 4 groups and two Level 4 Teen Groups (for parents of teens) were offered in FY 20-21. In FY 20-21, 52 parents participated in the Triple P groups. Median attendance was 8 sessions and maximum attendance was 10 sessions.

[35] "Family Transitions Triple P is designed for parents who are experiencing personal distress from separation or divorce, which is impacting on or complicating their parenting…Family Transitions Triple P assists parents who need extra support to adjust and manage the transition of separation or divorce. It focuses on skills to resolve conflicts with former partners and how to cope positively with stress….Parents who benefit from this program are those who have been or are going through separation and divorce where there are unresolved conflicts and difficulties communicating effectively with former partners." *Source: Course Summary provided by program staff.* More information about Triple P Level 5 can be found here: https://www.triplep.net/glo-en/the-triple-p-system-at-work/the-system-explained/level-5/

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Strengthening Families: Triple P Level 4 Attendance, FY 20-21

Group Type	Number Enrolled	Average Attendance	Maximum Attendance	Duration
Triple P Level 4 Group	6	11	12	August to September 2020
Triple P Level 4 Group	5	4	7	October to December 2020
Triple P Level 4 Group	13	5	8	January to March 2021
Triple P Level 4 Group	9	8	8	April to June 2021
Triple P Level 4 Group	3	3	4	April to June 2021
Triple P Level 4 Teen Group	6	7	2	January to March 2021
Triple P Level 4 Teen Group	10	8	2	April to June 2021
Total Participants	**52**			

The **Depression, Anxiety and Stress Scale (DASS-21)**[36] is used to assess the severity of an individual's distress. It includes 21 questions that are scored from zero to three to indicate frequency of the symptoms (never, sometimes, often, almost always). A higher score indicates higher severity.

In FY 20-21, 68 of the 88 participants were able to complete the pre-assessment. Twenty parents declined.

Reduction in Severity of Depression

- The average change on the depression severity subscale was a decrease of two points.
- The changes ranged from an increase of 8 points to a decrease of 18 points. Participants with mild to extremely severe depression experienced the largest decreases in depression.
- Of the 45 parents who completed the pre- and post-assessments, 21 individuals reported a **decrease in depression severity (47%)**, 12 individuals reported increased severity and twelve indicated no change.

[36] More information about the DASS-21 can be found here: http://www2.psy.unsw.edu.au/dass/over.htm and the tool can be found here: https://www.workcover.wa.gov.au/wp-content/uploads/sites/2/2015/07/3.dass21withscoringinfo.pdf

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Cope Family Center: Strengthening Families:
Transitions Groups (Triple P, Level 5), Level 4 Group, Level 4 Teen Group, and Level 4 Standard
Depression Severity (DASS-21 Scores) Pre- and Post-Participation, FY 20-21

		Number of Participants			
		PRE Screening		POST Screening	
Depression Scale Score	Depression Severity	Frequency	Percent	Frequency	Percent
0-9	Normal	41	60%	35	73%
10 to 13	Mild	5	7%	6	13%
14 to 20	Moderate	15	22%	6	13%
21 to 27	Severe	3	4%	1	2%
28+	Extremely Severe	4	6%	0	0%
	Total Participants	**68**		**48**	

Reduction in Severity of Anxiety

- The average change on the anxiety severity subscale was a decrease of two points.
- The changes ranged from an increase of ten points to a decrease of 12 points.
- Of the 45 parents who completed the post-assessment, 24 individuals reported a **decrease in anxiety severity (53%)**, 11 individuals reported increased severity and 10 indicated no change.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Cope Family Center: Strengthening Families
Transitions Groups (Triple P, Level 5), Level 4 Group, Level 4 Teen Group, and Level 4 Standard
Anxiety Severity (DASS-21 Scores) Pre- and Post-Participation, FY 20-21

		Number of Participants			
		PRE Screening		POST Screening	
Anxiety Scale Score	Anxiety Severity	Frequency	Percent	Frequency	Percent
0-7	Normal	37	54%	32	67%
8 to 9	Mild	4	6%	1	2%
10 to 14	Moderate	11	16%	9	19%
15 to 19	Severe	4	6%	2	4%
20+	Extremely Severe	12	18%	4	8%
	Total Participants	**68**		**48**	

Reduction in Stress Severity

- The average change for the stress severity scale was a decrease of four (4) points.
- The changes ranged from an increase of 10 points to a decrease of 10 points.
- Of the 45 parents who completed the post-assessment, 25 individuals reported a **decrease in stress severity (56%)**, 11 individuals reported increased severity and 9 indicated no change.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Cope Family Center: Strengthening Families
Transitions Groups (Triple P, Level 5), Level 4 Group, Level 4 Teen Group, and Level 4 Standard
Stress Severity (DASS-21 Scores) Pre- and Post-Participation, FY 20-21

		Number of Participants			
		PRE Screening		POST Screening	
Stress Scale Score	Stress Severity	Frequency	Percent	Frequency	Percent
0-14	Normal	39	57%	38	79%
15 to 18	Mild	6	9%	4	8%
19 to 25	Moderate	13	19%	6	13%
26 to 33	Severe	7	10%	0	0%
34+	Extremely Severe	3	4%	0	0%
	Total Participants	**68**		**48**	

Healthy Relationships Groups

Healthy Relationship groups were offered by Mentis in Spanish to parents in Napa County. In FY 20-21, 28 parents participated in three Healthy Relationships sessions. Typically, the groups consist of eight sessions each and take place in community locations, during COVID all supports were done individually.

Decrease in Symptoms of Mental Health Distress

Mentis uses the **Emotional Rating Scale**[37] for individuals to self-report their mental health symptoms at the beginning and end of services. Individuals rated five areas on a scale of 0 to 4. Higher scores mean the individual was experiencing more symptoms, and a decrease in the score means a reduction in symptoms. The maximum score is 20. In FY 20-21, the ERS scores decreased after participation for all participants who completed a pre and post scale (n=14).

- The average change in ERS score was a decrease of 3 points.
- The minimum change was an increase of 2 points.
- The maximum change was a decrease of 10 points.

[37] The Emotional Rating Scale is a validated mental health symptom scale developed by Mentis. For more information, contact Rob Weiss, Executive Director, at Mentis: rweiss@mentis.org.

The results are presented below by quartile to illustrate the changes that individuals reported. At the beginning of the group, over half reported scores that were in the two highest quartiles, by the end of the group only 20% remained in these two groups.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Strengthening Families: Healthy Relationship Groups
Mental Health Symptoms (ERS scores) Pre- and Post-Participation, FY 20-21

	Number of Participants			
	PRE Screening		POST Screening	
Emotional Rating Scale (ERS) Score	Frequency	Percent	Frequency	Percent
0 to 5	8	31%	7	47%
6 to 10	7	27%	5	33%
11 to 15	8	31%	2	13%
16 to 20	3	12%	1	7%
Total Participants	**26**		**15**	

Decrease in Depression Severity

The **PHQ-9**[38] is a screening tool used to diagnose depression and assess the severity of symptoms. It consists of nine questions that are scored from 0 to 3 to indicate the frequency of symptoms. In FY 20-21, the depression severity decreased after participation for all participants who completed a pre and post screener (n=11). At the pre-screening, three (3) individuals (12%) indicated moderately severe to severe depression. At the post-screening, no participants scored in these categories.

- The average change in the PHQ-9 scores was a decrease of six points.
- The minimum change in score was a decrease of one point.
- The maximum change in score was a decrease of 19 points.

[38] More information about the PHQ-9 can be found here: https://www.phqscreeners.com/select-screener

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Strengthening Families: Healthy Relationship Groups
Depression Severity (PHQ-9 Scores) Pre- and Post-Participation, FY 20-21

		Number of Participants			
		PRE Screening		POST Screening	
PHQ-9 Score	Depression Severity	Frequency	Percent	Frequency	Percent
0-4	None-Minimal	3	13%	8	62%
5 to 9	Mild	14	58%	4	31%
10 to 14	Moderate	4	17%	1	8%
15 to 19	Moderately Severe	2	8%	0	0%
20-27	Severe	1	4%	0	0%
	Total Participants	**24**		**13**	

Referrals: In FY 20-21, Cope referred 46 individuals and Mentis referred 12 individuals to more intensive mental health treatment. These 58 individuals were primarily referred to HHSA or to Mental Health Plan providers.

FY 19-20: Activities and Outcomes

Outreach: In FY 19-20, Cope provided 20 outreach activities ranging from tours of the Cope agency offices (10%) to presenting to local providers (45%) and tabling at community events (45%). One event was held in American Canyon; the rest took place within the City of Napa (95%). The outreach events ceased in March 2020 after the Shelter in Place Order. In the first three quarters of the fiscal year, Cope reached more than 2,155 participants. In the fourth quarter, staff designed new outreach to be delivered virtually in FY 20-21.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Strengthening Families: Outreach Participants, FY 19-20

Participants	Frequency	Percent
General Public	1,807	84%
Medical Providers	75	3%
Other Social Service Providers	50	2%
Faith Leaders	40	2%
Behavioral Health Providers	8	0%
Other	175	8%
Total Participants	**2,155**	

Screen Parents: The Resource Specialists at Cope screened families to determine needs. Families were referred to the Triple P Level 4 and Level 5 interventions and the Healthy Relationships groups and/or mental health services in the community based on identified mental health needs. In FY 19-20, 69 of the parents screened were referred for mental health supports and services including the Triple P Family Transitions Program Level 5 (44 parents) and the Healthy Relationships Group (37 parents). Overall, mental health referrals made up 16% of all the referrals given to parents during the fiscal year.

Support Parents: Cope and Mentis provided groups for parents to strengthen their parenting skills and to address mental health concerns. Cope offers Triple P Level 5 Group also known as Family Transitions group. Mentis offers Healthy Relationships groups. In FY 19-20, the Family Transitions groups were offered in English and the Healthy Relationships groups were offered in Spanish.

Triple P Family Transitions Group (Level 5)

Triple P Family Transitions support is designed "for parents whose family situation is complicated by problems such as partner conflict, stress or mental health issues."[39] In FY 19-20, two Family Transitions Groups were offered in Napa County using PEI funding, both were held at Cope Family Center and 18 parents participated. Each group is five sessions.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Strengthening Families: Triple P Level 5 Transitions Groups Attendance, FY 19-20

Location	Number Enrolled	Average Attendance	Maximum Attendance	Duration
Cope Family Center	12	10	12	July to September 2019
Cope Family Center	6	6	6	September to November 2019

The **Depression, Anxiety and Stress Scale (DASS-21)**[40] is used to assess the severity of an individual's distress. It includes 21 questions that are scored from zero to three to indicate frequency of the symptoms (never, sometimes, often, almost always). A higher score indicates higher severity. In FY 19-20, Seventeen of the eighteen participants were able to complete the pre-assessment. One parent declined.

Reduction in Severity of Depression

- The average change on the depression severity subscale was a decrease of five (5) points.
- The changes ranged from an increase of twelve points to a decrease of 22 points.
- Of the fourteen parents who completed the post-assessment, ten individuals reported a **decrease in depression severity (71%)**, two individuals reported increased severity and two indicated no change.

[39] "Family Transitions Triple P is designed for parents who are experiencing personal distress from separation or divorce, which is impacting on or complicating their parenting…Family Transitions Triple P assists parents who need extra support to adjust and manage the transition of separation or divorce. It focuses on skills to resolve conflicts with former partners and how to cope positively with stress….Parents who benefit from this program are those who have been or are going through separation and divorce where there are unresolved conflicts and difficulties communicating effectively with former partners." *Source: Course Summary provided by program staff.* More information about Triple P Level 5 can be found here: https://www.triplep.net/glo-en/the-triple-p-system-at-work/the-system-explained/level-5/

[40] More information about the DASS-21 can be found here: http://www2.psy.unsw.edu.au/dass/over.htm and the tool can be found here: https://www.workcover.wa.gov.au/wp-content/uploads/sites/2/2015/07/3.dass21withscoringinfo.pdf

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Strengthening Families: Transitions Groups (Triple P, Level 5)
Depression Severity (DASS-21 Scores) Pre- and Post-Participation, FY 19-20

		Number of Participants			
		PRE Screening		POST Screening	
Depression Scale Score	Depression Severity	Frequency	Percent	Frequency	Percent
0-4	Normal	6	35%	8	57%
5 to 6	Mild	1	6%	0	0%
7 to 10	Moderate	2	12%	0	0%
11 to 13	Severe	0	0%	1	7%
14+	Extremely Severe	8	47%	5	36%
	Total Participants	**17**		**14**	

Reduction in Severity of Anxiety

- The average change on the anxiety severity subscale was a decrease of four (4) points.
- The changes ranged from an increase of four points to a decrease of 18 points.
- Of the fourteen parents who completed the post-assessment, nine individuals reported a **decrease in anxiety severity (64%)**, two individuals reported increased severity and three indicated no change.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Strengthening Families: Transitions Groups (Triple P, Level 5)
Anxiety Severity (DASS-21 Scores) Pre- and Post-Participation, FY 19-20

		Number of Participants			
		PRE Screening		POST Screening	
Anxiety Scale Score	Anxiety Severity	Frequency	Percent	Frequency	Percent
0-3	Normal	4	24%	3	21%
4 to 5	Mild	1	6%	3	21%
6 to 7	Moderate	1	6%	0	0%
8 to 9	Severe	0	0%	2	14%
10+	Extremely Severe	11	65%	6	43%
	Total Participants	**17**		**14**	

Reduction in Stress Severity

- The average change for the stress severity scale was a decrease of five (5) points.
- The changes ranged from an increase of six points to a decrease of 14 points.
- Of the fourteen parents who completed the post-assessment, nine individuals reported a **decrease in stress severity (64%)**, two individuals reported increased severity and three indicated no change.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Strengthening Families: Transitions Groups (Triple P, Level 5)
Stress Severity (DASS-21 Scores) Pre- and Post-Participation, FY 19-20

		Number of Participants			
		PRE Screening		POST Screening	
Stress Scale Score	Anxiety Severity	Frequency	Percent	Frequency	Percent
0 to 7	Normal	2	12%	6	43%
8 to 9	Mild	0	0%	2	14%
10 to 12	Moderate	3	18%	1	7%
13 to 16	Severe	3	18%	2	14%
17+	Extremely Severe	9	53%	3	21%
	Total Participants	**17**		**14**	

Healthy Relationships Groups

Healthy Relationship groups were offered in Spanish to parents in Napa County. In FY 19-20, 40 parents participated in three Healthy Relationships groups. Typically, the groups consisted of eight sessions each and take place in community locations.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Strengthening Families: Healthy Relationship Group Attendance, FY 19-20

Location	Number Enrolled	Average Attendance	Maximum Attendance	Duration
Von Brandt Center, Napa	9	8	9	July to August 2019
Up Valley Family Centers: Calistoga	19	15	19	September to November 2019
Up Valley Family Centers: St Helena	5	4	5	September to October 2019
Online	7	n/a	n/a	April 2020 to June 2020

Decrease in Symptoms of Mental Health Distress

Mentis uses the **Emotional Rating Scale**[41] for individuals to self-report their mental health symptoms at the beginning and end of services. Individuals rated five areas on a scale of 0 to 4. Higher scores mean the individual was experiencing more symptoms, and a decrease in the score means a reduction in symptoms. The maximum score is 20. In FY 19-20, the ERS scores decreased after participation for all participants who completed a pre and post scale (n=27).

- The average change in ERS score was a decrease of 5 points.
- The minimum change was a decrease of 2 points.
- The maximum change was a decrease of 9 points.

The results are presented below by quartile to illustrate the changes that individuals reported. At the beginning of the group, over half reported scores that were in the two highest quartiles, by the end of the group only 7% remained in these two groups.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Strengthening Families: Healthy Relationship Groups
Mental Health Symptoms (ERS scores) Pre- and Post-Participation, FY 19-20

	Number of Participants			
	PRE Screening		POST Screening	
Emotional Rating Scale (ERS) Score	Frequency	Percent	Frequency	Percent
0 to 5	2	7%	12	44%
6 to 10	9	32%	13	48%
11 to 15	11	39%	2	7%
16 to 20	6	21%	0	0%
Total Participants	**28**		**27**	

[41] The Emotional Rating Scale is a validated mental health symptom scale developed by Mentis. For more information, contact Rob Weiss, Executive Director, at Mentis: rweiss@mentis.org.

Decrease in Depression Severity

The **PHQ-9**[42] is a screening tool used to diagnose depression and assess the severity of symptoms. It consists of nine questions that are scored from 0 to 3 to indicate the frequency of symptoms. In FY 19-20, the depression severity decreased after participation for all participants who completed a pre and post screener (n=26). At the pre-screening, 16 individuals (54%) indicated moderately severe to severe depression. At the post-screening, no participants scored in these categories.

- The average change in the PHQ-9 scores was a decrease of eight points.
- The minimum change in score was a decrease of two points.
- The maximum change in score was a decrease of twelve points.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Strengthening Families: Healthy Relationship Groups
Depression Severity (PHQ-9 Scores) Pre- and Post-Participation, FY 19-20

		Number of Participants			
		PRE Screening		POST Screening	
PHQ-9 Score	Depression Severity	Frequency	Percent	Frequency	Percent
0-4	None-Minimal	2	7%	2	8%
5 to 9	Mild	2	7%	14	54%
10 to 14	Moderate	8	29%	10	38%
15 to 19	Moderately Severe	12	43%	0	0%
20-27	Severe	4	14%	0	0%
	Total Participants	**28**		**26**	

[42] More information about the PHQ-9 can be found here: https://www.phqscreeners.com/select-screener

FY 19-20: Changes due to COVID

- The outreach efforts done by Cope were paused as events and gatherings were restricted. Staff used the remainder of FY 19-20 to prepare outreach formats for FY 20-21.
- The screening and referral processes done by Cope were all moved to phone conversations. These meetings had previously been done using a combination of phone and in person conversations.
- Strengthening Families was able to engage families who were previously unable to attend in-person services, including families living in more remote locations and/or without transportation. Staff used this information to plan for future services and anticipate offering a hybrid of in-person and virtual services to continue make services accessible.
- The Healthy Relationship groups shifted to online individual sessions rather than group in person sessions.
- Two individuals received nine sessions of the Healthy Relationships interventions (the standard is eight sessions) due to the shift to individual sessions.

NEWS: Kids Exposed to Domestic Violence (KEDS)

Community Needs Addressed by Program

- Children exposed to domestic violence are at risk of developing PTSD and/or poor mental health outcomes.
- Need for Trauma Informed supports for children in response to domestic violence

FY 20-21: Activities and Outcomes

Community Engagement: The KEDS Collaborative generally meets every other month to promote system-wide understanding of how the trauma of domestic violence impacts children and the services available. Members learn about Trauma Informed responses and share information about resources for children exposed to domestic violence. Agencies are encouraged to refer children to KEDS for support.

- **KEDS Collaborative:** Sixteen organizations participated in the KEDS Collaborative to learn about how domestic violence impacts children and to share resources. In FY 20-21, they were able to meet six times. The number of agencies attending stayed steady at an average of 12 and three new members attended each meeting on average. Overall attendance averaged 25 attendees (18 being the lowest, 32 the highest).

  Presenters were invited each month to provide information about access to their agency's resources, specifically for children who have experienced domestic violence. In FY 20-21, presenters included:

  - Napa County Public Health
  - Family Violence Appellate Projects
  - North Bay Regional Center – Napa
  - NEWS Prevention, Education & Outreach
  - School Wellness Program
  - Courage Center
  - Monarch Justice Center

- **Referrals:** In FY 20-21, KEDS received referrals from other programs within NEWS (48%) and from five other agencies. All of the referring agencies participated in the KEDS Collaborative.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Kids Exposed to Domestic Violence (KEDS) Program
Comparison of Attendance at KEDS Collaborative and Referrals to KEDS Program by Agency, FY 20-21

	Attendance at KEDS Collaborative		Referrals to KEDS Program	
Referring Agency	**Frequency**	**Percent**	**Frequency**	**Percent**
NEWS *(Housing, Legal, and Sexual Assault Programs)*	6	100%	56	48%
Napa Police Department	4	67%	41	35%
Napa County Child Welfare Services	6	100%	6	5%
ParentsCAN	6	100%	6	5%
Napa County Public Health (HHSA)	6	100%	4	3%
Cope	6	100%	6	5%
Totals	**6 Meetings**		**116 Referrals**	

Outreach: KEDS staff provided outreach to parents about the signs and symptoms of mental illness and the impact of domestic violence on children's mental health.

- **Intake for NEWS services:** Upon beginning services with NEWS, parents receive information about the mental health impact of domestic violence on children. In FY 20-21, this information was shared with 170 parents at the intake meeting.[43]

KEDS staff also **participated in community events and offered presentations to community groups** about the signs and symptoms of mental illness and the impact of domestic violence on mental health. In FY 20-21, KEDS staff:

- Participated in a back-to-school event and a support group reaching out to 43 parents in person.
- Presented on KEDS/Mental Health at three family resource centers and NVUSD staff reaching a total of 44 social service providers via Zoom.

[43] A brochure is distributed to parents at the intake meeting. The KEDS program's goals and services are also included on the NEWS website: https://www.napanews.org/resources/kids.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Kids Exposed to Domestic Violence (KEDS) Program
Community Outreach Contacts, FY 20-21

Type of Outreach	Outreach Contacts	Frequency	Percent
Zoom	Social Service Providers	44	51%
In-Person	Parents	43	49%
	Total Outreach Contacts	**87**	

Social Media Outreach

KEDS staff also continued to do outreach using social media and reported reaching over 50,000 users a month with these efforts.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Kids Exposed to Domestic Violence (KEDS) Program
Number of Followers, Estimated Reach and Engagement Social Media Outreach, FY 20-21

	Facebook (English)	Facebook (Spanish)	Instagram	Twitter
Number of Followers	2,393	115	346	32
Estimated Reach (Average Month)	42,425	n/a	10,131	n/a
Engagement (Average Month)	7,521	n/a	1,549	20

Support Children

Advocacy: KEDS staff advocated in the schools on behalf of the children served by NEWS in the community. Staff talked with school staff, counselors, and teachers to identify supports the children may need to be successful at school and to ensure children have wraparound support from school staff. In FY 20-21, 170 children and youth received this support.

Support Groups: The KEDS program provided weekly support groups for 139 children and youth in FY 20-21. The KEDS staff designed each group to emphasize self-regulation, self-worth/self-esteem, and healthy relationships. During the groups, children and youth completed craft and art projects and learned coping skills.

- Projects include dream catchers, self-portraits, collage, mini-gardens, and journals.
- Coping skills include meditative breathing and mindfulness, positive self-talk, setting boundaries, journaling, and exercise.

In FY 20-21, support groups were online and there was limited attendance. The virtual groups had an average of two to three attendees at each session.

Staff centered the support groups around a variety of topics to teach coping skills and strategies. The most common topic was Deep Breathing/Meditation/Mindfulness.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Kids Exposed to Domestic Violence (KEDS) Program
Support Group Topics, FY 20-21

	Frequency of Topic by Age Group			Percent of
Support Group Topic	**Children age 5-12**	**Youth age 13-17**	**Overall**	**Support Groups**
Deep Breathing/Meditation/Mindfulness	4	6	10	19%
Emotional Awareness/Coloring	7	2	9	17%
Journaling	1	5	6	12%
Setting Boundaries	2	2	4	8%
Self-Reflection	3	1	4	8%
Positive Affirmations	2	1	3	6%
Positive Self-Talk	1	2	3	6%
Communication	0	3	3	6%
Reframing	2	0	2	4%
Building Support Networks	2	0	2	4%
Teamwork/Problem Solving	1	1	2	4%
Exercise	1	1	2	4%
Gratitude	0	1	1	2%
Stress Ball	0	1	1	2%
Other	7	0	7	13%
Total Support Group Sessions	**28**	**24**	**52**	

In FY 20-21, 100 children and youth had attended the previous support group session and were able to respond with a show of hands to questions about the coping skill they learned.

- 91% of the participants in the community groups reported they **liked the coping strategy** they had learned in the previous session.
- 80% had **used the coping strategy**
- 68% had **shared the strategy** with their family

Mental Health Support: To screen for mental health concerns, the NEWS staff talked with the parent during the intake process. The behavioral, social, emotional & psychological, and cognitive impacts of domestic violence on children were reviewed and the parent was asked if they noticed any of the concerns in their children. Children were referred to mental health services as parents identified concerns.

FY 19-20: Activities and Outcomes

Community Engagement: The KEDS Collaborative generally meets every other month to promote system-wide understanding of how the trauma of domestic violence impacts children and the services available. Members learn about Trauma Informed responses and share information about resources for children exposed to domestic violence. Agencies are encouraged to refer children to KEDS for support.

- **KEDS Collaborative:** Fourteen organizations participated in the KEDS Collaborative to learn about how domestic violence impacts children and to share resources. In FY 19-20, they were able to meet three times. After moving the meetings to Zoom due to the Shelter-in-Place Order, the number of agencies attending, and overall attendance increased from the first quarter.

  Presenters were invited each month to provide information about access to their agency's resources specifically for children who have experienced domestic violence. In FY 19-20, presenters included:

  - **Abode Services** discussing housing options for families beyond the NEWS housing resources.
  - **PACT Adoption Alliance**, an agency specializing in "creating strong, loving adoptive families for children of color."[44]
  - **Bay Area Crisis Nursery** which provides emergency child care for children age birth to 5 years old.

- **Referrals:** In FY 19-20, KEDS received referrals from other programs within NEWS (56%), and from four other agencies. All of the agencies participate in the KEDS Collaborative. The Napa Police Department was the most frequent source of outside referrals in part due to a NEWS staff person working within the department to support families as they are identified.

[44] For more information: https://www.pactadopt.org/app/servlet/HomePage

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Kids Exposed to Domestic Violence (KEDS) Program
Comparison of Attendance at KEDS Collaborative and Referrals to KEDS Program by Agency, FY 19-20

	Attendance at KEDS Collaborative		Referrals to KEDS Program	
Referring Agency	**Frequency**	**Percent**	**Frequency**	**Percent**
NEWS *(Housing, Legal, and Sexual Assault Programs)*	3	100%	54	56%
Napa Police Department	1	33%	21	22%
Napa County Child Welfare Services	3	100%	13	14%
Cope	3	100%	4	4%
Napa County Public Health (HHSA)	3	100%	4	4%
Totals	**3 Meetings**		**96 Referrals**	

Outreach: KEDS staff provided outreach to parents about the signs and symptoms of mental illness and the impact of domestic violence on children's mental health at the NEWS office when parents began seeking services and at the family shelter when parents stayed at the shelter.

- **Intake for NEWS services:** Upon beginning services with NEWS, parents receive information about the mental health impact of domestic violence on children. In FY 19-20, this information was shared with 116 parents at the intake meeting.[45]
- **Family Support at Shelter:** NEWS operated a shelter for families who were seeking safety from domestic violence. Staff at the shelter shared information about how domestic violence impacts children's mental health with the families each day as they went about their routines. In FY 19-20, 18 families were able to use the shelter and stayed for an average of 21 days, resulting in a total of 376 outreach contacts. During the Shelter-in-Place Order this support took place by phone as families were housed in other settings.

KEDS staff also **participated in community events and offered presentations to community groups** about the signs and symptoms of mental illness and the impact of domestic violence on mental health.

- In FY 19-20, KEDS staff participated in several resource fairs and did specific outreach to educators, parents, families and behavioral health providers. The largest event, Dia de la Familia, in July 2019 resulted in 79% of the program's total outreach contacts in the community.

[45] A brochure is distributed to parents at the intake meeting. The KEDS program's goals and services are also included on the NEWS website: https://www.napanews.org/resources/kids.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Kids Exposed to Domestic Violence (KEDS) Program
Community Outreach Contacts, FY 19-20

Outreach Contacts	Frequency	Percent
General Public	2,000	79%
K-12 educators	200	8%
College and university educators	50	2%
Behavioral Health Providers	40	2%
Parents	82	3%
Students	166	7%
Total Outreach Contacts	**2,538**	

Support Children

Advocacy: KEDS staff advocated in the schools on behalf of the children served by NEWS in the community and at the shelter. Staff talked with school staff, counselors, and teachers to identify supports the children may need to be successful at school and to ensure children have wraparound support from school staff. In FY 19-20, 154 children and youth received this support.

Support Groups: The KEDS program provided 37 weekly support groups for 42 children and youth in FY 19-20. The KEDS staff designed each group to emphasize self-regulation, self-worth/self-esteem and healthy relationships. During the groups, children and youth completed craft and art projects and learned coping skills.

- Projects include dream catchers, self-portraits, collage, mini-gardens, and journals.
- Coping skills include self-soothing, positive self-talk, setting boundaries and exercise.

Children and youth who were staying at NEWS' family shelter participated at the shelter location, those who were staying outside of the shelter were invited to participate at a community location. In FY 19-20, support groups were generally offered weekly until the third quarter when the Shelter-in-Place Order took effect. Given the capacity of the shelter, the groups held there had an average of three children/youth attending each session. The community groups were larger with an average of 13 children/youth at each session. The attendance was relatively equally distributed across the first three quarters, no groups were held in the fourth quarter.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Kids Exposed to Domestic Violence (KEDS) Program
Support Group Sessions and Attendance Overall and by Location, FY 19-20

		Location			
		Shelter		Community	
Criteria	Overall	Frequency	Percent	Frequency	Percent
Number of Sessions	37	13	35%	24	65%
Number of Children/Youth Attending[46]	345	33	10%	312	90%

Staff centered the support groups around a variety of topics to teach coping skills and strategies. The most common topic was Positive Self-Talk. Most strategies were used in both the shelter and community groups.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Kids Exposed to Domestic Violence (KEDS) Program
Support Group Topics, FY 19-20

	Frequency of Topic			Percent of Topic
Support Group Topic	Shelter	Community	Overall	Overall
Positive Self Talk	3	5	8	21%
Self-Affirmations	1	5	6	16%
Family Bonding/ Communication	1	4	5	13%
Healthy Communication Strategies	2	3	5	13%
Setting Boundaries	3	2	5	13%
Stress Ball-stress relief	1	3	4	11%
Exercise	1	2	3	8%
Distraction (games)	1	0	1	3%
Self-Soothing	1	0	1	3%
Total Support Group Sessions	**14**	**24**	**38**	**100%**

The KEDS staff shared a meal with the children/youth prior to each community session. During this meal, KEDS staff asked participants about the coping strategies they learned in the previous week. The conversations were used to evaluate how the strategies were received and integrated. In FY 19-20, 243 children/youth had attended the previous session and were able to respond. This data was not collected for the children/youth who participated at the shelter.

- 91% of children/youth in the community groups reported they **liked the coping strategy** they had learned in the previous session.
- 79% had **used the coping strategy**
- 73% had **shared the strategy** with their family

[46] This is a duplicated count of participants. Some children/youth participate in several support groups. Attendance is reported for each group, but individual participants are not tracked. On average, each child attended eight groups during the fiscal year (345 total attendance/42 youth).

Mental Health Support: To screen for mental health concerns, the NEWS staff talked with the parent during the intake process. The behavioral, social, emotional & psychological and cognitive impacts of domestic violence on children were reviewed and the parent was asked if they noticed any of the concerns in their children. Children were referred to mental health services as parents identify concerns.

FY 19-20: Changes due to COVID

- KEDS collaborative meeting was moved to Zoom in May 2020.
- Fewer families chose to use the shelter due to COVID. Parent outreach moved to phone calls as families chose alternative housing options.
- The support groups for children were suspended. They began again on Zoom in July 2020.
- KEDS staff shifted outreach to social media when events were cancelled. Outreach information was posted to the agency's four social media accounts to reach parents and the broader community.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Kids Exposed to Domestic Violence (KEDS) Program
Number of Followers, Estimated Reach and Engagement Social Media Outreach, FY 19-20

	Facebook (English)	Facebook (Spanish)	Instagram	Twitter
Number of Followers	1,843	115	133	24
Estimated Reach (Average Month)	186,782	n/a	n/a	n/a
Engagement (Average Month)	8,126	n/a	n/a	n/a

Early Intervention

Early Intervention programs are intended to serve populations who have higher risks for mental health concerns and to provide early treatment to address risks and symptoms. Two of the nine programs were funded to provide Early Intervention Services.

Overview

The Early Intervention programs focus on identifying individuals with mental health concerns and providing them with immediate supports.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Overview of Early Intervention Programs: Population Served and Activities

Agency: Program	Population Served	Outreach	Mental Health Screenings and Referrals	Mental Health Services and Supports
Napa County Office of Education: Court and Community Schools Student Assistance Program	Students in 9th to 12th grade	*(not funded by PEI in FY 19-20)*	PHQ-9	Social Worker and Intervention Specialist support students with identified mental health concerns.
Mentis: Healthy Minds, Healthy Aging	Older Adults	Presentations to older adults, caregivers and agencies on topics related to Older Adults and Mental Health.	PHQ-9, SF-12v2™	Case Management and Therapy services offered to all participants.

Outcomes

The Early Intervention programs track mental health outcomes for participants. The programs reported the following outcomes:

- Improved mental health and reduced severity of depression
- Improved quality of life for older adults

Napa County Office of Education (NCOE): Court and Community Schools Student Assistance Program

Community Needs Addressed by Program

- Social emotional needs of youth are not addressed in traditional academic curriculum.
- Student success relies on students feeling safe and having the social emotional skills to learn.
- Schools are a common place where students' social emotional needs are identified but often have few resources to serve these needs.

FY 20-21: Activities and Outcomes

Screening for Mental Health Concerns: All students were evaluated at intake for mental health concerns and if indicated were assessed using the Patient Health Questionnaire: Depression Module (PHQ-9).[47] In FY 20-21, 107 students were evaluated by the NCOE Social Worker. Of these, 42% reported symptoms of mild to severe depression.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Court and Community Schools Student Assistance Program
PHQ-9 Depression Assessment at Intake, FY 20-21

PHQ-9 Risk Category	Frequency	Percent
Minimal Depression	58	54%
Mild Depression	27	25%
Moderate Depression	12	11%
Moderately Severe Depression	4	4%
Severe Depression	1	1%
Not Available or Refused	5	5%
Total Students Assessed	**107**	**100%**

Mental Health Supports and Services were offered to students by the NCOE Social Worker and/or the Intervention Coordinator. Students were also referred for mental health services with other on site and community mental health providers.

The NCOE Social Worker and Interventions Coordinator supported 84 students (78%) during FY 20-21, and 3 individuals were referred to outside mental health services.

- In FY 20-21, 84 students participated in support visits.
  - 45% with the Social Worker (211 visits)
  - 55% with the Interventions Coordinator (248 visits)
- As in 19-20, the second half of the fiscal year contributed far more support visits (77% of total visits) than the first half.

[47]More information about the Patient Health Questionnaire (PHQ-9) can be found here: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1495268/

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Court and Community Schools Student Assistance Program
Number of Support Visits, by Quarter, FY 20-21

Quarter	Frequency	Percent
Q1: Aug-Sept	8	2%
Q2: Oct-Dec	99	21%
Q3: Jan-Mar	145	31%
Q4: Apr-Jun	215	46%
Total Support Visits	**467**	**100%**

Outcomes

Improved Behavior: Refocus room data was not tracked in FY 20-21. The space was not available due to social distancing and COVID guidelines.

Improved Mental Health: Very few students were able to complete a second PHQ-9 assessment at the end of the school year due to COVID restrictions. For those that did (n=17), 16 of 17 students (94%) had lower assessment scores indicating a decrease in mental health symptoms.

FY 19-20: Activities and Outcomes

Screening for Mental Health Concerns: In FY 19-20, 143 students were evaluated by the NCOE Social Worker. Of these, 30% reported mild to severe depression when assessed using the PHQ-9.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Court and Community Schools Student Assistance Program
PHQ-9 Depression Assessment at Intake, FY 19-20

PHQ-9 Risk Category	Frequency	Percent
Minimal Depression	44	31%
Mild Depression	22	15%
Moderate Depression	11	8%
Moderately Severe Depression	7	5%
Severe Depression	3	2%
Not Screened	56	39%
Total Students Assessed	**143**	

Mental Health Supports and Services: The NCOE Social Worker and/or the Interventions Coordinator supported 85 students (60%) during FY 19-20, and 10 individuals (7%) were referred to outside mental health services.

- In FY 19-20, 85 students participated in 2,107 support visits.
    - 44% with the Social Worker (931 visits)
    - 56% with the Interventions Coordinator (1,176 visits)

- The staff more than doubled the number of support visits in the second half of the fiscal year.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Court and Community Schools Student Assistance Program
Number of Support Visits, by Quarter, FY 19-20

Quarter	Frequency	Percent
Q1: Aug-Sept	240	11%
Q2: Oct-Dec	377	18%
Q3: Jan-Mar	844	40%
Q4: Apr-Jun	646	31%
Total Support Visits	**2,107**	

- The fifteen students who were able to complete services while still on campus received mental health services and supports for an average of four months (range: two to seven months).

Improved Behavior: The refocus room is a separate space on the school campus where students can take time to remember their goals, calm down and try again. It is furnished with comfortable furniture and staffed with a classroom aide who checks in with each student who comes in. It also has offices for the intervention staff, probation, and the school resource officer. Students can use those supports as needed. The mental health supports, and services are intended to decrease the number of times individuals are referred to the refocus room by staff due to classroom behavior.

In FY 19-20, staff planned to track the number of times students who received mental health services and supports were referred to the refocus room one month prior to beginning services and again for the last month of services. Data on the use of the refocus room during the last month of services was not available for 70 of the 85 students receiving mental health supports. Due to the Shelter-in-Place Order in March 2020, students were not on campus and did not have access to the resource.

With the small sample of students who were able to complete the interventions prior to the Shelter-in-Place Order, the data suggests that the number of visits remained relatively stable.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Court and Community Schools Student Assistance Program
Use of Refocus Room, Prior to Services and During Last Month of Services, FY 19-20

	One Month Prior to Mental Health Services and Supports		Last Month of Mental Health Services and Supports	
Number of Referrals to Refocus Room	**Frequency**	**Percent**	**Frequency**	**Percent**
0	59	69%	10	67%
1	11	13%	2	13%
2	7	8%	0	0%
3	5	6%	1	7%
4	2	2%	1	7%
5	1	1%	0	0%
6	0	0%	1	7%
Total Students	**85**		**15**	

Improved Mental Health

Very few students were able to complete a second PHQ-9 assessment at the end of the school year due to COVID restrictions. Though post data was collected, the scores are not reported due to the small sample size (n<10).

FY 19-20: Changes due to COVID

- Staff reported an increase in their contacts with students and families due to the Shelter-in-Place Order. Staff suggested that the increased needs due to COVID made families more likely to accept services to find resources.
- The refocus room data will not be tracked in FY 20-21. The space is not available due to social distancing and COVID guidelines.

Mentis: Healthy Minds, Healthy Aging (HMHA)

Community Needs Addressed by Program

- Older adults face specific age-related challenges to access and to utilize behavioral health services.
- Older adults have high rates of depression (15%-30%), high anxiety rates (20%) as well as higher prevalence of suicide, abuse of alcohol and misuse of drugs.

FY 20-21: Activities and Outcomes

Activities

Outreach: In FY 20-21, the Healthy Minds, Healthy Aging program provided 11 outreach activities to seniors, caregivers, and providers on a variety of topics. Most events were virtual due to shelter-in-place and high COVID infection rates. As viewed below, the pandemic significantly affected outreach activities.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Healthy Minds, Healthy Aging
Method/Location of Outreach Events, FY 20-21

	Outreach Events	
Location	**Frequency**	**Percent**
Virtual	8	73%
Telephone	1	9%
St. Helena	0	0%
Calistoga	1	9%
Napa	1	9%
Total	**11**	**100%**

Of the outreach topics, about half were focused on Question Persuade Refer (QPR) Training (46%). Other topics were focused on COVID anxiety and support, the newly developed warmline, a resource and a health fair, and body and brain health.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Healthy Minds, Healthy Aging
Outreach Topics, FY 20-21

Outreach Topic	Frequency	Percent
Body/Brain Health	1	9%
Health Fair/Stress	1	9%
COVID Anxiety and Support	2	18%
QPR Training	5	46%
Resource Fair	1	9%
Warmline	1	9%
Total	**11**	**100%**

During FY 20-21, staff focused on activities for seniors, their caregivers, and social service providers. Only 5% of all participants were members of the general public.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Healthy Minds, Healthy Aging
Outreach Participants, FY 20-21

Participants	Frequency	Percent
Seniors	166	78%
Other social service providers	18	8%
Faith Leaders	12	6%
General Public	11	5%
Behavioral Health Providers	6	3%
Total Participants	**213**	**100%**

Intake/Screenings/Assessment: The Healthy Minds, Healthy Aging (HMHA) program received 49 referrals in FY 20-21. The majority came from service providers (76%) and the remainder came from caregivers, including family members (12%), and individuals who self-referred (12%). Intake included screening individuals using the Eight-item Informant Interview to Differentiate Aging and Dementia (AD8)[48] to screen for dementia, assessing overall quality of life with the SF-12v2™, [49] and assessing symptoms of depression using the PHQ-9.[50]

[48] More information can be found here: https://www.alz.org/media/Documents/ad8-dementia-screening.pdf
[49] This tool assesses the "impact of health on an individual's everyday life." Four of the eight domains in the assessment relate to emotional problems and/or mental health. A sample of the survey can be found here: http://www.health.utah.gov/prescription/pdf/guidelines/SF-12v2Standard-Sample.pdf. The scoring rubric is proprietary and not available online.
[50] More information about the Patient Health Questionnaire (PHQ-9) can be found here: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1495268/

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Healthy Minds, Healthy Aging
Referrals Received by Source, FY 20-21

	Referrals Received	
Referral Source	**Frequency**	**Percent**
Service Providers	37	76%
Collabria Care: Intake and Assessment, Case Management, Palliative/Hospice	*10*	*20%*
Adult Protective Services (APS)	*7*	*14%*
Queen of the Valley Medical Center: CARE Network	*5*	*10%*
Ole Health	*3*	*6%*
UpValley Family Centers	*3*	*6%*
Queen of the Valley Medical Center: Medical offices	*2*	*4%*
Share the Care	*2*	*4%*
Continuum of Care Hospice	*2*	*4%*
Kaiser Social Work Department	*2*	*4%*
Napa County Victim Advocate	*1*	*2%*
Family Member/Caregiver/Gatekeeper	6	12%
Self-Referral	6	12%
Total	**49**	

In FY 20-21, individuals were screened for dementia using the Eight-Item Informant Interview to Differentiate Aging and Dementia (AD8). Individuals were screened for dementia and 26% (13 individuals) were referred to Collabria Care for assessment due to identified risks. Another six individuals were already enrolled or had already been referred.

Case Management and Therapy: Case managers facilitate access to services for individuals to address identified needs. Therapists in the project provide mild to moderate mental health treatment as indicated.

- **Case managers supported all 49 of the individuals** who received services from Healthy Minds Healthy Aging. They received an average of 3.6 visits per person, with a range from 1 to 21 visits.
- **Therapists supported 36 of the 49 individuals** (73%) with an average of 6.3 visits per individual. Participants received from 1 to 20 visits.

Referrals: Of those referred for therapy services with Mentis, 60% were referred on the same day they were assessed. After being referred, 32% had their first appointment within a week. As needs were identified, individuals were referred to additional services. The most common referrals were to Collabria Care for further assessment and support.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Healthy Minds, Healthy Aging
Referrals for Additional Supports, FY 20-21

Referral	Frequency	Percentage
Collabria Care: *Intake and Assessment, Case Management, Palliative/Hospice*	9	21%
Transportation: *NVTPA (Vine-Go, Taxi Scrip), Transportation Services*	5	12%
Housing: *Fair Housing, Public Housing/Community Housing, Homeless Services*	5	12%
Season of Sharing	3	7%
Safety: *Adult Protective Services, NEWS*	3	7%
Legal: *Bay Area Legal Aid, Napa County Victim Advocate*	3	7%
In Home Support Services	3	7%
Mental Health Services: *Kaiser, Redwood Support Services*	3	7%
Queen of the Valley Medical Center: *Community Outreach, CARE Network*	2	5%
Share the Care	2	5%
Alcohol and Drug Treatment: *Alternatives for Better Living*	2	5%
UpValley Family Center	2	5%
Food: *Meals on Wheels*	1	2%
Totals	**43**	**100%**

Improved Quality of Life: Five individuals completed a pre and post survey about their quality of life related to emotional and mental health using the SF-12v2™.

- Of the five individuals with a pre and post score, four reported their quality of life was better than previously.
- One individual reported their mental health was worse than previously reported.

Improved mental health/Reduced severity of depression: Forty-eight individuals completed the PHQ-9 at intake. Of these, 52% reported symptoms of Moderate to Severe Depression. Of those who had a pre and a post score for the depression assessment (n=18), 22% were assessed as not experiencing depression at the beginning of their participation. At the final screening, 44% were assessed as not having depression. When looking at just those who have a pre and post screening score:

- Fourteen individuals (78%) reported fewer symptoms of depression,
- Two remained the same (11%), and
- Two individuals reported more symptoms (11%).

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Healthy Minds, Healthy Aging
PHQ-9 Depression Screening, FY 20-21

	Pre Screening		Post Screening	
PHQ-9 Risk Category	**Frequency**	**Percent**	**Frequency**	**Percent**
Minimal Depression (0-4)	4	8%	8	16%
Mild Depression (5-9)	19	39%	8	16%
Moderate Depression (10-14)	14	29%	1	2%
Moderately Severe Depression (15-19)	7	14%	1	2%
Severe Depression (20-27)	4	8%	0	0%
Not Screened	1	2%	31	63%
Total Individuals Screened	**49**		**49**	

FY 19-20: Activities and Outcomes

Outreach: In FY 19-20, the Healthy Minds, Healthy Aging program provided 44 outreach activities throughout Napa County on a variety of topics. About half of the events were held UpValley and 30% were held in the City of Napa. During the Shelter-in-Place Order, the outreach was moved online.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Healthy Minds, Healthy Aging
Location of Outreach Events, FY 19-20

	Outreach Events	
Location	**Frequency**	**Percent**
Napa	13	30%
Yountville	1	2%
St. Helena	13	30%
Calistoga	6	14%
Online	11	25%
Total	**44**	

The outreach topics were about equally divided between Brain Functioning (30%), Healthy Habits (30%), and Support and Training (35%). A few outreach events focused on the program's services overall (7%).

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Healthy Minds, Healthy Aging
Outreach Topics, FY 19-20

Outreach Topic	Frequency	Percent
Brain Functioning *(Brain Health, Alzheimer's, Dementia)*	13	30%
Healthy Habits *(Stress Management, Positive Thinking, Meditation/Grounding, Self-Love, Self-Care)*	13	30%
Caregiver Support and Training	6	14%
QPR Training	3	7%
Depression	4	9%
Grief Support	2	5%
HMHA services	3	7%
Total	**44**	

The Healthy Minds, Healthy Aging program specifically reaches out to seniors, their caregivers, and social service providers. These groups represent the primary participants in the outreach activities. About 10% of the activities were presented for the general public and/or educators.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Healthy Minds, Healthy Aging
Outreach Participants, FY 19-20

Participants	Frequency	Percent
Seniors	186	33%
Other social service providers	166	30%
Consumers and/or family members	153	27%
General Public	45	8%
K-12 educators	8	1%
Other	4	1%
Total Participants	**562**	

Intake/Screenings/Assessment: The Healthy Minds, Healthy Aging (HMHA) program received 83 referrals in FY 19-20. The majority came from service providers (66%) and the remainder came from caregivers, including family members (18%), and individuals who self-referred (16%).

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Healthy Minds, Healthy Aging
Referrals Received by Source, FY 19-20

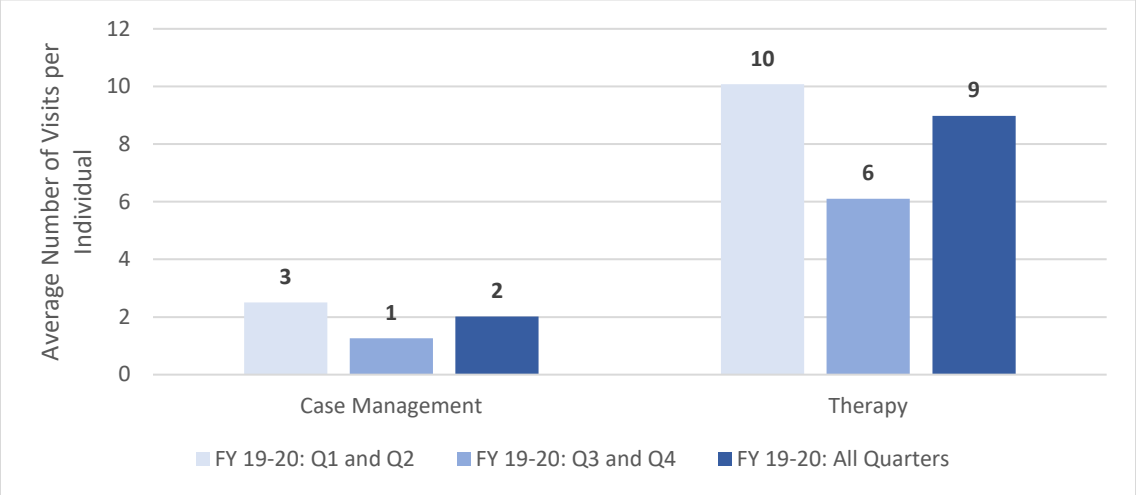
	Referrals Received	
Referral Source	**Frequency**	**Percent**
Service Providers	55	66%
Queen of the Valley (Medical Offices, Community Outreach, CARE Network, etc.)	*19*	
Collabria (Intake and Assessment, Case Management, Palliative/Hospice, etc.)	*10*	
OLE Health	*7*	
Share the Care	*7*	
Adult Protective Services	*6*	
UpValley Family Centers	*2*	
Adventist Home Care	*2*	
Continuum of Care Hospice	*1*	
Mentis	*1*	
Family Member/Caregiver/Gatekeeper	15	18%
Self-Referral	13	16%
Total	**83**	

In FY 19-20, individuals were screened for dementia using the Eight-Item Informant Interview to Differentiate Aging and Dementia (AD8). 85 individuals were screened for dementia and 56% were referred to Collabria Care for assessment due to identified risks.

Case Management and Therapy:

- **The case manager supported 90 of the 91 individuals** who received services from Healthy Minds Healthy Aging. They received an average of 2 visits per person, with a range from one to 22 visits.
- **The therapists supported 86 of the 91 individuals** (95%) with an average of nine visits per individual. Participants received from one to 31 visits.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Healthy Minds, Healthy Aging
Average Number of Case Management and Therapy Visits per Individual, FY 19-20



Referrals: Of those referred for therapy services with Mentis, 67% were referred on the same day they were assessed. After being referred, 46% had their first appointment within a week. As needs were identified, individuals were referred to additional services. The most common referrals were to Collabria Care for further support.

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Healthy Minds, Healthy Aging
Referrals for Additional Supports, FY 19-20

Referral	Frequency	Percent
Collabria Care *(Intake and Assessment, Case Management, Palliative/Hospice, etc.)*	20	38%
Season of Sharing	6	11%
Adult Protective Services	5	9%
Food: Food Bank, Meals on Wheels	5	9%
Bay Area Legal Aid	4	8%
In Home Support Services	4	8%
Queen of the Valley Medical Center: Community Outreach	3	6%
Share the Care/Stop Falls	3	6%
NVTPA (Vine-Go, Taxi Scrip)	2	4%
Kaiser (Mental Health Services)	1	2%
Total	**53**	

Improved Quality of Life: Twenty-seven individuals completed a pre and post survey about their quality of life related to emotional and mental health using the SF-12v2™.

- 74% reported their quality of life was better than previously (n=20),
- One individual's mental health remained the same, and
- Six individuals (22%) reported their mental health was worse than previously.

Improved mental health/Reduced severity of depression: Ninety individuals completed the PHQ-9 at intake. Of these, 62% reported symptoms of Moderate to Severe Depression. At the time of the post screening, only 13% reported symptoms in this range.

Of those who had a pre and a post score for the depression assessment (n=53), 15% were assessed as not experiencing depression at the beginning of their participation. At the final screening, 51% were assessed as not having depression. When looking at just those who have a pre and post screening score:

- Forty-six individuals (87%) reported fewer symptoms of depression,
- One remained the same, and
- Five individuals reported more symptoms (9%).

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Healthy Minds, Healthy Aging
PHQ-9 Depression Screening, FY 19-20

	Pre Screening		Post Screening	
PHQ-9 Risk Category	**Frequency**	**Percent**	**Frequency**	**Percent**
Minimal Depression (0-4)	12	13%	23	25%
Mild Depression (5-9)	22	24%	18	20%
Moderate Depression (10-14)	24	26%	8	9%
Moderately Severe Depression (15-19)	24	26%	4	4%
Severe Depression (20-27)	8	9%	0	0%
Not Screened	1	1%	38	42%
Total Individuals	**91**		**91**	

FY 19-20: Changes due to COVID

- Outreach activities were moved online.
- The Healthy Minds Healthy Aging staff worked remotely, and still offered both case management and therapy via phone calls and/or video calls. Staff reported that most contacts were done by phone (very few video calls) because of the resistance of individuals to use the technology, and/or individuals' lack of technology or internet services.
- Staff opened up a "Warm Line" offering telephone support in English and Spanish to all older adults between 9:00 a.m. and 5:00 p.m., as the anxiety level was high.
- As support services moved online, there was a lull in the referrals given to clients. Staff report that there was a pause as the agencies reconfigured their services and made changes and accommodations to comply with the Shelter-in-Place guidelines. Services that had previously been in person were the most challenging to connect to immediately.
- At the start of the Shelter-in-Place Order, staff reached out to past clients to check in with them.

Section Three: Summary of FY 18-19 Program Activities and Outcomes

Introduction

The nine Prevention and Early Intervention (PEI) programs in Napa County have been funded to provide services since 2011. In FY 16-17 they began piloting program evaluation measures with the intent that program evaluation would continue into FY 17-18. Several things occurred that interrupted the program evaluation:

- In October 2017, Napa County experienced devastating fires. This event meant that the mental health division staff and each of the funded agencies turned their attention to disaster response for several months.
- The MHSA staff person who developed the program evaluation pilot measures and worked with the programs to plan the FY 17-18 evaluation, took a position in another division. Due to hiring freezes, the disaster, and other obligations, filling this position took longer than anticipated. The program evaluation was not supported during this time.

As the first PEI Three Year Evaluation Report became due, the data for FY 16-17 and FY 17-18 data were reviewed. A review of the data available for evaluation showed that programs had diligently collected and submitted the demographic and outreach data. There was significant variability in the submission of the outcome data intended for the evaluation report. The following scenarios summarize the situations encountered:

- Partial outcome data was collected and reported. For several programs, data was reported for most of the outcome measures.
- The outcome data submitted was tabulated incorrectly and the original source data was not available to verify the calculations.
- The outcome data collected for FY 17-18 did not align with the outcome data collected in FY 16-17. Due to program staffing changes, it was not clear which data should be collected and why. In FY 17-18 program staff collected and submitted data that was not relevant to the program activities funded by PEI.
- The data was not collected. In some cases, this was because program staff was confused about how to collect the information, in other instances, the surveys and/or forms needed were not developed for the programs. This was the most frequent scenario.

MHSA staff and the Acting Mental Health Director reviewed the spotty program evaluation data and decided to include only the portions that were verifiable and relevant. This resulted in very little data.

MHSA staff began working with an evaluation consultant to develop program logic models, evaluation plans and data collection tools in May and June 2019. The resulting changes took place largely in the first half of FY 19-20. Program evaluation results for FY 19-20 and FY 20-21 can be found in Section One and Two of this report. This section provides a brief summary of each program's activities and outcomes in FY 18-19 prior to the full implementation of the program evaluations.

Stigma and Discrimination Reduction

On The Move: LGBTQ Connection

- 46,452 individuals reached through 61 outreach events. This includes in-person events and social media outreach.
- 862 individuals were served with individual and group support. Five individuals volunteered with the program.
- 72 Organizations received technical assistance to make their services for welcoming.

Program Activities

Activities	Summary
Outreach	• 61 Outreach events
Participant Services	• 194 Served with One on One Counseling • 491 Participated in Youth Groups • 177 Participated in Senior Groups • 5 Individuals Volunteered
Technical Assistance	• 574: Gay Straight Alliance (GSA) Technical Assistance, Schools • 15: LGBTQ Best Practices en español • 230: LGBTQ Best Practices General • 521: LGBTQ Committee Representative • 200: LGBTQ Data Collection • 15: LGBTQ Medical Best Practices • 8: LGBTQ Parent Presentation • 113: LGBTQ Schools Best Practices, Schools • 36: LGBTQ Seniors Best Practices • 127: LGBTQ Technical Assistance • 40: LGBTQ Youth Best Practices • 174: Other Total of 2,053 Individuals reached for Technical Assistance

Program Outcomes

No program outcomes were collected or reported in FY 18-19.

Prevention

Suscol Intertribal Council: Native American PEI Project

- 174 Individuals reached through workshops
- 35% of workshop participants identify as American Indian or Alaska Native, compared to 10% of all PEI participants.
- 6,869 individuals reached through outreach.

Program Activities

Activities	Summary
Outreach	61 Outreach Events and meetings to plan Outreach
Workshops	84 Classes and workshops to teach about Native History, Culture and Art
Partnerships	Worked on partnerships with Napa Valley Unified School District, the Veterans Home, Aldea

Program Outcomes

No program outcomes were collected or reported in FY 18-19

UpValley Family Centers: UpValley Program PEI Project (CLARO/CLARA)

- 215 individuals reached through outreach events and activities
- 117 youth participated in ongoing workshops about identity and culture

Program Activities

Activities	Summary
Outreach	• 13 outreach events to encourage students to participate in CLARO/CLARA • One parent meeting to discuss program with parents • One award event to celebrate the students' success
Workshops	• Workshops held for male and female students at Robert Louis Stevenson Middle School, St Helena High School, Calistoga Middle School and Calistoga High School
Support	• Staff expanded a mentoring option for youth. Youth met with staff outside of the scheduled session in St Helena and Calistoga. • Staff met with teachers and administrators to encourage referrals for the Mentoring support.

Program Outcomes

- 69% CLARO/A students reporting engaging in fewer risky behaviors.
- 78% CLARO/A students reporting they have more skills to help solve problems.
- 95% CLARO/A students feeling increased pride in their cultural identity.
- 76% of CLARO/A students identifying there is an adult they can depend on for help if they need it.
- 83% of CLARO/A students reporting having more positive relationships with other students.

Napa Valley Education Foundation: American Canyon Student Assistance Program

- 419 individuals were reached through outreach and trainings on school campuses and at a mental health conference
- 323 individuals screened for mental health concerns
- 343 students received mental health supports and services

Program Activities

<table>
<tr><th>Activities</th><th>Summary</th></tr>
<tr><td>Outreach</td><td>

11 outreach events for students and parents
4 trainings for Youth Mental Health First Aid
2 trainings for Restorative Practices for Staff
One Mental Health Conference

</td></tr>
<tr><td>Screenings</td><td>
<table>
<tr><th>Reported Difficulties using the SDQ[51]</th><th>NJES[52]</th><th>ACMS[53]</th><th>ACHS[54]</th></tr>
<tr><td>Close to Average Number of Difficulties (0-15)</td><td>53%</td><td>49%</td><td>54%</td></tr>
<tr><td>Slightly Raised to High Number of Difficulties (16-19)</td><td>32%</td><td>25%</td><td>25%</td></tr>
<tr><td>Very High Number of Difficulties (20-40)</td><td>16%</td><td>26%</td><td>21%</td></tr>
<tr><td>Total Students Screened</td><td>19</td><td>190</td><td>114</td></tr>
</table>

323 students were screened for mental health concerns.
Across all sites, 51% of students reported an average number of difficulties, 25% reported a moderate to high number and 24% reported a very high number of difficulties.

</td></tr>
<tr><td>Services</td><td>

343 students received mental health related services across the three campuses.
195 students received mental health interventions (support groups, one on one counseling, case management, classroom observations/teacher consultations)

</td></tr>
</table>

Program Outcomes

No program outcomes were collected or reported in FY 18-19.

[51] Strengths and Difficulties Questionnaire (SDQ)
[52] Napa Junction Elementary School (NJES)
[53] American Canyon Middle School (ACMS)
[54] American Canyon High School (ACHS)

Cope Family Center: Home Visitation

- 95 providers participated in a multi-disciplinary team meeting to coordinate care for families of children 0-5.
- 158 parents and children attended four outreach events
- 18 parents and 2 children were enrolled in the Parents as Teachers (PaT) Home Visiting program.

Program Activities

Activities	Summary
Outreach	• 10 Multidisciplinary meetings with an average of 10 providers at each meeting were held to coordinate care and mental health supports for families of children 0-5. • Four events for families and their children that were focused on early childhood social-emotional growth. 158 parents and children attended.
Services	• Staff served 20 new participants in the Parents as Teachers program. 18 adults and 2 children.

Program Outcomes

- No program outcomes were reported in FY 18-19.

Cope Family Center: Strengthening Families

- 2,801 individuals participated in outreach events
- 226 parents participated in parenting support groups. These groups were offered in English and in Spanish.

Program Activities

Activities	Summary
Outreach	• 33 outreach events were held to bring parents together and to educate providers about the needs of parents and families.
Services	• 115 parents participated in 8 week parenting classes at Cope. • 101 parents participated in 56 group sessions provided by Mentis.

Program Outcomes

- 101 parents completed a pre and post screening of mental health risks using the PHQ-9 and the Emotional Rating Scale (ERS).
    - 67 parents (66%) reported reduced depressions symptoms and improved PHQ-9 ratings.
    - 68 parents (67%) reported reduced mental health risks on the ERS
- Program outcomes for the parenting classes were not reported in FY 18-19.

NEWS: Kids Exposed to Domestic Violence (KEDS)

- 462 individuals participated in outreach events
- 111 children who had been exposed to domestic violence participated in support groups.

Program Activities

Activities	Summary
Outreach	• An average of 25 providers attended each of the KEDS Collaborative meetings to coordinate services and supports for children exposed to domestic violence. • Outreach events were designed to share information about the impact of domestic violence on children.
Services	• 111 children who had been exposed to domestic violence participated in support groups.

Program Outcomes

- No program outcomes were collected or reported in FY 18-19.

Early Intervention

Napa County Office of Education (NCOE): Court and Community Schools Student Assistance Program

Program Activities

Activities	Summary
Screening	• 115 of the 129 (90%) students supported by the student assistance program were assessed for depression symptoms using the PHQ-9.
Services	• 129 (100%) students were supported with mental health check ins, individual sessions and/or crisis interventions. • 45 (35%) students participated in Restorative Justice
Referrals	• 16 (12%) students were referred to Napa County Mental Health's ACCESS program for further assessment and treatment.

Program Outcomes

- 78% of the students reported fewer symptoms of depression on a post assessment using the PHQ-9.

Mentis: Healthy Minds, Healthy Aging (HMHA)

Program Activities

Activities	Summary
Outreach	• 451 individuals attended 32 outreach events
Assessments	• 95 older adults were assessed for mental health needs • 76 (80%) of the older adults assessed reported symptoms of depression.
Services	• 154 older adults received short-term therapy. • 809 short term therapy visits were completed.
Referrals	• 4 individuals were referred to ACCESS for further mental health assessment and treatment

Program Outcomes

- 28 individuals showed improvement from intake to discharge.
- 24 individuals reported an improved quality of life on the SFY-12v2™ at the end of the program.
- 24 individuals reported fewer depression symptoms after services (PHQ-9)

Appendices

Appendix One: Tables for Reporting Monthly Activities and Services

FY 20-21

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Partnerships by Month, FY 20-21

Month	Number of Partnership Meetings	Percentage of Meetings
July 2020	12	4%
August 2020	18	6%
September 2020	30	10%
October 2020	33	11%
November 2020	25	8%
December 2020	20	7%
January 2021	29	10%
February 2021	29	10%
March 2021	32	11%
April 2021	26	9%
May 2021	25	8%
June 2021	17	6%
Total Meetings	**296**	
Total Partners	**119**	

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Outreach Events and Attendance by Month, FY 20-21

	Outreach Events		Attendance	
Month	Frequency	Percent	Frequency	Percent
July 2020	4	8%	27	0%
August 2020	5	9%	59	0%
September 2020	6	11%	83	1%
October 2020	6	11%	107	1%
November 2020	9	17%	1,529	12%
December 2020	0	0%	0	0%
January 2021	3	6%	153	1%
February 2021	3	6%	43	0%
March 2021	2	4%	33	0%
April 2021	5	9%	10,013	82%
May 2021	6	11%	103	1%
June 2021	6	11%	108	1%
Total Outreach	**53**		**12,258**	

FY 19-20

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Partnerships by Month, FY 19-20

Month	Number of Partnership Meetings	Percentage of Meetings
July 2019	10	5%
August 2019	13	6%
September 2019	13	6%
October 2019	17	8%
November 2019	9	4%
December 2019	8	4%
January 2020	28	14%
February 2020	20	10%
March 2020	12	6%
April 2020	13	6%
May 2020	17	8%
June 2020	8	4%
Total Meetings	**202**	
Total Partners	**73**	

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Outreach Events and Attendance by Month, FY 19-20

	Outreach Events		Attendance	
Month	**Frequency**	**Percent**	**Frequency**	**Percent**
July 2019	9	7%	2,034	23%
August 2019	13	10%	100	1%
September 2019	10	8%	758	9%
October 2019	11	9%	1,383	16%
November 2019	20	16%	943	11%
December 2019	8	6%	57	1%
January 2020	18	14%	1,998	23%
February 2020	21	17%	972	11%
March 2020	6	5%	252	3%
April 2020	-	0%	-	0%
May 2020	6	5%	69	1%
June 2020	6	5%	35	0%
Total Outreach	**128**		**8,601**	

FY 18-19

Napa County Mental Health Services Act Prevention and Early Intervention Programs
Outreach Events and Attendance by Month, FY 18-19

	Outreach Events		Attendance	
Month	**Frequency**	**Percent**	**Frequency**	**Percent**
July 2018	10	4%	5,583	11%
August 2018	19	7%	800	2%
September 2018	20	8%	1,183	2%
October 2018	24	9%	432	1%
November 2018	18	7%	384	1%
December 2018	10	4%	10,155	19%
January 2019	19	7%	1,008	2%
February 2019	19	7%	380	1%
March 2019	25	10%	7,656	15%
April 2019	36	14%	3,400	6%
May 2019	25	10%	9,669	18%
June 2019	30	12%	11,833	23%
Event Date Not Reported[55]	5	2%	--	--
Total Outreach	**260**		**52,483**	

[55] In FY 18-19, the event date was not reported for some events.

Innovation Round 2- Addressing the Mental Health Needs of the American Canyon Filipino Community Project

Program Report, August 2021

Overview

The Addressing the Mental Health Needs of the American Canyon Filipino Community Innovation Round 2 Project was funded to address the disparity in reported MH risks and MH service use by Filipino youth. The disparity in needs was uncovered using the California Healthy Kids survey data and the service use was reviewed using school records.

Learning Questions

Innovation projects are developed to address learning questions. The following learning questions guided the activities and the evaluation of the Filipino Life and Generational Groups (FLAGG).

- Does an intergenerational approach to mental health support change:
    - Intergenerational empathy and understanding about wellness needs of parents and students?
    - Willingness of Filipino youth and families to use supports to promote and maintain wellness?
- Do the ideas generated by the intergenerational approach change how the district and mental health providers support changes to:
    - Screening process to identify mental health risks of all students, not just those with external behaviors?
    - Supports available to promote and maintain wellness for all students?

Summary of Learning

Data was collected and reviewed throughout the project to inform the program planning. The findings are organized by learning question.

Does an intergenerational approach to mental health support change intergenerational empathy and understanding about wellness needs of parents and students?

- In the surveys and in the interviews, there was evidence that the intergenerational approach increased empathy around how stress is experienced by adults and youth.

Does an intergenerational approach to mental health support change willingness of Filipino youth and families to use supports to promote and maintain wellness?

- The participants spoke clearly about the need for groups like FLAGG that combine the discussion of mental health with the discussion of culture. Though they noted the importance of more

intensive supports like therapy and counseling, they were clear that it was very difficult to suggest to Filipino adults.

- Because of the resistance to therapy and counseling, youth were cautious about discussing their own mental health needs with adults. Several youth noted the mandated reporting guidelines inhibited them from using supports themselves and/or offering supports to other youth.

Do the ideas generated by the intergenerational approach change how the *district and mental health providers* support changes to screening process to identify mental health risks of all students, not just those with external behaviors?

- The participants were asked about their ideas for how to identify stress and mental health concern among Filipino youth and adults. They shared that stress is most likely to appear as anger/irritability in adults and as behavior changes in youth. In some cases, individuals may share that they are stressed, but this was not a common response from participants.
- Participants used described mental health concerns as changes in Feelings/Emotions, Behaviors and risks of Harm/Danger. They were more likely to indicate that youth will Tell Someone when they have a mental health concern or show a change in behaviors. Mental health concerns in adults were more likely to be described as resulting in Isolation/Withdraw.
- Suggestions about how to identify students with mental health concerns in schools included establishing relationships with students, so you know when there is a change in their behavior, integrating mental health discussions into classrooms, providing anonymous ways to express themselves and hear that the experiences are common, consider peer programs and address the stigma of mental health directly. They agreed that academic indicators alone will not identify the needs.
- These ideas have not yet been shared widely with district and mental health providers, but are being reviewed and implemented by American Canyon High School Wellness staff. (pending discussion)

Do the ideas generated by the intergenerational approach change how the *district and mental health providers* support changes to supports available to promote and maintain wellness for all students?

- When participants were asked for suggestions on how to promote and maintain wellness for Filipino students, they described Discreet/Safe Spaces, Changes in the Classrooms, and Support for Adults.
- When asked what they would change about the current supports in schools, they talked about the need to address confidentiality, consider the impact of academic pressures and offer breaks, incorporate more clubs and cultural supports, and extend school year supports through the summer.

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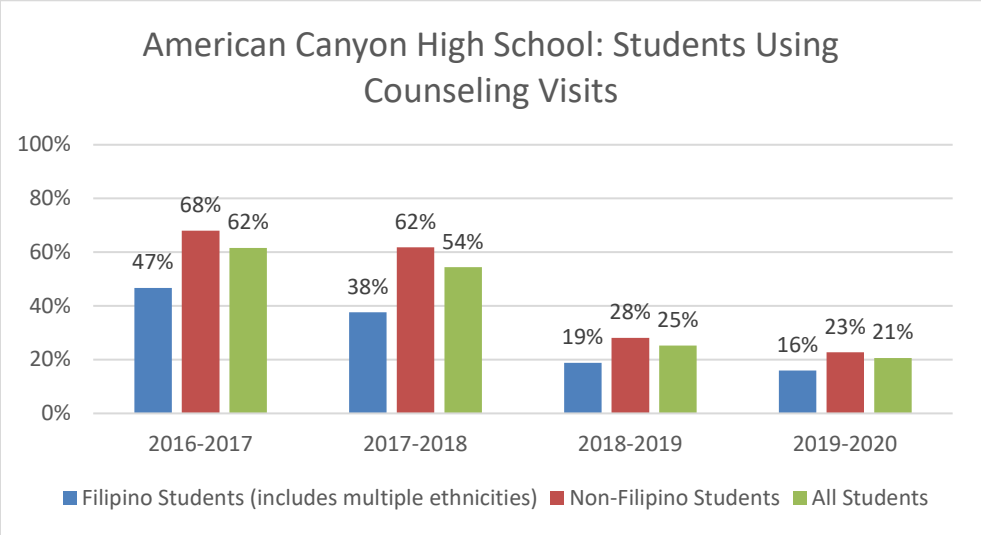
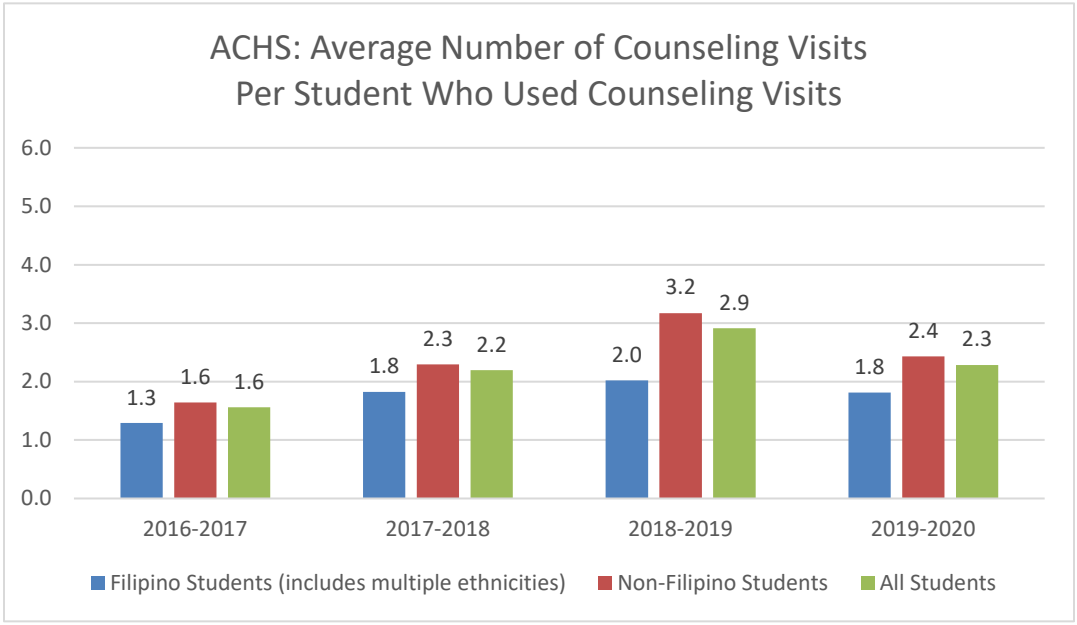
The Need

To identify the needs to be addressed, NVUSD staff reviewed their internal data about how students use counseling services at a school and how they report risks on the California Healthy Kids Survey. The data for American Canyon High School is shown in the following graphs. Filipino Students are represented by the blue bar in all graphs. The data was reviewed for FY 16-17 through FY 19-20 as this was the collected in a format most easily reviewed for mental health related services.



In the first graph, the **Filipino students are shown as being less likely to use counseling visits** at the high school when compared to non-Filipino students.

The disparity in service use continues when the data was examined to see how many visits students have with the counseling staff. **Filipino students who did use services had fewer visits than those who identified as non-Filipino.**

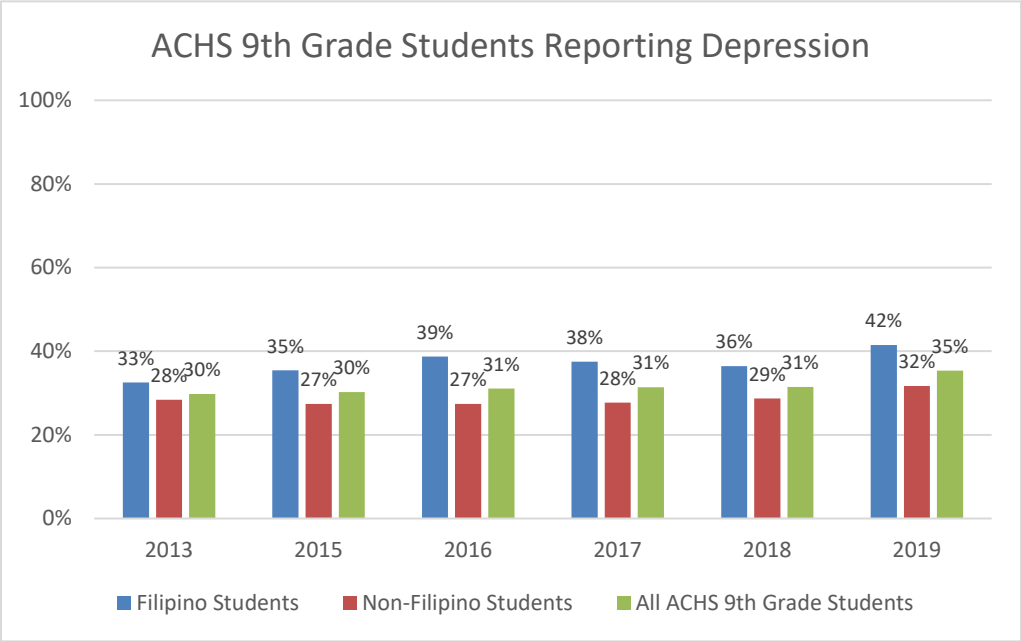


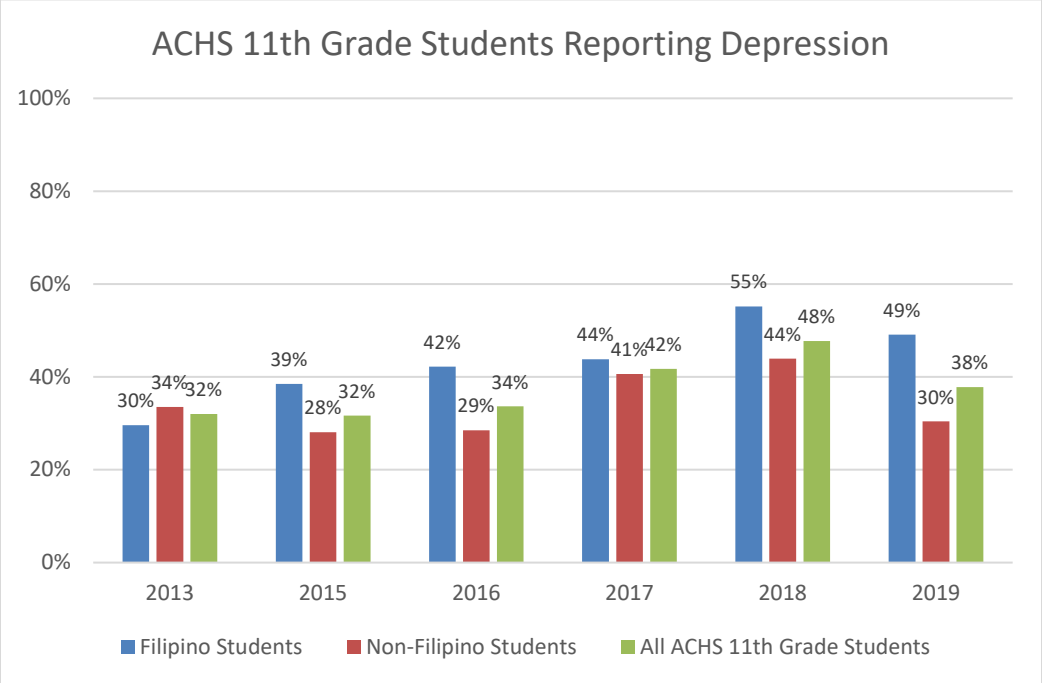
Next, the data from the California Healthy Kids Survey (CHKS) was reviewed to understand the risks that the students reported on the biannual anonymous survey. The trend in these graphs is easily seen as the blue bar representing Filipino students is generally higher than the bar for Non-Filipino studetns. This indicates they are reporting MORE risks despite using less services.

The next two graphs are based on responses to the California Healthy Kids Survey question regarding **Depression.** The patterns seen in these graphs was also found in the data for Anxiety and Suicidal Thoughts. See Appendix B for all of the graphs.

"In the past 12 months, have you ever felt sad or hopeless almost every day for 2 weeks?"

Ninth grade students who identify as Filipino have reported risks more frequently than non-Filipino students since 2013.





Eleventh grade students who identify as Filipino have reported more risks for depression than students who identify as non-Filipino since 2015.

The Innovation

The Innovation in this project was to use an intergenerational group to have conversations about mental health. The project staff tried several approaches to convene individuals over the course of the project. Each of the attempts resulted in learning for the district and county mental health staff who were involved in program planning.

Community Survey

As the project started up at the high school, a survey was done in the community as well as at the high school to understand more about the needs of Filipino youth. The surveys were also used to understand what types of events youth and adults were interested in attending to be sure the outreach events were well targeted. Over 400 individuals completed the survey.

Key findings from the survey included:

- **Differences in Perceived Stress:** Adults were slightly less likely to agree that students feel stressed at school (88% of Adults and 97% of Youth indicated yes)
- **Differences in Sources of Stress:** Adults and Youth had different overall responses to what makes students stressed at school. In general, youth were more likely to indicate that an area contributed to student stress. The difference was the most pronounced for Teachers, Home, Parents and School Work.

What do you think makes students stressed at school? (Community Survey, 2018)					
	Adult		Youth		Difference (Youth-Adult)
Response	Frequency	Percent	Frequency	Percent	Percent
Teachers	48	48%	259	77%	29%
Home	35	35%	201	59%	24%
Parents	50	50%	229	68%	18%
School Work	82	82%	330	98%	16%
Other	13	13%	49	14%	1%
Friends	50	50%	168	50%	0%
Nothing	3	3%	5	1%	-2%
Total Respondents	**100**		**338**		

The survey also asked about the types of events and school activities that individuals were interested in attending. It was noted that the events focused on College, Music Festivals and Family Fun were most popular with both youth and adults. The resource fair and wellness fair were rated the lowest. This informed the project planning as staff began organizing events to bring youth and adults together. The events were not marketed with a wellness focus.

Please check all events that you would most likely attend (Community Survey, 2018)						
	Adult		Youth		Overall	
Event	Frequency	Percent	Frequency	Percent	Frequency	Percent
College Fair	58	58%	215	64%	273	62%
Music Festival	63	63%	202	60%	265	61%
Family Event with Fun Activities	57	57%	170	50%	227	52%
Job Fair	42	42%	177	52%	219	50%
Pista Sa Nayon	66	66%	89	26%	155	35%
Education Event	41	41%	85	25%	126	29%
Resource Fair	30	30%	67	20%	97	22%
Wellness Fair	28	28%	54	16%	82	19%
Other	5	5%	8	2%	13	3%
Total Respondents	**100**		**338**			

When the question was asked in terms of school events, the wellness workshop was rated lower than the other options.

What school events have you or are planning to attend? (Community Survey, 2018)						
	Adult		Youth		Overall	
School Event	Frequency	Percent	Frequency	Percent	Frequency	Percent
Sporting Events	68	68%	241	71%	309	71%
Back to School Night	64	64%	105	31%	254	58%
Theater/Choir Events	48	48%	206	61%	169	39%
Parent Night	44	44%	26	8%	70	16%
Wellness Workshop	21	21%	30	9%	51	12%
Other	5	5%	35	10%	40	9%
Total Respondents	**100**		**338**		**438**	

The project staff for the Outreach phase of the project emphasized the importance of cultural context and identity in the discussion of mental health needs in the Filipino community. Two questions were included in the survey to understand if individuals were interested in this approach.

- **Interest in Cultural Connections:** 91% of adults and 45% of youth said they wanted to be more connected to their culture.
- Overall, adults and youth were most likely to indicate that Language, Cultural Dances, and Community Events were ways they could be more connected to their culture.

What are ways that you can be more connected to your culture? (Community Survey 2018)						
	Adult		Youth		Overall	
Responses	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
Language	60	60%	258	76%	318	73%
Cultural Dances	70	70%	197	58%	267	61%
Community Events	78	78%	162	48%	240	55%
Cultural History	57	57%	110	33%	167	38%
After School Program	30	30%	43	13%	73	17%
Other	6	6%	26	8%	32	7%
Total Respondents	**100**		**338**		**438**	

An additional finding that emerged from the community survey was the range of ways that individuals reported their culture/ethnicity. The survey asked individuals about their culture/ethnicity and left the answer open ended (without categories or checkboxes).

- **Diversity of Overall Responses**:137 different responses were received from the 444 respondents. This was a surprise to all of those involved in the project planning and implementation.
- **Diversity of Filipino Responses:** The project staff reviewed the responses to understand the myriad ways that someone with Filipino heritage may identify. The list of responses is included in Appendix A.

Outreach Events

The Community Survey responses led the project staff to plan a series of events to bring youth and adults together. In response to the community survey response and the input of other Bay Area programs during the project planning, the first phase of the project did not explicitly mention the mental health focus of the work and included wellness as a secondary purpose. These events were designed to encourage families to attend together, and project staff intended to invite them to participate further in the mental health aspects as they identified interested families. Though the events were planned for those with Filipino heritage, all families were welcomed.

Filipino Club

Because of the time between project planning and implementation, the students who contributed to the project proposal had graduated once the project was beginning. The students in the Filipino Club were invited to participate in the Innovation Project. The students helped with outreach, attended events, facilitated discussions at events and spoke with the project staff about the project activities and goals. When interviewed at the end of the school year, student members indicated they preferred spending time with their friends and were less interested in involving their parents in their social activities. Though they were supportive of the project goals, they were not universally interested in participating.

College Nights

College nights were very intergenerational and popular with families, students, and community members. However, since they were focused on college admissions, there was less attention on

conversations about other topics like mental health or family dynamics. Though the program staff asked the college representatives to talk about the wellness needs of students and the services available on campus, this was not an effective way of engaging families about mental health.

Film Screenings and Movie Nights

These events created opportunities for connecting, discussion of important issues, and some follow-up activities. Movie nights seemed to be the most successful in terms of the core goals of the project. Silent Sacrifices brought in a good crowd and led to some important discussions of family life and family stressors. Students from the Filipino Club facilitated discussion groups with the attendees after the screening. When interviewed, the youth noted that they felt uncomfortable inviting their own relatives to the events but enjoyed the discussions with other non-related adults.

Parol Making

This was an important cultural activity and people responded positively to it. It was not presented as a mental health support which resulted in strong attendance, and an unclear connection to the overall goals of the project. Though a few participants were interested in the Innovation project, most were not.

At the culmination of the outreach activities, it was evident that the events did not draw the attention or have the impact on recruitment that was intended. When interviewed one staff reported that at a college night*, ". . . parents who were just like, "How do I get my kid into college? How do I find out more about getting my kids into college?" We had the signup sheet for, be a part of this intergenerational group. They were starting to be like, "What the hell?" It just felt like a mismatch.* While the events were in some cases well-attended, they did not lend themselves to discussions of the mental health needs of Filipino students and the innovation project's goals of convening an intergenerational group. Some parents indicated interest in participating in the Innovation project, but overall the outreach was not as effective as planned.

Filipino Life and Generations Group: FLAGG

At the culmination of the outreach, the project staff person left for another opportunity in a neighboring county. A new project staff person was hired with the explicit goal of convening an intergenerational group. This group began in Fall of 2020 and continued throughout the school year. The FLAGG group met weekly over Zoom beginning in September 2020 to discuss Filipino culture, history and traditions as well as how the cultural context and identity impact mental health.

The project staff who implemented the final phase of the project developed a calendar of topics for the group based on a leadership group he had previously facilitated with a church youth group. The FLAGG group was co-facilitated by the social worker from the American Canyon High School Wellness Center. As the topics led from culture and history to personal identity and mental health, they worked together to plan the discussions and lead the group. The calendar of topics was modified over time to accommodate emerging interests and directions within the group and to work within the limitations of

the pandemic. The final topic and event list can be found in Appendix C. Key learning from the lesson planning included:

- **Incorporating Additional Voices:** Guests with insight into Filipino culture and mental health were invited from other cities to participate in the Zoom calls. Project staff also used podcasts, YouTube videos and other resources to bring the experiences and stories of Filipino individuals into the group.
- **Adjusting Topics as Ideas and Needs Emerge**: Project staff adjusted the weekly topics and activities based on the discussions from the previous sessions as well as participant's responses to the pre-survey about mental health in the Filipino community.
- **Participation in Data Collection:** Collecting data from the participants while all interaction was virtual was a new challenge in the pandemic. It is not clear if the group was hesitant to provide the information, if the online format of the data collection was a barrier or if another barrier was present. In the end, demographic information was received for 71% of the group, the pre-survey was completed by 54% and the post survey by 58% of the participants.

The Learning

This Innovation project was designed to advance learning for the following questions.

1. Does an intergenerational approach to mental health support change:
    - Intergenerational empathy and understanding about wellness needs of parents and students?
    - Willingness of Filipino youth and families to use supports to promote and maintain wellness?
2. Do the ideas generated by the intergenerational approach change how the district and mental health providers support changes to:
    - Screening process to identify mental health risks of all students, not just those with external behaviors?
    - Supports available to promote and maintain wellness for all students?

Administration

For the first few years of the project, most of the learning took place at the administrative level.

- **Universal Screening for Mental Health Concerns:** In response to the findings in the original project proposal that the indicators of risk that were being monitored by the school district did not identify all of the students at risk, project staff were able to advocate for universal screening of all students for mental health concerns. During the time this program was being implemented, the district piloted the Strengths and Difficulties Questionnaire in a few schools and then expanded it to all schools and all students in the district. The SDQ is used by other districts in Napa County as well.
- **New Location, New Administration, New Program:** From the proposal development to implementation, the venue shifted from the middle school to the high school. At the time, the shift seemed to accommodate the youth with higher risk indicators and to support a new campus wellness center. In hindsight, the shift to a new school:
    - Changed contacts and communication. The high school had three assistant principals and a new principal at the time. Since the project and the wellness center were new, there were no established relationships to rely on as the project launched.
    - Rules about meetings, events and activities were more restrictive than at the middle school and finding rooms to use and ways to advertise events was frustrating for project staff at the beginning of the project.
    - The project was initially housed in the new wellness center. Given the stigma about mental health and the new services, there were not a lot of students initially using the wellness center as the project began.
- **Innovation Process**: The flexibility of the Innovation project was an asset and a liability. For some of the project staff, the ability to change course was very useful. For others, the lack of clarity about the direction of the project and the overall project plan was stressful and made it difficult to share the project's activities and intentions with others.
- **Translation and Language**: As the project began to send out flyers for surveys and events, the project staff encountered a district policy that all information sent out to parents is required to be in English and Spanish. This added an interesting twist to the translation need for flyers

intended for English and Tagalog-speaking families. Though the Tagalog-speaking population in the American Canyon schools is significant, parent information is translated based on the threshold language of the district, not the school.

Empathy

After all of the weekly sessions were completed, participants were asked to complete a post-survey online. In June 2021, seven participants completed an interview to talk about their experiences with the project and their recommendations. Each were asked what they learned about mental health and wellness for Filipino youth and adults.

This section describes the findings from the online pre/post survey and the participant interviews.

Does an intergenerational approach to mental health support change intergenerational empathy and understanding about wellness needs of parents and students?

In the surveys and in the interviews, there was evidence that the intergenerational approach increased empathy around how stress is experienced by adults and youth.

Youth and adults were asked to reflect on their own levels of stress and to estimate the levels of stress that Filipino Youth and Filipino adults experience. They completed the survey at the midpoint of the project and at the end of the project. When the responses were compared,

- **Participants' Stress Increased:** Youth and Adult participants reported their own stress levels increased (30% higher for Youth, 32% higher for Adults). This may be an increased willingness to admit the stress or due to the ongoing impacts of the pandemic, school and other stressors.
- **Adult Report of Youth Stress Increased:** Adult participants indicated that youth experienced more stress (23% higher), and a slight decline in their estimated stress scores for other adults (2% decrease).
- **Youth Report of Adult Stress Increased:** Youth participants indicated that adults experienced more stress (19% higher). They also increased the estimate for youth (17% higher).
- **Reports of Stress Increase Higher in Matched Sample:** Due to the low response rate, only 33% of the participants had a pre and post survey response. Within this smaller sample, the estimated stress scores for youth and adult increased more than the overall sample (38% higher for youth and 31% higher for adults).

Change in Stress Scores	Youth	Adult	Matched Sample
For Self	30%	32%	16%
For Youth	17%	23%	38%
For Adult	19%	-2%	31%

Conversations Changed Perceptions: In the participant interviews, the youth indicated that they were surprised by the adults' frank conversations about mental health needs. **They did not expect the adults to speak openly and honestly.**

- *In regard to adults, I think I feel like a lot of us put adults on a pedestal and they don't seem like they have any issues. They seem put together because they really have to be. Hearing it from them, it was also interesting to see what they've gone through and what they don't get to say either because they're the adults and they're the people in charge and they have to keep it together.*

- *It was really eye-opening to hear from them, what they've gone through, too, and realize that we all go through it and let's help each other through it.*

Youth also spoke about being **surprised that many of the adults had gone through the same cultural identity issues** that they were experiencing.

- *It made me realize that a lot of Filipino adults that grew up here, I can really relate to them. They went through struggles with their culture, their identity as well…*
- *It's like adult A is having trouble realizing that they're Filipino enough, and then this other teen is yes, saying they're experiencing the same thing at the same time, and it has nothing to do with age… I guess hearing them open up and be open about their experiences and their problems, I guess, helps you realize that maybe they're not all bad. Maybe there are some people that are like, "Oh, maybe they're just going through stuff."*

Youth were **relieved and delighted to find out that adults could be allies and resources.**

- *…they're not just going to give you advice and then have you scoot on, move on to the next person. No, they're going to take their time with you…because everybody is important. Everybody deserves time to talk.*
- *I didn't feel I had to hold back. [one of the adult participants] didn't even feel like [they] had to hold back on some things. When there were some things that I didn't want to talk about, or things that I wanted to word carefully, so it would not be offensive to anybody or whatever, [they were] just outspoken, and ..took the words out of my mouth. I'm like, "… you're real. You're a real one..."*

Adults reported similar experiences and talked about adults' role in addressing youth mental health.

- *I'm telling you, I'll say it again, I said it earlier, what surprised me is that these kids need their parents to be taught how to deal with mental health issues. When they get home, there's different sorts of expectations of where they should be and what they should do, based on whatever their family is telling them.*
- *I learned that they're hesitant to talk to their own parents sometimes, or most of the time. They were able to open up to people that they trust. They will not tell you right away. You talk to them, and they will tell you're acting like a counselor, there's a barrier. You still need to establish that relationship…Having FLAGG, they're more open to you. If you act like you're the adult, "You need to talk to me," No, I don't think so. You really need to establish that relationship.*
- *I learned about the generation gap and that we need to be responsive to the needs this time. We need to double it up because of the pandemic. Most of our kids, adults, too, sometimes, they have their own mental problems. It's a case by case basis, but we have to address what everybody needs, and we don't really know.*

Mental Health Supports

Does an intergenerational approach to mental health support change willingness of Filipino youth and families to use supports to promote and maintain wellness?

The participants spoke clearly about the need for groups like FLAGG that combine the discussion of mental health with the discussion of culture. Though they noted the importance of more intensive supports like therapy and counseling, they were clear that it was very difficult to suggest to Filipino adults.

Because of the resistance to therapy and counseling, youth were cautious about discussing their own mental health needs with adults. Several youth noted the mandated reporting guidelines inhibited them from using supports themselves and/or offering supports to other youth.

FLAGG

When asked which types of supports they would recommend for Filipino youth adults, respondents overwhelmingly talked about the need to continue to offer a safe cultural group like FLAGG.

- *I think that might depend on what they're going through. If they're going romantic relationship problems, maybe I wouldn't say go to FLAGG because we talk about relationships, but more like family and not so often, boyfriend/girlfriend type of relationships. Or someone's struggling with school, I especially would recommend FLAGG to them because we talk about school out there and struggling with school and grades and expectations in the Filipino family.*
- *… joining like FLAGG, for example, a group where they could open up about this stuff.*
- *I think that there are those ways, the traditional ways, and the other way. The other way is the more discreet way. Not all people will go that traditional way, like you have to go to the counselor and undergo mental health. I find FLAGG a discreet way of addressing the issue. If you undergo the mental health program at the school and go through the counselor, what stuck in the mind of people was, "You're in trouble. You need help." It's like a degrading thing, the way I interpreted it from the students that discussed this there. Maybe it's a culture thing. I'm Filipino and I grew up in the Philippines. You don't announce your weakness in public. FLAGG is a discreet way of addressing the issue because you are joining the club. The traditional way is a straightforward way. The educational system has to do that and offer it to students and address to the community. Well, that's my way of understanding. I think before it turns into a severe case, we have something like they can call their support system in a discreet way.*

Interviewees noted the importance of therapy, and also talked about the difficulty of bringing it up.

Therapy/Counseling

- *Especially hearing the extent of what so many people go through without telling anyone. I know ACHS offers counseling without telling your parents. That was something that they had offered me because I told [them], "Oh I don't want my parents to know." I understand that not everyone is ready to tell their parents. I would recommend that at least but definitely I think it could be really helpful, nice to have some kind of support for everyone.*
- *…therapy is really good. Except it's just how to bring it up and how to actually recommend it in a way that's not insulting is the hard part. Then talking about like most Filipinos, because my mom*

is different, she is a little bit more open to therapy and talking about therapy, but I know people like my dad will completely not-- once you hear the word therapy, he's out, or he doesn't want to listen because he thinks that it's not real or doesn't work. Therapy would actually help. It's just a matter of bringing it up or wording it.

- *I think there is therapy and counseling, but I know that's an acquired thing. I know not everyone likes that, especially one-on-one, they sound scary. That is an option though and that's something that I've done. I would say it's helped me.*

Other supports that were mentioned included coping strategies, cultural supports and talking to someone.

Coping Strategies

- *There are also little things you can do. I don't want it to seem it is a cure, but there are little things like journaling or meditation that might help at least temporarily. It helps for me to journal or to take a step back and pray or something. All of those little habits that I think you can build up over time that will help you*
- *..maybe for the time being it's just like a little journal where [adults] get comfortable being open, but I think they definitely need someone to be able to express that with because I think a lot of adults really do keep it in.*

Cultural Supports

- *It would be nice if there was a class offered like they offer the ethnic studies. Is there ethnic studies already? It should be offered.*

Talk to Someone

- *I would recommend talking to a friend, of course…*
- *In a general sense, I would recommend talking to someone*

One of the adult interviewees talked about **stigma and the trickiness of using mental health as a term when offering support.**

- *I don't think you call it mental health. I think you call it something else. I think you call it transitional support, cultural support. I don't know. I think something creative: new immigrants, family support, or family achievement. Nobody's going to respond to mental health. Nobody wants to be sick in the head… What it is, is life achievements, how to succeed here.*

Youth interviewees were **concerned about confidentiality and being able to access supports without parental involvement**. One indicated they would temper their support recommendations with information about mandated reporting.

- *The fact that we don't feel comfortable telling our parents. I think it's something that we need to address as well but the immediate mental health concern? For a lot of people it is easier to receive support without their parents knowing. They know that their parents just going to be like, "No. Stop."*
- *But obviously, I will tell them to be careful who you talk to because I understand that obviously, you're a mandated reporter, so obviously, you're going to have-- Especially if the person, let's*

say, self-harms, obviously, you're going to have to report that. That's your job as well, but sometimes, it makes the situation of the person worse. I feel like I would definitely recommend groups or people to them, but I would tell them to be cautious a little bit, and then I guess wait until the right moment when you think you could trust them enough to let them know.

Identifying Mental Health Needs

Do the ideas generated by the intergenerational approach *change how the district and mental health providers support changes* to screening process to identify mental health risks of all students, not just those with external behaviors?

The participants were asked about their ideas for how to identify stress and mental health concern among Filipino youth and adults. They shared that stress is most likely to appear as anger/irritability in adults and as behavior changes in youth. In some cases, individuals may share that they are stressed, but this was not a common response from participants.

Participants used described mental health concerns as changes in Feelings/Emotions, Behaviors and risks of Harm/Danger. They were more likely to indicate that youth will Tell Someone when they have a mental health concern or show a change in behaviors. Mental health concerns in adults were more likely to be described as resulting in Isolation/Withdraw.

Suggestions about how to identify students with mental health concerns in schools included establishing relationships with students, so you know when there is a change in their behavior, integrating mental health discussions into classrooms, providing anonymous ways to express themselves and hear that the experiences are common, consider peer programs and address the stigma of mental health directly. They agreed that academic indicators alone will not identify the needs.

These ideas have not yet been shared widely with district and mental health providers but are being reviewed and implemented by American Canyon High School Wellness staff.

Identifying Stress

Participants were asked about stress to incorporate discussion about areas that impact wellness but are not mental illness in the intergenerational conversations. Generally participants noted that stress will sometimes be shared by both youth and adults, but generally shows up as anger/irritability in adults and changes in behavior in youth.

Signs of Stress	Youth	Adults
They Will Tell You	• *Sometimes they'll explicitly say so* • *They say they are stressed.* • *… I see them vent in person or in social media about their social, academic, and personal life*	• *They talk about their stress* • *Some… tell their families directly or show, in some way, that they're exhausted* • *When they discuss and talk [about] what stresses them.*

Signs of Stress	Youth	Adults
Anger/ Irritability	• *Irritability* • *Sometimes temper*	• *Angry* • *Being rude and hurtful to loved one* • *Being short, not knowing how to express … feelings and needs in a positive manner.* • *Inability to talk about problems, keeping problems bottled up* • *Irritability* • *Make it known to people around them, are mad, lash out to kids mainly* • *They complain and get mad about every little thing* • *Tense* • *They may start to become a little toxic in some way* • *Unchecked anger, blowing up* • *Unhappy* • *Yelling a lot* • *Anger* • *Anger when interacting with others* • *Angry* • *Cursing a lot* • *Doing things with force.* • *Slamming doors* • *Talking more rudely/snapping* • *They act in a very toxic manner It's very common for them to be emotionally/mentally abusive towards younger people.* • *They are lashing out at younger ones for no apparent reason* • *They start nitpicking on their children*

Signs of Stress	Youth	Adults
Changes in Behavior	• *Fidgeting* • *Escapism (such as using technology rather than finishing work)* • *… their reaction to homework* • *Lack of concentration* • *Lack of interest* • *…not talking to friends or family as often* • *Often, they won't eat or sleep much.* • *They'll … cry often, sometimes at school.* • *…they ask to dress or if they can do activities that they may not have shown interest in, in the past.* • *Being less talkative, more blunt or not thinking clearly, they are more withdrawn and hold back from social interactions* • *Depression, lack of motivation, social withdrawal, anxiety* • *… when they are more quiet then usual or they seem on edge* • *Not being themselves/detached, sad/depressed* • *They become reclusive and lose self-confidence.* • *They have a hard time opening up* • *We stop talking to each other…and we're just in awe about how stressed we are.*	• *Increased use of alcohol* • *Lack of focus and being easily distracted* • *Lack of sleep* • *Not thinking openly and rationally* • *Overeating* • *Over-working* • *Poor concentration* • *Their attitude changes* • *They get overwhelmed when someone is trying to talk to them (in my experience)* • *Lack of sleep* • *Lack of focus* • *Not communicating well* • *It seems as if they try to hide it for their children and their child's peers* • *You can definitely tell in their fake smiles and deep breaths that they are trying to get through the day.* • *They could be stressed if they are beginning to seem more reserved*
Signs May be Subtle	• *They'll appear to be very tired* • *…our faces turn red..* • *As they talk about the challenges they face from family, school and the pandemic, I feel they are stressed* • *… it is really hard to tell virtually but I can sense when they're talking about their family issues*	• *?* • *Not sure. In my experience, they hide or don't talk about their problems.*

Defining Mental Health Concerns

Youth and adults indicated that the term "mental health" is not commonly used by Filipino individuals. When surveyed, youth and adults described a mental health concern is a Feeling/Emotion, Behaviors, and/or a situation that includes Harm or Danger.

Feeling/Emotion

- *A feeling or disorder*
- *Bad emotion that doesn't go away, is persistent When someone displays or conveys that they do not feel themselves.*
- *Psychological disorder affecting how we … think.*
- *When someone is withdrawn, constantly pessimistic or down*
- *A mental health concern involves thoughts and feelings, which negatively affect one's happiness, well-being, and interactions with others, and can cause any number of mental health problems, i.e..: stress, anxiety, depression, suicidal tendencies, low self-esteem, etc.)*

Behavior

- *Any behavior which results in self-harm, erratic behavior, breaking from normal past behavior, exhibiting violent behavior, being unable to distinguish fantasy from reality*
- *Psychological disorder affecting how we feel, act…*
- *A mental health concern is an ongoing issue that negatively influences the wellbeing and lifestyle of someone, especially if they seem more downcast and antisocial.*
- *Change in attitude or weird behavior.*

Harm/Danger

- *A health situation that can be dangerous*
- *A mental health concern is when a person is in a very negative state of well-being, which could be detrimental to themselves and/or others*
- *I think it's when the person starts hurting themselves/is hurting physically/emotionally/mentally*
- *Talking as if they do not plan a future for themselves*
- *A (potentially dangerous) situation in which a person's mental well-being is compromised*
- *Once a person starts harming themselves (physically, emotionally, and mentally).*

Of the participants who completed the surveys, about one-half indicated they had experienced a mental health concern. This percentage of respondents who indicated they knew a youth or an adult who had a mental health concern remained relatively stable from the pre to the post survey. A little less than half indicated they knew an adult with a mental health concern, and about two-thirds indicated they knew a youth with a mental health concern.

Signs of a Mental Health Concern, Youth and Adults

Sign of a Mental Health Concern	Youth	Adults
They will Tell You	• *They have personally told me so* • *I would ask them how they are doing* • *If they seem quiet, I would ask them if they are okay* • *missing out on events* • *They have told me themselves.* • *They tell me they are experiencing a mental health concern,* • *They tell me things that point to an ongoing mental health concern, such as going to therapy, they are taking medication, etc.*	• *They tell me about their health concerns*
Feeling/ Emotion/ Thoughts	• *Always sad* • *Anxious* • *Depression* • *Depression* • *Emotional* • *Emotional outbursts* • *Lack of empathy for others* • *Racing thoughts* • *Overthinking* • *Depressive manners such as upset mood*	• *Angry* • *Change in attitude* • *Depression* • *Emotional* • *They start getting really sad* • *They regret making big decisions* • *Maybe anxious too* • *They get irritated easily* • *Sad* • *Anger*

Sign of a Mental Health Concern	Youth	Adults
Isolation/ Withdrawn	• *Isolating yourself* • *Keeping it to themself* • *Lack of interest* • *Sometimes they'll isolate themselves* • *Wanting to space out but needing affection* • *Withdrawn, avoiding people, avoiding talking* • *A shutdown on communication* • *Social withdrawal* • *They are more withdrawn and keep to themselves*	• *Holding in problems and ignoring them* • *Inability to talk with others* • *Lack of motivation* • *Lose the motivation to do anything* • *Withdrawn* • *If they start going out less and stop being active* • *It's harder to tell with Filipino adults, as many were raised to not be open about their feelings* • *Social withdrawal* • *They have the same symptoms that us teenagers would have, but they try to hide it more.* • *When they seclude themselves away from others.*
Behavior	• *Academically disturbed* • *Change in behavior* • *Change in performance* • *Crying a lot* • *Excitable and erratic behavior; erratic speech; narcissistic ideas* • *Inability to complete their job responsibilities* • *Inability to focus* • *Lack of sleep* • *Lack of sleep* • *Loss of energy* • *Lower performance in school* • *Stop sleeping or eating as much* • *Anger* • *Social media posts (or lack thereof)* • *Their school might be negatively impacted* • *They post more downcast subjects on their social medias or stop posting altogether* • *They do things slowly or more sluggishly*	• *Decrease in performance ability* • *Inability to complete work and home responsibilities* • *Lashing out in anger at family* • *Over sleeping and over eating* • *Sleeping and eating problems* • *They might act differently than usual* • *Change in behavior* • *Tiredness*

Sign of a Mental Health Concern	Youth	Adults
Harm/Danger	• *Drug and alcohol use* • *Suicidal thoughts* • *Experiencing a break from reality* • *Mental breakdowns* • *Self-harm*	• *Manic depression*
Not Sure	• *I am actually not sure, maybe because their generation is very different*	• *?* • *In the past it has been difficult to tell.* • *I am not sure; I have not witnessed many*

In the interviews, participants were asked what they would **change about how Filipino youth with mental health concerns are identified in schools**. Suggestions included establishing relationships with students, so you know when there is a change in their behavior, integrating mental health discussions into classrooms, providing anonymous ways to express themselves and hear that the experiences are common, considering peer programs and addressing the stigma of mental health directly. They agreed that academic indicators alone will not identify the needs.

Establish Relationships with Students

Get to know the person. Definitely get to know the person first. Once you find their usual lifestyle, their usual personality, their usual behavior, when you find that one single thing that's off, you'll realize, "There's something wrong about this person." For example, for me, I'm a very talkative person. I'll talk throughout the whole entire school day. If I'm silent, and maybe I'm still smiling, I still got a grin on my face or whatever, but if I'm silent, people will realize, "Oh, yes, you haven't been talking for the whole entire day. Are you okay?" That's when I'm like, "Man, you got me." It's more on the fact that you need to get to know the person.

People are going to try to hide it. You just got to realize that we're all different and we all need to get some time to be known, to be considered.

I don't think it could just be the students finding other people… a little bit more teachers too or just staff at school. I feel sometimes the type of relationships that students have with teachers, the teachers could more easily see or suggest what that student needs…

Let them complain about their parents…It won't be about not watching TV or not doing that, it'll be about the pressures that we talked about this past year. It'll be cultural, it'll be familial, things like that.

Classrooms

I feel like teachers don't exactly know what to do… I feel like if teachers knew the different things they could suggest to students… If they knew more ways to help students, they could better support them in different ways.

… a lot of people don't do well in schools and only some of the good teachers could see that it could be because of home. I feel like it would be really, really helpful if teachers knew about [FLAGG], too.

In eighth grade, there was advisory, which was just like 30 minutes that you spend in a separate teacher's classroom with other people of all of the grades. It's all mixed. It was really nice because in those advisory classrooms, you'd have little circle times, just like, pass a ball or talk about your favorite color or talk about feelings or how you feel today, just stuff like that. Then you'd play games and stuff. It seems like a very childish thing to do but honestly, that helped me. I was very comfortable around the people there even though we're all different grades. I was comfortable with the teacher there because I had no work imposed on me or forced down upon me. I didn't feel scared or anything. It just felt very open. Then I think in those environments, the teacher someday could propose groups that the students can go to… I just felt very free in that classroom.

Back when things were in-person, when there was PAC time at the high school. For me, I don't think that would work quite as well as going to entire separate classroom because nothing really changes. The environment doesn't change from the previous classroom that you were just in because you have your second period class and then it goes into the PAC time, which is just the same teacher that you just had giving you the announcements. There's nothing like new or refreshing or different environment where you don't feel like, not forced, where you don't feel like you're obligated to do work or something. I think it's just like an environment where you feel more free and you have to be there is just like, is where teachers or the school can offer those health services so people feel more inclined to reach out for those.

Opportunities for Expression

… I would say, maybe having a platform to write or speak freely about what they're going through. The survey is like the Healthy Kids survey, it has questions about mental health. They're like "Have you experienced this?" or "Have you experienced that?" There's really no space for students to talk about their specific struggles and to actually be open about what they're really going through. Interviewer: Would that be like a class assignment? I feel I would personally benefit from that had that been offered to me. Yes, I think so…I think if it was anonymous and then they just looked at the majority just see what was going on without singling out individual people. It's hard to get people to be able to share, but hopefully, that would help.

… I thought of maybe creating…a survey to at least provide an anonymous way of venting out your problems and stuff, but finding the specific people would definitely be hard… I feel like instead of focusing on, or just finding out the specifics, I would probably look at the general community instead. I'm not really sure how to pick out the specific people that actually need help.

Consider Peer Programs

…they could talk to their friends…… It's hard talking to an adult in general.

It's got to be peer to peer. Then I think it's how you guys frame it. It ain't nothing about mental health…

You will not notice them unless they say something. They will not tell you. They will tell first their friends before they will approach an adult. Yes. They always have hesitations.

Address Stigma

…I think we have to acknowledge first and foremost that the reason a lot of us aren't open about mental health. It's not anyone's fault. I think a lot of times people feel guilty or are forced into feeling guilty for the way they're feeling, or they're trying to make themselves not feel that way, and that's why they don't want to talk about it. I think addressing that stigma and its roots and how it's developed and why it's like that, I think that would help a lot of people feel it's not their fault for feeling the way they do and to understand they deserve to be able to be open about it, and to confide to people.

… a lot of people showed their mental health problems in a very different way. For me, I don't even want to show my problems at all. Maybe I'll have a sad resting face or whatever.

Use more than Academic Indicators

…just because someone has good grades and is still passing school, et cetera, it doesn't mean that they don't need help as much as the ones who are failing school… If, let's say, they do end up…starting programs that would benefit the ones who are failing, I think they should also let the ones who they think are doing great in life or have good mental health have the same opportunities and to be in the same programs as the others, because I feel like, just because the physical part of it isn't as obvious, that doesn't mean we don't experience the same thing mentally.

Well, [students in need are] not going to stand out. They're not going to be involved, they might be involved, and they might be suffering as well. I believe we had [involved, successful students] on our call, which…you wouldn't necessarily identify as somebody involved in that. Although when I think about it, yes, probably, it's a possibility. I don't know.

Participant Recommendations

The project did not complete the outreach to district and mental health providers beyond those directly involved in the project. The participants did offer their own recommendations about how the approaches should change and those ideas are shared here.

Mental Health Supports

Do the ideas generated by the intergenerational approach change how the *district and mental health providers* support changes to supports available to promote and maintain wellness for all students?

When participants were asked for suggestions on how to promote and maintain wellness for Filipino students, they described Discreet/Safe Spaces, Changes in the Classrooms, and Support for Adults.

When asked what they would change about the current supports in schools, they talked about the need to address confidentiality, consider the impact of academic pressures and offer breaks, incorporate more clubs and cultural supports, and extend school year supports through the summer.

Participants also offered advice for other projects that may try to replicate FLAGG. They emphasized the importance of outreach to individuals to ensure a good response and encouraged the combining culture and mental health in the discussions. They also had input on the meeting logistics.

These ideas have not yet been shared widely with district and mental health providers but are being reviewed by American Canyon High School Wellness staff.

Types of Supports

When participants were asked for suggestions on how to promote and maintain wellness for Filipino students, they described Discreet/Safe Spaces, Changes in the Classrooms, and Support for Adults.

What types of supports do you think would promote and maintain wellness for Filipino students? What would you to see offered?

Discreet, Safe Spaces

There are also kids who look like average, but they have something on their mind, and they just need something to spark them so that they say something. Having maybe like a club that they can join that they can open up.

I like the idea of the discreet way of helping kids and adults through FLAGG.

One way to approach this is through leadership… How do you mix mental health and leadership? You can't be a leader unless your head is on straight. Then in order to be a good leader, here are the things that you need to address.

I guess I would provide anonymous spaces. I don't have a specific idea of what those spaces are, but yes, anonymous spaces for people to simply vent. Let's say, I create a Google survey and it's anonymous, and they're supposed to create a fake name or something, and then obviously their problem or their situation, and then person in charge or I guess, I would reach out to them using

that fake name to, I don't know, just talk about it or help them with their situation. Interviewer: Knowing the person's name would make people less likely to come forward? *I feel so because more people would know about their business, and maybe they don't want people to know.*

Maybe because arts for high school is so limited, because they have to finish their academic requirements, but they can also have something that they want to do that they enjoy, that's not being graded. Like building skills, learning how to make jewelry, learning how to dance ballet, how to develop their voice, kind of thing. I feel kids really love it.

Cultural Resources

Definitely, the classes…the cultural classes and about their history, especially history in America, considering it still isn't really talked much about for some reason.

Teachers/Classrooms

I would just say some teachers I know are good, providing their own short periods of class to just talk about mental health or just dealing with mental health because the only type of support I would say that teachers could offer students would be guidance counselors or joining FLAGG. I don't have many ideas for other types of things, but I would say being proactive, like the school not just giving support when they see it, but just teachers automatically giving more time for students to talk and work on their mental health.

… I was definitely too anxious to join any clubs. Even though I did, it was more for the volunteer hours and stuff. We should go ahead and implement this into our classes.

One thing that we had this…year was, every Wednesday, our teacher would go ahead and ask us these silly questions. At the end of the questions, there would be, "How are you feeling? Is there anything that you want to talk to me about? If you are too afraid to tell me, that's fine. We'll go on with the day, but we're just going to have a free flowing conversation." I wish I had that in freshman year. It was just mostly about work, but towards the end of my school, that's when a lot of people were like, "Hey, we're more than just teachers. We're people that want to help you out and succeed."

Definitely implement it into classes. Teachers know that they give a heavy workload. At the end of maybe finals or whatever… They need to check in with their students after that and be like, "What is something that I could do for you guys to help you guys succeed? I want to be there for you guys."

[Our teacher is] almost a sarcastic comedian type of guy. He doesn't really get into, "Oh, yes, I'm so happy and all that." He's just like, "I'm here for you guys." He's pretty chill. He's not going to blow up all in your face about, "Are you guys okay? Do you guys need anything?" He's just like, "Just let me know if you guys have any questions. I'm more than happy to spend my time with you guys. I'm more than happy to take my time to help you guys on non-school hours and stuff." He definitely knows a lot about all of us and it's all different things. He knows where some kids, they talk about their job and at the end of the day, he's jokes about their work and stuff.

Relationships

You know, this is where Zoom was probably wrong, it'd be nice to have been in person. Because then the in-person stuff allows you to see people, body language, and all that. Also, if there're [people] there, particularly for me, if I warmed up to them, made them feel more comfortable. Call me, text me, whatever it is that you needed. I was getting text messages…about a [FLAGG] meeting, and I didn't know half the numbers. I didn't have time to sift through a dozen numbers…

It'd be nice to have probably a leader to say, "Well, I always offer myself, you just call up anytime, anybody call me." It would be nice to have that. One person as a resource.

Promote the Wellness Center

Maybe learning more about who is in the wellness center, what you should expect when going there and how the process works when you just walk in. Who do you see first? What do you do? I went to the wellness center a few times…and it felt very stagnant in there, lonely. I didn't know anyone there aside from my counselor. It would help a lot to know who else is in there and what goes on. Interviewer: Would it help to have something like FLAGG located there? *… If things were in-person, I wouldn't prefer for FLAGG to be in there just because I, myself associate the wellness center as being quiet and sometimes some people just need it to be quiet. I know some people that have cried in there, including me. I would feel uncomfortable seeing a whole other group just hanging out and talking a lot in there while I'm going through my own stuff.*

Support Adults

… I have this program. It's a four-week without devices activity. I think it will help kids stay away from their computer, help them do something like art. Without technology because they've been doing that, how many hours in a day, do you think? Adults, too.

I feel like having them [adults/parents], being involved with their child's school and those types of things may make them feel more comfortable with what type of schools that their child is attending. It may put them more at ease. This is a nice area for you to be around. The other parents here are nice as well and just those parent groups, they always seem like the parents are super happy and they feel a lot more comfortable with the school….but also being involved with the school.

I think informational meetings and just a main speaker, a way that not all adults in a meeting have to say something, there's a main speaker to talk about their experiences with their children or something or their experience in the US transitioning from the Philippines. Just something like that where it feels like you can just observe…. it's better to talk about culture and children rather than something more hot like religion. That's something that a lot of people wouldn't go to.

I want [adults] to be able to talk about [mental health] with their family as well, especially with their parents …. Obviously, I know that it's hard.

I feel like [adults] should let themselves take breaks from their work life especially, and then allow themselves to join social groups like FLAGG. I know there's other Filipino associations or whatever. It's those kind of social interactions where it's not toxic because I know there's a lot of toxicity, even in those social groups that are supposed to help you be around Filipinos, et cetera.

For me, I do something different after my job because it helps my sanity. I think it's not only for adults but also for kids.

When asked what they would change about the current supports in schools, they talked about the need to address confidentiality, consider the impact of academic pressures and offer breaks, incorporate more clubs and cultural supports, and extend school year supports through the summer.

Change Supports

What is ONE THING you would change about how the schools support Filipino students and families? Why?

I think the problem is not them not being able to provide enough for the Filipinos, but it's more like the teens or the students are the ones that aren't able to reach out to them because of their personal reasons. I know that counselors urge you to talk to them if you need help. Even our teachers sometimes tell them or tell the students, "Oh, if you just wanted to talk, feel free to do so."

Confidentiality Considerations

I don't really know of any interactions between the school and the parents, other than obviously school announcements or class announcements.

I experienced like, "Please don't report me." … because [they are] a mandated reporter, [they] had to tell my parents… Then it kind of ruined that whole month for me because I was okay, and I understand that they're mandated reporters, but I wish that they didn't have to tell my parents specific stuff because e….although most of the time it'll end up working out, it's sometimes just puts the teen, or the student, or me at that time in even more danger. I shut everyone out for a month. I never did that ever.

I would talk to [the student] and I guess come up with a script on what to tell [the] mom and that would leave out the major sensitive parts, but still having this topic about how the parents and the school could help [the student] with…mental health.

I know there's the thing called the 504 plan where the school is maybe easier on the students because of things that may make school harder for them or hold them back. I think how much the school goes to the parent in order for the children to be allowed to have that type of help in school. That doesn't entirely make sense to me because I feel like if a child is struggling because of mental health…because of people at home and the school is going to go through the people at home in order to help the child... It's like them saying, "Oh, here's this thing that can help you, but we're going to go through the people who brought you down in the first place." You're not going to get too far with that.

I think there are some situations where the family has to be involved. I think other times when the problem is just simply affecting the student and there's not much you could do about it at home, that's when it becomes impossible type of situation [to involve the family].

Academic Breaks

… I really wish they would have offered was more of an academic break, just from all the work and everything. For me and for a lot of my friends, especially during the pandemic, it's just been so hard to keep up with everything. It was just hard for so much to be expected of us when there were so many other things going on for a lot of people… The world is going crazy, and then we still have like the homework due the next day.

I don't know if that's something that schools currently offer, but a lot of students are really just suffering from all of the schoolwork that they had to feel responsible for and feeling like they had to keep their grades up and they had to perform at the same level that they normally do, even with so much going on. They still had to get everything in on time and they still had to learn all the same stuff even though we're learning through a screen and that's really hard.

… I'm sure all of us have gone through just a lot of mental health issues because of schoolwork and all of the pressure that that brings. Honestly, especially in a Filipino family, because there's also that stereotype that we have for like, you have to get all A's and we have to get good grades and we have to be a doctor or nurse and do that. We need to get straight As.

I hope that the district would stop giving students overwhelming amount of schoolwork and homework or whatever. I hope they'd give us like a mental health day, kind of. I know other schools in the district have mental health days. Like Wednesdays, they have it off usually because that's a mental health day. I wish my school would do that too because sometimes, we just really need a break.

Clubs/Cultural Supports

… open up a program that the school endorses, too. Kids from the beginning, especially the freshmen, they need help. Other than the orientation on the structure of the school and all the other things that they need, the units and everything, they know that they have this club or this organization exists.

Towards the end of the school year, we can also recognize the students…. We also recognize the "Filipino at heart" who help the community, because there are so many.

I want to share with other ethnicities, too, so that they understand. For example, we get the right hand of our elders and put it on our forehead, it's called mano po. That's a form of respect to our elders. These kinds of things that we want to share with the Filipino Americans and also the other ethnicities so that they're aware and to establish more respect.

I think this is one of the issues that kids at school hesitate to identify their own ethnicity. I consider the club a multicultural club. I think it's beautiful if you call it multicultural. That's one of the things.

Supports in Summer

… the major problem is, well for me at least, is during the summer, when we aren't really connected with those programs are available to us by the school, I hope that they could recommend people or groups that could help us throughout the summer.

Advice for Future Projects

Participants were asked what they would recommend if they were starting up another FLAGG project.

Overall, they noted the importance of outreach to individuals to ensure a good response. They also would encourage the combination of culture and mental health in the discussion. They also had input on the meeting logistics.

One on One Outreach

… I feel like it appears intimidating to just see signs up there saying joining this support group for Filipino families, people may see that and be scared because it just sounds like such a serious thing to join. I would say have them start by telling their friends about it just so they could give a more in-depth explanation about what FLAGG really is, because it's a lot to put into words, but it's important to hear every single one of those words, because FLAGG could just be so many things for so many people.

I would say have them start by telling their friends about it and then have a few meetings that. Then those friends tell more friends and then once the group is big enough, I would say, then you can start bringing in the entire community because the more people that they see there, the more comfortable they may be to join.

Focus on Culture for Context of Mental Health Discussion

I think if it was similar to FLAGG and if it's specific to Filipino, like I mentioned earlier, I'd recommend, or urge them, or encourage them to have discussions about the culture itself because it's hard. Because we have questions in FLAGG or discussions in FLAGG, and we have questions like, "How does your mental health relate to your culture or something?" Even I find it hard answering their questions. Like, "What are you going to compare if you don't know much about the culture?"

I think I'd urge them to give the people within the group more opportunities to learn more about it, and obviously, not straying away from the mental health bit, but also still focusing on the Filipino bit of the group.

… we should at least have a basic understanding of the culture before diving into the mental health part, especially if you're comparing or relating the two…

A lot of people are just there to talk about their problems and understand other people. They're not really here to-- I don't know how to put it, but they're not really here to-- We all already know a lot about mental health because of the way that we grew up. It's not when you feel like, "Oh yes, they're just teaching us about mental health again and all we know." It de-motivates people because it's not really the true definition of trying to talk to others.

Meet In Person if Possible

I would have liked more mandatory in-person meetups, especially as like, numbers got lower or people started attending less, including myself. Just like that, that first meeting in the Summer of 2020, I would have liked something like that in April of this year or something or March, because

it brings back that motivation and obligation to be there for the meetings and also to remember that everyone is just real.

… if FLAGG was in-person, I would say it would be nice to have one-on-one conversations on the side, because if that was happening in-person, I feel like it may be easier to open up.

Meeting Format

Actually, it does seem that even though it was like during the whole pandemic, every time I went into the meeting, everyone had their camera on and everyone was talking. There was no awkward silence like what you see in many other Zoom meetings and everyone's always nodding. One thing that I always liked was how every time someone talks about something, there's snapping that you do instead of clapping. There's none of those clapping emojis on Zoom and the snapping thing just seemed very genuine.

I liked how we had different topics to talk about, but also how we still talked about mental health at each meeting. Even just a little check-in. I liked that they were different things to learn about culturally.

Weekly Meetings (pros and cons)

I would say to obviously keep the weekly meetings as much as possible.

It's the scheduling. It's so hard for me, for adults, to commit to an every week meeting. I could not commit to like every week, maybe every other week would help, but every week, it's too much.

Smaller Groups (Pros and Cons)

I think that that could create an even more intimate experience. Especially if the group is big. You can get a lot closer to them. If you don't feel comfortable talking in your big group you can talk in a small group and hopefully being with that tinier group on a regular basis you can feel really close to them and be able to really be able to do anything with them. I don't think there's anything I would get rid of. I don't think I noticed anything that was like, "No, no, don't do that ever again."

I think I would tell them to start small with their group

One thing that I would implement, and I think they had tried to implement, it was just difficult because there weren't that many people participating but having little groups. It depends how big the group is but if the group is big enough for having smaller groups that you can kind of split into sometimes.

I would just say no to the breakout rooms, because it seems having one-on-one conversations, it's hard to create bonds there or have really personal conversations because if you're talking to someone that you don't know as well through a screen, it might be a really difficult conversation to have, or you're less likely to open up as much and as crazy as I think this may sound, I feel like having everyone in a single group online to have just one big open conversation that would work out more than having breakout rooms online

Meeting Plan (Pros and Cons)

The thing that I really liked that FLAGG did when I was really active was that every week, Clarence would send an email talking about-- not only does it have like the Zoom links and everything, but it talks about what that week's meeting is going to talk about and what to prepare ahead of time and who will be speaking for that meeting. In 2021 the emails got less thorough, but I really liked it in the beginning because they helped me feel like I know what I'm getting into every time I open the Zoom and I feel like it gives me a heads up on like, what I'm going to share what I'm going to say. I didn't want to be surprised. Just having that preparation because it just makes me feel a little bit less anxious, like what are we going to talk about today?

I would say it's nicer to have some structure towards the beginning and to know where they're headed. Not that I blame them for that, again we were just all trying to navigate this new thing, whatever this was, but,…, it was a little strange, just showing up, being like, I don't really know what to do today, but it's okay.

Definitely add free conversation, free flow. If it goes off the lesson plan and everybody's just discussing this and that, if we get interrupted and they're like, "Oh yes, we still have to go to another activity," some people are just going to be left out and stuff.

Most of the FLAGG presentations that we had, when we started going towards the end, we did have a lesson plan, but most of the time, we would skip some of the activities and just go into free conversation. Everybody loved that free flow. I would definitely add free flowing events when you start up a new FLAGG.

Staff Recommendations

At the end of the project, staff shared the following recommendations. These recommendations are intended for the school district staff and administration to consider as they work with Filipino youth and families.

Language

- Filipinx: We recommend the use of the term "Filipinx'' to refer broadly to students who identify as: Filipino, Filipino-American, or of mixed Filipino heritage. This helps start the conversation with Filipinx students and increases cultural sensitivity to Filipino identity, since "Who is Filipino" depends on many factors, including place of birth, length of residence in the United States, knowledge of English and/or Filipino language, family influence and immigration status.
- Terminology and Stigma: Terminology is important and needs to be considered for outreach and services. This is important as certain words in the Philippine language (primarily Tagalog) carry heavy stigma and negative connotations, which can deter individuals from seeking mental health services. We recommend the creation of a guidebook and website that therapists and counselors treating Filipinx students can use as a resource to learn about these Filipino language and cultural nuances.

Identify Needs

- Explore the feasibility of check-ins of students by school counselors and adults, to proactively identify mental health issues of students.
- Encourage services focused on peer-to-peer support, as they are well received by Filipinx students. Filipino culture encourages older students to mentor younger students.

Mental Health Supports

- Conduct outreach with school officials, city government departments, and other education and mental health professionals to develop additional programs & activities for Filipinx students on the topic of mental health awareness. FLAGG has made many connections in this area, and we recommend that those efforts continue.
- Continue the FLAGG program, as a resource for Filipinx students in the areas of peer and adult mentor support and guidance, (2) cultural education and exploration, (3) mental health education and coping, and (4) community outreach for issues important to Filipinx students
- Expand the FLAGG program via in-person group meetings, student leadership training, recruitment of additional students and adult mentors, and engage in additional activities as planned by students. Covid-19 restrictions prevented in-person meetings, and when these restrictions are lifted, we expect FLAGG will have more success in meeting project goals.
- Identify and engage Filipinx therapists, as there is a need for their cultural and linguistic skills. Students and adults have highlighted the difference this would have in their ability and willingness to engage in mental health services.
- Given the lack of Filipinx therapists and counselors, we recommend that if none are available for any given location, FLAGG-type programs can serve as a resource for non-Filipinx therapists and counselors, to help them develop successful approaches and connections to Filipinx students, for more effective treatment of mental health challenges.

Appendix A: Culture/Ethnicity Responses

What is your culture/ethnicity? (Community Survey 2018)				
	Did not indicate age group	Adult	Youth	Total All Respondents
African American	1	0	5	6
African American and Latinx	0	0	1	1
African American, Filipino, and White	0	0	1	1
African American; Black	0	0	1	1
African American/Filipino	0	0	1	1
African-American	0	0	1	1
African-American, Portuguese	0	0	1	1
American	0	0	1	1
American Canyon	0	0	1	1
American. The type with NO hyphen attached.	0	1	0	1
American/Hispanic	0	0	1	1
American/Mexican/Hispanic IDK	0	0	1	1
American/Taiwanese	0	0	1	1
Asian	0	0	1	1
Asian	0	1	6	7
Asian (Filipino)	0	0	1	1
Asian, Chinese	0	0	1	1
Asian/Filipino	0	0	2	2
Black	0	0	1	1
Black and Filipino	0	1	0	1
Black/ African American	0	0	1	1
Black/ African-American	0	0	1	1
Black/Filipino	0	0	1	1
British, Filipino and Korean	0	0	1	1
Caucasian	0	0	2	2
Caucasian (Jewish)	0	0	1	1
Caucasian, Native American	0	0	2	2
Chicana	0	0	1	1
Chinese	0	0	3	3
Chinese & Filipino	1	0	0	1
Chinese and Russian	0	0	1	1
Eurasian	0	0	1	1
Filipina	0	1	2	3
Filipina/Ilocana	0	0	1	1

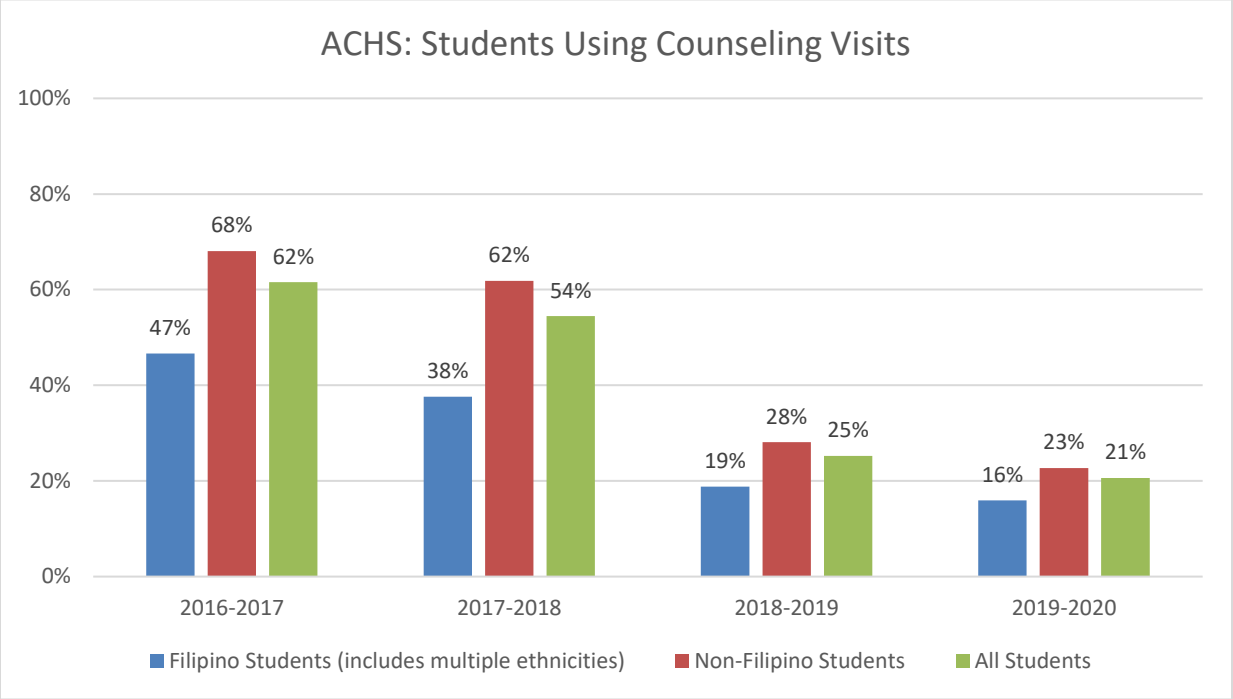
What is your culture/ethnicity? (Community Survey 2018)				
	Did not indicate age group	Adult	Youth	Total All Respondents
Filipino	3	60	128	191
Filipino - Illicano	0	0	1	1
Filipino (Asian)	0	0	1	1
Filipino (Kampampangan)	0	0	1	1
Filipino American	0	4	4	8
Filipino and African American	0	1	0	1
Filipino and Chinese	0	1	1	2
Filipino and Hawaiian	0	0	1	1
Filipino and Irish	0	0	1	1
Filipino and Mexican	0	1	2	3
Filipino and Portuguese	0	1	0	1
Filipino Islander	0	0	1	1
Filipino P	0	1	0	1
Filipino-American	0	2	3	5
Filipino-American?	0	0	1	1
Filipino, American, Spanish	0	1	0	1
Filipino, Black, Mexican, and	0	1	0	1
Filipino, Black, Spanish, French, Native American, etc.	0	0	1	1
Filipino, Chamorro, Spanish	0	0	1	1
Filipino, Chinese	0	0	1	1
Filipino, Chinese and White	0	0	1	1
Filipino, German, Spaniard	0	1	0	1
Filipino, Island Pacificer	0	0	1	1
Filipino, Native American, Ch	0	0	1	1
Filipino, Spanish, Hawaiian	0	0	1	1
Filipino, Taiwanese	0	0	1	1
Filipino, Vietnamese, Korean,	0	0	1	1
Filipino/Asian	0	0	1	1
Filipino/Asian	0	1	0	1
Filipino/Chinese	0	0	1	1
Filipino/Chinese	0	1	2	3
Filipino/Hawaiian	0	1	0	1
Filipino/Irish	0	0	1	1
Filipino/Mexican	0	0	2	2
Filipino/Salvadoran	0	0	1	1
Filipino/Salvadorian	0	1	0	1
Filipino/White	0	0	2	2
Filipinx	0	1	0	1

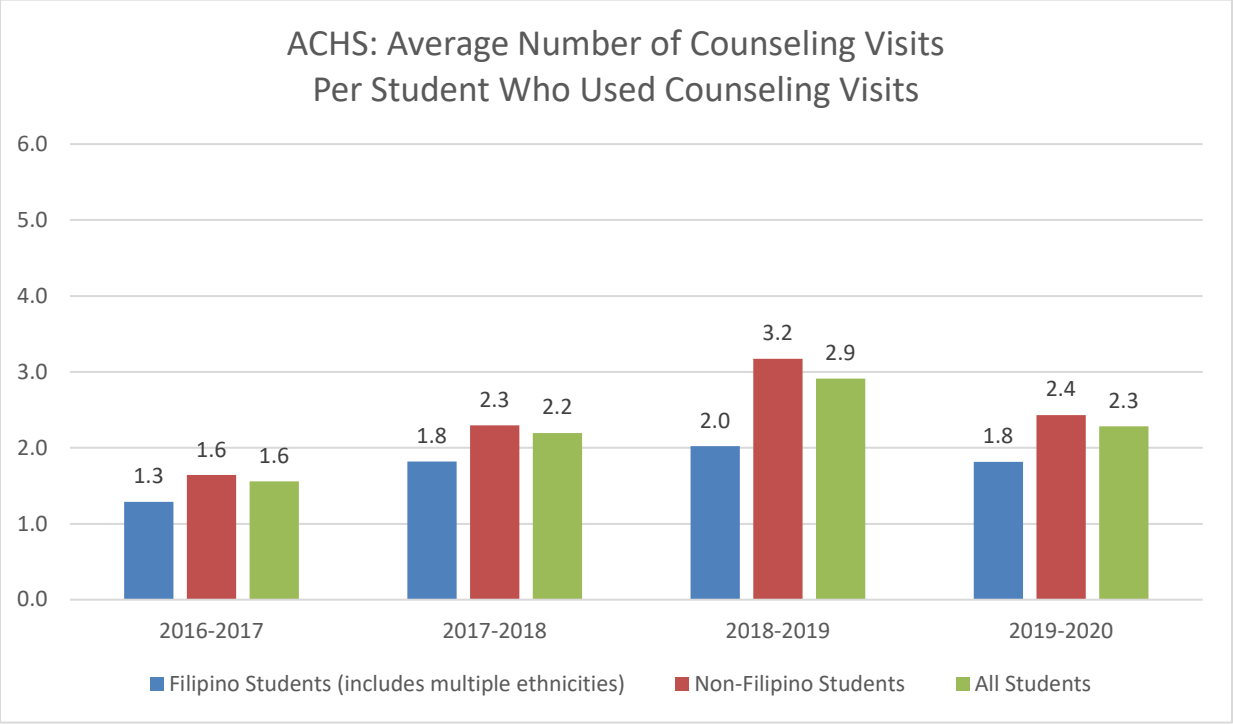
What is your culture/ethnicity? (Community Survey 2018)				
	Did not indicate age group	Adult	Youth	Total All Respondents
Full Filipino	0	0	1	1
Guamanian/Filipino	0	0	1	1
Half Filipino and Half Mexican	0	0	1	1
Hispanic	0	0	4	4
Hispanic	0	1	20	21
Hispanic / Latino	0	0	1	1
Hispanic/Latina	0	0	1	1
I am a Latina from Central America	0	0	1	1
I am a Second Generation Filipino	0	0	1	1
I am a White African American	0	0	1	1
I am African American and Filipino	0	0	1	1
I Am African American, Spaniard	0	0	1	1
I don’t know	0	0	1	1
I am Hispanic.	0	0	1	1
Indian	0	0	2	2
Indian (From India)	0	0	1	1
Indian/Punjabi	0	0	1	1
Irish & German	0	1	0	1
Irish German and Filipino	0	0	1	1
Latin	0	0	2	2
Latina	0	0	2	2
Latina/Hispanic	0	0	1	1
Latino	0	0	7	7
Latino/Hispanic	0	0	1	1
Lebanese, Spanish, Irish, German	0	0	1	1
Mexican	0	0	8	8
Mexican American	0	0	1	1
Mexican and Colombian	0	0	1	1
Mexican-American	0	0	1	1
Mexican/ Arabic	0	0	1	1
Mexican/ Filipino	0	1	0	1
Mexican/ Hispanic	0	0	1	1
Mexican/Hispanic/ Latina	0	0	1	1
Mexican/Latino	0	0	2	2
Middle Eastern	0	0	1	1
Mind Your Own Business	0	1	0	1
Mixed	0	0	2	2
Mostly Asian	0	0	1	1

What is your culture/ethnicity? (Community Survey 2018)				
	Did not indicate age group	Adult	Youth	Total All Respondents
N/A	0	0	1	1
Nigerian/ Canadian	0	0	1	1
Not Filipino	0	0	1	1
Pacific Islander	0	1	3	4
Pacific Islander; Hispanic	0	0	1	1
Pakistani	0	0	1	1
Pakistani Or Middle Eastern.	0	0	1	1
Pilipino/American/White	0	0	1	1
Pilipino American	0	1	0	1
Polynesian	0	0	1	1
Prefer Not To Say	0	0	1	1
Salvadorian	0	0	1	1
Swedish and Nigerian	0	0	1	1
Swedish, African American	0	0	1	1
Taiwanese	0	0	1	1
Vallejo	0	0	1	1
Vietnamese	0	1	6	7
Vietnamese and Hmong	0	0	1	1
Vietnamese/Chinese	0	0	1	1
White	0	0	13	13
White and Filipino	0	0	2	2
White and Filipino (mainly a Filipino household)	0	0	1	1
White, Filipino, Latina, European	0	0	1	1
White, Mexican, Indian, etc.	0	0	1	1
White/ Caucasian	0	0	1	1
White/Filipino	0	0	1	1
White/Mexican	0	0	1	1
Total Respondents	**6**	**100**	**338**	**444**

Appendix B: Service Use and Reported Risks

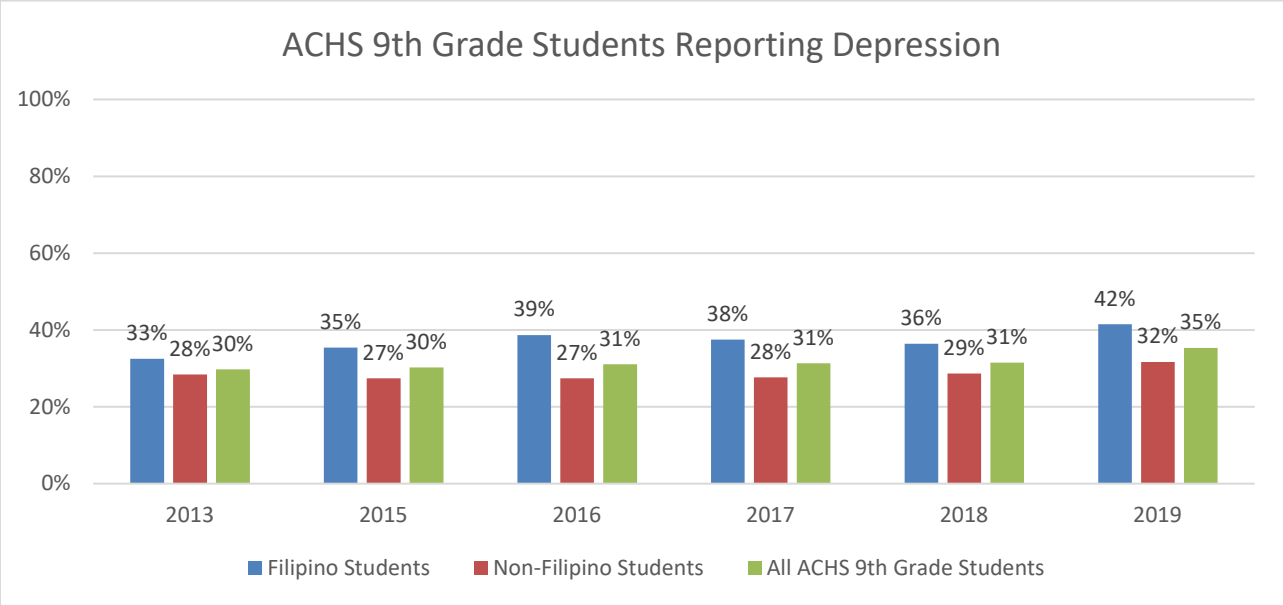
The graphs on this page are based on NVUSD data about the use of **Counseling Visits at American Canyon High School (ACHS).**

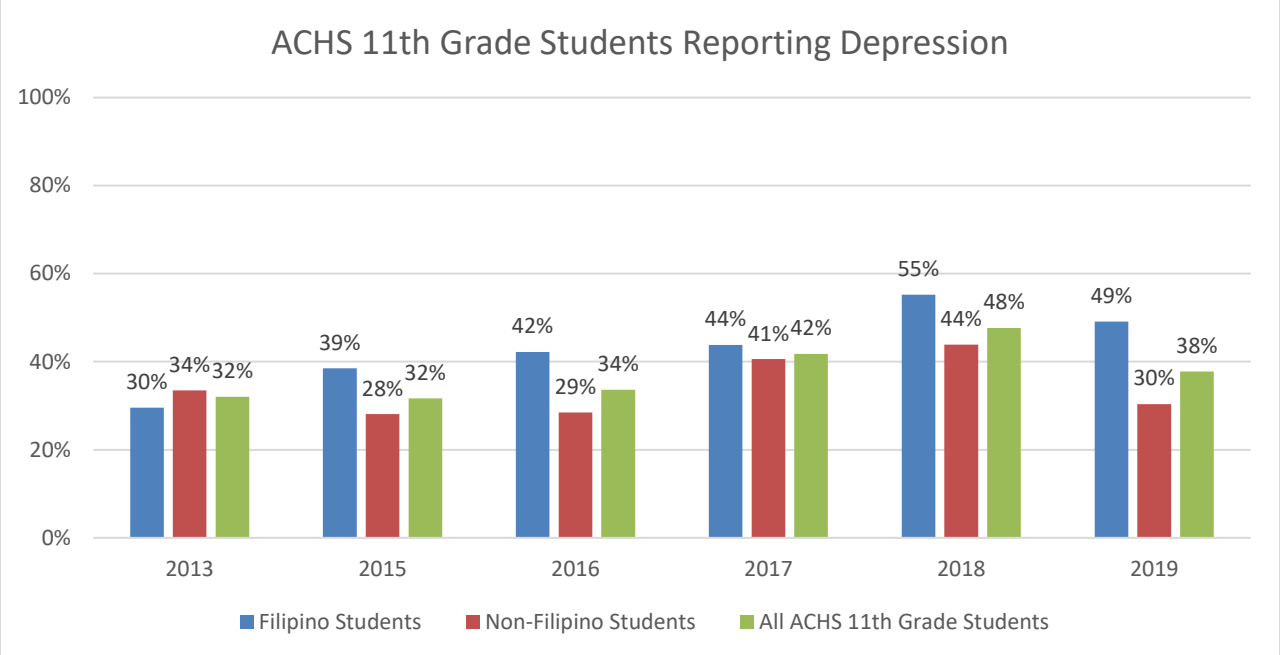




These two graphs are based on responses to the California Healthy Kids Survey question regarding **Depression.**

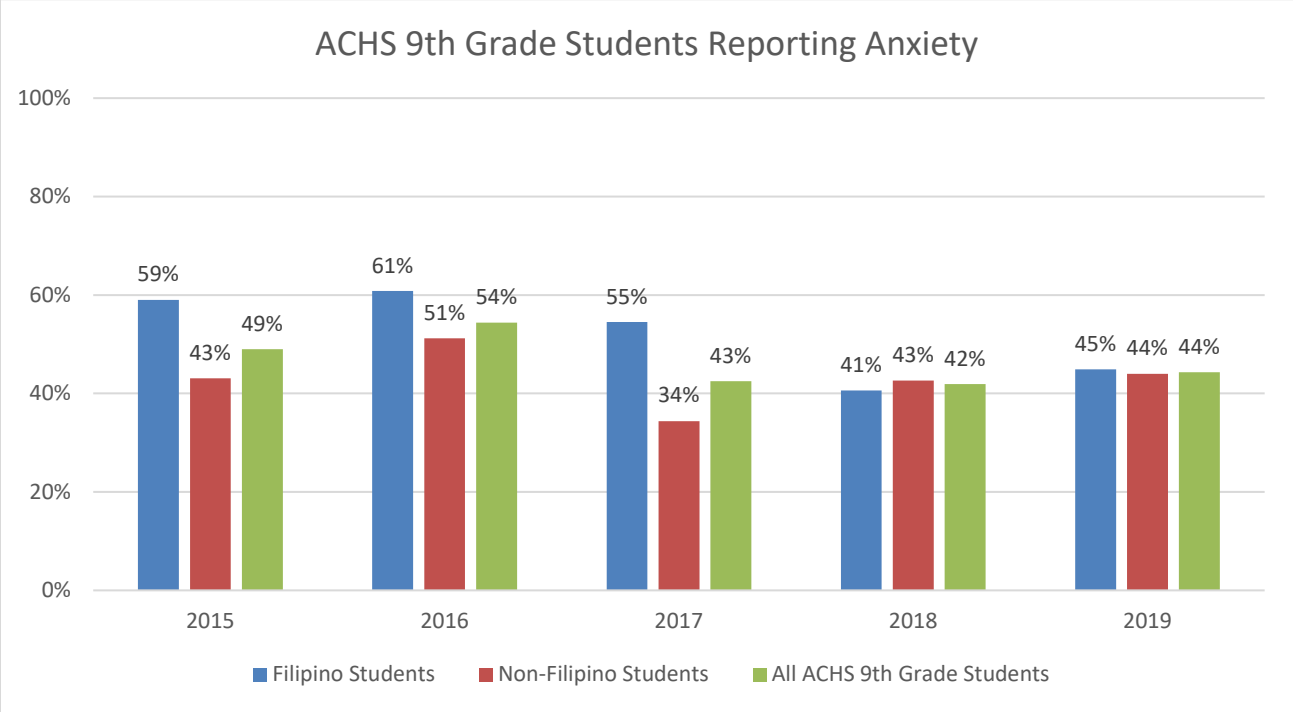
"In the past 12 months, have you ever felt sad or hopeless almost every day for 2 weeks?"

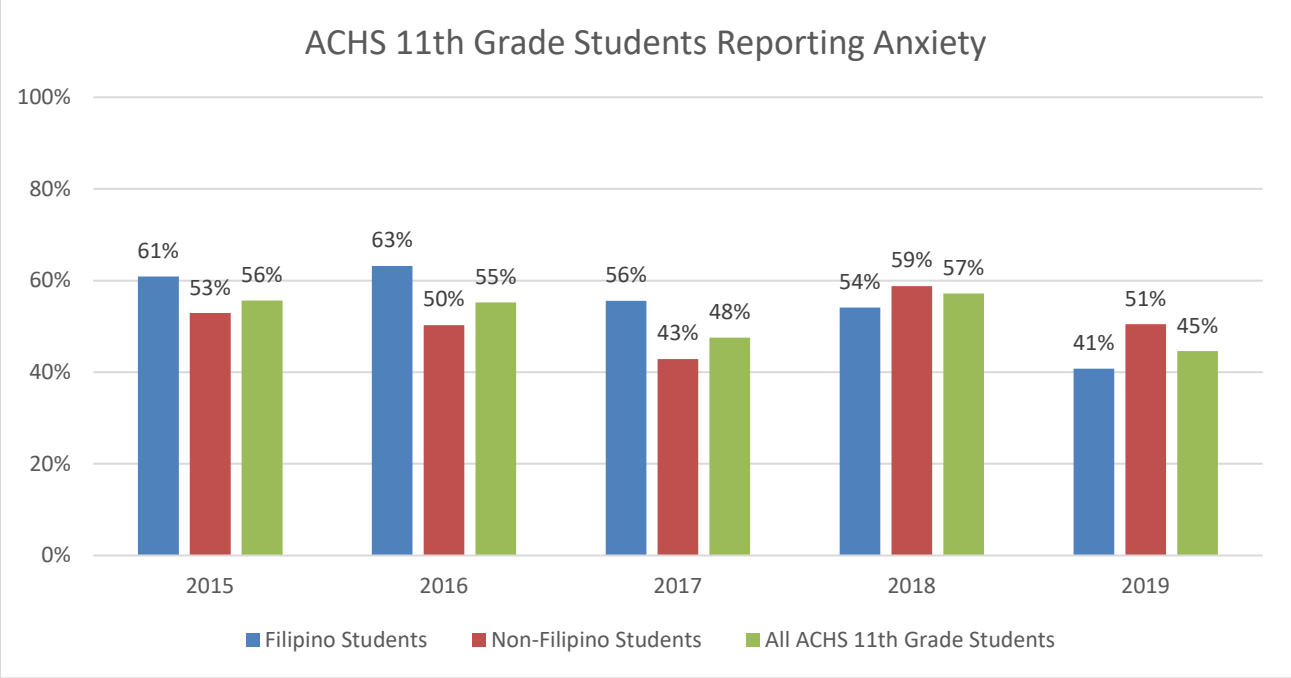




The graphs on this page are based on responses to the California Healthy Kids Survey question regarding **Anxiety**.

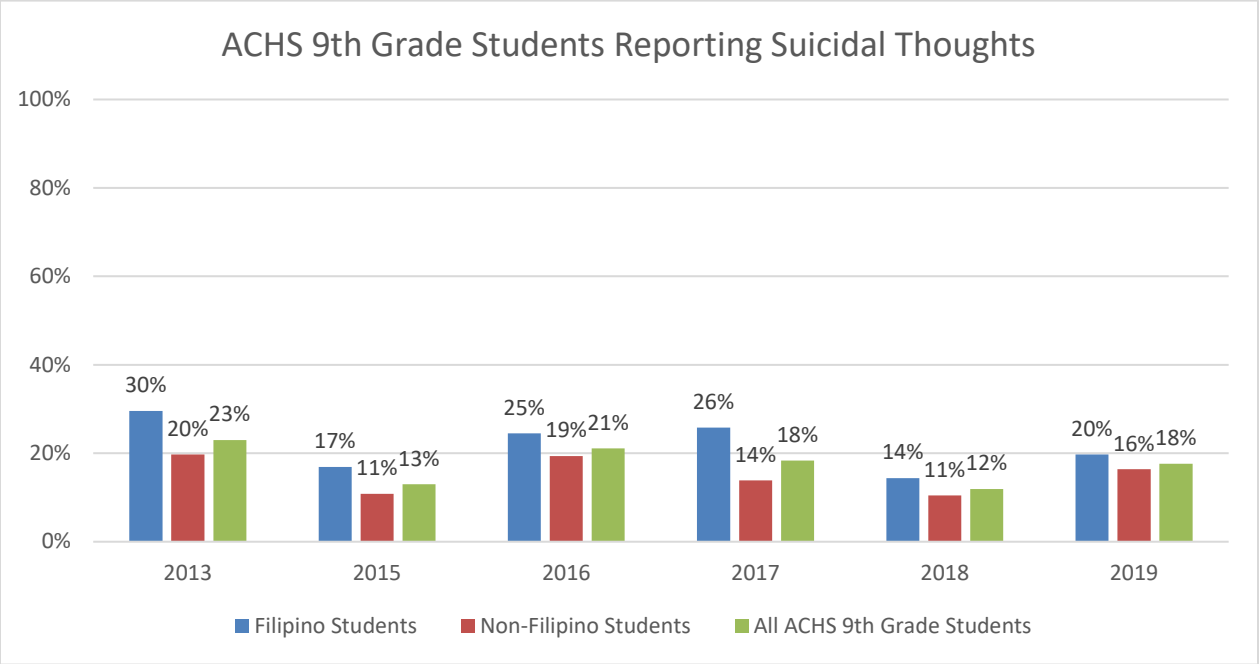
"In the past 6 months, did you feel so nervous, anxious, frightened, or worried that you had difficulty concentrating?"

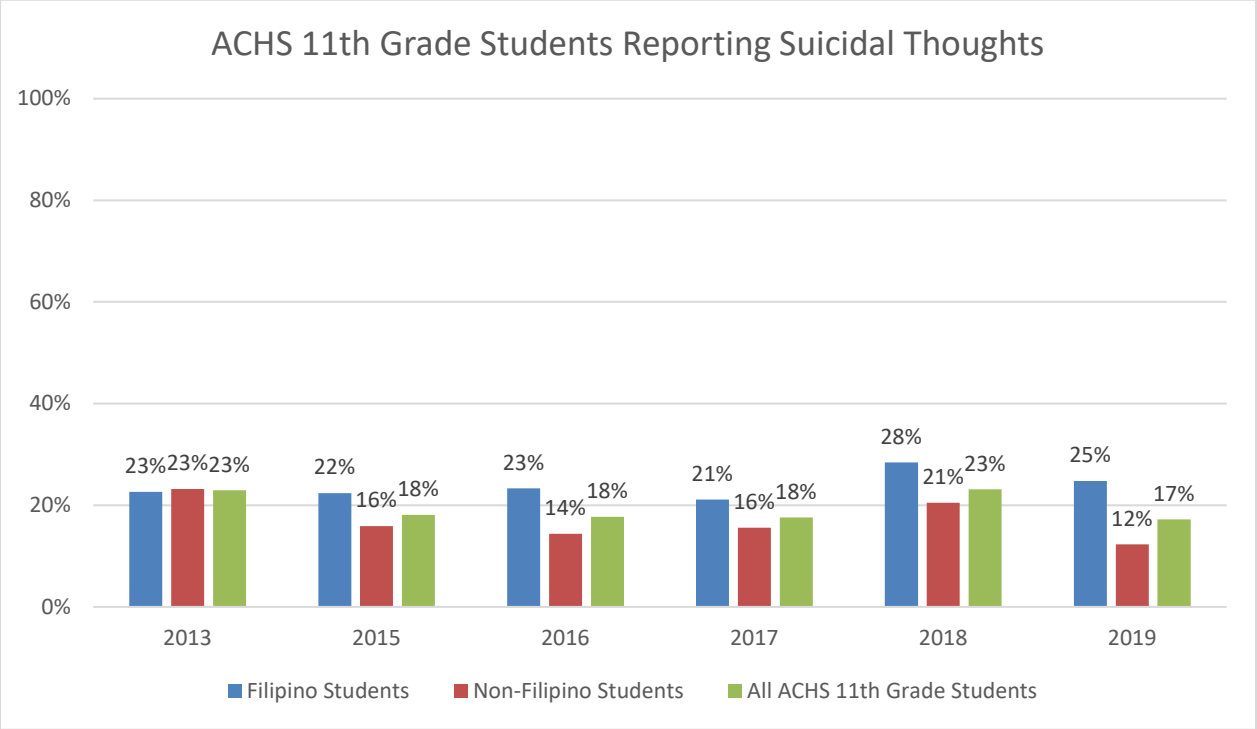




The graphs on this page are based on responses to the California Healthy Kids Survey question regarding **Suicidal Thoughts.**

"In the past 12 months, did you ever seriously consider suicide?"





Appendix C: FLAGG Calendar and Topics

Introduction

The following information was provided by program staff to explain the shift in the calendar and the topics that were part of the initial FLAGG program. The calendar was influenced both by the emerging needs of the participants as well as by the emerging needs in the community. These needs related to both Filipino experiences and the COVID-19 Shelter in Place Order.

Changes in Topics

Early changes came about from FLAGG student leader input:

1. "FILIPINO HISTORY" was changed to "FILIPINO HISTORY - MYTHOLOGY" because student leaders were more interested in ancient Filipino mythology stories, rather than an overview of history. This was welcome, as condensing 600+ years of history was challenging.

Other changes came from adult mentor input:

2. "WHO IS FILIPINO" PARTS 1 & 2, were added in response to events experienced by an adult mentor in the American Canyon Filipino community. Many factors were discussed, including place of birth, blood relations, knowing the Filipino language, familiarity with Filipino culture, and being raised in the Philippines. It was revealing and cathartic for a lot of members who get "culturally shamed" by other Filipinos for not fitting a certain mold.

The shift to mental health topics was influenced by participants and the learning goals.

3. In January 2021, project staff pivoted to mental health. The focus at the beginning of the FLAGG project was on cultural education. As part of this, staff created an atmosphere focused on gaining trust and having open, non-judgmental discussions. Staff with mental health training was instrumental in focusing the group on mental health topics and communicating coping strategies. Students were eager to share openly about their challenges when the proper atmosphere was created.

   This shift to mental health occurred in response to FLAGG members request for useful coping strategies to address the mental health challenges that adults, students, friends, and family were facing during COVID-19, as well as the mental health concerns that were encountered prior to members involvement with FLAGG. The shift also aligned the program more closely with the learning goals.

   - LET'S TALK ABOUT MENTAL HEALTH, PARTS 1 & 2
   - SELF IMAGE, PART 2
   - COPING WITH DEPRESSION
   - STRUGGLES & DEPRESSION
   - COPING WITH STRESS

   Some of the previous topics got incorporated into the revised calendar, as we took a deeper dive in to mental health:

   - SELF-ESTEEM & SELF-IMAGE

- HEALTH & WELLNESS
- FILIPINO CHALLENGES

Other topics were dropped in making the pivot to mental health. These may be added to future FLAGG workshops.

- SPEAKER NIGHT
- FILIPINO COMEDY & STEREOTYPES
- JUSTICE & EQUALITY
- SPIRITUALITY
- CROSSING THE LINE

Changes in Events

Some calendar events got dropped altogether due to Covid-19 restrictions and not being able to meet in person.

4. Project staff anticipate adding these events to future FLAGG workshops.
   - Student & Adult Leader Check-Ins (these were done by emails & texts)
   - FLAGG Socials
   - Community Services Events

Additional events were added during the year which, while unexpected, fit in well with the program goals.

5. FILIPINO HISTORY MONTH PROCLAMATION
   As the direct result of the participation of an adult mentor, the City of American Canyon invited FLAGG members to the Filipino History Month Proclamation. A FLAGG student leader received the City's proclamation and was able to speak about FLAGG to American Canyon City Council.

6. ASIAN SOLIDARITY RALLY
   This event was organized by an adult mentor, and FLAGG participants (adults and youth) spoke at the rally to express FLAGG members' solidarity and cultural concerns in response to Asians being affected by Anti-Asian hate crimes.

FLAGG Meeting Topic and Event Calendar, Initial and Final, FY 20-21

Unless otherwise noted, all meetings were planned/held over Zoom from 4-5pm on Mondays.

Date		**Initial Calendar** (As of Fall 2020)	**Final Calendar** (As of June 2021)
September 2020	21	Student Check-In Meeting	Student Check-In Meeting
	24	Adult Mentor Check-In (Thursday)	Adult Mentor Check-In (Thursday)
	28	Student & Adult Leader Meeting	Student & Adult Leader Meeting
October 2020	5	Leader Orientation & Survey	Leader Orientation & Survey
	12	Getting Acquainted & Survey	Getting Acquainted & Survey
	19	Communication	Communication
	20		Filipino History Month Proclamation 7:30 PM @ City Hall (Tuesday)
	26	Who Is A Filipino?	Who Is A Filipino?
November 2020	2	Who Is Filipino, Part 2	Who Is Filipino, Part 2
	9	Filipino Family	Filipino Family
	16	Music Meeting	Music Meeting
	23	Filipino History (Pre-Modern)	Filipino History - Mythology
	30	Filipino Food & Healthy Habits	Filipino Food & Healthy Habits

FLAGG Meeting Topic and Event Calendar, Initial and Final, FY 20-21

Unless otherwise noted, all meetings were planned/held over Zoom from 4-5pm on Mondays.

Date		**Initial Calendar** (As of Fall 2020)	**Final Calendar** (As of June 2021)
December 2020	7	Immigration	Immigration
	12		Parol Festival & Competition- Filipino Christmas Event (Saturday)
	14	Filipino Leadership Event	Belonging
	20	FLAGG Christmas Caroling – Social 7:00 – 9:00pm (Sunday)	No Meeting: Winter Break
	28	Student & Adult Leader Check-In	No Meeting: Winter Break
January 2021	4	Student & Adult Leader Mid-Year Evaluation/Survey (TBD)	Student & Adult Leader Mid-Year Evaluation/Survey (TBD)
	11	School & Student Life	Current Events
	18	Filipino Mythology	No Meeting: MLK Day
	25	Careers And Choices	
	31	Sunday Student & Adult Leader Check-In	
February 2021	1	Speaker Night Topic: Local Filipino History Or Other Topic TBD by Leaders	Who Am I?
	8	Filipino History (Modern)	Let's Talk About Mental Health I
	12		We Love Everyone In AmCan - Cultural Diversity Event (Friday)
	15	No Meeting: Mid-Winter Break, Social: Movie Night, Dinner, Ice Cream Social, Outdoor Hike (TBD)	No Meeting: Mid-Winter Break
	22	Filipino Comedy & Stereotypes	Let's Talk About Mental Health II

FLAGG Meeting Topic and Event Calendar, Initial and Final, FY 20-21

Unless otherwise noted, all meetings were planned/held over Zoom from 4-5pm on Mondays.

Date		**Initial Calendar** (As of Fall 2020)	**Final Calendar** (As of June 2021)
	28	Student & Adult Leader Check-In (Sunday, TBD)	
March 2021	1	Self-Esteem & Self-Image	Self-Esteem & Self-Image
	9	Spirituality	Self-Image II
	15	Filipino Challenges	Coping With Depression
	22	Health & Wellness	Health & Wellness
	28	Student & Adult Leader Check-In (Sunday, TBD)	
	29	Careers And Goals	
April 2021	5	No Meeting: Easter Break	No Meeting: Easter Break
	12	Community Service Event (TBD)	
	19	Affirmations	Struggles & Depression
	26	FLAGG Social 6:00 – 8:00 PM @ ACHS	Coping With Stress
		FLAGG Program Survey	
May 2021	3	Student & Adult Leader End-of-Year Evaluation (TBD)	Affirmations
	10	Student & Adult Leader End-of-Year Evaluation	Student & Adult Leader End-Of-Year Evaluation
	15		AmCan - Asian Solidarity Rally (Saturday)

FLAGG Meeting Topic and Event Calendar, Initial and Final, FY 20-21

Unless otherwise noted, all meetings were planned/held over Zoom from 4-5pm on Mondays.

Date		**Initial Calendar** (As of Fall 2020)	**Final Calendar** (As of June 2021)
June 2021		FLAGG Program Evaluation & Reports Student & Adult Leader Recruitment	FLAGG Program End-of-Year Evaluation & Reports
July 2021		New Leader & Adult Leader Training Participation in Pista Sa Nayon Filipino Festival and/or 4th of July Parade (TBD)	FLAGG Leader & Mentor Social (TBD) New Leader & Adult Leader Recruitment (TBD)

Innovation Round 2- Understanding Native American Historical Trauma and Healing

Program Report, August 2021

Overview

The Suscol Council Intertribal Council's Understanding Native American Historical Trauma and Healing Project was funded to respond to the lack of information about Native history and experience and to respond to the community's curiosity about the use of the healing methods demonstrated in Suscol's community education. The project was designed specifically for mental health providers to expand understanding, compassion, and resources available to the Native individuals seeking mental health supports.

Learning Questions

Innovation projects are developed to address learning questions. The following learning quesitons guided the activities and the evaluation of the Native American Historical Trauma and Healing Workshop Series.

- Does the workshop series change mental health providers' understanding and compassion for Native American individuals with mental health concerns and a traditional view of trauma?
- Do providers integrate the learning into their own self-care? Why or why not?
- Do providers use their knowledge of Native American culture and history and their experiences with traditional wellness and healing methods[1] to change their professional practice? How? Why?

Summary of Learning

Data was collected and reviewed throughout the project to inform the workshop series and to understand how individuals were using the information. The findings are organized by learning question.

Does the workshop series change mental health providers' understanding and compassion for Native American individuals with mental health concerns and a traditional view of trauma?

Yes, the participants reported changes in their understanding of the Native history and experience and reported feeling both inspired and overwhelmed by the information. The participants talked about the emotional impact of the learning and reported changes in knowledge, attitudes, and behaviors as a result of participating. A community wide survey done at the end of the project also showed increased familiarity with regional Tribes, and more information about historical trauma among the community mental health providers.

Do providers integrate the learning into their own self-care? Why or why not?

[1] In this report, "healing methods," "healing traditions," and "healing elements" are used interchangeably. These terms are all meant to describe a process of healing.

The participants reported positive changes after experiencing the healing elements at the end of the workshops and the majority of the providers were comfortable integrating the learning into their own self-care. A few were concerned about cultural appropriation and did not feel as comfortable.

Do providers use their knowledge of Native American culture and history and their experiences with traditional wellness and healing methods to change their professional practice? How? Why?

Yes, after the workshops about 40% of the participants indicated they planned to use at least one of the methods with clients. Several providers shared the elements with co-workers as a way to promote using the elements with clients served by their agency. Among the providers who did not plan to use the elements, some indicated it felt inappropriate for them because it wasn't their tradition, other talked about referring individuals to Suscol or other agencies and/or community members who can provide the elements for Native individuals.

Table of Contents

The Need

From the Proposal

The incidence of mental illness in the Native American population is higher than in the general population.

- Native Americans are 1.5 times more likely to experience "serious psychological distress", and
- Twice as likely to experience post-traumatic stress disorder.
- "The most significant mental health concerns today are the high prevalence of depression, substance use disorders, suicide and anxiety".[2]

Despite the increased prevalence of serious mental illness, very few Native American individuals seek treatment services in Napa County.

- In Napa County, the estimated prevalence of Serious Mental Illness for Native Americans is 8.7%, twice the rate for the general population (4.1%).
- In 2014, 51 individuals who identified as Native American were eligible for public mental health services. Eight received services.[3] In 2015, 42 individuals qualified and 4 were served.[4]

Mental Health America explains that Native American worldviews can be useful in finding more effective ways to provide support.

> *There have not been many studies about Native American attitudes regarding mental health and mental illness. There is a general Native American worldview that encompasses the notions of connectedness, reciprocity, balance, and completeness that frames their views of health and well-being. Studying this experience may help lead to the rediscovery of the fundamental aspects of psychological and social well-being and the mechanisms for their maintenance.*[5]

There are few culturally-competent resources available to the population of Native Americans in Napa County. Those that exist are not focused on increasing the cultural competency of the mental health system though the estimated incidence of serious mental illness for Native Americans is higher than in other populations. This project is designed to address the gap in culturally-competent services by sharing the information about historical trauma and healing practices with mental health providers.

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[2] American Psychiatric Association. (2010). Mental Health Disparities: American Indians and Alaska Natives. http://www.integration.samhsa.gov/workforce/mental_health_disparities_american_indian_and_alaskan_natives.pdf, accessed 4/1/17.
[3] Mental Health Data Dashboard, Utilization Review Steering Committee, 02/16/17, page 3. Provided by Napa County Mental Health Division Staff, 03/01/17.
[4] Ibid
[5] Native American Communities and Mental Health. Accessed at Mental Health America, http://www.mentalhealthamerica.net/issues/native-american-communities-and-mental-health, 04/01/17.

The Innovation

The innovation for this project was providing workshops directly to mental health providers about Native American history and experiences and the healing methods used by Native individuals. The workshops were designed and facilitated by Native American individuals and focused on the experiences and traditions of California and Napa County Tribes.

By combining information about cultural strengths and the historical trauma with the experience of a healing tradition, Suscol Council hoped to change providers' understanding of and compassion for the Native American experience and encourage each participant to appreciate, use and share both the history and the traditional Native American healing practices.

Cultural Advisory Committee

The project began in 2017 by hiring staff and convening the Cultural Advisory Committee. The staff and the advisors met monthly for 15 months to develop the workshop format and content. These meetings lasted a full day, and included time to discuss the previous workshops, develop the upcoming workshop and/or to share the results of outside research.

The Cultural Advisory Committee primarily discussed what should be shared with non-Native individuals, and what should be kept within the Native community. The Committee was made up of four individuals. One of the members was a Native person who grew up in Napa and recently received a PhD in Native American Studies. This member advised the staff by verifying the accuracy of the workshop content using academic and online resources. The other members of the group were individuals who are descended from the Native people who are indigenous to Napa County. They currently live on reservations and rancherias in Sonoma and Mendocino counties. These members advised the staff by sharing the oral traditions, recounting their own history and experiences, and by discussing workshop content with four different Tribes in Sonoma, Mendocino, and Lake counties to be sure the Tribes were comfortable with what was being shared with non-Native mental health providers.

There were two primary areas of discussion that continued throughout the first two cohorts.

History and Experiences

The workshop's Native history and experience component began with California history, and then moved to focus on the local experiences of Native individuals. In order to bring this information to the workshops, the elders, advisors and staff shared a lot of their own family history and personal experience. In addition to talking about how much information to share, the group also acknowledged the impact of sharing personal and family stories of trauma with the group over the course of the five workshops. The group opted to hold the workshops monthly so staff could restore from the previous workshop and gather with the advisors and elders to plan for the next workshop.

To further the focus on healing, the group intentionally wove stories of resilience into each workshop. The elders, advisors and staff developed workshops that explained how the Native communities lived during the thousands of years of history prior to European contact, the traumatic impact of European contact, and how the families, Tribes and communities have survived and thrived.

Healing

In the second portion of each of the workshops, the staff introduced and demonstrated a healing practice. It was very important for the workshops that discussed trauma to also highlight the resilience of the Native individuals and to demonstrate the cultural supports used by Native people.

Choosing which healing methods to share was an extended discussion with the Cultural Advisory committee. Elders and advisors felt strongly that portions of the Native culture should remain within the Native community. Ultimately, they chose healing methods that were widely available and generally known in mainstream culture. The staff focused on demonstrating and discussing how to respectfully use the items that individuals had already been exposed to and in some cases used. The group agreed that they would not introduce lesser known methods, or traditions that included medicine that is in limited supply and may be difficult for Native individuals to access.

In planning for the original proposal, the Native staff intended to use and demonstrate the following methods: smudging, writing/art, drum circles, clapper sticks, drum making and drum blessing. After meeting with the Cultural Advisors and elders over several months, the group shifted to using and demonstrating the following ideas: Sage, Tobacco, Salt, the Rattle and the Drum.

Community Survey

While the planning with the Cultural Advisory Committee was progressing, the staff developed and distributed an online survey for mental health providers in Napa County. The survey was intended to gather information about (1) the mental health providers who serve Native American individuals, (2) their knowledge and experience with Native American history and healing methods, (3) where they go to find information, and (4) how they use the learning in their practice.

The Cultural Advisors, elders and staff all reviewed the survey questions prior to the survey being distributed. They suggested adding several questions to act as indicators of individuals' understanding of the history and experience of Native individuals in Napa County. The questions were intended to evaluate respondents' knowledge and to pique their interest in participating in the first cohort. In addition to the Cultural Advisors, the staff also reached out to three Native and Indigenous individuals who provide mental health services in Napa County to review the survey and provide feedback from the perspective of the provider.

The survey was completed by over 150 individuals, 101 of whom identified as mental health providers. The recruiting for the first cohort took place shortly after.

The community survey was administered twice during the project. First in July and August 2018, during the planning phase and again in April and May 2021 to understand what may or may not have shifted in the community of mental health providers. Both surveys were distributed online by Suscol staff.

Key findings from the initial survey are described below by topic area. The findings from the second survey are included in the Learning Questions sections.

Serving Native American Individuals in Napa County

Almost two-thirds of those who responded to the survey indicated they were a mental health provider. They primarily identified as female (77%), represented several racial/ethnic groups and reported between 0 to 46 years of experience in mental health. Of the mental health providers, **22% are currently serving and 50% have previously served Native American individuals**. The respondents

reported serving individuals in all age groups and in all areas of the county. Half of the providers (51%) reported they serve veterans, and 90% serve individuals who identify as LGBTQ.

Knowledge of and Experience with Native American Culture

Respondents were asked to rate their knowledge and experience with practices, people and places that relate to Native American culture. They were **most likely to report knowledge and experience with using sage**. About half of the respondents had interacted with individuals from local Tribes and attended a Native American gathering. Very few respondents indicated they were very familiar with the regional Tribes, and about **half reported some familiarity with the Pomo, Wappo and Miwok Tribes.**

Less than half of the respondents knew that Native Americans used all parts of Napa County prior to 1850. Though all areas of the county were chosen by at least some of the respondents, most of the areas were indicated by about half of the individuals.

The majority of the mental health providers who responded indicated they believe in historical trauma (84%) and 12% said they were not sure and needed more information. Only two respondents (one mental health provider, one other respondent) indicated they did not believe in historical trauma.

Finding Information about Native American Culture

The Suscol Intertribal Council was interested in how mental health providers learn about Native American people, places and practices. Several questions were used to understand sources of information where providers go when they want to learn more.

The most common ways that **mental health providers learned about regional Tribes was through the regional Native American sites (parks, preserves), and reading/research.** Only 12% reported learning about the Tribes through professional development.

When they want more information about how to serve Native American individuals, respondents reported that they **use libraries and the internet to research and read relevant materials and talk to Native American individuals and/or tribal organizations.**

Overall, the **respondents were three times more likely to have taken a general cultural competency course than a course specific to Native American culture**. Providers indicated that the general cultural competency courses and the Native American cultural competency courses were of similar quality, and the Native American courses were more likely to include information about historical trauma.

Use of Information in Mental Health Practice

Of those who reported that they were currently serving Native American individuals, 78% reported that they had prepared a space as part of their practice. The most common methods reported were incorporating nature in the space used for treatment, grounding or clearing the room prior to beginning, and displaying specific art and symbols relevant to Native Americans.

The majority of the providers did not know where to refer Native American individuals for further supports (67%). Those who do make referrals primarily indicated that they referred to Suscol Intertribal Council.

Over half of the respondents indicated that an understanding of Native American history and healing practices benefits all clients. A few providers felt it benefits some individuals, but not all.

The Workshops

The Cultural Advisory group began with the learning that Suscol Council had acquired over years of sharing the history of Native individuals with community members and professionals. The first workshop was an Overview of the Napa County Regional History. The presentation content had been used by staff in the Napa communities for several years prior to the project. The Cultural Advisory Committee reviewed the content and agreed with staff that it was a relevant and appropriate way to begin the series. The next four workshops were developed by the staff and advisors during the monthly Cultural Advisory Committee meetings. They intentionally began the workshop series by sharing the ways that Native individuals lived prior to European contact and included information about the resilience of Native people in each workshop. The topics in each cohort were as follows:

- **Overview of Napa County Regional Native History**: History from pre-Colonial to Contemporary Times
- **Pre-colonial History of California Natives:** The beauty and complexity of the local Native communities before European contact
- **Colonial History in California Native Territories**: The intense trauma of a 10,000+ year old civilization decimated in 25 years
- **Post-Colonial History of California Natives**: Discussions of the core causes of lateral violence and substance abuse within the Native Community today
- **"Thrival" and Tribal Resiliency:** How culture and ceremony help Native communities survive and thrive

To get further feedback on the relevance of the workshops, the staff invited the three Native and Indigenous mental health providers who had advised them on the community survey to participate in the first cohort. These individuals gave input on how the workshop content applied to their daily work and to the clients they serve.

Workshop Dates and Attendance

The first cohort began in August 2018 and continued monthly through January 2019. Twenty one individuals attended. The second cohort of 25 individuals began in February 2019 and continued through June 2019.

After the first two cohorts, individuals were invited to a drum workshop at the Suscol land base in Pope Valley. The drum workshop in August 2019 was intended for those who had completed the cohort and wanted to make a drum for their own use. The drum workshop was facilitated by a drum maker and drum keeper of the White Buffalo Woman Council Drum. Each participant made a drum during the two day workshop.

The original workplan included two cohorts and a drum workshop. As part of the workshops, staff had planned to distribute incentives to encourage individuals to attend. These stipends were not needed, and the remaining funds were used to plan a third cohort and an additional drum workshop.

Cohort and Workshop Dates and Attendance

Cohort/Workshop	Dates	Attendees
Cohort One	08/28/18 to 01/22/19	21
Cohort Two	02/26/19-06/25/19	25
Drum Workshop	08/03/2019-08/04/2019	14
Cohort Three	09/04/19-11/06/19	26
Drum Workshop	05/29/21	14

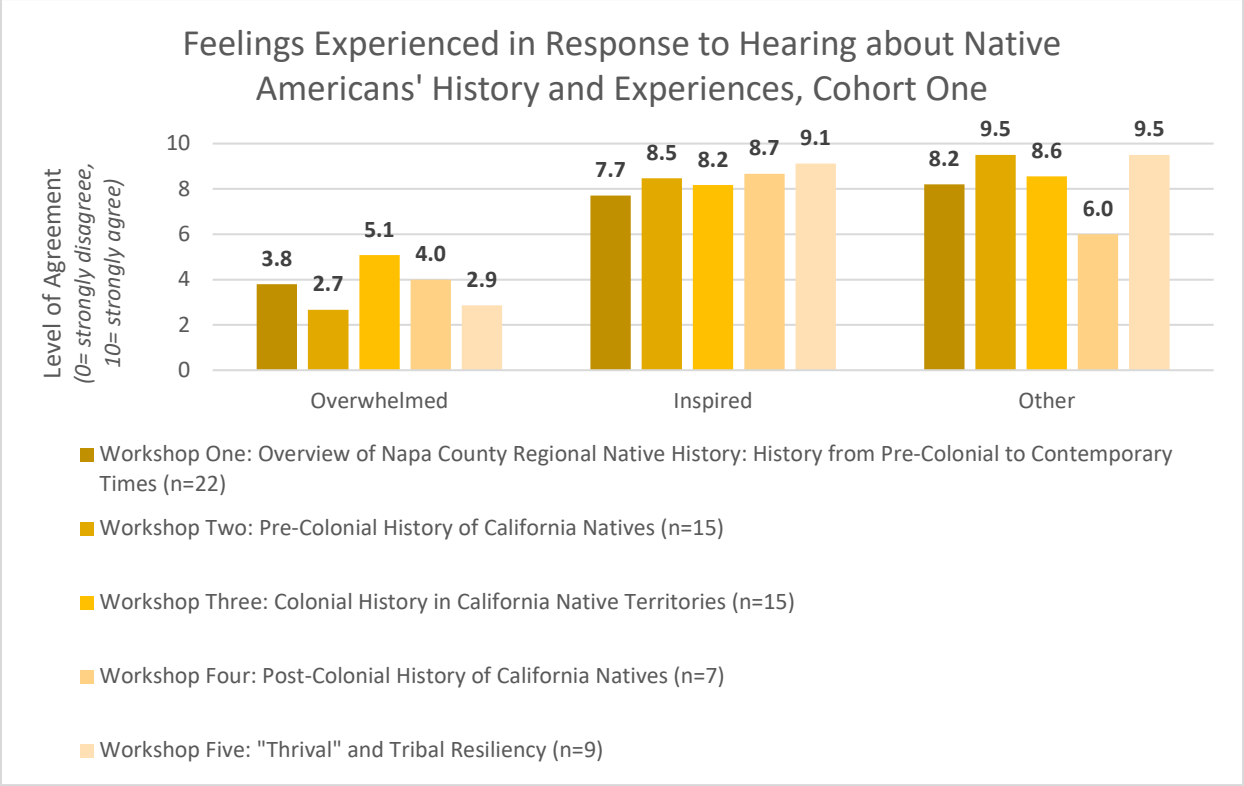
A summary of the demographics for all cohorts can be found in Appendix C. The flyers for each cohort and the drum workshops can be found in Appendix A.

Participant Response and Workshop Changes

The Cultural Advisory Committee, elders and staff developed each workshop as they went through the first Cohort. The attendees completed surveys after each workshop and the feedback was used to evaluate how individuals were responding to the workshop content.

One of the key areas they reviewed was how individuals reported feeling after learning the Native history and experience information. During the first cohort, the responses generally leaned toward feeling inspired, but those planning the workshops noted the rise in overwhelming feelings in the third workshop.

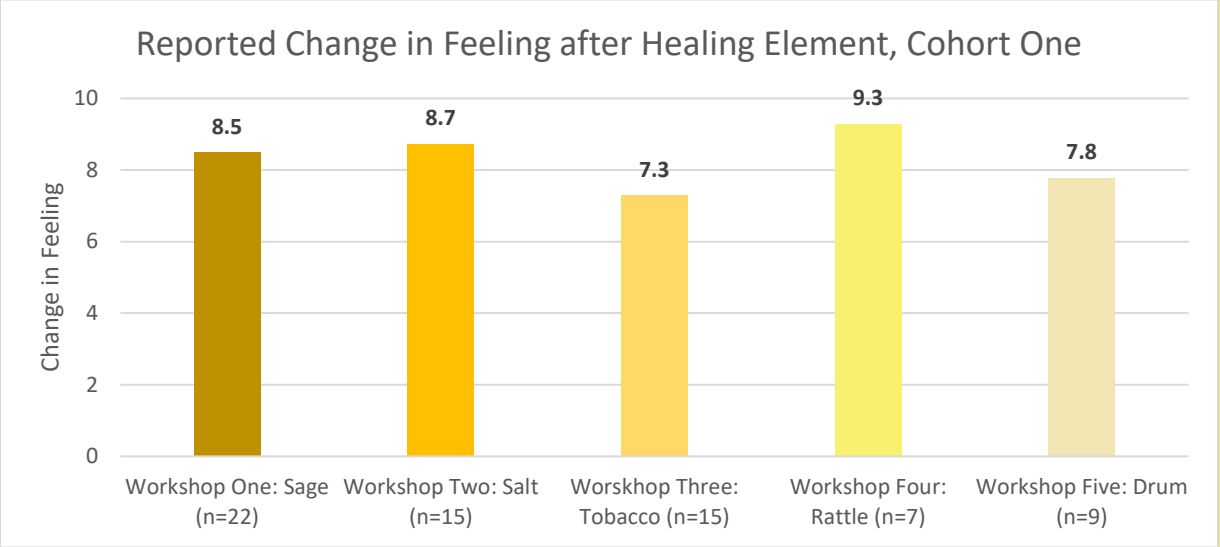
Hearing about oppression and historical trauma can overwhelm and/or inspire individuals.
How are you feeling right now?
Scale of 0-10, where 0 was Strongly Disagree and 10 was Strongly Agree.



- The previous figure shows that the third workshop had more individuals reporting they felt overwhelmed after hearing the history and experience information.
- Participants in all workshops were more likely to report feeling inspired than overwhelmed.
- When asked about "other" feelings they were experiencing, 18% of participants in workshop one, 25% of participants in workshop two and 38% of the participants in workshop three indicated feeling sad or angry. Though the number of comments about other feelings decreased in the final two workshops, there was only one response of sad in the fourth workshop, and all positive responses in workshop five.

The second area the Cultural Advisory Committee reviewed was how individuals were responding to the healing elements. They realized that tobacco was reported as the least likely to change how individuals were feeling and was being demonstrated in the third workshop which was the most likely to result in individuals feeling overwhelmed.

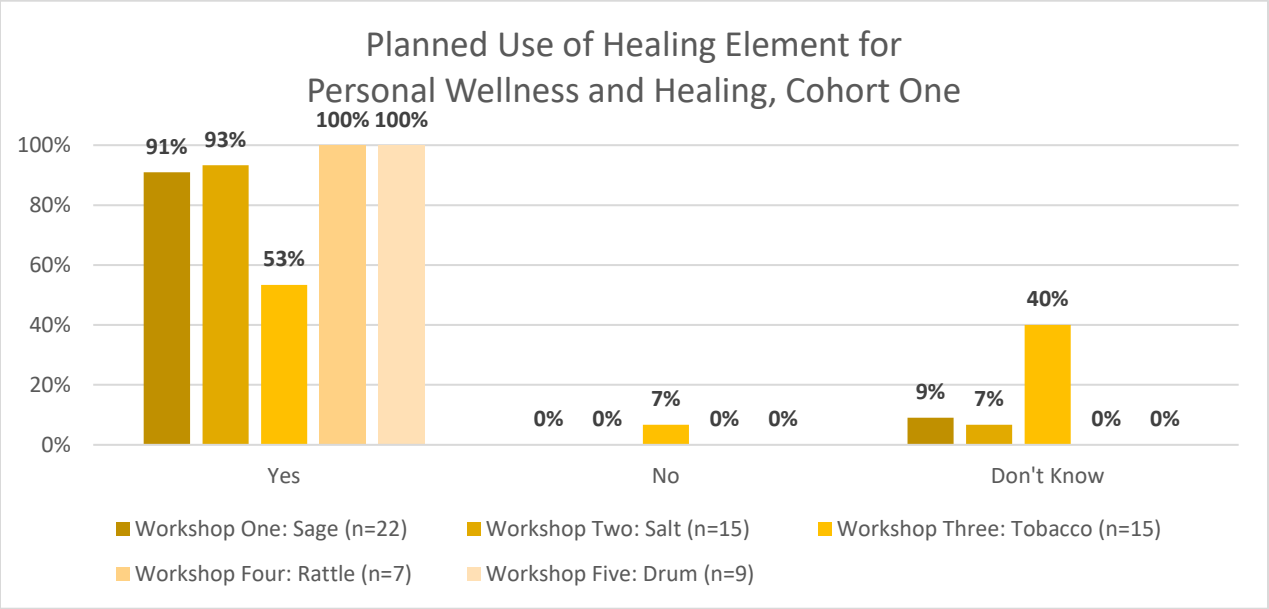
In your opinion, did the healing element change how you were feeling?[6]



[6] Note: Responses were on a scale of 0-10, where 0 is "I felt much worse after experiencing the healing element" and 10 is "I felt much better after experiencing the healing element". A rating of 5 is "I felt the same after experiencing the healing element."

Additionally, the respondents indicated they were the least likely to use the tobacco for their own self-care.

Do you plan to use [healing element] for your PERSONAL wellness and healing?



Based on this feedback, the staff shifted the discussion and demonstration about tobacco to the second workshop where individuals did not indicate being as overwhelmed and used salt as the healing element for the third workshop. Salt was noted by staff and attendees as very accessible to individuals and applicable across cultures and healing traditions.

Besides the shift in the pairing of the information and the healing element, the workshop topics and outlines remained the same across all three cohorts.

The Learning

The project's learning was informed by the workshop surveys, participant interviews and the second community survey. The results are presented in this section by learning question for easy reference.

Workshop Surveys

Each cohort participant was asked to complete a survey at the end of each workshop. The summarized responses were reviewed by the Cultural Advisory Committee, the elders and the staff to refine the workshop content. See Appendix B for a sample of the workshop survey.

Participant Interviews

The participant interviews took place in May-July 2020. This was planned for about 6 months after the third cohort to be sure all interviewees had a chance to try and use the information for their own self-care and/or to make changes in their mental health practice. The full list of participants was sampled to be sure that a range of experiences were represented. A primary sample of 30 individuals was chosen in the hopes of completing twenty interviews. A second sample was used to contact more individuals until a total of 21 interviews were completed.

Participant Interview Sampling

Sampling Criteria	Number in Primary Interview Sample	Number in Secondary Interview Sample	Number in Final Interview Sample
Tribal Affiliation	8	0	6
Contact With Suscol After Workshops	10	2	8
Director role at agency	6	4	7
Direct service role at agency	9	2	4
Did not attend all workshops	9	4	6
Total Sample Size	**30**	**12**	**21**

Community Survey

The community survey that was distributed during the planning phase of the project was distributed again at the very end of the project in April/May 2021. This second survey was intended to understand how individuals may have continued to shift their understanding, attitudes and behaviors after the workshops.

Change in Understanding and Compassion

Does the workshop series change mental health providers' understanding and compassion for Native American individuals with mental health concerns and a traditional view of trauma?

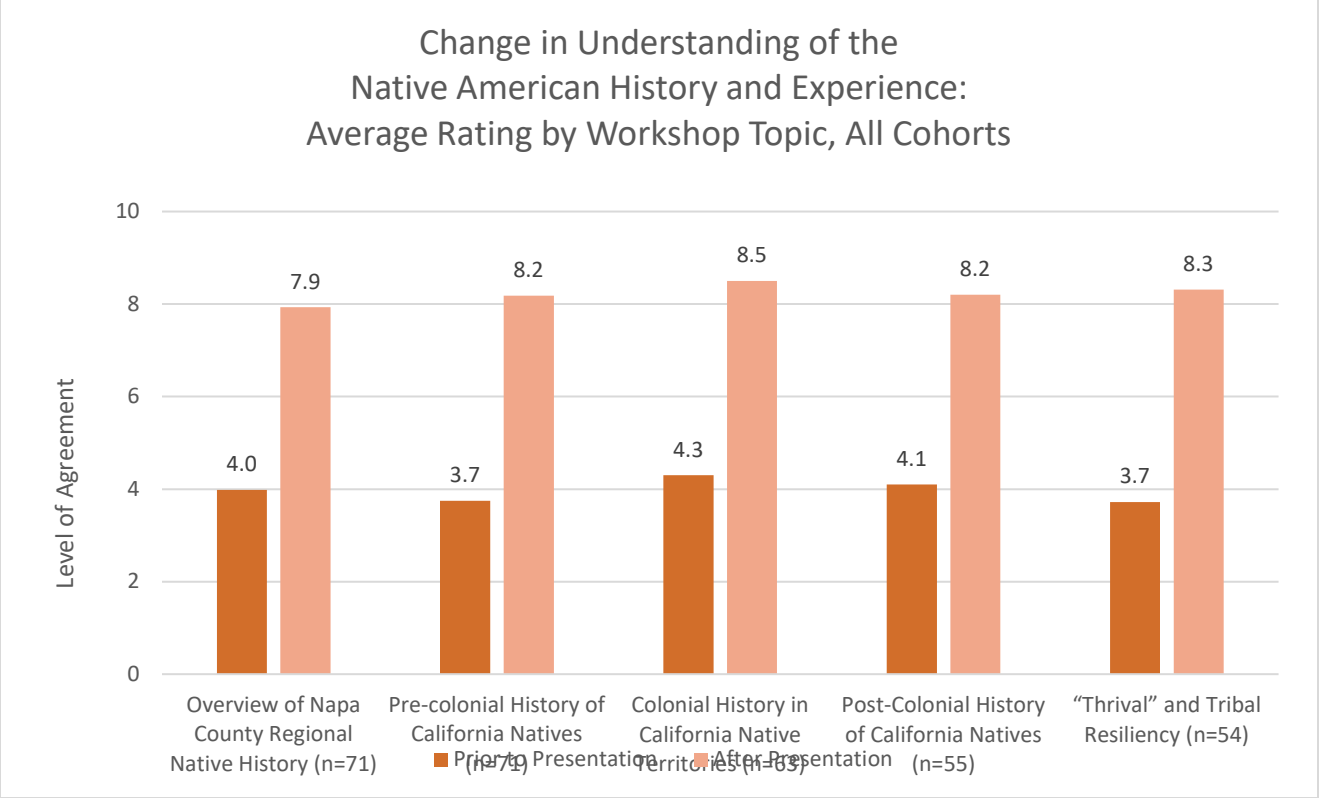
- Workshop participants reported changes in understanding and compassion after each of the workshops.
- Generally, the learning inspired them. They also reported feeling overwhelmed with the learning about Native history and experience, particularly after the two workshops that focus on trauma.
- The cohort members reported changes in their own feelings after experiencing the healing methods.
- In interviews, participants spoke about the emotional impact of the information as well as the historical learning. They reported changes in their knowledge, attitudes and behaviors as a result of participating in the cohorts.
- In a 2021 community survey given after the cohorts were completed, the community providers reported more information and familiarity with regional Tribes, and more information about historical trauma when compared to a similar survey in 2018.

Workshop Survey

Questions about understanding and compassion were included in the workshop surveys. Participants were asked how well they understood the workshop content on Native American History and Experience and how they felt after the presentation. The average ratings for all three cohorts are shown in the charts below.

At the end of each workshop, participants were asked to rate two statements about whether they understood the topic prior to the workshop and after the workshop.

Change in Understanding of Native American History and Experience, Average Rating by Workshop Topic, All Cohorts[7]

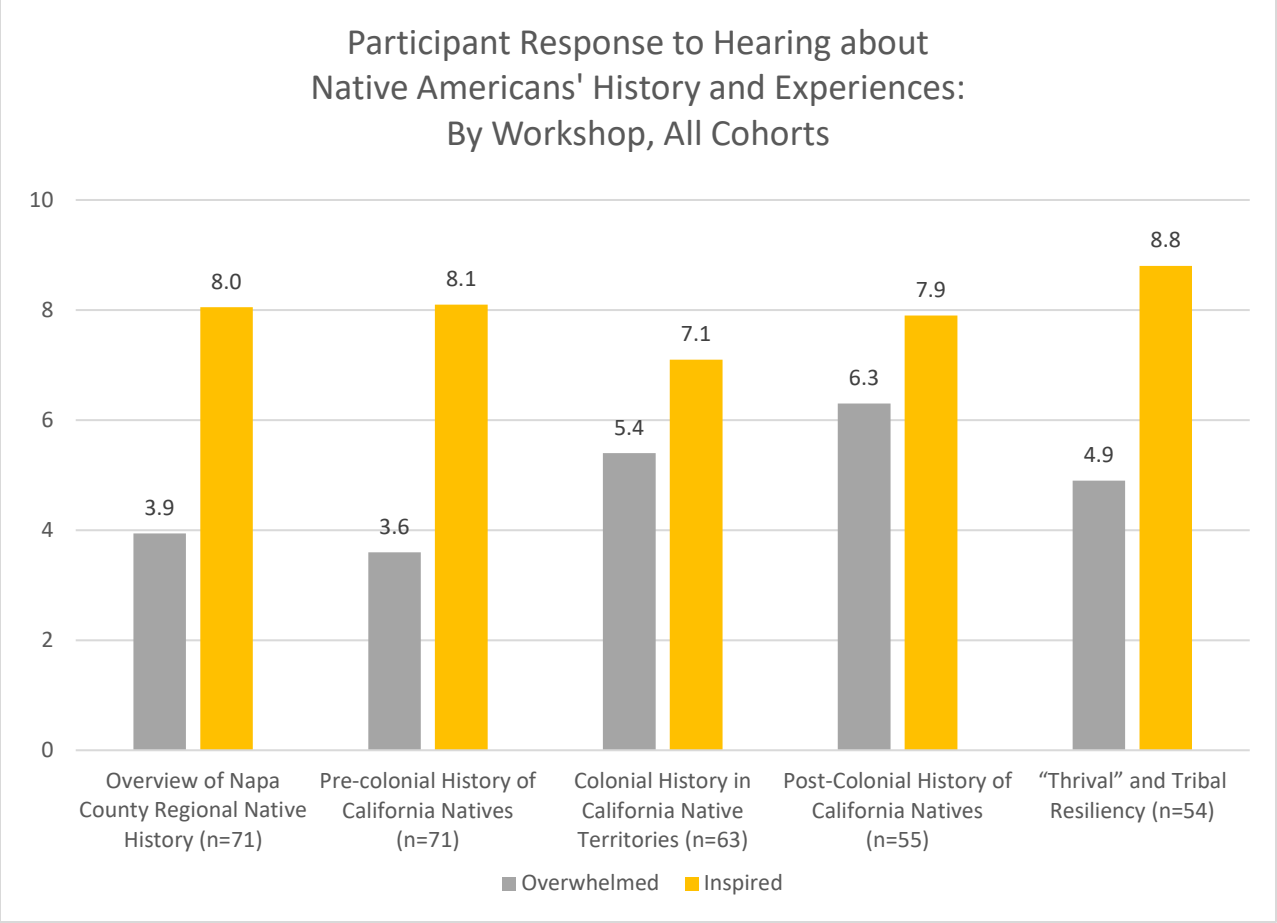


- **In all cohorts, the participants reported a change in understanding after the presentation**. They reported the smallest change in understanding in the first workshop (change of 3.9) and the largest in the precolonial and Tribal Resiliency workshops (change of 4.5 and 4.6 respectively).

The staff and advisors were very interested in how individuals responded to each of the workshops. The workshop survey included a question about how they were feeling. Each person was asked to rate whether they felt overwhelmed and whether they felt inspired.

[7] Respondents' answers were on a scale of 0-10 where 0= Strongly Disagree and 10=Strongly Agree.

Participant Response to Hearing about Native Americans' History and Experiences: Average Rating by Workshop, All Cohorts[8]

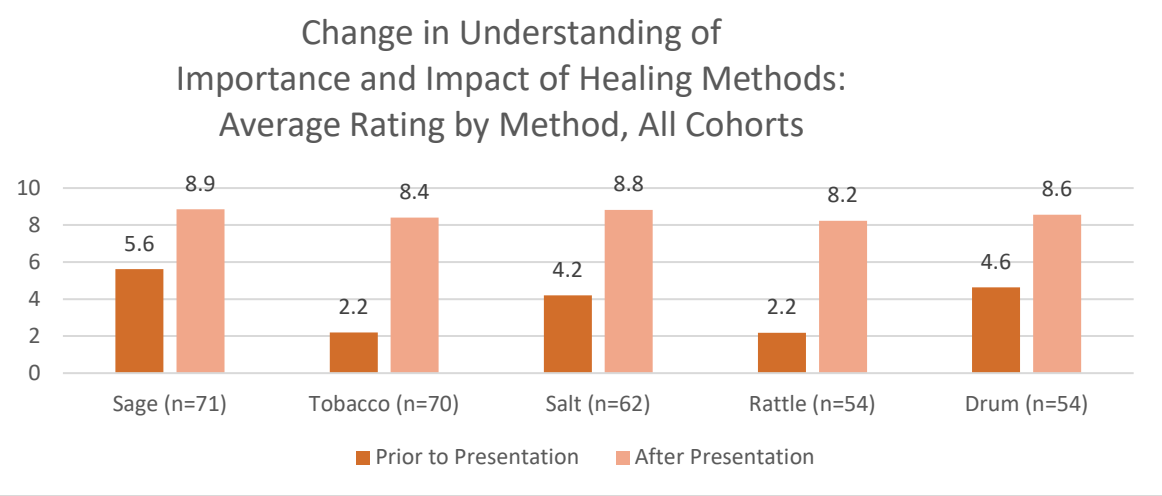


- **The primary feeling at the end of all workshops was inspired**.
- **Participants were more likely to report feeling overwhelmed in the third and fourth workshops** which focused on the trauma of European contact and the impact on Native individuals and communities.

After each presentation about the history and experiences of Native individuals, staff presented a healing element. The goal of these demonstrations was to give participants the experience of receiving medicine from Native healing. The Cultural Advisory Committee, elders and staff agreed that in addition to sharing the methods, they would teach individuals about the importance and impact of the method, the different ways it is used in different Native communities and how to use it respectfully. Workshop participants reported increased understanding in all of these areas after the workshops.

[8] Respondents' answers were on a scale of 0-10 where 0= Strongly Disagree and 10=Strongly Agree.

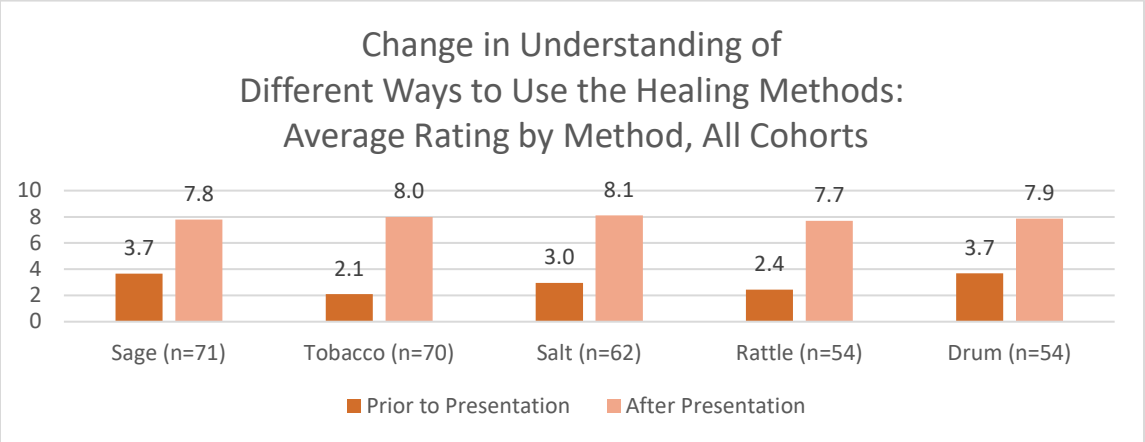
Change in Understanding of Importance and Impact of Healing Methods: Average Rating by Method, All Cohorts[9]



- Participants reported the least amount of prior knowledge about tobacco and the rattle. **They were the most familiar with the use of sage prior to the workshops.**
- At the end of the workshops, the participants reported the most understanding of sage and salt, followed closely by the drum.

A question about the different ways the method can be used in different Native Communities was added to assess the participants understanding of the varied culture within Native communities and their wellness and healing traditions.

Change in Understanding of Different Ways to Use Healing Methods: Average Rating by Method, All Cohorts[10]

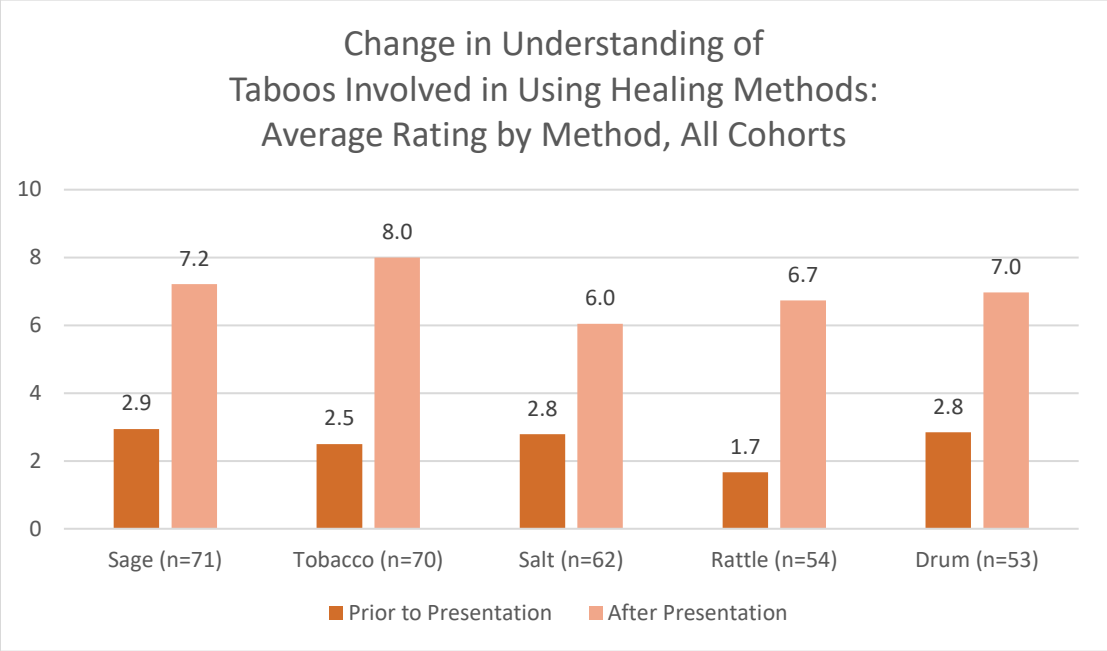


- **Participants indicated less prior knowledge in this area and significant learning as a result of the workshop.**

[9] Respondents' answers were on a scale of 0-10 where 0= Strongly Disagree and 10=Strongly Agree.
[10] Respondents' answers were on a scale of 0-10 where 0= Strongly Disagree and 10=Strongly Agree.

Finally, the attendees were asked about their understanding of how to use the method appropriately and respectfully.

Change in Understanding of Taboos Involved in Using Healing Methods: Average Rating by Method, All Cohorts[11]



- Though **all reported greater understanding of how to use the methods respectfully**, attendees reported being less knowledgeable in this area at the end of the workshop when compared to other knowledge questions about healing methods.
- Some individuals reported they appreciated experiencing the healing, but they did not feel comfortable using it themselves. They were not confident they would use it appropriately and wanted to be respectful after hearing about the importance of using the methods with permission.

Participant Interviews

The participants who were interviewed spoke vehemently and clearly about the change in their knowledge of Native history and experience and their compassion for Native individuals. The interviews began with an open question "What is different for you now that you have completed the workshops?" and the response was immediately about the shift in perspective that individuals experienced.

More Knowledge

*I think what's different for me is **a much richer understanding of the local experience**, in addition to the pain. A lot of the beauty that I was never taught as someone who grew up here and was schooled here. **The beauty, the richness, the atrocities, I guess the way it was illuminated, was in a way that was hard and important**. It was also told in a way that-- It wasn't just overwhelmingly hard. It was also enriching, enlightening, beautiful, and helpful.*

[11] Respondents' answers were on a scale of 0-10 where 0= Strongly Disagree and 10=Strongly Agree.

That's the emotional side of it… related just to my experience of being a white person who grew up in Napa and never learned to talk about or understand that.

*I think what I was thinking that I would get out of these workshops is a deeper sense of culture and history. What I also got was a really-- It felt kind of like eye-opening, and more of a social justice sense of there's all this … that you've been stepping on and walking on every day and going through and not questioning**. It really changed my perspective of realizing how much impact colonization has had. I've studied that in other contexts, but not right here in Napa or in California.***

*I would say that **this series made it… very approachable to understand the Native American experience and white people's roles in understanding and being part of that.** I'm sure we did lessons in elementary school…I remember doing a few, and I remember visiting the old Adobe …, but it was never fully brought home.*

More Awareness/Connection

I just really got a better sense of awareness about the Napa Valley and the Native population in that area. Now, I'm more aware of that. More aware of their struggle to be recognized.

I felt a little more connected to a Native American community here in Napa.

*Definitely, after the workshops, there's just a **greater awareness and gratitude for the land and paying respect to the Natives that were here that were here before us**. It made me think about it a lot more.*

*There was a lot that I wasn't aware of. Definitely the information that was provided in the workshops is something that you are not exposed to in regular education, in school, or anything like that. You don't hear any of that stuff, so **it is very eye-opening and powerful. I think it has affected the way that I see things.***

***I got more books in this last year to read more about traditional healing methods for indigenous people of Mexico, and also, just learning more about Native American history that's here local, and just being more in touch with that**. I've really purchased a ton of books in this last year in relation to that.*

Beginning to Make Changes

It opened me up to more exposure to the Native American community. I want to be a bigger part of it now since that workshop.

*It gave me **the ability to have a different perspective [and] not to clump everything together**. I learned about more of the functioning, the family functioning in the unit of each Tribe and their ancestors, how they went forward, and taught their young, their children. **I think it gives me a perspective of how to interact with a little bit more of sensitivity.***

*We [serve] a lot of children [who] are biracial, mixed, and go through trauma….I have team members, who are … primarily Caucasian. …[I] remind them to be mindful of the child that's in front of them. The child probably does not share their same background or values. Especially with the history that a lot of Native Americans had with authority figures and police, and now I'm thinking, "Okay, remember, these kids have a way different perspective. **Their ancestors may***

have not had such a great experience [with] authority figures and now, having to have you there, it's probably not what they're expecting".

When asked specifically which of the five workshops was the most impactful, interviewees frequently indicated the third workshop about European contact and the resulting trauma. Some talked about the workshops focused on resiliency and thriving, others noted that all of the workshops were impactful.

European Contact Workshop

The one that struck me most was-- I'm looking back to my journal … ***The third one really detailed all of the horrors visited upon this land. That was trauma day, basically.***

Obviously, ***the one that resonates and hurts a little more is the one where they talk about the genocide, the killings of our Native American people****. I think that one also resonated because I'm Catholic and it just brings up all those emotions about how can this be right? It makes you really think and question.*

I should have got my notebook. ***There was one where we went into the trauma… I think the most intense was the trauma. The one where we saw how the destruction happened.*** *I think in that workshop, there was a quote or something that Charlie mentioned…, "How do we teach the history to our kids without creating hate, or how do we teach about this without having that anger in our future generations." That was the heaviest. …* ***That was the most impactful for me. It shook the whole day for me.***

I think when they went into detail about the way that the government brutalized the people and ran them out of here, out of the valley*. The bloody history, it was really impactful.* ***It's something that I had never heard before*** *because all you've ever heard was the savage Native, right? That's the message. Hearing how brutal it was, it's made it that much real, I think, and that much more powerful to me. Just knowing that it was just 25 years. Just that alone is so like, "What? You wiped out of culture in 25 years?" You never hear it. I'm sure they don't teach that at Napa High.*

It was the middle [workshop] when the colonists came? That one was deeply disturbing to me*. …That this isn't being taught at all is unbelievable.*

… the trauma and the eradication of people and how lightly that had been spoken off. That was huge. The lies, ***basically the history that we would talk about versus the history that was****.*

I think ***the one where they talked about the removal of the children*** *and the whitening of the Indian children, the stripping of the culture, essentially, and* ***how they did it in Napa, that was really impactful because here we are in Napa.***

Resilience and Thrival Workshops

… when you actually got to the experiences that they've all had, the Fort Bragg thing…. Alcatraz and all of that. It was like, wow. Then ***to find out that there's actual Native American heroes that I've never even heard of, like, wow. I've never even heard of half of them****. I was thinking that that was cool. That was inspiring. I think the fourth and the fifth were really good ones.*

I liked the one I think it was called Thrival. I liked that one the best because it was more of a sense of pride. ***All the bad stuff that has happened, and then here we are, we're thriving, I'm***

> ***thriving.*** *That was the one that I liked the most. Because no matter what we went through, we're still here and we're still thriving.*
>
> ***…ultimately the resilience. It was pretty awesome.***
>
> *They were all good, but* ***the Thrival one was my most favorite****.*

All Workshops

> ***I absolutely felt impacted by every single workshop.***
>
> *I thought everything was laid out really well, and the facilitators did a great job communicating clearly and very understandably. Everybody could totally understand what had happened.* ***They did it in a really respectful way which was-- I saw the room there and they really had everybody's attention.*** *I think they did it. I think it was the facilitators and how they presented it, it's why it came out so well. I think they were very prepared, or maybe it's just being prepared and knowing their material, mostly.*
>
> *I heard something out of every single one. There wasn't one that I could say, "That was a waste that we went to," or "That one was a bit drier." No,* ***each one had some little nugget of like, "Oh my God."*** *No. I can honestly say no. I think they all had impact definitely.*
>
> ***I appreciated every single one.*** *I really appreciated…. learning about every person's particular role. When Sal went into every particular role-- the child, the grandparent, the aunt, the uncle-- and the passing of the drum or the stick. The passing of the stick to be able to speak now, just like the order of things and how things happened, and the respect that happens in that circle. I still think about that.*

The primary impact noted was the emotional and personal impact of learning the history, and the second impact was the actual historical and cultural learning.

> *Right off the bat, I think there were a couple of things I heard when we talked about General Vallejo, I'm not sure which one that was but when we were talking about him, I had no idea what a piece of shit he was because that's not taught. That was very impactful like, "Oh my gosh, all the kids go to the missions. We all build these little missions and things." These were people that were part of slavery.* ***That was one of the things that just woke me up. That was so like a smack in the face.***
>
> ***…[the information included] much deeper levels of content that are much more cognitively challenging, in this case, much more emotionally challenging, and on some levels, depending on who is in the room, culturally challenging*** *because most of… the content that was delivered, most of it ran counter to any of the traditional storylines that have been popularized in schools, in government, in politics about Native Americans.*
>
> ***I was not looking forward to hearing more about [colonization], but I understand how important it is to understand what happened.***
>
> *It was just heavy it definitely* ***brought up some emotions, created some reactions****. I loved that they gave us a journal on the first day to help process and reflect on what we were learning.*

> ***… the systematic way that they were really just trying to control a lot of the Tribes,*** *and their interactions with each other. Historically, it's divide and conquer, the idea of spreading them apart and not really having them align with each other to be able to work together.*

Some were intrigued by the possibilities of healing through use of the elements. Others have changed their minds completely about the healing rituals and relationship of nature to humanness.

> ***That [the healing elements] can help a lot, especially people with serious mental illness dealing with psychotropic drugs.*** *If they can, for their physical health, use some of the tobacco or other things that would be…what a relief.*
>
> *When I think of Whole Person Care, now I think of that too…**These healing practices should be part of Whole Person Care for individuals who are coming from the community that practices these.***

When hearing about the history of the elements, some participants railed against the commercialization of them. For example, seeing a three dollar plastic bag of sage in a nearby pharmacy.

> *It's totally peaked my awareness. Good Lord, I saw sage in Pharmaca the other day in a plastic bag. You can buy it for like three bucks. Who does that? I know that people do that. Do you know what I mean? When you start to see it… it opens your eyes. It takes your veil off.* ***You start to see all of the ways in which people are truly marginalized. It's not they're just marginalized for their color or their race, everything about them is marginalized, including their cultural traditions and religion.***
>
> ***I think about [sage] now, which I guess I never thought about it.*** *I'd always thought about it in terms of Wiccan. That was what I identified as a kid. I knew it was Native American based, of course. Every time I lit it, I didn't think of Native Americans, which I think I do now.*

Others mentioned how colonization and the church attempted to eradicate the practices in the name of Christianity and Western civilization.

> *I have to remember that we're colonized people. Because we're colonized people, all of these healing practices and all these traditions were literally taken away from us. The Europeans, the white people, the Spaniards, the Catholic Church, they all try their best to erase this from us. Really using it …is empowering and it's literally taking a stand against colonization.* ***We're decolonizing our life by being able to learn all of this and do some of these healing practices at home.***
>
> *Yes, it's both special and it's a challenging thought because* ***the church did appropriate a lot of things and used it against people****. I'm okay with that challenge. There's a lot about being white and coming into racial justice after growing up in a place that didn't talk to me much about it.* ***That is challenging and I think that's a good thing.***
>
> *I think that mostly what's changed for me is even in my Catholic tradition in my family is very conservatively Catholic. We were taught that doing things in other religions is not okay. I think one of the biggest things that changed for me in part because of this experience was* ***a more openness to other traditions in the power and the healing and the connectedness*** *is a lot of*

them in a beautiful way, in addition to ***the challenging way of how the church misused some people's practices against them.***

When asked directly about what has changed for individuals as a result of learning about this history, the participants shared shifts in knowledge, attitudes, and behaviors.

Knowledge

I really gained a better understanding of how sacred this knowledge is for people*. I was really humbled to be in the room with Charlie and Sal knowing that the things they were sharing with us, not every Native American person would be willing to share.*

I know that they made that clear that it seems they almost have to ask permission about what things to share and what things not to share. That's something that I hadn't considered before. ***It brought me to a greater level of respect and humbleness around having learned this knowledge from them.***

Attitudes

Wow. ***I wanted to say it increased compassion.*** *I was always intrigued by the Native people and wanted to know more about them, but it was more of not necessarily a superficial interest, but this knowledge is huge and profound.* ***I think it just really opened my eyes to what they've suffered and what they've come through and how resilient they are.***

I don't know that it's changed anything. I think I have always thought about how amazingly resilient people are. That's been the forefront of my therapy. It's just like, what an honor it is to work with somebody who you still hear the process of what you've been through, but also, again, it's like the Holocaust and it's like this was a genocide. ***Yet, there's such power in just believing somehow that you'll make it through and not lying down. It hasn't changed anything. I think it's made it more real.***

I interact with others with more compassion *probably … I have integrated more compassion and more empathy in the work I do, kind of allowing space for more understanding.*

Behaviors

Every culture around the world has different things that help them, and ***I encourage them to learn about their culture.***

I guess just being more mindful about the history sharing. *Not correcting, but informing others around me, that really is a choice that you make every day consciously on how you interact with everybody and that you are never in someone's skin. You know it's different experiences for everybody and you have to be aware of that.*

Other than just ***looking at what other history do I not know about.*** *Starting with the Black Lives Matter movement, and just realizing there are other parts of history that I don't know more about and would like to know.*

I think we all know this isn't just about Native Americans as we look at other groups such as African Americans. The stories are different, yet the stories are the same, so I feel with the

> *current uproar, it's giving me more of a context and depth. Even to be able to handle what I'm hearing from my African American colleagues…and to be able to realize that you can do it.* ***You can listen, you can attend, you don't have to pull up back in shock, and horror, and shame. I feel all of those things, but I can stay at the table.***

Community Survey

On the second community survey, given at the very end of the project, **the respondents' familiarity with local Tribes increased for all Tribes** when compared to the responses from 2018. The number of individuals who indicated they were "Very Familiar" with a particular Tribe ranged from 3 to 5 (9-16% of 32 respondents).

Respondent Ratings of Familiarity with Regional Tribes, Community Survey, 2018 and 2021[12]

How would you rate your familiarity with the following Tribes?		
Regional Tribe	**2018**	**2021**
Miwok	0.8	1.6
Ohlone	0.5	1.4
Onasatis (Wappo)	0.8	1.8
Patwin	0.3	1.1
Pomo	0.9	1.8
Wintu	0.3	0.8

In 2021, **the percentage of mental health providers who knew that Native Americans used all parts of Napa County prior to 1850 increased.** Almost three-quarters (72%) reported that Native people used all parts of the county. This is in contrast to 2018 when less than half of providers surveyed (44%) knew this to be true.

[12] Respondents' answers are on a scale of 0 to 4 with 0=Not at all Familiar and 4=Very Familiar.

Respondent Ratings of Historic Use of Napa County by Native Americans, Community Survey, 2018 and 2021

To the best of your knowledge, what areas of the county were used by Native Americans prior to 1850?		
Areas of Napa County	**2018**	**2021**
All Areas of Napa County	**44%**	**72%**
Angwin	45%	88%
American Canyon	50%	78%
St Helena	51%	88%
Lake Berryessa	51%	88%
Pope Valley	56%	94%
Yountville	52%	88%
Calistoga	59%	97%
Napa	63%	88%
Other	18%	3%
Native Americans did not live in Napa County	1%	3%
No Response	20%	0%
Total Respondents	**101**	**32**

In 2021, **all mental health providers (100%, n=32) who responded to the survey indicated they believed in Historical Trauma.** This is in contrast to 84% of providers (n=101) in 2018.

Integrate Learning into Self-Care

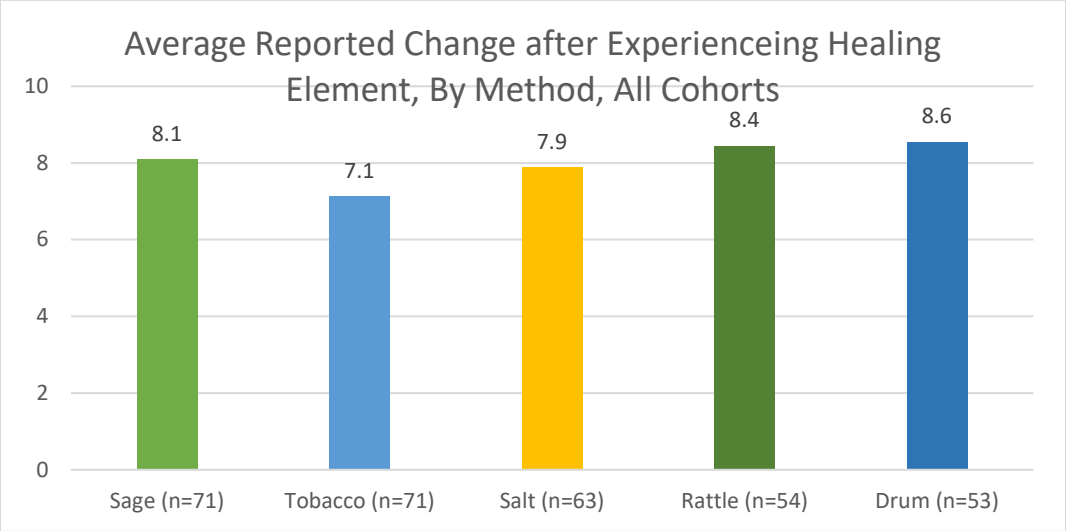
Do providers integrate the learning into their own self-care? Why or why not?

- On average, the participants reported positive changes in how they were feeling after experiencing the healing elements. This change was highest for the drum and lowest for tobacco.
- The participants indicated they were most familiar with using sage prior to the workshops, and the majority planned to use elements for their personal use after the workshops. This intention was the highest for salt and lowest for tobacco.
- A few were unsure if using the healing elements for their personal use was appropriate and described concerns about cultural appropriation.
- When community members were asked about their use of healing methods in a 2021 survey, they were most familiar with the methods described in the workshops and least familiar with experiences that were limited by the restrictions of the pandemic (visiting a Reservation or Rancheria, talking with members of local Tribes, etc.).

Workshop Survey

Questions about how individuals felt after experiencing the healing element, their prior experience with the element and their planned use of the element were asked after each workshop.

Responses to "In your opinion, did the healing element change how you were feeling?"
Average Ratings from Workshop Surveys, All Cohorts[13]

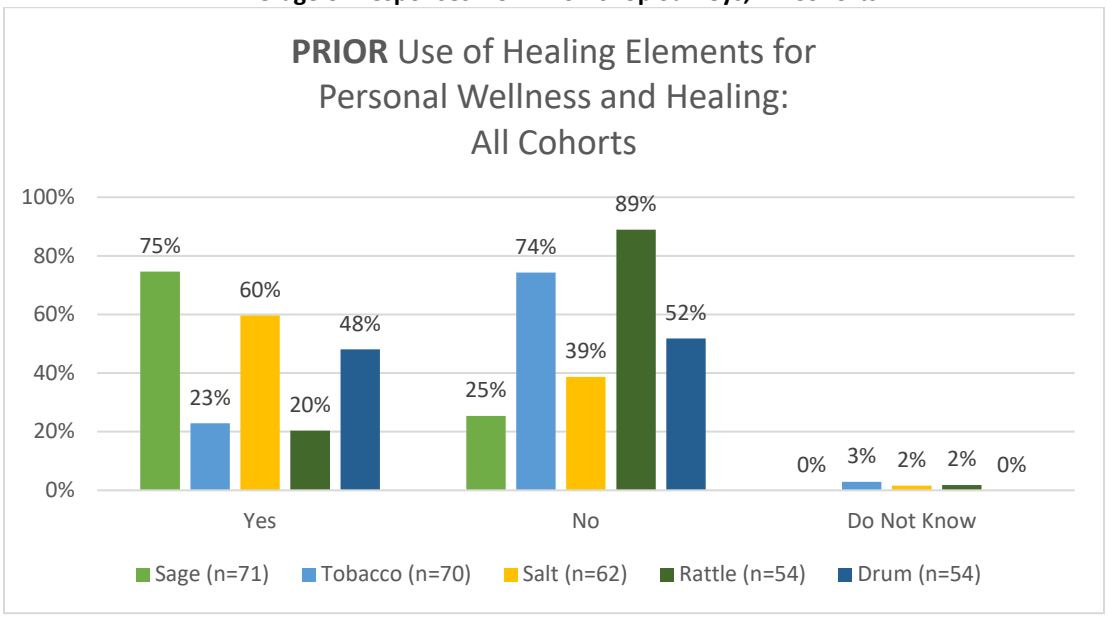


- On average**, individuals reported a positive change after the healing element**. (A rating of 5 was neutral).
- The average reported change was the **lowest for tobacco and the highest for the drum**.

[13] Respondents' answers were on a scale of 0-10, where 0 was "I felt much worse after experiencing the healing element" and 10 was "I felt much better after experiencing the healing element". A rating of 5 was "I felt the same after experiencing the healing element."

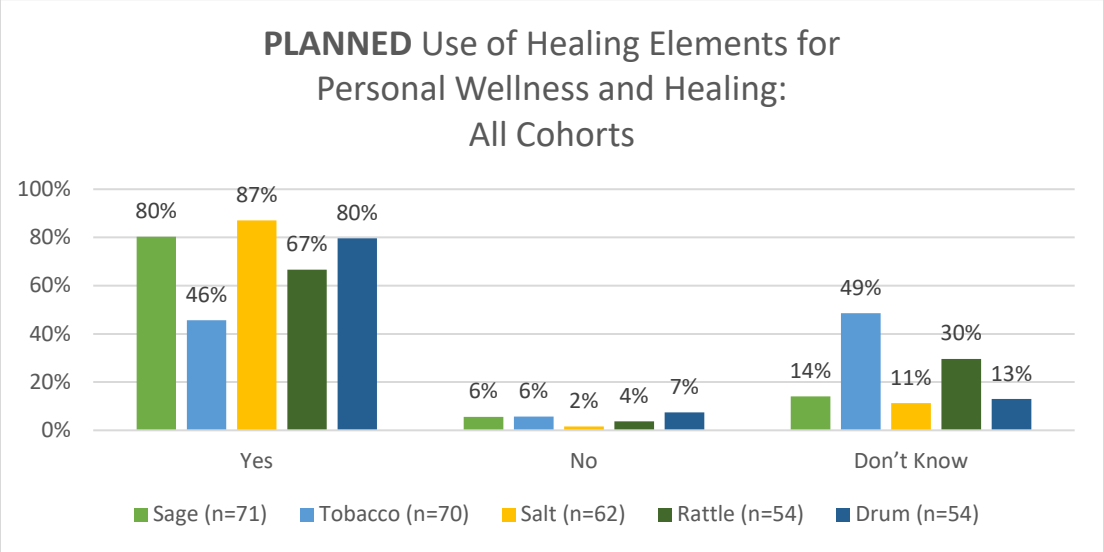
When asked about their prior use of the healing elements, they were **most likely to indicate they had used sage previously. They were the least familiar with the rattle and with tobacco.**

Responses to "Have you ever used [healing element] for your PERSONAL wellness and healing prior to this workshop?"
Average of Responses from Workshop Surveys, All Cohorts



When asked what they planned to use, on average, all of the methods were intriguing, and they were the **most likely to indicate planning to use salt, sage and the drum.**

Responses to "Do you plan to use [healing element] for your PERSONAL wellness and healing prior to this workshop?" Average of Responses from Workshop Surveys, All Cohorts



Participant Interviews

In the participant interviews, individuals spoke about having a shift in their perspective on use of elements for personal healing

> *I think just like thinking about it when I'm going through something hard, and calling on, or thinking about what healing I need to help after that hard or heavy thing has happened.*

> *Again, just more intrigued than anything else.* ***I love the idea that the salt absorbs all the negativity, that you can go and smudge your room and those kinds of things but actually using them-- With the drum making, I have a drum that I use myself and I would definitely use the smudging myself****, but I would not with clients.*

> *Well, it is somewhat different, I'd say, because* ***the way we're all raised in a western culture is you perhaps are allowed to think of animals as having personalities, but you're certainly not encouraged to think of plants, or rocks, or the sky or anything as kind of beings****. I'm trying to word this in a way that doesn't make it all wishy-washy sentimental. Maybe it is wishy-washy sentimental, but* ***just by regarding those things as not just objects, but…something with its own way, its own purpose, its own possibility*** *of in a way communing with them. That's different for me because we're trying to think that's all just mystical nonsense in the way we were brought up, so yes that is different.*

When asked directly about how they have used the elements in their self-care, individuals mentioned the sage and the salt. Some had used it themselves, a few mentioned using it with their family.

> *I could just burn [sage] in my room and it just lightens the air in my room. Although some of my kids don't like the smell of it. I try to make sure that the windows are open, of course. They did*

mention that all the windows should be open because the bad energy goes out. I just burn it in my room. ***Sometimes I sage myself if I'm feeling really icky****, which I could do in my backyard by myself. The salt thing,* ***my daughter was having nightmares, so I put the little bowl of salt under her bed. It actually worked****. Then I told her "Throw it outside, just not on my plants." Salt's good for everything but your plants. I thought that was pretty cool.*

What I did was one day, it was a bad day through the system here, like a BAD day. ***I actually had some dry sage in my office just there as a form of medicine even though I couldn't turn it on because of rules. I took a walk and around the building, I just use it in my walk****. I was then concerned because instead of the healing and relaxing, people were looking at me like… "I thought that was a blunt." Or they looked at me and said, "You're going to start a fire."*

I have sage and ***I tried smudging around my house.***

*Have I talked about it? No, because I don't think I realized that until I talked to you just now. You know what? Actually, I do think from listening to [that person] even talk about, "Oh, my gosh, that's healing sage." I realized, "****Oh, if anything, maybe I need to do it more often."*** *Not just like, "Oh, I just need to do the house* ***but to do it on myself really****."*

An experience I had last week when we had those high winds, I just did not feel comfortable in my room. I had a feeling it was too dark, and I just had an eerie feeling. That morning I went ahead and ***saged my room and my doorways and my windows just to get a reminder I have that to wrangle in whatever my feelings or whatever's going on in my room at that time****.*

I've tried the salt myself. I use it to clear energy, and I also use it in the bath*…Even before doing this cohort, I was a big Epsom salt person. I also use bath salts and different things, so I've always been big into that. I probably take a bath twice a week... I used to do it once every two weeks or so, but* ***now I do about, like I said, twice a week, sometimes even more, depending on how my body's feeling.***

This would be the first time saging my home*. We've been living here for three years now. It'll be the first time saging our home. I think the best thing I can do is just bring it up to my family. I feel like it's just a good teaching opportunity. Let them know why we're doing this and the meaning of it. That's something that I'm looking forward to doing.*

Some felt the elements were inappropriate to use and did not try it for self-care.

I think the whole idea of ***not being a practitioner was the biggest challenge****. I think the appropriation kept popping into my mind and in my heart.* ***Is it okay for me to be doing this?*** *Not from the Catholic side. I'm okay with that, whatever but from the-- Is it okay to be using someone else's sacred practice or healing practice?*

I'm not going to be running around claiming to sage *out people's homes and their evil spirits.*

Community Survey

On the second community survey, given at the very end of the project, respondents were asked about their knowledge of Native American practices, places and people. The **most familiar areas were the**

practices demonstrated during the workshops, with sage and the drum rated highest. The largest percentage gain in familiarity was around knowledge of where Native Americans gather in Napa County (57% increase) and knowing individuals from regional Tribes (61% increase). The largest change in experience was for the elements demonstrated during the workshops (34% increase). Part of this was due to the pandemic and the lack of access to the geographic locations and/or individuals during the shelter in place orders.

Participants' Ratings of Knowledge and Experience with Components of Native History and Experience, Community Survey 2018 and 2021[14]

	Knowledge			Experience		
Please indicate your knowledge/experience of the following:	**2018[15]**	**2021**	**Percentage Change**	**2018**	**2021**	**Percentage Change**
The Use of Sage (2018) /Sage (2021)	1.9	2.3	21%	1.6	2.1	34%
Tobacco		2.0			1.5	
Rattle		2.0			1.4	
Drum		2.3			1.9	
Salt		2.1			1.5	
Where Native Americans gather in Napa County	0.8	1.3	57%	1.3	1.3	5%
Where Regional Rancherias and Reservations are located	0.9	1.1	16%	0.9	0.8	-11%
Individuals from Regional Tribes	0.8	1.4	61%	1.3	1.3	4%

[14] Respondents, answers are on a scale of 0 to 4 with 0=Not at all Knowledgeable/Experienced and 4 =Very Knowledgeable/Experienced.

[15] Some of the healing elements were not part of the 2018 survey as the Cultural Advisory Committee discussed which to include.

Change Professional Practice

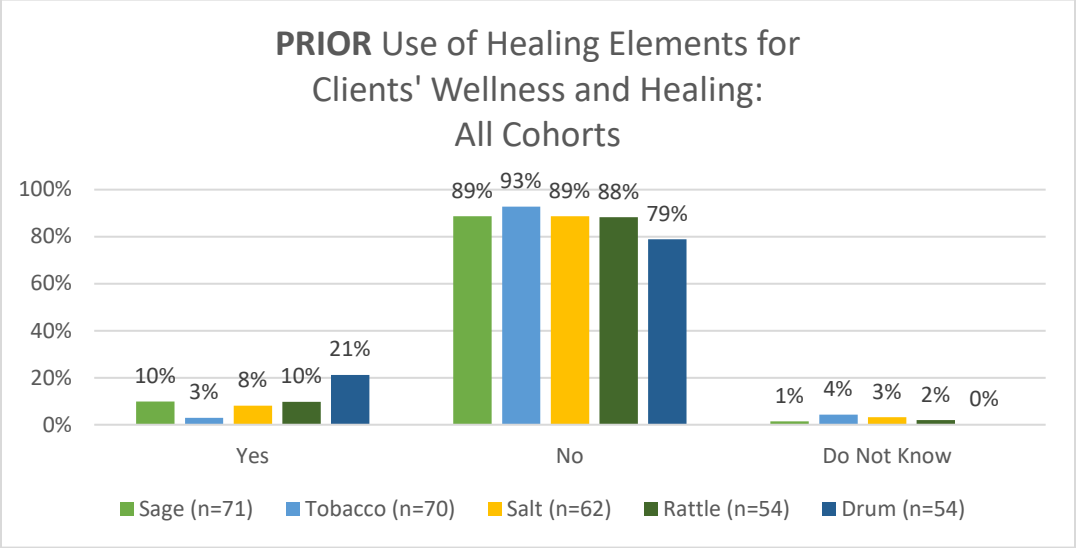
Do providers use their knowledge of Native American culture and history and their experiences with traditional wellness and healing methods to change their professional practice? How? Why?

- Prior to the workshops, very few participants had used the healing methods with their clients. After the workshops, about 40% of participants indicated they planned to use the element with clients. This was a bit lower for tobacco (19%).
- Some providers talked about how they used the elements. Some of these providers identified as indigenous, and some felt like there was support in their workplace for using the elements.
- Some intend to use the elements but haven't done it yet. Some talked about being unsure if a client was interested, others talked about not feeling comfortable using it at work
- Several providers shared the elements with co-workers as a way to promote using the elements with clients served by their agency.
- Among the providers who did not plan to use the elements, some indicated it felt inappropriate for them because it wasn't their tradition, other talked about referring individuals to Suscol or other agencies and/or community members who can provide the elements for Native individuals.

Workshop Survey

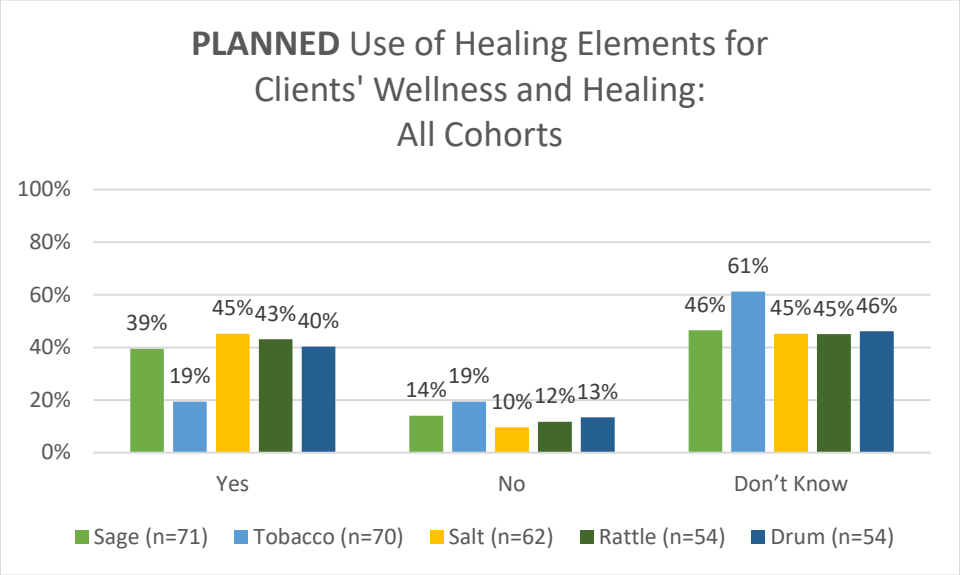
In the workshop surveys, participants were asked if they had used the element with clients prior to the workshop and if they planned to use it with clients after the workshop. **Very few participants had used the elements with clients previously.**

Responses to "Have you ever used [healing element] to promote YOUR CLIENTS' wellness and healing prior to this workshop?"
Average of Responses from Workshop Surveys, All Cohorts



About 40% of the participants indicated they planned to use the element with clients after the workshop. This was a bit lower for Tobacco (19%).

Responses to "Do you plan to use [healing element] to promote YOUR CLIENTS' wellness and healing?"
Average of Responses from Workshop Surveys, All Cohorts



Interviews

Use of the healing elements in professional environments, created a lot of discussion and examples during the interviews. Some participants talked about what they would like to do. For example, using sage or having a bowl of salt in their office. Others mentioned burning sage, applying sage oil, or using a rattle or drum. Barriers to using the elements in an office environment included fire danger, offending people who do not like the smell, or supervisors who are not on the same page.

The participants described a range of ways that they share the information with clients. For some, they use it directly with clients. Others described the intention to use the elements but had not tried it yet. These participants shared that they felt nervous or unsure or hadn't have an opportunity yet.

Use with Clients

I use the sage oil with clients. *I always ask, "Are you allergic to anything?" With one youth, he was Indigenous, I just shared some with him and used it like an essential oil, and he was just happy to see, "Oh, there are people actually out there at least trying to understand." When I was asking about if he had any times that he has seen or hear things that other people can't here, I'm looking more for psychotic symptoms. That's when he said, "Well, I don't know, people might think I'm crazy because I do communicate with my ancestors or I just pay attention to my thoughts. I don't want you to think I'm crazy."…he wanted to make sure that I wouldn't judge him for having that connection to ancestors or listening to other. I said, "No."* ***I did ask him if I could share the sage oil if he was comfortable with it. At first, I just left it there and I said, "You're welcome to smell it." Then he used it.***

We use music in a lot of things [at work] and I definitely hear a lot of the elements of storytelling in other cultures and other things. *It's starting to make that universal connectedness for me.*

*Also, **I'm learning to use [the drum] really well so I can integrate it into my group.** I have a gardening group that I usually do when things are normal. Then another support group out in the community to do what I was doing, and so I was hoping to bring it into there, into my support groups in the community introduce it as a way to do different things with it, healing with it…That's why I've signed up for their classes, the drumming circles that we have every Thursday, so that I can learn how to do it properly, learn the right songs, learn how to use the drum properly.*

I have about the salt because one of my coworkers gifted those rocks**, I actually gave that to somebody because I had the one that Charlie gave me. I have shown the one that Charlie gave me to people and talk to them about it. **I had been thinking I was going to get some small rocks to give to people, then we quickly went into a quarantine.

***The salt I have spoken with a couple of people about that,** about how to use that.*

*I probably have only met in the 13 years that I've been [at my job] …probably just a handful of women that openly identify as Native American, I think, indigenous from Mexico and Latin America way more. Then again**, some of the practices and the history is so similar that some of the things that I've learned can be applied to them.***

*Even though he might not identify himself as indigenous, he identified himself as Chicano or Mexican. After he's like, "Oh my god, are you going to ask me because every time they asked me if I'm Native." He wanted that healing. He's like, "I don't want to say that I'm Indigenous if I don't know anything about it. I don't know about my roots." He was afraid to misuse it. He said, "People just assume I'm Native because of how I look. I don't get offended; **I just wish I knew more about their medicine so I can use that as a coping skill."***

*I can think of one client who really enjoys sort of rhythmic drumming on tables or anything that's around us. **I think that person might really enjoy the rattle or the drum if we were in person** which we can't be for months and months now. I think a lot of it is just about sort of accessibility. **I'm not going to burn anything in the office and I'm not going to have a tobacco plant in the office, and I have neighbors on either side. In terms of consideration of noise or air or practicality of the five healing elements, four of them are just not quite as accessible to my professional work.***

*I'm trying to do what I can to spread awareness of what I learn and opportunity that I had. I'll show you, even in my office I put-- I mean, I'm trying to change but the visual that if people were to see something-- I try to be cautious about what I put but just to make it visible. This is where I had the sage and things. **People do ask me, "Are you Native American?" It's a question not just with clients but coworkers or people that come and check my office. "Are you Native American?" When I bring my medicine, I have necklaces from clients that they are being made by Miwok Tribes that I was given. I say, "I am indigenous."** They were, "What Tribe are you from?" I just say …the region I am from in Mexico or the people. They are like, "Oh, so you're Mexican?" I said, "Yes." They get into like, "No, what I mean if you were Native American what Tribe from here, from the US?" There's this sense of you're indigenous or you're Native American only if you are from the US area. There is no more Native American outside the US. Sometimes with some people that are generally interested, I don't mind having that conversation but when*

it's people that you know they're just going to be like, "If you're not registered with a Tribe then you are not Indigenous.

Intend to Use with Clients, Barriers

***If I had a client that was interested, I definitely would try some of the healing ideas**. Probably the smudging, and, of course, the salt is really, really easy.*

*We do have sage here [at work], but I don't think I'm comfortable enough to use it on other people**. I guess they could [use it], we've never offered it though.***

***I have not [used it at work] so much just because I think they would raise an eyebrow to it.** I think it's going to take some time for me to integrate some of this into my work. I'm also dealing with other things like people that aren't housed, and they need other things that are more important in the time being. Not to say your spirit and your soul is not important but having a roof over your head and having clothes on your back can take precedence sometimes over some other things.*

*I think if there was a space or setting where we're talking about things like this. This spring we had a missed opportunity because of COVID, [a group] was planning a self-care day, and it was going to be mostly about mental and spiritual self-care. **I was supporting the event and I was planning to share some of the stuff at this event.***

*I'm thinking probably just my own courage if that makes sense. Maybe it's just because I'm not that familiar with it. … **I often have to be fairly careful with what I do say to people, so they don't look at me like I'm an absolute idiot and never come back again.***

Many talked about bringing the elements into conversations with co-workers or using them with co-workers at work as a way to introduce them into the mental health treatment the agency does.

With Co-Workers

***The rattle, I got a rattle in November. I went to the Suscol Art Auction and I got at the auction. I brought it to my office, and I share that with everybody**. It wasn't as popular as the salt. People didn't run around to buy rattles, but it was well enjoyed.*

*Sometimes I wish I could use it at my office, but I don't know if that's ever going to change because fire hazard. We're not supposed to burn anything inside the building. **Although just between you and me, we did that once at the office.** This was before the workshop. There was so much going on, we just felt like let's smudge the whole office, but it was really quick. We opened all the windows. Part of me was uncomfortable because I said, "Well, [my employer] supported this training and if I get in trouble and I get called into somebody's office, I'll try to explain that, 'Hey, I went to this workshop. This is part of it.'"*

*We've talked about it at work. Since we do have a Native staff member, she actually saged me one time. She was like, "Oh my God, that's too much. That was really horrible. You need to come outside, let's sage." I was like, "Yes." Then another staffer complained about the smell. It's like, "This is healing, this is medicine. What are you talking about?" **They're like, "Well, the smell is…really I find it offensive." I'm like, "Oh, jeez." Just so many people and opinions**.*

When [Suscol staff is presenting], everybody goes out to the front and they get saged. Sometimes I just go out there just to do that.

I certainly have suggested offering tobacco to the earth….*I've spoken about how that is an honoring of what you take from the world. Again, it's really interesting because people are so different. You do get people that are wonderfully open about work stuff.*

I think as more and more of my colleagues go through the training, then we can implement it as a team, *as a unit, and…We can have a unified front on it.*

At work, yes, for sure. *Someone brought it up and I said, "Oh, yes, let's do it.* ***Let's sage our space."***

While interested in using the healing elements, participants were also aware of appropriating someone else's cultural tradition. While some used the elements (as previously mentioned), others felt that the elements were totally off limits to them.

Not Comfortable Using Elements

I feel very much like that's not my business. *I feel blessed to be in the presence of someone else. Whenever you're in a room with [individual, he/she] tends to smudge the place. I always feel very honored to be in that space. I quite honestly, maybe this is my own shortcoming or maybe I just am not as developed as a thinker as I wish I were, but I feel like that is off-limits to me and that I shouldn't touch it because I've never been given permission. I'm just one of those that feels like I have no business treading there at all.*

…I'm telling you, it's not mine. I've enjoyed White privilege in my life. I have a great-grandmother who came from Mexico and another one out of Oklahoma. On her marriage certificate, it just says, "Cherokee woman." We have those documents in my family, but there is no way… that I feel like I have any business … claiming that ancestry. Instead, I've chosen to commit my life to helping Native people. That is how I've decided to use my power and my privilege… No, I don't feel like I have any business touching that. ***Until someone from that community comes up to me and says, "This is yours. It belongs to you. You should do it," I don't think I can.***

Participants who referred others to healing elements, often cited the drumming circles and other classes sponsored by the Suscol Council. Others encouraged friends, coworkers or clients to take the workshops.

Referred to Suscol Intertribal Council

I've referred people to the drumming circles.

I like using the healing. The groups that Suscol has every week, even when they had the basket weaving, I've referred people when Suscol's had the series going on. I don't know if they attended.

Clients, parents. Sometimes parents are trying to figure out something that will help them find a group or something that they're trying to, like a hobby or self-care learning how to do that. I thought that'd be neat.

I did refer somebody to Suscol actually, one person. People don't come in and say "Hi, I'm Native American." They just don't do that; I think they've learned not to do that… It was actually a couple of people who said that they were Native American on our intake form….

I did reach out to Sal knowing what he does, and then I said, "How can I refer people to you? How can I send this person because I have to get a release from the person so I can link you to know how get that person to you so you can support them and help them and provide that."

I've told people [about] the drumming circle. I've brought it up at [work] a couple times in check-ins and stuff.

I haven't had that kind of an opportunity. In the work that I do, it's not so one on one, it's more in groups. If I share anything, it has to be very applicable to, I think, the group unless I'm talking to somebody one on one, but I have referred people to do the cohort.

If people need medicine, I would like to know that I can refer them to Suscol because from what I learned about the medicine is that you don't buy it. You have to be careful who it comes from. A way that we can say, "You can contact Suscol, they will guide you so you can get some medicine if you're interested." That way they can learn directly from Suscol and then use it properly but get it from a person instead of saying "Oh yes, I'll just go Google it and go to Amazon and buy the sage." I feel like then I'm enabling that. I don't do that with my medicine.

Providers who took the workshop have also referred clients to other programs serving Native Americans. Participants grasped that the cultural differences and needs call for a different approach.

Referred to other Agencies or Individuals

In [our program] had two youth who were Native American and one of them identified as two-spirit also and in addition to feeling like we were gaining more understanding about them and their experiences, and being able to have more conversations with those youth, we also referred them to the programs in Sonoma County to make sure they were connected to Native serving, specifically Native American serving programs in Sonoma County to help them in any ways that they needed that were more direct and specific to that.

I requested a therapist [for a client] that is aware of Indigenous history and experience.

It reminded me to really introduce that to the clients that I work with and ask if they smudge and then connecting them back to culture. A lot of times when we're working with clients, it's going through all the paperwork and counseling processes, but really, there's either reconnecting them to that or introducing that idea. I have a friend here, who he loves to gift smudge to people. Making sure clients have that knowledge where they can get it if they don't know where to get it. I could give his phone number out. He's an elder gentleman. He loves doing that because he feels it's really important. I think from that training, it really brought that focus back to do that.

I don't know if this matters or not, but I even brought it up. He's like, "I want somebody that can understand, that is aware of the forms of medicine that we can use in session. Otherwise, I just don't want to be just seen as, "Are you all crazy?" because these are my beliefs, this is who I am or to be judged." I'll rather, you know-- If you can find somebody. It was hard even because he wasn't trusting the organization to give him somebody who understood. I said, they are going to

call you. Answer the phone. I already asked and requested. It was just interesting how I needed to walk him over to the person that will provide the medicine or the healing. Mental health is perceived differently seen different cultures and different indigenous cultures. LGBT is seen as two spirits. It's just totally different perspectives.

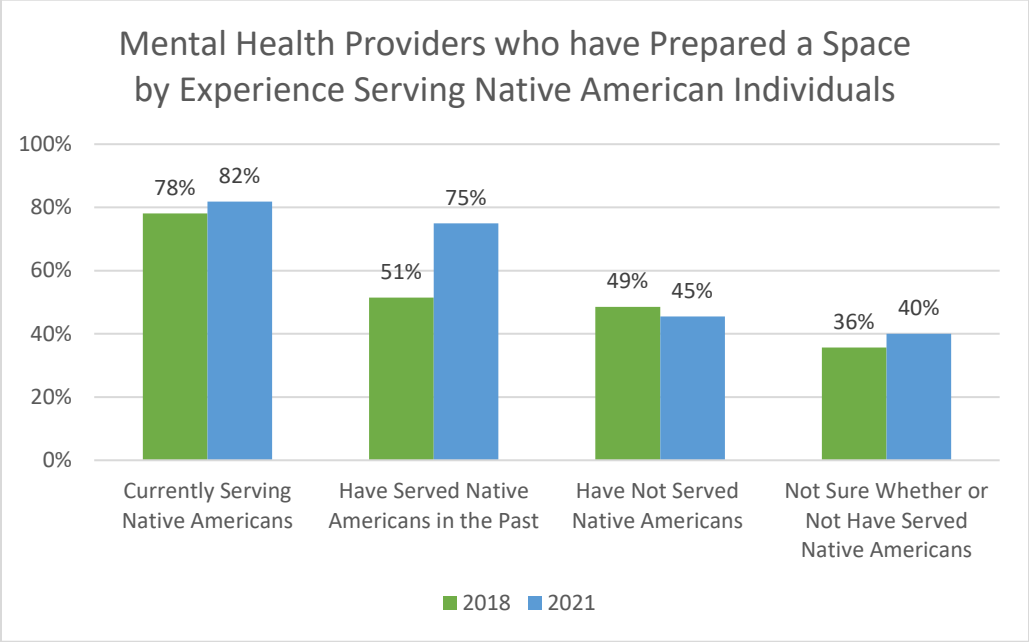
Anyone Native, I put them in contact with [a Native staff person]. Anything that I can say, "Oh, there's this, there's a talking circle over here." I just get them in contact with her. She discusses all of these, the healing aspects. They could go through Indian health. It made me think a lot more about our Native American clientele. It's given me a whole new perspective.

Community Survey

In 2018 and 2021, the community survey asked mental health providers to share whether or not they had incorporated practices to prepare a space to serve Native Individuals.

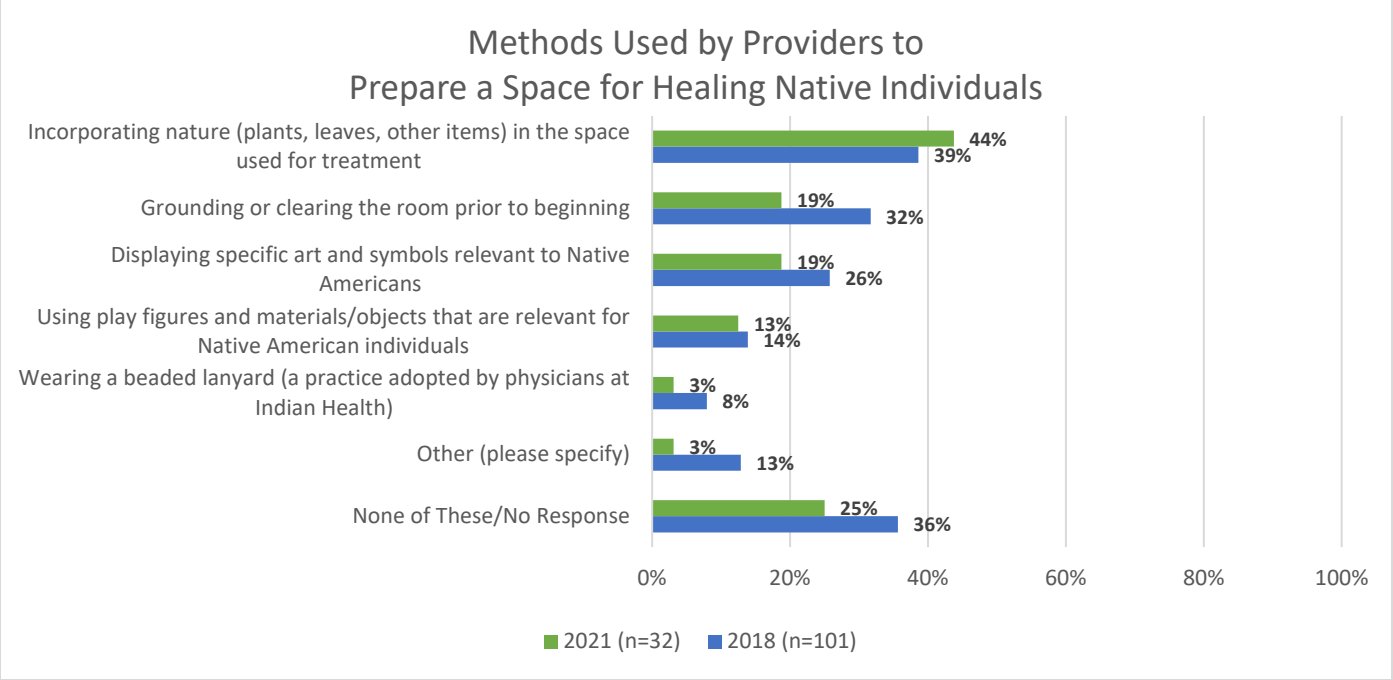
Those who reported currently serving Native American individuals were the most likely to report preparing a space (82%), a slight increase over the percentage reported in 2018 (78%). Those who weren't sure if they had served Native American individuals were the least likely to report preparing a space (40%).

Percentage of Mental Health Providers who have Prepared a Space for Healing Native American Individuals by Providers' Experience, Community Survey 2018 and 2021



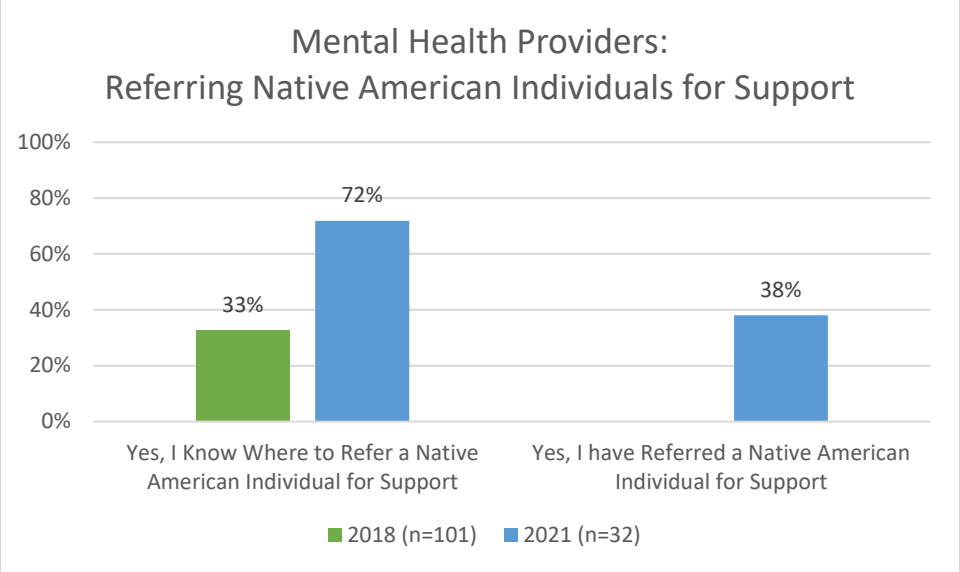
Of the options developed by the Cultural Committee and project staff, the **respondents were most likely to indicate they had incorporated nature into the space used for treatment.** Respondents in 2021 may have been less likely to report changes in their physical space as most had not been seeing individuals in person during the pandemic.

Methods Used by Providers to Prepare a Space for Healing Native Individuals, Community Survey 2018 and 2021



In 2021, **mental health providers who responded to the survey were more than twice as likely to indicate that they knew where to refer a Native individual for support** (72% vs. 33% in 2018). In 2021, a question was added to ask about whether or not a provider had referred a Native person for support and 38% indicated they had.

Percentage of Mental Health Providers indicating they know where to Refer Native American Individuals for Support, Community Survey 2018 and 2021



Respondents were also asked if they had changed their practice in response to learning and/or experience with Native Americans.

- **In 2018, about one quarter of respondents indicated they had made changes (24%)** and 13% reported they had not made changes. Another 8% were unsure or planned to make changes but haven't made them yet.
- **In 2021, about the same percentage (28%) indicated that had made changes.** On this survey, more individuals answered this question, and there was an increase in those who had not made changes and were not sure about making changes. Some of the difficulty was related to the restrictions during the pandemic.

Changing mental health practices

In 2021, 28% of mental health providers (n=9) reported changing their mental health practices. Some spoke about incorporating nature, others talked about using some of the healing elements taught in the workshops. Several talked about reframing how they do their work with individuals who identify as Native.

- *I have incorporated the use of sage and salt*
- *I inquire individuals to see what would be helpful to them.*
- *More attention to environment, natural objects and symbolic objects in the room, listening more and gently indicating interest in any cultural practices or experiences related to ethnicity*
- *Using the framework of knowledge around the impact of historical trauma to develop new and innovative programming that can help alleviate trauma symptoms in-the-moment*
- *Viewing the cultural/ethnic group marker as also a trauma/resilience marker*
- *Yes, I use the elements, like the trees and sun, more plants*
- *Yes. I am more aware of historical trauma and how it affects communities to the present day.*
- *Yes. We have taken many suggestions given to us by Suscol Intertribal Council. Using mirrors, smudging, planting rosemary and lavender, bringing more plants to the spaces we use. and more.*
- *Decolonization practices*

Not Changing Mental Health Practices

Thirteen responses indicated they were not changing their mental health practice (41%). Of these four of the respondents indicated "no". Others noted that they had not made changes due to the limitations of the pandemic. A few talked about what they had been doing prior to the workshops, and a few indicated they have not seen Native individuals.

- *Not really recently*
- *Not really since the pandemic hit*
- *Have always incorporated awareness of nature*
- *Not since the class, but have incorporated grounding, plants and rhythm into my practice through my diversity training in grad school. Pacifica Graduate Institute incorporated diversity training in a very important way for me.*
- *I will be using my learning if I have any Native American clients as I am re-opening my private practice.*
- *In thirty years, in several counties, I have not seen a Native American in the California Mental Health system.*

- *No (4 responses)*

Not Sure about Making Changes

Seven respondents were unsure about making changes to their mental health practice (22%). Of these, four respondents reported that the changes were not applicable. A few indicated they had more awareness but did not indicate they had made a change. One indicated they did not have information about Native people in relation to mental health treatment.

- *Greater awareness although none of our clients identify as Native American*
- *I have become more aware of historical trauma.*
- *I have not learned much about Native Americans in relation to mental health treatment*
- *Not Applicable (4 responses)*

Recommendations

Interviews

In the interviews, participants were asked “Thinking about your experiences learning and applying the information from the workshops, what are your recommendations about how the learning can be used to promote mental wellness and address mental health concerns?”

Recommendations focused on continuing training/workshop opportunities and building partnerships with other sectors to make sure that the information is widespread and accessible.

Education

The call for more accessibility to the workshop for more people was very strong among the participant interviews.

> *I told my son, I said, "If you have a co-worker that you really like, as a person, as a friend outside of work." I said, "I need them to go to this workshop." He's like, "Why Mom? Why?" I said, "It's going to change their whole perspective. It's going to change their life." He invited two of his friends. It literally did change their life. Literally. They were in tears about it afterwards. Whether it's a CPS case, whether it's a domestic violence case, whether it's a DUI case, at some point or another, they're going to come through a mental health door because they have to, because they're going to want to get their kids back, or they're going to want to save their marriage, or for whatever. For whatever a non-Native has to go to mental health, a Native is going to have to go to mental health, too. I just think it's so important that as many people could learn this workshop or just attend it, it's so important. So, so important to them.*
>
> *Right now, this kind of learning is very underground. It's hard to find learning like this.*
>
> *Maybe if I had an avenue for more people, I guess, to be able to participate or be able to maybe get into the workshops easier. I know the workshops are not for everybody right now, right? They are not opened, I suppose.*
>
> *Actually just more, and more and more. The information sharing, [Suscol has] to get approval [from elders] to share information. I'm not sure if we'll get more. I'm just hoping we can get more, someday.*
>
> *It's one step to educate, but if you're trying to change systemic racism or culture, you'd have to look at a lot of pieces. This is one piece of that is teaching the cultural practices. Other areas that would need to be considered are how do you create the structure to have programs that are provided within a person's community? We’ve been taught that we really shouldn't be doing some of these practices unless we're part of the Tribe. Supporting that and connecting people that may be disconnected from their own community, that would be important.*
>
> *Yes, just the healing practices of the culture could be used easily. I think there's a lot from the culture that we can learn, acceptance, tolerance, all that good stuff. I just need to expose people, more people to it, I think.*

Participants mentioned several ways to make the materials more accessible to more people in addition to workshops. For example, several mentioned creating one or more videos. A short video to pique interest in the materials and a longer video of the entire workshop featuring Charlie and Sal.

Video

… maybe having access to a small video with just the snippets of information to pique people's interest.

I really appreciate the workshop talking about the resiliency of our people… It's really easy to feel discouraged, feel anger, feel shame. When you talk about the resilience of these groups, the healing elements and all of these, then it really paints a better picture of the reality of these communities. I think that would be important to integrate in something like a short video.

I would say to have it recorded with Charlie talking through it, that's great because maybe she doesn't want to travel down South, maybe she doesn't want to fly out to Utah anymore… but to have her voice-- And then you have that strong stoic man voice of Sal... It's nice to hear it, and so to have him doing his story, too, I mean, just have him recorded, that would be awesome.

Sometimes people are into videos. I have shared YouTube links to them like, "Check out this YouTube link and then you can learn about this." Something that is short, that would pique people's interest and encourage them to learn more. I don't know that everybody would have access to attend a workshop like this, but something short like a five-minute video. I don't know if people would be open to that, but I find it helpful... I thought that would be great, a place to direct people… I figured, just a small video, five minutes, where you can have some facts and some information about how the real history, and then how that is has affected these groups throughout generations.

Participants often mentioned staying engaged and informed after the workshop. A newsletter or email about how the project is evolving would be helpful to some. Many spoke about the impact of the workshop and their hope that they would continue.

… I hope that its founders find a way to expand and extend the work because it's very important work and we don't have many opportunities anywhere in our community or really anywhere else really outside of a Native American program…

I'm happy that these classes are happening. I hope they keep happening.

I definitely know that it did work. I would definitely continue. As Indian people, I mean we're not guaranteed tomorrow at all, but as long as they can keep [the workshops] going, … I think it's really important. Really, really important.

Others talked about the importance of the tenor of the workshops and the willingness of the presenters to share generously.

I really appreciated Sal bringing in everything he brought in like a lot of really cool stuff that we could look at and not touch. I really appreciated the attitude of the workshops. It was like, here's something that is sacred and sensitive and vitally important. We're going to share it with you because we're trusting you to treat it as such. That there were some things that they acknowledged that they weren't going to tell us because it's sacred and that's totally fine. They

weren't presenting it in a way that was mushed down too much to appeal to people or to loop in an audience.

I really appreciated that it was just like, this is what it is. Here's what happened. We're not going to sugarcoat it for you, and you should know that, and you can handle it.

They have no reason to trust us but they're going out on a limb. Everyone in the room really honored that. I hope everyone in the room really honored that, it felt like it.

The way the workshop was done… we need storytellers. We attended the workshops in person, and you hear the passion. You hear when their throat's about to break and cry, that is powerful.

Those working in mental health saw the potential for using the healing elements especially now, during the pandemic.

A lot of people in the mental health communities are really having strong behaviors [due to COVID] …this is something that's scaring everybody and maybe some of the elements can help them just calm and be peaceful.

[During COVID, we are] talking about trying to get medicine for everybody. Medicine means either some root or some sage…. I think just how being able to have that available for people is important. Medicine and in the prayer and then to be on that mind, body and spirit.

Definitely, having these healing elements and creating this healing space that you could do something intentionally within this space where it's quiet and it's a bubble and we're calm and we're witnessing. I think that alone can be really cathartic.

Some of the people that we work with are dealing with … a lot of people who are suicidal….so getting people to be able to smudge or pray or just to be able to have that be part of their daily routine be having self-care and getting mindful is very helpful to people, because if they did that to their everyday routine that can help them stay on a different track rather than getting back into their … negative cycle.

Drum making, and drum circles were frequently mentioned specifically as an important healing element to share.

… I know Suscol had a drum circle. … I think things like that going on in the community without having to-- you don't have to come in with a diagnosis, you come and you do something that is generally for your wellbeing, but also has deep spiritual and cultural roots. Without having to put a label on, "Oh, I'm an alcoholic", or, "I have anxiety. I have whatever".

Yes, I certainly remember when I went out to that to do the drum making and spent the night on the hilltop. That was awesome because that just felt so natural and real and that might be the big learning if you can get people to do that.

The drum workshop was fantastic. It really was amazing. It was just so authentic in everything that was said and done and how just the respect with which the whole area was treated, and the fire was made. That really brought everything home. We know how to do this. This is the respect we show the earth.

> *My biggest recommendation would be to have the experience with the drum making. To make sure that that's not overlooked… I think that was probably one of the most powerful things for me....*

A few comments included specific recommendations. These included using the Suscol property as a way to bring people to healing and partnering with Tribes and/or Mental Health Divisions to share the cultural practices more widely for Native individuals.

> *… there should be much more availability and for different groups of people, not just mental health educators and much deeper learning for those who want to go deeper. I would encourage [Suscol to use their property] as a way of bringing people into that healing space.*

> *If there's a robust tribal structure, they may already be supporting these practices. If there isn't but there's a large population of individuals from this culture who could benefit from these practices, then the Mental Health Division might consider trying to find people that are qualified to run some of the cultural practices.*

Partnerships

A recurring theme in the recommendations from participants was partnering with other systems in the community. Some of the comments were more general about social services and others spoke specifically about health care, schools, and law enforcement.

> *Everybody, both non-Native and Native providers are in that group, and I really like that. I think maybe somehow creating… a buddy system… for encouraging non-Native service providers to find out what…the agency does, and vice versa. People have more working knowledge of, "Hey, we have all these programs. We can really work together. What does that look like?"*

> *If I was in charge, I'd make everybody go to it. Well, it wouldn't be optional if I was in charge because we're trying to address cultural incompetencies. We have identified these groups of people as being culturally underserved and yet we're not making it mandatory. It doesn't make any sense to me. We have to do this. We have to hit this population. We have to break through, and we can't do it if only a couple of us are learning about it. It has to be a team effort. Everyone has to learn about it.*

> *I think any of these social services. There's a lot of agencies that need to be aware of this that are working with this population. That's all these nonprofits... It's all of these helping human services with the county. It's all of these.*

> *We want to improve people's health and lives. This type of training is one component of it, and continuing funding so that there are ways to keep this type of training going is important… This needs to be part of what they're considering in terms of offerings throughout the state.*

Health Care

> *Maybe, if they could go into the health clinics, or any organization that serves people in the community, providing more information and knowledge to front line staff that are working with people to promote deeper understandings about mental health issues.*

I think it's just more of also a cultural awareness for our providers and understanding what all of these things mean to the Native American community, these traditions, these healing practices. I think it's really more about that bringing it to a provider awareness, so it's not just-- I know that's sometimes a very difficult sector to not necessarily attract, but to actually get in the room and it's like that for a lot of different things because of time and schedule. The medical society has in Napa, they meet monthly, or I don't know how often, but that might be a good group to do a presentation to.

OLE Health has a large provider group … and having a topic like this to that group I think will fascinate them. I feel that …they would be very open to having something like this to talk about. Something different than productivity.

Schools

I think it needs to go to schools, it's not just mental health. It needs to be offered to way more people. I think it should be just like racial sensitivity training. It should be required training. I think it should. Absolutely. Get the teachers, get some of these kindergarten teachers in here and do it. People who change their minds, things will change if we start letting more of the outside community into it.

I think that schools have an opportunity right now… teaching our kids to change things. Just like they brought the conversation of LGBTQ into schools. They need to bring the conversation, and the real [Native American] history into the schools...

Law Enforcement

Now that we're talking about the police, I think the police should be doing it.

Certainly, certainly our police force needs to have a deeper understanding of who their community is and what the needs are in the community to really be able to serve and protect current affairs being considered. This is just learning.

… How would I get a Tribal family to really give me more details on the things like sexual assault? A lot of the cases that we have here, the perpetrator is not a stranger, it's a relative. To have a Native family who's very close, actually have a child who will divulge anything against the relative… How would we get that communicated to… an authority figure who…doesn't really know your background?

Appendix A: Cohort and Drum Workshop Flyers

Suscol Intertribal Council Curriculum Topics for Cohort 1: 5 Workshops

These are the 5 curriculum topics, presented in chronological time for cohorts on Historical Trauma. Information is presented in sections. In addition to the workshop topic, there are healing elements, journal prompts, and other topics covered, as detailed in the Workshop Content General Outline. All workshops will briefly touch upon examples of resiliency, but the last workshop will go into greater depth with examples and explorations of tribal resiliency.

ALL workshops at same venue: N.V. Unitarian Universalist 1625 Salvador Ave Napa Ca

1. Workshop 1, August 28th, 2018 9am-11:30am
Topic: **Overview of Napa County Regional Native History.** History from pre-Colonial to Contemporary times
Healing Element: **Traditional uses of sage** The importance and impact of smudging with sage, the different methods used by native communities, and the taboos involved.

2. Workshop 2, September 25th, 2018 9:30am-12:00am
Topic: **Pre-colonial History of California Natives** The beauty and complexity of the local Native communities before European contact.
Healing Element: **Traditional uses of salt** The traditional healing and ceremonial uses of salt.

3. Workshop 3, October 23, 2018 9:30am-12:00pm
Topic: **Colonial History in California Native Territories** The intense trauma of a 60,000 year old civilization decimated in 25 years.
Healing Element: **Traditional uses of tobacco** The traditional healing and ceremonial use of tobacco

4. Workshop 4, November 13, 2018 9:30am-12:00am
Topic**: Post-Colonial History of California Natives** Discussions of the core causes of lateral violence and substance abuse within the Native Community today
Healing Element: **Traditional uses of the rattle** The traditional healing and ceremonial uses of the rattle. How different types of rattles are used.

5. Workshop 5, January 22, 2019, 9:30am-12:00pm
Topic**: "Thrival" and Tribal Resiliency** How culture and ceremony helps Native communities survive and thrive.
Healing Element: **Traditional Uses of the Drum** The traditional healing and ceremonial uses of the drum. How different types of drums are used.

Contact Suscol Intertribal Council for questions or to register for workshops, No CECs for this first Cohort Suscol@suscol.net #707-256-3561
Native American Historical Trauma and Traditional Healing Project. This project is made possible by the Napa County Mental Health Service Act Innovation Funds and N.V. Unitarian Universalist co-sponsor

Suscol Intertribal Council Presents 2019

Native American Historical Trauma and Traditional Healing Project. Five Workshops, presented in chronological order. Learning objectives: 1) Understand the accurate history of Native Americans in Napa County; that Native people lived in structured, civilized, complex societies in permanent villages. 2) Explain the historical process of the extreme systematic trauma to the Native population. 3) Show how California Natives are still present, active and involved in the modern world. Will share examples and explorations of tribal resilience.

1. Workshop 1, February 26, 2019 9:30am-12:00pm
Topic: Overview of Napa County Regional Native History History from pre-Colonial to Contemporary times
Healing Element: Traditional uses of sage The importance and impact of smudging with sage, the different methods used by native communities, and the taboos involved.

2. Workshop 2, March 26, 2019 9:30am-12:00pm

Topic: Pre-colonial History of California Natives The beauty and complexity of the local Native communities before European contact.

Healing Element: Traditional uses of salt. Traditional healing, ceremonial uses of salt.

3. Workshop 3, April 23, 2019, 9:30am-12:00pm

Topic: Colonial History in California Native Territories. The intense trauma of a +10,000 year old civilization decimated in 25 years.

Healing Element: Traditional uses of tobacco. The traditional healing and ceremonial use of tobacco

4. Workshop 4, May 21, 2019, 9:30am-12:00pm

Topic: Post-Colonial History of California Natives Discussions of the core causes of lateral violence and substance abuse within the Native Community today

Healing Element: Traditional uses of the rattle. The traditional healing and ceremonial uses of the rattle. How different types of rattles are used.

5. Workshop 5, June 25, 2019, 9:30am-12:00pm

Topic: “Thrival” and Tribal Resiliency How culture and ceremony help Native communities survive and thrive.

Healing Element: Traditional Uses of the Drum. The traditional healing and ceremonial uses of the drum. How different types of drums are used.

Contact Suscol Intertribal Council for questions or to register for workshops, suscol@suscol.net #707-256-3561 Native American Historical Trauma and Traditional Healing Project. This project is made possible by the Napa County Mental Health Service Act Innovation Funds

Suscol Intertribal Council Presents Sept 4 -Nov 6, 2019

Cohort 3: Native American Historical Trauma and Traditional Healing Project.

Five Workshops, presented in chronological order. Learning objectives: 1) Understand the accurate history of Native Americans in Napa County; that Native people lived in structured, civilized, complex societies in permanent villages. 2) Explain the historical process of the extreme systematic trauma to the Native population. 3) Show how California Natives are still present, active and involved in the modern world. Will share examples and explorations of tribal resilience.

Napa Valley Unitarian Universalist hosted 1625 Salvador Ave Napa Ca

1. Workshop 1, Wed. September 4, 2019 6:00pm-8:00 pm

Topic: Overview of Napa County Regional Native History from pre-Colonial to Contemporary times
Healing Element: Traditional uses of sage. The importance and impact of smudging with sage, the different methods used by native communities, and the taboos involved.

2. Workshop 2, Wed. September 25, 2019 6:00pm-8:00 pm

Topic: Pre-colonial History of California Natives The beauty and complexity of the local Native communities before European contact.

Healing Element: Traditional uses of tobacco. Traditional healing, ceremonial uses of tobacco.

3. Workshop 3, Wed. October 2, 2019 6:00pm-8:00 pm

Topic: Colonial History in California Native Territories. The intense trauma of a +10,000 year old civilization decimated in 25 years.

Healing Element: Traditional uses of salt. The traditional healing and ceremonial use of salt

4. Workshop 4, Wed. October 16, 2019 6:00pm-8:00 pm

Topic: Post-Colonial History of California Natives Discussions of the core causes of lateral violence and substance abuse within the Native Community today

Healing Element: Traditional uses of the rattle. The traditional healing and ceremonial uses of the rattle. How different types of rattles are used.

5. Workshop 5, Wed. November 6, 2019 6:00pm-8:00 pm

Topic: "Thrival" and Tribal Resiliency How culture and ceremony help Native communities Survive and thrive
Healing Element: Traditional Uses of the Drum. The traditional healing and ceremonial use of the drum. How different types of drums are used.

Contact Suscol Intertribal Council for questions or to register for workshops, Third Cohort Suscol@suscol.net #707-256-3561 Native American Historical Trauma and Traditional Healing Project. This project is made possible by the Napa County Mental Health Service Act Innovation Funds. Venue N.V. Unitarian Universalist

Drum Making Workshop August 3rd-4th, 2019

Camp Checklist Food will be provided

- Tent (if needed)
- Reusable water bottle
- Sleeping bag/blanket/pillow
- Extra Clothing, socks
- Sneakers or hiking boots
- Light Jacket or long sleeved shirt for sun protection and mosquitoes at night
- Camp chair
- Flash Light
- Towel
- Must provide on toiletries, Biodegradable. Outdoor, cold water shower
- Hat, Allergy medicine, Sun Block, Bug Repellant
- Suscol will not be responsible for anything lost stolen or broken.

Meet at Suscol Office 9am Sat morning. Caravan/carpool to site.
If you are traveling to site alone let me know, please.
Folks who are going back and forth or only one day can ride with Sal as he will be going back and forth each day.

Schedule**: Sat Oct 3rd 9am meet at Suscol Office 575 Lincoln Ave #215 Napa** just east of Wal-Mart
10am Arrive orientation set up camp
11:30 am Lunch
12:30 pm Begin drum classes. Snacks self-help breaks.
4ish plant identification walks gentle slow
6pm Dinner
7:30 fire talking circle/drum songs
Sunday Oct 4th, 2019, Sunday folks meet Sal at Suscol office 9am
8am morning Hike for those who desire
9am Breakfast
10am ceremony fire dream discussions drum
12 noon lunch
1pm Departure and closure. There will be a flow to ceremony walks and time for self-contemplation and socializing throughput the weekend this is an outline of activities.

HISTORICAL TRAUMA & TRADITIONAL HEALING

DRUM MAKING WORKSHOP

May 29, 2021, 10am-6:00pm

JOIN US FOR A DAY OF DRUM MAKING, COMMUNITY, STORIES AND SONG

Drums are used by Indigenous cultures from around the world for ceremony and healing. The making and use of drums is a sacred practice and a transformative experience. You are invited to participate in this special opportunity with the notion that you will use your hand drum for the healing of yourself and others. The drums are not decorations or objects, but are infused with powerful healing energy and spirit, which are to be respected.

During this workshop you will:

- Learn about the sacred aspect of the drum, the energy and spirit it holds
- Learn how to craft your very own beautiful and unique healing drum and how to care for it
- Learn about the benefits of drumming and how to use your drum
- Be supplied with everything you need to create your own hand drum and drum stick

The workshop is led by Barbara Clifton Zarate, who is a drum-maker and the drum keeper of the White Buffalo Woman Council Drum. She will guide participants on the proper techniques and fundamentals of drum making.

We give gratitude to the Spirit of the Four-Leggeds, thanking them for giving their lives in providing the hides; to the Spirit of the Tree Nation, thanking them for their sacrifice in providing the hoops; and to the Spirit of the drum, as a gift for healing the people.

NOTE: Because of the need for social distancing, we will be in an outdoor setting with plenty of ventilation and spaced at least 6 feet apart. Masks will be required.

Appendix B: Sample Workshop Survey

Thank you for your participation today. This survey is intended to help us understand how the information we shared today is understood and how it will be used.

The survey is anonymous, you do not need to include your name on the survey. All surveys will be aggregated for reporting.

When you have finished the survey, please put it in the envelope provided and give it to the staff.

1. Thinking about today's topic, "*[insert topic]*" please rate the following statements:

PRIOR **to this presentation, I understood this topic: (Circle your response)**

Strongly Disagree					Neither Agree or Disagree					Strongly Agree
0	1	2	3	4	5	6	7	8	9	10

AFTER **this presentation, I understand this topic: (Circle your response)**

Strongly Disagree					Neither Agree or Disagree					Strongly Agree
0	1	2	3	4	5	6	7	8	9	10

2. Thinking about today's healing element, "[insert healing element]," please rate the following statements.

	0 Strongly Disagree	1	2	3	4	5 Neither Agree or Disagree	6	7	8	9	10 Strongly Agree
PRIOR to this presentation, I understood the ***importance and impact of using the [insert healing element].***											
AFTER this presentation, I understand the ***importance and impact of using the [insert healing element].***											
PRIOR to this presentation, I understood the ***different [insert healing element] methods used by Native communities.***											
AFTER this presentation, I understand the ***different [insert healing element] methods used by Native communities.***											
PRIOR to this presentation, I understood the ***taboos involved in using the [insert healing element].***											
AFTER this presentation, I understand the ***taboos involved in using the [insert healing element]..***											

3. Hearing about oppression and historical trauma can overwhelm and/or inspire individuals. How are you feeling right now?

	0 Strongly Disagree	1	2	3	4	5 Neither Agree or Disagree	6	7	8	9	10 Strongly Agree
I feel overwhelmed.											
I feel inspired.											
I feel _____. (*please specify*)											

4. In your opinion, did the healing element change how you were feeling? (Circle your response)

I felt much worse after experiencing the healing element					**I felt the same after experiencing the healing element.**					**I felt much better after experiencing the healing element**
0	1	2	3	4	5	6	7	8	9	10

5. Please respond to the following statements:

	Yes	**No**	**Do not Know**
Have you ever used the *[insert healing element]* for your PERSONAL wellness and healing prior to this workshop?			
Do you plan to use the *[insert healing element]* for your PERSONAL wellness and healing?			
Have you ever used the *[insert healing element]* to promote YOUR CLIENTS' wellness and healing prior to this workshop?			
Do you plan to use the *[insert healing element]* to promote YOUR CLIENTS' wellness and healing?			

6. Please indicate your intentions to share your learning from this workshop with others: *(Check all that apply)*

	Yes, with Friends	Yes, with Family	Yes, with Colleagues	No	Do not Know
I will share the learning about *[insert topic].*					
I will share the learning about the traditional uses of the *[insert healing element].*					
I will share the practice of using the *[insert healing element]* to promote healing and wellness.					

7. Additional Comments:

Thank you!

When you have completed the survey, put it in the attached envelope and give it to the staff.

Appendix C: Demographics

Native American Historical Trauma and Healing Workshop Series: Demographics

	All Cohorts		2018 Community Survey (Mental Health Providers Only)		2021 Community Survey (Mental Health Providers Only)	
Demographic Category	**Number of Participants**	**Percentage of Participants**	**Number of Respondents**	**Percentage of Respondents**	**Number of Respondents**	**Percentage of Respondents**
Age						
Young Adult 16-25	3	4%	4	4%	0	0%
Adult: 26-59	55	76%	76	75%	25	78%
Older Adult: 60+	12	17%	21	21%	7	22%
No Response	2	3%	0	0%	0	0
Gender						
Female	58	81%	78	77%	26	81%
Male	11	15%	13	13%	3	9%
Cis gender Male	1	1%	1	1%	0	0%
Demi-femme	0	0%	0	0%	1	0%
Fluid	0	0%	1	1%	1	0%
Gender queer and Female	0	0%	1	1%	0	0%
NA	0	0%	1	1%	0	0%
Two Spirit	1	1%	0	0%	0	0%
Transgender Female to Male	1	1%	0	0%	1	0%
No Response	1	1%	6	6%	0	0%
Race/Ethnicity						
European, White, Caucasian	28	39%	56	55%	22	69%
Hispanic, Latino, Chicano/a	21	29%	21	21%	3	9%
Mexican, Mexicano/a, Mex/Amer	10	14%	7	7%	2	6%
More than one race	19	26%	14	14%	3	9%
Indigenous American/Native American/Native Hawaiian	10	14%	9	9%	5	16%
African American, Black	2	3%	3	3%	0	0%
Jewish/Ashkenazi	2	3%	2	2%	0	0%

Native American Historical Trauma and Healing Workshop Series: Demographics

	All Cohorts		2018 Community Survey (Mental Health Providers Only)		2021 Community Survey (Mental Health Providers Only)	
Demographic Category	**Number of Participants**	**Percentage of Participants**	**Number of Respondents**	**Percentage of Respondents**	**Number of Respondents**	**Percentage of Respondents**
Asian, Pacific Islander/Filipinx/Indonesian	1	1%	1	1%	1	3%
Human	1	1%	2	2%	0	0%
No Response	0	0%	9	9%	2	6%
Role in Mental Health System						
Family member of someone who has used mental health services	36	50%	34	34%	15	47%
Someone who has used mental health services	32	44%	37	37%	17	53%
Mental Health Provider (community provider, family support worker, case manager, etc.)	38	53%	62	61%	21	66%
Mental Health Provider (licensed)	15	21%	46	46%	11	34%
Other (please specify)	20	28%	13	13%	4	13%
No Response	3	4%	0	0%	0	0%
Serve Native Americans						
Yes, I am currently serving Native American individuals	23	32%	22	22%	9	28%
Yes, I have served Native American individuals in the past	26	36%	51	50%	20	63%
No, I have not served Native American individuals	17	24%	23	23%	7	22%
Not Sure	12	17%	10	10%	4	13%
No Response	0	0%	0	0%	0	0%
Napa County Communities						
American Canyon	36	50%	48	48%	1	3%
Napa	61	85%	88	87%	24	75%
Yountville	29	40%	37	37%	2	6%

Native American Historical Trauma and Healing Workshop Series: Demographics

	All Cohorts		2018 Community Survey (Mental Health Providers Only)		2021 Community Survey (Mental Health Providers Only)	
Demographic Category	**Number of Participants**	**Percentage of Participants**	**Number of Respondents**	**Percentage of Respondents**	**Number of Respondents**	**Percentage of Respondents**
St Helena	34	47%	45	45%	5	16%
Angwin[16]	*Not asked*	*Not asked*	*Not asked*	*Not asked*	3	9%
Calistoga	32	44%	45	45%	2	6%
Unincorporated Areas	19	26%	23	23%	1	3%
Outside of Napa County	16	22%	27	27%	0	0%
Other	12	17%	11	11%	5	16%
No Response	1	1%	1	1%	0	0%
Years in the Mental Health Field[17]						
Less than 5 years	23	32%	20	20%	*Not asked*	*Not asked*
5-9 years	10	14%	13	13%	*Not asked*	*Not asked*
10-14 years	12	17%	18	18%	*Not asked*	*Not asked*
15-19 years	8	11%	8	8%	*Not asked*	*Not asked*
20-24 years	5	7%	16	16%	*Not asked*	*Not asked*
25+ years	9	13%	19	19%	*Not asked*	*Not asked*
No Response	7	10%	7	7%	*Not asked*	*Not asked*
Populations Served by Participants[18]						
Age Groups						
Young Children: 0-5	31	43%	40	40%	*Not asked*	*Not asked*
Youth: 6-15	38	53%	54	53%	*Not asked*	*Not asked*
Young Adult: 16-25	56	78%	77	76%	*Not asked*	*Not asked*
Adult: 26-59	54	75%	77	76%	*Not asked*	*Not asked*

[16] This category was added after feedback from respondents to the 2018 Community Survey.
[17] This question was not included on the 2021 Community Survey.
[18] This section was not included on the 2021 Community Survey.

Native American Historical Trauma and Healing Workshop Series: Demographics

	All Cohorts		2018 Community Survey (Mental Health Providers Only)		2021 Community Survey (Mental Health Providers Only)	
Demographic Category	**Number of Participants**	**Percentage of Participants**	**Number of Respondents**	**Percentage of Respondents**	**Number of Respondents**	**Percentage of Respondents**
Older Adult: 60-75	44	61%	60	59%	*Not asked*	*Not asked*
Older Adult: 76+	32	44%	33	33%	*Not asked*	*Not asked*
No Response	2	3%	1	1%	*Not asked*	*Not asked*
Veterans						
Work with Veterans	38	53%	52	51%	*Not asked*	*Not asked*
Do not work with Veterans	22	31%	46	46%	*Not asked*	*Not asked*
Not Sure	11	15%	1	1%	*Not asked*	*Not asked*
No Response	1	1%	2	2%	*Not asked*	*Not asked*
LGBTQ						
Work with LGBTQ Individuals	59	82%	91	90%	*Not asked*	*Not asked*
Do not work with LGBTQ Individuals	4	6%	5	5%	*Not asked*	*Not asked*
Not Sure	9	13%	4	4%	*Not asked*	*Not asked*
No Response	1	1%	1	1%	*Not asked*	*Not asked*
Total Participants/Respondents	**72**		**101**		**32**	

Innovation Round 2 – Adverse Childhood Experiences (ACEs) Project

Program Report, August 2021

Overview

Paraprofessionals, who are individuals' first contact with services, are often best positioned to intervene in the prevention and treatment of ACEs yet have the least professional support to address ACEs in their own lives. In contrast, licensed professionals receive training and often ongoing supervision to address their own trauma history and the impact it has in their work. The Adverse Childhood Experiences (ACEs) Innovation Project was designed to explore whether identifying and discussing the role of ACEs and Resiliency in the lives of paraprofessionals improves how individuals understand ACEs and Resiliency in the lives of the individuals they serve and/or improves how individuals manage workplace stress.

Learning Questions

The project was guided by three learning questions:

1. How does a paraprofessional's personal history with ACEs and Resiliency impact how they address ACEs with their clients?
2. How does a paraprofessional's personal history with ACEs and Resiliency impact their workplace stress?
3. Which supports do paraprofessionals find the most effective in changing how they address ACEs and Resiliency with individuals and/or how they manage workplace stress?

Summary of Learning

How does a paraprofessional's personal history with ACEs and Resiliency impact how they address ACEs with their clients?

- Most participants reported that understanding their own ACES has helped them to be more compassionate with their clients, to listen more, and to be more open to possible underlying causes or explanations for client behavior.
- When asked to describe the specific changes they made, the most common reports were: having more compassion; having more empathy; having more curiosity, making time and space to listen more; having a better understanding of trauma and being open to discussing candidly, or asking questions, that may have been uncomfortable for them previously; being aware of their own triggers and not responding emotionally, not mirroring a client's emotions; and, not taking things their clients do or say personally.
- Participants who said "yes" to making changes in the way they address ACES and Resiliency with their clients also reported that they'd observed changes in their clients as a result.
- Changes in RAISE training program participant survey responses over time indicate an increased awareness of the impact that that a paraprofessional's personal experience with past adverse experiences has on their ability to serve their clients.

How does a paraprofessional's personal history with ACEs and Resiliency impact their workplace stress?

Responses over time indicate an increased awareness among the majority of RAISE participants of the impact that a paraprofessional's personal history with past adverse experiences on their workplace stress.

Most RAISE participants interviewed at the end of the project acknowledged the impact that unaddressed ACEs can have on how a person manages their workplace stress.

Most referenced the need to take care of themselves, to take time out for things they enjoy, and to have a toolbox of self-care strategies that can be used in the moment

Which supports do paraprofessionals find the most effective in changing how they address ACEs and Resiliency with individuals and/or how they manage workplace stress?

Addressing ACEs

As noted previously, one of the main supports in changing how paraprofessionals address ACEs with clients was an improved understanding of how their personal experience with trauma informs their reactions to client situations.

When asked about the types of supports paraprofessionals find the most effective in changing how they address ACEs and Resiliency with individuals, the majority of RAISE participants reported the need to view behavior in the context of ACEs and past trauma, providing understanding and compassion, and making no assumptions about why individuals behave the way they do.

Sharing the Learning

During the project implementation, participants reported that sharing the information with the participants' coworkers, managers and/or supervisors helped them to use the information at work. The additional support of co-workers made the application of the learning more effective.

About one third of those who shared the learning with co-workers (4 of 11) reported changes about how ACEs and Resiliency was addressed in their organization.

A manager training component was added to the project as participant identified the need for more support from within their organization.

Managing Workplace Stress

Participants reported the need to find what works for "you" to address workplace stress. Most reported that they didn't think about self-care before RAISE, and they remind themselves to stay focused on consciously engaging in self-care activities. Many noted the need to focus on taking care of themselves, so they can take care of others.

Preferences for managing workplace stress varied by individual and included: being physically active, using strategies that could be done in the moment (e.g. breathing) and practicing the self-reflection they learned in the training.

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The Need

(From the Proposal)

> *Adverse Childhood Experiences are the single greatest unaddressed public health threat facing our nation today*. --Dr. Robert Block, former President of the American Academy of Pediatrics

What are ACEs?

In 1997, the Centers for Disease Control (CDC) and Kaiser Permanente published the results of one of the largest retrospective studies to examine the links between adverse childhood experiences (ACEs) and current adult health and well-being.[1] The study showed that exposure to severe or pervasive childhood trauma (including abuse, neglect, parental mental illness or substance dependence, parental incarceration, parental separation or domestic violence) dramatically increases the risk of chronic disease later in life. The study also found that the higher the incidence of exposure, the worse one's health outcome. Individuals who experience four or more ACEs have a 4.5 times greater risk for depression, a 2.5 times greater risk for chronic obstructive pulmonary disease, and 12 times greater risk for suicidality.[2]

Prevalence of ACEs

Children are most at risk for long-term adverse health impacts because their systems are still developing.[3]

- Of the 76 million children living in the United States, it is estimated that 46 million can expect to have their lives affected by violence, abuse, crime and psychological trauma.[4]
- One in eight US residents has four or more ACEs.[5]
- In Napa County, 64.5% of the population has at least one ACE[6] (Compared to 67% nationwide)[7]
- One in five (20%) residents of Napa County has four or more ACEs.[8] (Compared to 12.5% nationwide).[9]

Screening for ACEs

The Napa ACEs Connection, a group of social service agencies in Napa County working to implement ACEs screening and treatment, noted that though the member agencies are all interested in addressing ACEs, there is very little screening currently occurring. The one program that is known to screen for ACEs does not use the ACE Questionnaire but has incorporated questions about ACEs into other parts of its assessment. This program screens about 60 individuals each year. None of the other eight member

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[1] (Centers for Disease Control and Prevention [CDC], 2012). http://www.socialworkers.org/assets/secured/documents/practice/children/acestudy.pdf
[2] CDC-Kaiser Study: http://www.cdc.gov/violenceprevention/acestudy/
[3] American Journal of Preventative Medicine: http://www.ajpmonline.org/article/S0749-3797(98)00017-8/abstract
[4] US Justice Department, 2012 & www.socialworkers.org/asset
[5] CDC-Kaiser Study: http://www.cdc.gov/violenceprevention/acestudy/
[6] Center for Youth Wellness: https://app.box.com/s/nf7lw36bjjr5kdfx4ct9
[7] American Journal of Preventative Medicine: http://www.ajpmonline.org/article/S0749-3797(98)00017-8/abstract
[8] Center for Youth Wellness: https://app.box.com/s/nf7lw36bjjr5kdfx4ct9
[9] American Journal of Preventative Medicine: http://www.ajpmonline.org/article/S0749-3797(98)00017-8/abstract

agencies currently screen for ACEs, despite the tool being available and despite the known link between ACEs, health and wellbeing.

Needs of Paraprofessionals

Paraprofessionals are delegated a portion of professional tasks, but do not have a license to practice as an independent practitioner. Therefore, the supports that are available to licensed professionals to acknowledge and address their own trauma history are not in place for paraprofessionals. When individual's ACEs are identified, they are also offered information and support. This information and support are not offered to paraprofessionals.

Impact on Work

In many agencies, paraprofessionals are individuals' first contact with services. This project seeks to understand how paraprofessionals' own experiences with ACEs changes how they understand the role of ACEs for individuals and how they screen and refer individuals for ACEs. The project offers education and support to paraprofessionals that are available to licensed professionals and clients.

Impact on Workplace Stress

Current research shows that nationwide, 48% of the social work workforce experiences high levels of personal distress as a result of their work.[10] This work-based distress results in high incidence of suicide, high turnover rates in employment, high rates of burnout, and disruptive symptoms to personal lives resulting from traumatic stress.[11] This project seeks to learn more about how the paraprofessionals' experience with ACEs is related to workplace stress, turnover and burnout and offers self-care options to help paraprofessionals manage stress

[10] Strozier & Evans, 1998.
[11] Figley, 2002; McCann & Pearlman, 1990; Meyers & Cornille, 2002; Pryce, Shackleford, & Pryce, 2007; Valent, 2002.

The Innovation

There were four phases to the project. First, the project staff recruited individuals to participate in the educational component, next they screened a film to teach the community about ACEs and then they recruited individuals who would like to participate in further training. Once the training was underway, they began planning how to share the learning with co-workers, other providers and the broader community. A project timeline and detailed list of project activities is included in Appendix D for further reference.

Recruitment

The project began by inviting paraprofessionals from organizations in the community to participate in a film screening and discussion. To ensure that the learning from this project was spread throughout agencies that address mental health needs, organizations were contacted that spanned the geographic range of the county and served individuals throughout their lifespan (prenatal to older adult). Additionally, recruitment of participants included specific organizations with paraprofessionals who work directly with Napa County's underserved populations, and/or employ peer staff and family members as paraprofessionals.

The paraprofessionals viewed the film, *Resilience*, a one-hour documentary that delved into the science of ACEs toward the goal of treating and preventing toxic stress. Project staff intended to show the film to 45 individuals. Fifteen of the 45 were anticipated to participate in the training component and the remaining 30 would serve as the comparison group. Individuals were encouraged to self-select, and organizations were encouraged to nominate candidates. All participation was voluntary. If more than 15 individuals were interested in participating in the larger project, a selection process was planned to ensure representation of peers and family members, racial and ethnic groups, age groups, geography, language, LGBTQ, and veterans.

Film Screening: Resilience

As a result of leveraged funds from Kaiser Permanente Community Benefits Department Napa/Solano, countywide screenings of *Resilience* were held. This additional funding allowed a much broader reach of the education component, crossing multiple sectors as well as geographic regions beginning in November 2017. Outreach was done through the Napa ACEs Connection group, social media platforms, emails to key stakeholder groups, personal calls, and meetings with partner agencies.

Training Recruitment

In June 2018, program staff began recruitment for the training component, a professional development program for paraprofessionals in Napa County titled, RAISE: Resilience, ACEs Integration, Support & Education. A series of tailored emails were sent to: (1) *Resilience* screening participants who were paraprofessionals and expressed an interest in the training program; (2) Resilient Napa partners; and (3) Napa County human service organizations.

A total of 36 applications were received and reviewed by the Resilient Napa Members Council, with offers extended to 20 paraprofessionals in the county. Managers in the paraprofessionals' respective organizations completed an agreement to support staff participation in the training program. Key

components of the agreement included: paraprofessionals' direct work with clients; release from work for 15 days over 15 months (for RAISE training sessions and two convenings); facilitating a minimum of two opportunities per year for trainees to share their experiences and learning within the organization; consideration of offering space for one of the training sessions; and the offer of support to assist with securing professional development funds.

Education

Project staff initially planned for 45 paraprofessionals to participate in an education component about how ACEs and Resiliency impacts individual and community well-being; specifically, they would view a screening of the film, *Resilience*, with a question and answer period following. Prior to and after completing the film and discussion, screening participants would complete a survey about how ACEs and Resiliency impact their work and workplace stress. Interested paraprofessional participants would be encouraged to continue with the project, and participation would be voluntary for all individuals. With additional leveraged funding, countywide screenings of *Resilience* between December 2017 and June 2018 reached a total of 382 paraprofessionals. Each participant viewed the film, *Resilience*, participated in a discussion session, and completed a post-screening survey.[12]

Training

Project staff originally planned to recruit 15 paraprofessionals from those attending the *Resilience* screening. These individuals would receive further training to consider the role of ACEs in their personal and professional lives. The training was planned to incorporate two components:

- To address how ACEs and Resiliency impact their work, program staff planned to have participants complete a Reflective Facilitation session each month. The focus of these groups would be to understand barriers and supports to address ACEs and Resiliency with individuals.
- To address workplace stress, staff planned to have participants suggest potential self-care options and to encourage each person to try at least three different options during the project.

Based on 36 applications received, twenty paraprofessionals were selected from human service organizations throughout Napa County. One project participant dropped out prior to the start, resulting in a total of 19 participants. Twelve one-day sessions were held from September 2018 thru August 2019. The first half of each session focused on the presentation of content, and the second half of each session focused on reflective practice[13] and self-care. These sessions were purposefully structured not to be group therapy. The 19 participants were divided into two groups, and mental health professionals were hired to facilitate the reflective practice sessions.

Manager Training

In response to the project's learning about the importance of including managers in the training and discussion, a manager training component was developed and implemented. Managers were surveyed

[12] As the number of screenings expanded and reached a larger number of paraprofessionals countywide, the decision was made to shift from a set of pre-post screening surveys to one retrospective pre-post questionnaire.
[13] Reflective facilitation is a type of consultative process to discuss how paraprofessional's own ACEs scores and resiliency factors impact how they do their work with clients.

to provide input into this aspect of the program. Managers attended a half day training with their staff training participant where they co-created strategies in which the learning from RAISE would be brought back to their respective organizations. In addition, they participated in a facilitated reflective group with together. Three separate reflective supervision trainings were offered to provide further tools and education on how to bring reflective practice into their organizations.

Sharing Learning

The proposed project plan was to conclude with an exploration of the participants' own learning about how participation in the training, 'Assessing and Addressing ACEs and Resiliency', impacted their professional life and their workplace stress. As the project spanned populations and systems, the intent was that the learning would also reflect these varied perspectives.

Opportunities for sharing learning occurred throughout the duration of the project. RAISE program participants and Resilient Napa staff were provided with opportunities to share their learnings at additional trainings, encouraged to bring their learnings back to their organizations, and to participate in conferences.

Administration

Project staff used human-centered design principles and strategies to implement the RAISE project. This approach has been used throughout the Napa County communities after several local leaders were trained in the approach. Project staff used this approach to design the paraprofessional training cohort and steering committee members used it in developing and refining the training program curriculum.

Being an Innovation project and using the human centered design principles meant the project involved a number of professionals and a great deal of planning and effort. The RAISE project team included: an Executive Director, agency data support staff, a project coordinator, two Reflective Facilitation specialists, an external evaluation team, a series of didactic topical instructors, experts in various self-care strategies, and the project steering committee. This project also included a lot of detailed information in the planning and evaluation, and this detail is included in the Appendices for reference.

The Learning

The project learning centered on three questions. This section is organized by learning question for efficient reference. More detailed information about the findings for each learning question can be found in the Appendices.

The learning questions that guided the project are below:

- How does a paraprofessional's personal history with ACEs and Resiliency impact how they address ACEs with their clients?
- How does a paraprofessional's personal history with ACEs and Resiliency impact their workplace stress?
- Which supports do paraprofessionals find the most effective in changing how they address ACEs and Resiliency with individuals and/or how they manage workplace stress?

Addressing ACEs with Clients

How does a paraprofessional's personal history with ACEs and Resiliency impact how they address ACEs with their clients?

Most participants reported that understanding their own ACES has helped them to be more compassionate with their clients, to listen more, and to be more open to possible underlying causes or explanations for client behavior.

When asked to describe the specific changes they made, the most common reports were: having more compassion; having more empathy; having more curiosity, making time and space to listen more; having a better understanding of trauma and being open to discussing candidly, or asking questions, that may have been uncomfortable for them previously; being aware of their own triggers and not responding emotionally, not mirroring a client's emotions; and, not taking things their clients do or say personally.

Participants who said "yes" to making changes in the way they address ACES and Resiliency with their clients also reported that they'd observed changes in their clients as a result.

Changes in RAISE training program participant survey responses over time indicate an increased awareness of the impact that that a paraprofessional's personal experience with past adverse experiences has on their ability to serve their clients.

Although the question was not intended to elicit change in behavior as a result of participation in the RAISE training program, when asked the end-of-project interview question, '*How do you think a paraprofessional's personal history with ACEs and Resiliency impacts how they address ACEs with their clients?*', most participants reported that understanding their own ACEs has helped them to be more compassionate with their clients, to listen more, and to be more open to possible underlying causes or explanations for client behavior.

To assess participant behavior change in Addressing ACEs and Resiliency with clients, RAISE participants were asked the end-of-project interview question, '*Based on what you've learned in RAISE, have you made any changes in the way you work with your clients*?'. The majority of participants quickly provided affirmative responses (i.e., "oh yes", "definitely"), and when asked to describe the changes the most common reports were: having more compassion; having more empathy; having more curiosity, making time and space to listen more; having a better understanding of trauma and being open to discussing candidly, or asking questions, that may have been uncomfortable for them previously; being aware of their own triggers and not responding emotionally, not mirroring a client's emotions; and, not taking things their clients do or say personally.

All participants who said "yes" to making changes in the way they address ACEs and Resiliency with their clients also reported that they'd observed changes in their clients as a result. Observed changes include: clients are opening up more, having more progressive conversations, providing more feedback; clients are recognizing their own emotional reactions (because the paraprofessional pauses rather than reacts)*;* and, clients are starting to acknowledge their own ACEs, recognize their emotional reactions, and begin to change the way they respond to situations.

Changes in RAISE training program participant survey responses over time indicate an increased awareness of the impact that that a paraprofessional's personal experience with past adverse experiences has on their ability to serve their clients. All RAISE participants interviewed at the end of the project reported that someone's personal history with ACEs has a significant impact on their ability to work with clients who've experienced ACEs, particularly ACEs that are similar. All reported that education and awareness of ACEs is important in being able to understand the personal impact that they've made, build resiliency, and be able to recognize triggers and manage emotions that arise. Most reported that if someone hasn't addressed or processed their own ACEs, they are likely to be unknowingly triggered when working with a client who has similar ACEs, and perhaps be less tolerant, defensive, and/or avoidant. For more detailed information, see Appendix A.

Workplace Stress

How does a paraprofessional's personal history with ACEs and Resiliency impact their workplace stress?

Responses over time indicate an increased awareness among the majority of RAISE participants of the impact that a paraprofessional's personal history with past adverse experiences on their workplace stress.

Most RAISE participants interviewed at the end of the project acknowledged the impact that unaddressed ACEs can have on how a person manages their workplace stress.

Most referenced the need to take care of themselves, to take time out for things they enjoy, and to have a toolbox of self-care strategies that can be used in the moment.

At mid-project, RAISE participants were asked how the experience of ACEs might impact how a person manages workplace stress, their responses acknowledged the impact of ACEs on workplace stress. Though many responses indicated that it depends, about a quarter of the responses acknowledged the connection between workplace stress and ACEs.

Responses to "How do you think a paraprofessional's personal history with ACEs and Resiliency impacts how they manage their workplace stress?" (n=18)

Response	Frequency	Percent
Impact varies, it depends on person's skills and tools to manage stress	9	50%
If one's own ACEs are not addressed toxic stress may impact ability to work	7	39%
Recognition of one's own ACEs and triggers helps stress management	5	28%
ACEs impact personality and behaviors, people can get dysregulated and lose temper, depressed and overwhelmed	4	22%
Total Respondents	**18**	

Responses over time indicate an increased awareness among the majority of RAISE participants of the impact that a paraprofessional's personal history with past adverse experiences on their workplace stress. At the end of the project, RAISE participants were interviewed and asked the same question: *How do you think a paraprofessional's personal history with ACEs and Resiliency impacts how they manage their workplace stress?* Almost all responded with an acknowledgement of the impact that unaddressed ACEs can have on how a person manages their workplace stress. Most reported that education and awareness is key to understanding the personal impact that ACEs have had, as well as developing tools and coping mechanisms to manage emotional responses when triggered:

> *"Education is key, once you know what this is, you can understand why you respond in certain ways, awareness helps you manage it in a different way"*

> *"As I learned what impacts me, how to recognize my body's stress response, understanding the feelings I will get, I can take a moment to ground myself and come back and be present with my clients"*

Most reported that education and awareness is key to understanding the personal impact that ACEs have had, as well as developing tools and coping mechanisms to manage emotional responses when triggered. Most referenced the need to take care of themselves, to take time out for things they enjoy, and to have a toolbox of self-care strategies that can be used in the moment. For more detailed information, see Appendix B.

Effective Supports

Which supports do paraprofessionals find the most effective in changing how they address ACEs and Resiliency with individuals and/or how they manage workplace stress?

Addressing ACEs

As noted previously, one of the main supports in changing how paraprofessionals address ACEs with clients was an improved understanding of how their personal experience with trauma informs their reactions to client situations.

When asked about the types of supports paraprofessionals find the most effective in changing how they address ACEs and Resiliency with individuals, the majority of RAISE participants reported the need to view behavior in the context of ACEs and past trauma, providing understanding and compassion, and making no assumptions about why individuals behave the way they do.

Sharing the Learning

During the project implementation, participants reported that sharing the information with the participants' coworkers, managers and/or supervisors helped them to use the information at work. The additional support of co-workers made the application of the learning more effective.

About one third of those who shared the learning with co-workers (4 of 11) reported changes about how ACEs and Resiliency was addressed in their organization.

A manager training component was added to the project as participant identified the need for more support from within their organization.

Managing Workplace Stress

Participants reported the need to find what works for "you" to address workplace stress. Most reported that they didn't think about self-care before RAISE, and they remind themselves to stay focused on consciously engaging in self-care activities. Many noted the need to focus on taking care of themselves, so they can take care of others.

Preferences for managing workplace stress varied by individual and included: being physically active, using strategies that could be done in the moment (e.g. breathing) and practicing the self-reflection they learned in the training.

Addressing ACEs

As noted previously, one of the main supports in changing how paraprofessionals address ACEs with clients was an improved understanding of how their personal experience with trauma informs their reactions to client situations.

When asked about the types of supports paraprofessionals find the most effective in changing how they address ACEs and Resiliency with individuals, the majority of RAISE participants reported the need to view behavior in the context of ACEs and past trauma, providing understanding and compassion, and making no assumptions about why individuals behave the way they do. Most referred to a need for self-care and stress management. Many cited the need to become more aware of one's own personal

triggers and, more specifically, personal triggers that can occur in the workplace. And a few RAISE participants focused on client strengths and cited becoming more hopeful that resiliency can be built over time and change brain functioning. Changes RAISE participants cited that helped them to think differently about their clients included having more compassion, more empathy, and more patience.

Sharing the Learning

At the time the project was proposed, having participants co-develop content for learning presentations seemed like a good idea; however, as the project evolved it became clear that participants were continually sharing knowledge of ACEs, the impact of ACEs personally, professionally, and on the community as a whole, as well as strategies to manage workplace stress. Not only were they sharing this information within the workplace, but also with family, friends, and community members. The most powerful learning is personal learning – when the information is made real. The RAISE training participants made the information real to those around them, which is more powerful than assisting with content development for a PowerPoint presentation.

Informal sharing occurred throughout the project. As reported previously, mid-project survey results of RAISE participants reflect broad sharing of various aspects of the learning across multiple groups, including family, friends, clients, co-workers, managers, and community members.

Throughout the training program, RAISE participants were encouraged to share what they were learning in both formal and informal ways. One formal opportunity for sharing was involvement in the planning and delivery of the Spring 2019 ACEs conference, *Be The One Summit*. RAISE participants strategically served as table hosts, sharing their learnings and leading table activities with the 200+ attendees.

Co-Worker Support

At the end-of-project interview, RAISE participants were asked questions regarding if and how they had shared learnings with their co-workers, and if and how this sharing had resulted in changes within their organizations. The majority of participants reported that they had shared what they learned in RAISE with their co-workers, with most reporting formal opportunities within their respective work settings, such as staff meetings or discreet time set aside for this purpose. Some reported that their sharing had been limited to informal opportunities, with a couple of participants citing a lack of time or opportunity for formal sharing.

Fewer than half of the RAISE participants who had shared learnings with their co-workers (4 of 11) reported concrete examples of subsequent change within their organizations. Reported changes range from small steps in meetings, such as instituting check-ins at the beginning of all meetings and incorporating ice-breaker activities at the start of staff meetings, to broader efforts at creating a trauma-informed organization, including attempts to ensure that all staff know, understand, and use an approach that includes awareness and understanding of ACEs and resiliency, and bringing reflective supervision to all staff, holding cross-departmental reflective supervision groups for everyone, not just

direct-service staff. A few RAISE participants reported informal changes they've seen in their co-workers as a result of learnings shared, largely centered around the use of self-care strategies in the workplace.

Manager Support

Another formal structure for sharing learning was the manager component added to the end of the training program. Based on feedback from RAISE participants and their managers, two additional sessions for managers were added after the training program curriculum was complete. These trainings provided opportunities for trainees to share the lessons they had learned with their managers and to identify strategies for supporting the use of the information within their respective organizations.

Overwhelmingly, managers reported that it was important to them to carve out time for the RAISE participant to be off-line one day per month, expressing that it was a hardship for their respective programs and for the other staff who assumed responsibilities in the RAISE participant's absence, but supporting staff through this experience was perceived as highly valuable for their personal-professional growth. All managers interviewed reported that they discussed what was learned with their RAISE participant immediately following the program day, yet there was a great deal of variability in the extent to which the information was brought back to other staff within the organization.

Workplace Stress

To assess participant behavior change in managing workplace stress, RAISE participants were asked the end-of-project interview question, '*Are there any tools/strategies, etc., that you learned in RAISE that you're currently using to manage workplace stress?*'. The majority said yes; and, of those, all reported the need to find what works for "you", noting individual differences in what works for managing workplace stress. Most reported that they didn't think about self-care before RAISE, and they remind themselves to stay focused on consciously engaging in self-care activities. Many noted the need to focus on taking care of themselves, so they can take care of others. Individual differences were noted in specific responses, with some citing the need to be physically active, such as taking a walk or doing Zumba, some citing that they use strategies that could be done in the moment, such as taking a deep breath or taking a pause, and some cited self-reflection as helpful, reporting that they try to replicate what they learned in the reflective practice component of the training program, finding it helpful to talk through things on their own.

When asked about the types of supports paraprofessionals find most effective in how they manage workplace stress, the majority of RAISE participants reported finding one or more of the self-care strategies taught during RAISE to be helpful. Most responses included an awareness that every person is different, and some strategies will work for some while other strategies will work for others. Common themes included the importance of recognizing underlying triggers that could maximize workplace stress, being aware of one's own responses, and employing strategies that have been identified as personally helpful. For more information, see Appendix C.

Recommendations

At the end-of-project interviews, managers and RAISE participants were asked for their recommendations for future iterations of RAISE. These recommendations focused on the integration of managers into the training and how to strengthen the learning within organizations.

Managers

Managers' recommendations included being involved earlier on in the training program, being included in all communications with their staff, and being provided specific information about each training session so they could better support their staff. Recommendations for manager involvement were varied, from a year-long parallel cohort, to inclusion in the training program alongside their staff, to involving more staff and managers from within any one organization. There was also a suggestion for a Train-the-Trainer manager program so they could spread the learning to more paraprofessional staff.

Para-Professionals

Similar to a recommendation from the managers interview, some participants advised combining upper leadership with paraprofessionals for the training. Time with supervisors was appreciated, with participants noting that it strengthened the connection between them and their managers and helped them to plan together how the information could be brought back to others within their organizations. Rather than a year-long paired training program, a couple of participants suggested that supervisors/managers be brought in multiple times, such as at the beginning, middle, and end of the program. There was overwhelmingly positive feedback about the reflective supervision component and the two facilitators for the reflective practice sessions. Some noted, however, that dividing the training cohort into two groups, and maintaining those two separate groups for the entire year, created division among the training cohort.

Advice

All participants were asked to give advice to other communities interested in implementing a similar program. Their advice focused on three areas: Participant commitment, multi-agency membership, and supporting the participants by including nurturing and by focusing on building resiliency. More detailed information is included in Appendix E.

Participant Commitment

Many noted that the importance of emphasizing the year-long commitment and the voluntary nature of participation, reporting that some participants had been vocal about participating only because their supervisor requested it of them, and some participants did not engage with all aspects of the training program or all training sessions. Innovation projects can be chaotic as program staff sort out how to implement new practices and approaches. Some participants expressed appreciation for being included in the planning, however, stated that it felt too unstructured. Personal commitment may help participants weather the personal and programmatic challenges of this type of project.

Multi-Agency Participation

Many RAISE participants expressed appreciation of the multi-agency membership of the training cohort, noting that it increased their awareness and understanding of other agencies' work as well as how to support their colleagues in the community. Participants also largely appreciated meeting at different locations throughout the county to better understand the settings where their fellow paraprofessionals work.

Nurturing and Resiliency

Participants overwhelming appreciated was feeling 'nurtured' with great food, flowers, trinkets on the tables, and attentiveness from the reflective supervision facilitators. They also noted that they would recommend including more tools for building resiliency, and to cover resiliency earlier in the program curriculum, allowing for a deeper dive into this information.

Appendix A: Project Timeline

Timeline Element	Prior	2018							2019												2020
		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Development and refinement of the approach																					
Recruitment & Education																					
Assess and Address ACEs																					
Evaluation of the INN project		**1**						**2**											**3**		
Decision making about whether and how to continue project																					
Communication of results and lessons learned																					

Development and Refinement of the Approach

- **Apr-May 2017** Application for MHSA Innovation project
  - Planning process began in March 2016 when the Napa ACEs Connection was formed, as member organizations began to examine what was not working in the current mental health system regarding ACEs prevention and treatment
  - Original plan was to recruit 45 paraprofessionals from *Resilience* screenings using a post-film survey, 15 would be Resilience, ACEs Integration, Support, Education (RAISE) training program participants and 30 would be comparison cohort (assuming some within the comparison cohort would drop out)
- **Jan 2018** A Project Coordinator was hired to staff the Advisory Committee, recruit training participants, implement the training program, and assist with curriculum development
- **Ongoing** Napa ACEs Connection, the project steering committee, was renamed Resilient Napa Members Council and met monthly
- **Jun 2018** Project staff attended (on scholarship) a 'Designing for Social Systems' workshop at the Stanford d.school, an opportunity for leaders and practitioners to learn human-centered design dissemination principles and strategies. Application to the RAISE project included the involvement of paraprofessionals and steering committee members in developing and refining the self-care portion of the training program curriculum.

Recruitment & Education

- **Nov 2017-May 2018** Screenings of the *Resilience* documentary were planned to reach a broad demographic of individuals countywide, crossing multiple sectors as well as geographic regions beginning in November 2017.
  - This was possible due to leveraged funding from Kaiser Permanente Community Benefits Department Napa/Solano and the Well Being Trust. Outreach to these groups was done through the Napa ACEs Connection group, social media platforms, emails to key stakeholder groups, personal calls, and meetings to partner agencies. A complete list of screening dates and audiences is provided below.
  - Between December 2017 and June 2018, 382 paraprofessionals attended the initial learning sessions training course *Resilience* film with Q&A and surveys, from which we received 140 respondents.
    - 12/17/17: staff training for social service providers from Boys and Girls Club, Cope Family Center, Lilliput, On the Move and Aldea for practitioners
    - 12/17/17: parent training for Lilliput families for caregivers
    - 2/6/18: staff training for Health and Human Services agency and partner agencies for practitioners
    - 3/7/18: staff training for Napa County Probation, Law Enforcement and District Attorney's offices
    - 3/17/18: presentation to educators at Napa Valley Wellness Conference
    - 4/5/18 at Napa Valley Performing Arts Center: community members viewed and participated in Q&A
    - 4/25/18 at Calistoga High School Auditorium: community members viewed and participated in Q&A
    - 5/7/18: staff training at Kaiser Permanente Napa Clinic for practitioners
    - 5/22/18: training at Napa County Medical Society for physicians
- **May 2018** Training start date shifted to September 2018, 12 sessions
- **Jun 2018** Recruitment began for the professional development program for paraprofessionals in Napa County, *RAISE: Resilience, ACEs Integration, Support & Education*
  - 6/15/18 Resilient Napa Coordinator, sent three emails with an application deadline of July 1, 2018
    - Tailored emails were sent to: (1) *Resilience* screening participants who are paraprofessionals and expressed an interest in the training program; (2) Resilient Napa partners; and (3) Napa County organizations
  - 6/27/18 an email announcing the program went out to the Resilient Napa distribution, providing a brief description and links to the application and associated resources, with an application deadline of July 6, 2018
  - 36 applications were received

- **Jul 2018** The RAISE training program cohort was finalized with 19 participants
    - Male: 1 Female: 18
    - The organizations represented by the 19 RAISE participants range from Juvenile Justice to Women, Infant and Children (WIC) program, Napa Valley Unified School District (NVUSD) and non-profit providers. As a result, the cohort members could immediately apply the ACEs lens to their daily work, making lasting impacts on the families served by these county-wide providers. These impacts do not always come from traditional service-style contact, for example:
        - One RAISE participant, a lawyer currently working with the Napa District Attorney's Fraud Department, now has the foundational knowledge of Neuroscience, Epigenetics, ACEs and Resilience (NEAR) Science to apply to her ongoing cases making intervention solutions more applicable to the whole person of the perpetrator.

Baseline/Phase I Evaluation of the INN project:

- **Feb-May 2018** Screening Survey data collected from 140 screening participants and RAISE training program participants
    - 72% of screening survey data collected from first two screenings, Feb 6 & Mar 7, 2018
        - 38% of respondents attended a screening hosted by Napa County Health and Human Services Agency (HHSA) in Napa
        - 31% attended a screening hosted by County Probation
- **July-Aug 2018** Resilient Napa Members Council Survey (via Survey Monkey)
    - 10 completed surveys
        - 37% response rate (10 of 27)
            - Of those who opened the email: 63% completion rate (10 of 16)
            - Of those who clicked 'begin survey': 77% completion rate (10 of 13)
- **Sep 2018** Screening Survey data collected from RAISE participants
- Findings were shared with RAISE participants, project staff, and Resilient Napa Members Council

Assess and Address ACEs

- **Sep 2018-Jan 2019** First half of RAISE training program
    - 9/13/18: Orientation to RAISE Program
    - 10/11/18: Impact of Trauma on the Brain and Body
    - 11/8/18: Recognizing the Impact of Trauma and what you can do about it
    - 12/14/18: Resilience: What is it really and how do I build it?
    - 1/10/19: Trauma informed organizations

Mid-Project/Phase II of Evaluation of the INN project:

- **Dec 2018-Jan 2019** Mid-project surveys (via Survey Monkey) to RAISE training program participants (n=19) and to screening participants for whom contact information was available, those who responded created the initial comparison cohort (n=9)
- **Feb 2019** Focus Group with RAISE training program participants (n=16)
- **Apr 2019** Focus Group with comparison cohort members (n=4)

- Findings were shared with RAISE participants, project staff, and Resilient Napa Members Council to promote learning and make any indicated mid-course corrections

Development and Refinement of the Approach

- **May 2019** Amarette Ficco of VOICES Napa/On The Move was engaged to assist with planning and implementing the final three RAISE training program sessions, after the departure of Program Coordinator on 4/30/19
- **Jul-Aug 2019** Manager component developed to augment RAISE curriculum and support trainees beyond the grant cycle

Assess and Address ACEs

- **Feb-Aug 2019** Second half of RAISE training program
    - 2/14/19: Self Care Instruction and Practice & Focus Group with MH Evaluators
    - 3/28/19: Be the One Summit
    - 4/11/19: Summit Debrief and Website Training
    - 5/9/19: Dr. Bruce Perry Training
    - 6/13/19: Compassion Fatigue and Self-Care Inventory
    - 7/11/19: Kanwarpal Dhaliwal - Building Beloved Community: Restorative and Non-Violent Communication
    - 8/8/19: Human Centered Design Activity focused on Sustainability
- **Sep 2019** Manager Training in RAISE Topics and Reflective Practice Group
- **Oct 2019** Managers and RAISE Participants Co-Create Aspects of Training Program to Bring Back to Their Respective Agencies

Communication of Results and Lessons Learned

- **Ongoing** RAISE program participants and Resilient Napa staff are provided with opportunities to share their learnings at additional trainings, encouraged to bring their learnings back to their organizations, and participate in conferences
- **Mar 2019** Be the One Summit
    - RAISE trainees were strategically represented among tables of participants to share their learnings from the paraprofessional training program
- **May 2019** Dr. Bruce Perry Training: Trauma & Adversity in Early Childhood and How We Can Help & Heal

Appendix B: Addressing ACEs with Clients

Learning Goal 1: How does a paraprofessional's personal history with ACEs and Resiliency impact how they address ACEs with their clients?

- After screenings of the film, *Resilience*, 44% (n=37) of survey respondents who are direct service providers reported that they think ACEs might have 'A Lot' or 'A Great Deal' of impact on their ability to serve their clients
    - 60% (n=49) reported between 76-100% of their clients have ACEs, with 93% estimating an average ACE score for their clients of 4 or more
- The percent of RAISE participants reporting that their personal experience with past adverse experiences has 'A Lot' or 'A Great Deal' of impact on their ability to serve their clients increased from 30% to 37% from baseline to mid-project, largely due to a decrease in those reporting 'A Little' or 'Some' impact, from 58% to 53%
    - At the start of the project, the majority (65%) of RAISE training program participants estimated that between 76-100% of their clients have ACEs, with 94% estimating an average ACE score for their clients of 4 or more
        - Mid-project the percent of RAISE participants estimating between 76-100% of their clients was slightly higher than baseline (68%), but fewer estimated an average ACE score for their clients of 4 or more (88%)
    - At mid-project, RAISE participants reported spending between 50-100% of an average workday interacting with clients who have high ACE scores (average 82%, $\pm$17.6)
- At mid-project, RAISE participants were asked an open-ended survey question regarding how the experience of ACEs might impact a person's work performance; note that some responses reflected more than one theme:
    - 39% (n=7) experience triggers, bring up past trauma
    - 33% (n=6) highly variable, depends on resilience
    - 28% (n=5) biases may affect work, impair ability to help others, cause more strain, project or transfer their trauma to others
    - 22% (n=4) relate to others with similar ACEs, better understanding
- Also at mid-project, individuals (n=9) who provide direct service to clients recruited from screening of the film, *Resilience*, for comparison were asked the same open-ended survey question regarding how the experience of ACEs might impact a person's work performance; note that some responses reflected more than one theme:
    - 33% (n=3) decreased confidence, decreased belief in self-worth
    - 33% (n=3) impaired cognitive reasoning and decision-making
    - 22% (n=2) inability to identify triggers and negative self-reactions
    - 22% (n=2) absenteeism
    - 22% (n=2) risk of health issues (stress, anxiety)

  - 11% (n=1) for each of the following: inconsistent output; inability to be promoted or maintain employment; difficulty trusting team members; better ability to relate to clients; impact depends on coping skills
- At the end of the project, 80% (n=12) of the RAISE participants were interviewed and asked an open-ended survey question that had been asked at the beginning and the middle: How do you think a paraprofessional's personal history with ACEs and Resiliency impacts how they address ACEs with their clients?
  - 100% (n=12) responded that someone's personal history with ACEs has a significant impact on their ability to work with clients who've experienced ACEs, particularly ACEs that are similar
    - All reported that education and awareness of ACEs is important in being able to understand the personal impact that they've made, build resiliency, and be able to recognize triggers and manage emotions that arise
      - *"awareness of what has shaped me to become who I am, and allowed me to become resilient, allows me to relate and to have empathy, makes me have a different perspective of my clients"*
      - *"I wasn't aware of ACEs before this training, I didn't understand that I had trauma, it helped me to understand my own ACEs and ACEs in my clients"*
    - Most reported that if someone hasn't addressed or processed their own ACEs, they are likely to be unknowingly triggered when working with a client who has similar ACEs, and perhaps be less tolerant, defensive, and/or avoidant
      - *"for example, if someone is activated by something based on their own experience, it could negatively impact how they're working on a similar issue with a client"*
      - *"if there was never any healing or coming to terms with childhood traumas, they don't understand what they went through so may be less tolerant of others"*
    - Most reported that understanding their own ACEs has helped them to be more compassionate with their clients, to listen more, and to be more open to possible underlying causes or explanations for client behavior
      - *"depending on where you are with your ACEs, and with your resiliency, how you're coping emotionally and mentally impacts how well you can do your job with clients who have ACEs"*
      - *"the training helped me listen more and listen better to my clients, and to look at their ACEs and my own ACEs"*
- Also at the end of the project, co-workers of RAISE participants were surveyed (n=14) and asked the same open-ended question regarding how the experience of ACEs might impact a person's work performance; note that some responses reflected more than one theme:
  - 40% (n=4) experience triggers, bring up past trauma
  - 30% (n=3) biases may affect work, impair ability to help others, cause more strain, project or transfer their trauma to others
  - 30% (n=3) relate to others with similar ACEs, better understanding
  - 20% (n=2) highly variable, depends on resilience

Appendix C: Workplace Stress

Learning Goal 2: How does a paraprofessional's personal history with ACEs and Resiliency impact their workplace stress?

- After screenings of the film, *Resilience*, 76% (n=104) of survey respondents reported that they think ACEs have 'A Lot' or 'A Great Deal' of impact on themselves in their professional roles
- 69% of RAISE participants reported that ACEs have 'A Lot' or 'A Great Deal' of impact on themselves in their professional roles at the start of the project and at mid-project
- At mid-project, RAISE participants were asked an open-ended survey question regarding how the experience of ACEs might impact how a person manages workplace stress; note that some responses reflected more than one theme:
    - 50% (n=9) variable, depends on person's skills and tools to manage stress
    - 39% (n=7) if one's own ACEs are not addressed toxic stress may impact ability to work
    - 28% (n=5) recognition of one's own ACEs and triggers helps stress management
    - 22% (n=4) impact personality and behaviors, dysregulated and lose temper, depressed and overwhelmed
- Also at mid-project, individuals (n=9) who provide direct service to clients recruited from screening of the film, *Resilience*, for comparison were asked the same open-ended survey question regarding how the experience of ACEs might impact how a person manages workplace stress; note that some responses reflected more than one theme:
    - 56% (n=5) poor stress management
    - 44% (n=4) depends on tools, self-care strategies
    - 11% (n=1) for each of the following: inability to trust self; inability to trust co-workers or boss; fatigue; burnout; poor conflict resolution; decreased motivation; poor forethought; problems tolerating change; poor communication; isolation or withdrawal
- At the end of the project, 80% (n=12) of the RAISE participants were interviewed and asked an open-ended survey question that had been asked at the beginning and the middle: How do you think a paraprofessional's personal history with ACEs and Resiliency impacts how they manage their workplace stress?
    - Almost all (92%, n=11) responded with an acknowledgement of the impact that unaddressed ACEs can have on how a person manages their workplace stress, with many starting their response with something like, *"it's similar to the first question"*
        - Most reported that education and awareness is key to understanding the personal impact that ACEs have had, as well as developing tools and coping mechanisms to manage emotional responses when triggered
            - *"education is key, once you know what this is, you can understand why you respond in certain ways, awareness helps you manage it in a different way"*
            - *"as I learned what impacts me, how to recognize my body's stress response, understanding the feelings I will get, I can take a moment to ground myself and come back and be present with my clients"*

        - Most referenced the need to take care of themselves, to take time out for things they enjoy, and to have a toolbox of self-care strategies that can be used in the moment
            - *"awareness helps you make different choices, like taking a break, taking a walk, journaling"*
            - *"if we haven't acquired the tools to deal with and manage stress, if I don't take time for the things I like to do, I will burn out quickly"*
        - Some referenced the need to separate themselves from the stress their clients are experiencing, and to recognize that the behavior of others is outside of their control
            - *"in RAISE I realized I need to manage my work stress, stress that comes from the families I work with, sometimes I was trying to handle my stress and their stress"*
            - *"being realistic about what is within my control, not stressing about things I don't have control over"*
    - One RAISE participant interviewed was unable to acknowledge or recognize that her personal history with ACEs has any impact, *"I don't think my ACEs affected me in any way"*
- Also at the end of the project, co-workers of RAISE participants were surveyed (n=14) and asked the same open-ended question regarding how the experience of ACEs might impact how a person manages workplace stress; note that some responses reflected more than one theme:
    - 55% (n=6) inability to self-regulate, project issues on to others, hostility and aggression
    - 18% (n=2) variable, depends on person's skills and tools to manage stress
    - 18% (n=2) if one's own ACEs are not addressed toxic stress may impact ability to work
    - 18% (n=2) may not recognize the need or know how to take care of one's self
    - 18% (n=2) recognition of one's own ACEs and triggers helps stress management

Appendix D: Effective Supports

Learning Goal 3: Which supports do paraprofessionals find the most effective in changing how they address ACEs and Resiliency with individuals and/or how they manage workplace stress?

(a) supports paraprofessionals find most effective in changing how they address ACEs and Resiliency with individuals

At mid-project, RAISE participants were asked an open-ended survey question regarding what, if anything, they were doing differently in their role at work as a result of participating in RAISE; note that some responses reflected more than one strategy:

- 53% viewing behavior in the context of ACEs and past trauma - providing understanding and compassion, making no assumptions
- 41% better self-care and stress management
- 12% becoming more aware of personal triggers/personal triggers that can occur in the workplace
- 6% increasing self-awareness to better educate others
- 6% asking direct questions of clients
- 6% focusing on client strengths
- 6% becoming more hopeful that resiliency can be built over time and change brain functioning
- 6% taking work breaks and time off
- 6% make an effort to have a voice

Also at mid-project, RAISE participants participated in a focus group and were asked an open-ended question by the facilitator regarding what, if anything, they learned during RAISE that changed the way they think about their clients:

- Have more compassion (echoed a couple of times)
- Have more empathy (echoed many times)
- Do more active listening
- Pay more attention
- Share self-care strategies; particularly helpful to learn how to discuss self-care without triggering emotions
- Have more patience; understand that their process is their process, can't slow it down or speed it up

At the end of the project, 80% (n=12) of the RAISE participants were interviewed and asked: Based on what you've learned in RAISE, have you made any changes in the way you work with your clients?

- Two RAISE participants do not have or have not had direct interaction with clients
- Of the remaining 10, two (20%) participants responded "no"
    - One reported that this was already information she knew and things she was already doing; and,

- One reported that learning about ACEs was new to her, but she didn't change anything about how she works with her clients because she was already treating them the way she would want to be treated

- 8 of the remaining 10 (80%) reported "yes"
  - Changes made in the way they work with clients include:
    - Having more compassion
    - Having more empathy
    - Having more curiosity, making time and space to listen more
    - Having a better understanding of trauma and being open to discussing candidly, or asking questions, that may have been uncomfortable for them previously
    - Being aware of their own triggers and not responding emotionally, not mirroring a client's emotions
    - Not taking things their clients do or say personally
      - *"I have more compassion and understanding of trauma, it's helped me to be more open and provide space for learning, for understanding what is causing this person to behave like this… I have more patience to listen and learn why they are acting the way they do"*
      - *"I learned that when I listen more than talk, my clients are more open to talking and sharing"*
      - *"I tend to take things personally and be defensive; after RAISE I came to the understanding that none of it is personal"*
  - All who reported that they'd made changes in the way they work with their clients also reported that they'd noticed changes in their clients as a result. Changes observed in clients include:
    - Clients are opening up more, having more progressive conversations, providing more feedback
    - Clients are recognizing their own emotional reactions (because the paraprofessional pauses rather than reacts)
    - Clients are starting to acknowledge their own ACEs, recognize their emotional reactions, and begin to change the way they respond to situations
- Also at the end of the project interview, RAISE participants were asked to reflect on the current situation – COVID-19 and the stay-at-home orders, and the Black Lives Matter movement – and report if they thought they think they were doing anything differently <u>for their clients</u> that they wouldn't have done before their participation in RAISE.
  - 7 of 10 (70%) said "yes", reporting changes that include:
    - Being more focused on their clients (before RAISE, may have been more focused on themselves)
    - Reminding clients to take care of themselves, use self-care strategies that work for them
    - Taking time to check-in and give space for sharing
    - Having more compassion and understanding

        - Providing more support
        - Asking questions that may have been difficult before (specifically related to BLM)
    - 3 (30%) said "no", reporting:
        - RAISE hasn't changed the way I work with my clients (n=2)
            - Note, one of the two reported that it's changed the way she interacts with her co-workers and supervisors, but not clients, *"I've always treated my clients the way I want to be treated"*
        - Zoom doesn't provide the opportunity to be as supportive in person, and population may be more guarded because of the situation (n=1)

(b) supports paraprofessionals find most effective in how they manage workplace stress

At mid-project, RAISE participants were asked an open-ended survey question regarding what, if anything, they were doing differently since the start of the program to manage their workplace stress; note that some responses reflected more than one strategy:

- 35% prioritize self-care
- 29% meditation
- 24% breathing techniques
- 12% exercise/stretch/walk
- 12% pause and reflect
- 12% delegate to others/ask for help
- 12% don't take things personally
- 12% set boundaries/say "no"
- 6% challenge self to push beyond comfort zone
- 6% listen more
- 6% talk to supervisor
- 6% take time off
- 6% make an effort to have a voice
- 6% have more empathy
- 6% prayer
- 6% yoga
- 6% beauty routine
- 6% personalize office space
- There were four self-care strategies that were explicitly modeled and taught during the first half of the RAISE training program: yoga, chanting, aromatherapy, and meditation. At mid-project:
- 63% of RAISE participants reported meditation helpful in managing their workplace stress,
- 56% reported aromatherapy helpful,
- 31% reported yoga helpful, and
- 19% reported chanting helpful in managing workplace stress.

- After responding to specific survey questions about these four self-care strategies, RAISE participants were asked what other self-care strategies they had used, if any; note that some responses reflect more than one strategy:
    - 47% exercise/hike/walk
    - 24% socializing
    - 24% prayer
    - 18% breathing techniques
    - 18% listen to music
    - 18% art
    - 18% dance
    - 12% be more positive
    - 12% journal/write
    - 12% reading
    - 12% water therapy
    - 12% eating well
    - 6% meditation
    - 6% goal setting
    - 6% therapy
    - 6% be productive
    - 6% hold myself accountable
    - 6% singing
    - 6% photography
    - 6% disable email notifications on phone
    - 6% beauty routine
    - 6% sauna
    - 6% cooking
    - 6% massage
    - 6% "self-care deck"
- Also at mid-project, RAISE participants participated in a focus group and were asked an open-ended question regarding what, if anything, they learned during RAISE that changed the way they manage their workplace stress:
- Importance of doing self-care (echoed a couple of times)
- Specific strategies were mentioned as being personally helpful – aroma therapy, chanting
- "Giving myself permission for self-care"
- Learning what my own triggers are and stepping away
- Having boundaries (echoed a couple of times)
- Having empathy for co-workers and supervisors (be kind, because you don't know what they're going through)
- During the mid-project focus group, 56% of RAISE participants indicated (by show of hands) that they had changed their behavior by increasing the use of self-care strategies to manage workplace stress since participating in RAISE.

- They were then asked (during the mid-project focus group) to share the challenges or barriers they were experiencing to in trying to use self-care strategies to manage their workplace stress:
- Time (echoed)
- Energy
- Money
- Balance
- Expectations
- Family
- Motivation
- They were then asked what they had done, or what they thought could be done, to overcome these challenges or barriers (to using self-care strategies to manage their workplace stress):
- Have patience; take time; give myself time
- Try not to do everything at once
- Re-framing my emotions, my thoughts, the way I see things
- Practice what I've learned
- Have a conversation with your supervisor to let them know where you're at, what you are feeling
- Ask friends, family, co-workers, what they do for self-care
- Be compassionate with yourself
- Give myself permission to make self-care strategies a part of my workplace
- RAISE participants were asked (during the mid-project focus group) what they thought would be helpful for their managers or supervisors to do to help them manage their workplace stress:
- Give a raise; more money
- Take this class; this information needs to be at the top, too
- (participants should) Let them know what you need, because if you don't tell them, they won't know
- Allow time for self-care; some feel supported in words, but not in actions by their supervisors or managers to take the time for self-care; and some feel guilty if they take the time, even regularly-scheduled breaks and lunches
- Suggest taking a walk for supervision
- At the end of the project, 80% (n=12) of the RAISE participants were interviewed and asked: Are there any tools/strategies, etc., that you learned in RAISE that you're currently using to manage workplace stress?
- 10 (83%) reported "yes":
    - All reported the need to find what works for you, noting individual differences in what works for managing workplace stress
    - Most reported that they didn't think about self-care before RAISE, and they remind themselves to stay focused on consciously engaging in self-care activities
    - Many noted the need to focus on taking care of themselves, so they can take care of others
    - Some cited the need to be physically active, such as taking a walk or doing Zumba

    - Some reported that they used strategies that could be done in the moment, such as taking a deep breath or taking a pause
    - Some cited self-reflection as helpful, citing the reflective practice component of the training program and finding it helpful to talk through things by themselves
    - All strategies reported include: journaling, meditation, deep breathing, yoga, taking a walk, taking a break, bouncing a ball, listening to music, self-reflection, doing creative projects, drumming, aroma therapy
- 2 (17%) reported "no":
    - One reported that these were things she's been doing all along; and,
    - One reported that the strategies and techniques taught are not consistent with her religious beliefs.
- Those that responded "yes" were also asked if there were strategies taught that they didn't like, or that didn't work for them:
    - Some strategies require resources, such as going to a gym or doing yoga
    - Some strategies are not appropriate for the workplace, such as drumming or aroma therapy (if co-workers cannot tolerate scents)
- Also at the end of the project interview, RAISE participants were asked to reflect on the current situation – COVID-19 and the stay-at-home orders, and the Black Lives Matter movement – and report if they thought they think they were doing anything differently <u>to cope</u> that they wouldn't have done before their participation in RAISE.
- Two (17%) participants reported that the relationships they made during RAISE have helped them to build a support system for coping during the current circumstances
- Two (17%) participants reported changes in the way they work with their supervisors
    - One reported that their joint participation at the end of the training program strengthened their relationship, so she feels she can turn to her supervisor for additional support during this time
    - One reported that RAISE helped her to be more understanding of her supervisor, because you never know what someone has gone through or why they behave the way they do
- Most participants referred back to the responses they gave in the prior question, citing the importance of taking time for self-care, the importance of making it a priority, with many noting that they didn't think about self-care until RAISE
- Some cited explicitly taking breaks outside of the house, such as a walk or sitting in the yard/garden
- One participant reported that her usual strategies weren't working or weren't helpful, so she tried new things she learned in RAISE until she found something helpful
- One participant reported that RAISE taught her to have hope; specifically, learning about neuroplasticity gives her hope that there can be healing
- One participant said that because RAISE taught her to understand the impact of traumatic events, she understood why she didn't have any motivation to work this week

Appendix E: Advice from Project Participants

At the end of the project, 80% (n=12) of the RAISE participants were interviewed and asked: What advice would you give another community that wanted to implement a similar training program for paraprofessionals? What would you definitely include? What would you definitely change?

- Overwhelmingly, participants thought this was a valuable training program and something that should be offered again
    - A few asked to be brought back to share their experiences, or as mentors for a second cohort; they would like information on how to continue to be included
    - Many said their co-workers were interested in participating in a similar training program
- Given that all ideas might be considered, advice provided by RAISE participants includes:
    - Emphasize the importance of the year-long commitment and ensuring that participants want to be there, and are not participating only because their supervisor wants them to be there
        - One person said having participants who didn't want to be there limited her disclosure in the reflective practice sessions because she didn't feel like it was a safe space
        - One person suggested that not all participants had full supervisor support for participation
    - Combine upper leadership with paraprofessionals
        - Time with supervisors was appreciated, strengthened the connection and helped to figure out how the information could be brought back
        - A couple of people suggested that supervisors/managers be brought in multiple times, such as at the beginning, middle, and end of the program
    - Re: the curriculum
        - Plan the full-year curriculum/agenda in advance
            - Some appreciated being included in the planning, but stated that it felt too chaotic and unstructured
        - Knowing the curriculum in advance would help those whose knowledge base includes this information to opt out, or to indicate to their supervisor that the content would not be consistent with their beliefs
        - Have each lesson build upon the last, with a progression of information
        - Some felt there was too much emphasis on brain science
        - Some asked for more resiliency information, more tools for building resiliency; cover resiliency earlier in the program and allow for a deeper dive into this information

- Re: reflective supervision
  - Overwhelmingly positive feedback on the two facilitators for reflective supervision sessions
  - Some thought dividing into two groups, and maintaining those two groups for the entire year, created division among the training cohort
    - Perhaps switch mid-year
    - Having smaller groups was also suggested
  - Some noted that one or two people would consistently dominate the session, recommending that more attention be paid to allowing equal time for all to participate
  - One person thought it was too much like a counseling session
- Re: the multi-agency membership of the training cohort
  - Very much appreciated; increased awareness and understanding of others and how to support others in the community
  - More diversity was suggested
  - Be as inclusive as possible across different sectors
  - Create opportunities for explicitly interacting with different participants
- Re: holding meetings at different locations throughout the county
  - One person suggested having all meetings in one location for convenience
  - One person commented on how nice it was to get to know the settings in which other paraprofessionals work
  - A few people commented on the negative impact of visiting a locked facility, as it triggered past trauma for one of the participants
- Appreciated the 'nurturing' with flowers, food, trinkets, attentiveness from reflective supervision facilitators
  - Almost everyone mentioned how great the food was and how much they appreciated it!
  - A couple also noted the bonding that occurred during lunchtime
- Hold sessions twice per month, perhaps shorter sessions
  - Many noted that a month in between seemed like a long time and led to forgetting information from one session to the next
  - A few advised not skipping sessions for other learning opportunities, such as the Bruce Perry training and the Be the One Summit
- One person suggested the training should be made available to clients and members of the community
- One suggested that the training should be brought to other counties outside of Napa

- Additional input for 'definitely include':
  - ACEs questionnaire
  - ACEs research
  - All speakers and presenters
  - All activities
  - All self-care strategies, and emphasis on need for self-care to care for others
  - Reflective supervision
  - Brain development (Laura w/HHSA): challenging topic, some concepts were hard to understand, but important
    - Bring in later after more of a foundation
- Additional input for 'definitely change':
  - Most participants cited the Program Coordinator's departure, noting disruption, chaos, uncertainty when there was a change in program leadership
  - A few participants didn't like an opening exercise led by one of the new facilitators; felt forced and out-of-context because they already knew each another
  - The O.T. session didn't make sense to a number of participants until it was explained in a subsequent session… switch the order of these presentations
  - Don't skip sessions for other learning opportunities
  - More information on how trauma impact's people's lives
  - More information on the connection between mental and physical aspects of trauma experience
  - Include a journal, so participants can see where they started and where they ended
  - A binder with all presentations/PPTs in one uniform format
  - A mechanism for keeping in touch with other participants, like a Facebook page, a blog page, or an email group
  - A closing project, to share what they learned and the sense of empowerment they had after the training program
  - More concrete information about how to bring the information back to our workplace
  - More brain science information, such as from Kristie Brandt
  - Add personality information, such as from David Anglada

Innovation Round 2 Work for Wellness Project

Program Report, July 2021

Overview

The Work for Wellness project was funded to address the disparate definitions of successful employment for individuals with Serious Mental Illness. The project convened stakeholders and worked to increase commitment of the various stakeholders to each other in order to create common frameworks for describing and promoting success.

Organization

This program report begins with a review of data on underemployment for individuals with mental health needs despite the evidence based practices designed to promote successful employment. The next section is a discussion of the program planning and implementation and the learning that resulted from convening stakeholders and developing shared measures of success. The report continues with an overview of the Work For Wellness project and the findings from participant and staff interviews.

Learning Questions

- **How to create shared measures of success among all participants in the system?**
- **How to increase commitment of all system participants to each other?**
- **How to implement common measures of success?**

In addition to the original learning questions, MSHA staff asked project staff to include **learning about how mental health providers can support employment as an option for wellness and recovery.**

Key Findings

How to create shared measures of success among all participants in the system?

The first Phase of the project focused on the experiences of individuals with Serious Mental Illness and employment. The resulting measures of success reflected these perspectives but did not include the supported employment and employer points of view. Though this approach was good for building trust and promoting engagement from the employee group, the resulting model describing success was not clear to all participants.

The second Phase of the project prioritized hearing from the supported employment and employer point of view and resulted in a shifted definition of success. Previously the focus had been on the individual and their needs, this changed to a focus on the work and what an individual needs to have in place for themselves outside of work in order to do the work successfully.

How to increase commitment of all system participants to each other?

Phase One brought a disparate group of individuals with varied experiences and roles with employment and with mental health. The monthly meetings and group activities helped individuals learn about themselves and each other. Participants shared that the experiences in the first phase changed how they interacted with each other and how they thought about the challenges facing others. Several noted that they felt a sense of accomplishment and hoped the work would have an impact.

Despite disappointing engagement by employers and decision makers, at the end of Phase One individuals reported that the support they gave each other was a benefit to them. They felt the process of listening to each other was valuable and connected them.

How to <u>implement</u> common measures of success?

Plans to implement the common measures of success began at the end of Phase One as the project staff prepared for Phase Two. The initial plan was to test the STAFF model and share it with employers. After reviewing staff and participant feedback, it became apparent that there needed to be more stakeholder input.

Staff created a new plan for Phase Two to collect and incorporate the missing perspectives from supported employment, employers, and mental health providers. This resulted in a shift from focusing on the individual and their needs to the work and what the individual needs to have in place (outside of work) to do the work effectively.

At the end of Phase Two, project staff were planning to begin a life skills group at the ICC to support individuals who have been diagnosed with a Serious Mental Illness and want to prepare to work. Staff also noted that the shift to centering the work instead of the individual has been helpful in supporting individuals in other systems that sustain the vulnerable (transportation, housing, etc.)

Most of the participants who completed Phase Two indicated that they hoped to be involved in the upcoming Work for Wellness life skills groups.

How can mental health providers support employment as part of wellness and recovery?

Participants indicated that mental health providers should understand the types of supports available. They also reflected on the potential role of providers in addressing the stigma of mental illness that individuals encounter with supported employment and with employers.

Staff noted the main role of mental health providers is in keeping individuals with a Serious Mental Illness stable and able to use supported employment or to be employed. They also encouraged providers to avoid referring individuals to supported employment who are not stable or ready to be employed.

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The Need

The Work for Wellness Innovation Project was developed to address the disparity between the existence of evidence-based supported employment practices and the underemployment of individuals who have been diagnosed with a Serious Mental Illness.

From the Proposal:

Individual Placement and Support (IPS) Supported Employment is an evidence-based practice designed to assist individuals with disabilities in obtaining and maintaining employment. Despite the evidence based practice and other supported employment services, statewide and nationwide data show that Individuals with Serious Mental Illness are often unemployed and very few receive IPS and supported employment services. Additionally, it is difficult to get employers to work with the supported employment programs.

Nationwide, a study published in 2014 examined 2009-2010 employment rates for adults with mental illness age 18-64. The authors found that the employment rate declined as the mental illness severity increased. At the time of their study, 45.5% of the individuals with serious mental illness were unemployed or out of the workforce compared to 24.1% of individuals with no mental illness.[1] Other sources show:

- Half of competitive jobs acquired by people with SMI will end unsatisfactorily as a result of problems that occur once the job is in progress, largely the result of interpersonal difficulties.[2]
- Over time, people with SMI may come to view themselves as unemployable and stop seeking work altogether[3]

In 2015 in California, 8.3% of individuals with serious mental illness were employed (compared to 21.7% nationwide) and 0.1% receive supported employment services compared to 2% of individuals with SMI nationwide.[4] Data from the National Alliance on Mental Illness (NAMI) confirms the high rate of unemployment nationwide (80%) and indicates that California has the 5th highest rate of unemployment (90%) for individuals with SMI.[5]

In Napa County, supported employment participation is not tracked consistently for all individuals receiving mental health care for SMI in Napa County. To better understand how supported employment

[1] Luxiano, Alison, MPH and Ellen Meara, PhD. The employment status of people with mental illness: National survey data from 2009 and 2010 Psychiatr Serv. 2014 Oct 1; 65(10): 1201–1209. Accessed at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4182106/, 03/13/17.
[2] Becker DR, Drake RE, Bond GR, et al. Job terminations among persons with severe mental illness participating in supported employment. Community Mental Health J 1998; 34:71-82 Accessed at http://www.medscape.com/viewarticle/542517, 02/18/17.
[3] Link B. Mental patient status, work, and income: an examination of a psychiatric label. Am Sociol Rev 1982; 47:202-215. Accessed at http://www.medscape.com/viewarticle/542517, 02/18/17
[4] California 2015 Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System, pages 1-2, 14-16. Accessed at https://www.samhsa.gov/data/sites/default/files/California.pdf, 03/13/17.
[5] Mental Illness: NAMI Report Deplores 80 Percent Unemployment Rate; State Rates and Ranks Listed—Model Legislation Proposed. Accessed at http://www.nami.org/Press-Media/Press-Releases/2014/Mental-Illness-NAMI-Report-Deplores-80-Percent-Une, 03/23/17.

works for individuals in Napa County, an interview was conducted with a representative from the Department of Rehabilitation.

- The interviewee indicated that individuals with Serious Mental Illness are underserved by the existing supported employment services. The available services are time-limited and individuals with SMI often need more time and more support to adjust to the workplace.
- The interviewee also noted that while employer incentives exist to promote the hiring of individuals with serious mental illness, few employers demonstrate a willingness to work with employment programs.[6]

During the planning for the Work for Wellness project, project staff had several conversations with individuals from the Alameda County Behavioral Health Care Services (BHCS). During these conversations, project staff learned:

- BHCS used a promising model of Individual Placement and Support (IPS) to support individuals who were seeking employment. This model was primarily serving individuals with developmental disabilities and a lower number of individuals diagnosed with a Serious Mental Illness were participating.
- The contacts indicated that the IPS model was more successful with individuals with developmental disabilities than for those who had been diagnosed with a Serious Mental Illness.
- When asked about the rate of long term work placement and the availability of a wide variety of employment opportunities with IPS, the contacts indicated the rates were “not that high.”

[6] Interview with Department of Rehabilitation Resource Specialist, phone interview, November 2016.

The Innovation

Phase One

The project began in FY 18-19 with the intention of bringing together individuals from four areas of the employment and employment support systems. The Innovation was to have the group define shared measures of success, increase their commitment to each other and then implement the shared measures to see how they work.

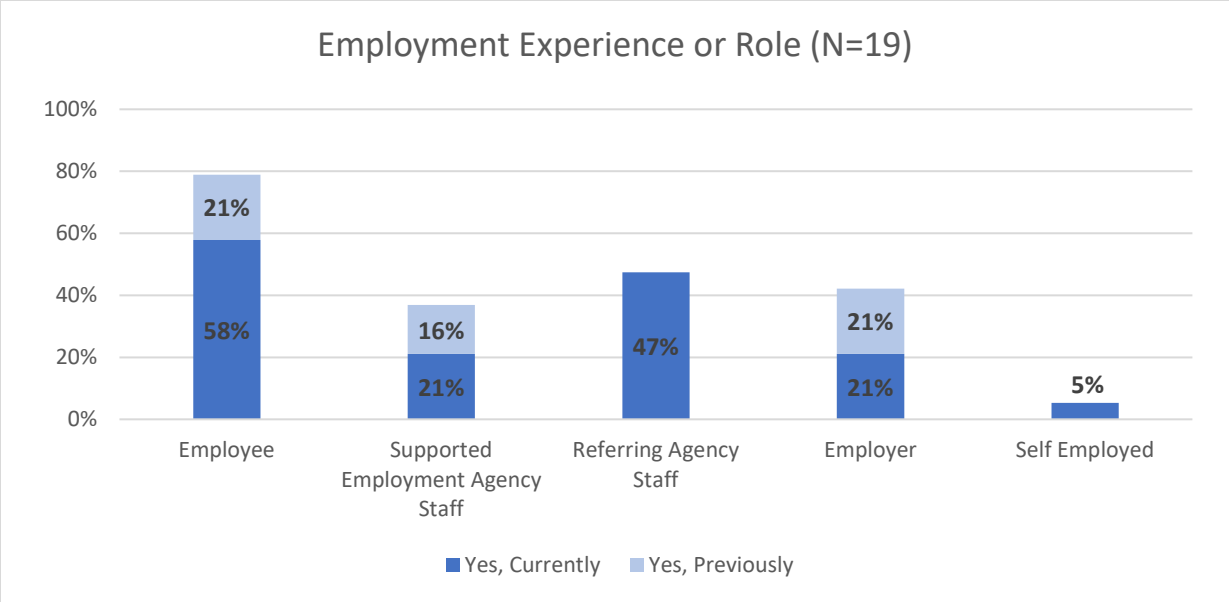
Work for Wellness, Phase One Activities

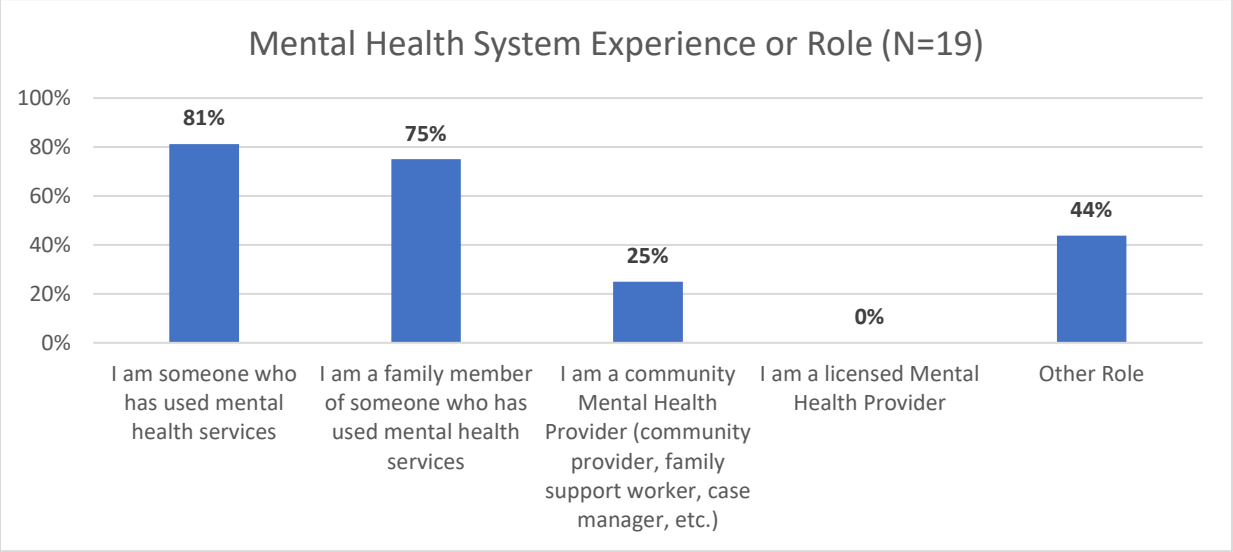
- **Recruit** 20 participants (individuals with SMI, employers, co-workers and system representatives (WIB, Cal Works, NBRC, OJT, NPS, PSI, DOR)) to work together and develop ideas about how to sustain employment for individuals with SMI.
- **Create measures of success** that are representative of individual, employer and system perspectives.
- **Develop ideas** for sustained meaningful employment that incorporate the measures of success.
- **Test ideas** within the supported employment system to promote the measures of success and sustained meaningful employment.

Staff who were involved in recruiting noted that while many employers were contacted, few answered the call to participate. Reasons were varied but centered around the time commitment and employers' hesitation working with people who have mental health challenges. Project staff also reported that participants with mental health challenges and seeking employment were quite willing and excited about participating.

On The Move staff convened individuals using On The Move's On The Verge (OTV) leadership and community building model. This is a model that has been used 44 times previously primarily with homogenous groups of individuals (community activists, youth, agency directors, etc.). The use of the model to bring together groups with varied roles and power relationships is a more recent adaptation. The OTV model was used in a previous Innovation program funded by Napa County MHSA to bring individuals who provide mental health services and individuals who use mental health services together to address system gaps.

The majority of the nineteen participants had experience as an employee (79%) and/or as someone who had used mental health services (81%). 18 of the 19 participants completed Phase One.





Staff involved in planning the agenda met monthly to discuss goals and activities for the next participant meeting. The participants met monthly for a year to listen to each other's experiences with mental health and employment, build empathy for each other's experiences, and to begin to work on way to define successful employment that reflected the individual, employer and employment support perspectives. The following table is provided for reference and illustrates a sample of the group's activities.

Phase One Group Activities

Activity	Description
Group Agreements	Foundational and traditional
Leadership Skills Assessment	Used to reflect on individual growth areas
Personal Job Maps	Shared individual's diverse employment experiences
Multiple Identity Charts	Individual's various roles
Masks (Individual Identity)	Discussed shame and vulnerability, reasons for masking identities
Effective Teams	Discussed five components of a functional group
Power	Individual providence and relationships to power
Feedback	Demonstrated and practiced giving and receiving constructive feedback
Promoting Ideas	Using various flags, participants promoted the idea of why one flag was the favorite
World Café	Discussion roundtable to share and understand the needs of employers and the needs of employees
Role Plays	Problem solving employment-related scenarios and trading roles in the role play to consider issues from a new perspective.
Kings and Queens game	Game format to help group discuss and define sustainable, meaningful employment from multiple perspectives

Near the end of Phase One, the group began talking about what sustained, meaningful employment meant to them. In general, the group responded that sustained, meaningful employment is a **job you like in a workplace where you are respected and there is accommodation for workers with all kinds of disabilities.**

- *Excited about the job and treated with respect*
- *Employer and co-workers understand mental health challenges*

- *Something you enjoy doing and you stay at it*
- *It's whatever is meaningful and sustaining to you. It might be a full-time job with benefits or two hours a week at CVS*
- *Finding something that matches your skill set*
- *Enjoying your work and being mindful of co-workers who have mental health concerns*
- *Deriving value beyond the paycheck, self-esteem, self-worth and a feel of contributing*

The group also spent time talking about what increased commitment would mean to them as a participant. What would it mean to be working together across experiences and roles? The responses included **attendance, level of participation at meetings, and willingness to work on group projects.** A few respondents reflected a desire to apply the commitment to making changes in employment.

- *People feel free to share with each other and people keep coming*
- *A continuation of sharing your vulnerability, and participating fully every time we meet*
- *Improving conditions in the work place so that everyone is treated equally and with respect*
- *Do the agencies, whether it's the county agency on the move or somebody else, are they really finding ways to support the employer? Does the employer feel like that they can contribute to something to them? Do the agencies feel like the employers are even interested or going to work with them in the process?*
- *Well, if throughout this process, there were places where someone like myself might actually jump in and volunteer and help on something, that would be my commitment*
- *Increased commitment to me means that people are going to show up. They're going to be here. They're going to be on time. They're going to be honest with their answers. They're going to provide thoughtful questions and just really help the group move forward in trying to figure out how do we offer sustainable employment to people who have mental health and other issues.*
- *Increased commitment to me means each person being held accountable for their part in the project.*

As the first year of the project began to come to a close, the participants began working on describing measures of success. Through field trips to local employers, role plays to address commonly discussed barriers to employment and brainstorming, **the group developed a lot of ideas about what success would look like**. The project staff summarized the findings into the STAFF model to represent the main themes. The full description of the STAFF model is included in Appendix A.

The STAFF Model: Work For Wellness, Phase One

Sustainable and Meaningful Employment occurs when those involved in the employment system are able to rely on each other and thrive in the following areas:

- **S**tability: not at risk; to be able to problem solve and seek support; not likely to change or fail; firmly established.
- **T**ransparency: implies openness in communication & accountability
- **A**daptability: willingness to adapt & compromise
- **F**lexibility: the quality of being able to adjust to new or changing conditions
- **F**airness: impartial

The model was a joint creation of both staff and participants. Participants worked with staff to break down what the key words in STAFF meant and to offer examples of each term in the workplace. Once the model was detailed, the participants began thinking of ways to test it and to bring it to others.

Sharing Project Goals and Learning

At the midpoint of Phase One, the staff invited decision makers to come and learn about the Work for Wellness Project. The meeting was held in April 2019 and twelve individuals were invited to attend. All of those invited attended the meeting to learn about the project and to share their individual hopes and the barriers they could see for the project. The staff and participants participated in the presentation and activities and shared the future meeting dates with the Advisory Committee.

Phase One of the project culminated in planning a second Advisory Committee meeting in October 2019 to share the group's learning and ideas. This second meeting was attended by one of the 12 invited decision makers. Staff talked with the single attendee to understand the disappointing attendance. The decision maker who attended suggested that rescheduling the meeting may have caused confusion, and that the overall lack of attendance may reflect that the integration of employment supports and mental health services is not prioritized over supports that have a more immediate impact on the safety and wellness of those receiving treatment services.

The disappointing turnout and engagement from decision makers at the end of Phase One gave the project staff pause. Staff were not sure of their roles in regard to next steps. The uncertainty about how to proceed was exacerbated by the pandemic.

Interviews were conducted with participants about the project's progress. Project staff and MHSA staff reviewed the input together and project staff redesigned the activities to attempt to learn more about what was needed to bring the decision makers to the table.

Additionally, Napa County MHSA staff asked project staff to consider what recommendations they would bring back to the Mental Health Division. The conversations to date had not involved a specific focus on mental health providers, and staff included discussions with mental health providers in their plans for Phase Two.

Phase Two

In Phase Two, the project staff invited project participants who wanted to continue the work to return. After noting the muted voice of employers in the first phase, the remaining participants planned to reach out to employers to understand their perspectives about hiring individuals with mental health experiences. They developed interview scripts and made plans to interview individual employers.

The participation in this phase and the outreach was hindered by the Shelter in Place order. The Order and the complexities of virtual meeting formats meant some participants who had intended to continue with the project were not able to participate. Despite these challenges, six individuals continued the work. Unfortunately, the pandemic also changed the community employers' ability to engage with the project.

> *Then employers, we started doing the surveys and still doing our employer outreach in March [2020]. Employers were like, "Yes, just back off." Even ones that before had said, "Sure. We'll jump on board when you got some more information", were just like, "Not right now."*
>
> *That's when we realized we had to also stop and change our approach with this idea about employer inclusion. We just had to have the group backtrack and simplify. I feel like we just kept saying there's a lot of great stuff that we can try to include and accomplish but it's such a big thing that maybe all the signs that we're being given is just constantly directing us back to this idea that, "What's the next foundational step? Okay, even more foundational than that. Okay, even more foundational than that." We've kind of been backpedaling to the very basic, "What's that little hole into the whole mess or problem?" that little crack in it.*

As the discussions progressed, the staff realized they were already applying the ideas that had been discussed in Phase One at their own workplace. The project staff for Phase Two worked at the Innovation Community Center (ICC). The ICC provides peer supports for adults who have been diagnosed with a Serious Mental Illness. As part of this work, individuals are referred to the center from Department of Rehabilitation (DOR) and the staff work with them as employers. Staff had been working very diligently to accommodate individuals' needs and to alter the employment opportunity to fit their capacity. They began to realize that centering the individual was not effective. It meant a lot of work was not being completed as people had a long list of accomodations that were needed.

> *We spent some time at the end of last quarter just looking at it all and saying, "What are they not thinking about?" We looked at what wasn't being talked about. We realized that what was missing was the discussion about the work.*

The missing piece in the discussion in Phase One was the employers. The lack of input to the group about the accountability of the workplace was being repeated at the ICC as they supervised staff. Project staff came to the realization that at the ICC and in the project, they needed to **center the work in the discussion of success**. When individuals notice that something is challenging, the work that needs to be accomplished does not change. Work For Wellness is about how to encourage the individual to address their own challenge so they can accomplish the work.

> *I don't know if it was the [ICC] first or the project first, but we started seeing it at work, too. We're like, okay, we've been just going a long time with certain folks who are not accountable, not orienting to the work.*

In this discussion, the project staff realized that the individuals who represented the supported employment and the employer perspective had not been encouraged to share their ideas about the limits of support and accommodation in Phase One. Though some employee needs are possible to accommodate, not all are reasonable or feasible. When asked to comment on what was different in Phase Two, staff spoke about the shift from centering the individuals needs to centering the work.

- *Work for Wellness is not all about the employer catering to you.*
- *I heard supported employment [representatives] talking and they were like, "Oh gosh, I'm afraid to say things to people sometimes."*
- *The few employers that we did have in [Phase One] …want[ed] to accommodate everybody and everything. I was thinking, "That's not reasonable."*

- *I think that's the hardest part about this whole project, is really saying the truth, right?* [Interviewer: On a scale of 0 to 10 with 10 being brutal, honest, total truth, no lies and 0 being saying nothing. Where was Phase One and where's Phase Two?] *Phase One was at a 2 and Phase Two is at an 8.*
- *If supportive employment and employers are trepidatious around their relationship with folks with mental health disabilities and being overly supportive or maybe holding a different bar, then folks are going to stay in this place of learned helplessness.*
- *If everyone is going to partner in a very effective way where the work is the focus, then we have to be very transparent about what the expectations are.*
- *The focus right now is the work, and the approaches … reorient the fact that we're talking about employment and employment is about work.*

At the end of Phase One, participants and staff were **asked how the information could be brought back to mental health providers**. What was their role in successful employment? As a result of these questions and the discussions, project staff began to include mental health providers and invited them to participate in a short film about the project.

> *If it's employee-driven, the mental health provider comes in at the pre-employment readiness piece. What doesn't exist in the supported employment system, from what we've heard, is employees coming into it with a degree of readiness…That's when the mental health system comes in. The employee is talking to the provider and saying, "Okay, I have kind of been thinking about work." …As a team, we talk about, "What are you really ready for?" and "What does ready look like?" Then all of us, with our own experiences, share with the employee what's needed. What they should have in place to be able to successfully and safely move toward employment. That's the first step. Then the step after that would be the consumer going to the mental health provider and saying, "These are the things that I want to work on because my goal is employment," or maybe it's volunteering, or whatever.*

Phase Two activities were designed to focus carefully on what success looks like from each perspective (supported employment, employers, and employees) and what individuals need to do to work toward that success. It also included frank discussions about when supports that are available are not effective and why. After hearing what the accountability parameters are to center the work as the goal, employees were asked to reflect on what they would need to have in place BEFORE starting toward supported employment services and employers. What did they need to do to prepare and what would they need to have in place to maintain employment?

The participants were divided into two groups. Group One focused on the experiences of Employer/Supported Employment and Group Two focused on the experiences of Employees. These groups reflected on (1) the definition of success from a more limited perspective, (2) how they could support success, and (3) what resources they would need. Group One also talked about (4) circumstances when supports were not effective. Group Two talked about (5) what OTHER resources they needed to maintain employment.

The learning goals did not change in Phase Two, only the approach to learning about each of the areas of inquiry. The logic model[7] was updated to clearly state the questions the group was hoping to address. These questions informed the agendas and the work of the Phase Two participants.

Work for Wellness, Phase Two Activities

Reflect

Supported employment providers and employers (Group One) meet to reflect on:

- What success looks like from an employee's perspective
- What mental health and supported employment providers can do to support employee's success
- What they need to successfully employ or connect individuals who are diagnosed with SMI
- Circumstances when supports are not effective

Employees (Group Two) meet to reflect on:

- What success looks like from an employer's perspective
- How individuals who are diagnosed with SMI can partner with mental health providers, supported employment programs and employers
- Circumstances when individuals do not meet employer's expectations
- The personal development individuals need to be work ready
- What resources individuals have to support personal development in preparation for employment
- What resources individuals have to support them while they maintain employment

Partner

Group One and Group Two meet to share their learning and their role in promoting success. (What is the goal? What would it look like if everyone was working as their BEST self?)

At the end of Phase Two, the remaining participants shared the findings and a short film[8] with the rest of the participants from Phase One and the mental health providers in the film. This meeting was done virtually on Tuesday, April 27th.

Recommendations

All Innovation projects involve challenges as project staff and stakeholders adjust to trying something outside of their typical experiences, roles and responsibilities.

The Work for Wellness project concept and design was led by an individual who retired prior to the project implementation. Without the original champion on the project team, the planning, outreach, and facilitation were reimagined by the project staff. Project staff had different relationships with stakeholders and less experience with facilitating disparate stakeholders.

[7] See Appendix B for the original and the updated logic models.

[8] The video can be viewed here: https://vimeo.com/538811828/a816bfc5cd

Project staff reflected that having **the same individual who designs the project be involved in implementation** would have been an excellent support. Several of the participants noted that they were unclear about what the goals and objectives were through most of the project.

> *Something that was a little bit difficult from time to time when … we would be given a little task, right, and here are the sheets, here are pins for everyone, and there were definitely a fair amount of times where I was uncertain what we were doing, and I would have to just fake it till I make it, walk through, and then I'd be like "oh, okay" and by the end, I would get it, but it was… I like to know what I'm doing. That, for me personally… I didn't really like that part.*

Several indicated that they would like to be **more involved in planning** the sessions.

> *I think after the first few groups, maybe the group itself should choose what the next thing they should do, like what they think they can put together. Maybe more choices towards a group, more involved with how the activity is going.*

A few recommended a **very strong facilitator for heated discussions**

> *….Other people I feel like didn't like it being put on the spot, or the pushing towards, which I know only came from good, to help someone grow and be open just like the rest of the group. But sometimes I could just see with others, they weren't there yet. I could just not mention the names, but a couple of people I noticed. [The facilitators] pushed was too far. There was a limit and it should have been not pushed anymore. It's happened a few times. I know it wasn't done intentionally to hurt anybody, but there has to be some line to draw for people. I feel like it did cause some [people] not to come as much.*
>
> *Once the momentum got going, and when we got heated, that's when the stuff would start happening. When people started getting riled up a little, that's when actually the good stuff came out. I think I might have a professional, one professional facilitator that really, that's their full-time job. Not even if they're spearheading it, but just to coach the other people, but somebody who really has a lot of experience.*

As participants reflected on their experiences in Phase One, they recommended **being inclusive and welcoming to representatives from supported employment agencies and employers and to involve decision makers as well as the general community**. There was less participation form these groups in Phase One, and they felt their ideas and involvement was key to making the project successful.

Be Welcoming

- *Being inclusive, I think that's a goal in every area. I feel that's where any group starts … Definitely, the goal is to involve everybody be one inclusive [have] an understanding towards each other. An open mind versus just completely shutting the doors. … everybody being inclusive, that's what I want to see.*

Supportive Employment Agencies

- *Maybe just…being a little bit more welcoming to the agencies even though if you feel a type of way about an agency because you have certain experience with them, maybe just being a little bit more welcoming.*
- *I don't think we included supportive employment very often.*

Employers

- *I feel like very often it was just throwing everything on the employer and like, "Oh, you have to accommodate me and deal with all this stuff."*
- *Indeed … just seemed like the employer was having to bend over backwards for the employee just because they have a mental health issue. I mean that's not going to happen. I feel like the group made it seem like the employer has to do everything for the employee rather than the employee getting support from their employer, but not taking advantage of said support.*
- *I just feel like now that I'm thinking back on it, it was-- I think the main thing we focused on is just how the employers can support the employee, what they can do to the employee rather than how the employee-- What the employee should be providing for the employer. I don't even think it was brought up like that. This is a job and we're supposed to be doing stuff for the employer.*

Involve Decision Makers

- *I recommend policy change at the level of key decision-makers. If they are not on board with building a dynamic and inclusive team, it demonstrates the futility of the endeavor and leaves open the opportunity to try something different. Additionally, if/when we are successful in taking steps to change the mental health system, it must be understood that this is a long-game project. While some changes can take place suddenly, large scale change almost always takes time.*

Involve the Community

- *I think the general society needs to hear [about this project] though.* [Interviewer: How would you get the information out there?] *Social media.*
- *I want to see it done. I want to see us really increase the numbers. I want to see a conversation happening in the community where it's like we're going to look back at this and be like this is where it started, and it was successful.*

The Learning

During the project, participants and staff completed interviews to talk about the learning and how the project was progressing. This section of the report relies on their perspectives and reports.

- **How to create shared measures of success among all participants in the system?**
- **How to increase commitment of all system participants to each other?**
- **How to implement common measures of success?**

In addition to the original learning questions, MSHA staff asked project staff to include learning about**:**

- **How can mental health providers support employment as an option for wellness and recovery?**

Creating Shared Measures of Success

How to create shared measures of success among all participants in the system?

The first Phase of the project focused on the experiences of individuals with Serious Mental Illness and employment. The resulting measures of success reflected these perspectives but did not include the supported employment and employer points of view. Though this approach was good for building trust and promoting engagement from the employee group, the resulting model describing success was not clear to all participants.

The second Phase of the project prioritized hearing from the supported employment and employer point of view and resulted in a shifted definition of success. Previously the focus had been on the individual and their needs, this changed to a focus on the work and what an individual needs to have in place for themselves outside of work in order to do the work successfully.

At the beginning of Phase One, the participants were asked to think about what it would look like to move toward creating shared measures of success. Many of the respondents focused on the individual benefits. For some this was getting advice, for others, it was a shift in the group dynamic to talking about "tough issues… in the real world of work". A few mentioned being able to see the results after they shared the measures.

- *I get the advice I need from the group*
- *If it helps people revise how they approach to employment*
- *In terms of measuring how well this group is moving forward for me is that it's causing me to look inward, it's causing me to reflect and it's giving me a platform to share*
- *I would see…people…celebrating their wins and their successes. That's what it would mean to me, and that's what I would say.*
- *As we start building trust, we will start moving towards that goal*
- *Until we talk about the tough issues, nothing is going to change. This isn't about therapy, it's about Work For Wellness and everyone needs to know what's happening out there in the real word of work.*

- *If we see some impact from the education, we receive. It might be anything from educating the community to how many jobs are created*
- *I think if at some point we have some kind of layout or plan about how either employers can help the employees or how employees can work with their employers to make sure that their needs are met*

During Phase One, the participants and the staff developed the STAFF model. Project staff felt the model was an accurate measure of success in terms of the individuals in the cohort and noted that the absence of employers in the group means that it is not likely representative of employers' views. They noted that the definition of success does not take into account the realities of work life. One staff person noted, "Okay, well, so we have this model that sounds cool, and now what?" A full description of the model is included in Appendix A.

The STAFF Model: Work For Wellness, Phase One

Sustainable and Meaningful Employment occurs when those involved in the employment system are able to rely on each other and thrive in the following areas:

- **S**tability: not at risk; to be able to problem solve and seek support; not likely to change or fail; firmly established.
- **T**ransparency: implies openness in communication & accountability
- **A**daptability: willingness to adapt & compromise
- **F**lexibility: the quality of being able to adjust to new or changing conditions
- **F**airness: impartial

At the end of the first phase, participants were asked to reflect on the STAFF model. Some of the individuals indicated the model was helpful and should be promoted more, and some were not sure what it was or how to use it. After reviewing the participants responses to the STAFF model, project staff suggested that the meaning behind the STAFF terms were different for everyone and that personal definitions may not line up with employer expectations (e.g., being on time, personal hygiene).

Promote Model

- *I would recommend we create an illustration of how to apply it (like a comic strip).*
- *I would just definitely promote it more.*
- *I feel like this became core for … the people who are in that circle of mental illness… I feel like somebody who's really sharp would have to go in there and teach employers about this, what it really means. It would be like a 30-minute training or 45-minute training, because I could see this going everywhere.*
- *I think [employers and supported employment agencies] like it. I just don't think they need-- I think their plates are full, and this would just be another pretty big thing for them, personally.*
- *I think [employers] like it. I don't know how deep the investment goes on it, because we're so geared as employers to watch the bottom line. It would have to be presented to them on a silver platter, "Hey, we're going to provide the STAFF model training for you guys."*

Did not understand Model

- *I don't remember [the STAFF model].*
- *The understanding of it which obviously, I don't think we did the best because not everybody even still knows what even-- I'm just being honest. Maybe we should have a better understanding of it.*
- *I don't know. I feel like it was more like a lot of homework. When we were just going over it and stuff, it could have been laid out differently. I don't know how to say it, but I just feel like everybody lost each other. Not lost each other but maybe I'm just speaking for myself. I don't know.*
- *Just the layout and I didn't even remember it. … I felt like when we were doing it, like those, we knew what we were doing. It was a good thing, but it didn't stick.*
- *Yes, so everybody could have an understanding and feel like, we all were on the same page and we just moved on.*
- *… I've had people ask me [about the STAFF model], and I'm like, "I don't know either." It felt like we were back in school and trying to look at each other's sheets.*

Recommendations

Generally, staff agreed that the model needed more explanation and there was a need for developing definitions for measures of successful employment that laymen can understand. Staff noted that without the realities of the employer's perspective, it was difficult to develop a shared definition of successful employment.

Participants also offered advice after Phase One. In regard to creating the shared measures of success, the participants recommended (1) moving the group through the team building sooner in order to start focusing on the work that the group is going to do and (2) starting to work with employers and businesses so the ideas can be developed with the context of where they will be applied.

Less Team Building, More Focus on Work

- *I personally felt like we spend way too much time team building. I feel like probably partway through, everybody already knew each other at least decently. We could've probably figured out something else to start focusing on.*
- *It was a lot of identifying the differences between employers, providers and employees and what different roles they have. I feel like we ended up discussing that several times. I feel like we had it down early on. I feel like anybody who's already willing or able to move forward and work on stuff, like maybe have them start working on something else, maybe have two things going on, one is continuing to make sure everybody understands these topics and other people that feel like or already understand these topics to start, like building something over here that when these people are done, they can move over here and continue supporting.*
- *I feel like often I would go and we'd sit there for several hours repeating what we had spoken about a meeting or two ago. I would have preferred to actually be able to get something done rather than just sit there and wait for everybody else to understand what's going on.*

Research/Apply Learning

- *There was one day that we went out as groups and we did a little job exploration on our own. I thought that was great. I would say doing more of that-- Going on more little field trips in groups.*
- *I think what could be done differently would be to have an actual live model to where we were working with employers, supportive employment and employees in getting someone a job and seeing how what we came up with was helping them be more successful because then we can use that outcome as further evidence to have future employees and employers.*

In Phase Two, the staff began to address the lack of employer perspective in the group by turning to their participants and their own experiences.

> *Well, in the beginning of this process, we were fearful of not having more community employers in the project. We were fearful of what that said about our ability to recruit and our ability to lure people into this fantastic project. I think that we were unrealistic. Employers are hard to reach…We were like, "Okay… We don't have them. Who do we have? We have ourselves as employers, we have [participants]… as an employer, we have our own experience with employers. We have employer perspective."*

Staff shared, "You can't create measures of success without having and sharing and understanding the perspectives of everybody involved." They also realized that the discussion needed to begin with a **focus on the work that needed to be done, and then progress to how the individual could do the work**.

> *The only way to implement or create or develop commitment… What had to happen was just to shift the focus from creating something for whatever the employee desires, to work. Work had to take precedence over all of it. The only way that that could happen was for every group to stand in the role they represented and to share, unadulterated, what they needed and what their experiences were.*
>
> *Then there needed to be movement from the employee, from this place of being a service recipient, and that couldn't happen until work became the central goal and until the other two groups just really shared what their experience and needs were. All three groups needed to represent themselves and acknowledge the necessary shifts, almost equally, around the idea that work is the central focus, not the employee.*

At the end of Phase Two, staff reflected on the projects' progress in creating shared measures of success.

> *What went well is that we finally held that separate meetings with our supported employment folks and our employers, and just really **spent that time working on getting the supported employment and the employer perspective**. I wish we would have done that sooner…I think that's what helped people shift their thinking or to be able to have conversations other than just what the employee needed.*

Increasing Stakeholder Commitment

How to increase commitment of all system participants to each other?

Phase One brought a disparate group of individuals with varied experiences and roles with employment and with mental health. The monthly meetings and group activities helped individuals learn about themselves and each other. Participants shared that the experiences in the first phase changed how they interacted with each other and how they thought about the challenges facing others. Several noted that they felt a sense of accomplishment and hoped the work would have an impact.

Despite disappointing engagement by employers and decision makers, at the end of Phase One individuals reported that the support they gave each other was a benefit to them. They felt the process of listening to each other was valuable and connected them.

Participants were interviewed at the start of Phase One to understand their expectations and how they would know they were successful at increasing the commitment of all system participants to each other. They emphasized the **importance of individuals showing up for the discussions, sharing their ideas and being honest.** The majority agreed that success would look at bit different for each of the participants since they all had different experiences and roles.

- *Okay, maybe this is a quite tangible, but from the beginning, the first two meetings, people were like jazzed and pumped up. If that goes away completely, when people start not showing up, then I know the air is going out of the group. There are other ways, but for me, that's a really simple one to see pretty quickly.*
- *One clear measurable is, do I or does someone else after we've articulated what needs to be done, want to participate? You probably could look to see how many people are wanting to continue on after this initial session*
- *The kinds of questions that people ask.*
- *I think we're getting there as a group a little bit more each month, but I don't feel like we're cohesive yet. I already know some of the people in the group, but I don't feel like we've quite bonded yet. It's getting there.*
- *I suppose the connections that we make, the personal connections, that that would be something that you would be able to tell individually with a person*

After a year of meeting together, the group was asked to reflect on what they learned and what had changed for them. This discussion took place on the last day they met together and before they had presented their learning to the Advisory Committee.

The participants who attended this discussion talked about **learning more about themselves and each other and developing connections**.

- *I feel like I've grown a lot personally and professionally. I feel like I've made a lot more connections because of this group. I feel that I am, at least, if this is over, I'm walking away with a lot more, I would say, friends because I've made some friendships and I've made acquaintances. There's not somebody here that I wouldn't say hello to or help if I saw them….*
- *It feels great… getting to know the people here.*

- *I really enjoy the relationships that we built, the trust that we built with one another. I think we're a group that is genuinely happy to be here, and genuinely happy to be with each other.*
- *I guess what stands at the top is the people in here. I don't know if I've been with a better group, and I've been with a lot of different groups.*
- *You can almost trust everybody and feel comfortable with everybody, so that was huge.*
- *I'm grateful for all the friends I made here…*

Some talked about **how their perspective changed how they interact with each other** and how they think about the challenges others face hearing other people's experiences

- *…this group taught me how sometimes you have to be really flexible no matter how passionate you are about certain things.*
- *I thought I came to this group with a little bit of knowledge. It was through the process that I realized how much I didn't know, and how much I had to learn.*
- *I think I kind of had this abstract idea that everyone has more in common than differences, but I think meeting everybody here …we really do have more in common. I think that made me more empathetic, a better coworker… a better supervisor.*
- *It gave me an appreciation of it is really hard to go out in the workforce when you're struggling with something….*
- *I learned a lot about myself…. It makes me feel closer to the clients …I have a better understanding. I think I got a lot of knowledge through this group.*

Others talked about **the feeling of accomplishment** from being part of the discussion.

- *I just feel a lot more confident to be able to do things.*
- *I had a lot of years of not experiencing what it was like to be a part of something that was bigger than me, and then I've followed through, and I showed up, and I played an active role.*
- *I feared I was probably the lowest person on the totem pole as far as what I have to offer, and everybody else is more knowledgeable because they're professionals. What I've learned, and that's not necessarily the case, that I do have talents that maybe others don't flourish as much in.*
- *I don't think I've felt so empowered in my life where my voice is validated, wants to be heard. … it's very empowering for me and liberating at the same time.*

Several talked about their **hopefulness that what they learned would "ripple out" to others**. These comments had varied timeframes and scopes.

- *It's going to have a ripple effect. It might be slow, but if we can start in one little small corner, and make a difference in maybe 10 people's lives, that's something.*
- *I hope it comes through to our Advisory Committee today. There are things that can be done, and that will help.*
- *Hopefully, it will grow and grow. Who knows, 10 years from now, maybe it'll be something that's super known, and people are doing it all the time, and we'll have been the ones that were here in the beginning and helped spark it off.*

Phase One concluded with an Advisory meeting held at the Innovation Community Center. This meeting was held on Thursday, October 17, 2019, in the afternoon. This was the same day the participants had their last group meeting. Though 12 decision makers were invited, only one attended. This was a disappointment for those who prepared to share and for those who organized the event.

Over the next few weeks, the participants were interviewed to understand their experiences with the program and what they had observed and/or learned.

Most participants indicated that **the support that they were able to give each other (particularly between peers) was a benefit of the project.**

- *Let's say this [project] doesn't work and it's got to be put on hold for a year, at least we have us. We all have us. We all supported each other. That's what I saw happen is with our little group, we connected people…almost like you're squeezing the washcloth and the real stuff is coming out. Like the really pivotal things are now coming out, no matter how raw they were, because you can always fix them up.*
- *The open communication within the group allowed for continued support peer to peer, and mentor to peer.*

Participants enjoyed the team-building activities and reported that sharing stories and **listening to the experiences of others in the group was valuable and connected them to each other**.

- *That we were all looking for jobs at one time and we know how hard it is to find employment and we've had coworkers with mental or family members or we know what people-- we do. We all have some connections. We do…we have friends, we have family members, we know people and we worked with them and things like that so we all have connections.*
- *Yes, so the first time we had our community meeting, I think that the exercise that we did, putting everybody on the same page like I think that we asked, what was everybody's first job? We had already done that as a group, and we realized what it did for us. I think when we did it with the community members like I think it helped because they put everybody on the same playing field.*
- *I don't remember what exactly it was called each time but we did a lot of things where we-- They would put different things, different topics and papers around the room and then tape it to the wall. We would go write our perspectives and then discuss that. That was a good one. Then we would do things where we would break into small groups and we'd each have a topic to discuss and then we'd come back to the large group and share what we learnt. I think things like that you really found out that no matter where you were coming from, we were more similar that different.*
- *I think there was this one activity. I think it was probably a check-in…. Basically, it ended up with everybody just going around and explaining all the different issues that their mental health had brought up in their lives or getting to the current point. That was when everybody realized that everybody else in the room had, if not completely similar, then somewhat similar experiences to them. They all just got comfortable with each other. It was like, "Oh, we're all similar." That's when everybody was just like, "All right, we're comfortable with each other." Then, for some reason, we kept doing more team building.*
- *[The mask exercise] got rather intimate and emotional. I think that that was eye opening because there were people who would comment, like "I would never guess that about you." This type of thing,*

and it's like "Well, yeah, we're all people and we all have these different hurts and pains and things that we've gone through."

Participants felt the Phase One **activities they did where they applied the information they were discussing (the skits and the field trips) helped them understand different perspectives** and experiences and how the definition of success can look different for different people.

- *I felt like [the skit activity] was insightful because there was one story where this person was triggered for their anxiety, their panic attacks. They had just had something happen the day before work, and an employer was needing them, there was no one else coming in. It was really insightful because everyone had different ideas as how to deal with that because there's some people with panic attacks and anxiety attacks.*
- *I think without those things, we were all just kind of people in a room together, being polite and listening to each other. I don't think we really bonded until we actually started talking to each other, and like I said that one time we went on a little trip, for a field trip out to-- we went to Starbucks, but we entered different coffee shops. I think that was a point where we really bonded together.*

They also talked about the **lack of employer representation and the engagement of decision makers**.

- *I saw there were some employers, but not enough. To me, they weren't community leaders there. Maybe, but that one fell out and dropped off.*
- *The committees and the other supporting people and other people that just came to attend the meeting had very little idea of what we were even trying to do. I feel like if we knew what we were trying to do, then that would be helpful for everybody. Then probably give us a higher chance of being supported.*

Project staff reviewed the participant feedback. Staff agreed that the participant summary of feedback was accurate.

Recommendations

The most common recommendation was to **involve more employers** to provide the perspective that was missing from the discussion. Though they recommended more involvement they also noted that it was very difficult to engage employers.

- *I doubt employers would commit to the whole thing, but it would have been nice to have an employer be a guest speaker and I know again, that's just a suggestion for myself too because I had tried that and I didn't get anybody to come. That hard but again, it's just a suggestion for next time.*
- *The original idea was to get employers to participate in the whole time period and that was just no way, nobody was going to commit to that. I mean, they didn't even know if they were going to be working at the hotel or wherever that long, but understandably, they couldn't commit to that. It would have to be like a volunteer thing and everything. But I think we probably could have gotten speakers there just for a day and with employers, not even for a day, just for like a day, for a half-hour or something like that.*

Participants also recommended **sharing stories and listening** because they had found that effective as a way to understand each other.

I think that when somebody just stops and listens…and gives… their attention, that direct attention, that's good.

Additionally, participants at the end of Phase One were asked for advice to give someone trying a project like Work For Wellness. The participants noted the **importance of keeping an open mind and creating a community**. Though some participants recommended getting started on the work sooner others **really appreciated the team building focus**.

- *I would tell them to keep an open mind because there's always something to consider and learn from, there's a piece of truth to everything, and that look forward to being inspired, empowered.*
- *I would say- that's a hard one. I would say just being very positive and just reminding people to be open to the process. I think that everyone involved in this did a really great job in just explaining how it was a process and we didn't know where we're going with it, but we were just going to try to accomplish something.*
- *[Create] a community that feels like you're with people and there's lots of respect and offering advantages by doing it there. There's a social aspect and then there's, I think getting people involved really helps if it's fun.*
- *One of the things I noticed in the program is it was made easy because of the-- I don't want to say silliness-- the projects, we got to do the open-ended beginning questions, which broke the ice and everybody got a chance and everybody got to be whatever they wanted to be. If it was whatever animal you wanted to be, you could be a goofy … That wasn't seen as strange. It was something we could laugh about or be interested in. "Oh, wow. That's an interesting character they picked or animal." It was that stuff … that made us equal.*

Implementing Common Measures of Success

How to <u>implement</u> common measures of success?

Plans to implement the common measures of success began at the end of Phase One as the project staff prepared for Phase Two. The initial plan was to test the STAFF model and share it with employers. After reviewing staff and participant feedback, it became apparent that there needed to be more stakeholder input.

Staff created a new plan for Phase Two to collect and incorporate the missing perspectives from supported employment, employers, and mental health providers. This resulted in a shift from focusing on the individual and their needs to the work and what the individual needs to have in place (outside of work) to do the work effectively.

At the end of Phase Two, project staff were planning to begin a life skills group at the ICC to support individuals who have been diagnosed with a Serious Mental Illness and want to prepare to work. Staff also noted that the shift to centering the work instead of the individual has been helpful in supporting individuals in other systems that sustain the vulnerable (transportation, housing, etc.)

Most of the participants who completed Phase Two indicated that they hoped to be involved in the upcoming Work for Wellness life skills groups.

At the end of Phase One, staff all agreed that testing/implementation should be the next phase of the project based on what was learned. Staff generally agreed that they need to go back to the project learning goals and refocus as they began Phase Two.

When participants were interviewed, the suggestions about where to go next were mixed between (1) making a plan and getting more input from employers and decision makers, and (2) using the current STAFF model with employers and to support employment for Individuals who have been diagnosed with a Serious Mental Illness. Many indicated they were not sure what was next, and some said they were waiting to find out.

Continue Meeting and Make a Plan

- *… I don't think we're totally prepared … we'd come together and meet, and then come up with a plan. Come together again, come up with the plan to implement, actually go out there into the community.*
- *I'm anticipating that we will have to continue to get together and those who are definitely dedicated and ready to take and discover what the next steps will be, so I see it as getting together and collectively coming up with a plan. I see it as from what I've overheard from my coworkers that I'm testing it out, trying it out. Maybe here where I work, I don't know if there's any other places or how else that would look, but that's why I'm grateful that it's like we're a group. Where I might have some great ideas for one area of it, but you know what I mean? I wouldn't know how to organize that.*
- *We need to keep meeting.*
- *Really just getting into the reasons why we're doing it. Really get into the goal of ours and then break that down into how we're going to get there. Coming up with now the actual plan so that*

way we know what we're doing at every meeting kind of thing so that way it's we get it done quicker. Now that we trust, now that we've built the relationship, we started the conversation …

Implement the STAFF Model for Individuals with a Serious Mental Illness

- *[If someone brought in their own STAFF model], that would be so helpful because it gives me insight too and it helps me. I have to have [the person] explain it to me, sit down and I would just listen to what they said, so I think that would be wonderful.*
- *I think it would be nice to try [the STAFF model] out and see what it would be like to talk to an employer and find the things that you need and feel good, feel better about yourself. I think it would more practical- practicum would be better.*

When participants were asked how they would be involved in Phase Two, people talked about being a consultant or a resource for the next steps and a few wanted to work directly with employers. Some wanted to directly support people who have been diagnosed with a serious mental illness and one was hoping to receive support. A few noted they wanted to create jobs. Many indicated that they were not sure how they would be involved, but they were excited to continue to be part of the project.

At the end of Phase One, staff began considering how to **include mental health providers in the testing phase**. Staff agreed with participants' views about involving employers and decision-makers during any future activities.

As Phase Two began, the staff shifted the project's focus to understanding the experiences, resources and limitations of each of the three stakeholder groups and began centering the work and what is needed to complete the work. Staff began to create an endpoint for the project and direct it a bit more to create a path to get to the endpoint.

Even when we set our expectations for folks…. It is like building the structure, and then finding the way in, then …trying to go through it, to say, "Okay, that's not working. I still need to get over there but what's another way to get over there?"

What's been happening for folks with mental health issues, is that their framework has been…"No matter what, I'll just keep doing the same thing to get that job," and "Okay, that job didn't work. Well, I'm going to keep doing the same thing to get that next job."… That's what I think is happening now for Work for Wellness. There has to be something in place that can help you ***get to the point of realizing that it's not your way or no way, and to keep you from walking away when it doesn't work****. What foundational stuff needs to be in place so that you realize that you can still have this aim, but you have to be able to navigate all the different ways to get there?*

*I think that part of what they discovered is that, in the end****, this is going to be about the initiative of the participant, the employee, or potential employee****. It's going to be on them.*

It's not ever going to be employers who are going to step up and say, "Isn't this wonderful, and let's figure out what we can do." Then it's not going to be supportive employment. It isn't. That person who says they want employment, it's like, "Okay, do you really?" Now ***let's talk about how to put the support people around you, so you can be successful or try to be successful****, so if they learn nothing else, I think they certainly have that.*

> *This funding, of course, it's process funding, you don't know what's going to come out, you're asking questions, so you don't know what's going to come out. I think that people misunderstand that, okay you want to learn and you don't want to be like, "Okay, we're going to end up here, because you don't know where we're going to end up," but you got to end up somewhere.* ***It's okay to be a little bit directive and be like, "Okay, we have a lot of information. Now, where are we going? What do we want to try out?"***
>
> *It took them a long time to get to "work is actually the focus of employment". Which seems like a super obvious place to start but that was the second phase.*

At the end of Phase Two, project staff is working to create a Work for Wellness group for individuals who are interested in getting ready to get ready for employment. The group is intended to support individuals in identifying the team of individuals they need around them to be well enough to consider working. The process is led by the individual.

> *I've been working this past month on putting together a Work for Wellness group. It is kind of more of* ***a life skills group****, but I know a lot of people have employment goals and they want to meet those goals, they'll probably more likely to join a Work for Wellness group rather than a life skills group.... There's a curriculum, like, how do you get ready to get ready? …This isn't just, "We're going to get you a job by coming to this group"….you're working at becoming ready to work….hopefully, we'll have it ready in August, September.*

When project staff were asked how they are using what they learned in the project, they noted that the broader understanding of how **individuals can begin to see themselves as recipients of services rather than contributors** was key. Staff plan to use this insight to show individuals how systems work and what their role is in that system. Whether it is transportation, housing, mental health or another system of care for vulnerable individuals.

> *Understanding other parts of the system you're in, is the big takeaway here. You are not just a recipient with people there whenever you need them. You're a contributor and a participant in the system. … it's okay to say, "here's how this works" to folks, because if we're just always reactive and always responding: well, then we're sending them out to the world with a false sense of knowledge that structures don't exist.*
>
> *I hope that there are more individuals with mental health challenges and experiences employed at whatever level employment is for them, in a way that doesn't require case management and support. Independent employment for individuals with mental health.*

When the four of the five participants who completed Phase Two were interviewed, they spoke about how the discussions reinforced some of the things they already knew about accountability, the importance of listening, and how we all have different definitions of success. They were all eager to see the Work for Wellness group continue as a peer support. Those who represented the employer and supported employment perspectives talked about wanting to be involved in supporting individuals. Those who represented the employee perspective spoke about how the tenets of the planned Work for Wellness group were based on the types of support and guidance that had worked for them in the past and one of the individuals who represented the employee perspective hoped to be among the pilot participants in the group.

- *I'll certainly volunteer to help. I think it's a very important process.*
- *I learned quite a bit as I went, but I would say what I learned most is to just remind myself that **everyone's measure of success is different**. Sometimes a person might not even know that until they've gone through more experiences and more work experiences. For some people, a full-time job might be a success, supporting oneself. For other people, a volunteer job, for other people, a feeling that they're moving forward, they're moving up and out of the rut that they're in. I would say the biggest thing is that everyone's definition of success is different and that might include working and it might not.*
- *… I feel like I've walked through the things that ultimately are mostly being suggested here… where it starts with the individual and you get a team of folks and this, that, and the other. A lot of it has been all the ingredients that have actually literally taken place in my life personally a few years before Work For Wellness came into place. It's going to have to be the individual, **we can't expect all these things from the entities and the system, but we could start with the individual.***
- *…people with mental health challenges want and need scalable, meaningful employment. I had never really considered or understood in the world as a whole or in my community as a whole that this is an issue.*
- *Right now the issue is I'm so busy that I got to figure out a way to change my schedule to do [work]…She got me a template that I could figure out…Then she made some suggestions on some really busy days to maybe come in later to the center…. **You come to the employer and say, "Here's my resume. Here's what I can do. What do you need?"** I think when you get your team behind you, just like me, well now I got my calendar set. It's no problem. Nobody needs to know I had to go through all that stuff to fill out a calendar and get it to work.*
- *I was thinking, some people who've been on mental disability that never even had a chance to even look for a job or even think they can get a job. Being able to help them have an idea, **"We can help you if you'd like to start looking for a job or volunteering if that's something you'd be interested in." Just even put that out as an idea to somebody is, it starts a process.***

Recommendations

At the end of the first phase, participants were asked to give advice to others doing a similar project. They advised **sharing the goals of the project with stakeholders sooner and in more depth to give the project ideas a place to go after the project concludes**. These comments reflected the frustration of some participants about the Advisory Committee meeting that had been sparsely attended at the end of the project.

- *I feel like maybe gathering the [committees] the first time to explain what we're doing, was a good idea. Maybe having a better understanding of what we were even doing before that meeting would've been better.*
- *It feels like the furthest thing that we achieved that whole time was getting together that board and bringing up the topic to them, and then that was it.*
- *From what I hear at the [committee] meetings, a lot of it was just nonsense, and people that attended the meetings were kind of just like, "Oh, we don't have the money."*

Connecting to Mental Health Providers

At the request of Napa County MHSA staff, a question was included at the end of the first phase about how to connect the project learning to the work of mental health providers.

Recommendations

Project participants encouraged mental health providers to **understand the employment supports and services available to individuals with a mental health concern**, and to discuss employment opportunities with their clients.

- *Providers can educate themselves on available options for folks with a serious mental illness and accept the willingness to explore opportunities with regards to work. Providers could potentially be advocates on behalf of the individuals with SMI, as the additional supports are essential for the overall success of the individual.*
- *In my personal experience, while fighting the self, it is impossible to find, maintain, and keep employment. Therapists go to work to provide treatment. Included in their toolkits, are tests designed to help folks find interests and strengths to assist in finding meaningful employment. It would be advantageous if more therapists possessed this type of training available for utilization.*

They also recommended **building relationships with supportive employment providers to understand what is offered** and to help supportive employment providers effectively serve individuals.

- *I think that communication is a big part and having [mental health providers] communicate especially with [us]. [We] can help provide a lot of services for these clients. I think that's the biggest thing, it's being able to communicate and having them know … we have all these services that we can offer for them.*
- *I would say what I've learned is that communication and teamwork is really important. I find that … We have the most successful people when they have a team surrounding them of all their different support people and the support people communicate with each other. That's up to the individual, but I think it's really hard to make that first step when you're getting back into the working world. Once you get back in, it gets easier, but I think all the help, all the supports you can surround yourself with the better.*
- *I think that sometimes we find that when there's a lack of communication between the different supports at home and the supports at work, sometimes we're not as effective because we're not sure what's going on, there might be something going on that we're not aware of or maybe they can help us in supporting them. Because typically, like a supported employment agency, it doesn't have anyone that's a mental health provider, like a therapist on staff, so we accept any kind of help that we can get. Anything that's going to support the person be successful.*

Additionally, they encouraged mental health providers to **build relationships with employers to address the stigma around mental illness** and to potentially train employers about the needs of individuals who have been diagnosed with a serious mental illness.

- I think that there's going to need to be a cooperative approach with the mental health community and the employers. I think, first of all, they need to recognize the importance of providing something more than what we currently have to help people…

- I think what mental health providers can do is connect with their clients and come up with a plan for employers. Work with the training position, the individual and the employer, so it'd have to be like a three-part connection.

The question about how to involve mental health providers was also asked of project staff. The staff generally agreed that mental health providers could and should **be much more involved in the employment process** and that employment is an effective intervention for people who have been diagnosed with a serious mental illness. For individuals who are seeking employment, **collaborations between therapists, the Department of Rehabilitation (DOR) and supported employment providers makes sense before, during, and after the process of looking for and keeping a job**. It was suggested that mental health providers could assist individuals in interviewing skills, timeliness and effective communication. Even more critical to employment, they can **support individuals in remaining stable**.

- *I just think it's to figure out a way that [mental health providers] can partner with the individual in the early stages of employment whether the person is going out and doing job searching on their own or working with a supported employment agency. I think that the mental health provider needs to be part of that process.*

Staff also shared their perspective that supported employment does not have much success with individuals who have a serious mental illness. Referring clients to these services is potentially harmful.

- *Supported employment has flat-out told us that they have very little success with people with mental health issues. Putting people into a system that acknowledges that they have very little success, is potentially doing the person harm. That's the honest message to the mental health system. The message isn't necessarily about how mental health providers become involved in the employment system. You don't. You stay out of it.* ***You just recognize that the employment system is a complicated one, and that there is a great deal of readiness that's needed before people get referred for employment.*** *That's it. We can help your clients identify what would be helpful for them to be able to get ready to enter to the employment system, and then you as the mental health provider can work on being that glue, or that bridge between what the employees learned about themselves via this other process that Innovations can or can't support. The recommendation is not that they become part of the employment system or that they have an employment goal with their clients, or anything like that.* ***They just are very aware of not referring people out into that system without making sure that there's a great deal of support in place for that person.***
- *I think the first step starts with whoever that provider is* ***when they start hearing participants talk about having simple life goals, then they need to jump in and say, "What does that look like for you?"***

Staff also noted that they wished they had involved mental health providers sooner.

> ***I would've gotten mental health people in sooner. I would have maybe started with that piece,*** *and then brought that information to the focus groups with the different participants. The second phase got farther because we had employees saying, you know, "Yes, there's some accountability that's expected of me, and I have some things to learn about myself and the system that is going to help me with some of my insecurities, help me with some of my planning, how to get ready."*

Appendix A: STAFF Model

Sustainable Meaningful Employment: STAFF

On The Move

Sustainable and Meaningful Employment occurs when those involved in the employment system are able to rely on each other and thrive in the following areas:

Stability
Transparency
Adaptability
Flexibility
Fairness

These areas are individually defined as follows:

Stability: not at risk; to be able to problem solve and seek support; not likely to change or fail; firmly established.

Transparency: implies openness in communication & accountability

Adaptability: willingness to adapt & compromise

Flexibility: the quality of being able to adjust to new or changing conditions

Fairness: impartial and just treatment or behavior without favoritism or discrimination

What success looks like across all groups involved in the Employment System

The following chart shows how each group (Employers, Employees and Supported Employment) define what employment success looks when support has been received in STAFF areas.

Support	Definition	Success: Employers	Success: Employees	Success: Supportive Employment
Stability	Not at risk; to be able to problem solve and seek support; not likely to change or fail; firmly established	-employee and coworkers are able to perform duties -employees coming to work ready to work -workplace is not compromised -employers are educated	-knows skills, limits and abilities -knows job description -knows how and when to ask for help -supports in place	-skills to support STAFF -fulfillment in employment achieved -successes outweigh needs for intervention -growth in problem solving skills
Transparency	Implies openness, communication & accountability	-employers and employees are honest about needs -level field -employers have clear and concise expectation -employers model behavior they expect -employers and employees are able to express concerns -there is clear and concise delegation of task -employers check-in with employees -employers knows who employees are, and what challenges exist -everyone defines their expectations upfront - sharing information -staff being present and staff communicating -"I can't be helpful if I don't know what's going on." -limit setting -Genuine unconditional/respectful -Be present	-coworkers check-in -employees check-inwith employer -consistent communication -sharing struggles -letting employers know feelings, expectations, and what's going on -let employer know what your needs are --work ethic -safe emotionally -trust policy: do good even when no one is looking -honesty: report life changes -difficulties/ competing needs -communication: (about anxiety days) -step away relax -sharing information -expressing when something is confidential -ask for clarification -relationship building -job reviews	-Mediator -need to be vigilant of employer and employee -check-in with both employers and employees -educators/ knowledgeable on transparency -advocate -mediate -share unified understanding MH -educate/enlightenment better understanding of MH challenges to help employees/employers -let employers know what they are dealing with -someone to convey what is needed (sometimes we don't know what we need) --honesty -communication between all parties -same page goals needs/ challenges -clear on how/who is being served: criteria -neutrality -boundaries -advocacy -rights know them

Support	Definition	Success: Employers	Success: Employees	Success: Supportive Employment
Adaptability	Willingness to adapt & compromise	-having people try different things by exploring their qualities -spend time identifying strengths -patience -needs: schedule, personal crisis -changing approach to dealing with employees -changing job description based on skill and abilities -create jobs based on skills & abilities -provide incentives -feel that I can ask staff to do things outside job -agency vs personal needs -delegate tasks -you aren't going to lose your job if you don't understand Think outside the box/creativity -curiosity/genuine -tries to help employee gain understanding -different work style: understand	-open mind -willingness to do things differently -honesty about experience of environment -ask for support when needed -compromise change/environment -using support tolls at work as needed to doyour job -being prepared for unexpected tasks: even when not in job descriptions -take work home- make up hours when completing demands -cross training- takeon tasks communication to ensure this happens -willing to try new things -ongoing training -ability to move up/not standing still -culturally aware:respect	-Knowing needs, struggles employee employers -support advocating cohesive relationship -allowing window of time to take place process -educate/ knowledgeable about adaptability -allowed custom of time -knowing needs/struggles of Mental Health -finding what works for the employee (job coaching) --speak same language of participant and employer -meeting people where they are at -culturally sensitive -knowledgeable of Mental Health disabilities - get support through agency -have self-care -being recognized -counter transference -acknowledgment -have supportive network

Support	Definition	Success: Employers	Success: Employees	Success: Supportive Employment
Flexibility	The quality of being able to adjust to new or changing conditions	-discover and support employees needs -critical decision making -accommodating to the needs -patience to the process -honesty -compassion -mutual expectations -Flexible scheduling -provides incentives -ability to be accommodating based on employee need -incentives/ -acknowledgements - cross training -feedback about pros/cons -feedback about what employee needs to learn -how to accommodate progress & rewards -help people get to work -meet with employees: cases, needs, just to talk time with employees	-knowing my own limits -pushing myself to areas of growth -brainstorm plan ahead -identifying triggers -self-care (personal check) -accommodate employers needs -compensation --availability -ability to be accommodating based on employerneed -different hours/schedule adherence -non-traditional hours: being amenable -schedule- family first -taking on other tasks -knowing where colleagues are at -reviewing position	-rearrange schedule -modifying needs of employer, employee -educate/knowledgeable about flexibility -work with employee around personal process -seeing the whole person -writing sharing alternative solutions -provides information -finding the right environment for the employee -know the audience -training to represent qualifications -teamwork -knowing when to move a participant -part of team
Fairness	Impartial and just treatment or behavior without favoritism or discrimination	-employers role is understood -trust and willingness -accommodation	-ongoing employment -needs are met -feels understood	-good relationship with clients -feeling of achievement

Appendix B: Project Logic Models

Work for Wellness: Phase One Logic Model					
Needs being Addressed	**Learning**	**Activities/Strategies (How to Learn and Address Needs)**	**Short Term Learning/Outcomes**	**Long-Term Learning/Outcomes**	**Impact or Overall Change**
Despite the existence of evidence-based supported employment practices: Individuals with SMI are often unemployed Few individuals with SMI receive supported employment services Few employers work with supported employment programs The measures of success vary for different parts of the supported employment system.	How to create shared measures of success among all participants in the system? How to increase commitment of all system participants to each other? How to implement common measures of success?	**Recruit** 20 participants (individuals with SMI, employers, co-workers and system representatives (WIB, Cal Works, NBRC, OJT, NPS, PSI, DOR)) to work together and develop ideas about how to sustain employment for individuals with SMI. **Create measures of success** that are representative of individual, employer and system perspectives. **Develop ideas** for sustained meaningful employment that incorporate the measures of success. **Test ideas** within the supported employment system to promote the measures of success and sustained meaningful employment.	Individuals from all areas of the supported employment system participate in project Participants report increased understanding for other system participants and their experiences, strengths and limitations Participants report increased commitment to sustained, meaningful employment for individuals with SMI	Development of measures of success for sustained and meaningful employment Participants implement ideas to test measures of success Participants share learning with the larger mental health and supported employment system	Transform the Mental Health System Promote Interagency Collaboration Related to Mental Health Services, Supports and Outcomes

Work for Wellness: Phase Two Logic Model					
Needs being Addressed	**Learning**	**Activities/Strategies (How to Learn and Address Needs)**	**Short Term Learning/ Outcomes**	**Long-Term Learning/ Outcomes**	**Impact or Overall Change**
Despite the existence of evidence-based supported employment practices: Individuals with SMI are often unemployed Few individuals with SMI receive supported employment services Few employers work with supported employment programs The measures of success vary for different parts of the supported employment system.	How to create shared measures of success among all participants in the system? How to increase commitment of all system participants to each other? How to implement common measures of success?	**Reflect** *Supported employment providers and employers (Group One)* meet to reflect on: • What success looks like from an employee's perspective • What mental health and supported employment providers can do to support employee's success • What they need to successfully employ or connect individuals who are diagnosed with SMI • Circumstances when supports are not effective *Employees (Group Two)* meet to reflect on: • What success looks like from an employer's perspective • How individuals who are diagnosed with SMI can partner with mental health providers, supported employment programs and employers • Circumstances when individuals do not meet employer's expectations • The personal development individuals need to be work ready • What resources individuals have to support personal development in preparation for employment • What resources individuals have to support them while they maintain employment **Partner** *Group One and Group Two* meet to share their learning and their role in promoting success. (What is the goal? What would it look like if everyone was working as their BEST self?)	Participants understand employment success from another perspective. Participants identify and consider ways THEY as individuals can make employment more successful. (How can participants extend past limitations?) Participants identify specific ways each stakeholder group can work toward a shared vision of successful employment	Participants present findings to the Mental Health Board Participants and staff create a video to summarize learning for MH providers	Transform the Mental Health System Promote Interagency Collaboration Related to Mental Health Services, Supports and Outcomes

Mental Health Services Act

Collaborative Statewide Early Psychosis Program Evaluation

Deliverable 2:

Summary Report of the Activities of the LHCN

Final version submitted June 30, 2022

Prepared by:

University of California, Davis, San Francisco and San Diego

This report was supported by:

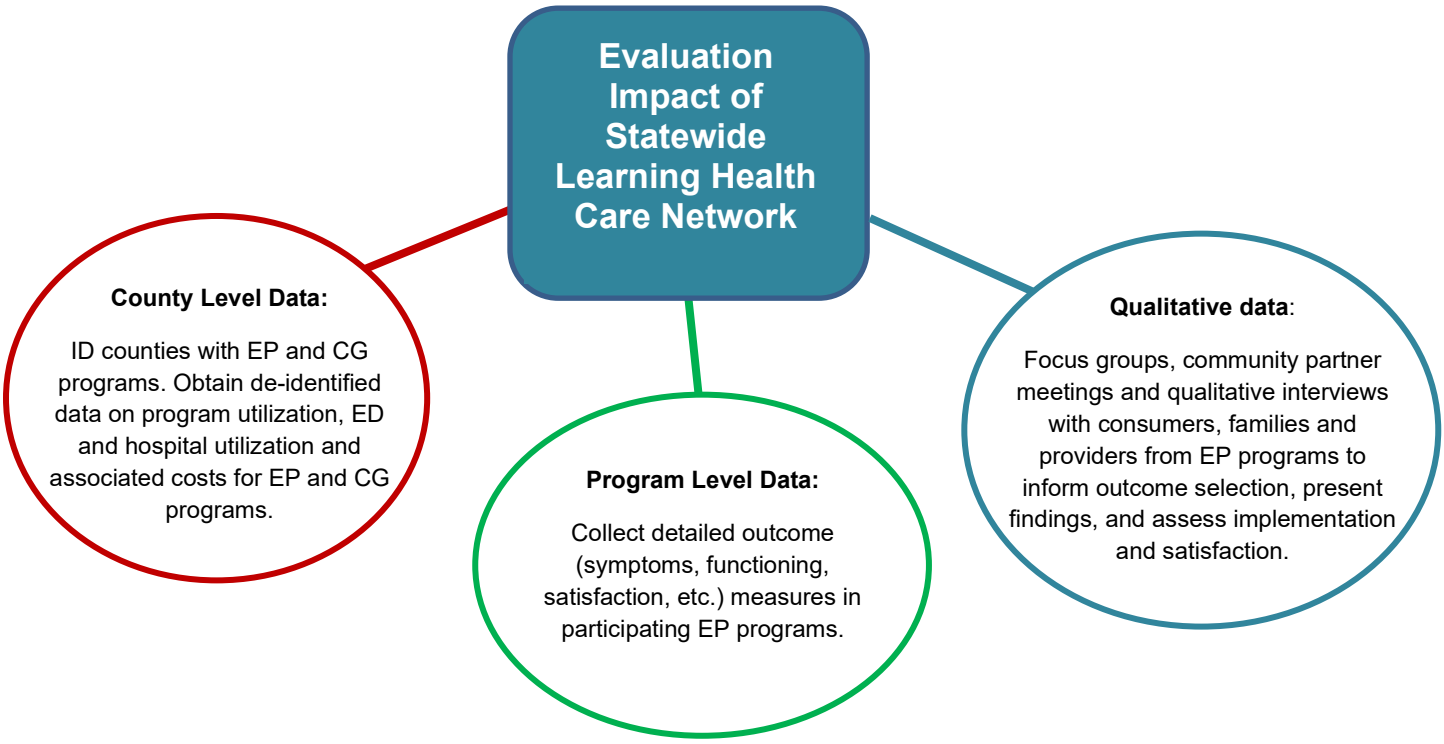
Table of Contents

Background

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

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

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



This project was approved for funding using Innovation Funds by the MHSOAC in December of 2018. The California Early Psychosis Learning Health Care Network (LHCN) represents a unique partnership between the

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

The purpose of the current Deliverable is to provide updates on progress since our last Deliverable report was submitted. The EPI-CAL team has made significant progress since our last Deliverable report. See below for more detail.

Current Project Goals

The current document summarizes project activities for the LHCN for the current deliverable period of the project. This includes the following project activities:

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

1.14 Finalize methods for multi-county-integrated evaluation of costs and utilization data

2.1 Provide quarterly phone/videoconference meetings with all participating county leadership and available EP program staff

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

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

2.13 Provide technical assistance to EP Program

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

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

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

Specifically, in each county we will identify an early psychosis (EP) group consisting of individuals served by the early psychosis program. We will also identify a comparator group (CG), consisting of individuals with EP diagnoses, within the same age group, who enter standard care outpatient programs during that same time period. This analysis focuses on data from Los Angeles, San Diego, Orange, Napa, Stanislaus, and Solano counties. For this component of the project, the evaluation has two phases: 1) the three years prior to the start of this project (e.g., January 1, 2017 – December 31, 2019) to harmonize data across counties and to account

for potential historical trends and 2) for the 2.5-year period contemporaneous with the prospective EP program level data collection (January 1, 2020 – June 30, 2022).

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

Table I. Multicounty Program Services and Billing Information

County	**San Diego**	**Orange**	**Solano**	**Napa**	**Stanislaus**
Program Name	Kickstart	OC CREW	Aldea SOAR	Aldea SOAR	LIFE Path
Clients Served	FEP, CHR	FEP	FEP, CHR	FEP, CHR	FEP, CHR
Census	140-160	42	26	10-15	Current 10-15, cap 40
Length of Services	(+/-) 2 yrs	2 - 4 yrs	(+/-) 2 yrs	(+/-) 2 yrs	2 yrs
Inclusion - Ages	Ages 10-25	Ages 12-25	Ages 12-30	Ages 8-30	Ages 14 - 25
Inclusion - Diagnoses	Any type of psychoses (NOS) but not required, SIPs score of 6	FEP	CHR diagnosis or FEP within 2 yrs	All Psychotic D/Os (within 2 yrs of meeting dx criteria) & CHR diagnosis	Psychotic d/os within 1 year of meeting dx criteria including affective, & CHR diagnosis
Inclusion - Insurance	Medi-Cal, Uninsured	None	Medi-Cal, Uninsured	Medi-Cal, Private, Uninsured	Medi-Cal, Private, Uninsured
Inclusion - Duration of Psychosis	First psychotic symptoms within 2 yrs	First psychosis within 2 yrs	First psychosis within 2 yrs	First psychotic episode within 2 years; Attenuated psychosis of any duration	First episode within 2 years;

Exclusion - Cognition	IQ < 70 - Case by case discretion	IQ < 70	IQ < 70	IQ < 70	IQ < 70, Substance induced psychosis, psychosis due to medical conditions including TBI
Exclusion - Diagnoses	Case by case discretion: Medical diagnosis that better explains symptoms; substance use	No substance use or medical condition that better explains symptoms	Substance dependence would not allow to participate in treatment – refer to substance abuse treatment, Head injury or medical condition	Substance dependence would not allow to participate in treatment – refer to substance abuse treatment, Head injury or medical condition	
Exclusion - Other	Qualitative Judgement call: Physically aggressive, sexually inappropriate, safety issues	Not received counseling prior for psychotic disorder in the last 24 months	Qualitative Judgement call: Physically aggressive, sexually inappropriate, safety issues	Qualitative Judgement call: Physically aggressive, sexually inappropriate, safety issues	Qualitative: requires 24 hour care/higher level; staff/peer safety issues
Assessments - Billing Codes	10	90899-6 (H2015)	90791	10	10
Assessments - Provider type	Clinicians	Clinician: master's level BHCI, BHCII, psychiatrist	Therapist; clinical supervisor	Therapist	LPHA
Assessments - Notes	Behavioral Health assessment and HRA (high risk assessment)	Code 90899-6 for each of multiple sessions leading up to intake completion; Same code for psychiatrist completing conservatorship evaluation, disability assessment, or eval for med services by telephone		Initial, Annual/ Periodic	Initial, periodic
Targeted case management - Billing Codes	50	90899-1 (T1017)	T1017	50	50

Targeted Case Management - Provider Type	All direct service staff: clinical team, OT, Peer Support or EES. As well as medical team (NP, Psychiatrist, or LVN)	BHCI, BHCII, psychiatrist, Mental Health Specialist, Psychiatrist, Behavioral Health Nurse, Mental Health Worker	Therapist, family partner; Medical director or PNP	Therapist, Family Partner/ Peer Case Manager	Clinician, Behavioral Health specialist
Targeted Case Management - Notes	Monitoring progress toward goals - information gathered from schools and parents	A variety of services can be billed under case management as long as they referred to coordination of care, monitor service delivery and linkage access to community services.	Examples: Therapist discusses client with PNP or Family Partner; Therapist or Family Partner discusses client need for housing with Caminar; Therapist facilitates client's transition to a new service upon completion of program	Linkage to Resources; SEE support	Linkages, evaluate other program/resource progress; verify progress
Group Psychotherapy - Billing Codes	35	90849 (H2015)	H2017	31 or 35 (Peer & MFG); Non-Bill (FSG)	38, 36
Group Psychotherapy - Provider Type	Clinician, Peer Support Specialist, Education Employment Specialist, OT	BHCI, BHCII, Mental Health Specialist, Behavioral Health Nurse	Therapist, Family Partner	Therapist, Family Partner/ Peer Case Manager	Clinician, Behavioral Health Specialist, Family Advocate
Group Psychotherapy - Notes	10 different groups offered. Collateral services billed 8-15 to capture other support specialist for any group with multiple facilitators	Group Psych-multifamily	Group rehab	Multi-Family Group, Family Support Group, Peer Group(s) for Adolescents & Adults	Multi-Family Group, Social Skills/Life Skills Group

1.14 Finalize methods for multi-county-integrated evaluation of costs and utilization data

The proposed analysis is based on pilot work conducted in Sacramento County, scaled to multiple counties (Niendam et al., 2016). It focuses on consumer-level data related to program service utilization, other outpatient services utilization, crisis/ED utilization, and psychiatric hospitalization and costs associated with

these utilization domains during two time periods: 1) the three years prior to implementation of project tablet in the Early Psychosis (EP) programs (e.g., Jan 2017 – Dec 2019), to harmonize data across counties and account for potential historical trends, and 2) for the 2.5 year period contemporaneous with the prospective EP program level data collection via the tablet (Jan 2020 - June 2022). Below, we describe the data extraction and analysis plans for the first time period.

Early Psychosis (EP) sample
First, all individuals entering the EP programs January 1, 2017 – December 31, 2019 will be identified using County Electronic Health Record (EHR) data. This list will be cross-referenced with the County EP program(s) to identify those individuals who received treatment versus only eligibility assessment and referral to another service. *We will restrict the comparison to individuals diagnosed with first-episode psychosis (FEP), and not include those at Clinical High-Risk (CHR) for psychosis, due to an inability to reliably identify individuals with CHR in the comparator group.*

Comparator Group (CG) sample
We will compare the utilization and costs of the FEP participants in EP programs to utilization and cost among a group of FEP individuals with similar demographic and clinical characteristics who do not receive care in the EP program during the same timeframe in the same County. FEP individuals meeting the same eligibility criteria for the EP program (e.g., FEP diagnoses, within the same age group) who enter standard care outpatient programs in the County during that same time period will be identified as part of the comparator group (CG). First, we will identify all FEP individuals meeting these criteria receiving any outpatient services who are not served in the EP program. The Comparator Group (CG) was defined as 1) any individual seen in outpatient mental health services between January 1st, 2017 - December 31st, 2019; 2) age as of first date of service during this period: 12 years 0 days – Less than 26 years 0 days; and 3) any primary psychosis diagnosis during this period. We also requested that the counties submit a dataset of prior diagnoses and service utilization for the period of January 1, 2013 – December 31, 2017. This will allow us to correctly identify individuals with “first episode psychosis” (FEP) for our sample. This is defined as individuals who received a psychotic disorder diagnosis within two years of their index service date. The index service date is the first outpatient service associated with a primary psychotic disorder diagnosis in the study period.

Service Utilization
Next, data will be requested from the County EHR on all services received by individuals in the EP programs and all services for members of both groups including 1) any non-EP outpatient services; 2) inpatient services and 3) crisis/ED services. As possible, we will also work with other systems identified by EP programs as having service use data not otherwise captured in the County EHR (e.g., databases of other EP program services; private inpatient hospitalizations not billed to the County; non-billable services, etc.). We have identified these potential additional sources of data in expert interviews with program directors and senior program staff to date and will investigate their availability once groups are defined.

Costs
Costs per unit of service will be assigned to each type of service. We will work with county staff to identify the most accurate source of cost data. This may include internal financial accounting systems, contracts, cost reports, or published rates. We will determine whether to apply a single cost across all services (by type of service) or to apply costs that are county or provider specific. We will include billable and non-billable services. Outcomes will be calculated per month to account for varying lengths of time receiving services during the active study period. Additional details on outcomes and cost data sources are described in Table II below.

Table II. Outcomes, Sources of Outcome Data, and Methods to Determine Costs Associated with Outcomes

Potential Outcomes of Interest	Sources of Data on Relevant Outcomes	Levels of Analysis	Sources of Cost Data associated with Outcomes
COUNTY LEVEL DATA VARIABLES			
Inpatient hospitalization for mental health concerns	• County hospitalization records	• Number/proportion of individuals hospitalized per group • Number of hospitalizations per client • Duration of each hospitalization (days) • Total duration of hospitalizations (days) per client	• Daily rate paid by County • Daily rate Medi-Cal reimbursement
Emergency Department or Crisis stabilization	• County crisis stabilization unit records	• Number/proportion of individuals with crisis visits per group • Number of visits, per client • Duration of each visit (hours) • Total duration (hours) of all visits, per client	• Hourly rate paid by County
Outpatient service utilization	• Service unit records by outpatient program from County *Examples:* • Assessment • Case management • Group Rehab • Group Therapy • Individual Rehab • Individual Therapy • Family Therapy • Plan Development • Medication management • Collateral Services • Crisis Intervention	• Service type • Number of service units (minutes)	• Contract service unit rates

Statistical Methods

Multi-County Analysis

The data will be harmonized on demographics, diagnoses, and service types across all participating LHCN counties, for EP and CG groups, then merged into a single dataset for our primary analyses. This combined, multi-county dataset will provide increased statistical power, allowing for a richer set of controls and error structure without compromising efficiency.

Analysis of Sample Characteristics

Student T-tests and Pearson Chi-square (or Fisher's exact) tests will be used to compare unadjusted group differences in demographic characteristics (e.g., age, sex, race, ethnicity, etc.) between the individuals in the

EP and CG groups. Both unadjusted and adjusted analyses will be used to examine group differences in clinical characteristics at time of index service such as primary diagnosis, as well as the duration of enrollment.

Analysis of Outpatient Service, Day Service/Crisis Stabilization, and 24-Hour/ Inpatient Psychiatric Hospitalization Data

All service data outcomes will be analyzed with a simple empirical equation: the independent variable is regressed on a county-specific fixed effect, an epoch-specific fixed effect, an indicator taking 1 for the EP group and 0 otherwise, a set of interactions between the EP group indicator and each epoch allowing the effect of the EP program to vary over time, and a set of individual-specific controls - measured at intake - consisting of sex, ethnicity, race, and primary language. We will use all demographic variables that were available and harmonized across all counties in time for this preliminary analysis. Standard errors will be always clustered at the individual-level because repeated measures of the same outcome for the same individual are correlated, and we are interested in describing individual-level differences. Further processing of the data will allow the addition of other individual-specific controls and clinic-specific effects to the empirical equation to account for other sources of confounding variation. These will be included in future analyses.

Total outpatient service time (in minutes) of all outpatient services and total minutes of each service type (e.g., medication management, individual therapy, group therapy, rehab services), and time per month will be analyzed by estimating the empirical equation described above with negative binomial regression for count data to determine if outpatient service use differs between the EP and CG samples.

Data related to individuals' use of Day Service/Crisis Stabilization, and 24-Hour/ Inpatient Psychiatric Hospitalization Data usage will be examined using multiple measurements based on the study period: 1) a binary indicator for whether the individual had ever been hospitalized; 2) a binary indicator for whether the individual had ever utilized crisis services; 3) number of hospitalizations per month; 4) number of crisis visits per month; and 5) mean duration of hospitalizations (i.e., length of stay [LOS]) in days; 6) mean LOS for Day/Crisis services (hours); 7) total duration of hospitalizations per month; and 8) total duration of Day/crisis services per month. Data for (1) and (2) will be analyzed by estimating the empirical equation described above with multiple logistic regression. Data for (3), (4), (7), and (8) will be analyzed by estimating the empirical equation described above with negative binomial regression for count data. Data for (5) and (6) will be analyzed by estimating the empirical equation described above with linear regression. These various methods will allow us to determine whether each respective outcome differed between the EP and CG samples.

Data transfer methods

While data transferred between EP program staff and County data analysts within the same County may be identifiable, all information will be de-identified and provided with a unique numeric ID before being submitted to the UCD evaluation team. Data will be shared through an encrypted and password protected SFTP server, which is housed on UCD secure servers. Counties will not have access to any identifiable data from the other counties. Counties receive instructions for uploading their data to the secure SFTP server. Each county is given a unique login and is able to securely login into the SFTP portal and upload their data directly to the UCD servers. Once we receive the data, we confirm with the county that all the information was received.

2.1 Provide quarterly phone/videoconference meetings with all participating county leadership and available EP program staff.

We have maintained a detailed meeting and call log over the course of the LHCN project, which includes dates, attendees, and the purpose of each call or meeting. These calls and meetings include county data analysis planning, focus group planning, training meetings, discussing data and preliminary results, and

reviewing project timelines. Please see Appendix I for details summarizing calls for the third and fourth quarter of Fiscal Year 2021/22.

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

Please note that our team is swiftly moving away from using the term "stakeholder" as it holds a violent connotation for Indigenous communities. We are now using the term "community partner" instead. This is the word you will see when we describe how we have met this deliverable.

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

We held the most recent Advisory Committee meeting on June 10, 2022. The meeting was held remotely due to the continuing COVID-19 pandemic. See Appendix II for a detailed agenda and Appendix III for a full list of attendees. During the meeting, we discussed recruitment and enrollment progress and challenges. Kathleen Nye gave a general overview of the status of training and enrollment across the LHCN. While many programs are making progress using Beehive (i.e., enrolling clients and supporting completion of surveys), as many programs have not integrated Beehive into their program to the degree necessary to achieve project aims. We discussed in the meeting that there are many reasons for this. For example, Lindsay Banks presented initial impressions from the barriers and facilitators interviews which have begun at sites who have been using Beehive consistently.

The next part of the meeting consisted of three breakout rooms, facilitated by EPI-CAL research team members, to brainstorm solutions to the challenges identified in the barriers and facilitators interview. The three topics for the breakout rooms were 1) Incorporating Beehive in Care, 2) Client Engagement, 3) Training & Beehive Learning Curve. The purpose of these groups was to hear from the EPI-CAL network what solutions they think would work best for them. To this end, each group was asked to identify two to three concrete and actionable solutions to address challenges and barriers associated with each discussion topic.

After the breakout rooms, the final portion of the meeting was devoted to debriefing in a large group discussion. Each breakout group shared their discussion and solutions with the larger group.

The Training & Beehive Learning Curve group shared that hands-on, one-on-one trainings have been helpful to reinforce concepts discussed in the large all-team Beehive core trainings. The group agreed that both live trainings and recordings of those trainings are important to engage different members of the team. Due to the large turnover at most programs, there is a need to retrain staff across multiple programs at regular intervals. One solution for this that was proposed is to offer network-wide trainings for new staff. There was agreement that having materials to reference alongside asynchronous training or to reference after a training is helpful (e.g., Beehive Resource Guide), and that sites would like more materials to support their usage of Beehive, such as one-page instruction sheets for certain workflows in Beehive. Beehive office hours where individuals can drop-in and ask questions in a group setting was another proposed solution. Finally, group participants agreed it would be helpful to have more guidance on creating increased buy-in for clients when clinicians are

introducing Beehive. Currently, the EPI-CAL team has created scripts and flyers for this purpose, but the group agreed they would like to hear more from the other breakout rooms about additional solutions to this issue.

The Client Engagement group included our peer and family partners in attendance at the advisory committee meeting. One solution proposed for providers is understanding that the process for engaging each client will be somewhat unique and tailored to that individual. Flexibility is needed. For example, if the day the team planned to introduce Beehive seems to be a day where the client is very overwhelmed or symptomatic, the team can choose not to introduce on that day but should try to re-introduce another time. One family partner shared the importance of reminding clients and families why this information is important in care. Some family members may not understand the relevance of questions about health history, for example. Explaining the relevance of certain questions and domains could increase buy-in. One peer shared the importance of including peers in clinical roles due to the powerful connection that peers can form with clients. If a peer shares a message about why Beehive is important, that may mean more to a client. Similarly, the importance of reminding individuals that this application—and all the questions in it—were developed in collaboration with peers and family members across the state and include the things they thought were important was discussed.

The Incorporating Beehive Into Care group shared details about the barriers they have experienced and possible solutions for each. One challenge is that clinical teams are having trouble integrating Beehive into their existing process. Lack of resources and limited time when teams are short staffed is a huge barrier. Possible solutions for this are: 1) to create a specific policy for adding Beehive into the intake procedure, 2) for leadership to ensure that clinical teams have time set aside for Beehive use and learning, 3) and to consider collecting the minimum necessary information. Another barrier is that use of Beehive is a shift in usual practice, and a possible solution for this is increasing visual reminders about Beehive. One program leader shared that use of Beehive on the tablets was helpful for staff to become more familiar with Beehive. A clinician and supervisor shared that they might benefit from a Beehive flyer which could be a reminder to use Beehive. It was also mentioned from several different attendees that engaging Beehive and using Beehive in-person has been more successful than engaging clients remotely via telehealth. To conclude the Advisory Committee meeting, Dr. Tara Niendam addressed that the change to practice needed to integrate Beehive into care is difficult, and we are all working hard to make the changes needed. To that end, closing remarks also addressed the need for program leadership to make the space and time for their program staff to learn and use Beehive.

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

We held a series of meetings with the EP program staff and county staff to address collection of the county-level utilization and cost data for the prior 3-year timeframe for the following counties: Los Angeles, Napa, Solano, San Diego, and Orange. We identified EP program information, including description of clients served, billing codes for each service, funding sources and staffing personnel during the retrospective period. Meetings were also held with the county data analysts to discuss details about the data extraction. The discussion included the time-period, January 1, 2017 – December 31, 2019, for which the LHCN team requested data, description of the clients from EP programs, description of CG clients, services provided by each program, other services provided in the county to the EP clients (i.e., hospitalization, crisis stabilization and substance use) and data transfer methods. Follow-up meetings with county data analysts have been scheduled. We will hold our retrospective data request meeting with Stanislaus County during the next deliverable period as per their contract.

Data Collection Process

These data extraction procedures have been completed for Los Angeles, Orange, San Diego and Solano counties. Napa and Stanislaus counties will complete the data extraction and upload data for future deliverables, as per their contracts.

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

Each county received the following data request via email:

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

For each service, each county was asked to check for these data elements and include as available: service/procedure code; location code, facility code; date; EBP/supported service code; charge description; minutes; number of people in service; episode of care (EOC); encounter type; HP1 and HP2; division; building; face to face; and place of service. We also requested a data dictionary from each county.

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

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

2.10 Report on feasibility of obtaining cost and utilization data

Our team provided support to the county data analysts and EP program managers regarding the cost and utilization data extraction and integration process through a series of email and phone conversations. The counties submitted their EP utilization, CG utilization and cost retrospective datasets through the secure web portal on the following dates: Orange County – EP dataset: December 7, 2020, CG dataset: November 15, 2021, cost dataset: November 8, 2021; San Diego County – EP dataset: December 22, 2020, CG dataset: September 9, 2021, cost dataset: January 3, 2022; Solano County – EP dataset: February 2, 2021, CG dataset: September 14, 2021, cost dataset: April 25, 2022; Los Angeles County – EP dataset: February 18, 2021, CG dataset: October 4, 2021, cost dataset: submitted with services data. Additionally, we requested a data dictionary from each county in order to accurately identify each variable and received the data dictionaries from all counties who submitted datasets. Napa and Stanislaus County will deposit their datasets during the next project period.

The cost data obtained thus far from each county are described in Table III, below. Los Angeles, Orange, and Solano counties submitted cost rates (i.e., total cost of the service and the service unit). In Los Angeles County, outpatient service costs are standardized per fiscal year for all providers. For Orange, Solano, and San Diego counties, service costs vary across programs. To account for these differences, Orange and Solano counties submitted price lists for services provided by their respective EP program and other programs in the county. To ensure the most accurate data were received, San Diego County provided final, reconciled costs attached to each Medi-Cal reimbursable service. We also requested that each county provide us with contracts and budgets for their EP programs as a way to account for non-billable activities and other unaccounted-for costs of running the program.

Table III: Cost data received from each county

County	EP Program Budget	EP Program Contract with County	Outpatient Service Rates	Day/Crisis Stabilization Service Rates	24 hour: Inpatient/residential Service Rates
Solano	TBD	TBD	Costs related to outpatient service use were based on contract service rates. Each outpatient service included a price per unit of service.	Costs related to day services/crisis stabilization were based on contract service rates. Each service included a price per unit of service.	Costs related to 24 hour services were based on contract service rates. Each service included a price per unit of service.

Orange	Received	N/A	Costs related to outpatient service use were based on contract service rates. Each outpatient service included a service unit rate and number of service units (in minutes)	Costs related to day services/crisis stabilization were based on contract service rates which included a service unit rate and number of service units (in minutes)	Costs related to 24-hour services were day rates which varied by contract. Inpatient/hospital stays include negotiated bed day rate for each HCA contracted acute inpatient facility. These rates are different from the general regional rates set by DHCS. Skilled Nursing Facility (SNF)/IMD rates were averaged and include a bed day rate. Crisis Residential rates include a day rate and charge for the medical services by the minute
LA	Awaiting annual allocation amounts	To be received: annual allocation amounts for the three CAPPS clinics	Costs rates were attached to each service and included all service types. For outpatient services, each cost rate was the total cost of the service and the service unit (recorded in minutes)	Costs related to day services included total cost of the service and the service unit (recorded in minutes)	Costs related to 24-hour services include inpatient county hospitals, Fee-for-Service hospitals and County contracted providers. These costs include total cost of the service and cost per service unit (recorded in days)
San Diego	Budgets calculated through annual allocation amounts	Received	County interim cost rates for outpatient services per service unit (15 minutes, bill in one-minute increments). Published reimbursable cost rates and actual reimbursable cost rates for EP community services, including case management, mental health services, medication support, and crisis intervention	County interim rates for day services/crisis stabilization per service unit (in hours)	County interim rates per service unit (in days) for inpatient/hospital stays, crisis residential, and therapeutic foster care. Contracted inpatient hospital rates for adult and adolescent services, effective February 1, 2020. Regional rate, effective July 1, 2021, for non-contracted inpatient hospitals

Description of submitted data

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

Table IV: Summary of clients for all counties- retrospective data pull

County	FEP served	CHR served	Total Number of Clients in EP Group
Orange	Y	N	87
San Diego	Y	Y	353
Solano	Y	Y	78
Los Angeles	Y	Y	91
Napa	Y	Y	TBD
Stanislaus	Y	Y	TBD

As anticipated, there is some variation in the data elements available for each county, which are summarized here and listed in Table V below.

Table V. Client and utilization data elements summary for all counties retrospective data

Data Type	Data Element	Source	County Availability
Non-identifying ID	Identifying client ID removed and new ID assigned	County	Available: Orange, LA, San Diego, Solano TBD: Napa
Program Name	Program Name	County	Available: Orange, LA, San Diego, Solano TBD: Napa
Psychosis – category	1) Clinical High Risk (CHR) and enrolled in treatment 2) First Episode Psychosis (FEP) and enrolled in treatment 3) Assessed and referred out during Jan. 1, 2017 – Dec. 31, 2019 (add reason, if possible) 4) Other and reason (e.g., incorrectly assigned to EP program)	Program	Data elements # 1 and # 2 available: Orange, LA, San Diego, Solano Data element # 3 available: Solano; N/A: Orange, LA, San Diego Data element # 4 available: Solano, San Diego; N/A: LA, Orange All data elements TBD: Napa
Assessed and referred out - open ended	Assessed and referred out – reason	Program	Available: Solano; N/A: Orange, LA, San Diego TBD: Napa
Other and reason - open ended	Other – reason	Program	Available: Solano;

			N/A: Orange, LA, San Diego TBD: Napa
Diagnoses associated with the episode of care	Diagnosis – Psychiatric	County	Available: Orange, LA, San Diego, Solano TBD: Napa
	Diagnosis – Substance use	County	Available: Orange, LA, San Diego, Solano TBD: Napa
	Diagnosis – Physical health	County	Available: Orange, LA, San Diego, Solano TBD: Napa
Date of birth	Year & month of birth (not date)	County/Program	Available: Orange, LA, San Diego, Solano TBD: Napa
Location (client zip code)	Zip code (as of first EP service)	County/Program	Available: Orange, LA, San Diego, Solano TBD: Napa
Demographics **(as of first EP service)**	Race	County	Available: Orange, LA, San Diego, Solano TBD: Napa
	Ethnicity	County	Available: Orange, LA, San Diego, Solano TBD: Napa
	Gender	County	Available: Orange, LA, San Diego, Solano TBD: Napa
	Education level	County	Available: LA, San Diego, Solano; N/A: Orange TBD: Napa
	Marital status	County	Available: LA, San Diego, Solano; N/A: Orange TBD: Napa
	Preferred language	County	Available: Orange, LA, San Diego, Solano TBD: Napa

	Insurance status (i.e., insurance type)	County	Available: Orange, LA, San Diego, Solano TBD: Napa
	Employment status	County	Available: LA, San Diego, Solano; N/A: Orange TBD: Napa
	Living arrangement (housing status)	County	Available: Orange, San Diego, Solano; N/A: LA TBD: Napa
	Sex assigned at birth	Program	Available: Orange, San Diego, Solano; N/A: LA TBD: Napa
	Gender identity	Program	Available: Orange, San Diego, Solano; N/A: LA TBD: Napa
	Sexual orientation	County	Available: Orange, San Diego, Solano; N/A: LA TBD: Napa
	Military service / Veteran status	County	Available: Orange, San Diego, Solano; N/A: LA TBD: Napa
	Foster care / Adoption	County	Available: San Diego, Solano; N/A: LA, Orange TBD: Napa
Outpatient mental health services in EP program between Jan. 1, 2017 – Dec. 31, 2019	Date	County	Available: Orange, LA, San Diego, Solano TBD: Napa
	Duration	County	Available: Orange, LA, San Diego, Solano TBD: Napa
	Service / procedure code	County	Available: Orange, LA, San Diego, Solano

			TBD: Napa
	Funded plan (original pay sources, subunit)	County	Available: Orange, LA, San Diego, Solano TBD: Napa
	Service location code	County	Available: Orange, LA, San Diego, Solano TBD: Napa
	Facility code	County	Available: Orange, LA, San Diego, Solano TBD: Napa
	Evidence Based Practices (EBP) / supported service code	County	Available: Solano, LA; N/A: Solano, Orange, San Diego TBD: Napa
	Medi-Cal beneficiary	County	Available: Orange, Solano; N/A: LA, San Diego TBD: Napa (claims person will have information on private insurance)
All other mental health services utilized by clients that started services between Jan. 1, 2017 – Dec. 31, 2019	Service / procedure code	County	Available: Orange, LA, San Diego, Solano TBD: Napa
	Location code	County	Available: Orange, LA, San Diego, Solano TBD: Napa
	Facility code	County	Available: Orange, LA, San Diego, Solano TBD: Napa
	Service Date	County	Available: Orange, LA, San Diego, Solano TBD: Napa
	Evidence Based Practices (EBP) / supported service code	County	Available: LA; N/A: Solano, Orange, San Diego TBD: Napa
	Service – Inpatient	County	Available: Orange, LA, San Diego, Solano TBD: Napa (Inpatient hospitals: Crestwood BH, state hospital, Bella

			House (12 bed psychiatric transitional program), (Crestwood may serve minors))
	Service – Crisis residential	County	Available: Orange, LA, San Diego, Solano TBD: Napa (Progress Place is the name of the crisis residential service in Napa County)
	Service – Crisis stabilization	County	Available: Orange, LA, San Diego, Solano TBD: Napa (Crisis stabilization unit for Napa County is operated by Crestwood and serves both youth and adults)
	Service – Urgent care	County	Available: Orange, LA, San Diego, Solano May be available: Napa
	Service – Long-term care	County	Available: Orange, LA, San Diego, Solano TBD: Napa
	Service – Forensic services and jail services	County/Program	N/A: San Diego, Orange, LA, Solano TBD: Napa
	Service – Referrals	Program	N/A: Solano, Orange, LA, San Diego TBD: Napa
	Service – Law enforcement contacts	Program	N/A: Orange, Solano, San Diego, LA TBD: Napa
	Service – Justice system involvement	Program	Available: San Diego N/A: Orange, LA, Solano TBD: Napa
	Service – Regional center involvement (any developmental issues)	Program	Available: San Diego; N/A: Orange, LA, Solano TBD: Napa
	Service – Substance use services	County	Available: Orange; N/A: Solano, San Diego, LA TBD: Napa

Over the last two deliverable periods and the current period (January 2021 through June 2022), we have held a series of follow-up meetings with each EP program's staff and County staff to address questions and gaps in the data submitted to us. This iterative process reflects significant effort contributed by the EP programs, County staff, and our team. As a result, we are confident that we have received/will receive all relevant data that is possibly available for this analysis.

On May 26, 2022, we met with Napa County to review the retrospective three-year period January 1, 2017 – December 31, 2019 data request and answer any questions Napa County had about depositing the data. Napa County will deposit their datasets during the next deliverable period. We anticipate that we can implement a streamlined process with Napa County based on the experience gained to date with the four prior counties.

2.13 Provide technical assistance to EP Program

Napa SOAR & Sonoma EMB ASPIRe SOAR Programs

Technical support provided to Napa and Sonoma programs are combined for the purpose of this deliverable because many of the staff overlap between the two programs and thus technical assistance provided has been applicable to both. Between January 1, 2022 and April 27th, 2022, most of the technical support provided to Napa/Sonoma Aldea SOAR sites were conducted through emails, live Zoom meetings with leadership, and one-on-one Zoom meeting support with clinicians. Once a week, Katherine Nguyen, EPI-CAL staff member and designated point person for Napa/Sonoma, would compile and send a check-in email, which includes a list of clients currently in survey window, clients who have not chosen their End-User License Agreement to share their data permission with UC Davis and the NIH, clients without diagnoses, and/or any other Beehive related issues and updates. During the live Zoom meetings with leadership in January and early February, we discussed enrollment expectations and reviewed some basic functions of Beehive, such as how to close episodes, how to access surveys, how to re-send surveys, and how to track survey due dates. Through these meetings, we were able to determine key issues and tailor a booster training session to help support the clinic staff. On February 24, 2022, Katherine Nguyen, along with EPI-CAL staff member Chris Hakusui, lead a Beehive booster training for Napa/Sonoma Aldea SOAR staff and reviewed how to access client's EULA completion status, how to view the surveys currently assigned to clients and their primary support persons and when their survey window closes, how to view clients' and their primary support persons' survey responses, how to complete clinician-entered data, and how to respond to urgent clinical issues triggered in Beehive. This booster training allowed clinicians to renew their knowledge and ask specific questions regarding Beehive, which lead to many more one-on-one live support meetings through Zoom in the following months.

Starting on April 27th, 2022, the Aldea SOAR sites (Napa, Sonoma, and Solano) began hosting their big team meeting for two hours every Wednesday morning. During the initial big team meeting, Katherine met with the Aldea SOAR team through Zoom to re-introduce herself and her role as point person, as well as gather feedback from clinic staff members regarding the issues they have identified while using Beehive. With the help of the EPI-CAL team, Katherine was able to propose a few solutions at the subsequent Aldea SOAR team meeting. She also facilitated a discussion with the Aldea SOAR team on ways in which Beehive could be improved to increase clinician's and client's engagement with the application. With the support from Aldea SOAR leadership and their active role in directing questions and concerns from clinic staff to point person, communication between sites and point person have greatly improved. This boost in communication has resulted in clinic staff members resolving urgent clinical issues sooner, volunteering to close discharged clients' episodes on their coworker's behalf, and taking initiative to re-send surveys to clients who have yet to complete them.

Overall, this continues to be an effective collaboration between the Aldea staff and the EPI-CAL team.

Discussion and Next Steps

Discussion

Over this last deliverable period, the team has continued to meet each of the goals that were set to out for this project period. It should be noted that the LHCN represents one of the first collaborative university-county partnerships between the University of California, Davis, San Diego and San Francisco with multiple California counties to implement and expand an integrated Innovation project. Through this endeavor, all parties hope to have a larger impact on mental health services than any one county can create on their own. While the project has experienced some delays in contracting and many barriers due to the global COVID-19 pandemic, the team feels confident that we are making excellent progress at meeting our goals and catching up with the original planned timeline.

We have completed Beehive training with all of the original LHCN counties and are in the midst of training our newest LHCN county program, Stanislaus LIFE Path. We are continuing to collect data on the core outcomes battery for the EPI-CAL project with 18 programs. Based on feedback from users in these programs, we have continued to work with Beehive developers to make modifications to the application, such as extending survey windows, as well as modify our training approach based on constructive feedback from programs.

As noted previously, we were able to successfully complete our primary goal for the retrospective county data analysis, to provide a preliminary demonstration of the proposed method for accessing data regarding EP programs and CG groups across California, and the first part of our secondary goal, to analyze service utilization and costs associated with those services across counties. However, we are still gathering additional data to inform a final analysis of the 2017-2019 period, which we expect to complete by December 2022.

While we were not able to integrate the cost data for all counties, we have described our cost analysis for San Diego County in section 9 above. We have obtained some cost data and are working with our county partners to obtain the remaining information. We are confident that the cost comparison analysis will be completed for the December 2022 deliverable.

Next Steps

In the next project period, we will continue to conduct fidelity assessments with EPI-CAL programs and meet with county and program leadership to provide detailed feedback on fidelity results. We will also continue and complete training of non-pilot EP programs from both the LHCN and larger EPI-CAL network. As implementation of Beehive continues, we will elicit feedback from EP programs how to improve both the training process and Beehive itself via feedback surveys, regular check-ins from point people, and qualitative interviews. Our goal is to continue to improve Beehive in an iterative process and to incorporate community partner feedback so that Beehive be a useful data collection and visualization tool for the programs using it. We are also working with sites to understand why enrollments are not matching the original projections and to support them to increase the degree to which they are integrating Beehive into their standard practice.

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

In addition, for all counties participating in the county data component of the LHCN, meetings will be scheduled over the next several months with each county to review the details of the EP and CG retrospective data pulls, the cost data, and to problem-solve any issues that arise. We will then conduct the statistical analyses for individual counties and across the integrated dataset.

In anticipation of the prospective data analysis, we have met with each county to discuss the timeline for obtaining their data and details of what will be included in the data pull. We will submit the formal data extraction requests in writing in July 2022, after we complete meetings with all relevant parties.

Appendix I: Summary of Meetings and Calls with County and Program Staff (Quarters 3 & 4, Fiscal Year 2021/2022)

Date	County/ Counties	Attendees	Summary of call/meeting
6/24/2022	Stanislaus	Kathleen Nye, Nitasha Sharma, Valerie Tryon (UC Davis), Diane Rose, Paloma Parra, Andromeda Lascano, Lisset Castillo, Lourdes Santos-Ortega (LIFE Path), Lisa Velarde (Stanislaus BHRS)	Training for Beehive iPad app
6/16/2022	Napa	Katherine Nguyen (UC Davis), Rose Perez (Napa SOAR)	Individual Beehive training
6/15/2022	Orange	Merissa Kado, Amanda McNamara (UC San Diego), Carlos Martinez, Ambar Green (OC Crew)	Individual Beehive Training for OC Crew new staff
6/15/2022	Napa	Rose Perez (Napa SOAR), Kathleen Nye (UC Davis)	Fidelity Interview
6/14/2022	Napa	Joaleen Johnson (Napa SOAR), Kathleen Nye (UC Davis)	Fidelity Interview
6/13/2022	Napa	Sarada Oglesby (Napa SOAR), Kathleen Nye (UC Davis)	Fidelity Interview
6/13/2022	Stanislaus	Rachel Loewy, Heather Garman (UCSF) Andrew Padovani (UC Davis) Lisa Velarde, Miranda Chalabi (Stanislaus County)	Retrospective cost and utilization data request
6/10/2022	Solano, Napa, Los Angeles, Sonoma, Stanislaus, San Diego,	See Appendix III	EPI-CAL LHCN Advisory Committee Meeting
6/8/2022	Los Angeles	Samantha Wettimuny, Vanessa Jimenez, Natalie Navarrete, Lindsay Banks (UC Davis)	San Fernando Fidelity Site Leader and Abstractor Training
6/7/2022	Los Angeles	Tara Niendam, Valerie Tryon, Kathleen Nye (UC Davis), Merissa Kado-Walton, Amanda McNamara, Shadeh Rassoulkhani (UCSD), Samantha Wettimuny (LACDMH), Zeida Carnatz (The Help Group)	LACDMH Beehive Integration Update
6/2/2022	Solano	Rachel Loewy, Christopher Blay, Heather Garman (UCSF) Tracy Lacey, Cathy Woodhall (Solano County)	Timeline discussion for availability of prospective cost and utilization data
6/1/2022	San Diego	Kathleen Nye (UC Davis), Hope Graven (San Diego Kickstart)	Meeting to collect program-level survey
5/31/2022	Stanislaus	Valerie Tryon, Sabrina Ereshefsky, Nitasha Sharma, Chelyah Miller, Stephania Hayes (UC Davis) Diane Rose, Tiffany Rivera, Andromeda Lascano, Paloma Parra, Lourdes Santos-Ortega, Dayana Lopez (LIFE Path Program), Enedelia, Denise Dillon, Carlos Cevantes, Lacey West (Stanislaus County Behavioral Health)	Beehive Part 2 Training

5/26/2022	Napa	Rachel Loewy, Christopher Blay (UCSF) Felix Bedolla, Liset Esqueda (Napa County)	Retrospective cost and utilization data request
5/25/2022	Solano	Mark Savill (UC Davis), Kristin LaCross (UCSF), Sarada Oglesby, Natalia Martinez, Erin Zamora, Julie Falicki	Fidelity Feedback Meeting
5/23/2022	Los Angeles	Rachel Loewy, Christopher Blay, Heather Garman (UCSF) Merissa Kado (UC San Diego) Kara Taguchi, Samantha Wettimuny, Lisa Benson, Yen-Jui (Ray) Lin (Los Angeles County)	Timeline discussion for availability of prospective cost and utilization data
5/19/2022	Orange	Rachel Loewy, Christopher Blay, Heather Garman (UCSF) Andrew Padovani (UC Davis) April Howard (Orange County)	Timeline discussion for availability of prospective cost and utilization data
5/16/2022	San Diego	In person: Amanda McNamara, Merissa Kado (UC San Diego), Hope Graven, Abygail Martinez (San Diego Kickstart) Remote: Kathleen Nye (UC Davis), Sandesh Malpure, Raviteja Neeli (Quorum Technologies)	Onsite troubleshooting of Beehive
5/12/2022	Orange	Hilary Peralta, Raquel Williams, Mark Savill (UC Davis), Kristin LaCross (UCSF), Lindsay Banks (UC Davis)	Fidelity Feedback Meeting
5/10/2022	Stanislaus	Nitasha Sharma, Kathleen Nye (UC Davis), Tiffany Rivera, Diane Ross, Liz Castillo (LIFE Path), Lacey West, Lisa Velarde, Carlos Cervantes, Miranda Chalabi (Stanislaus BHRS)	Intake Workflow Meeting for Beehive Integration
5/3/2022	Napa	Sarada Oglesby, Erin Zamora, Erika Alorro, Natalia Martinez, Ricardo Romero, Lindsay Banks (UC Davis)	Fidelity Site Leader and Abstractor Training
4/27/2022	Los Angeles	Amanda McNamara (UC San Diego), Erika Valle Alvarado, Angelica Ahmad (The Help Group)	The Help Group Beehive refresher training
4/25/2022	Solano	Rachel Loewy, Christopher Blay (UCSF) Todd Gilmer (UC San Diego), Andrew Padovani (UC Davis) Tracy Lacey, Cathy Woodhall (Solano County)	Follow-up discussion about received county-level cost and utilization data
4/19/2022	San Diego	Amanda McNamara (UC San Diego), Abygail Martinez (Kickstart)	Follow-up meeting with Kickstart new staff member to discuss progress since training
4/12/2022	San Diego	Amanda McNamara, Shadeh Rassoulkhani (UC San Diego), Abygail Martinez (Kickstart)	Individual Beehive training for new Kickstart staff member
4/8/2022	Los Angeles	Amanda McNamara, Shadeh Rassoulkhani (UC San Diego), Vanessa Jimenez, Arek Yetenekian, Liliana Rojas, Natalie Navarrete (SFVCMHC)	SFVCMHC Beehive refresher training
4/8/2022	Stanislaus	Tara Niendam, Sabrina Ereshefsky, Kathleen Nye, Nitasha Sharma, Chelyah Miller, Katherine Nguyen, Christopher	Beehive Part 1 Training

		Hakusui (UC Davis), Diane Rose, Tiffany Rivera, Lisset Castillo, Andromeda Lascano, Lourdes Santos-Ortega (Stanislaus LIFE Path), Lisa Velarde, Miranda Chalabi, Keri Magee, Carlos Cervantes, Janelle Villaba, Denise Dillon, Enedelia Garcia (Stanislaus BHRS)	
4/4/2022	Los Angeles	Rachel Loewy, Christopher Blay (UCSF) Todd Gilmer, Merissa Kado (UC San Diego) Samantha Wettimuny, Kara Taguchi, Lisa Benson, Yen-Jui (Ray) Lin (Los Angeles County)	Follow-up discussion about received county-level cost and utilization data
4/1/2022	San Diego	Claire Riley (SD County), Tara Niendam, Kathleen Nye (UC Davis), Merissa Kado, Amanda McNamara (UC San Diego)	Met with Claire to discuss outcomes data collection requirements in San Diego county as a barrier for Beehive usage at Kickstart
3/29/2022	San Diego	Tara Niendam, Mark Savill, Lindsay Banks (UCD) Michael J Garrett (Kickstart)	Fidelity Assessment Next Steps
3/28/2022	Stanislaus	Rachel Loewy, Christopher Blay (UCSF) Andrew Padovani (UC Davis) Lisa Velarde, Carlos Cervantes, Miranda Chalabi (Stanislaus County)	Introduction to the county data component of the LHCN
3/21/2022	Napa	Rachel Loewy, Christopher Blay (UCSF) Andrew Padovani (UC Davis) Felix Bedolla, Liset Esqueda (Napa County)	Introduction to the county data component of the LHCN
3/18/2022	Stanislaus, Los Angeles, Orange, Sonoma	Tara Niendam, Kristin LaCross, Kathleen Nye, Sabrina Ereshefsky, Christopher Hakusui, Stephania Hayes (UCD), Tiffany Rivera, Diane Rose (Stanislaus LIFE Path), Arek Yetenekian, Vanessa Jimenez, Liliana Rojas (SFVCMHC), Ambar Green, Luke Tostado, Hilary Peralta (OC CREW), Angelica Ahmad, Erika Valle, Tyler Davis, Isabel Velazquez, Carmen Joma, Destinie Hernandez, Norma Franco, Elsie Martinez, Yenci Garcia (The Whole Child)	Training on Trauma Treatment in EP
3/17/2022	Los Angeles	Merissa Kado, Amanda McNamara, Shadeh Rassoulkhani (UCSD), Tara Niendam (UCD), Samantha Wettimuny (LA County), Zeida Carnatz (The Help Group)	Discussing Beehive Implementation in LA County
3/16/2022	Napa, Los Angeles	Mark Savill, Tara Niendam, Lindsay Banks, Sacramento Team, Napa Team, LA Teams	Introduction to Fidelity Assessments
3/15/2022	Solano	Katherine Nguyen (UCD), Solano Team	Informed site about urgent clinical issue and closing client's episode on Beehive
3/14/2022	Orange	Rachel Loewy, Christopher Blay (UCSF), Andrew Padovani (UCD), Todd Gilmer (UCSD), April Howard	Follow-up discussion about received county-level cost and utilization data
3/1/2022	Solano	Katherine Nguyen (UCD), Solano Team	Asked about due dates for county reporting and reminded site about closing clients in Beehive

2/25/2022	Orange, Los Angeles, San Diego	Tara Niendam, Sabrina Ereshefsky, Kathleen Nye, Katherine Nguyen, Lindsay Banks, Nitasha Sharma (UCD), Christopher Blay (UCSF), James Pelk, Alfredo Flores, Ruby Negrete, Mary Morris, Ali Jazayeri, Gilbert Morquecho (IMCES), Arek Yetenekian, Liliana Rojas, Vanessa Jimenez (SFVCMHC), Erika Valle Alvarado (The Help Group) Samantha Wettimuny (Los Angeles), Jimmy Lee, Laura Venegas, Hilary Peralta, Ambar Green (OC CREW), Hope Graven (Kickstart)	Training on Trauma Assessment in EP
2/24/2022	Napa, Sonoma	Christopher Hakusui, Katherine Nguyen (UCD), Zuly Fernandez, Ricardo Romero, Alice Anamosa, Gwyn Walker, Ellen Nichols, Rose Perez (Napa/Sonoma)	Beehive Booster Training
2/24/2022	Napa, Sonoma	Katherine Nguyen, Christopher Hakusui (UCD), Sarada Oglesby, Natalia Martinez	Relaying enrollment expectations, asking about intake date vs. actual survey anchor date and discharge workflow
2/23/2022	Stanislaus	Nitasha Sharma, Kathleen Nye (UCD), Lisa Velarde, Miranda Chalabi, Janelle Villalba (Stanislaus County), Diane Rose, Tiffany Rivera, Luis Ortega (LIFE Path/Sierra Vista)	Pre-Training Meeting to Prepare for Beehive Training Series with Program
2/18/2022	San Diego	Kathleen Nye (UCD), Amanda McNamara (UCSD), Hope Graven (Kickstart)	Beehive Refresher Training & check-in about site barriers
2/17/2022	Solano	Katherine Nguyen, Christopher Hakusui (UCD), Louise Harris, Peter Chow (Solano)	Closing client episode in Beehive, pushing surveys to clients, and editing client data
2/15/2022	Solano	Katherine Nguyen, Christopher Hakusui (UCD), Solano Team	Discussing discharge protocol, relaying enrollment expecations, asking about clients who aren't in Beehive
2/8/2022	Solano	Katherine Nguyen (UCD), Solano Team	Reminded site of clients currently in survey window and shared Beehive Spanish EULA guidelines
2/4/2022	Stanislaus, Los Angeles	Tara Niendam, Sabrina Ereshefsky, Kathleen Nye, Chelyah Miller, Katherine Nguyen, Christopher Hakusui, Nitasha Sharma (UCD), Diane Rose, Andromeda, Liz Castillo, Jessica Reyna-Gonzalez, Tiffany Rivera, Paloma Parra (Stanlislaus LIFE Path), Denise Dillon, Miranda Chalabi, Carlos Cervantes, Enedelia, Kim Saing (Stanislaus County), Diana McRyan, Erika Valle Alvarado, Angelica Ahmad (The Help Group), Vanessa Jimenez, Arek Yetenekian, Liliana Rojas (SFVCMHC), James Pelk, Michael Juarez, Mary Morris, Lala Abed Cheharmehali, Tara Omrani, Gilbert Morquecho, Dr. Jazayeri, Luis Cordova, ruby negrete, Itoro Udoeyop (IMCES)	Training on EPI-CAL Functioning Assessments (Global Functioning Role & Global Functioning Social Scales)
2/2/2022	Napa,	Christopher Hakusui, Katherine Nguyen	Walkthrough Beehive and clinician-

	Sonoma	(UCD), Sarada Oglesby, Natalia Martinez	entered data, looked at how to access Pathway to Care survey and how to push surveys, discussed survey timeframes
2/1/2022	Solano	Christopher Hakusui, Katherine Nguyen (UCD), Solano Team	Correcting intake dates/answering questions
1/31/2022	Stanislaus	Kathleen Nye (UCD), Lisa Velarde (Stanislaus)	Call to debrief from prior week's intro visit and discuss county need to review consents in advance.
1/31/2022	Orange	Amanda McNamara (UC San Diego), Jordan Harris, Laura Venegas (OC CREW)	Individual Beehive tablet training
1/28/2022	Stanislaus	Tara Niendam, Mark Savill, Kathleen Nye, Nitasha Sharma, Stephania Hayes, Sabrina Ereshefsky, Katherine Nguyen, Christopher Hakusui, Chelyah Miller (UCD), Rachel Lowey (UCSF), Diane Rose, Andromeda Lascano, Paloma Parra, Jessica Reyna, Liza Castillo, Tiffany Rivera (LIFE Path), Denise Dillon, Enedelia, Lisa Velarde, Carlos Cervantes, Miranda Chalabi, Keri Magee, Kim Saing, Janelle Villalba (Stanislaus County)	EPI-CAL Intro Meeting with LIFE Path program and Stanislaus County
1/25/2022	Los Angeles	Amanda McNamara, Merissa Kado, Shadeh Rassoulkhani (UCSD), Kathleen Nye, Nitasha Sharma, Christopher Hakusui, Sabrina Ereshefsky, Chelyah Miller, Katherine Nguyen (UCD), Yair Torres, Cheyenne Spencer, Norma Franco, Isabel Velazquez, Yency Garcia, Carmen Joma, Maria Jauregui (The Whole Child)	Beehive Part 3 Training: The Whole Child
1/25/2022	Solano	Katherine Nguyen (UCD), Solano Team	Correcting intake dates, reminding site about upcoming CSFRA due dates
1/20/2022	Solano	Kristin LaCross, Solano Aldea SOAR Program Staff	Fidelity Interview
1/20/2022	Solano	Kristin LaCross, Solano Aldea SOAR Program Staff	Fidelity Interview
1/19/2022	Solano	Kristin LaCross (UCSF), Solano Aldea SOAR Program Staff	Fidelity Interview
1/19/2022	Solano	Kristin LaCross (UCSF), Solano Aldea SOAR Program Staff	Fidelity Interview
1/19/2022	Napa, Sonoma	Christopher Hakusui, Katherine Nguyen (UCD), Sarada Oglesby, Natalia Martinez	Answering questions about tracking CSFRA due dates and how to close episodes in Beehive
1/18/2022	Solano	Lindsay Banks (UCD), Solano Team	Consent clinical team for fidelity interviews
1/18/2022	Solano	Christopher Hakusui (UCD), Solano Team	Entering EULA and diagnoses
1/11/2022	Solano	Christopher Hakusui, Katherine Nguyen (UCD), Solano Team	Entering EULA and diagnoses
1/10/2022	Solano, Sonoma, Napa	Tara Niendam, Christopher Hakusui (UCD) Solano/Napa/Sonoma Teams	Training: CSFRA Completion & Clinician Entered Data in Beehive

1/5/2022	San Diego	Lindsay Banks, Mark Savill (UCD), Hope Graven	Fidelity Feedback Session
1/5/2022	Los Angeles	Amanda McNamara, Merissa Kado, (UCSD), Kathleen Nye, Chelyah Miller, Katherine Nguyen, Nitasha Sharma, Christopher Hakusui, Sabrina Ereshefsky (UCD), Carlos Velasco, Zeida Carnatz, Rosalinda Sanchez, Erika Alvarado, Angelica Ahmad, Iga Gaj (The Help Group)	Beehive Part 3 Training: The Help Group
1/4/2022	Solano	Christopher Hakusui, Katherine Nguyen (UCD), Solano Team	Correcting intake dates

Appendix II: Advisory Committee Meeting Agenda

California Early Psychosis Learning Health Care Network Advisory Committee Meeting	June 10, 2022 2:00-3:30 PM (PDT)

Meeting called by EPI-CAL Team led by Dr. Tara Niendam, PhD

Attendees: EPI-CAL Team, Representatives from EPI-CAL programs and counties, & Community Partners (EP clients and families)

2:00-2:05 PM **Welcome & Introduction | Valerie Tryon, PhD**

Please put your name and affiliation in the zoom chat when you join

2:05 PM – 2:30 **Enrollment and Implementation Progress & Challenges**

2:05-2:20 General Overview of Training & Enrollment | **Kathleen Nye**

2:20-2:30 Initial Impressions from Barriers & Facilitators Interviews | **Lindsay Banks**

2:30-3:00 **Brainstorming Breakout Rooms**

Incorporating Beehive In Care | **Sabrina Ereshefsky, PhD & Dan Shapiro, PhD**

Client Engagement | **Tara Niendam, PhD & Lindsay Banks**

Training & Beehive Learning Curve **|Valerie Tryon, PhD & Kathleen Nye**

3:00-3:30 **Discussion of Ideas and Solutions**

Led by **Tara Niendam, PhD**

Appendix III: Advisory Committee Attendees

Attendee Name	Attendee Role
Samantha Wettimuny	Program Lead for PIER Early Psychosis Los Angeles County
Felix Bedolla	MHSA Coordinator Napa County
Liset Esqueda	Analyst for Napa County mental health
Hope Graven	Program Director- Kickstart San Diego
Bonnie Hotz	Parent Partner, Former Family Advocate for SacEDAPT
Casandra Singleteary	Parent Partner
Brandon Bond	Peer Partner
Rachel Hotz	Peer Partner
Tara Niendam	Associate Professor, EPI-CAL Principal Investigator
Valerie Tryon	EPI-CAL Project Manager
Kathleen Nye	EPI-CAL Training & Beehive Development Project Manager
Sabrina Ereshefsky	EPI-CAL Postdoctoral Scholar
Nitasha Sharma	EPI-CAL Outcomes Junior Specialist
Katherine Nguyen	EPI-CAL Outcomes Junior Specialist
Karina Muro	Psychology Postdoctoral Fellow - SacEDAPT
Merissa Kado	UCSD Program Evaluations Specialist
Chelyah Miller	EPI-CAL Junior Specialist
Amanda McNamara	UCSD Program Evaluations Specialist
Lindsay Banks	EPI-CAL Clinical Research Coordinator
Stephania Hayes	EPI-CAL Postdoctoral Scholar
Vanessa Jimenez	San Fernando Valley INC
Diane Rose	Program Coordinator, LIFE Path program
Kali Cowden-Sherwood	Mental Health Therapist ACS/SOAR
Cameron Carter	Professor, Co-Investigator EPI-CAL project
Paloma Parra	Clinician, LIFE Path program
Denise Dillon	Behavioral Health Advocate, LIFE Path program
Dr. Gilbert Morquecho	Clinical Supervisor, IMCES
Fabiola Espinosa	Program Planning & Evaluation Analyst, Sonoma County Department of Health Services

Julie Falicki	Program Director, Solano SOAR program
Dr. Ali Jazayeri	Clinical Supervisor, IMCES
Sonya Gabrielian, PhD	Homelessness Consultant for EPI-CAL
Adam Wilcox, PhD	mHealth Implementation Consultant for EPI-CAL
Steve Lopez, PhD	Spanish Language & Latinx Cultural Consultant for EPI-CAL
Adriana Furuzawa	Director of Felton Institute
Dan Shapiro, PhD	EPI-CAL Investigator, Director of Operations for UC Davis Early Psychosis Programs
Don Addington, PhD	Fidelity Assessment Consultant for EPI-CAL
Dayana Lopez	Stanislaus LIFE Path
Elise Martinez	
Heline Mirzakhanian, PhD	Clinical Director of UCSD CARE Program
Kristin Cadenhead, MD	Medical Director of UCSD CARE Program
Lisa Velarde	Stanislaus County Community Grant Coordinator
Lourdes Santos-Ortega	Clinician, LIFE Path Program
Luana Turner, PhD	Clinical Director UCLA Aftercare Program
Monica Done	Clinic Coordinator of UCLA CAPPS Program
Sarada Oglesby	Clinical Director of Aldea SOAR programs (Solano SOAR, Napa SOAR, & Sonoma EMB ASPIRe clinic)
Sydney Hoff	Clinical Director of San Mateo Felton EP Programs
Yair Torres	Program Manager of Intensive Services at The Whole Child

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Appendix 4: Napa County's Proposed Participation in the MHSOAC's FSP Collaborative Innovations Project

County Contact and Specific Dates

- Primary County Contact: Felix Bedolla, MHSA Coordinator, Felix.Bedolla@countyofnapa.org
- Date Proposal posted for 30-day Public Review: Friday, July 8 – Monday, August 8, 2022
- Date of Local MH Board hearing: Monday, August 8, 2022
- Date of BOS approval or calendared date to appear before BOS: TBD

Description of Local Need

FSP Program Overview: Napa County has five Full Service Partnership (FSP) programs. During FY 2020-2021, these programs served a total of 249 consumers served including 54 children served by Children's FSP, 35 youth served by Transition Age Youth (TAY) FSP, 73 adults served by Adult FSP, 34 adults served by the Adult Treatment Team (ATT) FSP, and 53 older adults served by Older Adult (OA) FSP. Individuals who identified as White, 46%, were the highest represented group. Hispanic/Latinos were the second largest group receiving services, 27% of individuals identified as Hispanic/Latino. Only 1% of individuals identified as Native American and under 1% identified as Mixed, making both of these groups the least represented. Napa county FSP programs provided 4,105 aggregate services in FY20-21. The service provided most frequently was intensive care coordination and individual therapy. The services least provided were DBT group rehab intervention, TCM placement service and court related activity.

FSP Challenges: Local stakeholders have identified a number of challenges that could be addressed through the Multi-County FSP Innovation Project.

- **Telling the Story of FSP's Impact:** Local stakeholders have asked the MH Division to provide evaluation data to demonstrate the effectiveness of FSP services. They point out that the MH Division requires contractors to evaluate their own programs and they have expressed strong interest in reviewing FSP evaluation data, however, the following issues have made it difficult to paint an accurate picture of the impact of the FSP services provided by Napa County staff.
- **Data collection, reporting, and training challenges:** Napa County has reported outcomes for the individuals served by the previously mentioned FSPs in the California Department of Health Care Services Data Collection and Reporting (DCR) System. In the early years of MHSA implementation, staff were able to extract meaningful data from the system and generate accurate FSP outcome reports, however, as time went on unresolved DCR issues made it difficult to impossible to extract useful and meaningful data from the DCR System. Additionally, limited training opportunities for FSP staff have contributed to lack of understanding around how to make best use of the DCR system. FSP staff are committed to providing high quality care for their FSP partners and focus on completing progress notes for our Electronic Health Record (EHR). Unfortunately, staff are not as consistent entering data into the DCR and neglect to complete Key Event Tracking or 3M Quarterly Forms because it is separate data entry

process and their priorities are focused on documentation of the services they provide to ensure they are maintaining productivity standards.

- **Lack of Clear Definitions of Discharge Reasons:** When compiling FSP outcomes to report in the FY 21-22 Annual Update, staff determined that FSP programs each have their own understandings and reasons for selecting "Administrative and NA" as the reason for discharge. A significant number of cases were closed under these discharge reasons; however, it is difficult to identify or track a standard for this discharge. Through participation in the FSP Collaborative, staff hope to work with FSP staff to create shared definitions for discharge reasons and identify cases and scenarios when these reasons are applicable and share best practices.
- **Staff Turnover and Outliers:** The MH Division has experienced significant staff turnover throughout the years and some staff have left abruptly without reassigning partners to other staff or closing partners who are no longer receiving services. As a result of this situation, there are outliers in the DCR that skew the outcome results and don't present an accurate picture of the true outcomes of the FSP programs. Efforts to resolve these outliers with DCR Technical Assistance have been unsuccessful and so these outliers continue to skew outcomes and invalidate outcome reports.

Response to Local Need

Through this Innovation proposal, Napa County Behavioral Health Services seeks to participate in the statewide initiative to increase counties' collective capacity to gather and use data to better design, implement, and manage FSP services. The key priorities outlined in the Innovation Plan will allow Napa County Behavioral Health Services to address current challenges and center FSP programs and services around meaningful outcomes for participants. More specifically, participating in this project and aligning with the identified priorities will enable the department to:

1. Develop a clear strategy for how outcome goals and performance metrics can best be tracked using existing state and/or county-required tools to support meaningful comparison, learning, and evaluation.
2. Develop training materials for staff and supervisors to support increased accuracy in the completion of DCR Outcome reports and forms.
3. Develop FSP Outcome and Audit reports that accurately reflect the impact FSP services are having on FSP partners
4. Create a model of best practices that is relevant for the current needs of FSP partners in the age of Covid, housing challenges, etc.
5. Incorporate learnings for other cohorts participating in the Multi-County FSP Collaborative to improve services and practices in Napa County FSPs
6. Improve existing FSP performance management practices (i.e., when and how often program data and progress towards goals are discussed, what data is included and in what format, and how next steps and program modifications are identified).

In addition, this project will provide Napa County Behavioral Health Services the opportunity to share and exchange knowledge with other counties participating in this project and through the statewide learning community.

Local Community Planning Process

As was previously mentioned, stakeholders have been requesting accountability through meaningful evaluation reports for the County's FSP programs. Staff presented this proposal to participate in the Multi-County FSP Collaborative to the Stakeholder Advisory Committee on April 6th, 2022. This proposal was well-received by Stakeholders, who were supportive of the goal of being able to tell the story of the impact of FSP services on community members receiving services.

The Stakeholder Advisory Committee (SAC) has been active in all stages of the MHSA planning throughout since 2006 when the committee was convened to develop and guide implementation of MHSA Components and programs. The SAC has been meeting monthly since that time to share information, changes and updates regarding MHSA Components and programs as well as other Mental Health Division services and plans. Participants work with NCMH to ensure that their constituencies receive the information necessary to be able to give input and participate in the planning process. SAC meetings take place every first Wednesday of the month and meetings are open to the public.

Although the SAC is the most involved in the planning process, other groups also have the opportunity to participate. MHSA information is distributed to MH Division staff, the Napa County MH Board, MHSA Contractors, community mental health providers and the Behavioral Health Cultural Competence Committee.

Public review and public hearing

The 30-day Public Review and Comment Period for the FY 22-23 Annual Update to the MHSA Three Year Plan will take place from Friday, July 8th to Monday, August 8th with a public hearing held via Zoom at a publicly noticed meeting of the Napa County Mental Health Board on Monday, August 8th at 4pm.

Budget Narrative

Napa County will contribute up to $844,750 over the 4.5-year project period to support this statewide project. This amount will support project management and technical assistance provided by Third Sector, fiscal intermediary costs, and evaluation provided by RAND.

TOTAL BUDGET REQUEST BY FISCAL YEAR:

Total budget by fiscal year for the county collaborative portion of the costs.

	FY 22/23	FY 23/24	FY 24/25	TOTAL
Total Napa County Contribution to Collaborative	332,450	428,733	83,567	844,750

Consultant Costs/Contracts

The budget includes $844,750 for contracted services over three years. This includes $650,000 for Third Sector, $69,750 for CalMHSA (9% of Third Sector and RAND costs), and $125,000 for RAND as the Evaluator. The total budget over four years is $844,750.

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY FOR COUNTY-SPECIFIC NEEDS

EXPENDITURES						
PERSONNEL COSTS (salaries, wages, benefits)		**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Salaries	0	0	0	0	0
2.	Direct Costs					
3.	Indirect Costs					
4.	Total Personnel Costs	0	0	0	0	0
OPERATING COSTS		**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
5.	Direct Costs	0	0	0	0	0
6.	Indirect Costs					
7.	Total Operating Costs	0	0	0	0	0
NONRECURRING COSTS (equipment, technology)		**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
8.	Desk, Chair, Computer, Laptop	0	0	0	0	0
9.	Software	0	0	0	0	0
10.	Total Non-recurring Costs	0	0	0	0	0

CONSULTANT COSTS/ CONTRACTS (clinical training, facilitator, evaluation)		**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
11a.	Direct Costs (Third Sector)	295,000	355,000	0	0	650,000
11b.	Direct Costs (CalMHSA)	27,450	35,400	6,900	0	69,750
11c.	Direct Costs (RAND)	10,000	38,333	76,667	0	125,000
12.	Indirect Costs	0	0	0	0	
13.	Total Consultant Costs	332,450	428,733	83,567	0	844,750
OTHER EXPENDITURES (please explain in budget narrative)		**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
14.		0	0	0	0	0
15.		0	0	0	0	0
16.	Total Other Expenditures	0	0	0	0	0
BUDGET TOTALS						
Personnel (line 1)		0	0	0	0	0
Direct Costs (add lines 2, 5 and 11 from above)		332,450	428,733	83,567	0	844,750
Indirect Costs (add lines 3, 6 and 12 from above)		0	0	0	0	0
Non-Recurring costs (line 10)		0	0	0	0	0
Other expenditures (line 16)						
TOTAL INNOVATION BUDGET		332,450	428,733	83,567	0	844,750

BUDGET NARRATIVE FOR TOTAL BUDGET CONTEXT- EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR:

Funding for the project will come from MHSA Innovation funds.

TOTAL BUDGET CONTEXT- EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY):

TOTAL BUDGET CONTEXT- EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)
ADMINISTRATION:

A.	**Estimated total mental health expenditures for <u>ADMINISTRATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Innovative MHSA Funds	332,450	390,400	6,900	0	**719,750**
2.	Federal Financial Participation	0	0	0	0	0
3.	1991 Realignment	0	0	0	0	0
4.	Behavioral Health Subaccount	0	0	0	0	0
5.	Other Funding	0	0	0	0	0
6.	**Total Proposed Administration**	322,450	390,400	6,900	0	**719,750**
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Innovative MHSA Funds	10,000	38,333	76,667	0	**125,000**
2.	Federal Financial Participation					
3.	1991 Realignment					
4.	Behavioral Health Subaccount					
5.	Other Funding					
6.	**Total Proposed Evaluation**	10,000	38,333	76,667	0	**125,000**
C.	**Estimated TOTAL mental health expenditures (this sum to total for funding requested) for the entire duration of this INN Project by FY & the following funding**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**

	sources:					
1.	Innovative MHSA Funds	332,450	428,733	83,567	0	**844,750**
2.	Federal Financial Participation					
3.	1991 Realignment					
4.	Behavioral Health Subaccount					
5.	Other Funding					
6.	**Total Proposed Expenditures**	332,450	428,733	83,567	0	**844,750**

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Request for an extension of the Napa County MHSA Innovations Round 2 Project Addressing the Mental Health Needs of the American Canyon Filipino Community, now known as Filipino Life and Generation Groups or FLAGG, for FY 2022-23

Overview

The MHSA Round 2 Innovation Grant, Addressing the Mental Health Needs of the American Canyon Filipino Community, now known as Filipino Life and Generation Groups or FLAGG, intends to create an intergenerational approach to support Filipino youth in American Canyon. American Canyon middle and high school students self-report (CA Healthy Kids Survey) higher levels of anxiety and depression than their peers. The project focuses on listening, learning, and addressing the root causes and developing meaningful intergenerational interventions to support them.

The project is divided into three phases. Phase 1 focused on building trust, recruiting community, parents, and students, and developing listening sessions to learn about the specific needs and issues that Filipino adolescents were facing. Phase 2 builds on the first phase and develops intergenerational FLAGG (Filipino Life And Generational Groups) working groups to support student mental health within the group itself and within the school community. Peer leadership, training regarding mental health and resilience, and learning about Filipino culture are highlights of Phase 2 activities. Phase 3 has students taking their voice and their learnings forward to the school and community to educate others and influence systems.

Justification for Extension

The project is currently in Phase 2. Because of the pandemic and school closures, most of Phase 2 has been conducted virtually, making it difficult for the project staff to quickly make gains and progress in group cohesion, learning goals and output. As the funding stands, the project must wrap up Phase 2 soon, to provide adequate time for the final phase. Preferably, the project could be extended for another year to provide additional Phase 2 time in-person and on-site to deepen the project impact and provide students with the opportunity to conduct Phase 3 activities in a way that may change systems and deepen community knowledge.

Filipino Life and Generation Groups (FLAGG)
A Filipino Cultural and Wellness Program for ACMS & ACHS Students

Rationale for a FLAGG Program extension and amended funding.

1. Due to Covid restrictions beginning March 2020, FLAGG Coordinators, Student Leaders, Adult Mentors, and members have not met in person. From August 2020 to the present, Leader trainings, member recruitment, weekly group discussions and project surveys were conducted via Zoom and email.

This was always a project limitation, and in our opinion, not a "best practice" for a student wellness group. We believe that conducting FLAGG activities and meetings "in-person", with the advantages of face-to-face discussion and personal connection, will:

a) improve student leadership
b) increase member recruitment
c) improve the quality and depth of group discussions
d) increase participation in project surveys
e) increase student trust and achievement of project goals

With these improvements, we believe that FLAGG's adoption of "in-person meetings", when Covid restrictions are eased and more participants are vaccinated, will certainly provide more insightful and relevant data to analyze the issue of why Filipino-American students report high levels of mental health issues and consistently under-utilize mental health supports.

Extending the FLAGG project, especially considering that our efforts in the 2020-2022 school years have created a core group of students who are now familiar with FLAGG project goals, have developed a strong relationship of trust and caring with each other and the adult Mentors, and have a strong group of student leaders who are ready to continue their leadership responsibilities, will be of immense value in meeting project goals.

2. Despite Covid limitations, FLAGG has found measurable success in analyzing the complex issue of why Filipino-American students report high levels of mental health issues and consistently under-utilize mental health supports. We have uncovered many underlying issues of cultural and familial relevance which we are just beginning to understand and report. Extending the FLAGG project will allow us to better analyze these factors and cultural nuances. It is our hope that this data will allow California educators and school administrators to create practical and useful solutions for the

mental health problems of Filipino-American students.

3. Covid restrictions and weekly meeting limitations (i.e., meeting for only 1 hour on Mondays, due to fear of Zoom fatigue, and cancelling meetings due to school holidays) allowed FLAGG to only reach the project goal of "mental health coping strategies" towards the end of the project timeframe. An extension would benefit the project and all FLAGG members, by allowing more time to share different coping strategies for multiple mental health issues, such as depression, anxiety, stress, etc. To date, FLAGG has partially discussed coping strategies for "depression". There are many more mental health coping strategies to discuss. FLAGG's final project goals of "sharing/learning mental health supports" and "describing the mental health supports that are needed for Filipino families and students", will also benefit from additional time, as these issues are complex.

4. In a short period, FLAGG has developed partnerships with city and community groups, and gained recognition for these efforts. This demonstrates the need for the FLAGG project to continue these relationships, to serve as a contact group for interested 3rd parties seeking advice and information, and to help Filipino-American students via FLAGG activities. These city and community partnerships include:

a) The City of American Canyon (FLAGG received the "Filipino-American History Month Proclamation from the City in October 2020);
b) American Canyon Councilman David Oro (who serves as a FLAGG adult mentor);
c) American Canyon High School and American Canyon Middle School, via FLAGG
d) The City of American Canyon Parks and Recreation Department (via the "Teens Tell" program, sharing poetry and art created during the pandemic. Other youth-centered mental health activities are planned with the Parks & Recreation Department via FLAGG Coordinator Clarence Mamaril, who also serves as a Parks Commissioner;

5. Anti-Asian Hate Crime response. In addition to other mental health problems faced by Filipino-American students and adults, a rising national concern is anti-Asian hate crime. For example, an elderly Filipina-American woman was attacked in New York City, the incident was videoed, and that video shows hotel workers/bystanders not coming to her aid. This is not an isolated incident, nor are Anti-Asian hate crimes a recent development. An anti-Filipino-American hate crime occurred in American Canyon in January 2013, which many Fil-Am residents still remember vividly.

Captain Jennifer Gonzales of the Napa County Police Department reached out to FLAGG in March 2021, to show concern from local law enforcement and to create an appropriate response with Fil-Am students and adults. These efforts, including a rallies in support of victims of Anti-Asian hate crime are ongoing.

Continuation of the FLAGG project will allow additional date gathering on this issue and its effect on Filipino-American students. It will also allow FLAGG to participate in responsive activities (i.e., the upcoming Anti-Asian hate crime rally and demonstration) and develop specific coping strategies and

law enforcement partnerships for this alarming stressor on Asian-American students.

6. Other successful FLAGG outcomes. FLAGG has shown that its basic format (inter-generational meetings with students and adult "mentors" who are not the parents of the student members) works in:

a) Responding to the needs of Filipino-American students identified in the CA Healthy Kids Survey as having multiple mental health issues;
b) Exploring cultural, familial, social and mental health topics relevant to Fil-Am students;
c) Filling an educational niche for Fil-Am students, who did not previously exist; Providing much-needed crisis identification for Fil-Am students who need mental health support, and giving a direct connection to mental health supports via ACHS and ACMS counselors;
d) Providing support for Fil-Am students & adults in a non-judgmental and trusting setting, allowing for mutual respect, and understanding.

In conclusion, we hope that these reasons clearly show that the FLAGG program is deserving of continuation and amended funding. The FLAGG coordinators, student leaders, adult mentors and members have built a solid foundation for mental health and wellness work, and we look forward to more efforts for the well-being of Filipino-American students.

Proposed Funding - *Full or partial funding* of the July 1, 2022 - June 30, 2023, budget of $138,425 would provide:

Project Director 0.10 FTE	$11,300
FLAGG Coordinator 0.25 FTE	$14,125
Social Worker 0.50 FTE	$98,000
Program Supplies	$15,000